SPURWINK
going the distance

May 9th, 2023

Re: LD 328, An Act to Improve Mental Health in Maine

Thank you, Senator Baldacci, Representative Meyer, and distinguished Committee Members for accepting this testimony in support of LD 320. My name is Ben Strick. I am a licensed clinical social worker and the Senior Director of Adult Behavioral Health for Spurwink Services.

Assertive Community Treatment (ACT) is an evidence-based practice designed to help individuals with serious mental illness, like schizophrenia, live in the community rather than a psychiatric hospital. It is the highest level of community-based care available.

Evidence based practices are scientifically validated treatment models that generate superior results when followed with fidelity. For ACT, fidelity is measures using the Dartmouth Assertive Community Treatment Scale (DACTS). The intent of this bill is to do one thing: improve care for vulnerable Mainers by aligning MaineCare regulations with the DACTS.

MaineCare recently took huge steps towards ACT program sustainability by improving rates and shifting from a daily to weekly rate. Unfortunately, the MaineCare guidance concerning these changes included an overly restrictive definition of how face-to-face contacts are counted, and disallowed billing for outreach, both in clear conflict with the DACTS.

Approximately a quarter of Spurwink's ACT client panel is homeless at any given time. Of those who are homeless, over 80% struggle with a co-occurring substance use disorder. Each of these clients requires hours of weekly outreach at different campsites around the county. Even with this outreach, it is hard to meet MaineCare's billing requirements for these clients. And while we average 3.3 face-to-face contacts per week across our client panel, MaineCare requirements make it so we are unable to bill for 25th of our most vulnerable clients. We want to continue serving these clients with full fidelity to the ACT model but will be unable to without a MaineCare structure that supports the service.

I've attached DACTS fidelity standards and MaineCare guidance to my testimony. I respectfully request you support this legislation and help us serve some of our highest-needs community members.

Thank you for your time and consideration,

LCSW

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January 1, 2023 Behavioral Health Rate Adjustments Frequently Asked Questions

Updated April 14, 2023

I. General

1. **How will Program Integrity incorporate the recent changes into their reviews of providers?**
   Answer: Program Integrity is aware of ongoing communications regarding changes to rates and billing guidance and will take those communications into account and exercise enforcement discretion as relevant and appropriate for any reviews that include dates of service during this period.

2. **Will there be an opportunity to comment on the rate models proposed for the final rates?**
   Answer: Pursuant to 2021 P.L. ch. 639, the Department accepted and will be responding to the public comment on the Burns rate model and has taken these comments into consideration in determination of the final rates. The Department will be posting responses to public comment on the rate model in early February. In addition, the rate changes that were implemented on January 1, 2023, will still go through the Administrative Procedures Act (APA) rulemaking process which includes notification of proposed rulemaking, a public hearing, and opportunities to submit comments prior to rule adoption. For additional information please refer to the proposed rules page.

II. Section 17, Assertive Community Treatment (ACT) Services

1. **How will Kepro handle the transition from authorizations under the old units to authorization under the new units?**
   Answer: Providers should continue to use their existing authorizations and should bill for services using the new weekly unit rate. Kepro will end the original authorization on February 19, 2023, and will create a new authorization starting on February 20, 2023, that will be set up for weekly billing units.

2. **Do we need to have collateral contacts on non-face-to-face days to bill the week?**
   Answer: Collateral contacts are not required on non-face-to-face days to bill the weekly rate. However, providers must deliver services as needed based on the individualized treatment needs of the member which may include collateral contact on non-face-to-face days. As described in Section 17.04-3, ACT provides individualized intensive integrated services that are delivered by a multi-disciplinary team of practitioners and are available twenty-four (24) hours a day, every day, three hundred and sixty-five (365) days a year. ACT services are delivered primarily in the community and not in an office- based setting. Assertive interventions, including street outreach, are employed by the team as

appropriate. ACT teams must provide at least, on average, three (3) face-to-face contacts per week with each member.

3. **How do we bill week of intake/discharge or weeks with hospitalization or jail?**
   Answer: The expectation is that providers will meet the monthly calendar average of three (3) contacts per week, as described in Section 17.04-3. This flexibility allows for occurrences such as those listed in this question that may prevent a provider from having three contacts with a member every week. In cases where the provider is unable to meet with a member three (3) times in one week, the provider must clearly document in the member's record why the three (3) contacts did not occur. Examples of information providers may include in documentation to support why three contacts were not possible in a week include, but are not limited to:
   - Provider did not have contact with the member but made multiple attempts to reach and meet with the member, including instances where the member was unexpectedly unavailable or the contact occurred through a closed door.
   - There were contacts with the member to transition the member to another level of care, and the member transitioned prior to having at least 3 contacts with the providers.

4. **If we don't hit the minimum threshold for face-to-face monthly average of three (3) contacts per week, can we bill the full week if we document the reasons why in the clinical record?**
   Answer: As stated in the MaineCare Benefits Manual Chapter II, Section 17.04-3, providers must ensure that the delivery of services meets the minimum standard of a calendar monthly average of three (3) face-to-face contacts per week. A provider may not bill for a week if they have not met this standard, even if they document the reason for not meeting the requirement in the member's record.

5. **Does outreach still count as face to face as indicated in Section 17?**
   Answer: Outreach does not count as a face-to-face contact. Providers may still bill during a week when they have conducted outreach but not met the three contacts with the member, as long as they are still meeting the requirement to average three contacts per week. The provider should clearly document all outreach attempts.

6. **How do I know if I can bill for a week for a member if I do not yet know whether I will meet the requirement to average three (3) contacts a week for the month?**
   Answer: You may either hold weekly claims until the end of the month to determine billable weeks, or you may determine on a rolling week by week basis whether you have met the requirement for the past month.

III. Section 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations

1. **What is the difference between providers of school health related services that are subject to Service Provider Tax (SPT) versus SPT exempt?**

Answer: Exemptions to the Service Provider tax are detailed in Maine Revised Statutes, Title 36, Chapter 358: Service Provider Tax. Providers may consult with their tax attorney and/or accountant to determine the appropriate tax laws applicable to their circumstance. Additional information can be found at the Maine Revenue Services webpage.

2. **What Board Certified Behavior Analyst (BCBA) services are required/included in the new "bundled rate?"**
Answer: Providers of BCBA services will continue to adhere to the requirements outlined in Section 28, to include the delivery of BCBA services in connection with Specialized Services for Children with Cognitive Impairments and Functional Limitations (Specialized Services). The BCBA is responsible for the supervision and delivery of the Specialized Services. For specific BCBA service definitions, please refer to Section 28.04-3.

3. **Can an approved specialized RCS provider bill for BCBA services for any youth who is not receiving specialized services from the agency?**
Answer: BCBA services must be delivered as part of an approved specialized services program. Section 28 does not provide for billing of "stand-alone" BCBA services. As a result of the rate study, we now have a code that could be used to bill this service if it is added through rulemaking in the future.

4. **(New – 2/10/23) For community-based services that have new modifiers, will providers need to request new prior authorizations for one-to-one codes?**
Answer: Kepro will automatically end-date authorizations, effective 2/19/23, copy the case of the member, and create new authorizations with correct coding and the original end date/units.
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5. **(New – 2/17/23) Will providers need to submit new PAs with the new codes?**
Answer: Providers must end existing authorizations effective February 19, 2023 and request new PAs with the new codes. Providers must update the unit requests to reflect current utilization.

6. **(New – 2/17/23) Will providers need to request new authorizations to bill for one-to-one and group modifiers?**
Answer: Providers do not need to request new authorizations to add group modifiers. Providers will continue to bill using the group modifiers at the claims level. When one-to-one services require a modifier, providers must submit the modifier with the authorization.

IV. Section 65, Behavioral Health Services

1. **Why were there no rate increased for psychiatric medication management services despite Burns' guidance recommending significant increases in rates for medication management services provided by physicians?**

Answer: Burns recommended reintroducing separate medication management rates for physicians versus non physicians (nurse practitioners, physician assistants). The change from the currently "blended" rate model effective October 1, 2021 where there is a single rate for both physicians and non-physicians would have been a decrease for non-physicians and an increase for physicians. Due to maintenance of effort (MoE) requirements associated with Section 9817 of the American Rescue Plan, the Department may not implement the rate decrease at this time. It does not make sense to have the current blended model apply only to non-physicians when it was intended to be a rate that would cover physicians as well. As such, for at least as long as the Section 9817 MoE requirements are in place through the end of March 2025, the single blended rate approach will remain in place.

2. **Why are there no longer Bachelor's and Master's level rates for Outpatient Services provided by Licensed Alcohol and Drug Counselors (LADCs)?**
   Answer: The rate model for Outpatient Services provided by an LADC was developed by determining a straight average wage assumption calculated from the LADC Bachelor's Degree and LADC Master's degree, in alignment with the fact that LADC licensure includes various educational and experience requirements (32 M.R.S.A. §§6212, 6214-D, 6216).

3. **Should providers bill Triple P and Incredible Years services under HCT or Outpatient?**
   Answer: Providers should continue to bill Triple P and Incredible Years under Section 65.05-17, Behavioral Therapies for Children with Disruptive Behavior Disorders.

4. **What is the approved place of service code for Outpatient Services provided in the community?**
   Answer: Providers should use the "99" place of service code to designate Outpatient Services delivered in the community.

5. **Are child-serving agencies now able to bill for Dialectic Behavior Therapy provided to children under Specialized Group Services?**
   Answer: The eligibility for Specialized Group Services has not changed and continues to be for members aged eighteen (18) or older or emancipated minors, as described in Section 65.05-16 (A).

6. **What is "HCT-OCFS funded" referring to?**
   Answer: This refers to OCFS Child Welfare contracts with HCT providers services outside of MaineCare-funded services.

7. **For providers who serve high hours of HCT in tough cases can MaineCare add to the rule to allow an hourly billing once a member hits the ten hours in a week that the weekly rate assumes?**
   Answer: The HCT rate model is based on the weekly average of members served per BHP (5) and per Clinician (6), not on the estimated number of hours each member receives services throughout the week. The weekly case rate was developed using

averages and recognizes the variability in treatment needs and time required to provide services across the caseload mix at this level of care. If the member requires more intensive treatment, it may be that the member requires a higher level of care.

8. (New – 2/10/23) **What will happen to current authorizations that have a code or modifier that is no longer used?**
Answer: For outpatient services, Kepro will end-date all existing authorizations with codes and modifiers no longer being used on February 19, 2023. The provider will need to submit a new registration and align existing end-dates with current authorizations.

   For comprehensive assessment services, Kepro will end-date all comprehensive assessment codes on February 19, 2023. Providers will exhaust existing comp assessment authorizations then will need to submit a new authorization request.

9. (New – 2/10/23) **If a member is receiving co-occurring services for both substance use outpatient therapy AND mental health outpatient therapy, will you deny the authorizations?**
Answer: No. Kepro has a standard practice to block duplication based on service description. For example: If one LCSW/LCPC is providing mental health outpatient services and another LCSW/LCPC is providing substance use outpatient services, the second clinician providing the additional service must contact Kepro so that Kepro can create a shell case. A shell case is when Kepro puts in a request that is duplicative so the provider can submit the rationale for why there are two services for the same dates and time.

10. (New – 2/10/23) **For children's behavioral health day treatment services, will providers need to request new authorizations from Kepro for one-to-one codes?**
Answer: Providers are required to exhaust units in the existing authorization then submit a new Continued Stay Review (CSR) when units are exhausted or an end-date is due.

11. (New – 2/10/23) **Will HCT providers be required to follow the same billing guidance and service requirements as adult ACT services (Section 17)?**
Answer: Although there are similarities between the Section 17, Adult ACT services and Section 65, HCT services, the guidance is not exactly the same.

    For HCT services, all expectations included in the MaineCare Benefits Manual Chapter II, Section 65.09 continue to apply. Additionally, providers should aim for a monthly average of three face-to-face or telehealth contacts per week, of which at least one contact per week is a clinical intervention with the clinician. Qualifying contacts are interventions provided by a treatment team member (clinician and/or BHP), which directly address the youth's identified treatment goals and may include collateral contacts as defined in Section 65.05-10.

12. (New – 2/17/23) **How will MaineCare retroactively reimburse providers for HCT services provided by an HCT clinician?**

Answer: Kepro will end date old codes on February 19, 2023 and create new authorizations retroactively to January 1, 2023. Providers will continue to bill under existing authorizations until February 19, then must utilize the new authorization for services provided on or after February 20, 2023. Providers must adjust their claims after the new authorization is granted (after February 20) to bill with the new codes and modifiers, as well as the appropriate service model (weekly bundled rate and/or outpatient services-community), with the newly approved authorization.

13. **(New – 2/17/23) Is Sunday through Saturday an appropriate timeframe for a weekly billing cycle and can providers submit claims with overlapping weeks between monthly cycles?**
Answer: The claims system can accommodate overlapping weeks between months. The system does not restrict a week to be Sunday through Saturday as long as the minimum requirements are met to bill for the weekly rate.

14. **(New – 2/17/23) Is there a process to transfer children receiving "Clinician-only" HCT services to Outpatient Community Services?**
Answer: Kepro will process services transitioning from "Clinician only" HCT services the same as requests for outpatient therapy. No referral is needed for outpatient services. The provider enters the required information into the Atrezzo system for an initial registration and continued stay reviews, as well as a community place of service location instead of the office as the place of service.

15. **(New – 2/17/23) If the HCT team loses the BHP mid-treatment, but intends to rehire for that position, must they close the HCT case and reopen it as Outpatient Community Services?**
Answer: If the HCT team loses their BHP staffing, the provider has two options, based on clinical necessity and family choice. The provider can:
    a. End date the HCT case and create a community-based outpatient case, OR
    b. Adjust the number of clinician hours required to meet the service requirements and treatment needs of the member until a BHP is hired.

16. **(New – 2/17/23) Are all HCT providers automatically eligible to bill for Outpatient Services delivered in the Community?**
Answer: Clinicians who provide HCT services are also allowed to provide outpatient services and bill the appropriate code (H0004 or H2000) and modifier combinations, based on the clinician credential specific to the services delivered.

17. **(New – 2/17/2023) What are the billing requirements and reimbursement rates for Outpatient Services delivered in the community?**
Answer: Providers must meet all expectations included in the MaineCare Benefits Manual Chapter II, Section 65.05-3, that apply to outpatient services delivered in the community. Outpatient services delivered in the community include the following procedure codes and modifiers:

Procedure Code	Modifier(s)	Code Description	Unit of Service	Rate
Outpatient Services - Comprehensive Assessment - Community				
H2000	AH U2	Psychologist	15 min	$38.37
H2000	HO U2	LCSW/ LCPC/ LMFT	15 min	$31.26
H2000	U2	Deaf Services	15 min	$40.17
H2000	HN U2	LADC	15 min	$28.99
H2000	HM U2	CADC	15 min	$24.20
Outpatient Services - Individual/Family Therapy - Community				
H0004	AH U2	Psychologist	15 min	$38.37
H0004	HO U2	LCSW/ LCPC/ LMFT	15 min	$31.26
H0004	U2	Deaf Services	15 min	$40.17
H0004	HN U2	LADC	15 min	$28.99
H0004	HM U2	CADC	15 min	$24.20
H0004	ST U2	Trauma-Focused Cognitive Behavioral Therapy	15 min	$38.55

18. (New – 2/17/2023) **How will changes to Outpatient Services delivered in the community impact providers, members, and central enrollment requirements?**
Answer: Providers enrolled as a Mental Health Agency, a Substance Use Agency, or an Independent Practitioner can now all deliver outpatient services in the community. These changes may improve members' access to services as more MaineCare enrolled providers can offer services, including substance use related services, in the community. Additionally, members are not subject to central enrollment requirements for outpatient services, which may assist with a reduction in members' wait times to receive services, further improving access to services.

19. (New – 2/17/2023) **What are the performance measures and reporting requirements for HCT? How do providers bill for services before the Department defines and communicates the performance measures?**
Answer: The Department will propose changes to payment structures through the formal rulemaking process, which will include a public comment period for stakeholders to offer feedback. New performance metrics and performance-based payment provisions will not begin until the Department has formally adopted a final rule.

20. (New – 2/17/2023) **How are HCT contacts defined with clinician, BHP, collateral, and telehealth contacts? Are there minimum time requirements for each?**
Answer: HCT services delivered to a member are based on level of care needs, not on a minimum amount of time spent with the member per contact. HCT services are designed to meet the member's individualized treatment needs delivered through a combination of medically necessary clinical interventions and may include the following:
    - individual therapy session(s) for the identified child,
    - family therapy session(s),
    - treatment team/stakeholder meetings, and/or
    - collateral contacts.

The HCT treatment team (clinician or BHP) provides services that include at least one face-to-face or telehealth contact with a clinician and a monthly average of three face-to-face or telehealth contacts per week. These services are not separately billable, as they are incorporated into the weekly rate of reimbursement.

21. (New - 3/7/2023) **Does the covering clinician who provides outpatient services to my clients when I am out need to submit a new authorization?**
Answer: If the covering clinician has the same credentials as the primary clinician, then a new PA is not required. For example, if the primary clinician is an LCPC, and the covering clinician is also an LCPC, a new authorization is not required and that provider may bill under the active PA. If the covering clinician has a different credential (for example, psychologist is covering for an LCPC), the covering clinician must submit a new PA.

22. (New - 3/7/2023) **Can Section 65 providers submit one authorization for all services for all outpatient services provided in the office, community and/or group setting, or are separate authorizations required for each service location?**

Answer: For initial Prior Authorizations (PA), providers may submit one PA to request all services whether delivered in the office, community and/or group setting. When registering for outpatient services with Kepro, the provider may indicate one or more settings in which the service may be delivered on a single authorization.

23. (New - 3/7/2023) **When will the Kepro Atrezzo system show changes to the new service modifiers?**
Answer: Effective February 20, 2023, Kepro updated the Atrezzo system to reflect the changes to the service codes and modifiers.

24. (New – 4/04/23) **How will Kepro handle existing authorizations for specialized groups?**
Answer: Kepro end-dated existing specialized authorizations as of February 19, 2023. Providers must resubmit a new registration with a start date of February 20, 2023.

25. (New – 4/04/23) **How will Kepro handle authorizations for Triple P, PCIT and Incredible Years behavioral therapies?**
Answer: Kepro end-dated existing authorizations as of February 19, 2023. Kepro created new authorizations by copying the existing cases and aligned existing end dates with the number of units/sessions stated in the MaineCare Benefits Manual. Providers are required to submit a Continued Stay Review (CSR) off the newly created cases and stagger the end dates. What this means is that when you submit your request, please do not have your end dates all on the same date, as this would make them due all on the same day for their next continued stay. Please evenly distribute (stagger) your end date requests so all requests do not expire on the same day.

26. (New – 4/14/23) **How should providers approach HCT billing for services provided from January 1, 2023 until final updates to Section 65 are adopted?**

Answer: For HCT services, all requirements set forth in the MaineCare Benefits Manual Chapter II, Section 65 continue to apply. These baseline requirements include that providers render services at a level of care consistent with the member's clinical needs, in accordance with the provisions of the HCT service model, based on the comprehensive assessment and as identified in the individualized treatment plan. Specifically, Section 65.05-9 provides that HCT is for members in need of mental health treatment based in the home and community who need a higher intensity service than Outpatient Services but a lower intensity than Children's ACT Services, and Section 65.05-9A provides clinical eligibility standards for the service.

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

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