Department of Health and Human Services

MaineCare Comprehensive Rate System Evaluation Interim Report

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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

- Table of Contents 2
- List of Tables 2
- Executive Summary 4
- Overview 21
- Evaluation of Current MaineCare Methodologies and Fee Schedules 24
- Stakeholder Comments 35
- Development of Recommendations and Priorities 38
- Implementation Considerations 72
- Appendix A: Stakeholder Engagement 80
- Appendix B: Section Specific Recommendations 116
- Appendix C: Glossary of Terms and Acronyms 140

List of Tables

- Table 1: Priority Groupings 12
- Table 3: Estimated Spending for Medical Supplies and DME 17
- Table 4: Estimated Spending for Hospice 17
- Table 5: Model 1, Median Commercial Fee Schedule 18
- Table 6: Model 2, 67% of Median Commercial Rates for Diagnostic, Preventive, and Endodontic Services; Median for All Others 19
- Table 7: Expenditures by Policy Section 25
- Table 8: Policy Sections with Methodology Review Only 28

- Table 9: Analysis Metrics 28
- Table 10: Summary of Findings 30
- Table 11: Stakeholder Meetings 35
- Table 12: Discussion Questions/Prompts 36
- Table 13: Stakeholder Themes Related to Methodology 37
- Table 14: Stakeholder Themes Related to Rate 37
- Table 15: Methodology Scores 39
- Table 16: Priority Groupings 50
- Table 17: Priority List 53
- Table 19: Estimated Spending for Medical Supplies and DME 75
- Table 20: Estimated Spending for Hospice 76
- Table 21: Model 1, Median Commercial Fee Schedule 76
- Table 22: Model 2, 67% of Median Commercial for Diagnostic, Preventive, and Endodontic Services; 50% of Median for All Others 77

Executive Summary

The Maine Department of Health and Human Services (DHHS or the Department) engaged the firm of Myers and Stauffer, LLC, to conduct the following activities:

- Evaluate MaineCare's rates and rate setting methodologies for MaineCare provider reimbursement.
- Develop recommendations to create a comprehensive, streamlined, and coherent system to set rates for specific services and programs.
- Develop a draft plan to implement recommendations.

The goal of the Department is to establish and maintain Medicaid program rates that are sufficient to sustain the financial viability of Maine providers, thereby ensuring that MaineCare members have access to high value services, as required by Section 1902(a)(30)(A) of the Social Security Act.[1]

This interim report provides Myers and Stauffer's recommendations to MaineCare for developing a plan to update and maintain rate methodologies, a priority list for implementing those recommendations, implementation steps for the first year, and estimated costs for the implementation. Myers and Stauffer's recommendations consider the following:

- Guiding principles for rate methodologies based on best practices for rate development across state Medicaid agencies and Medicare (defined in the report that follows).
- The assessment of MaineCare rates in comparison to Medicare rates, selected state Medicaid agency rates, and payment by commercial health plans in Maine.
- How long it has been since the last update to rates.

[1] Although states have flexibility in setting the amounts that they are willing to pay for health care services, Title XIX sets a ceiling and a floor on payments; i.e., the rates have to be low enough to encourage efficiency and economy but high enough to incentivize quality and participation. Section 1902(a)(30)(A) of the Social Security Act states, in part "A State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Source: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

- The Department's strategic goals, including, where feasible, those related to Alternative Payment Models (APMs).[2]
- Stakeholder comments regarding the impact of rate methodologies and adequacy of rates.

The final report, to be issued at the end of February 2021, will build upon this interim report by including more detail on the individual recommendations and a more refined implementation plan.

Recommendations for the Development, Review and Updating of Rates and Rate Methodologies

The review of the current methodologies and fee schedules, interviews with Department staff, and stakeholder feedback indicate the following themes:

- Inconsistency in frequency of, basis and rationale for, and implementation of updates across policy sections
    - MaineCare updates methodologies and payment rates regularly (e.g., annually) for some policy sections, whereas there have been no updates in many years for others. Fee schedules based on Medicare rates for a certain year, for example, are now out of date and contain inconsistencies as new codes and rates are added in subsequent years, creating inequities across providers, and potential financial incentives for the delivery of some services in favor of others because of the payment rates.
    - For some policy sections, there is no regular update process, and for others MaineCare updates the rates due to legislation. Updates do not necessarily address policy sections based on relative need to improve member access or to address methodologies to better support the delivery of high value care. Further, the often ad hoc nature of the rate increases requires unplanned administrative time and support for implementation.
    - For some policy sections, MaineCare has conducted cost studies, but the Department did not implement rates due to internal decisions or prohibition by the Legislature because rates would have decreased. This suggests that some providers may be overpaid, and/or that the methodology should be examined further.

[2] Department goals address health, safety, resilience, and opportunity for MaineCare members, and with regard to APMs, the Department has established a goal of moving at least 40 percent of MaineCare payments for full MaineCare members to value-based APMs by the end of 2022. Source: OMS, Value-Based Purchasing Unit "Health Homes Regional Forums 2020" Presentation. November 17, 2020.

- Burdensome processes to update rates
  - Some rates are in statute, which requires new legislation to execute a change to a methodology or an inflation update.
  - While some sections of the MaineCare Benefits Manual (MBM) reference methodologies and/or online fee schedules that can be updated without the need for rulemaking, most sections currently include the rates in the rules themselves.[3] Inclusion of rates in rule can result in a lengthy rulemaking process when changes, such as the addition of a new service code, a national coding change, or annual inflation adjustments, occur.
- Inconsistency in benchmarks and rate amounts for similar services
  - Some providers are paid at varied reduced percentages of the Medicare fee schedule without a rationale for the differences between services. Nationally, while payers commonly apply a reduction to the physician fee schedule for non-physician practitioners, a common percentage is generally applied across provider types.
  - There are comparable services across policy sections that have different assigned rates. For example, within Home and Community-Based Services (HCBS), some payment rates for certain similar services differ without a clear reason.
- Rate methodologies are administratively complex and/or do not promote provision of high-value services
  - MaineCare uses reimbursement with cost settlement for a number of policy sections, a process that provides little incentive for the provision of high quality, integrated, coordinated, and effective care. Under retrospective systems, the amount paid is determined based on the provider's reported costs after the services are rendered. These programs can be costly to administer for the Department and are complex for providers. Prospective rates, in contrast, are set in advance and are known by all parties before services are provided.
  - Stakeholders expressed concern about the administrative complexities of prospective payment methodologies and billing requirements for various policy sections.

General recommendations about development of rate methodologies and processes for maintaining and updating rates are described below.

[3] https://www.maine.gov/sos/cec/rules/10/ch101.htm. For example, Section 90 Physicians indicates that rates are 70% of 2009 Medicare -- or the year a new code came into existence -- and all rates are then published online.

Recommendation: Implement the Rate Methodology Plan to Provide Direction for Future Rate Reviews

- Implement a reimbursement methodology plan that provides for regular, scheduled updating of methodologies and rates. This approach can replace the ad hoc, reactive process that MaineCare defaults to now to develop rates. A planned approach with timelines for review and updates gives legislators, providers, and MaineCare a schedule that advises when methodologies are to be reviewed and when rate increases may occur based on planned analyses.
- To address special circumstances that may arise for providers or MaineCare, consider use of an advisory body to review specific requests outside of the planned schedule. Some Medicaid agencies use a stand-alone advisory group that meets periodically.

Recommendation: Use a consistent and standard basis for developing rate methodologies and updating rates.

- Develop prospective rates wherever possible and move away from cost-settled systems that require cost settlements and that do not include other incentives for cost efficiencies. These are systems for a wide range of services, including hospital-based physicians, private psychiatric hospitals, Critical Access Hospitals (CAHs), nursing facilities, Intermediate Care Facilities (ICFs), and Private Non-Medical Institution (PNMI) Appendices E and F.
- Use Medicare methodologies and fee schedules where they exist, which may limit administrative burden for MaineCare staff and providers, especially those who also bill Medicare. Medicare methodologies and fee schedules are updated annually and provide a logical and tested basis for rates.
- Use consistent percentage benchmarks of the Medicare fee schedule. Even when a change to a consistent Medicare benchmark is fiscally neutral overall for a section of policy, it is important for purposes of promoting consistency and equity. Providers shared that they may currently base their business model around providing certain services where codes were added in more recent years and thus paid at a proportionally higher rate than for other services. This can result in a delivery system where availability of services may be driven disproportionately by differential rates versus by member access needs.
- Develop a consistent and logical approach to paying for new services/codes, and reviewing the payment amounts to assure consistency with other rates and appropriate financial incentives.
- Continue the use of rate studies that incorporate cost surveys for HCBS waivers, community-based behavioral health, and other identified services for which there are no Medicare methodologies and services are provided in a community-based setting or through a model that is unique to Maine. In particular, for HCBS waiver services, the Center for Medicare and

Medicaid Services (CMS) considers services that are classified as high cost and high volume as those where a rate study would be most appropriate.[4]

- Purchase a relative value, charge, or other database to determine appropriate rates for dental services. Alternatively, MaineCare could implement a more consistent approach by creating its own fee schedule using the data from Maine's All Payer Claims Database (APCD) to develop rates based on percentiles of allowed amounts, median amounts, etc. MaineCare should specifically address stakeholder concerns regarding adequate reimbursement for preventive dental services.
- Develop a methodology to incorporate supplemental payments into base rates for inpatient and outpatient hospital services, including hospital-based physician services. Consider this approach for CAHs as well as acute care hospitals. Retain a portion of the supplemental payment as an APM or ensure that base rates otherwise reflect a value-based model to increase hospital accountability for performance.
- Evaluate differential costs based on site of service (e.g., care in a hospital versus clinic-based setting or ambulatory care center). The Myers and Stauffer analysis showed that services billed with comparable procedure codes are paid at a higher rate in the outpatient hospital department than in the ambulatory surgical setting, even though MaineCare payment for ambulatory surgical centers (ASCs) is high in comparison to other payers. MaineCare should therefore consider reducing rates to outpatient hospitals for certain services delivered in the ASC setting where rates for those services are lower.[5] Decisions about revising payment rates should consider access, quality and other factors that might influence MaineCare's decisions about reducing rates. MaineCare should also consider incentivizing the use of less costly settings through APMs that reward provider cost efficiency.
- Determine if and how wage differences in urban and rural locations and/or municipalities that have their own minimum wages should be addressed in the rate methodology and rates. Wage differences across a state do not always signal a need for separate rates.
- Where payment methodologies create billing and other administrative complexities, consider opportunities to resolve those as payment methodologies are updated.

[4] https://leadingage.org/sites/default/files/3_-_National_Trends_in_1915%28c%29_Fee-for-Service_Rates_-_Final.original.1566476475.pdf.

[5] CMS is moving toward a goal of reducing the payment disparity in Medicare payments across settings. Source: https://www.cms.gov/newsroom/press-releases/cms-empowers-patients-and-ensures-site-neutral-payment-proposed-rule.

Recommendation: Review and update methodologies and rates on a standard schedule.

- Regularly review each methodology to determine if the methodology continues to result in rates that support MaineCare goals and objectives.
    - For services where MaineCare uses the Medicare fee schedule: Update no less frequently than once every three years, and as MaineCare evaluates methodologies, assess whether APMs might enhance or replace methodologies in use.
    - For other policy sections (e.g., where MaineCare is relying on cost reports): Base the timing of the methodology reviews on changes in the utilization or delivery of services, but at least every 5 years.[6]
        - Incorporate the review of assumptions used in the rate models, e.g., staffing and productivity, definition and use of peer groups, cost components, and ceilings on components of costs.
        - Where models based on updated analysis indicate rate decreases for certain services, confirm that the assumptions are valid. Where valid, implement reductions, potentially through a phased-in approach depending on resulting provider financial impact.
    - Stagger the methodology reviews for different policy areas and publish a schedule so that the Legislature and stakeholders will be aware of when reviews will occur. The schedule should take into account the priorities recommended in this report, and group policy sections where there is overlap in the services provided to ensure consistency in rates across the same services.
- Review paid claims history for new codes for which MaineCare has established payment amounts, and adjust rates when sufficient claims history is available, usually within 12 months of the rate being in place. Compare rates to rates used by Medicare and other states and determine whether to make adjustments.
- In addition to the scheduled methodology review and update, update rates every 1 to 2 years in years where there is no methodology update to reflect health care cost inflation in Maine. Some states include the process for inflation updates in their State Plans, with further clarification that the updates will only be made if the Legislature appropriates funding to support them.
- Conduct updates of fee schedules that are benchmarked to Medicare no less frequently than once every three years to maintain their integrity. Medicare updates include changes to fee schedule amounts, provide new code definitions, relative values, grouping assignments, etc.,

[6] Section 1915 of the Social Security Act requires that all HCBS waiver methodologies be reviewed every 5 years. https://www.ssa.gov/OP_Home/ssact/title19/1915.htm.

and delete outdated codes. Medicaid agencies and other payers implement these changes to keep billing and payment systems up to date. Other states regularly update fee schedules they model based on Medicare to maintain consistency with Medicare and to give providers consistency in managing their billing and receivables monitoring.

- Develop a process to determine whether and how to address changes subsequent to the rebase that affect prior rate assumptions, such as minimum wage changes or public health emergencies.

Recommendation: Make other adjustments to rates to move payments toward APMs and higher value care.

- Implement performance-based payments, including shared savings and downside risk programs, for services as possible.[7] For proposed rate increases, make at least some of the increase only payable if providers meet certain criteria. Similar to other states, MaineCare could phase in an approach for a specific service that first relies on reporting data, and then develop incentives and/or penalties designed to change specific provider behavior.
- Identify opportunities to bundle services into value-based payments that incent policy goals and support provider innovation, while providing greater flexibility and administrative simplicity.
- Work with other DHHS offices to coordinate rate reviews with policy initiatives to ensure that MaineCare rates and methodologies incent providers in a way that reflects the population needs and goals identified by these offices in accordance with Departmental priorities.

Priorities for Rate Methodology Reviews and Changes

Myers and Stauffer developed the prioritization of rate reviews by policy section or groups of services, using information drawn from various sources, as follows:

- Information about MaineCare methodologies, sources of data used in the methodologies, and the time elapsed since the last rate review and fee schedule adjustment.
- The comparison of MaineCare rates for each section of MaineCare policy to rates for Medicare and select state Medicaid programs. Myers and Stauffer reviewed MaineCare rate information for specific codes against Medicare rates and a sample of services and corresponding rates in five comparison states (Connecticut, New Hampshire, Vermont, North Carolina, and Montana), selected based on geographic location and because of the use of APMs in a fee-for-service (FFS) Medicaid environment. Myers and Stauffer also compared estimated allowed amounts from

[7] Providers and MaineCare would share in savings when spending is lower than expected. In downside risk programs, providers would pay MaineCare when spending is higher than expected. Source: http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_18_aco_final_sec.pdf?sfvrsn=0.

commercial health plans in Maine using the Maine Health Data Organization's (MHDO's) APCD, which is a collection of claims data for Maine residents submitted by commercial insurance carriers, third party administrators, and others. For each code, we generated a number of metrics for comparison purposes, and summarized these findings in workbooks for each policy section or groups of policies. These workbooks may be found at https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/mainecare-rate-system-evaluation.[8]

- The rate comparisons did not include a comparison of underlying rate assumptions for rates from other payers or an analysis of broader state economic factors, as doing so would have greatly increased the scope of work and corresponding time and resources needed for completion. The rate comparison serves to identify where MaineCare rates fall in comparison to rates from a selection of other payers, to highlight services where MaineCare is clearly out of alignment, and to determine services where MaineCare should conduct a more in-depth analysis to determine if the methodology and rates are appropriate.
- Input from MaineCare providers, members, and advocacy organizations regarding the adequacy of rates and impact of current payment methodologies, compliance with Federal regulations, and the degree of opportunity to improve value by improving quality and/or reducing overall cost through value-based purchasing (VBP) and APMs. The report summarizes the general themes associated with the comments of these individuals and organizations.
- Interviews with DHHS leadership regarding Department goals and priorities.

Priorities for Implementing Recommendations

MaineCare does not currently have a process for periodically reviewing rate methodologies and rates, and several of the methodologies and rates have not been updated in many years. However, MaineCare may not be able to implement all of the recommendations, from either an operational, administrative, or a financial perspective. Operationally, the review and development of new methodologies and rates can require significant time. MaineCare could contract with an external consultant to conduct methodology studies; however, staff time is still needed for tasks including but not limited to managing the reimbursement project, working with consultants, reviewing and making policy decisions, and programming changes in the state's Medicaid Management Information System (MMIS). Administratively, new methodologies most often require a combination of legislation, development of rules, submission of State Plan Amendments, coordination of efforts with impacted DHHS Offices, and other tasks. Finally, for many services, funding must be appropriated in order to support changes.

[8] The Comparison Workbooks, posted on November 30, 2020, have been updated with corrections; new workbooks and a log of changes are provided.

To help address these challenges, Myers and Stauffer has developed priority groupings for implementing recommendations, as set forth in Table 1.

Table 1: Priority Groupings

Group	Description	MaineCare Benefits Manual Policy Sections[9]
A	Address these policy sections first to address payment methodology principles related to access to services, equity for providers across policy sections, transparency, and updating frequency. Community-based behavioral health services (BHS) that support individuals transitioning from higher-level settings are also included in this group. Recommendations address multiple policy sections that MaineCare should evaluate concurrently. This group of services has a number of low and high outliers in the comparisons of MaineCare rates, and for some policy sections, there is an opportunity to rebalance rates within the policy section and to achieve savings.[10] There is also the potential for MaineCare to consider APMs as new methodologies and fee schedules are implemented.	• 5 Ambulance • 13 Targeted Case Management (TCM) • 60 Medical Supplies and Durable Medical Equipment (DME)* • 97-E Private Non-Medical Institutions (PNMI-E) Community Residences for Persons with Mental Illness • 25 Dental • 40 Home Health • 90 Physician Services • 85 Physical Therapy (PT) • 68 Occupational Therapy (OT) • 95 Podiatric Services • 75 Vision Services • 15 Chiropractic Services • 14 Advanced Practice Registered Nurse/Certified Registered Nurse Anesthetist (APRN/CRNA) • 109 Speech and Hearing • 30 Family Planning Agency • 101 Medical Imaging • 3 Ambulatory Care Clinics • 94 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) • 23 Developmental and Behavioral Clinic • 55 Laboratory • 65 Behavioral Health Outpatient Services** • 7 Free-Standing Dialysis • 91 Health Homes* • 28 Rehabilitation and Community Support for Children • 43 Hospice

[9] https://www.maine.gov/sos/cec/rules/10/ch101.htm.

[10] Low outliers are defined as procedure codes with a MaineCare percentage of the overall other state Medicaid / Medicare comparison rate below 40 percent; high outliers are defined as procedure codes with a MaineCare percentage of the overall other state Medicaid / Medicare comparison rate above 120 percent. The outlier thresholds (low = is 40 percent of comparison, high = 120 percent of comparison) are symmetrical (+/- 40 percentage points) around a midpoint of 80 percent of comparison. It is standard to define outliers in relation to the distribution of data points for the dataset at hand. Given that most MaineCare rates fall below 100 percent of comparison, it is reasonable to have the midpoint be below comparison than 100 percent of comparison.
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Group	Description	MaineCare Benefits Manual Policy Sections[9]
B	Policy sections in Group B primarily represent institutional and hospital settings. Addressing these policy sections may be more complex than addressing recommendations in Group A, but implementation of recommendations would provide meaningful payment methodology reform and movement toward APMs.	• 45 Inpatient Hospital • 46 Inpatient Psychiatric Hospitals • 45/46 Hospital Based Physicians • 50 Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) • 67 Nursing Facility • 97-C PNMI-C Medical and Remedial Service Facilities
C	For policy sections in Group C, MaineCare has recently rebased or updated rates, but there is sometimes incongruence between rates for the same services provided across different policy sections. MaineCare should review these services together to reduce the instances of rate inequities.	• 18 HCBS for Adults with Brain Injury* • 20 HCBS for Adults with Other Related Conditions* • 21 HCBS for IDD/DD* ** • 29 Support Services for Adults with IDD* or Autism • 102 Rehabilitative Services • 17 Community Support Services • 19 HCBS for Elderly and Adults with Disabilities* • 12 Consumer Directed Attendant* • 26 Day Health Services • 96 Private Duty Nursing and Personal Care* • 92 Behavioral Health Homes • 93 Opioid Health Homes*
D	Policy sections in Group D represent remaining residential settings that are not addressed in the above Groups. These sections have methodologies, but they need to be reviewed and rebased. Reviewing this Group at the end of the process will allow other system rates to be adjusted and for the community-based system of care to respond and react prior to examining the impact on residential settings.	• 97-B PNMI B Substance Abuse Treatment Facilities** • 97-D PNMI-D Child Care Facilities** • 97-F PNMI-F Non-Case Mixed Medical and Remedial Services • 2 Adult Family Care Homes • 107 Psychiatric Residential Treatment Facility (PRTF)
E	Little or no MaineCare action needed. There may be opportunities related to APM development for some of these policy sections.	• 9 Indian Health Services (IHS) • 31 Federally Qualified Health Centers (FQHC) • 103 Rural Health Clinics (RHC) • 4 Ambulatory Surgical Center (ASC) Services • 45 Hospital Acute Outpatient

**Rate methodologies have recently been updated or are in the process of being updated.*

***A rate study is currently in progress (Sec 65 Intensive Outpatient Programs, PNMIs B & D, Sec 21 waiver homes).*

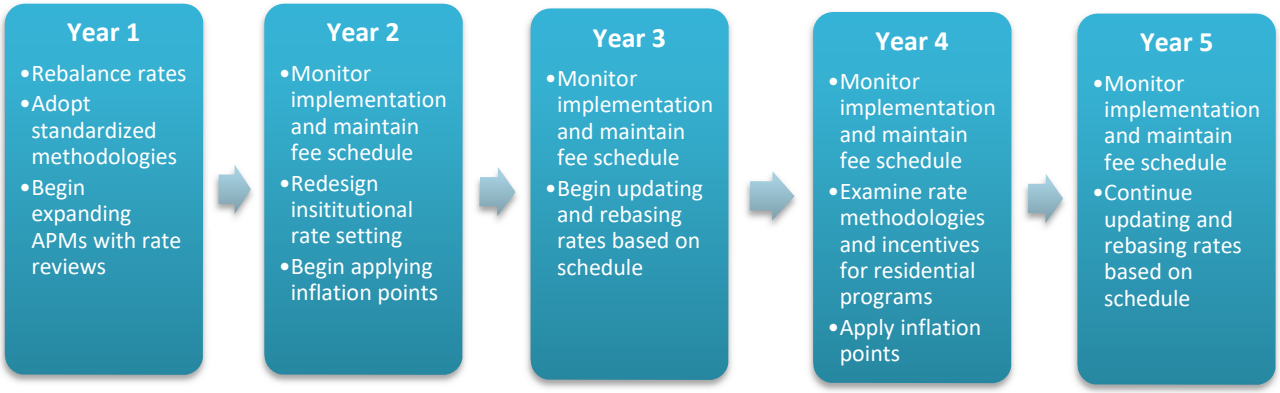
Implementation Considerations

Myers and Stauffer is developing a long-term work plan and timeline for implementing the recommendations according to the priorities established above that will be presented in the February final report. At this time, with input from MaineCare, Myers and Stauffer estimates that:

- Group A recommendations could likely be implemented within a two-year timeframe, to allow for multiple rulemakings to go through the Administrative Procedure Act process and to be approved by CMS.
- All recommendations could be implemented within five years.
- Two additional full-time equivalents (FTEs), at a cost of $230,798 per FTE per biennium are estimated as necessary to implement the long-term plan.
- The total cost of conducting rate studies over the five-year period will be up to $2 million for up to ten rate studies and for other consultant costs.

Figure 1 outlines a framework that specifies a series of tasks to cover a 5-year period for rate development, implementation, monitoring, and updates.

Figure 1: Five Year Implementation Process



Costs of Implementing New Rates

In addition to the administrative costs to MaineCare to implement the recommendations, there are Medicaid program fiscal impacts associated with implementing rate change recommendations according to the prioritization ranking. Myers and Stauffer developed estimates of fiscal impacts associated with fee schedule changes for those policy sections where specific fee schedules are recommended. For other policy sections, there are recommendations that require additional study, including rate reviews or assessments, to determine the amount of any fiscal impact.

Implementation of Updated Fee Schedules

To develop the spending estimates shown below, Myers and Stauffer compared 2020 MaineCare rates for codes in each policy section described, to the 2020 Medicare fee schedule, and for dental rates, a fee schedule modeled using Maine commercial rates. Spending estimates assume that the volume and mix of services stay constant, and include both federal and state dollars. The models presented below could be adjusted to increase or decrease estimated changes in current spending, and also phased in as necessary over multiple years based on the availability of funding.

- Physicians, APRNs, Medical Imaging, Speech Therapy, Chiropractic, CRNA, Vision, Podiatry, Occupational Therapy, and Physical Therapy. Myers and Stauffer recommends updating rates for policy sections paid according to the Medicare Physician Fee Schedule (PFS), and using comparable percentages of the Medicare PFS for two groups of policy sections: Physicians and APRNs; and Medical Imaging, Speech Therapy, Chiropractic, CRNA, Vision, Podiatry, Occupational Therapy, and Physical Therapy. The objective is to implement a rate model that would pay each of these groups using the same percentage of Medicare, and at the same time, implement the model for each group that would not result in a net decrease in total expenditures for any of the policy sections in that group. That is, while a rate update can result in either some codes experiencing a rate decrease or a rate increase, the total payments within a policy section will remain the same, assuming the current mix and volume of services stay constant.

  Myers and Stauffer developed a physician fee schedule model that is based on applying 71.4 percent[11] of the 2020 Medicare PFS rates to all providers except for the Affordable Care Act (ACA) rates intended for independent primary care physicians (ACA),[12] who would continue to be paid 100 percent of the Medicare PFS.[13] The rate model assumes that there will be only minor changes to overall payments to physicians (ACA) in the aggregate, and that the providers of services for all but one of the other policy sections will be paid rates that are higher in the aggregate than current levels. Table 2 summarizes the estimated change in Medicaid spending

[11] 71.4 percent is from the fact that Medical Imaging (Section 101) current rates are at 71.4 percent of 2019 Medicare, so increasing all other non-physician providers to 71.4 percent is the least costly way to achieve a uniform percentage among non-physician providers while ensuring no aggregate level reduction to any policy sections.

[12] The ACA required that states pay primary care providers 100 percent of Medicare rates in CY2 2013 and 2014 for certain primary care and emergency department codes. This did not apply to hospital-based physicians in Maine because they are cost settled or to physicians in FQHCs, Rural Health Clinics, and Indian Health Clinics due to the fact that they received cost-based encounter rates. MaineCare has continued these rates since the requirement ended in 2015.

[13] It should be noted, however, that MaineCare's current rates for these services are higher than the comparison rates – MaineCare rates average 114.1 percent of the comparison rates – so there is potentially room for reduction.

using the fee schedule, and the number of codes for which rates increase and the number of codes for which rates decrease within each policy section.

Table 2: Model 1, Estimated Change in Medicaid Spending by Policy Section for Services Paid using Medicare PFS

Section	Modeled Current Spending[14]	Current Average % of Medicare (Using 2020 Medicare PFS)	Modeled % of Medicare PFS	Estimated Change from Modeled Current Spending *	Estimated Change as % of Modeled Current Spending	Number of Codes with Rates that would Increase	Number of Codes with Rates that would Decrease
Medical Imaging (Section 101)	$8,672,175	71.4%	71.4%	$0.00	0.0%	265	146
Speech Therapy (Section 109)	$8,434,182	70.2%	71.4%	$143,370	1.7%	23	9
Chiropractic (Section 15)	$1,117,329	55.7%	71.4%	$315,187	28.2%	37	15
CRNA (Section 14)	$9,152,310	48.9%	71.4%	$4,210,255	46.0%	201	0
Vision (Section 75)	$13,138,345	59.4%	71.4%	$2,659,564	20.2%	34	15
Podiatric (Section 95)	$1,215,792	43.4%	71.4%	$782,117	64.3%	222	3
OT (Section 68)	$3,810,591	33.9%	71.4%	$4,211,451	110.5%	21	2
PT (Section 85)	$1,915,000	36.6%	71.4%	$1,817,444	94.9%	25	0
Physician (ACA) (Section 90)	$11,757,860	100.0%	100.0%	$125,785	1.1%	52	25
Physician (Non ACA) (Section 90)	$140,984,729	64.20%	71.4%	$15,707,478	11.1%	2626	708
APRN (Section 14)	$13,042,739	67.7%	71.4%	$703,907	5.4%	8	12
Total				**$30,676,556**	**14.4%**	**3515**	**935**

* *Includes state and federal spending.*

- Medical Supplies and Durable Medical Equipment. Myers and Stauffer recommended making adjustments to the DME fee schedule to apply urban and rural differentials, comparable to the methodology Medicare uses for DME rates. Adjusting rates to 100 percent of the 2020 Medicare

[14] Modeled current spending calculated as: 2019 units multiplied by 2020 rates.

fee schedule results in a reduction in MaineCare Medicaid spending as shown in Table 3. Rates for 576 codes increase, while rates for 170 codes decrease.

Table 2: Estimated Spending for Medical Supplies and DME

Section	Modeled Current Spending	Current Average % of Medicare	% of Medicare	Estimated Change from Modeled Current Spending*	Estimated Change as % of Modeled Current Spending	Number of Codes with Rates that would Increase	Number of Codes with Rates that would Decrease
DME (non-Cures) (Section 60)[15]	$10,724,601	101.2%	100%	-$131,624	-1.2%	575	111
DME (Cures) (Section 60)	$4,129,018.16	131.8%	100%	-$997,389	-24.2%	1	59
Total				**-$1,129,013**	**-7.6%**	**576**	**170**

**Includes state and federal spending*

- Hospice Services. Myers and Stauffer recommends decreasing hospice rates to 100 percent of the current CMS Medicaid fee schedule.[16] For hospice services, we used the 2020 CMS-approved Medicaid rates as the basis for a fee schedule. Adjusting rates to 100 percent of the CMS Medicaid rates results in a reduction in MaineCare spending, as shown in Table 4. Overall, rates for four codes increase and rates for one code decrease (out of a total seven codes in this section).

Table 3: Estimated Spending for Hospice

Section	Modeled Current Spending	Current Average % of CMS Medicaid	% of CMS Medicaid	Estimated Change from Modeled Current Spending *	Estimated Change as % of Modeled Current Spending	Number of Codes with Rates that would Increase	Number of Codes with Rates that would Decrease
Hospice (Section 43)	**$1,855,103**	**112.3%**	**100.0%**	**- $207,679**	**-11.2%**	**4**	**1**

**Includes state and federal spending.*

[15] Refers to the 21st Century Cures Act https://www.fda.gov/regulatory-information/selected-amendments-fdc-act/21st-century-cures-act which prohibits federal financial participation payments to states for certain DME.
[16] For each of the hospice procedure codes with MaineCare fee schedule rates, we based our analysis on a single locality; the paid amounts in our database represent the "average paid" amounts, not the actual fee schedule in place for each geographic area that is adjusted.

- Dental Services. Myers and Stauffer recommends that MaineCare increase dental rates. We developed two Medicaid spending estimates. In Model 1 as shown in Table 5, we apply a fee schedule using rates based on the 50th percentile (median) of estimated allowed amounts for commercial health plans in Maine in 2019. In Model 1, rates for 165 codes increase and rates for 10 codes decrease.

Table 4: Model 1, Median Commercial Fee Schedule

Sub-Section	Modeled Current Spending	Current Average % of 2019 Commercial Median	Proposed % of Median Commercial Rates	Estimated Change from Modeled Current Spending*	Estimated Change as % of Modeled Current Spending	Number of Codes with Rates that would Increase	Number of Codes with Rates that would Decrease
Diagnostic Services	$2,772,016	28.9%	100.0%	$6,822,256	246.1%	18	3
Preventive Services	$3,925,840	38.9%	100.0%	$6,159,368	156.9%	13	1
Endodontics Services	$404,873	24.4%	100.0%	$1,254,594	309.9%	15	0
Restorative Services	$4,874,226	41.1%	100.0%	$6,998,929	143.6%	24	0
Periodontics Services	$35,631	19.8%	100.0%	$144,435	405.4%	8	0
Prosthodontics (Removable) Services	$221,234	34.1%	100.0%	$426,861	192.9%	31	0
Prosthodontics (Fixed) Services	$794	28.5%	100.0%	$1,996	251.4%	3	0
Maxillofacial Prosthetics Services	$1,050	40.4%	100.0%	$1,550	147.6%	2	0
Oral and Maxillofacial Surgery Services	$4,860,365	48.1%	100.0%	$5,240,722	107.8%	30	3
Orthodontics Services	$196,683	37.3%	100.0%	$329,930	167.7%	4	3
Adjunctive General Services	$1,645,134	52.2%	100.0%	$1,506,206	91.6%	17	0
Total				**$28,886,847**	**45%**	**165**	**10**

* *Includes state and federal spending.*

Model 2, by contrast, sets rates at a percentage of the median commercial rate, but pays a higher percentage for diagnostic, preventive, and endodontics services than for other services, given that use of these services is associated with improved dental health. In Table 6 we apply a fee schedule based on 67 percent of the median of estimated allowed amounts for commercial health plans in Maine for diagnostic, preventive, and endodontics, and 50 percent of the median for all other dental services. Overall, in Model 2, rates for 141 codes increase and rates for 34 codes decrease.

Table 5: Model 2, 67% of Median Commercial Rates for Diagnostic, Preventive, and Endodontic Services; Median for All Others

Sub-Section	Modeled Current Spending	Current Average % of 2019 Commercial Median	Proposed % of Median Commercial Rates	Estimated Change from Modeled Current Spending *	Estimated Change as % of Modeled Current Spending	Number of Codes with Rates that would Increase	Number of Codes with Rates that would Decrease
Diagnostic Services	$2,772,016	28.9%	67.0%	$3,656,146	131.9%	15	6
Preventive Services	$3,925,840	38.9%	67.0%	$2,831,250	72.1%	13	1
Endodontics Services	$404,873	24.4%	67.0%	$706,970	174.6%	15	0
Restorative Services	$4,874,226	41.1%	50.0%	$1,062,352	21.8%	20	4
Periodontics Services	$35,631	19.8%	50.0%	$54,402	152.7%	7	1
Prosthodontics (Removable) Services	$221,234	34.1%	50.0%	$102,814	46.5%	29	2
Prosthodontics (Fixed) Services	$794	28.5%	50.0%	$601	75.7%	3	0
Maxillofacial Prosthetics Services	$1,050	40.4%	50.0%	$250	23.8%	1	1
Oral and Maxillofacial Surgery Services	$4,860,365	48.1%	50.0%	$190,179	3.9%	23	10
Orthodontics Services	$196,683	37.3%	50.0%	$66,624	33.9%	3	4
Adjunctive General Services	$1,645,134	52.2%	50.0%	-$69,464	-4.2%	12	5
Total				**$8,602,124**	**45%**	**141**	**34**

* *Includes state and federal spending.*

Rebalancing Rates with Current Fee Schedules

In addition to recommendations that change fee schedule amounts, Myers and Stauffer recommended changes to fee schedules to "rebalance" them, i.e., change outdated fee schedules to be consistent with current Medicare fee schedules. Myers and Stauffer modeled these changes to have a net neutral fiscal impact on each policy section, that is, Medicaid spending would be no more or less in the aggregate for each policy section, assuming the current mix and volume of services stay constant.

Myers and Stauffer recommended applying more current fee schedules and rebalancing the rates for Laboratory services. Rebalancing results in an increase in rates for 36 codes, and a decrease in rates for 806 codes.

Overview

Objectives of the Study

The Maine Department of Health and Human Services (DHHS or the Department) engaged the firm of Myers and Stauffer, LLC, to conduct an evaluation of MaineCare's rates and rate setting methodologies for MaineCare provider reimbursement, to develop recommendations to create a comprehensive, streamlined, and coherent system to set rates for specific services and programs, and to develop a draft plan to implement recommendations. The goal of the Department is to establish and maintain Medicaid program rates that are sufficient to sustain the financial viability of Maine providers, thereby ensuring that MaineCare members have access to high value services, as required by Section 1902(a)(30)(A) of the Social Security Act.[17]

The Department is interested in further advancing value-based models of care within the MaineCare program. A successful value-based care approach not only raises the bar for quality of services, but positively impacts health outcomes for MaineCare members, improves accessibility of services, reduces disparities, develops and sustains coordination of care, improves provider and member satisfaction, and reduces the total cost of care provided to MaineCare members.

The development of recommendations related to MaineCare's rate setting system incorporates, where feasible, consideration of the Department's goals related to Alternative Payment Models (APMs). The Department has established a goal of moving at least 40 percent of MaineCare payments for full MaineCare members to value-based Alternative Payment Models (APMs) by the end of 2022.[18] The MaineCare Value-Based Purchasing (VBP) strategy currently includes a number of interrelated efforts, including Accountable Communities, Health Homes, Behavioral Health Homes, and Opioid Health Homes. In 2021, MaineCare is implementing a new value-based payment model that will simplify and integrate the current Primary Care Case Management Program, primary care Health Homes, and the Primary Care Provider Incentive Program (PCPIP).

[17] Although states have flexibility in setting the amounts that they are willing to pay for health care services, Title XIX sets a ceiling and a floor on payments; i.e., the rates have to be low enough to encourage efficiency and economy but high enough to incentivize quality and participation. Section 1902(a)(30)(A) of the Social Security Act states, in part "A State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Source: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

[18] OMS, Value-Based Purchasing Unit "Health Homes Regional Forums 2020" Presentation. November 17, 2020.

Limitations of the Study

Myers and Stauffer used publicly available data, including fee schedules, from select other states' Medicaid programs, Medicare, and Maine commercial health plans, to help understand how the current MaineCare rates and methodologies compare to other payers' rates and methodologies. In the development of recommendations and priorities for revising methodologies and fee schedules, there were a number of limitations:

- State agencies maintain more detailed information about fee schedules and policies that may not be reflected in the information that is public. Methodologies that other state Medicaid programs use, and the resulting rates, are specific to the states' overall policies and economic environment. In other words, we may be taking information out of context in a rate comparison. For example, a state may intentionally have a low rate for a certain code to encourage utilization of another code, or another service. We have addressed that limitation by relying on more than just a rate comparison for the development of recommendations, and by recommending further study prior to assuming savings or investments for services that have rates based on rate studies.
- We could not provide comparisons to other states, Medicare, or commercial health plans for every service for which MaineCare pays because of differences in covered benefits, or how services are organized. In some cases, this reduced the number of comparison points. Apparent differences in rate levels may not always be meaningful: they could be due to limited sample sizes, and/or differences in payment methodologies and/or services covered. Additional research may be necessary to understand these variations.
- The rate comparisons did not include a comparison of underlying rate assumptions; to do so would have increased the scope of work and the time needed to complete it exponentially. The rate comparison serves to identify where MaineCare rates fall in comparison to rates from a selection of other payers, and to highlight services where it is clear that MaineCare is out of alignment, and services where MaineCare should conduct further study and more in-depth analysis to determine if the methodology and rates are appropriate.
- Stakeholders provided valuable feedback to MaineCare about service delivery, but they raised some issues that cannot be addressed through a change in payment methodology or rates and were not within scope of this study (e.g., billing rules or prior authorization requirements). We have included those stakeholder comments in our summaries, however, for further MaineCare reference.
- In some cases, our recommendations for reimbursement methodologies and rates are specific to a policy section or a related group of policy sections, but have to be considered in context of the changing MaineCare environment. For example, MaineCare has implemented and continues

to enhance its APMs and as recommendations are implemented, they must work in tandem or be complementary to those models. Further, we recognize that an APM in one policy section may require a modification to a recommendation in another.[19]

- The study was limited in terms of time and scope. We did not endeavor to provide detailed recommendations regarding particular points of specific methodologies. For example, stakeholders expressed concern about how costs are determined to be "allowable" in the development of payment rates that are based on components of cost with cost ceilings. In this case, we do not recommend in this report how allowable costs and cost ceilings should be determined, but we do recommend that in reviewing and updating methodologies, MaineCare review the assumptions used to develop any cost ceilings, not just recalculate rates using the same methods it does now. The review of methodologies we recommend related to many policy sections should address several of these types of stakeholder comments.

Description of the Contents of the Report

Included in this interim report are details of the analysis and prioritization process used to develop system-wide and section-specific recommendations for MaineCare. The overarching goal of the project is to create a rational approach to rate setting that results in sustainable rates for providers and a comprehensive system to serve MaineCare members. A final report to be issued at the end of February 2021 will include greater detail on the individual recommendations and a more refined implementation plan than is included in this interim report.

[19] Accountable Communities, for example, is an APM model, but it is not a subject to analysis under this report since it does not affect rates or rate methodologies for specific services, but rather focuses on a total cost of care approach, i.e., the total costs of healthcare for a given population. We make recommendations for APMs in the report, which need to be evaluated and potentially modified in terms of changes to the APMs that are underway.

Evaluation of Current MaineCare Methodologies and Fee Schedules

The study approach was designed to compare the MaineCare methodologies and fee schedules to those for comparable services from Medicare, a sample of state Medicaid agencies, and from commercial payers in Maine. The analysis of the fee schedules provides information about how rate amounts in Maine compare to other payers; the analysis of the methodologies provides information about how payment rates are determined and what impact this has on incentives for volume or value of services provided. We used this information to help identify opportunities to create a comprehensive, streamlined, and coherent system for determining and periodically updating payment rates for specific services and programs, and to develop a priority list of services for implementing those recommendations.

Rate Comparisons

For each applicable MaineCare policy section, Myers and Stauffer compared MaineCare rate information against rates for corresponding services under Medicare and five comparison state Medicaid agencies (Connecticut, New Hampshire, Vermont, North Carolina, and Montana). To conduct the analysis of data from other states' Medicaid programs, we used publicly available information, including fee schedules that were current as of October 31, 2020. We selected these states for review for the following reasons:

- Three of the states, Connecticut, New Hampshire, and Vermont, are located within the New England area, have similar market characteristics to Maine, and have also expanded Medicaid. New Hampshire has a risk-based managed care program, but continues to maintain its fee-for-service (FFS) fee schedule. MaineCare often looks to these states when evaluating and comparing Medicaid policies.
- The other two states, Montana and North Carolina, provide examples of FFS states that have robust fee schedule development and methodologies that are comparable to Maine's.[20] They also offer APMs that provide examples for MaineCare's consideration in program design.
- Together with Maine, these states are six of only eight remaining states that do not use risk-based managed care as a model of care delivery.[21] This is notable, as Managed Care

[20] North Carolina is moving into managed care, but current data reflects the FFS environment. http://files.kff.org/attachment/Report-A-View-from-the-States-Key-Medicaid-Policy-Changes.
[21] Risk-based managed care is defined as a program whereby the managed care company is under contract with states to pay for enrollees' care even if the costs exceed the capitated rates at which they are reimbursed. http://files.kff.org/attachment/Tables-Report-A-View-from-the-States-Key-Medicaid-Policy-Changes.

Organizations often take full responsibility for determining rates and rate methodologies for populations carved in under managed care.

We also obtained information from the Maine Health Data Organization's (MHDO's) All Payer Claims Database (APCD), which is a collection of claims data for Maine residents submitted by commercial insurance carriers, third party administrators, pharmacy benefits managers, dental benefit administrators, MaineCare, and the Centers for Medicare and Medicaid Services (CMS).[22] We reviewed claims incurred during Calendar Year 2019 with the selected procedure codes that were paid by commercial insurance.

Table 7 below provides a summary of expenditures associated with the codes/rates we compared within each section of policy and provides context on the magnitude of those expenditures relative to all expenditures within the policy section. We also provide information that shows the percent of codes within a policy section that we reviewed. As Table 7 indicates, we compared almost all codes in each section. We compared data by grouping for some policy sections to reflect the commonality of services provided across those sections of policy (e.g., codes for Home and Community-Based Services (HCBS) Waiver -- Supported Employment services span policy sections 18, 20, 21, 29, and 102). For those programs, we included individual services from multiple policy sections in the workbooks and therefore did not present total expenditures per section in Table 7.

Table 6: Expenditures by Policy Section

Policy Section	Total Expenditures	Expenditures Analyzed	Percent Spend Associated with Codes in Comparison
Ambulatory Care Clinic (Section 3)	$45,343	$45,343	100.0%
Ambulatory Surgical Center (ASC) (Section 4)	$1,895,536	$1,327,847	70.1%
Ambulance (Section 5)	$14,118,635	$14,106,367	99.9%
Targeted Case Management (TCM) Services (Section 13)	$37,433,146	$37,433,146	100.0%
Advanced Practice Registered Nurse/ Certified Registered Nurse Anesthetist (APRN/CRNA) Services – APRN (Section 14)	$12,505,075	$8,524,384	68.2%
HCBS Personal Care Home Health (Sections 12, 19, 20, 26, 40, 96)	-	$99,738,140	-
APRN/CRNA Services – CRNA (Section 14)	$2,150,724	$1,501,728	69.8%
Chiropractic Services (Section 15)	$950,121	$950,048	100.0%
Behavioral Health Services (BHS) - Adult Community-Based Behavioral Health (Sections 17, 65)	-	$48,801,637	-
BHS - Adult Outpatient Behavioral Health (Sections 17, 65)	-	$8,087,461	-

[22] https://mhdo.maine.gov/claims.htm.

Policy Section	Total Expenditures	Expenditures Analyzed	Percent Spend Associated with Codes in Comparison
HCBS - Day Habilitation (Sections 18, 20, 21, 29, 102)	-	$176,607,335	-
HCBS - Residential Habilitation (Sections 18, 20, 21, 29, 102)	-	$24,331,267	-
HCBS Clinical Services (Sections 20, 21, 102)	-	$9,456,730	-
HCBS Home Health and Nursing (Sections 19, 20, 21, 40, 43, 96, 102)	-	$1,245,541,946	-
Dental Services - Adjunctive General (Section 25)	$1,877,825	$1,877,825	100.0%
Dental Services - Diagnostic (Section 25)	$3,350,777	$3,350,777	100.0%
Dental Services - Endodontics (Section 25)	$398,005	$398,005	100.0%
Dental Services - Maxillofacial Prosthetics (Section 25)	$66,835	$66,835	100.0%
Dental Services - Oral and Maxillofacial Surgery (Section 25)	$4,857,551	$4,857,551	100.0%
Dental Services - Orthodontics (Section 25)	$4,147,423	$4,147,423	100.0%
Dental Services - Periodontics (Section 25)	$35,397	$35,397	100.0%
Dental Services - Preventive (Section 25)	$3,884,117	$3,884,117	100.0%
Dental Services - Prosthodontics (Fixed) (Section 25)	$794	$794	100.0%
Dental Services - Prosthodontics (Removable) (Section 25)	$222,265	$222,265	100.0%
Dental Services - Restorative (Section 25)	$4,761,401	$4,761,401	100.0%
Family Planning Services – Abortion (Section 30)	$46,312	$46,312	100.0%
Family Planning Services – Family Planning (Section 30)	$1,569,519	$1,473,392	93.9%
Hospitals - Hospital Outpatient Ambulatory Payment Classification (APC) (Section 45)	$149,455,332	$149,455,332	100.0%
Hospitals - Acute Inpatient Hospital Diagnosis-Related Group (DRG) (Section 45)	$212,644,466	$190,898,469	89.8%
Laboratory Services (Section 55)	$15,413,918	$11,094,180	72.0%
Durable Medical Equipment (DME) Services - Cures DME (with Medicare rates) (Section 60)	$5,284,921	$5,284,921	100.0%
DME Services - Cures DME (with no Medicare rates) (Section 60)	$1,637,834	$1,637,834	100.0%
DME Services - Medical Supplies and DME (with Medicare rates) (Section 60)	$12,710,912	$12,710,912	100.0%
DME Services - Medical Supplies and DME (with no Medicare rates) (Section 60)	$7,263,652	$7,263,652	100.0%
BHS - Adult Residential Behavioral Health (Sections 65, 97E, 97F)	-	$148,995,113	-
BHS - Children's Community-Based Behavioral Health (Sections 28, 65)	-	$211,472,468	-
BHS - Children's Outpatient Behavioral Health (Sections 65)	-	$3,486,277	-

Policy Section	Total Expenditures	Expenditures Analyzed	Percent Spend Associated with Codes in Comparison
BHS - Outpatient Mental Health (Sections 65)	-	$55,704,793	-
BHS - Substance Use Disorder (SUD) Services (Sections 65, 93, 97B)	-	$84,829,419	-
Occupational Therapy (OT) Services (Section 68)	$3,870,825	$3,630,247	93.8%
Vision Services (Section 75)	$3,827,097	$3,613,580	94.4%
Physical Therapy (PT) Services (Section 85)	$1,681,026	$1,673,292	99.5%
Physician Services – Anesthesiology (Section 90)	$3,788,177	$2,661,427	70.3%
Physician Services - Codes Increased by the Affordable Care Act (ACA) (Section 90)	$7,208,489	$11,757,861	61.3%
Physician Services - Physician (all other) (Section 90)	$43,002,640	$116,723,273	36.8%
Podiatric Services (Section 95)	$998,218	$772,533	77.4%
HCBS - Supported Employment (Sections 18, 20, 21, 29, 102)	-	$4,275,778	-
BHS - Children's Residential Behavioral Health (Sections 97D, 107)	-	$64,053,142	-
Medical Imaging Services (Section 101)	$8,800,598	$5,879,146	66.8%
Speech and Hearing Services – Agency (Section 109)	$6,740,098	$6,506,173	96.5%
Speech and Hearing Services – Independent (Section 109)	Total in Agency	Total in Agency	96.5%

Comparison Points

For each code, we generated a number of metrics for comparison purposes. We summarized these findings in workbooks for each policy section or groups of policies. These workbooks may be found at: https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/mainecare-rate-system-evaluation.

After the initial release of the workbooks, we obtained stakeholder comments and conducted additional reviews that resulted in some changes to the workbooks. These included revising the methodology for comparing commercial health plan data to the MaineCare data by including patient cost share in the commercial amounts, updating fee schedules for some services, and making other adjustments to data. Each updated workbook contains a change log with details of any changes that we made to the data since it was initially posted.

Summary of Findings

We present a summary of the rate comparison results in Table 10 below. It was not feasible for Myers and Stauffer to research all potential factors impacting differential rate amounts in other states, nor the assumptions made in the determination of other states' rates. These rate comparisons serve as points of reference, providing the opportunity to identify those service categories where MaineCare rates appear

out of alignment with those paid by other payers. For services with little variation between payers in terms of service model or methodology, this misalignment may indicate that an update to rates may be warranted to help MaineCare achieve its goals. For services where there is more variation in the service model, and/or where the service relies on rate studies to determine payment, further study may be needed in order to determine whether changes to rates or rate methodologies are appropriate.

Some of the policy sections included services where there was no reasonable comparison because of the different ways that each state Medicaid agency determines how to pay for that service, for example, applying different acuity adjustment factors, or grouping services differently. For those sections, we reviewed the methodologies, and presented rate information where available, but did not draw any conclusions about the comparisons. We have provided more detail about comparison issues in the summaries of comparisons, found in the workbooks for each policy section indicated in Table 8.

Table 7: Policy Sections with Methodology Review Only

Section of Policy and Description
2 Adult Family Care Services
9 Indian Health Services
23 Developmental and Behavioral Clinic Services
31 Federally Qualified Health Centers
45 Hospital Services
50 Intermediate Care Facilities for Individuals with Intellectual Disabilities
67 Nursing Facilities
91 Health Homes
92 Behavioral Health Homes
97 Private Non-Medical Institution (PNMI)
103 Rural Health Centers

Table 9 provides a summary of the sections and comparison points analyzed. For each policy section, or group of sections, we summarized the results of the comparison across procedure codes and calculated the following metrics.

Table 8: Analysis Metrics

Metrics Used in Analysis	
Minimum Comparison Rate Percentage	The lowest MaineCare reimbursement as a percentage of the overall other state Medicaid / Medicare average comparison rate[23] for all selected procedure codes.
Maximum Comparison Rate Percentage	The highest MaineCare reimbursement as a percentage of the overall other state Medicaid / Medicare average comparison rate for all selected procedure codes.
Average Comparison Rate Percentage	The average MaineCare reimbursement as a percentage of the overall other state Medicaid / Medicare average comparison rate for all selected procedure codes.

[23] The comparison rate for each code is the average of Medicare's and the other comparison states' rates.

Metrics Used in Analysis	
MaineCare Count of Low Outlier Codes[24]	Number of procedure codes with a MaineCare percentage of the overall other state Medicaid / Medicare comparison rate below 40 percent.
MaineCare Count of High Outlier Codes	Number of procedure codes with a MaineCare percentage of the overall other state Medicaid / Medicare comparison rate above 120 percent.
MaineCare Average Percentage of Comparison States	MaineCare reimbursement as a percentage of the comparison states' average rate.
MaineCare Average Percentage of Medicare	MaineCare reimbursement as a percentage of the Medicare rate for Maine.
MaineCare Average Percentage of Commercial 50th Percentile	MaineCare reimbursement as a percentage of the 50th percentile/median commercial insurance payment rate.
Total Current Spend as Percentage of Spend if Codes Paid at Comparison	Current rate expenditure calculated as the current MaineCare rate times the units paid in Calendar Year 2019 divided by the comparison rate expenditure calculated as the overall comparison rate times the units paid in Calendar Year 2019.

We used the summary information presented in this table to evaluate how the current MaineCare methodologies work in practice and to help develop recommendations, as we discuss further.

[24] The outlier thresholds (low = is 40 percent of comparison, high = 120 percent of comparison) are symmetrical (+/- 40 percentage points) around a midpoint of 80 percent of comparison. It is standard to define outliers in relation to the distribution of data points for the dataset at hand. Given that most MaineCare rates fall below 100 percent of comparison, it is reasonable to have the midpoint be below comparison than 100 percent of comparison.

Table 9: Summary of Findings[25]

Policy Section and Number		Minimum % Comparison Rate	Maximum % Comparison Rate	Average % Comparison Rate	Count of Low Outliers	Count of High Outliers	MaineCare Average % of Comparison States	MaineCare Average % of Medicare	MaineCare Average % of Commercial Median	Total Current Spend As % of Spend If Codes Paid at Comparison Rates
3	Ambulatory Care Clinic	42.2%	257.6%	96.3%	0	2	-	-	-	74.5%
4	Ambulatory Surgical Center	19.3%	181.0%	119.6%	1	19	126.7%	92.1%	127.4%	100.8%
5	Ambulance	85.1%	457.3%	183.4%	0	16	204.5%	96.8%	83.9%	160.0%
13	Targeted Case Management	96.3%	117.9%	110.2%	0	0	-	-	-	112.3%
14	CRNA	40.9%	56.2%	55.4%	0	0	57.3%	48.9%	-	55.4%
14	APRN	49.7%	104.1%	79.0%	0	0	79.9%	74.6%	-	73.7%
15	Chiropractic Services	43.0%	87.1%	73.2%	0	0	76.9%	69.7%	58.7%	65.5%
25	Dental Endodontics Services	12.8%	76.9%	46.1%	5	0	-	-	20.4%	52.2%
25	Dental Prosthodontics (Fixed) Services	42.0%	63.1%	53.1%	0	0	-	-	29.1%	58.3%
25	Dental Diagnostic Services	12.5%	111.7%	56.5%	6	0	-	-	31.3%	71.5%
25	Dental Prosthodontics (Removable) Services	40.7%	93.8%	61.1%	0	0	-	-	35.3%	56.1%

[25] Information in this table is summarized from the Phase 1 revised workbooks. These workbooks may be found at: https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/mainecare-rate-system-evaluation.

Policy Section and Number		Minimum % Comparison Rate	Maximum % Comparison Rate	Average % Comparison Rate	Count of Low Outliers	Count of High Outliers	MaineCare Average % of Comparison States	MaineCare Average % of Medicare	MaineCare Average % of Commercial Median	Total Current Spend As % of Spend If Codes Paid at Comparison Rates
25	Dental Periodontics Services	29.7%	122.1%	64.6%	5	1	-	-	27.8%	36.1%
25	Dental Preventive Services	42.6%	115.9%	68.7%	0	0	-	-	44.7%	64.6%
25	Dental Restorative Services	26.9%	153.1%	78.2%	2	4	-	-	38.6%	76.6%
25	Dental Orthodontics Services	37.3%	139.0%	80.6%	2	1	-	-	99.6%	124.7%
25	Dental Oral and Maxillofacial Surgery Services	22.8%	222.5%	84.4%	9	13	-	-	57.4%	86.1%
25	Dental Adjunctive General Services	24.2%	175.0%	94.6%	1	3	-	-	41.2%	101.2%
25	Dental Maxillofacial Prosthetics Services	79.0%	133.8%	106.4%	0	1	-	-	80.8%	79.0%
30	Abortion	55.7%	74.6%	66.5%	0	0	67.9%	61.0%	40.2%	63.9%
30	Family Planning	31.0%	115.8%	73.3%	1	0	-	-	67.6%	68.0%
45	Hospital Outpatient APC	54.6%	117.6%	91.8%	0	0	97.0%	83.7%	88.8%	95.7%
45	Inpatient Hospital DRG	28.7%	324.4%	102.6%	4	170	108.6%	90.2%	-	106.0%
55	Laboratory	73.4%	110.8%	91.5%	0	0	93.3%	85.3%	81.8%	89.4%

Policy Section and Number		Minimum % Comparison Rate	Maximum % Comparison Rate	Average % Comparison Rate	Count of Low Outliers	Count of High Outliers	MaineCare Average % of Comparison States	MaineCare Average % of Medicare	MaineCare Average % of Commercial Median	Total Current Spend As % of Spend If Codes Paid at Comparison Rates
60	Medical Supplies and DME (With Medicare Rate)	2.3%	162.5%	82.8%	6	12	84.5%	78.4%	113.0%	87.8%
60	Medical Supplies and DME (No Medicare Rate)	2.0%	394.7%	96.1%	28	39	-	-	113.3%	108.1%
60	Cures DME (With Medicare Rate)	43.9%	184.8%	104.7%	0	56	110.5%	94.8%	153.5%	111.1%
60	Cures DME (With No Medicare Rate)	22.2%	173.2%	109.9%	2	5	-	-	177.4%	126.8%
68	Occupational Therapy	32.2%	110.0%	54.6%	2	0	59.7%	43.9%	50.2%	46.8%
75	Vision	20.2%	88.1%	64.9%	1	0	67.3%	58.2%	54.2%	67.2%
85	Physical Therapy	36.5%	87.1%	52.4%	1	0	55.5%	42.2%	43.6%	49.8%
90	Physician Services - Anesthesiology	54.5%	69.7%	69.0%	0	0	70.0%	65.2%	-	67.7%
90	Physician Services - Physician (all other)	25.2%	172.4%	78.6%	4	3	79.2%	70.3%	61.8%	69.9%
90	Physician Services - Codes Increased by the ACA	97.1%	125.8%	111.2%	0	1	114.1%	98.9%	92.8%	108.7%
95	Podiatric Services	37.5%	94.7%	58.8%	2	0	60.9%	50.8%	53.8%	54.0%
101	Medical Imaging	55.4%	112.8%	75.6%	0	0	76.8%	73.6%	38.8%	76.4%
109	Speech/Hearing - Independent	52.8%	94.4%	77.5%	0	0	81.2%	62.5%	55.7%	77.5%

Policy Section and Number		Minimum % Comparison Rate	Maximum % Comparison Rate	Average % Comparison Rate	Count of Low Outliers	Count of High Outliers	MaineCare Average % of Comparison States	MaineCare Average % of Medicare	MaineCare Average % of Commercial Median	Total Current Spend As % of Spend If Codes Paid at Comparison Rates
109	Speech/Hearing - Agency	70.8%	130.5%	94.6%	0	1	99.3%	73.7%	66.6%	86.4%
20,21,102	HCBS Clinical Services	53.7%	113.1%	75.2%	0	0	-	-	-	74.3%
65	BHS - Outpatient Mental Health	59.9%	118.0%	77.8%	0	0	77.3%	78.9%	87.9%	66.6%
17,65	BHS - Adult Community-Based Behavioral Health	26.6%	180.0%	91.2%	1	1	-	-	134.3%	96.7%
65,93, 97B	BHS - SUD Services	58.6%	167.9%	92.0%	0	3	92.5%	60.5%	102.5%	76.1%
19,20,21, 40,43,96, 102	HCBS Home Health and Nursing	11.5%	386.1%	95.1%	6	7	-	-	-	140.1%
65, 97E, 97F	BHS - Adult Residential Behavioral Health	82.5%	107.5%	95.2%	0	0	-	-	-	104.1%
17,65	BHS - Adult Outpatient Behavioral Health	32.9%	125.8%	101.2%	1	4	-	-	-	100.8%
12,19,20, 26,40,96	HCBS Personal Care	45.0%	264.1%	104.7%	0	6	-	-	-	102.9%
28,65	BHS - Children's Community-Based Behavioral Health	36.0%	283.4%	105.8%	1	6	-	-	-	90.3%
65	BHS - Children's Outpatient Behavioral Health	98.9%	135.3%	120.0%	0	2	-	-	-	126.2%

Policy Section and Number		Minimum % Comparison Rate	Maximum % Comparison Rate	Average % Comparison Rate	Count of Low Outliers	Count of High Outliers	MaineCare Average % of Comparison States	MaineCare Average % of Medicare	MaineCare Average % of Commercial Median	Total Current Spend As % of Spend If Codes Paid at Comparison Rates
18,20,21, 29,102	HCBS Supported Employment	104.2%	173.0%	135.4%	0	3	-	-	-	107.4%
18,20,21, 29,102	HCBS Residential Habilitation	107.6%	199.9%	135.7%	0	3	-	-	-	111.2%
18,20,21, 29,102	HCBS Day Habilitation	113.2%	251.6%	149.5%	0	1	-	-	-	113.2%

Stakeholder Comments

The study objectives involve recommending necessary changes to current reimbursement methodologies, rates, and the overall rate setting system to ensure ongoing adequacy of rates and the provision of high value care. Recognizing that stakeholders can provide valuable insight into the current workings of the system, there were two rounds of stakeholder engagement with groups targeted toward providers and provider associations, and one round for MaineCare members and guardians. We scheduled the provider meetings by policy section or groups of policy sections, to cover comparable topics within the meeting. We held three member meetings scheduled in the afternoon and evening to provide opportunity for MaineCare members to participate in discussions about how reimbursement methodologies and rates may affect them and their access to services. We also provided a dedicated email address for stakeholders to provide written comments. Table 11 summarizes the meeting dates and participants, as well as the number of written comments we received.

Table 10: Stakeholder Meetings

	Phase 1 Provider Meetings	Member Meetings	Phase 2 Provider Meetings
Meeting Dates	October 5 - October 9, 2020	November 18 - November 19, 2020	December 2 - December 8, 2020
Number of Attendees	408	11	352
Number of Written Comments	47	29	105

For Phase 1 Provider meetings, we identified specific questions to focus the discussion on the impact of rate methodologies rather than the amount of the rates. For the three MaineCare member meetings, we posed questions designed to gain a greater understanding of how rates may be affecting member access and the quality of services. Phase 2 Provider meetings occurred following the release of the comparison workbooks and were therefore intended to gather feedback regarding the adequacy of rates and information that stakeholders felt may help elucidate the findings of the comparison report. We did not pose questions for the Phase 2 meetings, but instead provided informal prompts to focus feedback on the rate amounts and the results of the comparisons. Table 12 includes the questions and prompts asked for each round of stakeholder meetings.

Table 11: Discussion Questions/Prompts

Meeting	Questions
Phase 1 Provider Meeting	• How well is the current methodology working for the services you provide? • Does the payment methodology create the right incentives? • Do you believe that the payment methodology for the services you provide is equitable to methodologies for services provided by other provider groups? • Does the methodology result in administrative requirements or activities that are burdensome for you? • Is the methodology consistent with value-based purchasing?
Member Meeting	• Have you or any of your family members had trouble finding providers in Maine who accept MaineCare patients? If so, what type(s) of providers or services? Did they tell you why they do not accept MaineCare patients? • Are there MaineCare services that you are eligible to receive but that you have had trouble finding or getting? If so, what do you think is making it hard for you to get this care? • Are there MaineCare services that you are eligible to receive but the service(s) has a waitlist? If so, what is/are the service(s)? Approximately how long were you on a waitlist before you could begin receiving services? • Are there MaineCare services that you receive that you have to drive more than 30 minutes to get to? • When you go in for a MaineCare service or appointment, are the same staff available to see you, or are there a lot of changes in the staff who provides services to you? • Do you receive any services where you feel like the service is rushed or where you don't feel you have the time or opportunity to ask questions? • Do you receive any services where the service just didn't meet the needs you had or was not as effective as you were expecting? • Are you aware of any providers of services you receive under MaineCare that have had to close because of financial reasons? • Has your provider ever told you that the way they have to bill for MaineCare services means they can't always provide services to you the way they like? • What do you think MaineCare should think about when they decide how to pay providers (for example, paying once a month versus every 15 minutes, or changing how much they pay depending on how well a provider performs)?
Phase 2 Provider Meeting	• What additional points would you offer for our consideration as you look at the comparisons provided in the Phase I report? For example: - Are there assumptions or costs that are critical to consider that may be unique to Maine that would not be reflected in another state's rate? - Are there differences in payment methodology, services etc., that may explain some of the difference in certain rates, though it may not be evident by fee schedule or service descriptions? - Are there services where current rates contribute to access or quality issues? Do these issues then impact other parts of the service system?

Across both phases of provider stakeholder meetings, comments covered a large number of topics. In the table below, we provide a summary of the broad themes represented in the detailed provider feedback. Table 13 provides an overview of the themes that emerged from the first round of stakeholder meetings that focused on the impacts of the payment methodology. These comments reflect those that appeared in most sections. We noted where there was a population- or service-specific theme (e.g., children's services). Appendix A includes a comprehensive summary of individual provider comments.

Table 12: Stakeholder Themes Related to Methodology

Administrative Burden	Member Access	Equity Across Services
• Maine Integrated Health Management Solution (MIHMS) billing requirements do not align with those for other payers' electronic health records (EHRs). • Case management requirements are inconsistent across populations.	• Wait lists for community-based services for children make it difficult to have consistent access to services. • Prior authorizations are too restrictive and not easily adjusted. • Length of time and inflexibility in the way units and services are authorized make it difficult to adapt to the needs of the member.	• Rates are not the same for the same service offered for different populations. • Rates for the same service are not consistent when provided by an agency versus an independent provider. • Rates for some residential settings are cost based while others are not.

Table 14 provides a broad overview of the stakeholder comments received related to the adequacy of the rates. More detailed summaries grouped by meeting and policy section are available in Appendix A.

Table 13: Stakeholder Themes Related to Rate

Sufficiency of Rates	Frequency of Rate Updates	Minimum Wage/Compaction
• Rates do not reflect the cost of doing business. • Productivity assumptions for rates do not account for sufficient time for evidence-based practices or team-based care. • Payment methods are not always conducive to the way services are provided (e.g., unit of service or team based care) • Rates do not accomodate cost differences based on geography. • MaineCare should negotiate productivity factors with providers instead of setting them at unsustainably high levels.	• MaineCare has not updated rates for long periods of time; some have not been updated for more than 20 years. • Rates are not updated to reflect changes such as minimum wage increases or costs asssociated with the pandemic. • When new services are added and new rates are determined, old rates are not updated. This results in newer codes with higher rates than older codes.	• The rates do not account for recent changes to the minimum wage. • When rates are changed in one part of the service system it can create wage compaction in other parts. • Rates for the same type of provider are not updated across all policy areas. • Rates are not adjusted to provide compensation for higher qualified or more experienced staff. • Rates assume staff are hired and work only at minimum wage instead of a livable wage.

Some of these themes, such as administrative burden, included issues outside the specific scope of this project. However, we have considered all stakeholder comments to the extent appropriate in the development of recommendations and the prioritization of recommendations and have included stakeholder comments in the Priority Listing (Table 17 below) where relevant.

Development of Recommendations and Priorities

The key deliverables of the evaluation of MaineCare's rates and rate setting methodologies are the development of recommendations and a draft plan for the creation of a comprehensive, streamlined, and coherent system of rates for specific services and programs.

Principles for Reimbursement Methodology Design

To systematically review our findings regarding the current methodologies and rates and make recommendations, we reviewed the MaineCare methodologies for each policy section to determine their consistency with best practices used by Medicare, other state Medicaid agencies, and commercial health plans. Based on our experience, Medicaid reimbursement methodologies should:

- Create appropriate incentives for preventive, integrated, coordinated, high quality and effective care.
- Incorporate APMs that help create incentives for high value care.
- Promote access to care for MaineCare members.
- Be equitable in approach across all types of providers.
- Be documented, transparent, and administratively simple for providers.
- Be implemented as specified in regulations, policy manuals, and other governing documents, and be compliant with federal regulations.
- Be reviewed and updated on a periodic and scheduled basis.

Finally, regarding this study, methodologies and payment rates should be consistent with the goals of the Maine Department of Health and Human Services, with an emphasis on its following Offices:

- Office of Aging and Disability Services
- Office of Behavioral Health
- Office of Child and Family Services
- Office of MaineCare Services[26]

[26] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/What-We-Do.pdf.

Development of Recommendations

Myers and Stauffer developed general recommendations for determining rate methodologies and processes to review and update rates in consideration of the above principles. Myers and Stauffer developed a series of recommendations regarding change based on the review of the current methodologies, including dates of most recent updates or schedule for updates, as documented in Appendix B; the comparison of rates to those of Medicare, select Medicaid programs, and commercial health plans in Maine; and the input of provider and member stakeholders and of representatives from the DHHS Offices who participated in this study. We describe these steps below.

Review of Current Methodologies

Myers and Stauffer analyzed the current reimbursement methodologies and assigned scores to them as seen in the table below. We assigned scores from 1 to 5, measuring adherence to payment methodology principles, i.e., "best practices," based on the following criteria:

1: The methodology does not represent a best practice and is "atypical" in comparison to other states.

2: The methodology uses an approach with some elements of best practices but is missing significant features.

3: In general, the methodology contains elements of best practices, but the resulting fee schedules are outdated.

4: The methodology employs some features of best practices, with minor deviations.

5: The methodology is consistent with best practices, including a performance-based payment component.

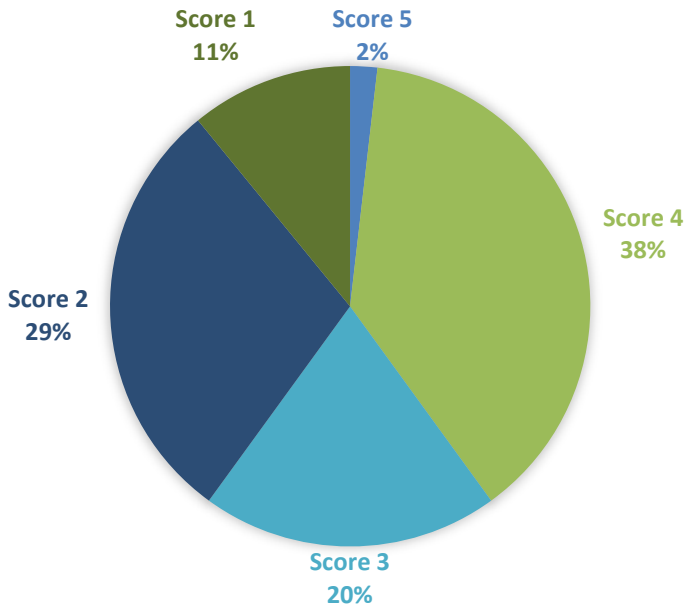
Table 14: Methodology Scores

Section of Policy and Description	Score
2 Adult Family Care Services	3
3 Ambulatory Care Clinic Services	2
4 Ambulatory Surgical Center Services	4
5 Ambulance Services	4
7 Free-standing Dialysis Services	4
9 Indian Health Services	4
12 Consumer Directed Attendant Services	4
13 Targeted Case Management Services	2
14 Advanced Practice Registered Nursing Services	2
15 Chiropractic Services	2
17 Community Support Services	1
18 Home and Community-Based Services for Adults with Brain Injury	4
19 Home and Community Benefits for the Elderly and Adults with Disabilities	4
20 Home and Community-Based Services for Adults with Other Related Conditions	4

Section of Policy and Description	Score
21 Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder	4
23 Developmental and Behavioral Clinic Services	1
25 Dental Services	1
26 Day Health Services	4
28 Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations	4
29 Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder	4
30 Family Planning Agency Services	2
31 Federally Qualified Health Center Services	4
40 Home Health Services	1
43 Hospice Services	3
45 Hospital Services - Acute Inpatient	3
45 Hospital Services - Acute Outpatient	4
45 Hospital Services - Critical Access Hospital (CAH)	4
45 Hospital Services - Rehab – Inpatient	3
45 Hospital Services – Hospital Based Physicians (Inpatient/Outpatient)	3
46 Inpatient Psychiatric Hospital Services	3
50 ICF-IDD Services	2
55 Laboratory Services	3
60 Medical Supplies and Durable Medical Equipment	1
65 Behavioral Health Services	3
67 Nursing Facility Services	2
68 Occupational Therapy Services	2
75 Vision Services	2
85 Physical Therapy Services	2
90 Physician Services	2
91 Health Home Services	4
92 Behavioral Health Home Services	5
93 Opioid Health Home Services	4
94 Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)	2
95 Podiatric Services	2
96 Private Duty Nursing and Personal Care Services	4
97B Substance Abuse Treatment Facilities	3
97C Medical and Remedial Service Facilities	4
97D Child Care Facilities	3
97E Community Residences for Persons with Mental Illness	1
97F Non-Case Mixed Medical and Remedial Facilities	3
101 Medical Imaging Services	2
102 Rehabilitative Services	4
103 Rural Health Clinic Services	4
107 Psychiatric Residential Treatment Facility Services	2
109 Speech and Hearing Services	2

Figure 2 below provides the summary of scores for the 55 sections of policy where we examined methodologies:

Figure 2: Methodology Scores



The methodologies for 33 of the 55 sections (60 percent) we reviewed did not adhere to payment methodology principles (i.e., they do not have a score of 4 or 5). Only two percent of the methodologies include some measure of performance-based payment (i.e., have a score of 5).

Based on our review of the current methodologies and fee schedules, we made a number of findings related to the development of rate methodologies and fee schedules, and the update of payment rates, as follows.

- Inconsistency in frequency of, basis and rationale for, and implementation of updates across policy sections
    - MaineCare updates methodologies and payment rates regularly (e.g., annually) for some policy sections, whereas there have been no updates in many years for others. Fee schedules based on Medicare rates for a certain year, for example, are now out of date and contain inconsistencies as new codes and rates are added in subsequent years, creating inequities across providers, and potential financial incentives for the delivery of some services in favor of others because of the payment rates.
    - For some policy sections, there is no regular update process, and for others MaineCare updates the rates due to legislation. Updates do not necessarily address policy sections based on relative need to improve member access or to address methodologies to

better support the delivery of high value care. Further, the often ad hoc nature of the rate increases requires unplanned administrative time and support for implementation.

- For some policy sections, MaineCare has conducted cost studies, but the Department did not implement rates due to internal decisions or prohibition by the Legislature because rates would have decreased. This suggests that some providers may be overpaid, and/or that the methodology should be examined further.
- Stakeholders discussed the out of date fee schedules and payment rates in nearly every stakeholder meeting. Rates that had not been updated were mentioned as being of great concern since the pandemic began as they do not reflect current minimum wage standards or the effects of public health emergencies that have complicated hiring. Further, stakeholders commented that they were faced with making business decisions to choose to provide services based on whether the affiliated service code had a rate that was developed more recently and thus was more likely to be adequate.
- Many of the Home and Community-Based Services were rated more highly because the rates have been developed using best practices, but the methodologies do not include performance-based measures as of yet. There are several emerging performance-based measures in the areas of Supported Employment as well the integration of physical and oral health in support of these populations. Stakeholders expressed concern about transitioning to APMs with this population and type of services. Any implementation of APMs should be a collaborative effort with provider groups and utilize performance measures that are reflective of the services they provide.

- Burdensome processes to update rates
  - Some rates are in statute, which requires new legislation to execute a change to a methodology or an inflation update.
  - While some sections of the MaineCare Benefits Manual (MBM) reference methodologies and/or online fee schedules that can be updated without the need for rulemaking, most sections currently include the rates in the rules themselves.[27] Inclusion of rates in rule can result in a lengthy rulemaking process when changes, such as the addition of a new service code, a national coding change, or annual inflation adjustments, occur.
  - For some policy sections, there is no regular update process, and for some policy sections, MaineCare updates rates based on legislation. Updates do not necessarily address policy sections based on relative need to improve member access or to address

[27] https://www.maine.gov/sos/cec/rules/10/ch101.htm. For example, Section 90 Physicians indicates that rates are 70% of 2009 Medicare -- or the year a new code came into existence -- and all rates are then published online.

methodologies to better support the delivery of high value care. Further, the ad hoc nature of the increases requires unplanned administrative time and support for implementation.

- Inconsistency in benchmarks and rate amounts for similar services
  - Some providers are paid at varied reduced percentages of the Medicare fee schedule without a rationale for the differences between services. Nationally, while payers commonly apply a reduction to the physician fee schedule for non-physician practitioners, a common percentage is generally applied across provider types.
  - There are comparable services across policy sections that have different assigned rates. For example, within HCBS, some payment rates for certain similar services differ without a clear reason.
- Rate methodologies are administratively complex and/or do not promote provision of high-value services
  - MaineCare uses reimbursement with cost settlement for a number of policy sections, a process that provides little incentive for the provision of high quality, integrated, coordinated, and effective care. Under retrospective systems, the amount paid is determined based on the provider's reported costs after the services are rendered. These programs can be costly to administer for the Department and are complex for providers. Prospective rates, in contrast, are set in advance and are known by all parties before services are provided.
  - Stakeholders expressed concern about the administrative complexities of prospective payment methodologies and billing requirements for various policy sections.

Recommendations

Using the scoring of reimbursement methodologies; the results of the rate comparisons discussed above; and consideration of state and federal regulations, DHHS priorities, and stakeholder feedback, we made recommendations about the methodologies and rates, updating the rates, and implementing APMs. We provide a detailed summary of those recommendations specific to each policy section in Appendix B. Below we summarize the recommendations applicable to policy sections in general, and some specific recommendations.

Recommendation: Implement the Rate Methodology Plan to Provide Direction for Future Rate Reviews

- Implement a reimbursement methodology plan that provides for regular, scheduled updating of methodologies and rates. This approach can replace the ad hoc, reactive process that

MaineCare defaults to now to develop rates. A planned approach with timelines for review and updates gives legislators, providers, and MaineCare a schedule that advises when methodologies are to be reviewed and when rate increases may occur based on planned analyses.

- To address special circumstances that may arise for providers or MaineCare, consider use of an advisory body to review specific requests outside of the planned schedule. Some Medicaid agencies use a stand-alone advisory group that meets periodically.

Recommendation: Use a consistent and standard basis for developing rate methodologies and updating rates.

- Develop prospective rates wherever possible and move away from cost-based systems that require cost settlements and that do not include other incentives for cost efficiencies.
- Use Medicare methodologies and fee schedules where they exist, which may limit administrative burden for MaineCare staff and providers, especially those who also bill Medicare. Medicare methodologies and fee schedules are updated annually and provide a logical and tested basis for rates.
- Use consistent percentage benchmarks of the Medicare fee schedule. Even when a change to a consistent Medicare benchmark is fiscally neutral overall for a section of policy, it is an important for purposes of promoting consistency and equity. Providers shared that they may currently base their business model around providing certain services where codes were added in more recent years and thus paid at a proportionally higher rate than other services. This can result in a delivery system where availability of services may be driven disproportionately by differential rates versus by member access needs.
- Develop a consistent and logical approach to paying for new services/codes, and reviewing the payment amounts to assure consistency with other rates and appropriate financial incentives.
- Continue the use of rate studies that incorporate cost surveys for HCBS waivers, community-based behavioral health, and other identified services for which there are no Medicare methodologies and services are provided in a community-based setting or through a model that is unique to Maine. In particular, for HCBS waiver services, CMS considers services that are classified as high cost and high volume as those where a rate study would be most appropriate.[28]

[28] https://leadingage.org/sites/default/files/3_-_National_Trends_in_1915%28c%29_Fee-for-Service_Rates_-_Final.original.1566476475.pdf.

- Purchase a relative value, charge, or other database to determine appropriate rates for dental services. Alternatively, MaineCare could implement a more consistent approach by creating its own fee schedule using the data from Maine's APCD to develop rates based on percentiles of allowed amounts, median amounts, etc. MaineCare should specifically address stakeholder concerns regarding adequate reimbursement for preventive dental services.
- Develop a methodology to incorporate supplemental payments into base rates for inpatient and outpatient hospital services, including re-purposing funding currently used to cost-settle hospital-based physician services. Consider approach for critical access hospitals as well as acute care hospitals. Retain a portion of the supplemental payment as an APM or ensure that base rates otherwise reflect a value-based model to increase hospital accountability for performance.
- Evaluate differential costs based on site of service (e.g., care in a hospital versus clinic-based setting or ambulatory care center). The Myers and Stauffer analysis showed that services billed with comparable procedure codes are paid at a higher rate in the outpatient hospital department than in the ambulatory surgical setting, even though MaineCare payment for ambulatory surgical centers (ASCs) is high in comparison to other payers. MaineCare should therefore consider reducing rates to outpatient hospitals for certain services delivered in the ASC setting where rates for those services are lower.[29] Decisions about revising payment rates should consider access, quality and other factors that might influence MaineCare's decisions about reducing rates. MaineCare should also consider incentivizing the use of less costly settings through APMs that reward provider cost efficiency. Due to federal regulations, directing MaineCare members to lower cost settings may not be possible to the extent that it is possible for Medicare or commercial payers.[30] Higher or lower rates for some services do not mean that more MaineCare members will obtain services from the lower cost settings. MaineCare should therefore develop appropriate performance goals related to cost efficiencies within APMs to shift care from the more costly settings.
- Determine if and how wage differences in urban and rural locations and/or municipalities that have their own minimum wages should be addressed in the rate methodology and rates. Wage differences across a state do not always signal a need for area-specific rates. There are two rate

[29] CMS is moving toward a goal of reducing the payment disparity in Medicare payments across settings. Source: https://www.cms.gov/newsroom/press-releases/cms-empowers-patients-and-ensures-site-neutral-payment-proposed-rule.

[30] Under section 1902(a)(23) of the Social Security Act, Medicaid beneficiaries generally have the right to obtain medical services "from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide . . . such services." Source: https://www.medicaid.gov/federal-policy-guidance/downloads/smd16005.pdf.

issues here for MaineCare to consider: one is minimum wage and the other is geographic variation in rates.

- Minimum wage plays a role in reimbursement rates for services where the rate is driven by labor costs and the benchmark salary/ wage amounts used in the rate assumptions are set at or near the minimum wage. There are 11 states with 44 municipalities that have differences in the minimum wage.[31] Colorado provides a geographic adjustment for wage differences for the Denver area only for some services. Providers are required to pass through 85 percent of the increased adjustment to employees.[32] Arizona adjusts the wage rates only for the Tucson area based on location of the member. Policies to implement adjustments to rates should be designed to avoid inappropriate incentives for providers to change service locations or take other actions only to obtain an enhanced rate. These activities might include establishing billing requirements that require the provider to have a physical location, and restricting a provider from establishing a billing office that does not serve at least a specific percentage of its patients/members within that locality.
- States also recognize and make adjustments for costs that differ by geography. Geographic rate variances are not always a reflection of differences in wages. For example, Montana adjusts some of its community-based rates to reflect increased travel costs, not wages or housing costs.[33] States may also pay a single state rate when increased costs (e.g., travel) in rural areas may offset the increased costs in urban areas (e.g., higher wages).
- MaineCare should look at the costs reported by providers in each locality as part of regularly scheduled costs studies to determine if a geographic rate variance is necessary in order to ensure equity of payment and member access.

- Where payment methodologies create billing and other administrative complexities, consider opportunities to resolve those as payment methodologies are updated. Stakeholders commented about burdensome enrollment procedures, Medicaid-specific billing requirements, etc., that are time-consuming and frustrating to them. They recommended changes to simplify these processes would, like rate increases, make them more willing to provide services to MaineCare members.

[31] The Economic Policy Institute, "Minimum Wage Tracker", Values as of January 7, 2021, https://www.epi.org/minimum-wage-tracker/.
[32] https://www.colorado.gov/pacific/sites/default/files/HCPF%20OM%2020-089%20City%20and%20County%20of%20Denver%20Rate%20Increases%20for%20Home%20and%20Community%20-%20Based%20Services.pdf.
[33] https://dphhs.mt.gov/dsd/developmentaldisabilities/ddpratesinf.

Recommendation: Review and update methodologies and rates on a standard schedule.

- Regularly review each methodology to determine if the methodology continues to result in rates that support MaineCare goals and objectives.
    - For services where MaineCare uses the Medicare fee schedule: Update no less frequently than once every three years, and as MaineCare evaluates methodologies, assess whether APMs might enhance or replace methodologies in use.
    - For other policy sections (e.g., where MaineCare is relying on cost reports): Base the timing of the methodology reviews on changes in the utilization or delivery of services, but at least every 5 years.
        - Incorporate the review of assumptions used in the rate models, e.g., staffing and productivity, definition and use of peer groups, cost components, ceilings on costs.
        - Where models based on updated analysis indicate rate decreases for certain services, confirm that the assumptions are valid. Where valid, implement reductions, potentially through a phased-in approach depending on resulting provider financial impact.
    - Stagger the methodology reviews for different policy sections and publish a schedule so that the Legislature and stakeholders will be aware of when reviews will occur. The schedule should take into account the priorities recommended in this report, and group policy sections where there is overlap in the services provided to ensure consistency in rates across the same services.
    - Determine if rates for community-based services encourage the supply of community services to facilitate the transition of members from higher cost residential settings to community placements. Also consider APM approaches that create payment incentives for residential settings to prepare members for appropriate discharge.
- Review paid claims history for new codes for which MaineCare established payment amounts, and adjust rates when sufficient claims history is available, usually within 12 months of the rate being in place. Compare rates to rates used by Medicare and other states and determine whether to make adjustments.
- In addition to the scheduled methodology review and update, update rates every 1 to 2 years in years where there is no methodology update to reflect health care cost inflation in Maine. Some states include the process for inflation updates in their State Plans, with further clarification that the updates will only be made if the Legislature appropriates funding to support them.

- Conduct updates to fee schedules that are benchmarked to Medicare no less frequently than once every three years to maintain their integrity. Medicare updates include changes to fee schedule amounts, provide new code definitions, relative values, grouping assignments, etc., and delete outdated codes. Medicaid agencies and other payers implement these changes to keep billing and payment systems up to date. Other states regularly update fee schedules they model based on Medicare to maintain consistency with Medicare and to give providers consistency in managing their billing and receivables monitoring.
- Develop a process to determine whether and how to address changes subsequent to the rebase that affect prior rate assumptions, such as minimum wage changes or public health emergencies.

Recommendation: Make other adjustments to rates to move payments toward APMs and higher value care.

- Implement performance-based payments, including shared savings and downside risk programs, for services as possible.[34] For proposed rate increases, make at least some of the increase only payable if providers meet certain criteria. Similar to other states, MaineCare could phase in an approach for a specific service that first relies on reporting data, and then develop incentives and/or penalties designed to change specific provider behavior.
- Identify opportunities to bundle services into value-based payments that incent policy goals and support provider innovation, while providing greater flexibility and administrative simplicity.
- Work with other DHHS offices to coordinate rate reviews with policy initiatives to ensure that MaineCare rates and methodologies incent providers in a way that reflects the population needs and goals identified by these offices in accordance with Departmental priorities.

In addition to the general recommendations described below, we provide more detailed recommendations related to policy sections in Appendix B.

Process for Assigning Priorities

Using the reimbursement methodology principles discussed previously, we summarized our findings for each policy section and made recommendations for changing methodologies and rates, and then

[34] Providers and MaineCare would share in savings when spending is lower than expected. In downside risk programs, providers would pay MaineCare when spending is higher than expected. Source: http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_18_aco_final_sec.pdf?sfvrsn=0

determined the priority groupings for implementing change. To assign priorities, we considered the following:

- Stakeholder feedback, particularly related to member access issues and long-term sustainability of services.
- How much MaineCare's current methodology deviates from national trends or best practices for the service type (i.e., the methodology scores from Table 9).
- Results of MaineCare rate comparisons to rates used by Medicare, other state Medicaid agencies, and Maine commercial health plans.
- Whether additional analysis is needed to understand comparison rates, especially where there were fewer comparison states and payers and the service models were more complex, or where there are known access issues but MaineCare rates compare favorably to comparison points.
- Potential for savings resulting from restructuring rates in current methodologies. Myers and Stauffer considered potential for savings only for policy sections where there is higher certainty that savings are likely and appropriate, for example, where fee schedules are available for comparison purposes. There is less certainty about potential savings if there is variation between states regarding how services are provided.
- Length of time since the last rate review or update.
- Interviews with DHHS leadership regarding Department goals and priorities.
- Whether a change in methodology, rates, or both, could support MaineCare's goals to improve the value of services provided to MaineCare members.
- Whether a proposed change can be made given the overall service delivery system. For example, a methodology that is designed to provide incentives for residential or institutional providers to transition members to communities requires that there be sufficient access to community-based services. Those contingencies are considered in the priority ranking.

Priority List for Implementing Recommendations

MaineCare does not currently have a process for periodically reviewing rate methodologies and rates, and several of the methodologies and rates have not been updated in many years. However, MaineCare may not be able to implement all of the recommendations, from either an operational, administrative, or a financial perspective. Operationally, the review and development of new methodologies and rates can require significant time. MaineCare could contract with an external consultant to conduct methodology studies; however, staff time is still needed for tasks including but not limited to managing reimbursement changes, working with consultants, reviewing and making policy decisions, and programming changes in the state's Medicaid Management Information System (MMIS).

Administratively, new methodologies usually require a combination of legislation, development of rules, submission of State Plan Amendments, coordination of efforts with impacted DHHS Offices, and other tasks. Finally, for many services, the legislature must appropriate funding in order to support changes.

To help address these challenges, Myers and Stauffer has developed priority groupings for implementing recommendations, as set forth in Table 16.

Table 15: Priority Groupings

Group	Description	MaineCare Benefits Manual Policy Sections[35]
A	Address these policy sections first to address payment methodology principles related to access to services, equity for providers across policy sections, transparency, and updating frequency. Community-based behavioral health services that support individuals transitioning from higher-level settings are also included in this group. Recommendations address multiple policy sections that MaineCare should evaluate concurrently. This group of services has a number of low and high outliers in the comparisons of MaineCare rates, and for some policy sections, there is an opportunity to rebalance rates within the policy section and to achieve savings.[36] There is also the potential for MaineCare to consider APMs as new methodologies and fee schedules are implemented.	• 5 Ambulance • 13 Targeted Case Management (TCM) • 60 Medical Supplies and DME* • 97-E Private Non-Medical Institutions (PNMI-E) Community Residences for Persons with Mental Illness • 25 Dental • 40 Home Health • 90 Physician Services • 85 Physical Therapy (PT) • 68 Occupational Therapy (OT) • 95 Podiatric Services • 75 Vision Services • 15 Chiropractic Services • 14 Advanced Practice Registered Nurse/Certified Registered Nurse Anesthetist (APRN/CRNA) • 109 Speech and Hearing • 30 Family Planning • 101 Medical Imaging • 3 Ambulatory Care Clinics • 94 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) • 23 Developmental and Behavioral Clinic • 55 Laboratory • 65 Behavioral Health Outpatient Services** • 7 Freestanding Dialysis

[35] https://www.maine.gov/sos/cec/rules/10/ch101.htm.

[36] Low outliers are defined as procedure codes with a MaineCare percentage of the overall other state Medicaid / Medicare comparison rate below 40 percent; high outliers are defined as procedure codes with a MaineCare percentage of the overall other state Medicaid / Medicare comparison rate above 120 percent. The outlier thresholds (low = is 40 percent of comparison, high = 120 percent of comparison) are symmetrical (+/- 40 percentage points) around a midpoint of 80 percent of comparison. It is standard to define outliers in relation to the distribution of data points for the dataset at hand. Given that most MaineCare rates fall below 100 percent of comparison, it is reasonable to have the midpoint be below comparison than 100 percent of comparison.
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Group	Description	MaineCare Benefits Manual Policy Sections[35]
		• 91 Health Homes* • 28 Rehabilitation and Community Support for Children • 43 Hospice
B	Policy sections in Group B primarily represent institutional and hospital settings. Addressing these policy sections may be more complex than addressing recommendations in Group A, but implementation of recommendations would provide meaningful payment methodology reform and movement toward APMs.	• 45 Inpatient Hospital • 46 Inpatient Psychiatric Hospital • 45/46 Hospital Based Physicians • 50 Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) • 67 Nursing Facilities • 97-C PNMI-C Medical and Remedial Service Facilities
C	For policy sections in Group C, MaineCare has recently rebased or updated rates, but there is sometimes incongruence between rates for the same services provided across different policy sections. MaineCare should review these services together to reduce the instances of rate inequities.	• 18 HCBS for Adults with Brain Injury* • 20 HCBS for Adults with Other Related Conditions* • 21 HCBS for IDD* ** • 29 Support Services for Adults with IDD or Autism* • 102 Rehabilitative Services • 17 Community Support Services • 19 HCBS for Elderly and Adults with Disabilities* • 12 Consumer Directed Attendant* • 26 Day Health Services • 96 Private Duty Nursing and Personal Care* • 92 Behavioral Health Homes • 93 Opioid Health Homes*
D	Policy sections in Group D represent remaining residential settings that are not addressed in the above Groups. These sections have methodologies, but they need to be reviewed and rebased. Reviewing this Group at the end of the process will allow other system rates to be adjusted and for the community-based system of care to respond and react prior to examining the impact on residential settings.	• 97-B PNMI B Substance Abuse Treatment Facilities** • 97-D PNMI-D Child Care Facilities** • 97-F PNMI-F Non-Case Mixed Medical and Remedial Services • 2 Adult Family Care Homes • 107 Psychiatric Residential Treatment Facility
E	Little or no MaineCare action needed. There may be opportunities related to APM development for some of these policy sections.	• 9 Indian Health Services (IHS) • 31 Federally Qualified Health Centers (FQHC) • 103 Rural Health Clinics • 4 Ambulatory Surgical Center (ASC) Services • 45 Hospital Acute Outpatient

**Rate methodologies have recently been updated or are in the process of being updated.*

***A rate study is currently in progress (Sec 65. Intensive Outpatient Programs, PNMIs B & D, Sec 21 waiver homes).*

When developing this list, we recognize that there are many priorities. The detailed priority list below assumes that there will be an implementation over a five year period that includes adoption of new

rates or methodologies, ongoing review and monitoring and then rebasing as the applicable three to five year time periods come up for each policy section.

Prioritization List

Table 17 below includes the policy sections in order of priority. Some of the recommendations such as adopting the Medicare Physician Fee Schedule cover many sections of policy.

Table 16: Priority List

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
Group A: Priority Changes (Access, Equity, Cost Savings, Medicare Fee Schedule)					
1	Section 5: Ambulance Services	Continue updating rates annually based on Medicare fee schedule. Conduct further analysis of non-Medicare ambulance services and mileage rates and re-assess fee schedule for non-Medicare rates and mileage rates.	Current methodology is consistent with Medicare for Medicare covered codes, but the comparison percentage for non-Medicare codes is high.		
2	Section 13: Targeted Case Management	Review the methodology and rate studies to determine an adequate rate. Phase in the results if necessary.	Cost savings may be possible as MaineCare rates appear to be out of line to those in other states examined. Also, whereas Maine pays per 15 minutes, states most commonly use a per member per month (PMPM) rate to create more sustainability and consistency, paired with certain quality standards and contract requirements.	Current rates have providers struggling to fill positions. Minimum wage requirements impact what they are required to pay. Providers indicate that OADS has more burdensome oversight requirements relative to those of other DHHS Offices, which adds to the administrative burden for providers.	A rate study completed in 2016-2017 recommended a rate decrease; however, the rate change was not implemented after providers expressed opposition.
3	Section 60: Medical Supplies and DME	Realign rates to conform to the Medicare fee schedule and to reflect urban or rural settings.	This area is scheduled for review in 2021. Rates vary widely in comparison with Medicare, other states, and commercial plans. MaineCare does not comply with CMS Upper Payment Limit (UPL) requirements for Medicare-covered services in part because MaineCare rates do not adjust for urban and rural location. Non-compliance with UPL requires that the state fund payments in excess of	The pandemic has caused increased product costs, creating supply chain shortages and major blockages and accessibility issues that are expected to continue well into 2021. Providers can no longer offer some products due to reduced Medicare reimbursements, such as 10 non-narcotic service codes for pain management developed in response to the opioid epidemic.	

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
			the UPL with general fund and without federal match. MaineCare is currently evaluating ways to change rates to reduce spending to the UPL.		
4	Section 97-E: Private Non-Medical Institution (PNMI-E): Community Residences for Persons with Mental Illness	Transition from current budget-based payment to a standardized fee schedule-based methodology.	Potential cost savings may be possible as well as administrative efficiencies for transitioning to a more consistent methodology.	The PNMI-E methodology works well since providers can submit requests for rate adjustments. Cost settlement is an issue; if staff cannot be hired and retained as needed, providers end up with paybacks.	
5	Section 25: Dental	Update rates using a current benchmark.	There have been no updates to dental rates in the recent past and MaineCare rates are low in comparison to other states and to commercial reimbursement levels for most dental services, especially endodontics, periodontics, removal prosthodontics, fixed prosthodontics, and diagnostic services. More than 25 percent of codes analyzed for endodontics are low outliers.	Stakeholders provided a large amount of feedback regarding dental services, primarily around the inadequacy of rates and the resulting access issues. Stakeholders also expressed concern about lack of adult coverage for preventive dentistry that results in poor oral health and higher numbers of extractions and restorative services. Financial and administrative barriers are often cited as the primary reasons that dentists do not accept Medicaid patients. Stakeholders consistently and often described these as issues in Maine.	
6	Section 40: Home Health	Rebalance rates.	Comparison percentage is close to 100 percent; however, there is a need for rebalancing. Cost coverage percentages range from 12 to 386 percent of comparison rates.	Stakeholders expressed concern with the way services were authorized and how that prevented them from adjusting services to adapt to member needs.	There is no record of the methodology now in place; there was a study of costs completed in 2015, but it was not implemented.

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
			The current payment methodology is outdated and does not address provider costs.	Stakeholders expressed that the current methodology has not been updated to reflect inflation, changes to minimum wage and licensing requirements, time and mileage expenses of delivering care to more rural parts of the state, etc.	
7	Section 90: Physician Services	Update to a revised percent of a more current Medicare Physician Fee Schedule (PFS).	Rates have not been updated since 2010 (2013 for ACA codes). Stakeholders have expressed concern about maintaining access to services. The current fee schedule results in variations in the percentage of the Medicare PFS used (especially for the "all other services" category of physician services) because new services are priced using more current Medicare fee schedule rates than the existing rates. There is also considerable unexplained variation in the percentages of the fee schedule used to set rates for non-MD providers in the sections of policy ranked 7-20 below. Re-purpose funding currently used for cost settlement for hospital-based physicians (included in Section 45) to instead be used for performance-based payments under Section 90.	Physicians have ethical obligations to serve MaineCare but may impose limits on the number of MaineCare members they will accept because of inadequate reimbursement.	Policy Sections ranked 7-20 should be updated as part of a single effort**.** This will bring all codes current to the same benchmark and reduce inequity among providers. The same Medicare year should be used for all policies, and the same percent of Medicare rates should be used with the exception of**:** • Lab (Sec 55), as laboratory services are on a different Medicare fee schedule. • Ambulance (Sec 5), as ambulance is also on a different Medicare fee schedule. These changes would be relatively quick "fixes" to fee schedule disparities.

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
8	Section 85: Physical Therapy	Update to a revised percent of a more current Medicare Physician Fee Schedule (PFS).	Current rates are 52 percent of the comparison rate. See further discussion in Section 90, # 7 above.	Low reimbursement rates for therapy services affect the pediatric practices more than those that see adults. Private non-hospital based practices have unique issues that present challenges to seeing MaineCare patients as part of the payer mix, while hospitals are paid more for commercial claims in PT and can make up their losses there.	
9	Section 68: Occupational Therapy Services	Update to a revised percent of a more current Medicare Physician Fee Schedule (PFS).	Current rates are 55 percent of the comparison rate. See further discussion in Section 90, # 7 above.	Providers reported that the Occupational Therapy (OT) rate methodology is inconsistent and incomprehensive; 40 percent of their rates have not been updated, which contributes to a fragmented and outdated healthcare system. Providers urge and support increases to OT rates, considering Maine has some of the lowest rates in the country. For patients of OT, 75 percent have MaineCare as primary or secondary insurance, so MaineCare has a significant impact.	
10	Section 95: Podiatric Services	Update to a revised percent of a more current Medicare Physician Fee Schedule (PFS).	Percentages are 59 percent of the comparison rate. See further discussion in Section 90, # 7 above.	In 2010, during the legislative emergency session, it was decided that rates must increase for non-hospital providers. Therefore, the legislature bumped up all the service codes. Chiropractic, podiatry, and vision codes were carved out and put on their own fee schedule with no rate increase, and there has been nothing since.	
11	Section 75: Vision Services	Update to a revised percent of a more current	Current rates are 65 percent of the comparison rate.	See comment in #10.	

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
		Medicare Physician Fee Schedule (PFS).	See further discussion in Section 90, # 7 above.		
12	Section 15: Chiropractic Services	Update to a revised percent of a more current Medicare Physician Fee Schedule (PFS).	Current rates are 73 percent of the comparison rate. See further discussion in Section 90, # 7 above.	See comment in #10.	
13	Section 14: APRN/CRNA Services	Update to a revised percent of a more current Medicare Physician Fee Schedule (PFS).	Percentages for CRNA services are 55 percent of the comparison rate, 79 percent for APRN. See further discussion in Section 90, # 7 above.	A primary care clinic that has an APRN who provides the same primary care as a physician is not eligible for the enhanced ACA funds, even though the APRN rates are much lower than everyone else's. This creates a financial gap for the clinic, especially for services paid under APRN for open-door transgender clinics.	
14	Section 109: Speech/Hearing	Update to a revised percent of a more current Medicare Physician Fee Schedule (PFS).	Current rates are 95 percent of the comparison rate for agency and 78 percent for independent. See further discussion in Section 90, # 7 above.	Rates for speech therapy services have not been increased in a very long time although the cost to deliver care has increased. Children may wait for months to get needed services. Providers have to bill an independent rate under speech therapy (ST) when services are provided in schools; they cannot bill as an agency, and the independent rates are 20 percent lower. MaineCare pays higher rates for other settings, but the independent providers should be paid the same as agency providers.	
15	Section 30: Family Planning Agency Services	Implement current Medicare PFS and apply a standard percentage	MaineCare pays 100 percent of the Section 90 rate for most services; no record for others.	The current payment methodology does not properly incorporate all the aspects of care provision	A PMPM bundled rate, tied to performance, would address some additional services that Family

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
		discount for non-MD providers. Alternatively, consider option for a bundled clinic rate or other model such as the Certified Community Behavioral Health Clinics (CCBHCs) that would allow Family Planning clinics to contract to provide a broader array of services.	Range in comparison percentages (minimum and maximum) suggests that Medicare PFS adoption might rebalance rates.	necessary for a full service provider. For example, these providers deliver a wide array of services to all patients, regardless of their ability to pay. However, the family planning fee schedule is structured in a way that does not provide the full value of the visit. Something like the fixed encounter rates that FQHCs receive would help sustain and support better quality of services.	Planning Agencies provide and the role they serve as a primary care provider. Some states use a clinic rate to support these types of services.
16	Section 101: Medical Imaging	Update to a revised percent of a more current Medicare Physician Fee Schedule (PFS).	Current rates are 76 percent of the comparison rate. See further discussion in Section 90, # 7 above.		
17	Section 3: Ambulatory Care Clinic Services	Integrate into the Medicare Physician Fee Schedule (PFS).	Provider type is not present in other states; best practice is to pay the same amount for services across settings.		Services in this category are generally paid using the Medicare PFS and should be considered at the same time as policy sections that will be based on the updated Medicare PFS fee schedule.
18	Section 94: Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Update to a revised percentage of a more current Medicare Physician Fee Schedule (PFS).	The EPSDT fee schedule is the fee schedule for each of the types of services delivered, based on the setting. See further discussion in Section 90, # 7 above, and Section 25, #5 above.		
19	Section 23: Developmental and Behavioral Clinic Services	Integrate into the Medicare Physician Fee Schedule (PFS).	Use of a separate code and rate methodology for a single provider is inefficient and adds to administrative burden. Apply a high-risk population modifier to an already existing physical and		This should be completed at the same time as other changes to the physician fee schedule.

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
			behavioral health care assessment code.		
20	Section 55: Laboratory Services	Update to a revised percent of a more current Medicare Physician Fee Schedule (PFS).	Updating the current Medicare fee schedule can address requirements of Section 1903(i)(7) of the *Social Security Act* that states that agencies may not pay more for diagnostic laboratory tests than Medicare would have paid.[37]	Current reimbursement does not support higher costs related to travel for picking up specimens in physician offices in rural Maine.	
21	Section 65: Behavioral Health Outpatient Services (also see priority #24)	Integrate procedures into the Medicare Physician Fee Schedule (PFS) when possible. Cost studies will be necessary for non-standard procedures, but should be conducted at the same time as other studies serving a similar population to reduce the chance of provider inequity or inappropriate incentives. Evaluate specialty services for APMs.	Standard procedures should be incorporated into fee schedule updates using the Medicare fee schedule. Other specialty services such as medication management should be evaluated for APMs that support care teams, such as CCBHCs.	Providers have had trouble increasing essential/helpful programming because of open positions that have still not been filled. Much of outpatient service work and medication management is non-billable by definition. Accessibility of outpatient mental health services, particularly in rural areas, is a problem. Many outpatient clinicians do not take MaineCare patients due to no shows, low reimbursement rates, and administrative complexity. Outpatient rates for private clinicians are too low. Outpatient therapy providers bill the same amount for each session even though sessions can vary in type and intensity and require different training and strategies. A tiered model that reflects these dynamics would work better.	It may be possible to leverage the existing Behavioral Health Home model for some services and some populations (e.g., incorporating medication management services into Behavioral Health Homes, and/or a new higher tier of services).

[37] Section 1903. [42 U.S.C. 1396b] Payment to States. https://www.ssa.gov/OP_Home/ssact/title19/1903.htm.

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
22	Section 7: Free-Standing Dialysis	Adopt a Maine specific fee schedule for all services, using Medicare as a starting point, and set to approximate Maine Medicare rates. Document payment methodology for all covered services and educate providers on what is included/excluded in the prospective rates.	Current rate methodologies represent a mix of approaches without a clear rationale for differences.		
23	Section 91: Health Homes	Continue efforts to simplify the program and advance it to performance-based payments.	Payments in this program are currently not performance-based. Changes are underway to integrate three separate programs (Health Homes, Primary Care Case Management, and Primary Care Provider Incentive Payments) and tie payment to performance.		MaineCare is currently seeking to leverage multi-payer reform through participation in the Center for Medicare and Medicaid Innovation (CMMI) Primary Care First Initiative.
24	Section 65: Community Based Behavioral Health Services (also see #21 and #25)	Review rates for Sections 65 and 28 services that represent children's community behavioral health to determine if there are barriers to access to services, particularly where there are waitlists.	Developing rates that are comparable for similar services may reduce the potential to create inappropriate incentives or inequity in rates.	Day Treatment providers reported that payment is complicated by the nature of the service and because the services are being provided in a classroom. Community Rehabilitation Services (CRS) are hard to effectively manage due to the challenges and constraints of the PNMI rate and ratio of numbers of staff to hours that are required in that model. Moreover, changes to the wages in one model causes issues with staffing and wage compaction when the other services are not updated at the same time.	

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
25	Section 28: Rehabilitation and Community Support for Children	Rate studies should be completed on a scheduled basis.	There are benefits to evaluating the services that support children within the community together (i.e., Section 65 Community Based Behavioral Health) in order to ensure coordination and equity across the service system and that rates and incentives meet overall policy goals.	MaineCare receives productivity information from providers to set reasonable expectations, but then a rate is set with unobtainable productivity standards, which makes services unaffordable to perform. Providers need standards that reflect their actual productivity rate. Any rate analysis should not be based on historical costs and human resource expenses, but should move towards a livable wage framework.	
26	Section 43: Hospice	Consider reducing rates to equal CMS published Medicare rates, with potential savings.	Some rates exceed the CMS published rates and could be reduced; MaineCare rates on average are higher than comparison rates from other states for some services.	Rate setting for Hospice should mirror Medicare rates, which are revisited annually and greatly simplified. The complexity of reimbursement is continually changing with government payers and commercial; providers would benefit if reimbursement is more in sync.	Medicare has separate rates for providers who report quality indicators and those who do not. MaineCare could evaluate using a similar approach.
Group B: Hospital and Institutional Services Review and Redesign					
27	Section 45: Hospital Services Acute Inpatient,[38] Non-Critical Access Hospitals, Rehab Inpatient	Implement a revised methodology that includes two-sided accountability and performance payments for quality (APMs). Use supplemental payments	Grouper version is more than 8 years old and does not reflect changes in technology or service delivery. Current system has many different policies, elements of retrospective and	The rate methodology is consistent with Medicare DRGs and APCs, and that the process is efficient and works well. Other payers typically offer a rate increase to the base, which has not	This recommendation should be implemented at the same time for Section 45 and Section 46 services. CMS is increasing scrutiny of supplemental payment programs which may fuel future policy changes away from this model.[39]

[38] Section 45: Hospital Services Acute Outpatient, Non-Critical Access Hospitals is included in Group E.

[39] https://www.manatt.com/insights/newsletters/manatt-on-health-medicaid-edition/congress-delays-medicaid-dsh-cuts-makes-targeted.

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
		to fund payments as part of hospital base rates, which may include CAHs. Rebase rates to a more recent grouper version and base year and consider use of All Patient Refined Diagnosis Related Group (APR-DRG) grouper to better classify cases. Develop prospective payment approaches for capital. Include all inpatient hospital services in the classification methodology, using a prospective per diem, peer group, or other policy adjustors to pay for certain services.	prospective reimbursement, and other adjustments that could be simplified. An APM strategy will improve transparency and accountability and support VBP strategies. MaineCare can continue to target special classes of providers with different rate/incentive structures.	happened in MaineCare for a long time. There are no issues other than a low conversion factor.	
28	Section 45: Critical Access Hospitals (CAHs), Inpatient and Outpatient	Consider whether services could be included in a rebased DRG methodology, through peer grouping alternatives or targeted payment, to provide consistency in methodologies and reduce administrative effort. Consider how CAHs could be included in quality improvement activities, or other APMs that reward performance.	Current approach that requires cost settlement is burdensome for providers and MaineCare. Other payment methodologies may provide incentives for providers to improve care delivery and increase overall value to MaineCare.		This recommendation should be implemented at the same time for Hospital Services Acute Inpatient, Non-Critical Access Hospitals, Rehab Inpatient.

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
29	Section 46: Psychiatric Hospital Services	At the time of rebasing the DRG methodology, consider options for classifying services provided by these providers in a prospective per diem or per discharge payment arrangement, using base year costs for these providers in the same way that the Acute DRG hospital rates are determined.	MaineCare determines payment through negotiation of charges, which is not consistent with best practices, because providers can increase charges as they choose, and the approach does not provide incentives for efficient, effective, quality care.		This recommendation should be implemented at the same time for Hospital Services Acute Inpatient, Non-Critical Access Hospitals, and Inpatient Rehabilitation.
30	Section 45/46: Inpatient and Outpatient Hospital Based Physicians (HBPs)	Repurpose funding currently used for cost settlement of HBPs to instead be used for performance-based payments.	A change in methodology could create opportunities for inclusion of additional providers in value-based approaches.	The outpatient side does not look bad. Outpatient Medicare reimbursement is standard. We would like it to be more than 83.7 percent of Medicare but like the structure because it is understandable. Outpatient includes a Cost of Living Adjustment (COLA) that is applied every year based on medical inflation. Therefore, it goes up 1.5 to 3.3 percent per year.	Consider options for including supplemental payments in base rates for physicians' services. See Section 90.
31	Section 50: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IDD)	Consider whether a resident assessment could better distribute payment and reduce need for budget requests and other administrative efforts. Alternatively, review staffing levels and develop models that predict staffing and costs for services so that	MaineCare has not reviewed the methodology in more than 10 years. There are features of the system that may be improved, such as a reliance on provider budget requests to fund additional staffing needs, when there are no staffing model standards by which to assess the requests; there are also no quality incentives included in the methodology.	Providers indicated that they felt minimum wage factors in to ICF services more than in other services.	Changes here should be evaluated to understand any potential impact on the waiver programs.

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
		reviewers can assess budget requests.			
32	Section 67: Nursing Facility Services	Continue the use of an acuity system, comparable to the practices of other states. Consider approaches to simplify the methodology by implementing prospective rates for all components, and incorporating adjustments into specific payment system features. Evaluate peer grouping methodology and calculation of cost components and ceilings. Implement performance requirements: a quality adjustment pool could be funded with withholds from potential increases, and only those providers with high performance would be paid the quality incentive payment.	A review provides opportunities to continue to use a case-mix methodology, but to evaluate current methodology and respond to/address stakeholder concerns by developing a less complex approach. There may be better approaches and opportunities to create rates that are performance-based if MaineCare updates methodologies more frequently. Numerous state Medicaid agencies use value-based payment approaches in their nursing facility reimbursement methodologies. Approaches range from payment for reporting quality metrics to performance-based payments.	Providers expressed concerns about what they see as a complex methodology. The caps and disallowances of costs reduce the rate. While the methodology is referred to as "cost-based", it does not actually reimburse for the full cost. No other industry holds to a low cap for contracting medically necessary services required by regulation; it is outdated and arbitrary. Under the current system, the biannual rebasing (including COLA and appreciation) process takes a long time to incorporate direct care and COVID-19-related costs into the rate. Over the last 10 years, a dozen homes have closed mostly for financial reasons. The payment cap prevents agencies from attracting and retaining physician coverage and medical directorship. Cost report settlements take up to two years, and the process is unfair. If a provider files a cost report and has a payable due, the facility has to immediately pay it. However, the provider must wait for the full time until it is settled before they are paid back.	A new methodology could result in a redistribution of payments across nursing facilities, so Maine Care will have to determine how those adjustments could apply and will likely require legislative changes depending on the exact nature of the methodology.

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
				There is a distinct difference in level of care provided in nursing facilities across states.	
33	Section 97-C: Private Non-Medical Institution (PNMI-C): Medical and Remedial Service Facilities	Evaluate services at the same time as Nursing Facilities to ensure that changes in one setting do not negatively affect the other and consider options to develop fully prospective rates.	The model is not commonly found in other states, but the methodology most closely resembles what is used for Nursing Facilities.	PNMI-Cs have in recent years seen fewer closings than Nursing Facilities, but underfunding is still an issue. The aggregate shortfall is $3.5 million, and the majority of the shortfalls are in multi-level facilities. The increased costs of compliance for Nursing Facilities is spilling over into assisted living, which is a key piece of the continuum in Maine.	The current model appears to be working to serve people who need services, but do not require Nursing Facility level of care. Considering the age demographics of Maine, there is likely to be an increased need of this service.
Group C: Rebasing Services that Use Rate Studies					
34	Section 18: HCBS for Adults with Brain Injury	Review methodology and rebase rates every 5 years. Evaluate employment support programs for APM.	Rates were last updated in 2020 for some and 2016 for others. Completing the rate study during a time when other similar services are studied may reduce the potential to create inappropriate incentives or inequity in rates.	Section 18 provides little support for group settings, which require twice the administration with paperwork and oversight and can only be supported with additional grant funding.	With the expected time to complete the prior tasks, we estimate that the 5 year time period would place these services within this grouping. The services in Sections 18, 20, 21, 29, and 102 should be reviewed together.
35	Section 20: HCBS for Adults with Other Related Conditions	Review methodology and rebase rates every 5 years. Evaluate employment support programs for APM.	Rates were last updated in 2020 for some services and 2016 for others See discussion in Section 18.	A 1:1 rate used in a variety of support settings would be helpful for members with challenging behaviors and would better sustain the specialized skills and training needed if paired with a higher, more sustainable rate.	
36	Section 21: HCBS for Members with ID/DD	Review methodology and rebase rates every 5 years. Evaluate employment support programs for APM.	Some services were determined through a rate study, with updates last in July 2018 and planned throughout 2021. See discussion in Section 18.	The overall methodology does not adapt to changes in cost drivers like minimum wage or allow for acuity measures effectively. Minimum wage is the primary metric that drives cost. The wage	

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
				floor should be 125 percent of the minimum wage plus the costs related to employment contributions. Section 21 "per diem" rate is a misnomer and extremely burdensome. Providers must meet a 92.5 percent staffing ratio to get the full rate for the day, but are not paid more if they staff over 100 percent. The original CMS approved rates for Section 21 included an incentive to work with people with challenging behaviors, but that behavioral health add-on has been removed.	
37	Section 29: Support Services for Adults with Intellectual Disabilities or Autistic Disorder	Review methodology and rebase rates every 5 years. Evaluate employment support programs for APM.	Rates were last updated in July of 2018 with updates planned throughout 2021. See discussion in Section 18.	Section 29 day program rates are not equitably set. The elderly rate is $14.03 and the IDD rate for the same services is $8, which does not reflect the service effort and is discriminatory.	MaineCare and OADS should consider utilizing a standardized assessment for determining person centered planning budgets. This can aid in supporting best practices for individualized planning and budgeting.
38	Section 102: Rehabilitative Services	Review methodology and rebase rates every 5 years. Evaluate employment support programs for APM.	Rates were updated last in 2010. See discussion in Section 18.		
39	Section 17: Community Support Services	Implement the results of the 2017 rate review to conform with other similar service Sections.	It is not clear what the original basis is for the rates for services in this Section. Subsequent rate reviews were not implemented.	Section 17 Daily Living Support (DLS) rate is not sufficient due to its high administrative burden for use and access issues for clients who wait a long time for staffing.	Community Integration duplicates many elements of Behavioral Health Homes, without the focus on integrated care.

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
		Review methodology and rebase rates every 5 years.	It may be useful to examine these community support programs alongside other community support programs for other populations.	Programs have run in the red and many have closed.	MaineCare is conducting quantitative evaluation of Behavioral Health Homes and Community Integration and children's TCM in 2021 to determine whether DHHS should move toward single model.
40	Section 19: HCBS for Elderly and Adults with Disabilities	Review methodology and rebase rates every 5 years.	Rate study was completed in 2016 and updated in 2020 for personal support services (PSS). Rate studies should be completed on a scheduled basis and done at the same time as similar services to reduce the opportunity for the same service to have a different rate in a different waiver.	More focus on providing value-based care that supports prevention and comprehensive care would be more flexible and produce better outcomes. Home care agencies close because of low reimbursement rates, high administrative costs, and high licensing costs. Develop a rate based on a local market evaluation. Weekly home care authorizations are tedious for providers; individuals receiving this service have various needs, and when the needs emerge at the end of the week, providers must address them immediately since little time is left.	The services in Sections 19, 12, 26, and 96 should be reviewed together. MaineCare and the OADS are currently working on an APM for care coordination services.
41	Section 12: Consumer Directed Attendant Services	Review methodology and rebase rates every 5 years.	Rate study was completed in 2016 with updates in 2020 for PSS. See discussion in Section 19.		
42	Section 26: Day Health Services	Review methodology and rebase rates every 5 years.	A rate study was used to develop rates, with the last update in 2020 with an inflationary increase. See discussion in Section 19.		
43	Section 96: Private Duty Nursing and	Review methodology and rebase rates every 5 years.	A rate study was used to develop rates, with the last update in 2020 for PSS.		Personal support and nursing services appear to be updated differently and at different times.

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
	Personal Care Services		See discussion in Section 19.		Equity among nursing rates in different policy sections should be considered when reviewing this Section.
44	Section 92: Behavioral Health Homes	Consider incorporating medication management into this model or evaluate the use of a CCBHC model. Include provisions in policy to indicate rebasing at least every 5 years, with some periodic updating of rates.	Rate methodology should be reviewed periodically to ensure that the rates are reflective of current practices.	The Behavioral Health Home incentive structure is unnecessarily punitive. Rather than a payment reduction when quality measures are not met, implement a baseline payment with incentive payments for quality measures.	Evaluation of this service should include some comparison to Section 17 Community Integration and Section 13 Targeted Case Management for behavioral health services coming in 2021. See note in #39 above.
45	Section 93: Opioid Health Homes	Review the rate methodology periodically to ensure that the rates are reflective of current practices. Include provisions in policy to indicate rebasing at least every 5 years, with some periodic updating of rates.	Last rate study conducted with rates implemented 2019.	Opioid Health Homes (OHH) billing could get complicated if providers are not able to bill under the OHH. Providers have to piece together services from Section 65, which do not cover all the services provided. Providers recommended that members who are in OHH should not have a minimum contact amount, so that they are not piecing services together.	Pay for performance provisions are anticipated in upcoming rule changes in 2021.
Group D: Residential Settings					
46	Section 97-B: Private Non-Medical Institution-B: Substance Abuse Treatment Facilities	Revise rates based on a pre-determined staffing level periodically to ensure an efficient and sustainable rate. Standardize staffing levels so that rate setting is more transparent and consistent between providers.	Labor costs are the primary driver for this service category. Staffing and covered services should be structured to reflect standards established by the American Society of Addiction Medicine (ASAM) levels of care.	The rate system needs an automatic trigger for updating the COLA to support ability of providers to recruit, train, and retain staff.	The Department started a rate review in fall 2020 which will be completed in spring 2021.

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
47	Section 97-D: Private Non-Medical Institution-D Childcare Facilities	Revise prospective rates based on a pre-determined staffing level periodically to ensure an efficient and sustainable rate. Staffing levels should be standardized so that rate setting is more transparent and consistent between providers.	Labor costs are the primary driver for this service category.	Bed hold days are an issue. Providers hold the bed if members need to be hospitalized or for therapeutic home visits, which could be a month. MaineCare should consider what could be a fair rate for holding a bed with no revenue generation.	The Department started a rate review in fall 2020 which will be completed in spring 2021.
48	Section 97-F: Private Non-Medical Institution-F Non-Case Mixed Medical and Remedial Services	Transition to prospective rates based on a pre-determined staffing level and revise periodically to ensure an efficient and sustainable rate. Standardize staffing levels so that rate setting is more transparent and consistent between providers.	See discussion in Section 97-D.	PNMI and Community Rehabilitation Services (CRS) providers both have MHRT 1's and experience minimum wage-related pressures such that they cannot increase the wage in the PNMI without unbalancing the wage in CRS.	
49	Section 2: Adult Family Care Homes	Review the rate model to ensure it is serving the population need as designed. A methodology redesign may be necessary to ensure the services are provided in the way the policy intends.	Rate model is very distinct from that for other residential settings and should be evaluated to determine if the methodology should be standardized to match similar other service models.	Look at creating parity for adult family care home (AFCH) rates with Section 97 Appendix C. AFCH's are often forgotten because the homes are small and rural but serve the same population as Appendix C but at a rate of about $50/day.	
50	Section 107: Psychiatric Residential	Review the methodology and rebase rates every 5 years.	Rate was determined in late 2018 with estimated direct care costs. There are currently no active providers. The methodology should be reviewed when		

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
	Treatment Facility (PRTF)		there are active providers and use of this service to provide a better understanding of costs.		
Group E: Minimal or No Changes Needed					
51	Section 9: Indian Health Services (IHS)	No changes recommended.	Federal Regulations apply.		
52	Section 31: Federally Qualified Health Centers (FQHC)	No changes recommended.	Federal Regulations apply. Services offered by FQHCs have grown nationally as they work to integrate physical and behavioral health. MaineCare should monitor the amount of services billed outside of the prospective payment system (PPS) to ensure that reimbursement is appropriate.	The methodology has not kept up with costs of changes in care delivery due to care team models, population health management, and the growing reliance on EHRs. Providers want to maintain the relaxed rules around telehealth.	MaineCare plans to provide the opportunity for FQHCs to participate in its Primary Care 2.0 plans (see #23 above).
53	Section 103: Rural Health Clinics (RHC)	No changes recommended.	Federal Regulations apply.		Provide opportunity for RHCs to participate in Primary Care 2.0 (see #23 above)
54	Section 4: Ambulatory Surgical Center Services (ASC)	No changes recommended. Payment rates are 100 percent of Maine Medicare fee schedule rates; although MaineCare pays a relatively high percentage of the Medicare fee schedule for these services, the costs of services in this setting are lower than costs of similar services provided in an outpatient hospital setting. As MaineCare reviews the methodology for outpatient services, it should determine if and	Recommendations rely on a review of the Outpatient Prospective Payment System (OPPS). A review is necessary before implementing recommendations to assess quality, access and other issues. MaineCare should also consider if APMs might be designed to reward providers for using ASC services when possible instead of more costly outpatient settings.		Federal regulations do not permit MaineCare to require MaineCare members to use a specific provider.

Rank Order	Policy Section	Recommendation	Rationale for Ranking	Stakeholder Feedback	Additional Notes
		how to reduce payment disparities for comparable services in various outpatient settings.			
55	Section 45: Hospital Services Acute Outpatient	None to the methodology, but consider reducing rates to outpatient hospitals for certain services delivered in the ASC setting where ASC rates for those services are lower. Decisions about revising payment rates should consider access, quality, and other factors that might influence MaineCare's decisions about reducing rates. MaineCare should also consider incentivizing the use of less costly settings through APMs that reward provider cost efficiency.	MaineCare pays 83.7 percent of the Medicare Ambulatory Payment Classification (APC) rates. Last update: January 2021. Analysis showed that services billed with comparable procedure codes are paid at a higher rate in the outpatient hospital department than in the ambulatory surgical setting, even though MaineCare payment for ASCs is high in comparison to other payers.		Assess ASC rates, OPPS rates and Physician Office rates to determine if site of service differentials are appropriate or if rates should be decreased for any services.

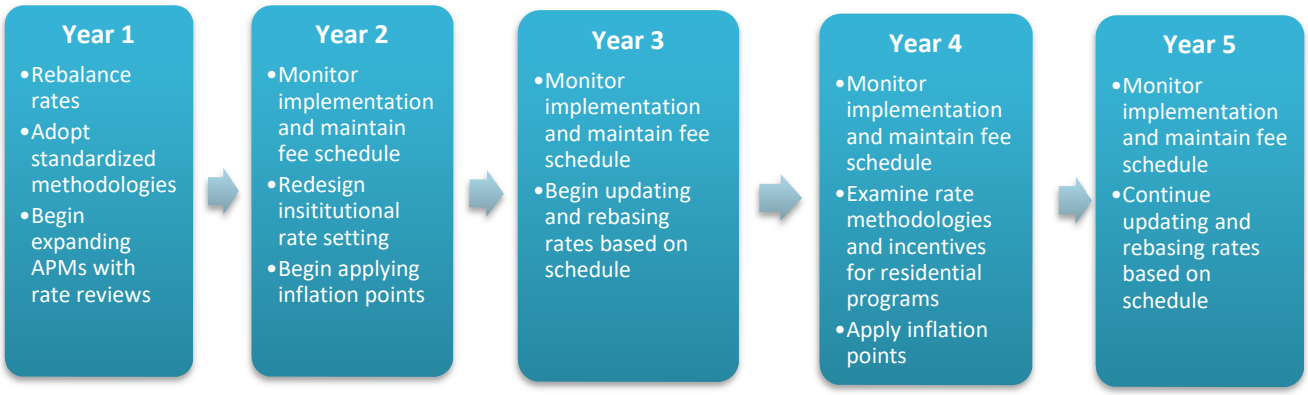
Implementation Considerations

The Department will need to make investment in staffing and commit other financial resources associated with the implementation of recommendations related to the MaineCare reimbursement methodologies and rates. There are costs to conduct the individual rate reviews, to perform ongoing oversight and maintenance of new methodologies and rates, and MIHMS change costs. Significantly, there are also costs associated with new spending for Medicaid services.

Implementation Timeline and Resource Requirements

Myers and Stauffer is developing a long-term work plan and timeline for implementing the recommendations according to the priorities established above that will be presented in the February final report. A preliminary implementation plan includes the framework of activities shown in Figure 3, to cover methodology and rate development, implementation, monitoring, and updates.

Figure 3 Five-Year Implementation Process



At this time, with input from MaineCare, Myers and Stauffer estimates that:

- Group A recommendations could likely be implemented within a two-year timeframe, to allow for multiple rulemakings to go through the Administrative Procedure Act process and to be approved by CMS.
- All recommendations could be implemented within five years.
- Two additional full-time equivalents (FTEs), at a cost of $230,798 per FTE per biennium, are estimated as necessary to implement the long-term plan.
- The total cost of conducting rate studies over the five-year period will be up to $2 million for up to ten rate studies and for other consultant costs.

Changes to MaineCare Spending

In addition to the administrative costs to MaineCare to implement the recommendations, there are MaineCare fiscal impacts associated with implementing rate change recommendations according to the prioritization ranking. Myers and Stauffer developed estimates of fiscal impacts associated with fee schedule changes for those policy sections where specific fee schedules are recommended. For other policy sections, there are recommendations that require additional study, including rate reviews or assessments, to determine the amount of any fiscal impact. The models presented below could be adjusted to increase or decrease estimated changes in current spending, and also phased in as necessary over multiple years based on the availability of funding.

Implementation of Updated Fee Schedules

To develop the spending estimates shown below, Myers and Stauffer compared 2020 MaineCare rates for codes in each policy section described, to a 2020 Medicare fee schedule, and for dental rates, a fee schedule modeled using Maine commercial rates. Spending estimates assume that the volume and mix of services stay constant, and include both federal and state dollars.

- Physicians, APRNs, Medical Imaging, Speech Therapy, Chiropractic, CRNA, Vision, Podiatry, Occupational Therapy, and Physical Therapy. Myers and Stauffer recommends updating rates for policy sections paid according to the Medicare PFS, and using comparable percentages of the Medicare PFS for two groups of policy sections: Physicians and APRNs; and Medical Imaging, Speech Therapy, Chiropractic, CRNA, Vision, Podiatry, Occupational Therapy, and Physical Therapy. The objective is to implement a rate model that would pay each of these groups using the same percentage of Medicare, and at the same time, implement the model for each group that would not result in a net decrease in total expenditures for any of the policy sections in that group. That is, while a rate update can result in either some codes experiencing a rate decrease or a rate increase, the total payments within a policy section will remain the same, assuming the current mix and volume of services stay constant.
- Myers and Stauffer developed a physician fee schedule model that is based on applying 71.4 percent[40] of the 2020 Medicare PFS rates to all providers except for the ACA rates intended for independent primary care Physicians (ACA),[41] who would continue to be paid 100 percent of the

[40] 71.4% comes from the fact that Medical Imaging (Section 101) current rates are at 71.4% of 2019 Medicare, so increasing all other non-physician providers to 71.4% is the least costly way to achieve a uniform percentage among non-physician providers while ensuring no aggregate level reduction to any policy sections.
[41] The ACA required that states pay primary care providers 100% of Medicare rates in CY2 2013 and 2014 for certain primary care and emergency department codes. This did not apply to hospital-based physicians in Maine because they are cost settled or to physicians in FQHCs, Rural Health Clinics, and Indian Health Clinics due to the

Medicare PFS.[42] The rate model assumes that there will be only minor changes to overall payments to Physicians (ACA) in the aggregate, and that the providers of services for all but one of the other policy sections will be paid rates that are higher in the aggregate than current levels. Table 18 summarizes the estimated change in Medicaid spending using the fee schedule, and the number of codes for which rates increase and the number of codes for which rates decrease within each policy section.

Table 18: Estimated Change in Medicaid Spending by Policy Section for Services Paid using Medicare PFS

Section	Modeled Current Spending	Current Average % of Medicare (Using 2020 Medicare PFS)	Modeled % of Medicare PFS	Estimated Change from Modeled Current Spending*	Estimated Change as % of Modeled Current Spending	Number of Codes with Rates that would Increase	Number of Codes with Rates that would Decrease
Medical Imaging (Section 101)	$8,672,175	71.4%	71.4%	$0.00	0.0%	265	146
Speech Therapy (Section 109)	$8,434,182	70.2%	71.4%	$143,370	1.7%	23	9
Chiropractic (Section 15)	$1,117,329	55.7%	71.4%	$315,187	28.2%	37	15
CRNA (Section 14)	$9,152,310	48.9%	71.4%	$4,210,255	46.0%	201	0
Vision (Section 75)	$13,138,345	59.4%	71.4%	$2,659,564	20.2%	34	15
Podiatric (Section 95)	$1,215,792	43.4%	71.4%	$782,117	64.3%	222	3
OT (Section 68)	$3,810,591	33.9%	71.4%	$4,211,451	110.5%	21	2
PT (Section 85)	$1,915,000	36.6%	71.4%	$1,817,444	94.9%	25	0
Physician (ACA) (Section 90)	$11,757,860	100.0%	100.0%	$125,785	1.1%	52	25
Physician (Non ACA) (Section 90)	$140,984,729	64.2%	71.4%	$15,707,478	11.1%	2626	708
APRN (Section 14)	$13,042,739	67.7%	71.4%	$703,907	5.4%	8	12
Total				**$30,676,556**	**14.4%**	**3515**	**935**

* *Includes state and federal spending.*

fact that they received cost-based encounter rates. MaineCare has continued these rates since the requirement ended in 2015.

[42] It should be noted, however, that MaineCare's current rates for these services are higher than the comparison rates – MaineCare rates average 114.1% of the comparison rates – so there is potentially room for reduction.

- Medical Supplies and Durable Medical Equipment. Myers and Stauffer recommends adjusting the DME fee schedule to apply urban and rural differentials, comparable to the process Medicare uses for DME rates. Adjusting rates to 100 percent of the 2020 Medicare fee schedule results in a reduction in MaineCare Medicaid spending as shown in Table 19.[43] Rates for 576 codes increase, while rates for 170 codes decrease.

Table 17: Estimated Spending for Medical Supplies and DME

Section	Modeled Current Spending	Current Average % of Medicare	% of Medicare	Estimated Change from Modeled Current Spending*	Estimated Change as % of Modeled Current Spending	Number of Codes with Rates that would Increase	Number of Codes with Rates that would Decrease
DME (non-Cures) (Section 60)[44]	$10,724,601	101.2%	100%	-$131,624	-1.2%	575	111
DME (Cures) (Section 60)	$4,129,018.16	131.8%	100%	-$997,389	-24.2%	1	59
Total				**--$1,129,013**	**-7.6%**	**576**	**170**

* *Includes state and federal spending.*

- Hospice Services. Myers and Stauffer recommends decreasing hospice rates to 100 percent of the current CMS Medicaid fee schedule.[45] For hospice services, we used the 2020 CMS-approved Medicaid rates as the basis for a fee schedule. Adjusting rates to 100 percent of the CMS Medicaid rates results in a reduction in MaineCare spending, as shown in Table 20. Overall, rates

[43] For each DME procedure code with Medicare fee schedule rates, Myers and Stauffer identified the rural and non-rural calendar year 2019 paid units based on the servicing provider zip code. Since our recommendations for DME include identifying rural and non-rural DME rates similar to Medicare, we used the current Medicare DME fee schedule and Medicare DME rural zip code identification file for the Medicare rates used in the budgetary comparisons. While we used the servicing provider's zip code, Medicare rates are based on the member's zip code of residence. We modeled expenditures and determined what percentage of Medicare would lend itself to a budget neutral approach based on 2019 utilization. This analysis was completed separately for CURES and non-CURES procedures codes. We only used codes where a Medicare rate exists – the other rates were excluded from this analysis.

[44] Refers to the 21st Century Cures Act https://www.fda.gov/regulatory-information/selected-amendments-fdc-act/21st-century-cures-act which prohibits federal financial participation payments to states for certain durable medical equipment.

[45] For each of the hospice procedure codes with MaineCare fee schedule rates, we based our analysis on a single locality; the paid amounts in our database represent the "average paid" amounts, not the actual fee schedule in place for each geographic area that is adjusted.

for four codes increase and rates for one code decrease (out of a total seven codes in this section.

Table 18: Estimated Spending for Hospice

Section	Modeled Current Spending	Current Average % of CMS Medicaid	% of CMS Medicaid	Estimated Change from Modeled Current Spending *	Estimated Change as % of Modeled Current Spending	Number of Codes with Rates that would Increase	Number of Codes with Rates that would Decrease
Hospice (Section 43)	**$1,855,103**	**112.3%**	**100.0%**	**- $207,679**	**-11.2%**	**4**	**1**

** Includes state and federal spending.*

- Dental Services. Myers and Stauffer recommends that MaineCare increase dental rates. We developed two Medicaid spending estimates. In Model 1, below, we apply a fee schedule using rates based on the 50th percentile (median) of estimated allowed amounts for commercial health plans in Maine in 2019. In Model 1, rates for 165 codes increase and rates for ten codes decrease.

Table 19: Model 1, Median Commercial Fee Schedule

Sub-Section	Modeled Current Spending	Current Average % of 2019 Commercial Median	Proposed % of Median Commercial Rates	Estimated Change from Modeled Current Spending*	Estimated Change as % of Modeled Current Spending	Number of Codes with Rates that would Increase	Number of Codes with Rates that would Decrease
Diagnostic Services	$2,772,016	28.9%	100.0%	$6,822,256	246.1%	18	3
Preventive Services	$3,925,840	38.9%	100.0%	$6,159,368	156.9%	13	1
Endodontics Services	$404,873	24.4%	100.0%	$1,254,594	309.9%	15	0
Restorative Services	$4,874,226	41.1%	100.0%	$6,998,929	143.6%	24	0
Periodontics Services	$35,631	19.8%	100.0%	$144,435	405.4%	8	0
Prosthodontics (Removable) Services	$221,234	34.1%	100.0%	$426,861	192.9%	31	0
Prosthodontics (Fixed) Services	$794	28.5%	100.0%	$1,996	251.4%	3	0

Sub-Section	Modeled Current Spending	Current Average % of 2019 Commercial Median	Proposed % of Median Commercial Rates	Estimated Change from Modeled Current Spending*	Estimated Change as % of Modeled Current Spending	Number of Codes with Rates that would Increase	Number of Codes with Rates that would Decrease
Maxillofacial Prosthetics Services	$1,050	40.4%	100.0%	$1,550	147.6%	2	0
Oral and Maxillofacial Surgery Services	$4,860,365	48.1%	100.0%	$5,240,722	107.8%	30	3
Orthodontics Services	$196,683	37.3%	100.0%	$329,930	167.7%	4	3
Adjunctive General Services	$1,645,134	52.2%	100.0%	$1,506,206	91.6%	17	0
Total				**$28,886,847**	**45%**	**165**	**10**

**Includes state and federal spending.*

Model 2, by contrast, sets rates at a percentage of the median commercial rate, but pays a higher percentage for diagnostic, preventive, and endodontics services than for other services, given that use of these services is associated with improved dental health. In Table 22 we apply a fee schedule based on 67 percent of the median of estimated allowed amounts for commercial health plans in Maine for diagnostic, preventive, and endodontics, and 50 percent of the median for all other dental services. Overall, rates for 141 codes increase and rates for 34 codes decrease.

Table 20: Model 2, 67% of Median Commercial for Diagnostic, Preventive, and Endodontic Services; 50% of Median for All Others

Sub-Section	Modeled Current Spending	Current Average % of 2019 Commercial Median	Proposed % of Median Commercial Rates	Estimated Change from Modeled Current Spending*	Estimated Change as % of Modeled Current Spending	Number of Codes with Rates that would Increase	Number of Codes with Rates that would Decrease
Diagnostic Services	$2,772,016	28.9%	67.0%	$3,656,146	131.9%	15	6
Preventive Services	$3,925,840	38.9%	67.0%	$2,831,250	72.1%	13	1

Sub-Section	Modeled Current Spending	Current Average % of 2019 Commercial Median	Proposed % of Median Commercial Rates	Estimated Change from Modeled Current Spending*	Estimated Change as % of Modeled Current Spending	Number of Codes with Rates that would Increase	Number of Codes with Rates that would Decrease
Endodontics Services	$404,873	24.4%	67.0%	$706,970	174.6%	15	0
Restorative Services	$4,874,226	41.1%	50.0%	$1,062,352	21.8%	20	4
Periodontics Services	$35,631	19.8%	50.0%	$54,402	152.7%	7	1
Prosthodontics (Removable) Services	$221,234	34.1%	50.0%	$102,814	46.5%	29	2
Prosthodontics (Fixed) Services	$794	28.5%	50.0%	$601	75.7%	3	0
Maxillofacial Prosthetics Services	$1,050	40.4%	50.0%	$250	23.8%	1	1
Oral and Maxillofacial Surgery Services	$4,860,365	48.1%	50.0%	$190,179	3.9%	23	10
Orthodontics Services	$196,683	37.3%	50.0%	$66,624	33.9%	3	4
Adjunctive General Services	$1,645,134	52.2%	50.0%	-$69,464	-4.2%	12	5
Total				**$8,602,124**	**45%**	**141**	**34**

** Includes state and federal spending.*

Rebalancing Rates with Current Fee Schedules

In addition to recommendations that change fee schedule amounts, Myers and Stauffer recommends changes to fee schedules to "rebalance" them, i.e., change outdated fee schedules to be consistent with current Medicare fee schedules. Myers and Stauffer modeled these changes to have a net neutral fiscal impact on each policy section, that is, Medicaid spending would be no more or less in the aggregate for each policy section, assuming the current mix and volume of services remain constant.

Myers and Stauffer recommends applying more current fee schedules and rebalancing the rates for Laboratory Services. Rebalancing results in an increase in rates for 36 codes, and a decrease in rates for 806 codes.

Conclusion

This interim report provides the results of a systematic and comprehensive evaluation of MaineCare's rates and rate setting methodologies for almost all of MaineCare policy chapters. The report summarizes Myers and Stauffer's recommendations to move away from the current disparate processes for developing rates to a comprehensive, streamlined, and coherent system to set rates for specific services and programs. It also establishes priorities for implementing the recommendations, and the framework for a plan to implement those recommendations. The next step is to develop a more detailed implementation plan to guide MaineCare through the recommended activities to formalize a planned approach with timelines for review and updates of all methodologies, anticipated to occur over a five year period. The final report, issued at the end of February, will provide that implementation plan, and may also include refinements to some individual recommendations.

Appendix A: Stakeholder Engagement

As part of the stakeholder engagement process, MaineCare and Myers and Stauffer held two phases of 11 meetings each with MaineCare providers and provider representatives:

- **Phase One**, from October 5 through October 9, 2020: Feedback requested on payment methodology.
- **Phase Two**, from December 4 through December 8, 2020: Feedback requested on sustainability of rates and rate comparison workbooks released prior to the meetings.

The meetings were grouped by similar policy sections of the MaineCare Benefits Manual (MBM). The following sections provide a summary of the feedback obtained in all 22 stakeholder meetings. Every effort was made to summarize the information while preserving the original intent and meaning as conveyed by the speaker.

1. MBM Policy Sections: Ambulance (5), Laboratory (55), Medical Supplies and Durable Medical Equipment (60), Medical Imaging (101)

Meetings held for Phase One on October 5, 2020 and Phase Two on December 4, 2020 included the following speakers, identified by meeting(s) attended.

Contributor Name	Company	Services
Phase One Meeting: October 5, 2020		
Elizabeth Donley, Manager	Affiliated Laboratory, Inc.	• Laboratory Services
Phase Two Meeting: December 4, 2020		
James McAvoy, CFO NorDx	Laboratory/MaineHealth	• Laboratory Services
Sean Andrews, Director of Financial Operations	Bedard Medical, Inc.	• Medical Supplies and Durable Medical Equipment (DME)
Catherine Hamilton, Senior Accountant	Acelleron	• Medical Supplies and DME
Kelly Hassett	MedCOR Professionals in Scarborough, ME	• Medical Supplies and DME
Jason Morin, President	HOMES Association	• Medical Supplies and DME
Diane Racicot, VP Payer Relations	National Seating and Mobility, Inc.	• Medical Supplies and DME
Laura Williard	American Association for Homecare, HOMES	• Medical Supplies and DME

The below table provides a summary of stakeholder comments received for the following MBM Policy Sections: Ambulance (5), Laboratory (55), Medical Supplies and Durable Medical Equipment (60), Medical Imaging (101).

Summary of Comments for MBM Policy Sections: Ambulance (5), Laboratory (55), Medical Supplies and Durable Medical Equipment (60), Medical Imaging (101)
General
• There are issues with enrollment/credentialing.

Summary of Comments for MBM Policy Sections: Ambulance (5), Laboratory (55), Medical Supplies and Durable Medical Equipment (60), Medical Imaging (101)
• When MaineCare is a secondary payer to a commercial plan, lab claims do not cross over, so providers must complete a manual process of scanning, copying, and uploading of the Explanation of Benefits (EOB) to be paid, which is extremely burdensome and costly. • There is a new administrative burden put on labs as a result of prior authorizations (PAs), and labs are not equipped to do this check; if the doctor orders and signs the order for the lab work, it is done. The clock is ticking on samples, and they sometimes have to send the specimen to a specialty plan. Any prior authorization on the lab is a huge administrative burden and does not reflect how the work flows in the clinical setting. • The pandemic has caused increased product costs, creating supply chain shortages and major blockages and accessibility issues that are expected to continue well into 2021.
Rate/Payment Methodology
• Providers can no longer offer some products due to reduced Medicare reimbursements, such as 10 non-narcotic service codes for pain management developed in response to the opioid epidemic. MaineCare has maintained its rates, which appears to have contributed to a decline in overdose deaths over the last 10 years. • The lab methodology does not limit access to care, but the rates do, especially in very remote areas. For example, when a lab has to provide results to a • Federally Qualified Health Center (FQHC), the lab has to courier to FQHCs and doctors' offices in rural areas particularly when the closest hospital is an hour away from the person and the member cannot reasonably go there for the test. Therefore, the test is done in the doctor's office instead, which results in high courier costs to pick up the samples and process the results.
Phase I Report
• It is unclear why two of the five states were selected, specifically with respect to some of the K codes, group wheelchairs, and the rental rates in the analysis. • Cures comparisons were made for 244 codes, but the aggregate was not used against Medicare. • Minimum wages and cost of doing business have and are continuing to increase, which is why a rate comparison with other states is insufficient. • The report gives a total paid amount of $10.5 million for 20 or 22 lab tests, but within that data set, six tests pertain to toxicology, which is a disproportionate amount of the total spend. Recommend adding more codes to include more routine services, especially molecular diagnostic testing and genetic testing.

2. MBM Policy Sections: Dental Services (25), Physician (90), Ambulatory Surgical Center (Oral Surgery Only) (4)

Meetings held for Phase One on October 5, 2020 and Phase Two December 2, 2020 included the following speakers, identified by meeting(s) attended.

Contributor Name	Company	Services
Phase One Meeting: October 5, 2020		
Norma Desjardins, DMD, Vice President, MDA	St. Apollonia Dental Clinic	• Dental Services
Becca Matusovich, Executive Director	Partnership for Children's Oral Health	• Dental Services

Contributor Name	Company	Services
Jeffrey Walawender, Executive Director/Chief Dental Officer	Community Dental (Portland, Biddeford, Rumford, Farmington, Lewiston, Monson)	• Dental Services
Angela Westhoff, Executive Director	Maine Dental Association	• Dental Services • Ambulatory Care Clinic Services (Oral Surgery Services Only) • Physician Services (Oral Surgery Only)
Phase Two Meeting: December 2, 2020		
Heidi Brouette and Carli Simon-Cleaves, Office Managers	Northern Maine Oral & Facial Surgery	• Dental Services • Ambulatory Care Clinic Services (Oral Surgery Services Only), • Physician Services (Oral Surgery Only)
Barbara Covey, Board President	Waterville Community Dental Center	• Dental Services
Norma Desjardins, DMD, Vice President, MDA	St. Apollonia Dental Clinic	• Dental Services
Brian Hoops, Owner	Brian Hoops, DDS, PA	• Dental Services
Becca Matusovich, Executive Director	Partnership for Children's Oral Health	• Dental Services
Beth Pearce, Oral Health Coordinator	Maine Primary Care Association	• Dental Services
Jeffrey Walawender, Executive Director/Chief Dental Officer	Community Dental (Portland, Biddeford, Rumford, Farmington, Lewiston, Monson)	• Dental Services
Angela Westhoff, Executive Director	Maine Dental Association	• Dental Services • Ambulatory Care Clinic Services (Oral Surgery Services Only) • Physician Services (Oral Surgery Only)

The below table provides a summary of stakeholder comments received for the following MBM Policy Sections: Dental Services (25), Physician (90), Ambulatory Surgical Center (Oral Surgery Only) (4).

Summary of Comments for MBM Policy Sections: Dental Services (25), Physician (90), Ambulatory Surgical Center (Oral Surgery Only) (4)
Dental
• We appreciate the transparency and opportunity to review the information. • Disease prevention is the primary focus of dentistry. • Dental professionals have ethical obligations to focus on disease prevention, but coverage for persons who are over the age of 21 does not allow for any preventive care such as a comprehensive exam, x-rays, and caries evaluation. MaineCare has only a handful of codes and the rates are extremely low (25% of the commercial rate), so providers can only focus on restorative care, which contradicts their training. Children are losing their teeth and cannot find a dentist to treat them. We need a system that pays for more preventive and restorative services for high risk kids and less for those who are lower risk. • Providers in southern Maine are no longer eligible for provider loan repayments. Loan repayment kept salary costs down and made lower reimbursement overall easier to accept, but the payer mix is over 50% MaineCare, which is not sustainable. • Prior authorizations can be unnecessary and delay appropriate care. PAs that require sign-off by a primary care physician (PCP) (e.g. dentures) are difficult to get and insulting to the dentist.

Summary of Comments for MBM Policy Sections: Dental Services (25), Physician (90), Ambulatory Surgical Center (Oral Surgery Only) (4)
• The billing system is very burdensome and does not reflect the way the service is provided. Dentists are expected to bundle the services themselves. • We spend more money on emergency care because we do not spend it on preventive care for both children and adults. Members then have to wait for a long time for oral surgery or something more involved. • The rates have not been updated in about 30 years; MaineCare has only updated codes for orthodontics and oral surgery. Denture reimbursement is so low, it doesn't even cover the lab work. • The MaineCare endodontics fees are quite low and have not been raised in 20 years, which is not sustainable, especially for the non-profit clinics. • Maine Dental Association, which represents 90% of Maine dentists, informally surveyed dentists and received 230 responses (30%): 41% take MaineCare, and 59% do not because of low rates (#1 reason), administrative burden (2nd), and patient no-shows (3rd). • Any kind of rate increase, come with an expected increase in value. How are current outcomes measured? Dentists do not feel involved in this discussion so far and want collaboration with MaineCare for Alternate Payment Methods (APM)/Value-Based Purchasing (VBP). • The report includes a few mistakes: the methodology for the commercial insurance is wrong - child prophy 147 and sealants 576 are much lower; in some of the codes, the lab costs alone are larger than the rate; the Medicaid rate comparison is good.
Ambulatory Service Centers (Oral Surgery Services Only)
• The rate MaineCare pays for the procedure this provider performs is terrible - $176.35 - and no one at MaineCare has been able to provide any guidance as to where that figure came from
Physician (Oral Surgery Services Only)
• Speaker has seen terrible oral health problems and disease come through the Emergency Department. • Access to essential medical care shouldn't be reliant on grants and donations. They used to have loan repayment but those options are no longer available so have to pay higher salaries.

3. MBM Policy Sections: APRN (14), FQHC (31), Physician (90), Health Home (91), EPSDT (94), and Rural Health Clinics (103)

Meetings held for Phase One on October 5, 2020 and Phase Two on December 4, 2020 included the following speakers, identified by meeting(s) attended.

Contributor Name	Company	Services
Phase One Meeting: October 5, 2020		
Jeff Kirby, Vice President of Finance	Maine Medical Partners	• Physician Services
Pete Plummer, COO	Woodfords Family Services	• Targeted Case Management (TCM) • Community Rehabilitation Services • Rehabilitative/Community Support for Children with Cognitive Impairments and Functional Limitations • Behavioral Health Day Treatment • Home and Community-Based Treatment (HCBT) • Behavioral Health Home Services

Contributor Name	Company	Services
		• Private Non-Medical Institution (PNMI), App D Therapeutic Foster Care Only
Darcy Shargo	Maine Primary Care Association	• FQHC Services
Rhonda Woodman, Medical Billing Manager	Family Planning Association of Maine	• Advanced Practice Registered Nurse (APRN) Services • Family Planning Agency Services • Physician Services
Phase Two Meeting: December 4, 2020		
Dan Morin, Director of Government Affairs	Maine Medical Association	• Ambulatory Care Clinic • Ambulatory Surgical Center • Free-Standing Dialysis • APRN • FQHC and Rural Health Clinic (RHC) Services • Physician • Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

The below table provides a summary of stakeholder comments received for the following MBM Policy Sections: APRN (14), FQHC (31), Physician (90), Health Home (91), EPSDT (94), and Rural Health Clinics (103).

Summary of Comments for MBM Policy Sections: APRN (14), FQHC (31), Physician (90), Health Home (91), EPSDT (94), and Rural Health Clinics (103)
General
• The FQHC Prospective Payment System (PPS) is straightforward and easily understandable, but the PPS has not kept up with costs of changes in care delivery due to care team models, population health management, and the growing reliance on electronic health records (EHRs). • The methodology cannot respond to emergencies such as COVID. • Providers want to maintain the relaxed rules around telehealth. • The billing process for medical services outside the clinic rate is extremely burdensome and inefficient, has high unnecessary administrative costs, and presents extreme limitations to resolve issues. • Physicians have ethical obligations to serve MaineCare but may impose limits on the number of MaineCare members they will accept because rates are so low, especially for independent physician-owned practices. • It is paramount to increase access and not cut physician or anesthesia rates. • A primary care clinic that has an APRN who provides the same primary care as a physician is not eligible for the enhanced Affordable Care Act (ACA) funds, even though her rates are much lower than everyone else's. This creates a financial gap for the clinic, especially for services paid under APRN for open-door transgender clinics. • Clinics are often the only provider for MaineCare patients, some of whom are covered by third party insurance. Clinics use a sliding fee schedule but struggle to financially sustain services.

4. MBM Policy Sections: Outpatient Behavioral Health Services[46]

Meetings held for Phase One on October 6, 2020 and Phase Two on December 7, 2020 included the following speakers, identified by meeting(s) attended.

Contributor Name	Company	Services
Phase One Meeting: October 6, 2020		
Maureen Bilodeau, Director of Children's Services and Case Management	The Progress Center	• TCM • Rehabilitative and Community Support Services for Children with Cognitive Impairment and Functional Limitations • Behavioral Health Home Services
Melissa Bowker-Kinley, Medical Director	Health Affiliates Maine	• Medication Assisted Treatment (MAT) • Medication Management
Christy Daggett, Chief Financial and Administrative Officer	Aroostook Mental Health	• Outpatient Behavioral Services
Blanca Gurrola, VP Clinical Services	Maine Behavioral Healthcare	• Outpatient Behavioral Services
Dale Hamilton, Executive Director	Community Health and Counseling Services	• Community Support Services: Day Supports Services • Behavioral Health Services: ▪ Behavioral Therapy ▪ Intensive Outpatient Program (IOP) ▪ MAT ▪ Medication Management ▪ Outpatient
Jillian Jolicoeur, COO	Assistance Plus	• Day Supports • Skills Development Services • Outpatient Behavioral Services
Margaret Longsworth, Director of Mental Health and Clinical Services	OHI	• Community Support Services: Skills Development Services • Behavioral Health Services ▪ Medicaid Management ▪ Outpatient
Patricia McKenzie, Clinical Administrator Outpatient and SUD Services	Kennebec Behavioral Health	• IOP • Outpatient Behavioral Services
Ken Olson, Executive Director	KidsPeace	• Behavioral Therapy • IOP • Behavioral Health Services: Outpatient
Pete Plummer, COO	Woodfords Family Services	• Medication Management • Outpatient Behavioral Services

[46] Includes: Targeted Case Management (13), Community Support Services (Assertive Community Treatment, Community Integration Services, Community Rehabilitation Services, Daily Living Support Services) (17); Rehabilitative and Community Support Services for children with Cognitive Impairments and Functional Limitations (28); Behavioral Health Services (ACT, Behavioral health Day Treatment, Clubhouse, Crisis, Home and Community-Based Treatment) (65); PNMI, Appendix D Therapeutic Foster Care only (97).

Contributor Name	Company	Services
Matthew Siegel	Maine Behavioral Healthcare	• Behavioral Therapy • IOP • Medication Management • Neurobehavioral Services • Outpatient Behavioral Services
Susan Slick	Acadia Hospital	• Behavioral Therapy
Jonathan Smith, Assistant Director of Case Management	UCP of Maine	• Outpatient Behavioral Services
Phase Two Meeting: December 7, 2020		
Dale Hamilton, Executive Director	Community Health and Counseling Services	• Community Support Services: Day Supports Services • Behavioral Health Services: ▪ Behavioral Therapy ▪ IOP ▪ MAT ▪ Medication Management ▪ Outpatient
Margaret Longsworth, Director of Mental Health and Clinical Services	OHI	• Community Support Services: Skills Development Services • Behavioral Health Services ▪ Medicaid Management ▪ Outpatient
Ken Olson, Executive Director	KidsPeace	• Behavioral Therapy • IOP • Behavioral Health Services: Outpatient
Pete Plummer, COO	Woodfords Family Services	• Medication Management • Outpatient Behavioral Services
Julie Schirmer, Vice President	NASW Maine	• Behavioral Health Services: Outpatient
Malory Shaughnessy, Executive Director	Alliance for Addiction and Mental Health Services, Maine	• Day Supports • Skills Development • Behavioral Therapy • IOP • MAT • Medication Management • Neurobehavioral Services • Outpatient Behavioral Services

The below table provides a summary of stakeholder comments received for the following MBM Policy Sections: Outpatient Behavioral Health Services.

Summary of Comments for MBM Policy Sections: Outpatient Behavioral Health Services
General
• Providers have had trouble increasing essential/helpful programming because of open positions that have still not been filled. • Much of outpatient service work and medication management is non-billable by definition. • Accessibility of outpatient mental health services, particularly in the rural areas, is a problem. Mental health is the fourth highest-ranking concern in rural areas, and accessibility to social workers, psychologists, and licensed chemical dependency counselors (LCDCs) is a huge issue. • Many outpatient clinicians do not take MaineCare patients due to no shows, low rates, and administrative complexity. • Electronic visit verification (EVV) is an unfunded mandate that becomes effective January 1, 2021 and requires a lot of extra effort, time, and setup.
Rates/Payment
• The Burns rate setting process did not feel transparent; rate assumptions should have been negotiated with the providers. • There has been little increase in MaineCare rates, which is a barrier to competitive hiring with rising expenses like rent, salaries, utilities, and other operating costs. • MaineCare receives productivity information from providers to set reasonable expectations, but then a rate is set with unobtainable productivity standards, which makes services unaffordable to perform. Providers need standards that reflect their actual productivity rate. • Outpatient rates for private clinicians are too low. • There are long waiting lists for services, and the rates are not high enough to hire staff to treat these children in the home on weeknights after school and on weekends. • The originally developed rate for Daily Living Support (DLS) and skills development was based on an assumption that a case manager, which the client was required to have to receive these services, would develop the assessment and treatment plan. However, when the service/rate was rolled out, it was discovered that MaineCare could not require case management. The assessment rate was never adjusted to reflect the extra work needed to perform the service without a case manager. • Section 65 should include a separate code or add-on for those supporting progressive treatment plans (PTP) for medication management. People with challenging behaviors can be successfully treated through a PTP but you cannot find providers who do this at the current low (or no) rate. • The basis for Section 65 is rate studies and other informal reviews. The last major update was in 2020 and included only some minor (2%) adjustments. Most rates have not been updated in a decade. • Limited fee-for-service (FFS) units do not work well for providers. For example, the initial psychiatric evaluation time limit is not sufficient, especially with administrative burden and paperwork time. Thirty minutes for follow up appointments is not sufficient or flexible enough. • Providers report that no-shows, short-notice cancellations, and irregular attendance for scheduled appointments are a big issue, which the Burns study and rate model did not fully take into account. Suggest incorporating actual utilization data using a 12-month look-back and a sample of provider attendance reporting. • Psychologists are paid for report writing, but master's level clinicians are not.

Summary of Comments for MBM Policy Sections: Outpatient Behavioral Health Services
• Evidence-based practices require training, consultation, data collection, and documentation to perform the service, but these are not considered billable or reflected in the current methodology. • The current methodology affects providers' ability to hire outpatient therapists. There is a lot of non-billable activity that is not reimbursable and affects the caseloads that the therapists are taking on. Is there a way to include an hour for non-billable activity for every hour of face-to-face services, even if they have different rates?
Outpatient Therapy
• Some school-based clinical services providers expressed positive feedback about VBP and understand what they can bill. • There is an equity issue with service authorizations for skills development services. The current process for authorization is very onerous and creates barriers for access; time limits are imposed on this service but not on others (e.g., 90 day or 1-year justification for continued authorization). • When multiple therapies are performed in a single day, one of the services has to be written off. This negatively affects members in rural areas who cannot travel on multiple days and want to receive all therapies on the same day.
Medication Management
• The current rate structure for medication management is outdated and does not account for restriction and documentation requirements. The rate does not permit crisis assessment or crisis planning to keep individuals out of the hospital. Providers cannot be paid for more than 30 minutes, so they refer members to crisis services or emergency departments, which creates disjointed care. • There is a need to reevaluate the children's program rates and methodology. Recent rate increases for psychiatrists incentivized the adult program for that provider. However, the agency felt forced to close the children's program since there was no rate increase to adjust for program losses. • There is interest in VBP but providers need to be involved. Medication management is perfect for APM if it is reimbursed properly. The current payment methodology includes no incentives for coordination of care, efficiencies of care, or documentation of quality. • Behavioral health indicators are often medical indicators and do not reflect the actual value of the behavioral health services. Providers should be evaluated on measures that are within their control. Some commercial insurers have contracts based on collaboration and quality, but they are payments outside the regular service, such as quality payments that reward for clients that meet benchmarks. • Members are discharged from the hospital with PTPs that are much harder to administer for members who have had multiple hospitalizations and do not understand their own conditions. It would be helpful to create a tier of service to reflect the different between very intense needs and those cases where the people are very stable and just need monitoring.
Phase I Report
• Outpatient therapy providers bill the same amount for each session even though sessions can vary in type and intensity and require use of different training and strategies. A tiered model that reflects these dynamics would work better.

Summary of Comments for MBM Policy Sections: Outpatient Behavioral Health Services
• Many outpatient services could lend themselves to VBP with full wraparound care coordination and inclusion of collateral services. This requires more targeted, measurable outcomes that are not unnecessarily focused on medical outcomes, but rather on outcomes that the provider can affect together with the client. • Maine has waitlists for many of these services, other services where there are no waitlists, and some, like medication management, that do not have a "waitlist" but appointments take 6 - 8 months to schedule. • We are already seeing a movement to include medication management expectations in contracts and comments in other statements of requirements. The requirement to participate in a PTP is much more for a medication management provider with new requirements that are not reflected in the rate. These add-ons need to be factored in above the base services and funded in a different manner.

5. MBM Policy Sections: Home and Community-Based Services for Older Adults and Members with Physical Disabilities[47]

Meetings held for Phase One on October 7, 2020 and Phase Two on December 8, 2020 included the following speakers, identified by meeting(s) attended.

Contributor Name	Company	Services
Phase One Meeting: October 7, 2020		
Dale Hamilton, Executive Director	Community Health and Counseling Services	• Home Health • Hospice
Jillian Jolicoeur, COO	Assistance Plus	• Home Health • Private Duty Nursing • Personal Care Services
Nathan Miller, Senior Program Director	Spectrum Generations	• Home and Community-Based Services (HCBS) for Elders and Adults with Disabilities (EAD) • HCBS for Intellectual Disabilities (ID) or Autism Spectrum Disorder (ASD) • Support Services for Adults with ID or ASD • Personal Care Services
Kristen Petersen, Associate Director	Residential Resources	• HCBS ID or ASD
Mathew Shankweiler, Owner	R&C Home Care Inc.	• Personal Care Services
Betsy Sawyer-Manter, CEO	SeniorsPlus	• Consumer Directed Attendant Services • HCBS for EAD
Phase Two Meeting: December 8, 2020		
Laurie Belden, Executive Director	Home Care & Hospice Alliance of Maine	• HCBS for EAD • Home Health Services • Hospice • Private Duty Nursing • Personal Care Services
Colleen Hilton, SVP & President	Northern Light Home Care and Hospice	• Home Health • Hospice

[47] Includes these services: Consumer Directed Attendant (12); Home and Community Benefits for the Elderly and Adults with Disabilities (19); Day Health Services (26); Home Health Services (40); Hospice Services (43); and Private Duty Nursing and Personal Care Services (96).

Contributor Name	Company	Services
Jillian Jolicoeur, COO	Assistance Plus	• Home Health • Private Duty Nursing • Personal Care Services
Nathan Miller, Senior Program Director	Spectrum Generations	• HCBS EAD • HCBS ID or ASD • Support Services for Adults with ID or ASD • Personal Care Services

The below table provides a summary of stakeholder comments received for the following MBM Policy Sections: Home and Community-Based Services for Older Adults and Members

Summary of Comments for MBM Policy Sections: Home and Community-Based Services for Older Adults and Members with Physical Disabilities
General
• More focus on providing value-based care that supports prevention and comprehensive care would be more flexible and produce better outcomes. • Methodologies that allow for a more person-centered approach would be helpful as demand for services increases and providers are unable (due to staffing shortages/high turnover and low rates) to provide all authorized services. • Some services were authorized but not provided to the member because the service was not available. For example, snow removal causes a lot of injury to the person and staff, but is not reimbursable. The providers continue to provide the service, because the person needs it. Too much snow can prevent other critical services, such as oil delivery. • Providers are frustrated that section 96 nurses were not included in the section 19 nursing bill. • Providers are frustrated with EVV and the 15-minute time increment for billing, which focuses service time on strategizing to create the greatest billable efficiency rather than providing needed care. • Weekly home care authorizations are tedious for providers; individuals receiving this service have various needs, and when the needs emerge at the end of the week, providers must address them immediately since there is little time left. • It is difficult to obtain authorization for additional hours for a member who needs additional services in the first week following hospital discharge. Hours cannot be transferred from week to week, so providers cannot adapt care to the patient's needs. Consider adopting an annual authorization of service hours to address varying needs (i.e., Adult Day Services and Respite). • Nurses should not be limited to billing for 15 minutes of face-to-face appointments with the member, since the nurse has other supplemental tasks, such as verifying medical supplies, checking food access, etc. Intermittent well-check nursing should be implemented using an hourly billing unit or a flat fee model. • Care should be more person-focused and not time-and-task-driven (e.g., billing by 10-minute increments for toileting and 15 minute increments for transferring the patient). This can be tedious for the providers and focuses on quantity over quality.
Rates/Payment Methodology
• The current methodology reflects the time it was developed and has not been updated to reflect inflation, changes to minimum wage and licensing requirements, time and mileage expenses of delivering care to more rural parts of the state, etc.

Summary of Comments for MBM Policy Sections: Home and Community-Based Services for Older Adults and Members with Physical Disabilities
• There is a lack of reimbursement for preceptors or mentors for new people. • The methodology does not support tiered employment; a 25-year service veteran and a 1-year of service staff member make the same rate. It does not support higher reimbursement for employees who have higher training and skills in things such as dementia care. • The current methodology does not provide for good care for patients who are sick and have been discharged from the hospital. For example, if a catheter falls out, a member is usually sent to the emergency department rather than being authorized for a much less expensive nursing visit alternative.
Phase I Report
• Home care agencies close because of low reimbursement rates, high administrative costs, and high licensing costs. Develop a rate based on a local market evaluation. • Declines in approvals for certified nursing assistants (CNAs) means higher needs people are being pushed into personal care and are not being given services that meet their needs. There are long wait lists and access issues, which are addressed in the Workforce Commission. The Commission wants 125% of minimum wage as the payment basis, but MaineCare reimbursement is too low. • The Centers for Medicare and Medicaid Services (CMS) has also been working on Section 96 intimate nursing issues, which is a great concern and needs high prioritization in 2021. • The upcoming paid time off (PTO) requirement is not reflected in the Maine rate. Members see budgets shrink because of EVV, the statewide minimum wage increase, and the Portland minimum wage increase. Rates are not keeping pace with all of these additional costs. • Rate setting for hospice should mirror Medicare, which is revisited annually and greatly simplified. The complexity of reimbursement is continually changing with government payers and commercial; providers would benefit if reimbursement were more in sync. • Providers would like to see Service Coordination moved to a PMPM rate.

6. MBM Policy Sections: Home and Community-Based Services for Members with Intellectual or Developmental Disabilities and/or Acquired Brain Injury and Other Related Conditions[48]

Meetings held for Phase One on October 7, 2020 and Phase Two on December 8, 2020 included the following speakers, identified by meeting(s) attended.

[48] Includes these services: Home and Community-Based Services for Adults with Brain Injury (18); Home and Community-Based Services for Adults with Other Related Conditions (20); Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder (21); Developmental and Behavioral Clinic Services (23); Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder (29); Intermediate Care Facilities for Individuals with Intellectual Disabilities Services (50); and Rehabilitative Services (102).

Contributor Name	Company	Services
Phase One Meeting: October 7, 2020		
Eric Berry, Financial Analyst	Penquis CAP Inc.	• Support Services for Adults with IDD or Autism
Andrew Cowan, CFO	John F. Murphy Homes	• HCBS ID or ASD • Support Services for Adults with IDD or Autism • Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IDD)
Rebecca Emmons, Executive Director	Mobius, Inc.	• HCBS ID or ASD • Support Services for Adults with IDD or Autism
Ryan Gallant, President	Gallant Therapy Services	• Rehabilitative Services • Support Services for Adults with IDD or Autism
Todd Goodwin, CEO	John F. Murphy Homes, Inc.	• HCBS ID or ASD • Support Services for Adults with IDD or Autism • ICFs/IDD
Ann-Marie Mayberry, Executive Director	GMS Southern Maine	• HCBS for Adults with Other Related Conditions • HCBS ID or ASD • Support Services for Adults with IDD or Autism
Eric Mucke, Business Manager	Sweetser	• HCBS ID or ASD • Support Services for Adults with IDD or Autism
Ray Nagel, Executive Director	Independence Association	• Rehabilitative Services • HCBS for Adults with Other Related Conditions • HCBS ID or ASD • Developmental and Behavioral Clinic Services • Support Services for Adults with ID or Autism
Pete Plummer, COO	Woodfords Family Services	• Rehabilitate Services • HCBS ID or ASD • Support Services for Adults with IDD or Autism • HCBS for Adults with Other Related Conditions
Mike Stair, President and COO	Care & Comfort	• HCBS for Individuals with Acquired Brain Injury (ABI) • HCBS for ID or ASD • Support Services for Adults with IDD or Autism
Catherine Thibedeau, Executive Director	Independence Advocates of Maine	• HCBS ID or ASD • Support Services for Adults with IDD or Autism • ICFs/IDD
Phase Two Meeting: December 8, 2020		
Todd Goodwin, CEO	John F. Murphy Homes, Inc.	• HCBS ID or ASD • Support Services for Adults with IDD or Autism • ICFs/IDD
Jennifer Kinnelly, Director of Support Services	Uplift Inc.	• HCBS ID or ASD
Joseph Kuhn, Director	BFLI	• HCBS for Adults with Other Related Conditions
Heidi LeBlanc, COO	Penquis	• HCBS ID or ASD • Support Services for Adults with IDD or Autism
Heidi Mansir, Executive Director	Uplift, Inc.	• HCBS for Adults with Other Related Conditions • HCBS ID or ASD • Support Services for Adults with IDD or Autism
Ann-Marie Mayberry, Executive Director	GMS Southern Maine	• HCBS for Adults with Other Related Conditions • HCBS ID or ASD • Support Services for Adults with IDD or Autism

Contributor Name	Company	Services
Bridget McCabe, Assistant Associate Director	GMS	• HCBS ID or ASD
Scott Miller, Com Sup Director	Support Solutions/Creative Trails	• HCBS ID or ASD
Eric Mucke, Business Manager	Sweetser	• HCBS ID or ASD • Support Services for Adults with IDD or Autism
Ray Nagel, Executive Director	Independence Association	• Rehabilitative Services • HCBS for Adults with Other Related Conditions • HCBS ID or ASD • Developmental and Behavioral Clinic Services • Support Services for Adults with ID or Autism
Pete Plummer, COO	Woodfords Family Services	• Rehabilitate Services • HCBS ID or ASD • Support Services for Adults with IDD or Autism • HCBS for Adults with Other Related Conditions
Deb Smith, Director of ID Services	OHI	• HCBS ID or ASD • Support Services for Adults with IDD or Autism
Dennis Strout, Director	Momentum	• HCBS ID or ASD
Catherine Thibedeau, Executive Director	Independence Advocates of Maine	• HCBS ID or ASD • Support Services for Adults with IDD or Autism • ICFs/IDD
Cliff Winn, Executive Director	Coastal Opportunities	• HCBS ID or ASD • Support Services for Adults with IDD or Autism • ICFs/IDD

The below table provides a summary of stakeholder comments received for the following MBM Policy Sections: Home and Community-Based Services for Members with Intellectual or Developmental Disabilities and/or Acquired Brain Injury and Other Related Conditions.

Summary of Comments for MBM Policy Sections: **Home and Community-Based Services for Members with Intellectual or Developmental Disabilities and/or Acquired Brain Injury and Other Related Conditions**
General
• Section 21 staffing ratio leads to a lot of administrative burden on providers, causing them to constantly schedule, track, and document the proper hours needed through clinical support and payroll records. The State does not have a tool or system to support the billing needs. • The receipt of the summary of service authorizations is sporadic and lacks a predictable cadence that creates high administrative burden to keep up with the input and to edit service authorizations. Services such as community supports under Section 21/29, could be authorized for 12 months instead of 6 months to reduce administrative burden and support individual planning that aligns with the required person-centered plan duration (12 months). • There are administrative burdens with multiple homes; providers should be able to bill as a single agency and not by individual home. • The pandemic will affect many healthcare services for probably 4 to 5 years, which will require a significant investment to train and retain qualified nurses.

Summary of Comments for MBM Policy Sections: Home and Community-Based Services for Members with Intellectual or Developmental Disabilities and/or Acquired Brain Injury and Other Related Conditions
Rates/Payment Methodology
• A 1:1 rate used in a variety of support settings would be helpful for members with challenging behaviors and would better sustain the specialized skills and training needed if paired with a higher, more sustainable rate. • Providers need a higher rate to sustain the community support industry and cover additional training and programing modifications from new HCBS requirements. • Section 29 day program rates are not equitably set. The elderly rate is $14.03 and the IDD rate for the same services is $8, which does not reflect the service effort and is discriminatory. • Section 21 rates for per diem home supports are based on an unknown methodology developed in 2005 and adopted in 2007 by contract, with no recent updates. All resulting rate changes are unrelated to the original formula and unclear. • The original CMS approved rates for Section 21 included an incentive to work with people with challenging behaviors, but that behavioral health add-on has been removed. • The shared living per diem rate works. • Section 21 “per diem” rate is a misnomer and extremely burdensome. Providers must meet a 92.5% staffing ratio to be paid the full rate for the day, but are not paid more if they staff over 100%. • Section 21 and Section 29 overall Quality of Care Methodology allows provider flexibility of service setting, both in a center and in community settings, but the $6.53 rate is too low for the current 1:3 ratio average. A separate higher rate for 1:1’s is needed to be sustainable. • The State-provided Section 21 and 29 rate calculator, as a secondary resource, lacks transparency, and consistency in how it is used when facilitating the person-centered planning process. The calculator and cap do not allow the individual to receive the PCP agreed-upon services, even when the team's recommendations fall within the cap. • The overall methodology does not adapt to changes in cost drivers like minimum wage or allow for acuity measures effectively. • There is a staffing crisis with the current low wages in the industry, and agencies are desperate to meet the minimum staffing requirements, all leading to higher turnover rates. The current methodology does not reimburse for administrative requirements (e.g., background checks) related to staff turnover. • Medical and dental professionals will not serve the IDD population because their needs are complex, their behaviors are challenging, and the payment rates are too low. • The age demographics often mean members require handicapped vans for transport to services, which are costly to buy and maintain and is not reflected in the rates. • The methodology should reflect changes to the HCBS regulations going into effect in 2123, which require more person centered and person focused services. • Minimum wage is the primary metric that drives cost. The wage floor should be 125% of the minimum wage plus the costs related to employer contributions. • Maine has stopped supplementing day habilitation with grants, which has contributed to a gap in services. • Day habilitation and supported employment are shifting priorities. Administrative burden with detail will be daunting, and payment methods should be focused on setting or staff but not both.

Summary of Comments for MBM Policy Sections: Home and Community-Based Services for Members with Intellectual or Developmental Disabilities and/or Acquired Brain Injury and Other Related Conditions
Phase I Report
• Providers are concerned about the peer state comparison used to set rates since access to institutions is more limited in Maine than in other states and in turn artificially inflates Maine's HCBS rates. Other states minimize HCBS costs by a heavier reliance on ICF/MRs and state institutions, both of which are entitlement programs. Other states also have higher individual budgets per person, as they do not have other settings to serve high needs individuals. The methodology should include an assumption that the cost per member should be higher than states that employ institutional level care. • The total cost of care should be used to compare services between the study state programs; transportation may be included or carved out in the rate paid in other states. • Maine also supports people with challenging behavior issues that require high staff, special equipment, and crisis management but without a behavior add-on and with limited crisis support. Maine's proposed crisis system has never materialized. • Minimum wage factors into Section 50 ICF services more than in other services. • We do not see other states using a 6% provider tax for HCBS; you need to subtract 6% from this rate for it to be comparable. • A 3-bed home serves six people in Florida, but you do not see any 6-bed homes in a 3-bedroom residence in Maine. The human rights factor is emphasized more here. The proposed amounts to serve 1:1 would not cover that cost. There is no day habilitation payment incentive to serve individuals with behavioral and physical limitation. • There are new licensing requirements for agency support homes, which is a new batch of costs. It was voluntary and is now mandatory. Costs of food and supplies are not provided through the rate, but rather through other means such as Supplement Nutrition Assistance Program (SNAP) and are not adequate for covering dietary needs and not covered under financial relief, such as over the counter medications. These are small costs but they add up. • We now have no rate for overnight or sleep, and the only way we have survived in our region has been to create situations where people come and sleep and can stay for extended time periods. We need some enlightened and creative strategies to address this problem. • Maine offers a housing subsidy, but the subsidy does not come close to the costs of the housing, food, utilities, and licensing requirements. The subsidy is calculated through Housing and Urban Development (HUD) guidelines, but they are not followed to the degree that they should. • The current rate is not sufficient. There needs to be more time and emphasis spent on creating a rate that is sufficient, and then MaineCare needs to keep a trend of reviewing those rates.

7. MBM Policy Sections: Community Behavioral Health Services[49]

Meetings held for Phase One on October 8, 2020 and Phase Two on December 7, 2020 included the following speakers, identified by meeting(s) attended.

Contributor Name	Company	Services
Phase One Meeting: October 8, 2020		
Elizabeth Cameron	The Margaret Murphy Centers for Children	• Rehabilitative/Community Support for Children with Cognitive Impairments • Behavioral Health Day Treatment
Natalie Childs, Program Director	Assistance Plus	• TCM • Community Integration Services • Daily Living Support Services
Sadel Davis	UCP	• TCM • Behavioral Health Home Services
Brandi Farrington, Administrator	Kennebec Behavioral Health	• TCM • Community Integration Services • Community Rehabilitation Services • Clubhouse Services • Behavioral Health Home Services
Scott Hayward, State Director	Pathways of Maine	• TCM • HCBT • Behavioral Health Day Treatment • Behavioral Health Home Services
Cheri LaFlamme, Clinical Director	R.I.S.E., Inc.	• TCM • Community Support Services: ▪ Community Integration Services ▪ Daily Living Support Services • Behavioral Health Home Services
Margaret Longsworth, Director of Mental Health and Clinical Services	OHI	• Community Support Services: ▪ Community Integration Services ▪ Community Rehabilitation Services ▪ Daily Living Support Services • Behavioral Health Home Services
Lauri Marchewka, Executive Director	Maine Special Education/ Mental Health Co	• Behavioral Health Day Treatment
Nathan Miller, Senior Program Director	Spectrum Generations	• TCM
Michael Mitchell	Crisis and Counseling Centers	• TCM • Crisis Services
Ken Olson, Executive Director	KidsPeace	• TCM • Behavioral Health Services-HCBT • Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations • PNMI-App D Therapeutic Foster Care Only

[49] Includes: Targeted Case Management (13), Community Support Services (Assertive Community Treatment, Community Integration Services, Community Rehabilitation Services, Daily Living Support Services) (17); Rehabilitative and Community Support Services for children with Cognitive Impairments and Functional Limitations (28); Behavioral Health Services (ACT, Behavioral health Day Treatment, Clubhouse, Crisis, Home and Community-Based Treatment) (65); Behavioral Health Home Services (92), Opioid Health Home Services (93); PNMI, Appendix D Therapeutic Foster Care only (97).

Contributor Name	Company	Services
Douglas Patrick, Director	Woodfords Family Services	• TCM • HCBT • Behavioral Health Home Services
Pete Plummer, COO	Woodfords Family Services	• TCM • HCBT • Community Rehabilitation Services • Rehabilitative/Community Support for Children with Cognitive Impairments • Behavioral Health Day Treatment • Behavioral Health Home Services • PNMI-Therapeutic Foster Care
Katie Rutherford, Executive Director	Frannie Peabody Center	• TCM
Susan Slick	Acadia Hospital	• Behavioral Health Home Services
Scott Tash, CEO	UCP of Maine	• TCM • HCBT • Rehabilitative/Community Support for Children with Cognitive Impairments • Behavioral Health Day Treatment • Behavioral Health Home Services
Doug Townsend, AVP	Acadia Hospital	• Opioid Health Home Services
Andrew Taranko, Maine Director, MACSP Board President	Living Innovations	• TCM • HCBT • Behavioral Health Home Services
Heather Willey, Case Management Director	Amicus	• TCM
Phase Two Meeting: December 7, 2020		
Paul Dann, PhD, Executive Director	NFI North	• Behavioral Health Services ▪ HCBT ▪ Behavioral Health Day Treatment
Jillian Jolicoeur, COO	Assistance Plus	• TCM • Community Support Services: ▪ Community Integration Services ▪ Daily Living Support Services • Behavioral Health Home Services
Margaret Longsworth, Director of Mental Health and Clinical Services	OHI	• Community Support Services: ▪ Community Integration Services ▪ Community Rehabilitation Services ▪ Daily Living Support Services • Behavioral Health Home Services
Kate Marble, Case Management Program Director	Health Affiliates Maine	• TCM • Community Support Services: ▪ Community Integration Services • Behavioral Health Home Services
Nathan Miller, Senior Program Director	Spectrum Generations	• TCM
Ray Nagel, Executive Director	Independence Association	• TCM
Ken Olson, Executive Director,	KidsPeace	• TCM • Behavioral Health Services-HCBT • Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations

Contributor Name	Company	Services
		• PNMI-App D Therapeutic Foster Care Only
Amanda Parker, CCM Program Manager	Living Innovations	• TCM
Douglas Patrick, Director	Woodfords Family Services	• TCM • HCBT • Behavioral Health Home Services
Pete Plummer, COO	Woodfords Family Services	• TCM • HCBT • Community Rehabilitation Services • Rehabilitative/Community Support for Children with Cognitive Impairments • Behavioral Health Day Treatment • Behavioral Health Home Services • PNMI-Therapeutic Foster Care
Malory Shaughnessy, Executive Director	Alliance for Addiction and Mental Health Services, Maine	• TCM • Community Support Services: ▪ Assertive Community Treatment (ACT) ▪ Community Integration Services ▪ Community Rehabilitation Services ▪ Daily Living Support Services • Behavioral Health Services: ▪ ACT ▪ Behavioral Health Day
Matthew Siegel, VP Medical Affairs - Autism and DD Service	Maine Behavioral Healthcare	• Behavioral Health Services: ▪ Behavioral Health Day Treatment • Behavioral Health Home Services
Ben Strick, Director of Adult Behavioral Health	Spurwink Services	• Community Support Services: ▪ ACT ▪ Community Integration Services • Behavioral Health Services: ACT • Behavioral Health Home Services • Opioid Health Home Services
Karen Turgeon, VP of Programs	The Opportunity Alliance	• TCM • Behavioral Health Services: Crisis • Behavioral Health Home Services • Opioid Health Home Services

The below table provides a summary of stakeholder comments received for the following MBM Policy Sections: Community Behavioral Health Services.

Summary of Comments for MBM Policy Sections: Community Behavioral Health Services
Rates/Payment Methodology
• Section 13 providers indicate that the burden and oversight of the Office of Aging and Disability Services (OADS) and DHHS in relation to payment methodology seems slanted; the other TCM divisions do not put in the resources that OADS does, which adds layers of administrative burden. • A representative payee should be a reimbursable activity for case management. MaineCare may be able to save money/reduce waste and duplication by considering a code for Family Case Management Code or Bundle – to serve one household under one overall, cost-saving plan. • The Behavioral Health Home (BHH) in Maine is the only service that has a face-to-face requirement, which is hard to implement in rural areas and not a standard requirement in other states. • The BHH model has taught providers the value of higher nursing support. Section 17 requires an APRN as part of service delivery, and there should be a Registered Nurse (RN) involved. • The BHH incentive structure is unnecessarily punitive. Rather than a payment reduction when quality measures are not met, implement a baseline payment with incentive payments for quality measures. • Several Section 17 providers also noted that only the direct services component qualifies for reimbursement. Current rates (quarter hour billing) are not sufficient to cover administrative time, which is especially true for service provision not within a tight geographic area. The providers suggested limiting unreimbursed travel time and administrative time to document these services. • Several Section 17 providers requested a rate-adjusted model that includes incentives and considerations for wage pressure, rising administrative costs, etc. • Some of the children with ASD cannot sit for an hour of treatment and need more frequent smaller units of treatment time. Additional flexibility with the billable unit may be required, such as 15 minute or 30-minute increments. • Section 65 Day Treatment providers reported that payment is complicated by the nature of the service and because the services are being provided in a classroom. Children can be in crisis at any time, which complicates staffing and makes FFS efforts break down. For example, during a crisis, a provider can only bill for one clinical and one behavioral health provider (BHP) even though a seriously dysregulated child in crisis often requires multiple BHPs for support. • Section 97 Therapeutic Foster Care is very different from other PNMI models insofar as they provide the services in the home of the therapeutic foster care parent. The per diem is a flat dollar amount and they are required to submit annual cost reports, but nothing is done with the information. The FFS programs are not adjusted to reflect costs and staff wages. • Mobile and residential crisis services are unit-based, rather than cost based, which does not reflect the nature of the services or the level of effort. • Community Rehabilitation Services (CRS) are hard to effectively manage due to the challenges and constraints of the PNMI rate and ratio of numbers of staff to hours. There is a large waitlist for PNMIs, but there is not enough CRS support to have a place for people who could leave the PNMI. PNMI providers offer CRS for their clients to transition out, but there is not a viable option within PNMI services. • The KEPRO/Atrezzo priority waitlist complicates service coordination and makes it hard to retain BHPs. The process is burdensome, duplicative, and restrictive, particularly in relation to the frequency of reviews and authorizations that require a significant amount of effort to manage. More flexibility with the current wait list process would help providers retain valuable, full-time staff members and plan around staffing concerns.

Summary of Comments for MBM Policy Sections: Community Behavioral Health Services
• The reimbursement, tuition support, and BHP certification requirements do not reflect the educational requirements. • BCBAs are paid less through MaineCare than other payers. Reaching clients in rural areas costs more and is not reflected in the reimbursement. • It is difficult to tell if a member's case is open with a BHH or an Opioid Health Home (OHH) program, so there are times when a provider is not paid for services they have already provided, due to the lag in prior authorizations and limitations of a member having an open case with another provider. • BCBA services can also be difficult to plan for and staff since services must be provided around a child's school schedule (generally nights and weekends), which limits the number of hours available to provide the service. An APM with an outcome-based rate that is a per member per month (PMPM) would better stabilize the service model. • Sections 13 and 17 provide very little opportunity to work on preventive activities, given the level of need the client must experience to receive the service. Section 13 specifically allows very little in terms of monitoring and prevention activities with children once an acute phase has passed. • Section 17 (including Skills Development, Daily Living Supports, and Community Rehabilitation) has a cumbersome and administratively burdensome authorization process (particularly for persons with diagnoses other than Schizophrenia and Schizoaffective Disorder) that creates a barrier to care and has caused agencies to stop providing services. • Documentation requirements are repetitive and duplicative. For example, in the first 30 days, providers must complete several assessments: Initial Assessment, LOCUS, ANSA, ACOK, Need for Change, and a Housing Needs Assessment. Time spent to complete them is wasteful in terms of the information yielded, and for clients who may be in crisis, especially at the start of service. • OHH billing could get complicated if providers are not able to bill under the OHH. Providers have to piece together services from Section 65, which do not cover all the services provided. Providers recommended that members who are in OHH should have a minimum contact amount that is similar to BHH so that they are not piecing services together.
Phase I Report
• Any rate analysis should not be based on historical costs and human resource expenses but should move towards a livable wage framework. Home and Community-based Treatment (HCT) does not have a rate that supports livable wages, and there is a parity issue with what we can afford to pay people who do similar work, such as for staff who have Bachelor's and Master's degrees and are often working on weekends and evenings. • When the rate is built, it is based on billable hours and does not take into account geographic issues that create complexity. You need to look at billable hours and productivity; HCBT services require travel to the clients' homes, which are unbillable hours that should be built into the formula. • The rate study for ACT references a rate from Montana, but that is based on daily billing. Maine can only bill for a limited number of days (21 days), so the equivalent rate would for Montana would be higher because they have more billable days. • Section 18 provides little support for group settings, which require twice the administration with paperwork and oversight and can only be supported with additional grant funding.

Summary of Comments for MBM Policy Sections: Community Behavioral Health Services
• Section 17 DLS rate is not sufficient due to its high administrative burden for use and access issues for clients who wait a long time for staffing. Programs have run in the red and many have closed. There is either no comparison or not enough information to compare. • Case management was higher than the average comparison rate, but the current rates have providers struggling to fill positions and serve all the clients. Many factors are not accounted for in the comparison, for example, the minimum wage in North Carolina is almost half that of Maine. The cost of doing business in Maine is a lot higher. • CRS is not just a step down service these days. People going into CRS right out of hospital were tough to do. • Regarding BHH, there are requirements around the number of screens people must have over the course of the year, especially now when they are struggling to see people. It would be nice during the pandemic to have some accommodation around that. Reimbursement should be built around a full-time case manager instead of a patient navigator. • There should be partial BHH reimbursement for clients engaging in one aspect of the program; if they only meet with a counselor, there should still be reimbursement for the work that is provided. A lot goes into engaging clients, and some payment should be considered for work that was done, especially now when the pandemic makes it hard to meet. Providers should be paid for meeting clients where they are, even if they cannot provide all of the required services. • Medication management services rates contribute to access issues; i.e., providers cease to provide medication management to children. • Children behavioral health day treatment has no methodology for family therapy, and no reimbursement to generalize the skills and improvements that are generated during that 6-hour day, yet it is an ethical requirement to generalize skills and is also clinically sound. • There are a number of issues related to non-billable activities that are necessary for effective service delivery. • The rate structure needs to be PMPM or for PAs to be completed on an annual basis for services for chronic mental illness. The rate needs to provide for overlap of the services for institutional placement - hospital or jail. There is an expectation that providers will do non-billable work, which reduces the quality. • Therapeutic foster care rates are a growing issue. Due to court judgments on the limitations of look-backs related to sexual abuse cases, the liability insurance is increasing. Providers cannot afford the impact of these higher liability insurance requirements. • Upstate New York looks a lot like upstate Maine. Within the past couple of years, New York wanted to expand access to services such as ACT and TCM, for their child and family treatment support services. To expand, the rate was enhanced by 20% so that providers could afford the startup of those services. In New York, there is an offsite differential for when service is provided in the home and an upstate and downstate rate to reflect cost of living differences.

8. MBM Policy Sections: Hospital (45), Psychiatric Hospital Services (46)

Meetings for Phase One held on October 8, 2020 and Phase Two on December 3, 2020 included comments from the following speakers, identified by meeting(s) attended.

Contributor Name	Company	Services
Phase One Meeting: October 8, 2020		
Valerie Barbour, Manager, Reimbursement	MaineHealth	• Hospital • Psychiatric Hospital
David Winslow, Vice President	Maine Hospital Association	• Hospital • Psychiatric Hospital
Phase Two Meeting: December 3, 2020		
Thomas Morgan (Skip), VP of Reimbursement	Maine Medical Center	• Hospital • Psychiatric Hospital
Penelope (Penny) St. Louis, AVP Payor Contracting	MaineHealth	• Hospital • Psychiatric Hospital
David Winslow, Vice President	Maine Hospital Association	• Hospital • Psychiatric Hospital

The below table provides a summary of stakeholder comments received for the following MBM Policy Sections: Hospital (45), Psychiatric Hospital Services (46).

Summary of Comments for MBM Policy Sections: Hospital (45), Psychiatric Hospital Services (46)
General
• The rate methodology is consistent with Medicare diagnosis-related groups (DRGs) and Ambulatory Payment Classifications (APCs), and that process is efficient and works well. • Other payers typically offer a rate increase to the base, which has not happened in MaineCare for a long time. There are no issues other than a low conversion factor. • The provider enrollment process is cumbersome, burdensome, and untimely. • Providers do not know enough about the other states to evaluate the comparison since they have not had enough time to digest this information. • The outpatient side does not look bad. Outpatient Medicare reimbursement is standard. We would like it to be more than 83.7% of Medicare but like the structure because it is understandable. Outpatient includes a Cost of Living Adjustment (COLA) that is applied every year based on medical inflation. Therefore, it goes up 1.5% to 3.3% per year. • The rate report states that 2012 rates were based on the costs for providing services in 2011, which is incorrect. Rates were based on the previous year's Medicaid spend, which is how the 83.7% was decided. • Inpatient was also based on spend, not costs, and includes no COLA. Providers expected that the inpatient comparison percent would be lower but recognize that the other states may have lower rates. • Request that the report expresses information as a percentage of cost, as well as evaluates hospital cost centers, which are driven by the cost of prescription drugs.

9. Specialty Services[50]

Meetings for Phase One held on October 8, 2020 and Phase Two on December 2, 2020 included comments from the following speakers, identified by meeting(s) attended.

Contributor Name	Company	Services
Phase One Meeting: October 8, 2020		
Ryan Gallant, President	Gallant Therapy Services	• Occupational Therapy • Speech and Hearing Services
Sara Hunter, Billing Specialist	Mark. R. Hammond Associates	• Speech and Hearing Services
Gwen Simons	Maine Chapter APTA	• Physical Therapy
Jen Corbeil	Mainely Kidz	• Occupational Therapy • Physical Therapy • Speech and Hearing Services
Phase Two Meeting: December 2, 2020		
Jillian OBrien	Pediatric Development Center	• Occupational Therapy
Shannon Fowler, Speech Language Pathologist	Hammond Associates	• Speech and Hearing Services
Ryan Gallant, President	Gallant Therapy Services	• Occupational Therapy • Speech and Hearing Services
Pete Plummer, COO	Woodfords Family Services	• Occupational Therapy • Speech and Hearing Services
Robert Reed, Executive Director	Maine Chiropractic Association	• Chiropractic Services
Gwen Simons	Maine Chapter APTA	• Physical Therapy Services
Jen Corbeil	Mainely Kidz	• Occupational Therapy • Physical Therapy • Speech and Hearing Services

The below table provides a summary of stakeholder comments received for the following MBM Policy Sections: Specialty Services.

Summary of Comments for MBM Policy Sections: Specialty Services
General
• The rate methodology is confusing and how rates are determined is unclear. The methodology for therapy services was originally based on a Resource-based Relative Value Scale (RBRVS) formula. More consistent updates and a more transparent methodology would make it easier to understand. • The rate for speech therapy is about 50% of the cost to provide the service, which affects quality of care and appropriate service provision. Reimbursement is not sufficient to support care coordination or integration of care. • The methodology is not equitable across provider types; some services are paid higher rates but require lower levels of education and licensure. Hospital outpatient services are very different from community outpatient services, and the rates are not equitable.

[50] Includes: Chiropractic Services (15); Occupational Therapy Services (68); Vision Services (75); Physical Therapy Services (85); Podiatric Services (95); and Speech and Hearing Services (109).

Summary of Comments for MBM Policy Sections: Specialty Services
• The Occupational Therapy (OT) rate methodology is inconsistent and incomprehensive; 40% of their policies have not been updated since 2015, which contribute to a fragmented and outdated healthcare system. Providers urge and support increases to OT rates, considering Maine has some of the lowest rates in the country. • It is very difficult to hire experienced therapists because of the lower reimbursement rate and the higher costs of delivering care. • Continued low OT rates will cause providers, particularly private providers, to create wait lists. Providers must balance a client caseload based on insurances to ensure financial solvency, while also serving the needs of their clients. • Provider enrollment takes a very long time for credentialing new therapists (estimates were 3 to 6 months), which delays cash flow and puts further strain on providers. • There has been no increase in rates for speech therapy (ST) services for a very long time even though the cost to deliver care has increased. Children may wait for months to get needed services. • 75% of OT patients have MaineCare as primary or secondary insurance, so MaineCare has a significant impact. • One of the major struggles is the impact on quality of care. It is hard to compete to keep quality therapists when we cannot meet the salary needs. • In 2010, during the legislative emergency session, it was decided that there must be a rate increase for non-hospital providers. Therefore, they took all the service codes and bumped them up. Chiropractic, podiatry, and vision codes were carved out and put on their own fee schedule with no rate increase then and there has been nothing since. • The chiropractic manipulation codes are about 70% of all the services, and I do not feel like it reflects the impact to the profession when 70% of the work is way behind the curve on Medicare.
Phase I Report
• Providers have to bill an independent rate under ST when services are provided in schools; they cannot bill as an agency, and the rates are 20% lower. MaineCare pays higher rates for other settings, but the independent providers should be paid the same. • Low reimbursement rates for therapy services affect the pediatric practices more than those that see adults. Private non-hospital based practices have unique issues that present challenges to see MaineCare patients as part of the payer mix, while hospitals are paid more for commercial claims in physical therapy (PT) and can make up their losses there. • This analysis highlights the need for OT to receive a rate increase. Therapists move out of state, creating a 50% turnover. In the last 10 years, education requirements for all therapists have increased to masters/doctorate level, which are not supported by the low rates. • Consider incorporating travel costs into the therapy rates. Lack of travel reimbursement limits the number of children whom we can accept in our caseload.

10. MBM Policy Sections: Residential Care[51]

Meetings held for Phase One on October 9, 2020 and Phase Two on December 4, 2020 included the following speakers, identified by meeting(s) attended.

Contributor Name	Company	Services
Phase One Meeting: October 9, 2020		
Kevin Brooks, CFO	Maine Veterans' Homes	• PNMI-App C
Lisa Trundy-Whitten, Principal	BerryDunn	• PNMI-App C
Brandi Farrington, Administrator	Kennebec Behavioral Health	• PNMI-App B, D, E
Mary Haynes-Rodgers, Executive Director	Shalom House	• PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Margaret Longsworth, Director of Mental Health and Clinical Services	OHI	• PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Heidi Mansir, Executive Director	Uplift Inc.	• PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Jeff Tiner, Chief Program Officer, Clinical Services	Catholic Charities	• PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Rick Erb, President & CEO	Maine Health Care Association	• Adult Family Care Services • PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Phase Two Meeting: December 4, 2020		
Rosalie Grondin	Fairpoint	• Adult Family Care Services
Eric Berry, Financial Analyst	Penquis CAP, Inc. Bangor	• PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Paul Dann, PhD, Executive Director	NFI North	• PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Clement Deveau, Program Director	AMHC	• PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Justin Gifford, Executive Director	Becket Family of Services	• PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Dale Hamilton, Executive Director	Community Health and Counseling Services	• PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Margaret Longsworth, Director of Mental Health and Clinical Services	OHI	• PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Heidi Mansir, Executive Director	Uplift Inc.	• PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Catherine Thibedeau, Executive Director	Independence Advocates of Maine and MACSP Co-Chair, PNMI Committee	• PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Jeff Tiner, Chief Program Officer, Clinical Services	Catholic Charities	• PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Rick Erb, President & CEO	Maine Health Care Association	• Adult Family Care Services • PNMI-App B, C, D (except Therapeutic Foster Care), E, and F
Shaun Quimby, Director of Residential Clinical Services	Becket	• Adult Family Care Services • PNMI-App B, C, D (except Therapeutic Foster Care), E, and F

[51] Includes: Adult Family Care Services (2); PNMI, Appendix B, C, D, E, F (excluding appendix D Therapeutic Foster Care) (97); and Psychiatric Residential Treatment Facility Services (107).

Contributor Name	Company	Services
		• Psychiatric Residential Treatment Facility (PRTF) Services
Malory Shaughnessy, Executive Director	Alliance for Addiction and Mental Health Services, Maine	• PNMI-App B, C, D (except Therapeutic Foster Care), E, and F • PRTF Services

The below table provides a summary of stakeholder comments received for the following MBM Policy Sections: Residential Care.

Summary of Comments for MBM Policy Sections: Residential Care
General
• Bed hold days continue to be an issue and a loss, especially when residents become hospitalized, which could be a month and for therapeutic home visits, and the provider cannot make up lost income. MaineCare should consider what could be a fair rate for holding a bed with no revenue generation. • Providers reported that Section 97 was a jumble of services with many different types of PNMI. For example, PNMI appendix F and C are completely different. The reimbursement mechanism for all different types of PNMI are not always clear. Total dollar caps do not always match what the service is providing, even if priced at the minimum wage level. • PNMI and CRS providers both have MHRT 1's and experience minimum wage-related pressures such that they cannot increase the wage in the PNMI without unbalancing the wage in CRS.
Phase I Report
• There are few if any similar programs in other states. Maine's PNMI-C's provide a higher level of care than other assisted living programs. One fourth of members qualify for nursing facility admission, so rates should be compared to nursing facilities. • Look at creating parity for adult family care home (AFCH) rates with PNMI-Appendix C. AFCH's are often forgotten because the homes are small and rural but serve the same population as Appendix C but at a rate of about $50/day. • PNMI-Cs have in recent years seen fewer closings than nursing facilities, but underfunding is still an issue. The aggregate shortfall is $3.5 million, and the majority of the shortfalls are in multi-level facilities. The increased costs of compliance for nursing facilities is spilling over into assisted living, which is a key piece of the continuum in Maine. • There is concern about the five comparison states and their minimum wages. By January 2021, Maine's minimum wage is higher than the minimum wage in all of the comparison states, which has a big impact on the lower level services because of the paraprofessional rates. • The long-term efficacy of the PNMI rests heavily on community support services and their ability to serve people. Better support will promote discharge to PNMIs and reduce the number of institutional beds. • There are anomalies with children's PNMI rates compared to PRTF with regard to Montana. Montana has three PRTFs that have 48, 52, and 60 beds and a very different system that accounts for the disparities in per diems. Most of the child PNMIs in Maine are very small. • Commenter did not understand the rationale for the high outlier being 120% of the comparison rate, and the low outlier is less than 40% of the comparison instead of 80% of the rate (i.e., would make more sense to be symmetrical around 100% of the comparison rate).

Summary of Comments for MBM Policy Sections: Residential Care
• The PNMI-E methodology works well since providers can submit requests for rate adjustments. The cost settlement is an issue; if staff cannot be hired and retained as needed, providers end up with paybacks. • The rate system needs an automatic trigger for updating the COLA to support ability of providers to recruit, train, and retain staff.

11. MBM Policy Sections: Nursing Facilities (67)

Meetings held for Phase One on October 9, 2020 and Phase Two on December 3, 2020 included the following speakers, identified by meeting(s) attended.

Contributor Name	Company	Services
Phase One Meeting: October 9, 2020		
John Bolduc, Executive Director	Odd Fellows' and Rebekahs' Home of Maine	• Nursing Facility Services
Kevin Brooks, CFO	Maine Veterans' Homes	• Nursing Facility Services
Tammy Brunetti, Principal	BerryDunn	• Nursing Facility Services
Richard Erb, President & CEO	Maine Health Care Association	• Nursing Facility Services
Deb Fournier, COO	Maine Veterans' Homes	• Nursing Facility Services
Thomas Gilmartin, CFO	National Health Care Associates, Inc.	• Nursing Facility Services
Wanda Pelkey, CFO	First Atlantic Healthcare	• Nursing Facility Services
John Watson, CFO	The Cedars	• Nursing Facility Services
Phase Two Meeting: December 3, 2020		
Tammy Brunetti, Principal	BerryDunn	• Nursing Facility Services
Richard Erb, President & CEO	Maine Health Care Association	• Nursing Facility Services
Kelley Kash, CEO	Maine Veterans' Homes	• Nursing Facility Services

The below table provides a summary of stakeholder comments received for the following MBM Policy Sections: Nursing Facilities (67).

Summary of Comments for MBM Policy Sections: Nursing Facilities (67)
General
• The caps and disallowances of costs reduce the rate. While the methodology is referred to as "cost-based," it does not actually reimburse for the full cost. No other industry holds to a low cap for contracting medically necessary services required by regulation; it is outdated and arbitrary. • Under the current system, the biannual rebasing (including COLA and appreciation) process takes a long time to incorporate direct care and COVID-19-related costs into the rate. Currently, if the payment for a resident does not pay their cost of care, the facility has to take it as a loss with no way to regain the margin. Other states handle these systems differently so that the facility does not bear the full brunt of the uncollected cost. This applies to people who fall within the five-year look back period for Medicaid eligibility, during which the Medicare copay is often not able to be collected from the participant. With the growth of Medicare Advantage plans, the copays start earlier than day 21.

Summary of Comments for MBM Policy Sections: Nursing Facilities (67)
• The case-mix rate is based on a semi-annual snapshot of the MDS reports, which unfairly affects PNMIs that serve Veterans with memory impairment. An individual MDS would be more accurate and equitable. • Providers request a review of peer groupings. The current peer-group methodology is outdated and does not account for providers with unique circumstances and requirements. • Over the last 10 years, a dozen homes have closed mostly for financial reasons. The payment cap prevents agencies from attracting and retaining physician coverage and medical directorship. • The payment system has no incentives for quality, access, and integration of care. • Provisions should be included to recognize cost increases incurred by providers, including annual pay increases, benefits, supplies, medications, food, utilities, etc. • Cost report settlements take up to two years, and the process is unfair. If a provider files a cost report and has a payable due, the facility has to immediately pay it. However, the provider must wait for the full time until it is settled before they are paid back. • Providers no longer receive the full bed-hold day rate since the direct care portion of the rate must be removed for those days, but facilities have to have minimum staffing ratios, which cannot be reduced just because one person is out. This is not equitable.
Phase I Report
• There is a distinct difference in level of care provided in nursing facilities across states. In each of the five study states, the level of resident need is lower than in Maine; Maine average number of ADLs is 4.38, and in the other five, it is 3.95-4.10. As a result, Maine nursing facilities staff higher than each of the other states. Payroll-based journals (PBJs report 4.4 hours nursing care per patient day, compared to 3.8 hours per day in the comparison states. • Maine nursing homes cannot recover all costs through the MaineCare rates, so costs are shifted to other payers. • The Legislature and the Department recognize that the industry has a shortfall in payment and has passed increases to help. The Medicaid shortfall is calculated by the percent of what is paid vs allowable costs. In 2017, there was a $33 million shortfall, and in 2019, a $20.3 million shortfall. • Cash-on-hand has a minimum measure of 90 days, and the average in Maine is 26 days. Nursing facilities bill Medicaid monthly for services already provided, so 26 days of cash-on-hand is not enough. • Although nursing facilities have seen measurable improvements due to the supplemental wage increase, the catch-up on the COLA, and timelier rebasing, the industry is still in a challenging financial situation, which needs to be considered when evaluating rates.

12. MBM Policy Sections: Ambulatory Care/Clinics[52]

Meetings held for Phase One on October 9, 2020 and Phase Two on December 4, 2020 included the following speakers, identified by meeting(s) attended.

Contributor Name	Company	Services
Phase One Meeting: October 9, 2020		
Nicole Clegg, Senior VP Public Affairs	Planned Parenthood of Northern New England	• Family Planning Agency Services
Evelyn Kieltyka	Maine Family Planning	• Family Planning Agency Services
Phase Two Meeting: December 4, 2020		
Nicole Clegg, Senior VP Public Affairs	Planned Parenthood of Northern New England	• Family Planning Agency Services
Rhonda Woodman, Medical Billing Manager	Family Planning Association of Maine	• APRN Services • Family Planning Agency Services • Physician Services except Oral Surgery

The below table provides a summary of stakeholder comments received for the following MBM Policy Sections: Ambulatory Care/Clinics.

Summary of Comments for MBM Policy Sections: Ambulatory Care/Clinics
General
The providers who attended this session were primarily from Family Planning clinics. • The current payment methodology does not properly incorporate all the aspects of care provision to be considered a full-service provider. For example, these providers deliver a wide array of services to all patients, regardless of their ability to pay. They screen for substance use disorder (SUD), smoking, obesity, and intimate partner violence. However, the family planning fee schedule is structured in a way that does not provide the full value of the visit. Services are broader than just birth control and sexually transmitted disease (STD) testing / treatment. Something like a PPS rate would help sustain and support better quality of services. • The process to update Current Procedural Terminology (CPT) codes in the system to make services available is arduous and time consuming. For example, there is a CPT code for rapid hepatitis testing, but providers have had difficulties getting this code added, which limits their ability to provide quality evidence-based care. • There is complexity when using family planning (FP) modifiers; Medicaid does not allow a FP modifier, but providers must submit dual eligible cases separately to include the FP modifier, or the claim is denied. • Family planning providers are undervalued when compared to other providers, even though there is enhanced match that funds family planning providers. Future reimbursement models should reflect the broad array of services offered at family planning by PCPs. The FQHC model reflects the breath and scope of the care that is being provided. The work that Family Planning Clinics do is very similar to FQHCs, so MaineCare should encourage the use of that standard of clinic billing and support. • Data related to abortion procedures should be added.

[52] Includes: Ambulatory Care Clinic Services (3); Ambulatory Surgical Center Services (4); Free-Standing Dialysis Services (7); and Family Planning Agency Services (30).

13. Stakeholders that Provided Written Comments

The below table lists individuals who submitted written comments, which are integrated into the above stakeholder comment summaries.

Contributor Name	Company	Service
Phase One Meeting		
Nina Bartlett, Director of Operations	Health Affiliates Maine	Section 65, Children's Behavioral Health
Chuck Munier DMD		Section 25, Dental Services
Judith Feinstein,		Section 25, Dental Services
Ilmi Carter, BSN, RN, NCSN	RSU #13 School Nurse, Oceanside High School	Section 25, Dental Services
Kim Yesis, Business Manager	Belfast Dental Care, LLC	Section 25, Dental Services
Stephen P. Letourneau, Chief Executive Officer	Jessie Albert Dental and Orthodontic Center	Section 25, Dental Services
Barbara Covey MD, President of the Board	Waterville Community Dental Center	Section 25, Dental Services
Jeffrey W. Kirby, VP	MMP Finance	Section 90, Physician Services
Amy R Johnson, Director, Payor Contracting & Network Development	Spectrum Management Services Company	Section 90, Physician Services
Katie Fullam Harris, Chief Government Affairs Officer		Sections 45, 46, 67, 55, 90, 91,103, 65
Melissa Bowker-Kinley, MD Medical Director	Health Affiliates Maine	Section 65, Medication Management
Pete Plummer, COO	Woodfords Family Services	
Genevieve Gardner, LCSW, MBS Executive Director	Connections for Kids and Kids Free to Grow	
Rebecca Emmons, MPH Executive Director	Mobius Inc.	Sections 21 and 29
Doug Townsend, LCPC, MBA Associate VP, Adult Services	Northern Light Acadia Hospital	Section 65, (Methadone)
Malory Otteson Shaughnessy, Executive Director	Alliance for Addiction and Mental Health Services, Maine	Sections 17, 65, 97
Laurie Belden, Executive Director	Home Care and Hospice Alliance of Maine	Sections 40, 43
Scott Miller, Community Support Director of Creative Trails	Support Solutions/Creative Trails	Community Support Waiver Section 21/29
Linda LaRue-Keniston		
David Dill, Director of Finance	New Communities, Inc.	
Sharon "Sam" Richardson, Staff Accountant	Leap Strong	
Deb Smith	Ohio Maine	2691 (Section 21 / Section 29 - Home Supports - Intermittent Supports - Community Supports)
Rachel Dyer, Associate Director	Maine Developmental Disabilities Council	
Margaret Longsworth, Director of Mental Health and Clinical Services	OHI	Section 65
Mary Dunn Director of Quality Improvement and Corporate Compliance	OHI	Section 65
Pete Plummer, COO	Woodfords Family Services	
Andrew Cowan, Chief Financial Officer	JFM Homes, Inc.	Section 65

Contributor Name	Company	Service
Justin Gifford, Executive Director	Children's Residential Services- Maine	Section 97
Diana Hardy - BCBA Director	ABC Behave LLC	
Kate Marble, LCSW Case Management Program Director	Health Affiliates Maine	Section 65
Jessica J. Bolduc DrOT, MSOTR/L, President | Ryan Gallant OTR/L, Owner	Maine Occupational Therapy Association | Gallant Therapy Services	Section 68
Rosalie Grondin-Bookkeeper		Adult Family Care
Kelley J. Kash, Colonel, USAF, Medical Services Corps (Retired) Chief Executive Officer | Deb Fournier, RN-BC, MSB, CHC, CPHQ Chief Operations Officer | Kevin Brooks, CPA Chief Financial Officer	Maine Veterans' Homes	Section 67, Nursing Facility
Kelley J. Kash, Colonel, USAF, Medical Services Corps (Retired) Chief Executive Officer | Deb Fournier, RN-BC, MSB, CHC, CPHQ Chief Operations Officer | Kevin Brooks, CPA Chief Financial Officer	Maine Veterans' Homes	Residential Care
Phase Two Meeting		
Stephen P. Letourneau, CEO	Catholic Charities Maine	Section 25, Dental Services
Steven McInnis		Shared living and family centered care providers
Gwen Simons, PT, JD, OCS, FAAOMPT Chair, Policy and Payment Committee	Maine Chapter of the American Physical Therapy Association	Section 85, Physical Therapy
Malory Otteson Shaughnessy, MPPM Executive Director	Alliance for Addiction and Mental Health Services, Maine & Maine Behavioral Health Foundation	Sections 17, 65, 97
Janet Rancourt Director of Communications & Program Development	New Communities	
Becca Matusovich Executive Director	Partnership for Children's Oral Health	Section 25, Dental Services
Margaret Longsworth Director of Mental Health and Clinical Services	OHI	Section 65, Behavioral Health
Cathy Hamilton Senior Accountant	Acelleron	Section 60, DME/Home Medical Equipment (HME)
Barbara Covey, President of the Board	Waterville Community Dental Center	Section 25, Dental Services
Dee A. Kerry, Executive Director	The Maine Chapter of the American Academy of Pediatrics	Section 25, Dental Services
Lindy Lynch Community Case Manager Supervisor	OHI	Section 13, Targeted Case Management
Katie Fullam Harris, Chief Government Affairs Officer	MaineHealth	
Savanna Havey, CLC, Breastfeeding Coordinator	Hancock and Washington Counties WIC Program	

Contributor Name	Company	Service
Oliver Bradeen, LCPC,Executive Director	Milestone Recovery	Section 65, SUD Services
Al Durgin, LCSW, VP of Continuous Quality Improvement Chief Compliance Officer	SpurWink	
Taylor Davis Statutory & Regulatory Analyst	New England Rehabilitation Hospital of Portland	Section 45, Inpatient Hospital Services
Marge Kilkelly, MS CED Policy Manager	Maine Primary Care Association	
Kelly Hassett	MedCOR Professionals	Section 60, DME
Jason Morin, MBA, RRT President & CEO	Home Medical Equipment and Services Association of New England	Section 60, DME
Tom McAdam Chief Executive Officer	Kennebec Behavioral Health	Section 65, Outpatient
Kelley J. Kash, Colonel, USAF, Medical Services Corps (Retired) Chief Executive Officer | Deb Fournier, RN-BC, MSB, CHC, CPHQ Chief Operations Officer | Kevin Brooks, CPA Chief Financial Officer	Maine Veterans' Homes	Section 67, Nursing Facility
Kelley J. Kash, Colonel, USAF, Medical Services Corps (Retired) Chief Executive Officer | Deb Fournier, RN-BC, MSB, CHC, CPHQ Chief Operations Officer | Kevin Brooks, CPA Chief Financial Officer	Maine Veterans' Homes	Residential Care
Amanda Richards Executive Director	Maine Osteopathic Association	Section 90, Physician Services
Melinda Norko, LSW Managing Director	Lighthouse Community Care LLC	Section 13, Targeted Case Management
Kate Marble, LCSW Case Management Program Director	Health Affiliates Maine	Community-Based Services
Nicole Clegg Senior Vice President of Public Affairs	Planned Parenthood of Northern New England Planned Parenthood Maine Action Fund Planned Parenthood Maine Action Fund PAC	Section 30, Family Planning
Sean Andrews Director of Financial Operations	Bedard Pharmacy & Medical Supplies	Section 60, Durable Medical Equipment and Supplies
Jeff Johnson Director	Bridges Home Services	Sections 19, 21, 26, 29, and 96 (OADS Sections 61, 63)
Bridget C. McCabe, LSW, Assistant Associate Director	Group Main Stream	Section 13, Targeted Case Management
David Winslow Vice President of Financial Policy	Maine Hospital Association	Hospital services
Kara Kaikini, MS, IBCLC Board President,	Maine State Breastfeeding Coalition	Breast pump reimbursement
Sandra Labelle, Case Management Director	Spectrum Generations	Section 13, Targeted Case Management
Kathy Adams OTL, ATP, AT Specialist	Maine CITE Program	Assistive Technology

Contributor Name	Company	Service
Evelyn Kieltyka Sr. VP of Program Services	Maine Family Planning	Section 30, Family Planning Agency Services
Julie Ewald MA, OTR/L	Pediatric Development Center	Section 68, OT Services
Lauri Marchewka, LCSW Executive Director	The Collaborative School	Section 65, Day Treatment
Julie M. Schirmer, LCSW	NASW Maine	Section 65 Outpatient Mental Health and Substance Use Treatment
Jason A. Canzano Managing Director	Acelleron	HCPCS: E0603, A4281, A4282, A4283, A4285, and A4286
Chelsea Osgood, MS, OTR/L	Children's Collaboration Center	Section 68, OT Services
Marissa E. Kelley, MS, OTR/L Owner	Children's Collaboration Center	Section 68, OT Services
Maddie Hughes, Owner		Section 68, OT Services
Paul L. Dann, PhD, Executive Director	NFI North	Section 65
Rebecca Hunter, LCSW	Community-Based Individual and Family Psychotherapy	Section 65 outpatient mental health counseling
Diane Racicot MBA RD Vice President, Payer Relations East Division	National Seating & Mobility, Inc. Hudson Home Health Care, Inc. Home Medical Equipment, LLC	Section 60, Durable Medical Equipment
Julia Bergquist ACT Team Lead	Sweetser	Section 17
Patricia S Engdahl, LCSW, MsPH Director Edmund Ervin Pediatric Center	MaineGeneral Medical Center, Edmund Ervin Pediatric Center and MGMC Palliative Care	Pediatric Services
Lisa A. Hill Finance Director	Life Enrichment Advancing People (LEAP)	HCBS for members with IDD, etc.
Scott Miller, director/founder	Creative Trails,	Sec 21 & 29 Com Sup Rate
Rebecca Emmons, MPH Executive Director	Maine Association of Community Service Providers (MACSP)	Sections 21, 29
Deb Smith Director of ID Services /Associate CEO	OHI	Sections 21, 29
Christa L. W. DiGiuseppe Managing Director	Summit Support Services LLC	Section 13, Targeted Case Management
Judy Gagnon		Waiver Section 21 Family Centered Home
Lindsey Tweed		HCT and Parent Child Interaction Therapy (PCIT)
Steven McInnis		Family center care and shared living
Susanne LaVallee, RDH, IPDH Founder/Director	Maine Dental Health Out-Reach, Inc.	Section 25, Dental Services
Amelia Hassler, PsyD		
Daniel Hett *Practice Administrator*	Pediatric Associates of Lewiston	Primary care
Jay Bradshaw, Executive Director	Maine Ambulance Association	Ambulance Services
Jeffrey Walawender Executive Director/Chief Dental Officer	Community Dental Maine	Section 65, Dental Services
Jennifer Malloy Executive Assistant	The Collaborative School	Section 65, Dental Services
Eric Stieritz Insurance & Contracting Specialist	Dynasplint Systems, Inc.	DME comments

Contributor Name	Company	Service
Katy Fulton		Section 68, OT Services
Katelyn Kiermaier, Occupational Therapist	Pediatric Development Center	Section 68, OT Services
Norah Brennan, MS, OTR/L Occupational Therapist		Section 68, OT Services
Gina Colantoni	Gallant Therapy Services	Section 68, OT Services
Laurie J. Belden, Executive Director	Home Care Alliance	Sec 40 & 43 services
Katie Shuey National Director, Reimbursement and State Government Relations	Encompass Health Corporation	Hospital
Tim Heald, Executive Director	Constellations Behavioral Services	ABA Services
Catherine Sigler	Gallant Therapy Services	Section 68, OT Services
Peter Sentner	retired social worker	Section 68, OT Services
Jaime Storey Kiesow OTR/L, SIPT Certified, IM Certified Director/Owner	StoreySmith Pediatric Clinic, PA Owner StoreyTime Learning Center and Aftercare	Section 68, OT Services
Kim Yesis Business Manager	Belfast Dental Care, LLC	Section 25, Dental Services
Bonnie Vaughan IPDH, MEd, MBA Executive Director	Kennebec Valley Family Dentistry	Section 25, Dental Services
Alyssa Smart Administrative Assistant	Gallant Therapy Services	Section 68, OT Services
Maddie Kelley, Therapy Director	Gallant Therapy Services	Section 68, OT Services
Chelsea Natale	Gallant Therapy Services	Section 68, OT Services
Abigail Roberts MS OTR/L Occupational Therapist	Gallant Therapy Services	Section 68, OT Services
Acadia Jerome, COTA/L Certified Occupational Therapy Assistant	Gallant Therapy Services	Section 68, OT Services
Mary Miller, COTA/L Certified Occupational Therapy Assistant	Gallant Therapy Services	Section 68, OT Services
Kristy Moody, MS, OTR/L *Occupational Therapist*	Gallant Therapy Services	Section 68, OT Services
Michelle Mathieu, COTA/L	Turning Point Pediatric Therapy Network,Inc.	Section 68, OT Services
Kourtney Gray, Administrative Assistant	Gallant Therapy Services	Section 68, OT Services
Hayley Norberto,COTA/L	Turning Point Pediatric Therapy Network,Inc.	Section 68, OT Services
Paxton Spiller, MS, OTR/L Occupational Therapist	Gallant Therapy Services	Section 68, OT Services
Jillian O'Brien, MS OTR/L President	Pediatric Development Center	Section 68, OT Services
Elizabeth W. Crampsey, Ed.D, M.S., OTR/L, BCPR Associate Clinical Professor	Community Therapy Center (CTC)	Section 68, OT Services
Ryan Gallant, MOT, OTR/L Occupational Therapist	Gallant Therapy Services	Section 68, OT Services
Daniel Hett *Practice Administrator*		Section 90
Rosalie Grondin		Adult Family Care facilities
Jessica Bolduc DrOT, MSOTR/L	MeOTA	Section 68, OT Services

Contributor Name	Company	Service
Dr. Todd A. Landry Director	Office of Child & Family Services	Payment Methodologies for PCIT, a core EBP for children's behavioral Health
Rachael Siegel-Berele, OTR/L Occupational Therapist	StoreySmith Pediatric Clinic, PA	Section 68, OT Services
Lindsey Tweed MD MPH		Payment Methodologies for PCIT, a core EBP for children's Behavioral Health
Jen Corbeil, PT, DPT, MHA Founder,	Mainely Kidz	Sections 68 and 85
Robert Reed Executive Director	Maine Chiropractic Association	Specialty Services- section 15, 75, 95
James Bass, Esq.	Maine Society of Anesthesiologists (MeSA)	Anesthesia
Jeannette Savage Owner/Administrator	*A Better Choice Home Care*	
Ann Robinson	Spectrum Healthcare Partners ("Spectrum Healthcare")	Anesthesia

Appendix B: Section Specific Recommendations

Section 2: Adult Family Care Services

Best Practices	Rate study with prospective per diem.
Current Methodology Score and Supporting Information	**3** Rates are based on a rate study. Last update: 2018 - *LD 925* 10% increase for rates attributable to wages and salaries for personal care and related services, the annual inflation thereafter, last updated July 2020.
Recommendations	Review the rate model to ensure it is serving the population need as designed. A methodology redesign may be necessary to ensure the services are provided in the way the policy intends.
Rationale for Recommendations	Originally, this model most closely resembled adult foster care, but has changed over time. Before the rate methodology is changed or updated, MaineCare should determine who the model is intended to serve and best practices for accomplishing that, and adjust methodology and reimbursement to conform to that policy decision.

Section 3: Ambulatory Care Clinic Services

Best Practices	Provider type is not present in other states, but best practice is to pay the same amount for the same services whatever the setting.
Current Methodology Score and Supporting Information	**2** There is no record of how the rates were originally determined. Rates were last updated in 2010.
Recommendations	See further discussion related to Section 90 - Physicians Services.
Rationale for Recommendations	See further discussion related to Section 90 - Physicians Services.

Section 4: Ambulatory Surgical Center (ASC) Services

Best Practices	Medicare ASC methodology.
Current Methodology Score and Supporting Information	**4** MaineCare pays 100% of the Medicare rate. Last update: 2021 - January annual update.
Recommendations	Assess ASC rates, outpatient prospective payment system (OPPS) rates and Physician Office rates to determine if site of service differentials are appropriate or if rate adjustments should be made to any services.
Rationale for Recommendations	There may be some cost savings.

Section 5: Ambulance Services

Best Practices	Medicare Ambulance Fee Schedule
Current Methodology Score and Supporting Information	**4** MaineCare pays 100% of the Medicare rate for most services. For neonatal transport services, MaineCare pays the average Medicare rate for critical care transport services. Last update: 2021 - January annual update.

Recommendations	Continue updating the MaineCare fee schedule annually to be consistent with updates using the Medicare fee schedule. Conduct further analysis of non-Medicare ambulance services and mileage rates and re-assess fee schedule for those services.
Rationale for Recommendations	Current methodology is consistent with Medicare for Medicare covered codes, but the comparison percentage for non-Medicare codes is high.

Section 7: Free-Standing Dialysis Services

Best Practices	Medicare fee schedule.
Current Methodology Score and Supporting Information	**4** 90999 - National Medicare rate without adjustments for geography or other factors For 90945, 90989, 90993 - Unknown Other -100% of Section 90 rate Last update: 90989 updated 2018; others updated 2009 or 2010.
Recommendations	Clarify the documentation for this service and how MaineCare will update the fee schedule and inflate rates. Review claims processing guidelines from Medicare regarding consolidated billing for dialysis services and implement billing edits.
Rationale for Recommendations	All payment methodologies should be documented and easily replicable. MaineCare should implement edits in the claims processing system to avoid paying for services that are included in the composite rate. There may be some savings associated with these efforts. MaineCare should also develop a rate review and updating process.

Section 9: Indian Health Services

Best Practices	Federal Regulations apply.
Current Methodology Score and Supporting Information	**4** MaineCare implements the IHS rates as they are published in the *Federal Register*. Last update: 2021 - January annual update.
Recommendations	None
Rationale for Recommendations	N/A

Section 12: Consumer Directed Attendant Services

Best Practices	Rate study with fixed fee schedule.
Current Methodology Score and Supporting Information	**4** Rates based on a rate study. Last update: 2018 July: *LD 925* brings rates up to reflect full 2016 Burns study 2020: 4/1/2020 different percentage increases for Personal Support Services (PSS) codes via budget
Recommendations	A rate study should be completed at the same time as rate studies for similar services offered in other community- based services programs. Apply pre-determined inflation factors periodically.

Rationale for Recommendations	Rate studies should be completed on a scheduled basis and done at the same time as rate studies for similar services to reduce the opportunity for the same service to have a different rate in a different policy section, even if not specifically a waiver service.

Section 13: Targeted Case Management

Best Practices	Most states use a rate study to establish and rebase rates. It is a proven methodology for developing a rate that is based on labor and other costs.
Current Methodology Score and Supporting Information	**2** There is no record of how the rates were determined. Last update: July 2018, a 2% increase per *LD 925.*
Recommendations	Implement rate study and update rates and rate model. Apply pre-determined inflation factors periodically. Consider use of an alternative payment model (APM) that ties quality standards to payment.
Rationale for Recommendations	In comparison, MaineCare rates appear to be out of line to those used in other states examined. Most commonly, states use a per member per month (PMPM) rate to create more sustainability and consistency, paired with certain quality standards and contract requirements.

Section 14: Advanced Practice Registered Nursing Services

Includes the following categories:

- Certified Registered Nurse Anesthetist (CRNA)
- Advanced Practice Registered Nurse (APRN)

Best Practices	See further discussion related to Section 90 - Physicians Services.
Current Methodology Score and Supporting Information	**2** MaineCare rates for APRNs are 100% of the Section 90 rate; rates for CRNAs are 75% of the Section 90 rate (see Section 90 below). Last update: 2013.
Recommendations	See further discussion related to Section 90 - Physicians Services.
Rationale for Recommendations	APRN availability promotes access to primary care services. See further discussion related to Section 90 - Physicians Services.

Section 15: Chiropractic Services

Best Practices	See further discussion related to Section 90 - Physicians Services.
Current Methodology Score and Supporting Information	**2** MaineCare determines rates based on 70% of the 2009 Medicare for Evaluation & Management (E/M) codes and radiology services. There is no record of how rates for non-E/M services were determined. Last update: 2010 for adjustments; E/M codes added 2019.
Recommendations	See further discussion related to Section 90 - Physicians Services
Rationale for Recommendations	See further discussion related to Section 90 - Physicians Services

Section 17: Community Support Services

Best Practices	Rate study with fixed fee schedule.
Current Methodology Score and Supporting Information	**1** There is no record of how rates were determined. Last update: 2018 July - 2% increase per *LD 925*.
Recommendations	Conduct a rate study for this and similar services offered in other community-based behavioral health programs. Apply pre-determined inflation factors periodically.
Rationale for Recommendations	Rate studies have been completed in the past, but not fully implemented. Completing the rate study during a time when other similar services are studied may reduce the potential to create inappropriate incentives or inequity in rates.

Section 18: Home and Community-Based Services for Adults with Brain Injury

Best Practices	Rate study with fixed fee schedule.
Current Methodology Score and Supporting Information	**4** Rate study for some services. Other rates from original institutional waiver services under Sec 97 App F. Last update: July 2020 for some services, April 2016 for other services.
Recommendations	A rate study should be completed along with rate studies for similar services offered in other community-based services programs. Apply pre-determined inflation factors periodically. Consider the use of APMs, particularly for supported employment or to provide integrated oral and physical health care.
Rationale for Recommendations	Rate studies should be completed on a scheduled basis and done at the same time as rate studies for similar services to reduce the opportunity for the same service to have a different rate in a different waiver.

Section 19: Home and Community Benefits for the Elderly and Adults with Disabilities

Best Practices	Rate study with fixed fee schedule.
Current Methodology Score and Supporting Information	**4** Rates determined by rate study. Last update: 2018: *LD 924* brings rates up to reflect full 2016 rate study. 2020: April 1, 2020 different percentage increases for PSS codes via budget.
Recommendations	A rate study should be completed along with rate studies for similar services offered in other community-based services programs. Apply pre-determined inflation factors periodically.
Rationale for Recommendations	Rate studies should be completed on a scheduled basis and done at the same time as rate studies for similar services to reduce the opportunity for the same service to have a different rate in a different waiver.

Section 20: Home and Community-Based Services for Adults with Other Related Conditions

Best Practices	Rate study with fixed fee schedule.
Current Methodology Score and Supporting Information	**4** Rate study for some services; other rates from original institutional waiver services under Sec 97 App F. Last update: 2020 July for some services, April 2016 for others.
Recommendations	See further discussion related to Section 18.
Rationale for Recommendations	See further discussion related to Section 18.

Section 21: Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder

Best Practices	Rate study with fixed fee schedule.
Current Methodology Score and Supporting Information	**4** MaineCare determined rates with a rate study for some services; no record of rates were determined for other services. Last update: July 2018; updates planned throughout 2021.
Recommendations	See further discussion related to Section 18.
Rationale for Recommendations	See further discussion related to Section 18.

Section 23: Developmental and Behavioral Clinic Services

Best Practices	Utilize existing codes in the Medicare Physician Fee Schedule (PFS).
Current Methodology Score and Supporting Information	**1** Rates determined by rate study. Last update: 2018 July - 2% increase per *LD 925*.
Recommendations	Integrate into the Medicare PFS. This should be completed at the same time as other changes to the physician fee schedule.
Rationale for Recommendations	Use of a separate code and rate methodology for a single provider is inefficient and adds to administrative burden. Apply a high-risk population modifier to an already existing physical and behavioral health care assessment code.

Section 25: Dental

Best Practices	The model of payment for dental services varies across state Medicaid programs: • Fee-for-service (FFS) systems like Maine. • Administrative Services contractors. • State engages a dental managed care organization. Research of the comparison states indicates use of "cost surveys" or a commercial database with relative values for the development of the fee schedule. Further, experiences of select states indicate best practices for improving access include implementation of "enabling conditions:" • Reimburse closer to market rates. • Patient and provider outreach. • Streamlined administrative procedures. • Enhanced incentive in underserved areas.[53]

[53] https://fr.milliman.com/-/media/milliman/pdfs/articles/medicaid-dental-program-models-factors.ashx

Current Methodology Score and Supporting Information	**1** MaineCare determined rates through recommendations from a Dental Consultant, and for some services, average rates from other Medicaid programs. Last update: There is no record, except that new codes have been added over time.
Recommendations	Use a relative value fee schedule or allowed charges database (commercially available) to develop and update fees. The Maine All Payer Claims Database could be used as a source of data. Review and update the fee schedule at least biannually. Review administrative requirements and how those differ from requirements placed on dental services providers in commercial practice, and develop approaches to streamline those. Identify opportunities to incorporate dental utilization and continuity of care goals into primary care incentive models, dental bundled or prospective payment models and if possible, into Accountable Communities (AC) incentive models.
Rationale for Recommendations	There is no documentation as to the rationale for the fee schedule now in place. There have been no updates in dental fees in the recent past, except for new codes, which are priced as they are added; a review of dental specialties indicates a wide variation of MaineCare fees in comparison to commercial fees and for the comparison states. MaineCare rates are relatively low in comparison to other states and commercial for most dental services, especially for endodontics, removable prosthodontics, and fixed prosthodontics; diagnostic services are also relatively lower than comparisons. Additionally, the comparisons show notable variation across rates, especially for oral and maxillofacial surgery. More than 25% of the codes analyzed for endodontics and periodontics are low outliers. There are wide variations in comparison percentages for multiple other services that demonstrate a need for review and updating of all rates. Furthermore, the percentage comparison is higher for restorative services than preventive services, suggesting that MaineCare places a lower priority on preventive care that could potentially reduce the overall cost of dental services for MaineCare members. More than for other services, dental services providers describe issues and challenges for MaineCare members to obtain access to dental services, particularly preventive services, and administrative requirements. These recommendations address both concerns.

Section 26: Day Health Services

Best Practices	Rate study with fixed fee schedule.
Current Methodology Score and Supporting Information	**4** MaineCare determined rates through a rate study. Last update: 2020 - July inflationary increase.
Recommendations	A rate study should be completed along with similar services offered in other community-based services programs. Apply pre-determined inflation factors periodically.

Rationale for Recommendations	Rate studies should be completed on a scheduled basis and done at the same time as similar services to reduce the opportunity for the same service to have a different rate in a different section of policy.

Section 28: Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations

Best Practices	Rate study with fixed fee schedule.
Current Methodology Score and Supporting Information	**4** MaineCare determined rates with a rate study. Last update: 2018 July - updated to the Burns' 2017 rate study (wage adjusted) and incorporated the 2% increase for *LD 925*.
Recommendations	See further discussion related to Section 18.
Rationale for Recommendations	See further discussion related to Section 18.

Section 29: Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder

Best Practices	Rate study with fixed fee schedule.
Current Methodology Score and Supporting Information	**4** There is no record of how rates were originally determined. Last update: July 2018; updates planned throughout 2021.
Recommendations	See further discussion related to Section 18.
Rationale for Recommendations	See further discussion related to Section 18.

Section 30: Family Planning Agency Services

Best Practices	Medicare Professional Fee Schedule
Current Methodology Score and Supporting Information	**2** MaineCare pays 100% of the Section 90 rate for most services; no record for others. Last update: 2010.
Recommendations	Implement current Medicare PFS and apply a standard percentage discount for non-physician providers. Obtain Medicare fee schedules as they are released and conduct analyses to implement, e.g., if they are to be budget neutral. Apply pre-determined inflation factors periodically. Make other changes consistent with recommendations in relevant policy sections. Consider option for a bundled clinic rate or other model such as the Certified Community Behavioral Health Clinics (CCBHCs) that would allow Family Planning clinics to contract to provide a broader array of services.[54]

[54] CCBHCs are responsible for directly providing (or contracting with partner organizations to provide) nine types of services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care.

Rationale for Recommendations	Range in comparison percentages (minimum and maximum) suggests that Medicare PFS adoption might rebalance rates. A PMPM bundled rate, tied to performance, would address some additional services that Family Planning Agencies provide and the role they serve as primary care providers. Some states use a clinic rate similar to the approach used to calculate Rural Health Center rates to support these types of services.

Section 31: Federally Qualified Health Centers (FQHC)

Best Practices	Federal Regulations apply. Most states use the payment model required by federal legislation, but some implement strategies to create greater integration with behavioral health. Twenty-one states have implemented CCBHCs to some degree. In some instances, these are new clinics. In others, FQHCs have become dually certified as CCBHCs to obtain a prospective payment system rate for a broader scope of behavioral health and SUD services.
Current Methodology Score and Supporting Information	**4** MaineCare follows the federally required methodology. 1999-2000 costs adjusted for inflation and approved changes in scope. Last update: 2021 - January annual update.
Recommendations	None. None related to the payment methodology. However, as MaineCare evolves its primary care programs, FQHCs should have the option to participate in the APMs. FQHCs will be included in Primary Care 2.0. Consider what role, if any, a CCBHC model could play in the integration of physical and behavioral health.
Rationale for Recommendations	APM recommendation supports the Department's goals to move to value-based approaches.

Section 40: Home Health Services

Best Practices	Most states use a fee schedule approach, some based on the costs of agencies within the state as reported on cost reports, and others based on rates that they continue to update (without clarification as to the source of the fees). We have not identified a state Medicaid agency that uses the Medicare approach, which pays per episode of care based on patient conditions. Prior to the implementation in 2000, Medicare used a fee schedule approach that many state Medicaid agencies adopted and continue to update.
Current Methodology Score and Supporting Information	**1** There is no record of how the rates determined. Last update: January 2019.
Recommendations	Rebalance current rates. Update and implement cost study results. Apply pre-determined inflation factors periodically.

Rationale for Recommendations	Comparison percentage is close to 100%; however, there is a need for rebalancing. Cost coverage percentages range from 12% to 386% of comparison rates. There is no record of the methodology now in place; however, a study of costs was completed in 2015, but not implemented. An approach that is outdated and that does not address provider costs does not meet the Department's goal for creating a rational payment system.

Section 43: Hospice

Best Practices	Centers for Medicare and Medicaid Services (CMS) Medicaid Methodology
Current Methodology Score and Supporting Information	**3** Rates determined by CMS for continuous home care, inpatient respite care, and general inpatient care. The rate is 123% of the Medicare rate for routine care. Last update: October 2020.
Recommendations	Consider rebalancing rates to equal CMS published Medicaid rates, with potential savings. Medicare has separate rates for providers who report quality indicators and those who do not. MaineCare could evaluate using a similar approach.
Rationale for Recommendations	Some rates exceed the CMS published rates and could be reduced; MaineCare rates on average are higher than comparison rates from other states for some services.

Section 45: Hospital Services – Acute Outpatient

Best Practices	Medicare OPPS, although a few state Medicaid agencies continue to use cost-based reimbursement to maximize payment for outpatient services, using supplemental payment programs.
Current Methodology Score and Supporting Information	**4** Ambulatory Payment Classifications (APCs)/OPPS at 83.7% of Medicare rate. Hospital-based physician costs, as follows: • Rural: 100% allowable costs • Non-Rural: 93.4% for emergency room, 83.8% for non-emergency room • Last update: 2021 - January annual update
Recommendations	No recommendations for changes to the methodology, but consider reducing rates to outpatient hospitals for certain services delivered in the ASC setting where rates for those services are lower than for outpatient hospitals. Decisions about revising payment rates should consider access, quality, and other factors that might influence MaineCare's decisions about reducing rates. Consider incentivizing the use of less costly settings through APMs that reward provider cost efficiency.
Rationale for Recommendations	Analysis showed that services billed with comparable procedure codes are paid at a higher rate in the outpatient hospital department than in the ambulatory surgical setting, even though MaineCare payment for ambulatory surgical centers is high in comparison to other payers.

Section 45: Hospital Services – Acute Inpatient, non-Critical Access Hospitals

Best Practices	Most state Medicaid agencies use Diagnosis-Related Group (DRG)-based payment, with the majority using All-Payer Refined (APR)-DRGs, and fewer using Medicare Severity Diagnosis-Related Groups (MS-DRG). Many commercial health plans also use APR-DRGs. APR-DRGs address some shortcomings of the MS-DRG approach, because APR-DRGs specifically are suitable for sick and healthy newborns, pediatrics, and obstetrics. States that use MS-DRGs may adjust the DRGs for newborns to better classify those services. APR-DRGs can also provide better information for measuring patient severity, utilization, costs, and quality, which may become more important to MaineCare as it continues to develop and implement APMs. Some states have followed Medicare's lead in developing quality incentive programs, such as the Hospital Inpatient Quality Reporting program, Inpatient Psychiatric Quality Reporting Program, and Outpatient Hospital Quality Reporting Program, whereby Medicare pays providers more, or withholds part of their annual increases, depending on whether hospitals successfully report measures, or meet other process, structure, outcome, or efficiency goals. Several state Medicaid programs also have implemented "episode of care" payments, for example, by developing a bundled payment for a specific surgical procedure, such as prenatal health services. If the provider manages care and can provide services at a cost less than the full rate, the provider keeps all or some portion of the savings; if the costs exceed the rate, there is no additional payment from Medicaid. Arkansas, Ohio, and Tennessee have implemented this approach for some episodes of care. Minnesota has developed payment bundles for managed care organizations to use.[55]
Current Methodology Score and Supporting Information	**3** DRGs based on SFY2011 MaineCare costs. Inpatient hospital-based physicians: 100% of allowable costs for "rural" hospitals, 93.3% of allowable costs for "non-rural" hospitals. Last update: 2012 July; January 2020 for Hospital-based physician payments to defined Rural Hospitals.
Recommendations	Rebase rates to a more recent grouper version and consider use of the APR-DRG grouper to better classify cases. Schedule reviews of DRG methodology to occur at least every 5 years, but update Grouper version each year to maintain the integrity of the approach and to keep up to date with coding changes. Consider prospective approaches for capital (include in DRG methodology) and medical education payment. Move to a prospective payment system that incorporates supplemental payments in the base rates. Develop approaches that involve hospitals in quality improvement activities and implement those at the same time as rebasing.

[55] https://www.ama-assn.org/system/files/2019-04/medicaid-value-based-care-models.pdf.

	Consider if episodes of care could be implemented to create opportunities for hospitals and physicians to share upside and downside risks with MaineCare. Rebasing DRGs provides opportunity to review claims data and determine potential episodes; blending in supplemental payments creates funding opportunities for hospitals and other providers who achieve desired performance levels. Implementation of episodes of care should consider other initiatives underway that affect hospitals, such as changes in the Accountable Communities program design.
Rationale for Recommendations	Grouper version is more than 8 years old and does not reflect changes in technology, service delivery, clinical pathways, costs, etc. A new methodology, APR-DRGs, for example, might better address current carve-outs: (psychiatric, substance use, etc.). Even if a per discharge or per diem approach is used to pay for certain services, the approach would allow for updating and revising rates at the same time other rates are implemented, to promote consistent payment policies. Eliminating cost-based payments with settlements would simplify the administration of the system and enable MaineCare to consider appropriate incentives in the rate. Folding supplemental payments into an APM strategy will improve transparency and accountability and support Value-Based Purchasing (VBP) strategies. MaineCare can continue to target special classes of providers with different rate/incentive structures.

Section 45: Hospital Services – Inpatient Rehabilitation

Best Practices	Medicare has implemented a rehabilitation services specific methodology, but state Medicaid agencies have generally not adopted that approach, continuing to use their DRG systems to assign cases to DRGs and then paying for them using per discharge or per diem approaches.
Current Methodology Score and Supporting Information	**3** Statutory; inpatient hospital-based physician - 93.3% of allowable costs. Last update: July 2018.
Recommendations	Evaluate all inpatient hospital services at the same time. Rebase at the same time inpatient acute hospital services costs are rebased (see above) and model alternative prospective approaches to determine how rates should be structured (included/ excluded, discharge, per diem, etc.). Implement a policy to review and update these rates when the inpatient methodology is updated.
Rationale for Recommendations	Rebasing will provide data for determining how these services should be reimbursed, e.g., included with DRGs, per diem, per discharge, or another approach. A regular review schedule and implementation of updates could allow this service to be treated the same as other inpatient hospital services and removed from regulatory requirements regarding payment. Reduce the number of different methodologies used to pay for inpatient hospital services.

Section 45: Critical Access Hospital (CAH), Inpatient and Outpatient

Best Practices	State Medicaid agencies often use cost reimbursement with retroactive cost settlements to pay for CAH Services, but cost reimbursement is not generally considered a best practice. Including CAHs in prospective payment with targeted payments, prospectively determined, for CAHs may provide an alternative approach.
Current Methodology Score and Supporting Information	**4** MaineCare payment is based on 109% of allowable costs and 100% of allowable costs for hospital-based physicians. Last update: 2020.
Recommendations	Consider whether services provided by CAHs could be included in a rebased DRG methodology, using a prospective payment approach, through peer grouping alternatives or targeted payment. Consider how CAHs could be included in quality improvement activities, or other APMs, that reward performance.
Rationale for Recommendations	Current approach that requires cost settlement is burdensome for providers and MaineCare. Other payment methodologies may provide incentives for providers to improve care delivery and increase overall value to MaineCare.

Section 46: Psychiatric Hospital Services

Best Practices	Cost reimbursement is frequently used, especially for state operated facilities to maximize federal reimbursement. However, cost reimbursement is not considered a best practice, and there may be other approaches to achieve payment objectives with prospective approaches.
Current Methodology Score and Supporting Information	**3** Negotiated 85% to 100% of charges for inpatient; 117% of cost for outpatient. Last update: October 2019.
Recommendations	At the time of rebasing the DRG methodology, consider options for classifying services provided by these providers in per diem or per discharge payment arrangements.
Rationale for Recommendations	Current approach is inconsistent with best practices. Exclusively cost-based approaches are incongruent with the goals of transformation and value. A change in the methodology could create incentives for service delivery in other inpatient hospital settings.

Section 45/46: Hospital Based Physicians (HBPs)

Best Practices	Prospective payment rates that are determined based on a fee schedule and that include performance payments.
Current Methodology Score and Supporting Information	**3** MaineCare pays hospital-based physicians: • Acute inpatient: 100% of allowable costs for rural hospitals and 93.3% of allowable costs for non-rural hospitals. • Acute outpatient: 100% of allowable costs for rural hospitals; for non-rural, 93.4% for emergency room, 83.8% for non-emergency room. • CAHs: 100% of allowable costs. • Distinct Part Psychiatric Units: 93.3% of allowable costs. • Inpatient Rehabilitation: 93.3% of allowable costs. • Outpatient Rehabilitation: 83.8%. • Inpatient Hospital, Substance Use Disorder (SUD), 93.3% of allowable costs.

Recommendations	See Section 90 discussion. Repurpose funding currently used for cost settlement of HBPs to instead be used for performance-based payments.
Rationale for Recommendations	The current approach, which includes cost settlements, is incongruent with the Department's goals of transformation and value. There are other approaches to make additional funding available through performance-based payments. A change in methodology could create opportunities for inclusion of additional providers in value-based approaches. Recommendations to consider episode of care payment approaches require sharing of risk, which does not flow from cost-based approaches where there are settlements to pay costs.

Section 50: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)

Best Practices	States base rates on reported costs, developing cost components and placing ceilings on costs, and periodically updating payment rates. However, the ICF/IDD programs in states vary considerably as to the individuals they serve. Some states include ICF/IDD in risk-based managed care programs, and others are reviewing opportunities to do so. Many states use an individual assessment, such as the ICAP (Inventory for Client and Agency Planning) or SIS (Support Intensity Scale) to determine the level of need and assign a payment rate.
Current Methodology Score and Supporting Information	**3** MaineCare determines variable and labor costs from 2004 cost reports, and adjusts this amount annually for inflation. MaineCare calculates fixed costs from most recent costs reports. Last update: 2020 - July inflationary increase.
Recommendations	Develop options to use a resident assessment to better distribute payments and reduce the need for budget requests and other administrative efforts. Alternatively, review staffing levels and develop models that predict staffing and costs for services so that reviewers can assess budget requests. New payment model should be fully prospective.
Rationale for Recommendations	Create a more predictable and prospective system, consistent with approaches used for other provider categories and with updated staffing levels.

Section 55: Laboratory Services

Best Practices	Medicare's clinical lab fee schedule.
Current Methodology Score and Supporting Information	**3** MaineCare pays 70% of the 2009 Medicare fee schedule. Last update: 2010.
Recommendations	Implement current Medicare fee schedule and update at least bi-annually. Rebalance rates, i.e., reduce fees that are greater than the fee schedule and increase rates that are above the fee schedule. There are potential cost savings associated with the recommendations for this policy area.

Rationale for Recommendations	Policy states that MaineCare will pay 70% of the 2009 Medicare fee schedule; however, analysis shows that for the codes reviewed the average MaineCare rate ranges from 65.4% to 100% of current Medicare rates. Using a more recent year will make rates more equitable across all MaineCare services; there could be some "rebalancing" as those paid at rates more than the selected percentage would be reduced and other rates could be increased.

Section (60) Medical Supplies and Durable Medical Equipment (DME)

Includes the following categories:

- DME with Medicare
- DME with No Medicare Rates
- DME Cures with Medicare
- DME Cures with No Medicare Rates

Best Practices	Most states use a rate based on a percent of the Medicare DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics and Supplies) rates, a few use a competitive bidding system for most of their DME services, a cost, Manufacturer Suggested Retail Price (MSRP), or invoice approach (discounted) for some services.
Current Methodology Score and Supporting Information	**1** • Non Cures Act rates – 85% of 2011 Medicare or average of other state. • Cures Act rates – 100% of current Medicare. • Price by Prior Authorization. • Incontinence - Invoice +40%. • Hearing aids - Contract. • Miscellaneous DME - MSRP – 20% or Invoice +30%. • Specialty modified low protein food - Invoice +15%. • Continuous Glucose Monitors - no record. Last update: 2018; 2021 - January annual update for Cures Act rates.
Recommendations	Review approaches to fee schedule development. There is a wide variation in how rates are determined (invoice, contracts, MSRP, etc.), and there may be opportunities to develop a simpler approach. MaineCare should base fees on Medicare wherever that is possible. Rebalance fees, i.e., reduce fees that are greater than the selected fee schedule approach/fees, and use those funds to pay rates that are lower than the selected fee schedule approach/fees. Include an inflation factor in rate methodology.
Rationale for Recommendations	This area is scheduled for review in 2021. Rates vary widely in comparison with Medicare, other states, and commercial plans. MaineCare does not comply with CMS Upper Payment Limits (UPL) requirements for Medicare-covered services in part because MaineCare rates do not adjust for urban and rural location. Non-compliance with UPL requires that the state fund payments in excess of the UPL with general fund and without federal match. MaineCare is currently evaluating ways to change rates to reduce spending to the UPL.

Section 65: Behavioral Health Services

Best Practices	Medicare fee schedule for codes where appropriate, rate study with fixed fee schedule for other rates. Many states are using APMs or other models that specifically target quality outcome measures.
Current Methodology Score and Supporting Information	**3** Rates based on rate studies and other. Last update: 2019-2020. • July 1, 2019, response to legislation - Methadone Medication Assisted Treatment (MAT) rate to $110 weekly - *P.L. 2019, Ch. 343*. • January 2020, response to legislation - Multi-Systemic Therapy/Functional Family Therapy (MST/FFT) increased 20% - Resolves 2019, Ch. 110. • April 2020, rate study and Department determination - Creation of Medication Management. Physician's rate (basis from Burns' 2017 rate study), and increase of Home and Community-based Treatment (HCT) behavioral health provider (BHP) rate. • May 2020 rate study - MST/FFT moved to weekly rates; G9007 HE/HT/HK modifiers eliminated. • August 2020 rate study - Rate study for Triple P, Incredible Years, Parent Child Interaction Therapy (PCIT), and Trauma-Focused Cognitive Behavioral Health Therapy (TF-CBT); 96112 HE and 96113 HE added for adaptive assessments, Department developed rate; H2010 HF and HFAF modifiers added for Medication Management Suboxone.
Recommendations	Integrate into the Medicare PFS. Evaluate specialty services for APMs. Review rates for Sections 65 and 28 services that represent children's community behavioral health to determine if they are barriers to access to services, particularly in services where there is a waitlist.
Rationale for Recommendations	Standard procedures should be incorporated into fee schedule updates using the Medicare fee schedule. Other specialty services such as medication management should be evaluated for APMs that support care teams, access to care, and improved outcomes such as CCBHCs. Studying the service system and supporting rates between similar services may reduce the potential to create inappropriate incentives or inequity in rates.

Section 67: Nursing Facility Services

Best Practices	Most states use a cost component system, place limits on the components of costs, and adjust direct care costs for resident acuity. States vary in a number of ways: • The definition of components of cost. • Determination of cost ceilings. • Use of a "floor" on the components of some costs, so if a provider's costs are lower than the floor, they will receive the "floor." • Type of acuity adjustment - Thirty-three states use Resource Utilization Groups (RUGs) approach to adjust base payment rates for nursing facilities, 8 states use a state-developed methodology and 9 do not use an acuity adjustment.[56]

[56] https://www.macpac.gov/wp-content/uploads/2020/10/Changes-in-Nursing-Facility-Acuity-Adjustment-Methods.pdf.

	• Application of case-mix adjustment to each resident or to the facility, and how often the acuity is adjusted (e.g., some as often as quarterly if facility rate rather than resident rate adjusted). • How capital is paid (depreciation and interest), or fair rental. The fair rental approach uses some form of replacement cost basis in lieu of payment for interest and depreciation costs to determine the nursing facility's capital value (i.e., the asset or rate base), which is then used as the basis for payment of a fee for capital expenditures, called an imputed fair rental amount. This leads to a steadier level of reimbursement throughout the life span of the facility and is viewed as an approach that better allows for up front investments. Beginning October 1, 2019, Medicare changed its system from RUGs to the Patient-Driven Payment Model, which predicts a resident's care needs based on their original diagnosis; CMS delayed the phase out of RUGS related questions from the resident assessment, giving states more time to decide if and how they would change their methodologies.
Current Methodology Score and Supporting Information	**2** Rates are based on costs reports, with cost caps on components of costs. However, there are no incentives for creating efficiencies or high performance and there is legislation that creates updates not available to other provider types: inflation every year and rebasing every other year. Last update: 2020 - July rebasing and annual inflationary increase.
Recommendations	For the next rebasing, review the methodology using more recent cost reports to determine if it continues to meet MaineCare goals regarding equity across providers and reasonable distribution of available funds. Consider approaches to simplify the methodology by implementing prospective rates for all components, and eliminating the adjustments and add-ons to the rates that could become part of the methodology. For example, there are adjustments for high MaineCare utilization as a percent of total facility utilization that could be better addressed through the methodology. Determine whether the approach could better address concerns about making funding available for capital improvements and expenditures. Consider fair rental and other approaches. Also, consider use of "floors" in rate components so that providers with relatively lower costs than other providers are not penalized and have opportunities to use funding for improvement in operations. Evaluate peer grouping approach to determine if it continues to meet MaineCare goals and determine if other approaches to wage differentials or other cost differences can be used or if other peer grouping approaches are appropriate. Implement performance requirements; the quality adjustment pool could be funded with withholds from potential increases, and only those providers with high performance would be paid the quality incentive payment.
Rationale for Recommendations	The methodology is documented and rates are updated annually through rebasing or inflation; however, the methodology itself has not been re-evaluated in many years and there is a potential for simplification in the process to make it easier to understand for stakeholders and to manage for MaineCare. The objectives of the methodology are not documented so it is not clear as to whether the current approach meets those objectives. Some providers expressed concerns about what they see as the complexities of the methodology and this recommendation attempts to address that concern.

	A new methodology could result in a redistribution of payments across nursing facilities, so Maine Care will have to determine how those adjustments could apply. P.L. 2017, Ch. 460, Sec. B-1, states that any rate change may not result in any nursing facility receiving a rate of reimbursement that is lower than that rate. Numerous state Medicaid agencies use VBP approaches in their nursing facility reimbursement methodologies. Approaches range from reporting quality metrics to performance-based payments.[57]

Section 68: Occupational Therapy (OT) Services

Best Practices	See further discussion related to Section 90 - Physicians Services.
Current Methodology Score and Supporting Information	**2** MaineCare pays some OT services based on 47.7% of the 2005 Medicare fee schedule; some services are paid based on the current Medicare fee schedule. MaineCare pays for Orthotics based on 85% of the 2011 Medicare fee schedule. Last update: 2012 with a 10% rate cut.
Recommendations	See further discussion related to Section 90 - Physicians Services.
Rationale for Recommendations	The range in comparison percentages (minimum and maximum) suggests that PFS adoption might rebalance rates. See further discussion related to Section 90 - Physicians Services.

Section 75: Vision Services

Best Practices	See further discussion related to Section 90 - Physicians Services.
Current Methodology Score and Supporting Information	**2** Current rates are based on 53% of the 2005 Medicare fee schedule, and by contract for eyeglasses. Last update: 2006.
Recommendations	See further discussion related to Section 90 - Physicians Services.
Rationale for Recommendations	The range in comparison percentages (minimum and maximum) suggests that PFS adoption might rebalance rates. See further discussion related to Section 90 - Physicians Services.

Section 85: Physical Therapy Services

Best Practices	See further discussion related to Section 90 - Physicians Services.
Current Methodology Score and Supporting Information	**2** MaineCare pays some services based on 47.7% of the 2005 Medicare fee schedule, some services are paid based on the current Medicare fee schedule. Orthotics 85% of 2011 Medicare. Last update: 2012 with a 10% rate cut.
Recommendations	See further discussion related to Section 90 - Physicians Services.

[57] For example, Arizona, California, Colorado, Florida, Georgia, Illinois, Indiana, Kansas, Minnesota, Montana, Ohio, Tennessee, Texas. Some of these programs are administered through Managed Care Organizations, and others exist within the fee-for-service structure.

Rationale for Recommendations	See further discussion related to Section 90 - Physicians Services. The range in comparison percentages (minimum and maximum) suggests that PFS adoption might rebalance rates.

Section 90: Physician Services

Includes the following categories:

- Anesthesiology
- Primary Care
- All Other

Best Practices	State Medicaid agencies and many commercial payers use the Medicare PFS as the basis of payment for professional services. The Medicare PFS is based on a resource-based relative value scale (RBRVS) that determines the resources used to provide one service in comparison to another. The federal government and professional associations have spent considerable resources to develop, refine, and update the payment approach, which is why so many payers use it. Medicare and other payers use the Medicare PFS to pay for other professionals. For advanced practice practitioners, states use the Medicare PFS and pay amounts from 60% to 100% of the Medicare PFS. States and other payers also use "policy adjustors" to revise the rate for some categories of service, e.g., primary care, family planning, etc.
Current Methodology Score and Supporting Information	**2** MaineCare pays for some services based on 70% of the 2009 Medicare fee schedule. MaineCare also pays 100% of the 2014 Medicare fee schedule for non-facility/non-clinic primary care codes. Last update: 2010 for most services, and January 2014 for non-facility/non-clinic primary care codes. Fees for physicians' oversight of anesthesia were modified in 2019 to apply standard anesthesia modifiers to stratify payment based on service delivery differences.
Recommendations	Implement the current Medicare PFS for all physicians and other non-physician groups who are currently paid with that fee schedule. Obtain Medicare fee schedules as Medicare releases them (once a year) and conduct analyses to implement them. Implementation could be budget neutral except for any pre-determined inflation factors to be applied, in years where planned rebasing is not occurring. Budget neutrality is achieved by updating codes, relative values, and distributing payments to providers accordingly. It is likely that there will be shifts in payment across categories of providers as relative values change: rates will be higher for some codes and lower for others, but modeling should assume that payments remain the same except for the addition of any allocated inflation adjustment. Rebase the methodology and rates every 3 to 5 years to review payments by provider specialty and to determine if the methodology continues to be consistent with MaineCare goals and the evolution of APMs. Apply pre-determined inflation factors periodically.

	Repurpose funding currently used for cost settlements for hospital-based physicians to instead be used for performance-based payment, which might include episodes of care or bundled payments that create performance-based payments. Such APMs should be coordinated with current APM activity, including the new Primary Care 2.0, the Accountable Communities models, and other initiatives so that providers have the opportunity for enhanced funding if performance goals are met.
Rationale for Recommendations	Primary Care rates compare favorably to those of comparison groups, Medicare, and commercial payers, demonstrating the State support for primary care initiatives. MaineCare also increased some emergency department and hospital services codes. Comparison rates are not as consistently favorable for anesthesiology and all other physicians' services. However, to maintain an up-to-date and consistent fee schedule, MaineCare should update the fee schedule as it updates fee schedules for other services. For all other services, the comparison rate percentages vary significantly, suggesting the need for rebalancing of rates if there are no fee increases. MaineCare implemented rate changes with the Affordable Care Act funding that it should now review to determine if policies to pay supplemental amounts should continue. There appears to be no rationale for the varying percentage discount applied to rates delivered by non-physicians. MaineCare should develop a consistent policy for the services covered in other policy sections (reviewed further in the body of the report). This recommendation creates a uniform, rational, and equitable approach to a payment methodology that is already familiar to providers. The use of a 2010 fee schedule results in a distortion of the methodology, i.e., codes and fees for those services may no longer reflect resources (i.e., are not "relative,") used to deliver them - one of the primary objectives of the RBRVS used by CMS to develop the fee schedule.

Section 91: Health Home Services

Best Practices	States generally pay a PMPM amount for care coordination and other functions in addition to the fee schedule payment.
Current Methodology Score and Supporting Information	**4** MaineCare determined rates based on a rate study. Last update: 2013.
Recommendations	Continue efforts to simplify the program and advance it to performance-based payments.
Rationale for Recommendations	Payments in this program are currently not performance- based. Changes are already underway to simplify three separate programs by merging them into one. MaineCare is currently leveraging multi-payer reform through participation in the Center for Medicare and Medicaid Innovation (CMMI) Primary Care First Initiative.

Section 92: Behavioral Health Home Services

Best Practices	States generally pay a PMPM rate for salary and other costs, contingent upon the Health Home conducting specific functions; some states also provide quality incentive payments for achievement of certain metrics. States have experienced a significant amount of cross over between behavioral health and SUD. This has led to the growing use of integrated models that serve both needs.

Current Methodology Score and Supporting Information	**5** MaineCare determined rates through a rate study. Last update: 2016 - based on Burns study.
Recommendations	Continue to periodically collect and use cost data and include a rate methodology update process to be consistent with best practices and to create a rational, documented methodology. Last rate study conducted with fees implemented 2016; include provisions in policy to indicate rebasing at least every 5 years, with some periodic updating of rates. The current pay for performance approach includes minimal risk; consider strengthening incentives and offering opportunity for reward.
Rationale for Recommendations	Periodic updating of rates will keep the methodology current.

Section 93: Opioid Health Home Services

Best Practices	States generally use a PMPM payment rate for salary and other costs, contingent upon conducting specific functions; some states also provide quality incentive payments for achievement of certain metrics. States have experienced a significant amount of cross over between behavioral health and SUD. This has led to the growing use of integrated models that serve both needs.
Current Methodology Score and Supporting Information	**4** MaineCare determined rates based on a rate study. Last update: 2019.
Recommendations	Continue to periodically collect and use cost data and include a rate methodology update process to be consistent with best practices and to create a rational, documented methodology. Last rate study conducted with fees implemented 2019; include provisions in policy to indicate rebasing at least every 5 years with some periodic updating of rates.
Rationale for Recommendations	Periodic updating of rates will keep the methodology current.

Section 94: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

Best Practices	See Section 90 (Physicians), Section (25) Dental, and descriptions in other relevant sections, depending on the type of service.
Current Methodology Score and Supporting Information	**2** Fees differ by provider type (encounter rate for FQHC, RHC, Sec. 90 for Physicians, etc.) Last updates: Differ by provider type.
Recommendations	Apply recommendations from other relevant policy sections.
Rationale for Recommendations	Multiple sections of policy affect the rates in this section.

Section 95: Podiatric Services

Best Practices	See further discussion related to Section 90 - Physicians Services.
Current Methodology Score and Supporting Information	**2** 47.7% of 2005 Medicare. Last update: 2012 - 10% cut.
Recommendations	See further discussion related to Section 90 - Physicians Services.

Rationale for Recommendations	See further discussion related to Section 90 - Physicians Services. The range in comparison percentages (minimum and maximum) suggests that PFS adoption might rebalance rates.

Section 96: Private Duty Nursing and Personal Care Services

Best Practices	Rate study with fixed fee schedule.
Current Methodology Score and Supporting Information	**4** A rate study was used to develop rates. Last update: 2018: *LD 925* brings rates up to reflect full 2016 Burns. 2020: 4/1/2020 different percentage increases for PSS codes via budget
Recommendations	Review methodology and rebase rates every 5 years.
Rationale for Recommendations	Personal support and nursing services appear to be updated differently and at different times. Equity among nursing rates in different policy sections should be considered when reviewing this Section.

Section 97B: Substance Abuse Treatment Facilities

Best Practices	Rate study with a fixed fee schedule.
Current Methodology Score and Supporting Information	**3** MaineCare determined rates through a review of historical staffing costs. Last update: 2018 July – 2% increase per *LD 925*.
Recommendations	This section is currently undergoing a rate study. Revise prospective rates based on a pre-determined staffing level periodically to ensure an efficient and sustainable rate. Standardize staffing levels so that rate setting is more transparent and consistent between providers.
Rationale for Recommendations	Labor costs are the primary driver for this service category. Staffing and covered services should be structured to reflect standards established by the American Society of Addiction Medicine (ASAM) levels of care.

Section 97C: Medical and Remedial Service Facilities

Best Practices	This is not a common model so best practices cannot be attributed to this model. The current model is more typical for a nursing facility.
Current Methodology Score and Supporting Information	**4** MaineCare rates based on: • Direct care - 1998 statewide peer group. • Personal care services - 1998 cost report (or year facility opened, if later). • Routine care services - 1998 cost reports (or year facility opened, if later), caps on annual inflation. Last Update: 2020 - July inflationary increase.
Recommendations	Evaluate services at the same time as Nursing Facilities to ensure that changes in one setting do not negatively affect the other, and consider other options to develop fully prospective rates.
Rationale for Recommendations	The model is not commonly found in other states, but the methodology most closely resembles what is used for Nursing Facilities. The current model appears to be working to serve people who need services but who do not require nursing facility level of care. Considering the age demographics of Maine, there is likely to be an increased need of this service.

Section 97D: Child Care Facilities

Best Practices	Rate review with a fixed fee schedule.
Current Methodology Score and Supporting Information	**3** MaineCare rates based on historical staffing costs. Last update: July 2016 - ~1% increase.
Recommendations	This section is currently undergoing a rate study. Revise prospective rates based on a pre-determined staffing level periodically to ensure an efficient and sustainable rate. Staffing levels should be standardized so that rate setting is more transparent and consistent between providers.
Rationale for Recommendations	Rate study is currently underway with a target effective date of October 1, 2021. Labor costs are the primary driver for this service category. Any change to residential rates or settings should occur after the community-based services are available and in place to support a change or shift in residential settings.

Section 97E: Community Residences for Persons with Mental Illness

Best Practices	Rate review with a fixed fee schedule.
Current Methodology Score and Supporting Information	**1** Rates based on annual budgets. Last update: 2020 - July annual budget update.
Recommendations	Transition to prospective rates based on a pre-determined staffing level and revise periodically to ensure an efficient and sustainable rate. Standardize staffing levels so that rate setting is more transparent and consistent between providers.
Rationale for Recommendations	Potential cost savings may be possible as well as administrative efficiencies for transitioning to a more consistent methodology. See discussion in Section 97-D.

Section 97F: Non-Case Mixed Medical and Remedial Facilities

Best Practices	Rate review with a fixed fee schedule.
Current Methodology Score and Supporting Information	**3** Rates based on cost reports. Last update: N/A
Recommendations	Transition to prospective rates based on a pre-determined staffing level and revise periodically to ensure an efficient and sustainable rate. Standardize staffing levels so that rate setting is more transparent and consistent between providers.
Rationale for Recommendations	See discussion in Section 97-D.

Section 101: Medical Imaging

Best Practices	See further discussion related to Section 90 - Physicians Services.
Current Methodology Score and Supporting Information	**2** MaineCare fees are based on 70% of the 2009 Medicare fee schedule; global rate for PET scans. Last update: 2010.
Recommendations	See further discussion related to Section 90 - Physicians Services.
Rationale for Recommendations	Policy states that MaineCare will pay 70% of the 2009 Medicare fee schedule; however, analysis of the services reviewed shows the average MaineCare rate ranges from 46% to 100% of Medicare. Using a more recent year will make rates more equitable across all MaineCare services, and fees should be limited to 100% of Medicare (or the percentage of the fee schedule is determined applicable). The new fee schedule could result in "rebalancing" as those codes paid at rates more than the selected percentage would be reduced, and potentially those paid at rates lower than the selected percentage could be increased.

Section 102: Rehabilitative Services

Best Practices	Rate study with fixed fee schedule.
Current Methodology Score and Supporting Information	**4** There is no record of how rates are based. Last update: 2010
Recommendations	See further discussion related to Section 18.
Rationale for Recommendations	See further discussion related to Section 18.

Section 103: Rural Health Clinic (RHC) Services

Best Practices	Federal Regulations apply.
Current Methodology Score and Supporting Information	**4** MaineCare follows the federally required methodology. Rates are based on 1999-2000 or 2016-2017 costs, adjusted for inflation, and approved changes in scope of practice. Last update: 2020 optional rebasing; 2021 - January annual update.
Recommendations	None related to the payment methodology. However, as MaineCare evolves its primary care programs, RHCs should have the option to participate in these APMs. RHCs will be included in Primary Care 2.0.
Rationale for Recommendations	N/A

Section 107: Psychiatric Residential Treatment Facility (PRTF) Services

Best Practices	Rate study with development of a fixed per diem.
Current Methodology Score and Supporting Information	**2** Two rate components: direct care, based on estimates of staffing costs, and routine and fixed costs, based on cost reports. Last Update: 2018 October for direct care portion of the rate.
Recommendations	No change to methodology, but MaineCare should review the methodology/rates at least every 5 years, and update the direct care rate for inflation.
Rationale for Recommendations	Rate was determined in late 2018, and this recommendation is consistent with recommendation to review methodology and rates every 5 years.

Section 109: Speech and Hearing Services

Includes the following sections:

- Agency Services
- Independent

Best Practices	See further discussion related to Section 90 - Physicians Services. States and other payers included in the comparisons do not have separate fees for Agencies and Independent Therapists.
Current Methodology Score and Supporting Information	**2** MaineCare rates are based on 70% of the 2009 Medicare fee schedule. Therapy: 69% of 2018 Medicare for agency, and 90% of agency rate for independents. Last update: 2019 for therapy, and 2010 for others.
Recommendations	Apply a uniform fee schedule to Agencies and to Independent Therapists. See further discussion related to Section 90 - Physicians Services.
Rationale for Recommendations	See further discussion related to Section 90 - Physicians Services. Percentage discounts should be comparable for comparable providers. Other payers apply the same fee schedule to therapy services whether provider is an Agency or an Independent Therapist. Stakeholders identified challenges for independent therapists that a uniform fee schedule could begin to address.

Appendix C: Glossary of Terms and Acronyms

Figure C.1 provides a listing of definitions for key terms and is followed by Figure C.2 that provides acronyms used in this report.

Figure C.1. Definitions of Key Terms

Definitions	
Accountable Communities	An important program within MaineCare's Value-Based Purchasing Strategy through which MaineCare contracts with groups of providers who volunteer to participate in a shared savings model. An Accountable Community shares in savings it achieves for the MaineCare program when it succeeds in reducing costs while meeting quality benchmarks.
Acuity	Measurement of intensity of care that is required by a patient.
Administrative Procedure Act	An Act that governs the process by which federal agencies develop and issue regulations. It includes requirements for publishing notices of proposed and final rulemaking in the Federal Register, and provides opportunities for the public to comment on notices of proposed rulemaking. The State of Maine also has its own Administrative Procedure Act.
Affordable Care Act (ACA)	Comprehensive health care reform law enacted in March 2010 (also known as the Patient Protection and Affordable Care Act) that has three primary goals: • Make affordable health insurance available to more people. • Expand the Medicaid program to cover all adults with income below 138% of the federal poverty level. (Not all states have expanded their Medicaid programs.) • Support innovative medical care delivery methods designed to lower the costs of health care generally
Physician Services - ACA	The ACA included a mandatory two-year increase in fees to Medicare levels for certain services provided by primary care physicians to Medicare levels to address issues related to access to physician services. Some states, including Maine, continue to pay the ACA rates.
All Payer Claims Database (APCD)	State databases that include medical claims, pharmacy claims, dental claims, and eligibility and provider files collected from multiple private and public payers. Maine's APCD is administered by the Maine Health Data Organization (MHDO).

Definitions	
Alternative Payment Model (APM)	A payment approach that provides incentives to provide high-quality and cost-efficient care. An APM can apply to a specific clinical condition, a care episode, or a population. APMs vary in design, but all aim to restructure payments in a way that financially incentivize high-value care, taking into account both the quality and cost of care.
Case Mix	Grouping of statistically related patients. The Case Mix Index (CMI) is the average relative diagnosis-related group (DRG) weight of a hospital's inpatient discharges, calculated by summing the Medicare Severity-Diagnosis Related Group (MS-DRG) weight for each discharge and dividing the total by the number of discharges. The CMI reflects the diversity, clinical complexity, and resource needs of all the patients in the hospital. A higher CMI indicates a more complex and resource-intensive case load.
Cost Report	A financial report that identifies the cost and charges related to a facility's healthcare activities.
Diagnosis-related Group (DRG)	A patient classification system that standardizes prospective payment to hospitals for inpatient care and encourages cost containment on a per discharge basis but does not contain incentives to reduce volume.
DRG-Grouper	A software program used to classify patients into groupings using demographic and clinical information: age, sex, discharge diagnosis, procedures, and presence of complications or comorbidities.
Fee-for-Service (FFS)	A system through which a payer, such as a state Medicaid agency, establishes the fee levels for covered services and pays providers directly for each service they deliver to members. It does not provided incentives to reduce volume or improve quality, and providers do not bear financial risk.
Fee Schedule	A complete listing of fees used by a payer (Medicaid, Medicare, or commercial insurance) to reimburse a physician and/or other providers on a FFS basis.
Health Homes	Established in Section 2703 of the ACA, a service delivery model that builds on the patient-centered medical home concept and that is targeted to individuals with multiple chronic conditions, which may include serious mental illness or Substance Use Disorder (SUD). Services include care coordination, case management, individual and family support, and health promotion/education. MaineCare administers three health home programs: primary care, Opioid, and Behavioral Health, which are component programs of

Definitions	
	Maine's Value-Based Purchasing Strategy. Eligible members are primarily those who have full MaineCare benefits and MaineCare as their primary payer. Participation in the programs is voluntary, and members can opt out at any time.
Home and Community-Based Services (HCBS)	Services and support provided by most state Medicaid programs in a member's home or community that provide services to enable the member to stay in a community-based versus institutional setting. Many HCBS services are provided under 1915(c) waiver programs approved for a state Medicaid program by CMS.
KEPRO	The Administrative Services Organization with which the State of Maine Department of Health and Human Services contracts to oversee authorization of a range of behavioral health services.
MaineCare	Maine's Medicaid Program, which provides **free and low-cost** health insurance to Mainers who meet certain requirements, based on household composition and income, with the State on average paying 1/3 of the cost and the Federal Government paying 2/3.
MaineCare Value-Based Purchasing (VBP) Strategy	A multi-pronged initiative aimed at reducing costs while improving quality and outcomes for MaineCare members through implementation of a payment system that includes the following inter-related reform efforts: • Accountable Communities • Behavioral Health Home Program • Health Home Program • Opioid Health Home Program MaineCare's goal under its VBP strategy is to move 40% of MaineCare spend on full benefit programs to APMs by the end of 2022.
Maine Health Data Organization (MHDO)	State of Maine agency that collects health care data and makes those data available to researchers, policy makers, and the public while protecting individual privacy. The purpose of the organization is to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens. MHDO administers Maine's APCD.
Medicare Ambulatory Payment Classification (APC)	Method of paying facilities for outpatient services for the Medicare program. APCs are an outpatient prospective payment system applicable only to hospitals and have no impact on physician payments under the Medicare Physician Fee Schedule. APC payments are made only to

Definitions	
	hospitals when the Medicare outpatient is discharged from the emergency department or clinic or is transferred to another hospital (or other facility) which is not affiliated with the initial hospital where the patient received outpatient services. APCs encourage cost containment on a per unit basis but do not contain incentives to reduce volume.
Medicare Ambulatory Surgical Center (ASC) Methodology	Method for paying for facility services provided in ASCs (e.g., nursing, recovery care, anesthetics, drugs, and other supplies). Encourages cost containment on a per unit basis but does not contain incentives to reduce volume.
Medicare Physician Fee Schedule (PFS)	Provides rates for more than 10,000 physician services, the associated relative value units, a fee schedule status indicator and various payment policy indicators needed for payment adjustment (i.e., payment of assistant at surgery, team surgery, bilateral surgery, etc.).
Member	Any person enrolled in the MaineCare program.
Pay for Performance (P4P)	Health care payment model that rewards providers financially for achieving or exceeding specified quality benchmarks or other goals. P4P payments may be made based on performance on structure, process, and/or outcome measures, with providers evaluated against benchmarks or by comparison with other providers.
Peer Grouping Methodology	Grouping providers with shared characteristics that result in comparable cost experience.
Per Diem or Per Discharge Payment Arrangement	A fixed amount for a patient day in the hospital or a full patient stay regardless of a hospital's charges or costs incurred for the care of the patient. Encourages cost containment on a per unit basis but do not contain incentives to reduce volume.
Performance-based Payments	Linking payments to improved performance by health care providers (e.g., reimbursing based on success in improving health outcomes).
Primary Care Case Management (PCCM) Program	Programs used by state Medicaid agencies in which members have a designated primary care provider who is paid a monthly case management fee to assume responsibility for managing and coordinating their basic medical care. Individual providers are not at financial risk in these arrangements and continue to be paid on a FFS basis. MaineCare administers a PCCM Program that covers eligible members, primarily those with full MaineCare benefits and MaineCare as their primary payer.

Definitions	
Primary Care Provider Incentive Program (PCPIP)	A MaineCare program that pays additional compensation to PCCM providers who deliver high quality healthcare and who rank above the 20th percentile for certain measures compared to other primary care physicians (PCPs).
Prospective Rates	Rates that are set in advance of services and are known by all parties before services are provided. Encourage cost containment on a per unit basis but do not contain incentives to reduce volume.
Rate Setting	Establishing the rate methodologies and rates paid to providers for covered services.
Retrospective cost-based systems	Under this system, the amount paid to a provider of services is determined based on the provider's reported costs after the services are rendered. Providers submit cost reports that are reviewed and receive additional payment if reported costs are more than reimbursement, and make repayments if costs are less than payments. Retrospective cost-based systems contain no incentives for cost containment, and in fact can provide an incentive for providers to spend more.
Risk-based Managed Care	Payment delivery model in which states contract with managed care plans to cover all or most Medicaid-covered services for members under a 1915(b) waiver. Plans are paid a fixed dollar amount per member per month to provide a defined set of services. They are at financial risk if spending on benefits and administration exceeds payments.
Shared Savings Model	APM that incentivizes providers to reduce spending for a defined patient population by offering them a percentage of any net savings they realize (upside risk) or a loss on excessive costs (downside risk), based on their performance on defined quality measures.
Supplemental Payments	Lump-sum payments in the Medicaid program that are not directly tied to the provision of particular services. For example, states are statutorily required to make disproportionate share hospital (DSH) supplemental payments to hospitals that serve a high share of Medicaid and low-income patients. In addition, states can also make non-DSH supplemental payments to providers up to the upper payment limit (UPL) of what Medicare would have paid in the aggregate for services provided to a particular class of providers. See the MaineCare Benefits Manual, Section 45 of Chapters II and III for additional information: https://www.maine.gov/sos/cec/rules/10/ch101.htm.

Definitions	
Value-Based Purchasing (VBP)	Linking payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

Figure C.2. Acronyms

Acronyms	
ABI	Acquired Brain Injury
ACA	Affordable Care Act
ACT	Assertive Community Treatment
ADEF	Ambulatory Diabetes Education and Follow-Up
ADL	Activities of Daily Living
AFC	Adult Family Care
AFCH	Adult Family Care Home
ANP	Adult Nurse Practitioner
APC	Ambulatory Payment Classifications
APCD	All Payer Claims Database
AP-DRG	All-Payer Diagnosis Related Groupings
APM	Alternative Payment Model
APR-DRG	All Patient Refined Diagnosis Related Groupings
APRN	Advanced Practice Registered Nurse
ASA	Assessing Services Agency
ASAM	American Society of Addiction Medicine
ASC	Ambulatory Surgical Center
ASD	Autism Spectrum Disorder
BCBA	Board Certified Behavior Analyst
BHH	Behavioral Health Home
BHHO	Behavioral Health Home Organization
BHP	Behavioral Health Professional

Acronyms	
BHS	Behavioral Health Services
BIPA	Benefits Improvement and Protection Act of 2000
BLS	U.S. Bureau of Labor Statistics
CADC	Certified Alcohol & Drug Counselor
CAH	Critical Access Hospital
CARF	Commission on Accreditation of Rehabilitation Facilities
CCBHC	Certified Community Behavioral Health Clinic
CCT	Community Care Team
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvement Amendments of 1988
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
COLA	Cost-of-Living Adjustment
CNA	Certified Nursing Assistant
CPI	Consumer Price Index
CPT	Current Procedural Terminology
CRMA	Certified Residential Medication Aid
CRNA	Certified Registered Nurse Anesthetist
CRS	Community Rehabilitation Services
CT	Computed Tomography
DCP	Direct Care Price
DLS	Daily Living Support
DHHS (Department)	Maine Department of Health and Human Services
DME	Durable Medical Equipment
DMST	Diabetes Self-Management Training
DO	Doctor of Osteopathic Medicine
DOL	U.S. Department of Labor
DRG	Diagnosis-Related Group
DSP	Direct Support Professional
EAD	Elders and Adults with Disabilities

Acronyms	
ED	Emergency Department
EHR	Electronic Health Record
E/M Codes	Evaluation and Management Codes
EOB	Explanation of Benefits
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment Services
EVV	Electronic Visit Verification
FFS	Fee-for-Service
FFT	Functional Family Therapy
FMS	Financial Management Service
FNP	Family Nurse Practitioner
FP	Family Planning
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent
FYE	Full-Year Equivalent
FY	Fiscal Year
HBP	Hospital Based Physician
HCB Benefit	The Home and Community-Based Benefit
HCBS	Home and Community-Based Services
HCBT or HCT	Home and Community-Based Treatment
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHP	Health Home Practice
HIT	Health Information Technology
HME	Home Medical Equipment
HUD	Housing and Urban Development
IADL	Instrumental Activities of Daily of Living
ICAP	Inventory for Client and Agency Planning
ICD	International Classification of Diseases
ICF/IID (ICF-MR)	Intermediate Care Facility for Individuals with Intellectual Disabilities formerly known as Intermediate Care Facility for Individuals with Mental Retardation

Acronyms	
ID	Intellectual Disabilities
IHS	Indian Health Services
IMAT	Integrated Medication-Assisted Treatment
IMD	Institutions for Mental Disease
IOL	Intraocular Lens
IOP	Intensive Outpatient Services
IPDH	Independent Practice Dental Hygienists
ITP	Individual Treatment Plan
ITRT	Intensive Temporary Residential Treatment
LADC	Licensed Alcohol and Drug Counselor
LCDS	Licensed Chemical Dependency Counselor
LCPC	Licensed Clinical Professional Counselor
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LMSW	Licensed Master Social Worker
LOC	Levels of Care
MAT	Medication Assisted Treatment
MBM	MaineCare Benefits Manual
MD	Doctor of Medicine
MDS	Minimum Data Set
MEI	Medicare Economic Index
MHDO	Maine Health Data Organization
MHRT	Mental Health Rehabilitation Technician
MIHMS	Maine Integrated Health Management Solution
MMIS	Medicaid Management Information System
MRI	Magnetic Resonance Imaging
MS-DRG	Medicare Severity Diagnosis Related Group
MSRP	Manufacturers' Suggested Retail Price
MST	Multi-Systemic Therapy
NCQA	National Committee for Quality Assurance

Acronyms	
NF	Nursing Facility
NTA	Neurobehavioral Testing Assistant
OADS	Office of Aging and Disability Services (within Maine DHHS)
OBH	Office of Office of Behavioral Health (within Maine DHHS)
OCFS	Office of Office of Children and Family Services (within Maine DHHS)
OHH	Opioid Health Home
OMS	Office of MaineCare Services (within Maine DHHS)
OPPS	Outpatient Prospective Payment System
OT	Occupational Therapy/Therapists
OTA/L	Occupational Therapy Assistant, Licensed
OUD	Opioid Use Disorder
PA	Prior Authorization
PASRR	Pre-Admission Screening and Resident Review
PBJ	Payroll Based Journal
PERS	Personal Emergency Response System
PCCM	Primary Care Case Management
PCIT	Parent Child Interaction Therapy
PCP	Primary Care Provider, or Primary Care Physician
PCPIP	Primary Care Physician/Provider Incentive Payment
PCS	Personal Care Services
PDN	Private Duty Nursing
P4P	Pay for Performance
PFS	Physician Fee Schedule
PHPOT	Prevention, Health Promotion, and Optional Treatment Services
PMD	Power Mobility Devices
PMH-CNS	Psychiatric and Mental Health Clinical Nurse Specialists
PMH-NP	Psychiatric and Mental Health Nurse Practitioner
PMPM	Per Member Per Month
PNMI	Private Non-Medical Institutions
PPS	Prospective Payment System

Acronyms	
PRTF	Psychiatric Residential Treatment Facility
PSS	Personal Support Services
PT	Physical Therapy/Therapists
PTO	Paid Time Off
PTP	Progressive Treatment Plan
QI	Quality Indicator
RBRVS	Resource-Based Relative Value Scale
RHC	Rural Health Clinic
RN	Registered Nurse
RNBC	Registered Nurse-Board Certified
RNC	Registered Nurse, Certified
RUGs	Resource Utilization Groups
SFY	State Fiscal Year
SIA	Service Intensity Add-On
SIS	Support Intensity Scale
SMI	Serious Mental Illness
SNAP	Supplemental Nutrition Assessment Program
SNF	Skilled Nursing Facility
SPA	State Plan Amendment
ST	Speech Therapy/Therapists
TCM	Targeted Case Management
TFC	Therapeutic Foster Care
TF-CBT	Trauma Focused Cognitive Behavioral Therapy
TMJ	Temporomandibular Joint
UPL	Upper Payment Limit
VBP	Value-Based Purchasing