



Alaska Rate Evaluations

Community Behavioral Health Services

Presented to:

Alaska Department of Health (DOH)

Presented by:

Guidehouse Inc.

1676 International Dr, McLean | VA 22102

September 30, 2025

guidehouse.com

This deliverable was prepared by Guidehouse Inc. for the sole use and benefit of, and pursuant to a client relationship exclusively with the Alaska Department of Health ("Client"). The work presented in this deliverable represents Guidehouse's professional judgement based on the information available at the time this report was prepared. Guidehouse is not responsible for a third party's use of, or reliance upon, the deliverable, nor any decisions based on the report. Readers of the report are advised that they assume all liabilities incurred by them, or third parties, as a result of their reliance on the report, or the data, information, findings and opinions contained in the report.

Table of Contents

A. Executive Summary.....	7
B. Overview and Background	10
C. Findings and Recommendations	16
C.1. Findings.....	16
C.1.1. Cost Benchmarking Process	16
C.1.2. Overall Reimbursement Adequacy	16
C.1.3. Rate Imbalances.....	17
C.1.4. High Indirect Costs	20
C.2. Recommendations	22
C.2.1. Rate Recalibration and Rebalancing	23
C.2.2. “Hold Harmless” Provisions and Other Risk Corridors.....	25
C.2.3. Geographic Adjustment Framework	26
C.2.4. Behavioral Health Cost Reporting System.....	29
C.2.5. Addressing Rate Disparities for Services under the Clinic UPL	31
C.2.6. Crisis Services	35
C.2.7. Service Definitions	36
C.2.8. Annual Administrative Rate Review.....	37
C.2.9. Staff Transportation Add-On Rate	38
D. Stakeholder Engagement	39
D.1. Rate Workgroup Structure.....	39
D.2. Additional Stakeholder Engagement.....	42
D.2.1. In-Person Provider Interviews	42
D.2.2. Service-Specific Focus Group Sessions.....	43
E. Data Sources	49
E.1. Overview of Data Sources.....	49
E.2. Provider Cost and Wage Survey	49
E.2.1. Survey Design and Development.....	50
E.2.2. Survey Administration and Support	51
E.2.3. Provider Cost and Wage Survey Participation	51
E.2.4. Provider Cost and Wage Survey Review and Validation	52

E.3. Claims Data	53
E.4. Other Data Sources	53
F. Peer State Comparisons	55
F.1. Overview	55
F.2. Comparison Approach	55
F.3. Comparison Results	56
G. Rate Methodologies and Components	64
G.1. Overview of Rate Methodologies	64
G.2. General Cost Assumptions	65
G.2.1. Staff Wages	66
G.2.2. Inflation Factors	70
G.2.3. Overtime and Other Supplemental Pay	71
G.2.4. Final Wage Adjustments	72
G.2.5. Employee-Related Expenses	75
G.2.6. Direct Care Staff Productivity	78
G.2.7. Occupancy	81
G.2.8. Supervision	81
G.2.9. No-Show Adjustment	83
G.2.10. Staffing Ratios	84
G.2.11. Staffing Ratios within Residential Settings	85
G.2.12. Administrative Expenses	86
G.2.13. Program Support Expenses	87
G.3. Service-Specific Rate Components	88
G.3.1. General Community Services	89
G.3.2. Assessment, Evaluation, and Screening Services	92
G.3.3. Autism (ABA) Service Methodologies	94
G.3.4. ASAM, Intensive Outpatient, and Partial Hospitalization Services	95
G.3.5. Residential Service Methodologies	102
G.3.6. Crisis Services	107
G.3.7. Other Service Methodologies	110
H. Fiscal Impact Estimates	111

H.1. Utilizing State Fiscal Year 2024 Claims Data	111
H.2. Comparative Analysis with Existing Rates	111
H.3. Incorporating Federal Medical Assistance Percentages (FMAP)	111
H.4. Geographic Differential Adjustments.....	112
H.5. Behavioral Health Service Mix	112
H.6. Fiscal Impact Scenarios.....	115
H.6.1. Scenario 1: Not Held Harmless, No Additional Inflation (Rates Effective 7/1/2025)	116
H.6.2. Scenario 2: Not Held Harmless, With 3.2% Inflation (Rates Effective 7/1/2026)	117
H.6.3. Scenario 3: Held Harmless, No Additional Inflation (Rates Effective 7/1/2025)	118
H.6.4. Scenario 4: Held Harmless, With 3.2% Inflation (Rates Effective 7/1/2026)	119
H.6.5. Overall Fiscal Impact	120
I. Benchmark Rates	123

Table of Figures

Figure 1: Overview of Project Initiatives	14
Figure 2: Peer States for Rate Comparison	55
Figure 3: Family Adaptive Behavior Treatment Guidance by Qualified Health Care Professional (with or without Patient Present) (97156).....	58
Figure 4: Behavioral Identification Assessment by Qualified Health Care Professional (97151)	58
Figure 5: Psychotherapy, Individual (90837)	59
Figure 6: Group Psychotherapy (Other than Multi-Family Group) (90853).....	60
Figure 7: Peer Support Services Individual (H0038)	61
Figure 8: ASAM 3.5, SUD Residential (Adult) (H0047 TG V1).....	62
Figure 9: Short Term Crisis Stabilization (H2011)	63
Figure 10: Supplemental Pay Over Time	72
Figure 11: Behavioral Health Service Grouping SFY2024 Medicaid Expenditures.....	113
Figure 12: Behavioral Health Service Grouping SFY2024 State Share Medicaid Expenditures	114
Figure 13: FMAP Percentage by Service Grouping	115

Table of Tables

Table 1: Estimated Annual Fiscal Impact by Recommendation	9
Table 2: Estimated Annual Fiscal Impact (Four Scenarios).	13
Table 3: Overview of Alaska Behavioral Health Services.	15
Table 4: Geographic Differentials	28
Table 5: Geographic Differentials Fiscal Impact	29
Table 6: Cost Reporting Fiscal Impact	30
Table 7: Psychological Service Rate Comparisons in Alaska	32
Table 8: Crisis Services Fiscal Impact	36
Table 9: Rate Workgroup Composition and Roles	40
Table 10: Provider Cost and Wage Survey Organization and Data Elements	50
Table 11: Survey Response Rates for all Populations	52
Table 12: Other Data Sources	54
Table 13: Overview of Rate Components*	66
Table 14: Average Hourly Wage Reported in Cost and Wage Survey, Weighted by FTEs	67
Table 15: Bureau of Labor Statistics Alaska and National Comparison	68
Table 16: Sources of Growth Rates in Relevant Costs and Wages.....	71
Table 17: Calculation of Wage Adjustment Factors.....	72
Table 18: Benchmark Wage Recommendations- Direct Care	73
Table 19: Benchmark Wage Recommendations – Supervisory Jobs	74
Table 20: Components of ERE for a Behavioral Health Aide.....	76
Table 21: Examples of Employee-Related Expenses Across Job Types.....	78
Table 22: Productivity by Service.....	79
Table 23: Supervisor Span of Control and Hours.....	82
Table 24: Staffing Ratios by Service.....	84
Table 25: Residential Facility Staff Calculation: Facility Size = 12 Beds.....	85
Table 26: Residential Facility Service Staffing Hours: Facility Size = 12 Beds	86
Table 27: Residential Service Substitution Hours Calculation	86
Table 28: Program Support Variables	88
Table 29: Guidehouse Behavioral Health Service Groupings	88
Table 30: General Community Job Types.....	90

Table 31: General Community Benchmark Rates.....	91
Table 32: Assessment/Evaluation Job Tyes and Unit of Measure Time Estimates	93
Table 33: Assessment and Evaluation Benchmark Rates	93
Table 34: ABA Benchmark Rates	95
Table 35: ASAM 1.0 and Outpatient Benchmark Rates	97
Table 36: ASAM 2.5 and Partial Hospitalization Benchmark Rates	98
Table 37: ASAM Residential Facility Sizes	100
Table 38: ASAM 3.1 – 4.0 Residential Benchmark Rates	101
Table 39: Adult Mental Health Residential Rates	105
Table 40: Children's Residential Treatment Service Benchmark Rates.....	106
Table 41: Therapeutic Treatment Homes (TTH) Service Rates.....	107
Table 42: Crisis Residential and Stabilization Services (CSS) Rate.....	108
Table 43: 23-Hour Crisis Observation and Stabilization (COS), Short-Term Crisis Intervention, and Short-Term Crisis Stabilization Rates	110
Table 44: Day Treatment for Children Rates	111
Table 45: Scenario 1- Not Held Harmless, No Additional Inflation (Rates Effective 7/1/2025)	116
Table 46: Scenario 2- Not Held Harmless, With 3.2% Inflation (Rates Effective 7/1/2026).....	117
Table 47: Scenario 3- Held Harmless, No Additional Inflation (Rates Effective 7/1/2025).....	118
Table 48: Scenario 4- Held Harmless, With 3.2% Inflation (Rates Effective 7/1/2026)	120
Table 49: Fiscal Impact (No Geographic Adjustment)	121
Table 50: Fiscal Impact (With Geographic Adjustment).....	121
Table 51: State Administrative/Overhead Costs	123
Table 52: Behavioral Health Benchmark Rates	123

A. Executive Summary

In this report, Guidehouse Inc. (“Guidehouse”) presents our evaluation of reimbursement for Medicaid community behavioral health services reimbursed by the Alaska Department of Health (DOH). The programs included in this service array are State Plan, 1115 Waiver (Substance Use Disorder and Behavioral Health), and Applied Behavior Analysis (ABA) Behavioral Health Services. In addition to our focus on Behavioral Health services, Guidehouse is also evaluating other critical Medicaid services including Long-Term Services and Supports (LTSS), Medical Transportation, and Federally Qualified Health Centers (FQHC) as part of a “Phase One” effort where additional services will be evaluated in “Phase Two”. These evaluations aim to support the Department’s goals by evaluating Medicaid payment structures and recommending options for rate methodologies that reflect the cost of care, promote access and encourage better outcomes. The evaluations will provide specific recommendations for improvement in reimbursement in separate reports. It is important to note that this particular report is specifically tailored to community behavioral health services. Guidehouse analysis and findings are centered around the unique needs and challenges associated with delivering mental health and substance use treatment in Alaska, identifying relevant and actionable solutions for the Department and its behavioral health provider partners.

Evaluation Findings and Recommendations

As a fundamental first step in our evaluation of community behavioral health service reimbursement, Guidehouse collected cost information from Alaska providers as well as public industry data to determine whether current payments are adequate to cover the costs of service delivery. Guidehouse conducted a detailed provider cost and wage survey process that invited all Alaska behavioral health providers delivering services within the scope of the rate review to participate. We further supplemented this survey data with a broader array of Alaska-specific and national industry data and cost standards to serve as an essential frame of reference for understanding the unique cost profile of delivering services within Alaska’s behavioral health system. Guidehouse employed an “independent rate build-up” methodology to model the various costs expected to be reasonably incurred in delivering each of the services reviewed in the study. These rate build-up models, which analyze rates into individual cost components, served as the basis for the benchmark rates used by Guidehouse as a standard to compare Alaska’s current reimbursement to expected provider costs.

Further details related to the findings can be found in the narrative of the report, but the overall findings themes are:

- Service reimbursement is misaligned with some services having adequate reimbursement while other services seem to be too high or too low.
- Indirect costs which represent the overhead costs to deliver services are disproportionately high, even when accounting for Alaska’s overall higher cost of living.
- Lack of historical standards (i.e., group sizes, wages and overhead assumptions) built into rate reimbursement has contributed to the misalignment of the system overall and has resulted in relying on historical costs without efficiency expectations.

These findings have resulted in recommendations that aim to help align overall service reimbursement, build transparent rate models that allow for more consistent updates and potential enhancements to the Alaska Department of Health’s operations to support long term goals. These recommendations are summarized as follows:

- Adjust individual rates for the community behavioral health service array using a building block style model for all services, not just the current subset of services. Implement consistent inputs for items such as wages, job types, group sizes and overhead costs. Adjustments may include decreases, minimal increases, large increases, inflationary factors and geographic adjustments.
- Plan for potential future changes to rates for geographic adjustments, transportation enhancements and adjustments due to the review of service descriptions.
- Enhance DOH operations and personnel to explore the possibility of building out a cost reporting capability for consistent monitoring of cost and increasing staff resources to review cost reports and perform annual administrative updates.

The combination of these recommendations resulted in projected fiscal impact either through the utilization of services or an investment from the state. All nine recommendations are summarized in **Table 1** below and broken out by individual recommendation, since many of the recommendations can be implemented independently of one another or stair-stepped in a phased implementation based on available resources or other timing considerations. In addition, some of these recommendations require investment from the state in the form of technology costs, additional staff time or administrative costs, separate from Medicaid claims reimbursement. These various costs are captured in the table below with assumptions built in to capture the estimated top end of costs and the bottom end. We have added an additional column that displays the “type of investment” to indicate if the fiscal impact is either through Medicaid service utilization or administrative overheads costs to the state. States may choose to implement all recommendations at the same time or depending on budget limitations and resources they could implement a percentage of the benchmark, specific service category changes or phase in over time.

Table 1: Estimated Annual Fiscal Impact by Recommendation

#	Recommendation	Type of Investment	Projected Min: State	Projected Max: State	Projected Min: Fed & State	Projected Max: Fed & State
BH-R1	Behavioral Health Methodology Transition and Rate Recalibration	Medicaid Service Utilization	\$4,141,000	\$5,022,000	\$13,143,000	\$15,553,000
BH-R2	Behavioral Health Hold Harmless	Medicaid Service Utilization	\$1,573,000	\$1,623,000	\$4,398,000	\$4,537,000
BH-R3	Behavioral Health Geographic Differentials	Medicaid Service Utilization	\$1,315,000	\$1,332,000	\$3,438,000	\$3,480,000
BH-R4	Behavioral Health Cost Reporting*	Administrative State Overhead	\$148,000	\$224,000	\$296,000	\$447,000
BH-R5	Behavioral Health Rate Rebalancing	Medicaid Service Utilization	--	--	--	--
BH-R6	Behavioral Health Crisis Services (Included in BH-R1)	Medicaid Service Utilization	\$282,000	\$286,000	\$1,361,000	\$1,371,000
BH-R7	Behavioral Health Service Definition Review	Medicaid Service Utilization	--	--	--	--
BH-R8	Behavioral Health Administrative Rate Review*	Administrative State Overhead	\$9,000	\$18,000	\$18,000	\$35,000
BH-R9	Behavioral Health Staff Transportation Rate Add-On	Administrative State Overhead	--	--	--	--
		Total***	\$7,186,000	\$8,217,000	\$21,293,000	\$24,052,000

*Assumes a 50% FMAP, should be reviewed as could potentially be at 90%

**Double dash marks do not indicate a budget neutral fiscal impact but is intended to illustrate that depending on the approach or utilization of services there may be a positive or negative impact

***Due to rounding, the individual category totals do not sum to the aggregate total

B. Overview and Background

The Alaska Department of Health has engaged Guidehouse Inc. (Guidehouse) in a comprehensive rate evaluation focused on community behavioral health services across both adult and youth populations. The purpose of this initiative is to evaluate current reimbursement rates considering service delivery realities and long-term sustainability of high-quality care. The study aims to generate actionable recommendations that align rates with provider costs, support a stable and qualified workforce, and improve service quality and access to care across diverse regions of the state.

Noting the general adequacy of Alaska Medicaid expenditures for community behavioral health, Guidehouse nevertheless found substantial disparities between current and benchmark rates at the individual service level. In some cases, cost benchmarking yielded significantly higher reimbursement than current rates. In other cases, Guidehouse observed opposite results, with benchmark rates positing cost thresholds significantly lower than current reimbursement. On a cost basis, at least, Guidehouse's findings suggest that Alaska's behavioral health rate structure is misaligned, leading to potential underpayment or overpayment, depending on the specific service in question. Benchmarking frequently illustrated rate disparities in the range of 30 to 40 percent, both higher and lower than the expected cost of service delivery based on the benchmarked rate.

One of Guidehouse's major findings from the benchmarking process and our analysis of provider survey data was that the indirect costs of delivering services are generally high, but also widely variable among participating behavioral health providers. Based on our survey data, Guidehouse developed indirect cost benchmarks that averaged administrative costs across the system at roughly 24 percent of direct care costs, with indirect program support costs coming in to approximately 44 percent of direct care costs. Together, these indirect costs constitute about 40 percent of total service costs, or 40 cents of every dollar spent by Medicaid to deliver services. Guidehouse's comprehensive findings are summarized below.

Finding 1 (BH-F1): In aggregate, current Medicaid funding for community behavioral health is reasonable to support service delivery. Guidehouse observed instances where services were higher or lower than proposed benchmark rates.

Finding 2 (BH-F2): At the individual service level, fee-for-service payments appear to be misaligned to the actual costs of delivering the service, with some rates well above, and some well below, benchmarked provider costs.

Finding 3 (BH-F3): Indirect costs as a proportion of total costs for community behavioral health services are substantially greater than indirect cost ratios typically observed in other states, even when accounting for Alaska’s overall higher costs.

Finding 4 (BH-F4): The lack of an efficiency standard or threshold on reasonable indirect costs has contributed to a payment framework that reimburses providers based on their historical reported indirect costs, without minimum efficiency expectations or rate incentives.

Finding 5 (BH-F5): High general indirect costs unallocated to well-defined cost centers in provider reporting or Medicaid reimbursement assumptions has fostered ambiguity and uncertainty about the types of costs rates are designed to cover or how best to target investments to improve outcomes.

Evaluation Recommendations

Guidehouse identified nine key recommendations to help Alaska Medicaid address the dual concerns of substantial rate imbalances throughout the reimbursement structure as well as the heightened indirect costs incurred in care delivery. Our core recommendation is to encourage DOH to adopt the “independent rate build-up” approach used in Guidehouse’s benchmarking to be implemented as Alaska’s behavioral health rate methodology moving forward for **all** services. This methodology would be used across the continuum and not for a limited subset of services as today. An important benefit of this methodology is that it standardizes cost component assumptions and rate methodologies across populations and programs where feasible and appropriate. This standardization ensures consistency, transparency, and fairness in how rates are determined. It allows for easier comparisons and evaluations of different programs and populations, ultimately leading to more informed decision-making.

In addition to this fundamental recommendation, Guidehouse developed eight additional recommendations designed to contend with specific obstacles likely to arise in the rebalancing process as well as other suggestions to assist DOH in grappling with high provider indirect costs in an effort to continue bending the cost curve toward value. The full summary of Guidehouse recommendations can be found below.

Recommendation 1 (BH-R1): Alaska Medicaid should transition its reimbursement methodology for **all** community behavioral health services to an “independent rate build-up” approach while implementing the benchmark rates derived from this methodology. Transition to a new methodology and cost assumptions would support rate rebalancing to improve alignment between provider payments and expenses at the level of individual services.

Recommendation 2 (BH-R2): As a part of the reimbursement methodology transition, Alaska Medicaid should implement a temporary “hold harmless” policy or other risk corridor to minimize payment volatility for behavioral health providers that might otherwise experience substantial rate decreases for select services.

Recommendation 3 (BH-R3): Alaska Medicaid should consider updating its geographic adjustment framework to account for variation in operating costs among providers serving different areas of the state. Geographic adjustment already exists for similar community services such as long-term services and supports (LTSS) and would improve access to services and fair distribution of provider payments.

Recommendation 4 (BH-R4): Alaska Medicaid should implement a behavioral health provider cost reporting system to overcome federal funding restrictions imposed by CMS “upper payment limit” rules and to facilitate ongoing monitoring of and responsiveness to changing provider costs.

Recommendation 5 (BH-R5): Alaska Medicaid should consider moving to the nationally recognized Resource Based Relative Value Scale methodology for services subject to the CMS “clinic UPL” and consider gradually aligning payment rates of psychological services subject to the “clinic UPL” and psychiatric services on Alaska’s physician and professional services fee schedule.

Recommendation 6 (BH-R6): Alaska Medicaid should establish rates for expanded crisis service options that are thoroughly informed by provider costs and well-suited to the delivery models adopted by Alaska providers.

Recommendation 7 (BH-R7): Alaska Medicaid should undertake a comprehensive review of service definitions for several key behavioral health interventions to clarify State service delivery expectations and assess whether existing requirements align with current rate assumptions and future policy objectives. Definitions in need of further review include adult and children’s residential treatment settings, case management, Assertive Community Treatment, and Treatment Plan Development and Review.

Recommendation 8 (BH-R8): Alaska Medicaid should consider implementing a process for reviewing rates annually and proposing targeted rate updates based on changing wage and cost benchmarks and their differential impacts across the behavioral health service array.

Recommendation 9 (BH-R9): Alaska Medicaid should consider implementing a rate add-on to account for the heightened cost of staff travel if service delivery extends beyond a threshold mileage radius. Specific parameters for defining the add-on will depend on additional transportation data collection.

Evaluation Fiscal Impacts

To better understand the financial implications of benchmark rate adjustments across programs, four basic fiscal impact scenarios were developed to model potential outcomes under varying assumptions. These scenarios are intended to be illustrative to understand potential impacts dependent on state decisions, budget limitations and time of implementation. Depending on the time of implementation of the rate recommendations, inflation may need to be revisited. The goal of this analysis was to estimate the total fiscal impact, including both state and federal shares, and to provide a comparative framework for decision-makers. These scenarios reflect key policy considerations: whether to apply an inflation factor and whether to apply a “hold harmless” methodology. The “hold harmless” option reflects a risk corridor that would allow services resulting in a reduced proposed benchmark rate to maintain current rates temporarily rather than decreasing as suggested by the benchmark rate established within the rate evaluation. Related to inflation there were multiple inflationary metrics applied dependent on time of proposed rate implementation. At the time of the rate evaluation multiple options were explored where additional inflation was included to model a full year and two full years out from the underlying data time period. Depending on the time of implementation, these inflationary metrics could potentially be evaluated to determine if they are representative of economic changes. The details of these fiscal impact scenarios are fully explained in Section H: Fiscal Impact Estimates and are summarized in **Table 2** below. **Table 2** displays the fiscal impact for the four scenarios for the implementation of the proposed benchmark rates for the recommendations attributed to Medicaid service utilization, not including the geographic differential. The dollars and percentage change represent a comparison between SFY24 utilization with rates effective November 2024 and the proposed benchmark rate dependent on the scenario. The fiscal impact does not represent the administrative overhead costs for the state. Scenarios 1 and 3 include a wage inflation of roughly 2.1 percent that moves the underlying wages forward to an effective date of July 1, 2025. Additionally, Scenario 2 and 4 model a full additional year of inflation, on top of the 2.1 percent, by applying a 3.2 percent inflationary metric to the modeled benchmark rate for rate implementation as of July 1, 2026. The 2.1 percent was developed using the Current Employment Statistics (CES) wage inflation metric as it was applied to wages. In comparison, the 3.2 percent was derived by looking at the historical inflation from the Producer Price Index (PPI). Both metrics were calculated using public data from Bureau of Labor Statistics (BLS). This analysis estimates the combined state and federal fiscal impacts for a set of modeled implementation scenarios in the first year of adoption, offering a comparative framework to inform decision-making.

Table 2: Estimated Annual Fiscal Impact (Four Scenarios).

Scenario	Description	Projected Total Fiscal Impact- (State & Federal Share)	Projected Total Fiscal Impact (State & Federal Share) % Change	Projected Total Fiscal Impact (State Share)	Projected Total Fiscal Impact (State Share) % Change
Scenario 1	Not held harmless with no additional inflation (Rates Eff 7/1/2025)	\$13,143,000	7.2%	\$4,141,000	7.0%

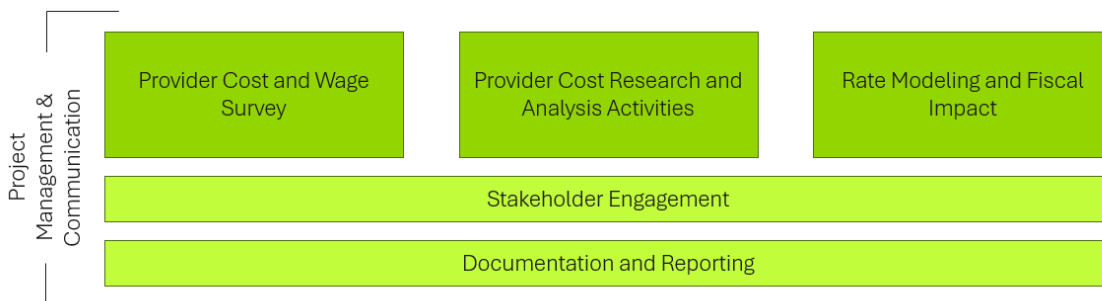
Scenario	Description	Projected Total Fiscal Impact- (State & Federal Share)	Projected Total Fiscal Impact (State & Federal Share) % Change	Projected Total Fiscal Impact (State Share)	Projected Total Fiscal Impact (State Share) % Change
Scenario 2	Not held harmless with 3.2% inflation (Rates Eff 7/1/2026)	\$15,553,000	8.5%	\$5,022,000	8.4%
Scenario 3	Held harmless with no additional inflation (Rates Eff 7/1/2025)	\$17,541,000	9.6%	\$5,714,000	9.6%
Scenario 4	Held harmless with 3.2% inflation (Rates Eff 7/1/2026)	\$20,090,000	11.0%	\$6,645,000	11.2%

Key Study Components

- **Provider Cost and Wage Survey:** Gathering data from providers for rate review and rebasing efforts.
- **Additional Cost Research and Analysis:** Performing research on other state, regional, and national data sources to inform rate development.
- **Rate Modeling and Fiscal Impact:** Developing rate models through research and cost analysis on the current models and assessing the fiscal impact of the benchmark rates.
- **Stakeholder Engagement:** Facilitating engagement with stakeholders including provider representatives and State staff to solicit feedback throughout the rate development process.

Figure 1 illustrates the overview of these project initiatives and Guidehouse’s approach for each activity as it related to one another.

Figure 1: Overview of Project Initiatives



Focus Areas for Alaska Behavioral Health Services

The rate study focused on key areas to ensure the effectiveness and sustainability of behavioral health services in Alaska. Sustaining quality and access is paramount. This involves setting rates that adequately cover the costs of delivering high-quality, evidence-based care in both community and facility-based settings. By doing so, we ensure that providers can maintain the standards

necessary for effective treatment and support. Additionally, workforce stabilization is a critical focus. The study incorporates comprehensive data and strategies to address persistent labor shortages, ensure competitive wages, and improve staff retention in behavioral health roles. By stabilizing the workforce, we aim to create a more reliable and effective service delivery system. Lastly, future budgeting and planning are aligned with the state’s strategic planning and long-term fiscal forecasts. This alignment ensures that the rate recommendations are not only sustainable but also consistent with the state's financial outlook. By integrating these considerations, we provide a robust framework for future financial planning and resource allocation. The programs and services in **Table 3** were reviewed as a part of the rate evaluation.

Table 3: Overview of Alaska Behavioral Health Services.

Service Category	Details
1115 Waiver: SUD Provider Services	- American Society of Addiction Medicine (ASAM) Services (1.0 - 4.0) - Community Recovery Supports - SUD Care Coordination - Intensive Case Management - Peer-Based Crisis - Crisis (Mobile Crisis, Mobile Crisis Follow Up, 23 Hour Crisis Observation and Stabilization and Crisis - Residential Stabilization) - Treatment Plan
1115 Waiver: Behavioral Health Provider Services	- Home-Based Family Treatment Services - Therapeutic Treatment Homes - Children’s Residential Treatment - Intensive Case Management - Community Recovery Supports - Assertive Community Treatment - Intensive Outpatient - Partial Hospitalization - Adult Mental Health Residential Services - Peer-Based Crisis - Crisis (Mobile Crisis, Mobile Crisis Follow Up, 23 Hour Crisis Observation and Stabilization and Crisis Residential Stabilization) - Treatment Plan Development or Review
State Plan: Community Behavioral Health	- Behavioral Health Screen - Alcohol and/or Drug Assessment - Case Management - Therapeutic BH Services- Peer Support Services - Day Treatment for Children - Treatment Plan Review - Oral Medication Administration - Methadone Administration - Ambulatory Detoxification - Clinically Managed Detoxification - Medically Managed Detoxification - Medical Evaluation - Residential SUD Treatment - Screening, Brief Intervention, and Referral for Treatment (SBIRT)
Autism Services (ABA)	- Adaptive Behavior Treatment (Individual, Family and Group) - Behavioral Identification Assessment

C. Findings and Recommendations

Establishing the right rate structures in behavioral health is crucial for ensuring both the sustainability of provider operations and equitable access for Medicaid beneficiaries. This section delves into the evaluation’s key findings regarding the current reimbursement structure for community behavioral health services and provides recommendations to address issues identified in the findings. Guidehouse’s high-level findings note that, despite adequate behavioral health reimbursement overall, the current rate structure exhibits substantial rate disparities and misalignments, positive and negative, between typical provider costs for specific services and the payments they receive through the fee-for-service rates. Guidehouse’s recommendations are designed to support the process of cost realignment and rebalancing for the sake of “equalizing” the rate structure to promote greater reimbursement equity.

C.1. Findings

C.1.1. Cost Benchmarking Process

As a fundamental first step in our evaluation of community behavioral health service reimbursement, Guidehouse collected cost information from Alaska Medicaid behavioral health providers as well as public industry data to determine whether current payments are adequate to cover the costs of service delivery. Guidehouse conducted a detailed provider cost and wage survey process that invited all Alaska behavioral health providers delivering services within the scope of the rate review to participate. We further supplemented this survey data with a broader array of Alaska-specific and national industry data and cost standards to serve as an essential frame of reference for understanding the unique cost profile of delivering services within Alaska’s behavioral health system. These financial data sets furnished Guidehouse with the information required to develop cost “benchmarks” to measure the reasonableness of provider-reported costs and to serve as a standard to evaluate the sufficiency of the current rate structure to supply providers with the resources necessary to deliver quality services.

Guidehouse employed an “independent rate build-up” methodology to model the various costs expected to be reasonably incurred in delivering each of the services reviewed in the study. These rate build-up models, which analyze rates into individual cost components, served as the basis for the benchmark rates used by Guidehouse as a standard to compare Alaska’s current reimbursement to expected provider costs. Although the benchmarks were informed by Alaska providers’ historical costs, the formulation of ideal benchmarks is designed to function as an independent frame of reference, correcting for the potential influence of historical under- or overfunding in gauging future budgetary needs.

C.1.2. Overall Reimbursement Adequacy

Finding 1 (BH-F1): In aggregate, current Medicaid funding for community behavioral health is reasonable to support service delivery. Guidehouse observed instances where services were higher or lower than proposed benchmark rates.

Guidehouse’s comparison of current and benchmark rates against the service utilization characteristics of Alaska’s community behavioral health system yielded several relevant findings. First, the benchmarking process indicated that Medicaid behavioral health reimbursement has largely kept pace with rising provider costs in the past half decade, despite significant inflationary pressures in the wake of the COVID-19 public health emergency (PHE). Although Guidehouse’s benchmark fiscal impact analysis identified the need for additional funding in SFY 2027, the projected need is not significantly higher than inflationary growth. The discrepancy between current expenditure levels and Guidehouse’s spend projections (based on our proposed benchmark rates) does not signal overall reimbursement inadequacy but reflects justifiable differences in the way the State’s current reimbursement methodologies gauge reasonable costs versus Guidehouse’s independent rate build-up approach.

C.1.3. Rate Imbalances

Noting the overall adequacy of Alaska Medicaid expenditures for community behavioral health, Guidehouse nevertheless found substantial disparities between current and benchmark rates at the individual service level. In some cases, cost benchmarking yielded significantly higher reimbursement than current rates. In other cases, Guidehouse observed opposite results, with benchmark rates positing cost thresholds significantly lower than current reimbursement. While appropriate rate levels may be judged not only by a cost standard but also according to a wider range of legitimate policy goals and priorities, cost principles are the norm for Medicaid reimbursement and serve as a basic test of rate adequacy unless other rate justifications have been articulated. On a cost basis, at least, Guidehouse’s findings suggest that Alaska’s behavioral health rate structure is misaligned, leading to potential underpayment or overpayment, depending on the specific service in question. In the detailed discussion of benchmark rate components and their fiscal impact in Sections G and H, Guidehouse explores these apparent rate misalignments in greater depth. However, it suffices to note here that benchmarking frequently illustrated rate disparities in the range of 30 to 40 percent, both higher and lower than the expected cost of service delivery based on the benchmarked rate.

Even if these misalignments do not necessarily affect overall expenditures or misrepresent budgetary needs, miscalibration of payment to level of effort in a volume-based, fee-for-service payment system like Alaska’s can have several negative consequences for service utilization and public expenditure. Misalignment can introduce perverse incentives and disincentives to deliver some services at the expense of others, encouraging providers to over- or underutilize certain treatment alternatives, regardless of clinical rationale. Misalignment may force providers into a precarious financial exercise of “balancing” service loss leaders alongside services able to generate stronger operating margins. While the financial consequences may be immaterial for a large provider that delivers a wide range of services and is scaled to absorb underpayments in particular service lines by compensating with others, misalignment can be highly detrimental to specialized providers that focus on a limited range of skilled services. Autism services offer a useful example, as these services tend to be delivered by specialized practices of behavioral analysis providers, where insufficient rates can diminish the system’s ability to maintain sufficient practitioners to deliver the service, compounding levels of unmet need for specific interventions. Simultaneously, overpayment can create artificial service niches for providers to build capacity beyond the genuine treatment needs of the population.

Finding 2 (BH-F2): At the individual service level, fee-for-service payments appear to be misaligned to the actual costs of delivering the service, with some rates well above, and some well below, benchmarked provider costs.

The root causes of rate misalignment for behavioral health services in Alaska are complex and multifarious. Some of the factors are not unique to the state but also exist in other public behavioral health systems across the country, reflecting wider systemic incongruencies in how behavioral health services are funded nationally. The community behavioral health system, as a “blended-and-braided” financing system that draws dollars from multiple state and federal public authorities and depends heavily on grant funding as well as fee-for-service dollars to serve mental health and substance use populations well beyond Medicaid, increasingly counts on Medicaid to make providers whole and to support service delivery more broadly. Relying on Medicaid as the chief funding stream for the larger public behavioral health system, however, is complicated by the heavy constraints the program imposes on payment requirements and eligibility for services. Some of Medicaid’s stringent requirements place uniquely difficult burdens on Alaska, where the demographic and geographic conditions impacting service delivery contrast sharply with Medicaid policy assumptions derived from programs in the lower 48.

A representative example of such challenges is Medicaid’s “upper payment limit” (UPL) requirements for services delivered in free-standing outpatient clinics, to which Alaska’s mental health and substance use treatment centers are also subject. Since the federal government is often the dominant partner in financing Medicaid services, UPL rules are a compromise in the federal-state partnership intended to give states broad flexibility to determine rates, while establishing a maximum threshold beyond which the federal government will no longer contribute a matching share. In the case of the “clinic UPL,” CMS defines the upper payment limit as the higher of clinics’ demonstrated costs or the reimbursement Medicare would pay according to its applicable clinic payments or equivalent physician and/or professional fee schedules. However, not all Medicaid services are subject to federal UPL rules, which makes this a fairly unique circumstance for this set of services and providers.

For clinic reimbursement in most states, the clinic UPL requirement is relatively unproblematic. Typically, Medicaid programs reimburse providers at levels well below Medicare, often between 60 to 90 percent of a state’s equivalent Medicare payment. Only a handful of states, including Alaska, establish rates above Medicare, frequently for physician and professional services for the purpose of attracting and retaining skilled practitioners. Moreover, medically-oriented clinic services have well-established cost reporting systems, but these programs are less often found among behavioral health clinics, which is also true of Alaska. The state’s lack of a cost reporting structure, combined with reimbursement needs that rise above Medicare levels, becomes a particularly acute issue for behavioral health, where Medicare’s role in financing mental health and substance use treatment is more marginal, and less incentive exists to ensure rate adequacy. As a result, Alaska’s payments for those clinic therapy services subject to the federal clinic UPL are artificially depressed in comparison to the costs covered for other services within the rate structure.

Rate equity is difficult to achieve partly on account of these types of external constraints. The clinic UPL rule is one of the reasons Alaska’s behavioral health rate structure today is analogous to a

squeezed balloon, where some parts of the balloon appear compressed and constricted, forcing other parts to bulge and bloat to compensate for the overall cost pressures to providers. Such contortions ultimately stretch and strain the system as a whole. Clinic UPL policy compounds rate inequity in multiple ways. First, and most obviously, it contributes to uneven rate increases for behavioral health services not subject to the UPL. Second, and less obviously, the clinic UPL narrows the system's room for maneuver in "right-sizing" or otherwise correcting payments for services that fall under the UPL requirements. Although clinic UPL services represent only about 5 percent of community behavioral health services as measured by expenditure, the rate structure for the psychotherapy and diagnostic and assessment services that make up this category is among the most unbalanced in the behavioral health service array. While individual psychotherapies are paid between 69 and 78 percent of the equivalent Medicare rate, group psychotherapies are paid between 126 and 155 percent. Psychological evaluations and intake assessments are each reimbursed at well over 200 percent of Medicare. Rebalancing payments for these services under the constraints of the clinic UPL is a challenge to undertake without generating major "winners" and "losers" in the effort, limiting the types of financial risk corridors that can be applied without running afoul of the UPL rules.

Guidehouse observations on rate disparities within the community behavioral health system should not fail to acknowledge the substantial reimbursement differences between the fee-for-service rates reviewed as a part of our study and the Medicaid encounter rates received by Tribal Health Organizations (THO) for the behavioral health services delivered to Alaska's tribal populations, which were outside the scope of Guidehouse's review. Unlike the public behavioral health system serving the majority of the State's non-tribal population, Alaska Medicaid reimbursement to tribal health clinics is paid according to the Indian Health Service (IHS) encounter rate established for these clinics, which is considerably higher than the fee-for-service rates paid through standard Medicaid. Additionally, services provided by Indian Health Services (IHS) facilities and tribal providers are not subject to the federal UPL. Collectively, behavioral health Medicaid funding through the tribal encounter rate amounts to approximately \$163.9 million, slightly less than half of total Medicaid behavioral health spending (compared to \$183.2 million in non-tribal provider revenues). However, this funding draws a 100 percent federal match, ultimately incurring no additional service expenditures to the State General Fund. Tribal providers also receive the encounter rate when serving non-tribal clients, but these are matched at the standard Federal Medical Assistance Percentage (FMAP), which is currently 52.42 percent.

It is important to note the rate differences between the tribal and non-tribal sectors of the behavioral health system, because these payments do reflect a significant rate differential that further complicates the picture of overall Medicaid behavioral health reimbursement in Alaska. The encounter rate with a 100 percent federal match supplies frontier Alaska with needed resources to serve all Alaskans, tribal and non-tribal, with crucial behavioral health services that would otherwise be infeasible in the remotest regions of the state, while simultaneously freeing IHS funds for a wider range of high impact uses. Since tribal reimbursement was outside the scope of our review and the state does not have rate setting authority over the IHS encounter rate for behavioral health services, Guidehouse did not study tribal encounter rates, but we did observe that encounter rate reimbursement supports collaboration overall, so that tribal and non-tribal services operate in greater coordination without devolving into parallel systems.

C.1.4. High Indirect Costs

One of the long-term effects of persistent rate misalignment is a lack of rigor in accounting for the true costs of delivering distinct services, both on the part of the provider and payer. Providers are understandably protective of higher rates and motivated to preserve healthy reimbursement for services on which they may have come to depend. Likewise, they are rightfully critical of inadequate reimbursement that potentially threatens the quality of services delivered. Where rate misalignment is entrenched, financial interventions to improve reimbursement are more often deflected to attention on payment in the aggregate, where it is more difficult to identify specific cost drivers, resource needs, or sources of inefficiency, thereby merely reinforcing rate inequity.

This tendency is compounded in Alaska by the nature of the state’s frontier service infrastructure and the number and types of behavioral health providers it can support. The expansive geography and sparse population in many regions of Alaska afford a scale and logistical requirements favoring a “catchment area” approach, in which service delivery depends on coordination by a single provider or small group of providers to cover a wide service area. While this approach mitigates the waste and duplication of scarce resources that often accompanies provider competition, it does not always generate the efficiencies and innovative dynamics that a competitive market environment can otherwise instill. Where the landscape is dominated by a small number of established service providers (by design or necessity), the rate structure is configured first and foremost to maintain existing provider operations crucial to guaranteeing basic access to services. The tradeoff is that the payment system is not necessarily geared to spur innovation or direct the system to more effective utilization.

One of Guidehouse’s major findings from the benchmarking process and our analysis of provider survey data was that the indirect costs of delivering services are generally high, but also widely variable among participating behavioral health providers. Survey results illustrated a number of community providers with lean operations, harnessing efficiencies to drive down administrative overhead and other indirect costs. However, these providers tended to be the exception rather than the rule. Based on our survey data, Guidehouse developed indirect cost benchmarks that averaged administrative costs across the system at roughly 44 percent of direct care costs, with indirect program support costs coming in to approximately 24 percent of direct care costs. Together, these indirect costs constitute about 40 percent of total service costs, or 40 cents of every dollar spent by Medicaid to deliver services.

Finding 3 (BH-F3): Indirect costs as a proportion of total costs for community behavioral health services are substantially greater than indirect cost ratios typically observed in other states, even when accounting for Alaska’s overall higher costs.

It is true that costs are generally higher in Alaska than in other states, and sometimes substantially higher, but the important point is not that indirect costs in Alaska are just elevated compared to other states—which Guidehouse would expect to be the case—but that they are proportionally greater than in other states, relative to direct care costs, and so also as a percentage of the total cost of services. Goods and services are more expensive in Alaska, but labor costs are, too. Thus, if the labor costs of the direct care workforce are also elevated in Alaska, the general fact of high costs does not necessarily explain why indirect costs are proportionately higher than direct care

costs, especially since a large portion of these indirect costs are also labor costs in the form of administrative and support personnel wages and benefits. Guidehouse would expect these indirect personnel costs to be higher in Alaska than in other states, but not relatively higher than the costs of direct care personnel. For these reasons, proportionally higher indirect costs can be a signal of business inefficiencies in provider operations.

The chief difficulty of evaluating indirect costs in Alaska is that the basic conditions of service delivery in the state are so unique that industry data, provider operations, or system experience derived from other states do not always serve as reliable bases for comparison. For example, in many of Alaska’s behavioral health services, transportation is an indirect cost that is not separately billable as a discrete service but must be accounted for as a background cost for delivering the billable service. However, transportation costs in Alaska, from mileage and the distances covered, to the lack of road networks and greater need for air travel, to the heightened maintenance expense and unbillable delays caused by extreme weather conditions, results in substantially higher indirect costs that are simply not comparable to other states in the lower 48, even frontier states like Montana or Wyoming. For this reason, Guidehouse is unable to pinpoint ultimate causes behind Alaska’s higher indirect costs, other than to note that the relative lack of a competitive provider market is evidence that business inefficiency may be a contributing factor.

Finding 4 (BH-F4): The lack of an efficiency standard or threshold on reasonable indirect costs has contributed to a payment framework that reimburses providers based on their historical reported indirect costs, without minimum efficiency expectations or rate incentives.

In Guidehouse’s benchmarking exercise, except for statistical outliers, we largely took provider-reported indirect costs at face value and did not prescribe a more stringent definition or threshold for determining “reasonable” indirect costs. Guidehouse rate benchmarks thus take for granted the elevated indirect costs reported by providers. Consequently, benchmarked rates that come in significantly lower than current rates should not be interpreted as an artifact of a prescribed indirect cost standard that imposes an ideal cost significantly lower than providers’ actual costs. In the case of indirect administrative overhead and program support costs, Guidehouse took providers’ historical experience as the standard for benchmarking.

Where this determination is relevant to our findings, however, is to note the current rates—just like Guidehouse’s benchmark rates—lack an efficiency standard that rewards providers for pursuing lower indirect costs, or a cost threshold or other financial guardrail that discourages disproportionate indirect cost growth. The absence of a cost standard for rate setting has been a dilemma for DOH, which updates rates based on providers’ historical costs. While this is an approach that may be a necessity with the financial information currently available to the Department for rate development, the higher proportion of indirect costs within the system nonetheless translates into investments by the State that are of relatively lower value than targeted infusions of dollars aimed at investing in the direct care workforce or improving the quality of care.

Finding 5 (BH-F5): High general indirect costs unallocated to well-defined cost centers in provider reporting or Medicaid reimbursement assumptions has fostered ambiguity and uncertainty about the types of costs rates are designed to cover or how best to target investments to improve outcomes.

A final consequence of Alaska’s higher indirect costs is that it is difficult to determine where those proportions of dollars are going and whether they represent impactful investments. Unlike direct care dollars, where there is greater clarity in how investments impact wages or help to shape benefit packages, indirect costs tend to be reported in aggregate, and providers are not incentivized to monitor more fine-grained expenses such as the cost of transportation. As the amorphous character of this cost center expands into a larger share of the reimbursement rate, it also generates ambiguity and uncertainty between providers and payers as to the types of expenses the rate is actually designed to cover. Because the current behavioral health rate methodologies used in Alaska do not model specific expectations or reasonable cost standards on specific program support costs like transportation, there are legitimate concerns as to whether the rate is ultimately accounting for and explicitly including these types of costs.

Guidehouse’s evaluation recommendations are intended to address the findings identified here and propose solutions that can help to address the issues raised.

C.2. Recommendations

Section C.2. outlines Guidehouse’s recommendations for addressing the rate disparities evident within Alaska’s community behavioral health system as well as engaging the high indirect costs of current service delivery. Specific benchmark recommendations by service are detailed in Section G and summarized in Section I, while in-depth fiscal impacts are modeled in Guidehouse’s analysis in Section H. This section examines the broad intent and implications of rate rebalancing, explaining the rationale for each recommendation as well as briefly analyzing potential impacts on cost, quality, and access to care within the community behavioral health system.

Guidehouse recommendations are summarized into the following nine areas for action:

1. Rate Recalibration and Rebalancing
2. “Hold Harmless” Provisions and Other Risk Corridors
3. Geographic Adjustment
4. Behavioral Health Cost Reporting
5. Disparities in Psychological Professional Services (“Clinic UPL”)
6. Reimbursement for Crisis Services
7. Comprehensive Review of Select Service Definitions
8. Annual Administrative Rate Review and Update
9. Staff Transportation Add-On Rate

C.2.1. Rate Recalibration and Rebalancing

As documented in the fiscal impact analysis, Guidehouse found that payments at the calculated rate benchmark would result in an overall reimbursement increase of 7 percent compared to existing rates, effective as of November 2024. While this percentage might be taken as an argument that current funding is inadequate overall, there are some important factors to consider in the benchmarking process that would suggest a different conclusion. Benchmarking was guided first and foremost by the concern to identify “best fit” in matching benchmark assumptions to actual system costs to determine whether cost standards are applied consistently across services where they should be the same. Guidehouse’s benchmarking was not a cost containment exercise, in which the goal was to identify the lowest “reasonable” cost assumptions to develop a minimum justifiable payment rate for each service.

For this reason, Guidehouse often applied the most generous assumptions where multiple standards were available. As detailed in Section G on the specific cost components of each rate, Guidehouse for the most part used provider-reported data as the basis for both direct care and indirect cost assumptions, despite the fact that reported behavioral health direct care wages were often significantly higher than industry means and medians, at least as measured by federal Bureau of Labor Statistics (BLS) indices and cost data seen in other state systems. Acknowledging the use of more generous standards is not to argue, conversely, that rate benchmarks are potentially bloated, but to underline the fact that a range of benchmarks—some higher, some lower—can equally be considered reasonable.

Pertinent to Guidehouse’s overall emphasis on rate rebalancing, however, is the fact that major disparities in current rates necessitated a “best fit” that runs the risk of overstating the costs of some services for the sake of *not* understating the costs of others. Like a statistical trend line in a graph of noisy data points, individual rates in Alaska’s behavioral health service array are scattered well above and below the consistent straight line of Guidehouse’s benchmarks.

The latest behavioral rates were updated in November 2024, six months after the mid-point of the wages reported in the survey (May 2024). Instead of adjusting wages by six months, we applied a full year of inflation to project rates for July 1, 2025. This led to comparing current rates with proposed benchmarks that include a 2.1 percent inflation adjustment. Therefore, Scenario 1 shows the comparison to proposed benchmark rates as of July 1, 2025, to the rates in effect as of November 2024. This comparison shows that Alaska would need to make an additional \$13.1 million total investment between federal and state dollars (or \$4.1 million in state share) to fund community behavioral health services at Guidehouse’s benchmark rates, requiring a 7 percent increase in funding. However, a more telling nuance to this number is the fact that when applying the “hold harmless”, maintaining rates at the current Alaska rate instead of decreasing, resulted in an additional \$4.4 million overall funding to the system (Scenario 3). Benchmarking rates according to more conservative standards would have resulted in higher overall increases but simultaneously widening sectors of the service array that appear significantly overfunded. As previously noted, benchmarking illustrated rate disparities in the range of 30 to 40 percent increases and decreases, exposing payment imbalances that would have surfaced regardless of the specific benchmarks chosen.

Recommendation 1 (BH-R1): Alaska Medicaid should transition its reimbursement methodology for community behavioral health services to an “independent rate build-up” approach while implementing the benchmark rates derived from this methodology. Transition to a new methodology and cost assumptions to support rate rebalancing to improve alignment between provider payments and expenses at the level of individual services.

Although Guidehouse considers overall funding for services to be adequate, we encourage the Department to adopt the “independent rate build-up” approach used to determine rate benchmarks as Alaska’s behavioral health rate methodology moving forward. An important benefit of this methodology is that it standardizes cost component assumptions and rate methodologies across populations and programs where feasible and appropriate. This standardization ensures consistency, transparency, and fairness in how rates are determined. It allows for easier comparisons and evaluations of different programs and populations, ultimately leading to more informed decision-making.

In addition to the overall reimbursement trends noted here, it is evident that existing rate structures do not employ cost components consistently across behavioral health services. Cost assumptions about productivity, job types, group sizes, staffing ratios, and administrative overhead should be evaluated to build in consistency where appropriate. Some specific examples of imbalances that would be addressed by adopting Guidehouse’s proposed rate methodology are for the following service categories:

- Autism service rates are historically low for the expertise they require and low in comparison to peer states.
- Reimbursement for community support services is misaligned, with Therapeutic Behavioral Health and Peer Support much better resourced than Community Recovery Support Services and Home-Based Family Treatment.
- ASAM adolescent and adult services show inverse relationships between levels due to varying treatment hour assumptions.
- Rate structures for Adult Mental Health Residential and Children’s Residential Treatment should align with the state’s expectations on service delivery.

Guidehouse’s base fiscal impact analysis assumed benchmarks for rates effective in July 2025. If Alaska Medicaid opted to implement the specific benchmarks used by Guidehouse it would also need to consider applying appropriate inflation adjustments for the anticipated effective date. Inflating Guidehouse’s benchmarks an additional year forward by applying a 3.2 percent increase would result in a total impact of \$15.6 million, inclusive of \$5 million in state share for a July 1, 2026, implementation date. Throughout the report Guidehouse illustrates four distinct fiscal impact scenarios that represent a combination of different inflationary impacts to represent the rate implementation dates in combination with the inclusion of a “hold harmless” scenario.

C.2.2. “Hold Harmless” Provisions and Other Risk Corridors

In the effort to address rate imbalances, some rates will ultimately need to decrease even though other rates and payments as a whole may be increasing. Although this rebalancing is ultimately helpful for the system and encourages providers to devote resources where they are most needed, rebalancing can also create payment volatility that injects new financial risks into the system that can threaten provider stability and potentially interrupt service delivery. In pursuing rate rebalancing, it will be critical for DOH to establish some level of “risk corridor” to mitigate volatility for providers and facilitate smooth transition to novel rate methodologies and a new, unfamiliar rate structure and reimbursement environment. However, in the case of behavioral health services, such risk corridors should be temporary since permanent rate freezes or other measures would ultimately defeat the point of a rebalancing effort.

Recommendation 2 (BH-R2): As a part of the reimbursement methodology transition, Alaska Medicaid should implement a temporary “hold harmless” policy or other risk corridor to minimize payment volatility for behavioral health providers that might otherwise experience substantial rate decreases for select services.

For the sake of analysis, Guidehouse chose a simple rate corridor, a “hold harmless” provision, as a straightforward proof of concept and an illustration of one potential solution to the challenge of rate volatility. In the scenario explored by Guidehouse, rates would be increased to the benchmark, but services otherwise seeing rate decreases would be held harmless, meaning that rates would be frozen at their current level for a certain amount of time to allow providers to adjust to full implementation of benchmark rates. Typical time spans may be a single year, or two years after initial implementation, or in the case of small rate decreases, until inflationary forces eliminate the need for a hold harmless.

In the case of behavioral health services experiencing major decreases, discrepancies between current rates and future benchmark rates are unlikely to disappear in the short term, suggesting that a hold harmless in itself may not be the most effective risk corridor for managing reimbursement transition. Depending on budgetary considerations and the appetite for speed of transition, the Department should consider alternatives, including a phased implementation of benchmark rates, a stop-loss/stop-gain implementation that gradually increases or decreases rates from year to year, or some other temporary measure. For the sake of promoting timeliness and maintaining momentum in rebalancing, Guidehouse recommends that transition should be planned for completion within three years of initial implementation. We have not attempted to model specific scenarios because the appropriate risk corridor and transition process should be decided based on available funding and requirements for implementation.

C.2.3. Geographic Adjustment Framework

In some other Medicaid programs in Alaska and across the country, providers receive regionally variable rates designed to reflect disproportionate costs in different areas of the state. However, no geographic differential currently exists for community behavioral health services. Guidehouse is recommending a geographical differential to adjust rates based on provider location, similar to the payment framework already in place for Medicaid Long Term Services and Supports (LTSS) reimbursement in Alaska. Geographical differentials are intended to account for increased costs related to cost of living, wages (including retention bonuses), utilities, food costs, transportation and purchasing power.

Guidehouse's draft methodology:

- Allows for yearly updates based on credible and publicly available sources.
- Promotes consistency with LTSS by applying the differentials using the 18 regions established within the LTSS space.
- Estimates an initial fiscal impact of 2.1% in increased expenditures if implemented, reflecting increased costs in rural and remote Alaska service areas.

Recommendation 3 (BH-R3): Alaska Medicaid should implement a geographic adjustment framework for non-tribal providers that applies a regional geographic rate factor that accounts for major variations in operating costs among providers operating in different areas of the state. Geographic adjustment already exists for similar community services such as long-term services and supports (LTSS) and would improve access to services and fair distribution of provider payments.

Guidehouse performed an analysis that leveraged cost and income across Alaska to create geographic differentials for various boroughs and census areas. DOH should consider implementing a geographic differential methodology to account for economic conditions across each region of the state. In contrast to the current geographic adjustment framework employed for LTSS, DOH should consider:

- Transitioning from the outdated, one-time survey data used in its 2008 source study to frequently updated public data sources representing statistically significant population / household / sample size.
- Accounting for both cost and income in regions where there are significant differences between the two parameters to account for relative purchasing power, in contrast to the existing cost-based approach for LTSS.

Geographic rate differentials should be implemented to adjust rates based on regional cost variations. This application would foster equitable access and provider viability across frontier, rural, and urban areas. By recognizing the varying costs of living and operating in different regions, geographic rate adjustments can help maintain provider viability and bolster access to necessary services in all areas of the state.

Leveraging the Economic Policy Institute Dataset

We use the Economic Policy Institute (EPI) dataset, which includes data from 2020 to 2024, as the cornerstone of our analysis. This dataset is a comprehensive collection of publicly available information sourced from reputable organizations, including the U.S. Department of Labor (DOL), U.S. Department of Agriculture (USDA), U.S. Department of Housing and Urban Development (HUD), the Medical Expenditure Panel Survey (MEPS), the federal Bureau of Labor Statistics (BLS), the National Bureau of Economic Research (NBER), and the Henry J. Kaiser Family Foundation (KFF). These sources collectively offer robust insights into various dimensions of economic and social indicators, ensuring a well-rounded perspective.

EPI Key Data Sources

- DOL: Provides data on employment, wages, and labor market conditions.
- USDA: Supplies information on agricultural economics, food prices, and nutritional assistance programs.
- HUD: Offers insights into housing affordability, rental markets, and urban development trends.
- MEPS: Delivers detailed data on healthcare expenditures, insurance coverage, and medical services utilization.
- BLS: Shares extensive statistics on inflation, productivity, and other critical labor economics metrics.
- NBER: Contributes research findings on various economic aspects, including business cycles and income distribution.
- KFF: Focuses on health policy analysis, healthcare costs, and public health issues.

Cost Categories

The seven cost categories represent essential areas of household spending:

- Housing
- Food
- Healthcare
- Transportation
- Education
- Childcare
- Miscellaneous

Each category is weighted based on the specific spending patterns of each borough or census area. This approach ensures the dataset accurately reflects local economic conditions and emphasizes the cost drivers most relevant to residents in each region.

Purchasing Power

The purchasing power factor, derived from the Economic Policy Institute (EPI) dataset, is a key element used to reflect regional differences in spending power. This factor is applied only to boroughs or census areas where it exceeds the average, ensuring that lower-income regions are accurately represented without distorting the overall analysis.

We placed greater emphasis on cost and purchasing power in regions without road access. By adjusting for these areas separately, the dataset better reflects their unique economic conditions.

By incorporating the purchasing power factor in this targeted manner, the analysis highlights the economic challenges faced by lower-spending-power regions and supports the development of more equitable, data-driven policy recommendations. **Table 4** highlights the geographic differentials that would be applied as an enhancement on the existing rates based on provider location.

Table 4: Geographic Differentials

Borough / Census Area	Geographic Differential
Aleutian Region	1.12
Anchorage Region	1.00
Arctic Region	1.23
Bethel/Dillingham	1.36
Delta Junction/Tok Region	1.15
Fairbanks	1.03
Glennallen Region	1.03
Juneau	1.09
Kenai Peninsula	1.01
Ketchikan/Sitka	1.09
Kodiak	1.25
Mat-Su	1.00
Parks/Elliott/Steese Highways	1.01
Prince William Sound	1.00
Roadless Interior	1.24
Southeast Mid-Size Communities	1.09
Southeast Small Communities	1.09
Southwest Small Communities	1.35

These rate structure recommendations hold immense value in ensuring a fair, sustainable, and accessible healthcare system. They address the need for accurate cost reflection, fair provider compensation, and equitable access across different regions. Implementing these recommendations will lead to a more balanced and effective healthcare system that benefits both providers and patients. **Table 5** illustrates the potential expenditures impact dependent on the larger fiscal impact scenarios that consider hold harmless and additional inflation approaches.

Table 5: Geographic Differentials Fiscal Impact

#	Recommendation	Projected Minimum Annual Cost (Fed + State)	Projected Maximum Annual Cost (Fed + State)	Projected Minimum Annual Cost – Initial Year (State Only)	Projected Maximum Annual Cost (State Only)
BH3	Behavioral Health Geographic Differentials	\$3,333,000	\$3,480,000	\$1,273,000	\$1,332,000

C.2.4. Behavioral Health Cost Reporting System

Implementing a cost reporting program for behavioral health centers delivering clinic services would address several distinct reimbursement challenges faced by Alaska. Reported cost data is likely to establish a higher reimbursement threshold than current ceilings imposed by the federal clinic upper payment limit (UPL). Cost reporting would promote greater transparency in monitoring provider financial needs and performance and responsiveness to disparate cost pressures driving service costs in different regions of Alaska.

Recommendation 4 (BH-R4): Alaska Medicaid should implement a behavioral health provider cost reporting system to overcome federal funding restrictions imposed by CMS “upper payment limit” rules and to facilitate ongoing monitoring of and responsiveness to changing provider costs.

Cost reporting would establish an alternative standard for determining federal upper payment limits. Without a cost standard, the State is constrained to pay for clinic services at rates no higher than the Medicare rate for comparable services. A UPL cost standard would set upper payment limits that account for service costs unique to Alaska and not reflected in Medicare standards, which have historically proven to be inadequate for reimbursement for services delivered in the state. A UPL cost standard would facilitate greater investment into artificially depressed clinic rates, allowing the State to address rate inequities and inappropriate utilization in the wider behavioral health service array. A cost reporting process would support critical administrative activities to foster longer-term efficiencies and behavioral health service delivery transformation.

- Cost data would generate additional insight into highly variable but generally elevated indirect costs reported by providers.
- Cost reporting would serve as a common “source of truth” when assessing provider reimbursement needs and could also facilitate regular administrative rate update to promote ongoing rate adequacy.
- Cost reporting would also furnish a foundation for gauging provider readiness for potential CCBHC payment and service transformation.

Guidehouse estimated that a single cost reporting program would require approximately 0.7 FTEs to review, audit, and manage provider cost reports based on information gathered from peer states that oversee similar programs. For example, in one peer state that manages programs of similar

magnitude and serving similar populations, 4.25 FTEs are required year-round to manage six cost reporting programs (DD Services, In-Home Services, Meals, Assisted Living Facilities, Personal Care, Nursing Facilities). The team is comprised of 3 auditor FTEs, 1 supervisor FTE who provides subject matter expertise and oversees the work of the three auditors, and 0.25 SME supervisor FTE who serves as a liaison between the auditors and the State. Given the similarities in the programs, a comparable staffing plan may work for DOH however the staffing would need to be evaluated and there could be enhanced need beyond what is budgeted within this report. The FTEs required may fluctuate upwards depending on decisions made by the Department in regards to the level of audit performed on each report. This staffing proposal assumes no existing infrastructure for DOH to leverage for implementing and managing the proposed programs. For example, if DOH can leverage existing FTEs that already assists with current cost reporting, the staffing requirements for the enhancements or new cost reports may be adjusted to account for existing staff.

Table 6 below includes the minimum and maximum cost of implementing Recommendation BH-R4. Unlike other recommendations that represent Medicaid reimbursement costs based on service utilization, these costs include Department staff time, technology costs and administrative time to stand up the reporting structure. Standing up the cost reporting process includes three separate cost considerations related to initial cost report development, maintenance of the cost reporting process and the potential for a web-based system. The cost reporting development estimates assume that 0.7 FTEs analysts receiving an annual compensation of \$91,000. DOH should continue to monitor and evaluate the staffing levels required to complete the administrative work as the FTEs provided by Guidehouse are estimates based on experience in other states and may not be reflective of the needs of Alaska in practice. In addition, we account for cost report development start-up costs as the cost reporting process will be new for behavioral health providers. The cost estimates for BH-R4 are inclusive of Recommendation LT-R4 in the LTSS Rate Evaluation. The estimated cost for implementing overall cost reporting ranges from \$63,700 to \$1.49 million (federal + state), with state-only costs between \$31,850 and \$745,388, reflecting a wide range of potential fiscal outcomes depending on the implementation approach.

Table 6: Cost Reporting Fiscal Impact

#	Recommendation	Projected Minimum Annual Cost (Fed + State)	Projected Maximum Annual Cost (Fed + State)	Projected Minimum Annual Cost (State Only)	Projected Maximum Annual Cost (State Only)
BH-R4	Cost Report Maintenance	\$64,000	\$127,000	\$32,000	\$64,000
BH-R4	Initial Cost Report Development	\$232,000	\$320,000	\$116,000	\$160,000
BH-R4	Web-Based System Development	\$682,000	\$1,363,000	\$341,000	\$682,000

C.2.5. Addressing Rate Disparities for Services under the Clinic UPL

While implementation of a cost reporting system would allow DOH essentially to lift the clinic UPL ceiling, addressing aggregate payment levels for these services is only one aspect of the solution required to arrive at appropriate reimbursement for the behavioral health services currently subject to the clinic UPL requirement. Guidehouse analysis revealed that rates for these services are among the most imbalanced in the community behavioral health service array, and correcting rate disparities will necessitate major shifts in how these services are paid in comparison to current reimbursement.

Unlike the rehabilitative services that comprise much of the behavioral health service array, the psychological services under the clinic UPL are more medically-oriented services that are also performed by psychiatrists and so are included and regulated by the Medicare professional services fee schedule (MPFS), with coding (Current Procedural Terminology, or CPT) and reimbursement principles formulated and overseen by the American Medical Association (AMA). These services involve individual, group, and family psychotherapies, as well as psychological testing, assessment, and evaluation services. Rate equity and resource needs for these services are measured according to a national standard, the Resource-Based Relative Value Scale (RBRVS), which considers parity not only among psychological services themselves, but also their relative resource needs in comparison to the tens of thousands of other professional medical services.

While the RBRVS is first and foremost a *physician* fee schedule, it has become the standard for most professional services, including those delivered by non-physician practitioners. The schedule is officially maintained by the AMA's Relative Value Scale Update Committee (RUC), which is itself composed of representatives from a range of physician specializations, including psychiatrists. However, non-physician industry groups also provide relevant input through the Health Care Professionals Advisory Committee (HCPAC), which is made up of psychologists and social workers in the behavioral health domain, but also audiologists, chiropractors, dieticians, nurses, occupational therapists, optometrists, physical therapists, physician assistants, podiatrists, and speech pathologists. In short, the RBRVS is the gold standard for evaluating professional services reimbursement.

Consequently, Guidehouse did not develop cost benchmarks for these services, because a superior benchmarking structure already exists in the form of the RBRVS. Comparison to Medicare rates thus becomes a kind of *lingua franca* in evaluating rate adequacy for these services, as well as serving as a common yardstick for measuring behavioral health services in relation to other healthcare services. In fact, cost benchmarks for other non-clinic behavioral health services are mainly necessary only because Medicare does not cover rehabilitative behavioral health services, resulting in the lack of a national standard for evaluating payment sufficiency outside of cost or market pricing.

It is notable that Alaska Medicaid does not align its clinic behavioral health services to the RBRVS. This creates two parallel reimbursement standards, with different rates paid for the same service, depending on whether the service is delivered by a psychiatrist, and so reimbursed based on Alaska's physician and professional services fee schedule, or whether it is delivered by a non-physician, and thus paid on separate fee schedules that govern community behavioral health centers or private practices for psychologists, licensed clinical social workers (LCSW), or other

common practitioners such as licensed professional counselors (LPC). These parallel tracks are not necessarily inherently problematic—Medicare also pays different rates to different practitioners for the same service—but comparison between Alaska’s different Medicaid fee schedules suggests that rate parity among different practitioners working in distinct settings has not received the attention it deserves to prevent pervasive misalignment.

The crux of the issue is that clinic behavioral health payments are highly imbalanced when evaluated against the RBRVS, which leads to inequitable and frankly counterintuitive results when considering payments across all behavioral health specialties, including psychiatry. These consequences can be illustrated through three basic service examples: psychiatric diagnostic evaluation (90791), 30-minute individual psychotherapy (90834), and group psychotherapy (90853). CPT coding generally has well-defined standards for each procedure, so the time and resource assumptions for delivering the service are typically straightforward to discern.

A psychiatric diagnostic evaluation, for example, is episode-based, and so not strictly defined by the length of time to perform the service. However, the evaluation must take at least 16 minutes for completion to be billable, but it cannot take more than 90 minutes without requiring additional coding to note the extended effort. The individual psychotherapy procedure, on the other hand, is strictly defined by a length of time of 30 minutes, and it pays a different rate than its 45- and 60-minute variants. Group therapy, like the evaluation, does not presuppose a set amount of time, but assumes a lower and upper bound of approximately 45-60 minutes. Unique to the group therapy service, though, are group size assumptions, since the therapist is able to bill for each individual participating in the session. Billing for this session requires at least two clients, but group sizes should be no larger than 12. Even though the group therapy requires a minimum of two, the Medicare rate typically assumes an average group size of 4 to 6 clients.

Table 7: Psychological Service Rate Comparisons in Alaska

CPT Code	Procedure	Alaska Medicare Rate	Medicaid Physician Rate	Medicaid Non-Physician Rate	Medicaid Physician Percent of Medicare	Medicaid Non-Physician Percent of Medicare
90791	Psychiatric Diagnostic Evaluation	\$230.89	\$315.85	\$662.04	137%	287%
90834	Individual Psychotherapy (30 min.)	\$109.89	\$144.11	\$75.39	131%	69%
90853	Group Psychotherapy	\$38.91	\$50.69	\$60.32	130%	155%

When comparing Alaska’s rates for these three services in different programs, several features become prominent. Notably, the rate paid in Medicare aligns closely with the assumptions informing each procedure’s service definition. The 30-minute individual therapy rate of \$109.89 is a little less than half of the assessment rate of \$230.89, which makes sense if the typical assessment requires between 60-90 minutes of practitioner time. The group therapy rate also aligns fairly well

with the individual therapy rate. While the group session runs longer than the 30-minute session, when compared to the 45- to 60-minute variants of the individual therapy, the group rate appears to be designed to support an average group size of 4-6 clients.

Turning to Alaska's Medicaid fee schedule for physicians, which is broadly aligned to the RBRVS methodology used by Medicare, comparison illustrates that the same payment rate relationships are in place among the three procedures. Significantly, though, the Medicaid rate is higher than the Medicare rate, reflecting Alaska's concern that federal Medicare rates are insufficient to attract and retain physician expertise, especially psychiatry expertise, which is in short supply across the country. Medicaid psychiatry rates are thus 30-37 percent greater than the corresponding Medicare rate, depending on the service.

Key to Guidehouse's rate imbalance findings and recommendations for realignment are the counterintuitive results that emerge when examining the relationships among these rates as established for non-physician practitioners such as psychologists, LCSWs and LPCs. The most striking impression of the diagnostic evaluation rate is that it appears extremely high. In contrast to coding best practice, the rate of \$662.04 is probably able to sustain an evaluation effort lasting 4.5-6 hours rather than a maximum of 1.5 hours. Although some evaluations can be time-consuming and run beyond 90 minutes, the evaluation time presupposed in the rate is likely not the norm for completing an evaluation. More likely, the high rate was established to cover preliminary client onboarding and "setup" activities that would be otherwise unbillable in Medicaid.

The amorphous time assumptions that go into the diagnostic evaluation rate also obscure the relationship with the other psychological services. The individual therapy rate is disproportionately low compared to the evaluation, while the group therapy rate, where the cost of therapist time is divided among two or more people, comes surprisingly close to the individual therapy rate. When compared to the corresponding Medicare rates, the evaluation rate is almost three times higher than the Medicare rate (287 percent of Medicare), while group therapy is 55 percent higher than Medicare. The Medicaid non-physician rate, on the other hand, is only two-thirds of the Medicare rate (69 percent of Medicare). The reason the group therapy rate is substantially higher than Medicare is that Alaska's group rates assume an average group size of the 2-client minimum, rather than the 4-to-6 clients in Medicare. Guidehouse's survey of provider behavioral health service delivery suggests that actual group sizes in Alaska's system come closer to the Medicare assumption.

When considering some of the potential impacts of these calibrations on service quality, the Department should note that clinic reimbursement is structured so that the dollars needed to serve clients within the system are "front-loaded." As illustrated with the diagnostic evaluation rates, but also with other initial interventions such as mental health intake assessments, behavioral health providers are essentially paid up front for onboarding clients, with less incentive to deliver more intensive individual therapy services down the road. The rate structure also encourages group therapy services, the higher the volume and group sizes the better, since those rates are relatively lucrative in the context of wider system payments. Although group therapies are often an appropriate intervention, with more effective clinical results than individual therapy depending on the needs of the client, safeguards should also be in place to mitigate the risk that group interventions are lieu of individual interventions merely because of the healthier rates. The current rate disparities between these two modes of therapy not only rewards providers for

privileging group over individual therapies but may actively penalize providers for delivering individual therapies with reimbursements below cost.

Evidence suggests, then, that non-physician clinic rates are seriously misaligned with each other and with Medicare, but also with psychiatrist reimbursement for the same services in Medicaid. Although a psychiatrist is better paid than a non-physician practitioner for providing individual therapy, it is not clear that the physician should be paid 43 percent more than a non-physician, especially when Medicare not only treats psychiatrists and psychologists as equivalent, but also entitles most allied health professionals and limited-license practitioners to 75-85 percent of the full physician rate. The reimbursement logic becomes extremely counterintuitive when examining the group therapy and evaluation rates. Despite superior expertise, the psychiatrist is paid only 63 percent of non-physician reimbursement for providing group therapy, and more surprisingly, only 36 percent of the clinic rate when performing psychiatric diagnostic evaluations.

Recommendation 5 (BH-R5): Alaska Medicaid should consider moving to the nationally recognized Resource Based Relative Value Scale methodology for services subject to the CMS “clinic UPL” and consider gradually aligning payment rates of psychological services subject to the “clinic UPL” and psychiatric services on Alaska’s physician and professional services fee schedule

The current misalignment of clinic behavioral health rates demonstrates why payments for these services based on a RBRVS methodology akin to Medicare is a best practice. One of the chief virtues of the RBRVS approach, apart from its administrative ease, is that it was designed specifically to ground payments in relative level of effort rather than rely on rates established through the arbitrariness of historical provider costs or the influence advocacy efforts or special interests. The RBRVS is as close to an objective standard for measuring rate equity as can be found in contemporary healthcare, which explains its ubiquity among public and private payers across the health sector.

In framing our recommendations, Guidehouse is advising DOH to pursue a gradual alignment with the RBRVS rather than an immediate rebalancing effort. There are multiple reasons for suggesting a cautious approach. The first is that payment rates calculated within RBRVS do not differentiate between setting and therefore are the same for non-physician practitioners in independent practice as well as the community behavioral health system. Therefore, rate rebalancing potentially affects reimbursements to all private practitioners, not just to those who deliver service in behavioral health centers. Guidehouse has not been able to assess wider fiscal impact, nor have we explored the most advisable policy for establishing parity between physician and non-physician payments. There are certainly good grounds for treating psychiatrists and psychologists as equivalents for payment purposes, but also for “discounting” rates for allied health professionals. By the same token, it is not clear that rates for psychological services should be the same for behavioral health clinics and private practitioners, since the public behavioral health system serves a much larger share of the state’s severely mentally ill (SMI) population than independent practice, with higher costs reflective of the population’s more intensive needs, with potentially greater indirect costs related to coordination of care within its more complex array of service interventions. These circumstances need to be considered before imposing a fully standardized

rebalancing initiative across the different touchpoints of the system. Implementation of a cost reporting system is likely to further inform the Department's understanding of these circumstances.

The second reason for a more gradual approach is that rebalancing options become more plentiful if DOH opts to establish a cost reporting system that can lift the current UPL ceiling. If that happens, DOH would not be limited to a cost-neutral rebalance or constrained to set psychological service rates at no higher than 100 percent of Medicare. As already demonstrated by Alaska Medicaid's physician fee schedule, there is a strong case to be made that the 100 percent of Medicare standard is neither sufficient to attract the specialized staff required to deliver these services, nor to cover provider costs. A rebalancing effort that can inject additional dollars into clinic services would help providers transition who would otherwise face payment reductions from decreasing rates where they currently draw substantial revenue.

C.2.6. Crisis Services

Crisis services must be evaluated to confirm whether rates reflect provider costs, especially given the complex needs and high acuity of their populations. These services require 24/7 staffing with a multidisciplinary team, including peer support, clinical specialists, nurses, case managers, nurse practitioners, and supervisors. Reasonable occupancy adjusters should account for constant patient turnover, and staffing ratios must adequately support this population to maintain care quality and reduce recurrences or escalation to inpatient care. Ongoing review is needed as the crisis continuum expands, especially considering unique geographic factors. Appendix A outlines the rate components that are included within the crisis residential and stabilization models.

Recommendation 6 (BH-R6): Alaska Medicaid should establish rates for expanded crisis service options that are thoroughly informed by provider costs and well-suited to the delivery models adopted by Alaska providers.

Although Guidehouse has developed cost components and rate models for these services along with exploring potential financial impacts at our benchmarked rates, the impact should be re-evaluated as service definitions, licensing requirements and the provider network continues to take shape. Although these services exist today, with a minimal amount of associated utilization, there remain a significant number of "hypotheticals" involved in understanding provider costs. Since low utilization of current services appears to us to be caused by low reimbursement, we expect that substantial rate increases combined with the Department's investment in the crisis continuum will spur utilization. Therefore, given the planned changes with Crisis services in the state the baseline data should be reviewed once more robust utilization numbers are available. Although we estimate impacts in **Table 8** below, we suggest that DOH continues to gain more information on provider costs and expected team deployments before arriving at a final projection of utilization.

Table 8: Crisis Services Fiscal Impact

#	Recommendation	Projected Minimum Annual Cost – Initial Year (Fed + State)	Projected Maximum Annual Cost Initial Year (Fed + State)	Projected Minimum Annual Cost-Initial Year (State Only)	Projected Maximum Annual Cost Initial Year (State Only)
BH-R6	Behavioral Health Crisis Services	\$1,361,000	\$1,371,000	\$282,000	\$286,000

C.2.7. Service Definitions

During stakeholder engagement sessions there was notable discussion related to the definition of services and State expectations in service delivery. Throughout the behavioral health service array, many services are not only ambiguous in their requirements but also lack a clear rationale for existing rate variation. Rate recommendations within this report are based on the existing service descriptions as they are written today. However, a key Guidehouse recommendation is for DOH to review the behavioral service catalogue and confirm service descriptions are clear, potentially adjusting reimbursement within the framework of our proposed independent rate build-up methodologies to reflect revised cost assumptions.

Recommendation 7 (BH-R7): Alaska Medicaid should undertake a comprehensive review of service definitions for several key behavioral health interventions to clarify State service delivery expectations and assess whether existing requirements align with current rate assumptions and future policy objectives. Definitions in need of further review include adult and children’s residential treatment settings, case management, Assertive Community Treatment, and Treatment Plan Development and Review.

The following services should be reviewed, with additional services potentially identified by DOH staff upon further review:

- Review Adult Mental Health Residential and Children’s Residential Treatment service expectations.
- Unit of Measure definitions for Case Management. The current case management rate was not updated as part of the rate evaluation as it was found that there are instances of heavy overbilling of the 15-minute service. DOH should explore the appropriateness of a monthly rate or create more specific definitions to differentiate between intensive and regular case management can be billed.
- Unit of Measure for Assertive Community Treatment. Assertive community treatment is a high acuity service that requires a multidisciplinary team of qualified staff to be available 24 hours a day, 7 days a week with on-call capacity. Given the demanding nature of the service a 15-minute unit makes standing up and maintaining the service a severe challenge for providers. Therefore, the state should explore moving this service to a monthly rate.

- Synchronizing the rate for the 1115 waiver services for Treatment Plan Development and Review with the State Plan Treatment Plan Review. In reviewing the services DOH should confirm if the intended outcome and staffing expectations are the same, which would constitute the same rate.

These are specific instances where the evaluation highlighted a need for further review to confirm coherence between service description language and DOH's expected service outcomes. Depending on the changes resulting from this detailed review, the Department can determine additional benchmarks of reasonableness to guide rate setting.

C.2.8. Annual Administrative Rate Review

One of the primary virtues of the independent rate build-up methodology is that it allows Medicaid to make targeted rate changes (usually increases) informed by up-to-date cost and service delivery data without having to engage intensive rebasing efforts. Although a thorough rate rebase is recommended every 4-5 years to refresh cost assumptions typically unavailable without a major survey effort, Guidehouse's recommended rate methodology would allow the State to leverage, on an annual basis, freshly published public staff wage and other data on provider expenses to update information on key cost drivers influencing the rates.

Recommendation 8 (BH-R8): Alaska Medicaid should consider implementing a process for reviewing rates annually and proposing targeted rate updates based on changing wage and cost benchmarks and their differential impacts across the behavioral health service array.

The Department should consider a regular process of administrative rate update that includes adjusting either wage assumptions or overall rate levels based on applicable inflation indices. If the Department were to implement the benchmark rate methodologies recommended by Guidehouse, it would be possible to review rate assumptions annually or bi-annually to assess the need for administrative update of specific types of costs—such as wages—without increasing rates uniformly across the board. The independent rate build-up approach for developing the rates would allow DOH to consider specific components of rate (e.g., administrative costs, program support costs, transportation) for further review and updates.

Prior to rate implementation, the Department is encouraged to review the annual growth trend basis to account for the changing economic environment (e.g., inflation, economic growth trends, etc.). Guidehouse recommends monitoring inflationary changes in the BLS Provider Price Index (PPI) data series. Its index on psychiatric and substance abuse hospital costs may serve as a useful proxy for identifying inflation in the behavioral health system. The BLS has collected data on changes in Medicaid providers' costs on a monthly basis and measured it with a unique inflation index since 2014. There are several advantages to using this index over potential alternatives:

- 1) The BLS updates the index monthly, providing a point-in-time indicator of cost growth for any current and future rate setting period,
- 2) The cost index is specific to behavioral health, making it more responsive to unique and evolving costs in this area than other general health care inflation metrics.

Additionally, DOH should track BLS Current Employment Statistics (CES) data that produces monthly earnings of workers comparable to providers in DPHHS's programs. Specifically, DOH may consider tracking CES data that spans all programs for Residential Mental Health and Substance Abuse Facilities Staff, Outpatient Mental Health Center Staff, Office of Mental Health Practitioners Staff, Child and Youth Service Staff, Assisted Living Facilities for Elderly Staff, Elderly and Persons with Disabilities Staff, Home Health Care Staff, Residential Intellectual Developmental Disability Staff, Vocational Rehabilitation Services, and Individual and Family Services. These BLS data sources are often used by similar programs in other states.

Depending on the scale of effort involved, Guidehouse projects that annual update might require up to 0.25 FTEs of Department personnel time to review and implement rate changes.

C.2.9. Staff Transportation Add-On Rate

Due to the remote nature of frontier Alaska, its weather conditions and limited road networks, transportation poses certain logistical challenges. It may be beneficial to consider additional transportation options rather than incorporating high transportation costs into all rates. Currently, rate models include indirect costs that could potentially be adjusted if above-average transportation expenses were categorized as “add-ons” in the rate models. The benefit of this approach is that it would focus the resources needed for additional transportation on the services and providers that actually incur these costs, rather than dispersing these higher indirect costs evenly and indiscriminately across the system.

Recommendation 9 (BH-R9): Alaska Medicaid should consider implementing a rate add-on to account for the heightened cost of staff travel if service delivery extends beyond a threshold mileage radius. Specific parameters for defining the add-on will depend on additional transportation data collection.

As part of the stakeholder engagement efforts, Guidehouse heard from providers that for specific services staff need to travel farther than average to provide a service.

- Create transportation add-ons that providers can bill when they travel outside a certain radius.
- As part of the 1115 waiver the State will be held liable for assumptions, therefore there needs to be realistic and defensible data assumptions to support transportation add-ons.
- Given the uniqueness of Alaska, using external data as a proxy to build data assumptions may cause challenges for the state when defending the methodology to CMS.

Although establishing transportation add-on rates is not strictly dependent on establishing a cost reporting system, the add-on framework is more likely to be effective if informed by detailed transportation cost information supplied by Alaska providers.

D. Stakeholder Engagement

Guidehouse conducted extensive stakeholder engagement throughout the rate evaluation process. These efforts included:

- Creating a provider rate workgroup that consisted of providers that deliver the services of interest, State staff and association members
- In-person onsite meetings with at least 12 individual providers and individual follow-up calls with numerous additional providers
- In-person onsite meetings with the Alaska Mental Health Trust, Alaska Native Health Board (ANHB), Alaska Behavioral Health Association and the Alaska Hospital and Healthcare Association
- Service specific focus groups for providers that deliver Adult Mental Health Residential, Children's Residential Treatment, Therapeutic Treatment Homes and American Society of Addiction Medicine (ASAM) services.
- Crisis residential and stabilization meetings to discuss providers looking to stand up crisis services and additional review of provider pro formas.

The combination of these various stakeholder efforts provided detailed insights into provider specific costs and overall service delivery across the behavioral health system.

D.1. Rate Workgroup Structure

To support the development of cost-based rates for the State's behavioral health Services, Guidehouse and DOH/DBH worked with service providers and association members in the rate development process. The rate study considered worker wage levels and benefits, providers' administrative costs, and program support costs, among other factors. This effort was informed by a comprehensive provider cost and wage survey soliciting broad provider participation, analysis of provider-submitted financial and service delivery data, as well as ongoing, extensive stakeholder input throughout the rate development process.

DOH/DBH convened a recurring stakeholder forum to support the rate study: a workgroup structure utilizing five specialized Rate Workgroups to address detailed technical components and advising the study more broadly across services and representing a wider array of stakeholder interests. **Table 9** describes the composition of this group, their respective roles, and discussion topics.

Table 9: Rate Workgroup Composition and Roles

Category	Details
Composition	• Membership representative of associations and providers directly impacted by rate changes • Provider representatives who reflect the full range of services included within the rate study scope • Members who have a strong understanding of provider finances, reporting capabilities, and service costs
Role	• Provide subject matter expertise on provider survey and rate methodology development • Review and validate rate model factors and assumptions, including wages, benefits, administration, program support and staffing • Provide insight into how current services are delivered • Provide recommendations for consideration in the Final Report
Discussion Topics	• Provider Survey results • Rate build-up approach and rate components • Benchmark wages and adjustments, including supplemental pay and inflation factors • Staffing levels and supervision ratios • Final rate assumptions, current service utilization landscape, and fiscal impact of proposed rates • Considerations for implementation and future analysis

In addition to the focused stakeholder workgroups, a provider survey was deployed to a wider provider community. Guidehouse conducted the first stakeholder meeting to serve as a training session for the wider provider community in filling out the survey. In this meeting, we shared the survey data collection process along with the objective and the methodologies that are used in the rate study. The provider rate workgroups were as follows:

Rate Workgroup Session #1: The first rate workgroup session was designed to provide an in-depth understanding of the rate study process, focusing on essential aspects and methodologies. Roles and expectations, communication goals, and the scope of the project were discussed. Guidehouse offered feedback on how to fill out the survey, highlighting key sections that required input and providing further details. These discussions were essential in refining the survey to better capture accurate data.

Additionally, the conversation shed light on how Alaska's rates compare with those of their peers, offering a perspective that is crucial for contextualizing the findings of the rate study. This comparative analysis helps in identifying areas where Alaska may need to adjust its rates to align more closely with industry standards and practices.

Rate Workgroup Session #2: The purpose of the second provider workgroup session was to offer a comprehensive overview of the rate study and display the high-level methodology used for calculating rates. Guidehouse led the session by presenting current survey submissions and preliminary survey results, including wage data gathered from the survey. A key focus of the discussion was collaborating with providers to gather feedback on various aspects of service delivery, including team composition, training, onboarding, recruitment, retention challenges, and transportation. This collaborative approach aimed to enhance understanding and address the challenges providers face in their operational environments.

Overview of Rate Study and its Components: Guidehouse walked through the rate-build up process, which includes but is not limited to the following components:

- i. **Wages:** Evaluating the compensation for various roles and adjusting for market rates.
- ii. **Benefits:** Incorporating the costs of health insurance, retirement plans, and other employee benefits.
- iii. **Supervision Costs:** Accounting for expenditures related to managerial oversight and administrative support.
- iv. **Billable Time Assumptions:** Estimating the proportion of time that staff can devote to billable activities.
- v. **Indirect Cost Assumptions:** Calculating overhead costs such as utilities, rent, and office supplies.
- vi. **Staff Mileage:** Including travel expenses incurred by staff for service delivery.
- vii. **Acuity Adjustments:** Making adjustments based on the intensity and complexity of client needs.
- viii. **Stipend Values:** Considering stipends provided to staff for additional duties or qualifications.

These components collectively ensure that the rates reflect the true cost of service delivery, taking into account various factors that influence pricing.

Rate Workgroup Session #3: In the third provider workgroup session, Guidehouse presented the final results of the provider cost and wage survey. The presentation was thorough and detailed, reflecting the extensive work that had gone into gathering and analyzing the data. Guidehouse shared that a total of **48** surveys were received from providers, marking a significant response rate that added credibility and depth to the survey results. This session focused on the in-depth wage analysis that Guidehouse completed that observed wage responses from the provider cost and wage survey, Bureau of Labor Statistics comparisons, and the addition of inflation and supplemental pay to wages. In addition, employee related expenses, billable time, and indirect cost analyses from the provider cost and wage survey were displayed.

Rate Workgroup Session #4: The fourth provider workgroup convened to discuss the draft preliminary benchmark rates and methodologies for providers. This session served as a refresher on how Guidehouse builds their rates and provided detailed examples of how each component discussed during the rate study fits into the final draft rate model calculations. Guidehouse also presented fiscal impact scenarios and additional considerations within the session.

The primary purpose of the call was to garner provider feedback and achieve buy-in on the components and methodology used to calculate the draft rates. Guidehouse emphasized the importance of collaboration and transparency in this process. Guidehouse included providers in discussions, making the proposed draft benchmark rates more informed and broadly accepted while promoting shared ownership of the rate structures.

D.2. Additional Stakeholder Engagement

D.2.1. In-Person Provider Interviews

In discussions with DOH/DBH Guidehouse understood the importance of in-person and on-site interviews with providers. In 2024 between November 18th and 22nd, the Guidehouse team conducted an onsite visit to Alaska for in-person stakeholder engagement including Anchorage, Mat-Su, Fairbanks, Juneau, Kenai Peninsula, Bethel, and Kodiak. The primary objective of this visit was to gain a deep understanding of the perspectives of providers and the nuances associated with delivering services in unique geographic locations across the state.

During the visit, the team met with a diverse array of providers and associations to learn more about the behavioral health services offered across Alaska. These stakeholders included:

- Alaska Behavioral Health Association
- Alaska Behavioral Health
- Alaska Hospital and Healthcare Association
- Alaska Mental Health Trust
- Alaska Native Health Board (ANHB)
- Bartlett Regional Hospital
- Cook Inlet Counseling
- Family Centered Services of Alaska
- JAMHI Health & Wellness
- Kenaitze Indian Tribe
- SetFree Alaska
- Southcentral Foundation
- SouthEast Alaska Regional Health Consortium (SEARHC)
- True North
- Volunteers of America (VOA)
- Yukon-Kuskokwim Health Corporation

The onsite interviews with these providers were highly engaging. These discussions offered valuable insights into the rate study approach and enabled the team to receive information from providers outside of their typical work groups and stakeholder meetings. The in-person format allowed for more dynamic exchanges and a deeper understanding of the challenges and opportunities faced by behavioral health service providers in Alaska. Conversations with providers also helped supplement findings from the provider costs and wage survey, allowing Guidehouse to gain a comprehensive understanding of the service delivery challenges outside of the costs and information submitted in the survey by providers.

Meeting with providers in person proved to be invaluable for several reasons:

- **Enhanced Communication:** Face-to-face interactions foster a more open and honest dialogue, allowing providers to share their experiences, challenges, and perspectives more freely. This direct engagement helps build trust and rapport, which is crucial for effective stakeholder collaboration.
- **Nuanced Understanding:** Being onsite enabled the Guidehouse team to observe firsthand the unique operational environments and logistical challenges faced by service providers in Alaska. This deeper understanding of the local context is essential for developing tailored solutions that address specific needs.
- **Diverse Perspectives:** The in-person meetings allowed the team to gather insights from a wide range of providers, including those who might not have typically participated in work groups or larger stakeholder meetings. This diversity of viewpoints enriched the overall understanding of the behavioral health landscape in Alaska.
- **Actionable Insights:** The valuable information obtained during these interviews directly contributed to the rate study approach. The team could incorporate practical experiences and suggestions from providers, ensuring that the study is grounded in real-world conditions and challenges.

Provider Workgroup Meeting (On-Site)

Most of the provider workgroup meetings took place virtually, however Guidehouse used the opportunity being on-site to host one of the provider workgroup meetings as a hybrid meeting. This meeting offered a more engaging conversation, allowing for a collaborative exchange of ideas and fostering a deeper connection between the providers and the team.

D.2.2. Service-Specific Focus Group Sessions

Beyond the formal rate workgroup structure, Guidehouse coordinated with DOH/DBH and stakeholders to conduct additional meetings that were service specific. The focus group sessions included Adult Mental Health Residential (AMHR), Therapeutic Treatment Homes (TTH), Children's Residential Treatment (CRT), and American Society of Addiction Medicine (ASAM) services. These sessions were intended to focus on the delivery elements and less on the cost elements of the service. For instance, during the discussions on therapeutic treatment homes there was extensive discussion related to the increased staff transportation costs. One provider noted that their offices are in Anchorage, however they have licensed homes in remote parts of the state where their case managers and staff need to fly to train foster parents and confirm a safe environment for the kids in care.

The meetings took place from March to the end of April 2025, after the cost recommendations were wrapped up. This collaborative effort ensured that the rate study was informed by diverse perspectives and expert opinions, ultimately leading to more accurate and actionable recommendations. By incorporating specific examples and stakeholder feedback, the rate-setting methodology was refined to better meet the unique needs of each service type. Below we discuss the specific focus group sessions and takeaways from these conversations. These individual recaps are intended to document details from the provider conversations at the time of the

meetings. It should be noted that the Department has already begun to make changes to address some of these challenges or plans to address some of these challenges in the future.

Adult Mental Health Residential (AMHR) Focus Group

The Behavioral Health Adult Mental Health Residential meeting was facilitated by Guidehouse to gather information from various providers to understand their perspectives and offer insights into the service specific elements. The following providers attended the meeting:

- Alaska Behavioral Health
- Arc of Anchorage
- JAHMI Health & Wellness, Inc.

Staffing and Service Delivery Considerations

Guidehouse facilitated discussions on staffing structures and practices among providers. Staffing models included 24/7 BH associates, daytime clinicians, case managers, and psych prescribers. There were clinicians and clinical associates at each site, a split clinical supervisor, registered nurse visits, and on-call psychiatric and clinical leadership. The discussions revealed diverse staffing models tailored to meet the needs of each provider's patient population.

Challenges

Guidehouse facilitated a comprehensive discussion among providers to gather insights on service delivery within adult residential care. Providers shared their experiences and challenges, highlighting significant variations in patient acuity and length of stay. Insights revealed extensive hours dedicated beyond the minimum treatment requirements, dealing with patients suffering from severe psychosis, hallucinations, and substance abuse issues. There were noted challenges with readmission rates and referrals from the department of corrections. The general takeaway was that providers do not utilize non-emergency transportation and vary in admitting patients based on chart reviews and waiver criteria. Length of stay ranges from six months to a year, with providers putting in more hours than the minimum required for patient care.

Guidehouse gathered insights on the primary challenges faced by providers in adult residential care. One highlighted the disproportionate amount of time and resources dedicated to adult residential care, despite it constituting a small revenue segment for the organization. Another identified hiring and retaining staff as the biggest challenge, hoping for better alignment of complex care residential homes with patient needs. Low reimbursement rates and the housing crisis in Alaska make it difficult to discharge patients appropriately. Challenges related to predicting patient acuity, holding beds for emergency services, and high vacancy rates were also discussed. Providers expressed discomfort with billing on top of the daily per diem rate. The general takeaway was the high time and cost involved in service delivery, issues with housing and discharging patients, staffing challenges, and unpredictability in patient acuity.

Key Takeaways

- Providers dedicate extensive hours beyond minimum treatment requirements for patient care.
- Challenges include readmission rates, referrals, housing crises, and staffing difficulties.
- Staffing models are diverse and tailored to each provider's needs.
- Providers in order to deliver appropriate levels of care tend to exceed minimum treatment hours to engage patients effectively.
- Future strategies should focus on addressing the identified challenges to improve adult residential care.

Therapeutic Treatment Homes (TTH) Focus Group

Guidehouse hosted two focus groups specifically for Therapeutic Treatment Homes. These meetings aimed to understand the operational challenges, staffing structures, and funding models that impact service delivery. The following providers were in attendance:

- Alaska Child & Family
- Denali Family Services
- Presbyterian Hospitality House (PHH)
- Residential Youth Care (RYC)

Staffing and Service Delivery Considerations

Discussion from the focus group sessions brought to light that organizations are experiencing considerable variability in their staffing levels and operational structures. The number of active licensed homes fluctuates from smaller providers with 5 homes to larger entities with up to 45 homes. Staffing compositions include foster care supervisors, case managers, and clinicians, with several reports indicating staffing shortages within certain organizations.

Discussions centered around the payment of stipends during travel and respite, funding limitations, and the double costs incurred when compensating foster parents during respite periods. Newly instituted waiver requirements now mandate that respite providers be licensed, thereby impacting billing processes. Additionally, some organizations have adopted structured reimbursement models to effectively manage non-billable days.

Clinical and crisis interventions remain essential, yet the non-billable nature of these services significantly contributes to overhead losses. There is a pronounced interest in developing crisis homes, which would entail specialized training and higher rates for foster parents capable of accepting youth on short notice or with acute needs. Furthermore, the ability to bill separately for crisis services is deemed critical to covering the actual costs associated with stabilization efforts.

The costs associated with family engagement, such as meals, lodging, and travel, are typically not covered by Medicaid, yet are imperative for delivering quality care and maintaining accreditation compliance. Providers frequently support parent coaching and engagement by covering such expenses.

Challenges

The two focus group sessions identified several significant challenges related to staffing, organizational structure, and financial management. There is a pressing need for additional clinicians and case managers, with some organizations operating at an annual loss due to the costs associated with these services. High recruitment costs for new therapeutic foster homes were noted, with some organizations spending as much as \$7,000 per month. Additionally, there are ongoing difficulties in finding and retaining qualified homes and staff. The financial burden is further exacerbated by significant transportation costs for both staff and clients, especially in cities that are only accessible by plane, which face higher training and staffing costs.

Issues with payment, billing, and funding models were also discussed during the meetings. Organizations face double costs when compensating foster parents during respite periods while also paying for the cost of care. New waiver requirements mandate that respite providers be licensed, thereby limiting billing flexibility. Retention bonuses for foster parents contribute to overhead costs, and there are complications with non-billable days, such as during hospitalizations or family vacations. Non-billable case management services and crisis interventions also contribute to financial losses, and organizations face additional costs for providing 24/7 support, which is primarily non-billable.

Clinical and crisis services present further challenges. Crisis intervention and stabilization services are often non-billable, leading to substantial overhead losses. There is a need for “crisis homes” that offer higher rates and specific training for foster parents to handle acute needs. Furthermore, costs associated with family engagement and support, such as meals, lodging, and travel, are not covered by Medicaid but are essential for providing quality care. High no-show rates for outpatient services (25-30%) and the unpredictable and expensive nature of crisis care for youth were highlighted as significant challenges.

Key Takeaways

- Staffing shortages and the diversity in operational structures among organizations have a direct impact on service delivery capabilities.
- Adjustments to payment models are necessary to effectively manage non-billable days and to cover travel/respite costs without incurring double expenses.
- The development of crisis homes and the ability to bill separately for crisis services are fundamental measures to mitigate overhead losses and to enhance care for youth with acute needs.
- Securing adequate funding for family engagement activities remains a challenge; however, it is crucial for sustaining quality care and meeting accreditation standards.

Children’s Residential Treatment (CRT) Focus Group

Guidehouse met with key stakeholders from the two child residential care providers listed below to discuss ongoing challenges, service delivery, staffing, and patient intake processes.

Attendees:

- Presbyterian Hospitality House (PHH)
- Residential Youth Care (RYC)

Staffing and Service Delivery Considerations

Providers indicated that Level 2 care typically lasts 90-180 days, while Level 1 care usually lasts around 90 days. Those from outside the community often stay longer. Child residential care involves school attendance with oversight and varying lengths of stay based on the level of care. Family therapy services are billed separately, increasing providers' financial responsibilities.

Staffing models in child residential care involve shift work and night monitoring to ensure proper care, with bed numbers and staff ratios adjusting to youth needs.

Patient intake comes from various sources like psychiatric facilities, community providers, and juvenile probation. Providers also handle travel arrangements for smooth intakes.

Challenges

Throughout the discussion child residential care providers brought up numerous challenges, including high treatment hours that exceed minimum requirements, financial burdens due to limited Medicaid funding for family therapy, and payment discrepancies for different levels of care. Initial intake of a child into CRT typically requires higher acuity services and increased staffing ratios due to crisis. Children that are within CRT are close to crisis at all times, therefore constant support is necessary to maintain stability justifying the need for consistent staffing ratios.

Key Takeaways

- Providers exceed minimum treatment hours, demonstrating exceptional commitment to patient care and a potential need to factor these into the rates and overall policy recommendations.
- Medicaid funding limitations pose financial challenges, prompting providers to cover additional costs themselves.
- Staffing shortages highlight the need for better reimbursement rates to ensure sufficient staffing levels.
- Service delivery includes comprehensive family therapy, crucial for holistic patient care but adds to financial burden.
- Effective patient intake processes with diverse referral sources ensure children receive the necessary care.

ASAM Services Focus Group

Guidehouse’s purpose for conducting the focus group was to gain a deeper understanding of the struggles faced by ASAM providers that may extend beyond typical financial concerns. The aim was to gather valuable insights that might not be captured through traditional survey methods.

Meeting Attendees:

- Central Peninsula Hospital
- Set Free
- Volunteers of America (VOA)

Staffing and Service Delivery Considerations

Providers have noted the differences in rates for comparable services and point out increased requirements for youth programs. The discussion included extensive provider services beyond weekly hours, lengths of residential stays, and billing practices. There is also a need for peer support billing and additional case management.

Facilities face staffing issues due to low wages and youth programs need extensive support requiring multiple clinicians, BH assistants, and nurses. Providers conduct integrated assessments and stress early discharge planning. Multi-dimensional evaluations are made, often for patients in crisis. Referral and assessment for youth include peer support and pre-planned discharge placements.

Challenges

Providers face challenges such as payment issues, handling patients with intense mental health issues, and transportation costs. Difficulties include transferring incarcerated individuals, managing patients with high-level mental issues, and transportation access challenges. There are also problems with public transportation comfort, family transportation issues, and staffing needs for youth programs.

Key Takeaways

- The need for better transportation solutions and the potential for making transportation a billable service.
- The critical nature of staffing ratios and the challenges of hiring and retaining qualified staff, emphasizing the need for competitive wages.
- The importance of thorough and early discharge planning to ensure smooth transitions for patients.
- Addressing the specific needs and higher demands of youth programs, including more intensive staffing and support requirements.

This gathering of information by Guidehouse from the providers highlights the complex challenges within ASAM services and offers valuable insights into potential areas for improvement.

E. Data Sources

E.1. Overview of Data Sources

Cost assumptions developed throughout the rate study relied on a wide variety of data sources. Guidehouse drew data from both DOH providers as well as national and regional standards to arrive at cost assumptions. Our approach for this study was to establish assumptions based on provider-reported and State-recommended data when available and appropriate, as well as extensive industry data that reflect wider labor markets for similar populations.

Guidehouse, alongside DOH and the Provider Workgroup conducted a cost and wage survey to obtain the cost of delivering services from providers including employee salaries and wages, administrative costs, program support costs, provider fringe benefits, and additional service-specific costs. The cost and wage survey, in particular, provided valuable and detailed information on baseline hourly wages, wage growth rate, administrative costs, program support costs, provider staffing patterns, and provider fringe benefits, as well as staff productivity for all programs included in the rate study. Guidehouse also analyzed trends in the detailed claims data for services that were in scope for this specific rate study from each of the programs to determine the fiscal impact of implementing the new benchmark rates resulting from the rate rebasing process.

Although a majority of cost assumptions used for rate development were derived from provider-reported survey data, publicly available sources were required for supplemental cost data and for benchmarking purposes to establish a comprehensive rate for some services.

We describe the key features of the provider cost and wage survey as well as the other sources used in the rate development process in the section below.

E.2. Provider Cost and Wage Survey

Guidehouse prepared a detailed Provider Cost and Wage Survey (“Survey”) based on the landscape of services provided in the community to individuals in Alaska with behavioral health service needs. During the Provider Workgroup meeting in September 2024, Guidehouse provided an overview of the survey including the objectives, topics, and questions on each worksheet within the survey document and solicited feedback from stakeholders. Guidehouse also gave providers time offline to review and propose feedback and changes to the survey following the initial workgroup meeting. The aim of the survey was to collect provider cost data across multiple services and programs that would serve as the basis for the rate studies. Additionally, Guidehouse aimed to utilize the survey to:

- Capture provider cost data to provide cost foundation for rate studies
- Receive uniform inputs across all providers to develop standardized rate model components
- Measure change in direct care worker wages over time
- Establish baseline cost assumptions for comparing and standardizing services operating in different programs and with different state plan and/or waiver authorities

- Determine cost basis for evaluating rate equity for services
- Gather needed data to understand billable vs. non-billable time and staffing patterns per service
- Investigate differences in costs among frontier/rural/suburban areas
- Solicit general feedback from providers to explore service delivery improvements and efficiencies

The survey was aimed exclusively at collecting information about provider costs incurred in delivering community behavioral health services under the programs included in the rate study. Although information was collected for clinic services that are subject to the UPL they were excluded from the rate setting process due to the limitations imposed by the UPL.

E.2.1. Survey Design and Development

Guidehouse designed this survey with input from DOH/DBH staff and the Provider Workgroup, as well as drawing on knowledge gained from conducting similar surveys in other states. The survey was designed in Microsoft Excel and included eleven sections or worksheets on topics outlined in **Table 10** below.

Table 10: Provider Cost and Wage Survey Organization and Data Elements

Worksheet Topic(s)	Survey Topics and Metrics	Time Period for Data Requested
Overview	A general overview of what to expect in the survey and the color coding throughout the survey	-
Provider Information	Provider identification, contact information, and organizational details	Most Recent Full Fiscal Year (Does not have to be audited)
Provider Site(s)	Provider site specific information	Most Recent Full Fiscal Year (Does not have to be audited)
Total Costs	Costs as reported on general ledger	Most Recent Full Fiscal Year (Does not have to be audited)
Programs & Services	Services delivered by the specific organization	April 1, 2024 – June 30, 2024
Wages	Job types, staff types, hourly wages, supplemental pay, and training time	April 1, 2024 – June 30, 2024 (Except for Column 17 use Annual Amount)
Benefits	Benefits that organizations offer full-time and part-time employees who deliver services – health, vision and dental insurance, retirement, unemployment benefits and workers’ compensation, holiday, sick time, and paid time off	April 1, 2024 – June 30, 2024
Service	Depending on which services the provider selected on the “Programs & Services” tab additional tabs would open to answer staff types unique to the type of service	April 1, 2024 – June 30, 2024

Worksheet Topic(s)	Survey Topics and Metrics	Time Period for Data Requested
Service Delivery and Staffing Patterns	Depending on which services the provider selected on the “Programs & Services” tab, additional tabs will open to answer service delivery specific questions unique to the type of service. Examples include: Billable vs. Non-Billable time, supervisor and staffing patterns, transportation, occupancy metrics and number of members served	April 1, 2024 – June 30, 2024
Transportation	Questions related to mileage and trips dependent on providers ability to split transportation by individual services	April 1, 2024 – June 30, 2024
Additional Information	Clarifying comments in addition to the information covered in other worksheets or sections, total amount of time it took to complete the survey	-

E.2.2. Survey Administration and Support

The survey was released via e-mail on September 16, 2024, to the entire provider community in scope for the rate study. To conduct a successful and accurate survey, Guidehouse facilitated a live provider training webinar available to all providers on September 19, 2024, following the release of the survey. In the training session, Guidehouse introduced the survey, provided an overview of the survey tool and each worksheet tab, and addressed provider questions. The training was recorded and posted to the Alaska website. A link to the recording of the webinar was shared with providers, and a frequently asked questions (FAQ) document was distributed to address common questions submitted by providers.

Additionally, Guidehouse offered ongoing support and resources to support providers in completing the survey through a dedicated electronic e-mail inbox which providers could access to receive answers to their specific questions. Providers were allowed eight and a half weeks to complete the survey and granted an extension option of two and a half weeks if additional time was needed to complete the service specific tabs, with a final survey deadline of December 2, 2024.

E.2.3. Provider Cost and Wage Survey Participation

In total, Guidehouse received 48 completed surveys which constitutes roughly 40% of eligible non-IHS Medicaid providers. Guidehouse measures “representativeness” by the number of providers, the relative size and scale of providers operations, and total State expenditures represented by surveyed providers. Provider expenditure is a reliable metric to represent the financial impact of the provider on the entire DOH/DBH system rather than the raw count of providers alone. Therefore, Guidehouse also reviewed the response rates by provider expenditure. When considering Medicaid expenditures, providers with more than \$50,000 in SFY2024 yearly non-IHS Medicaid dollars had an approximate survey response rate of 57.3%.

According to leading experience management firm, Qualtrics, typical survey response rates fall between 20-30 percent, though response rates depend heavily on survey design, medium, and

population size¹. In addition, Guidehouse also reviewed response rates by geographic region as specified within the claims data to determine reasonableness. **Table 11** below includes a detailed view of the survey response rates by providers and provider expenditure perspectives across regions in Alaska.

Table 11: Survey Response Rates for all Populations

Regions (Identified via field within State claims data)	Total Non-IHS SFY24 Medicaid Dollars	% of Non-IHS Medicaid Dollars with a Survey Response
Anchorage Municipality	\$34,159,000	62.9%
MatSu Borough	\$23,172,000	76.0%
Fairbanks North Star Borough	\$13,325,000	59.5%
Kenai Peninsula Borough	\$8,759,000	64.9%
Northern Southeast Region*	\$5,395,000	58.1%
Southern Southeast Region	\$4,206,000	59.2%
Not Identifiable in MMIS Claims Data	\$3,716,000	91.2%
Gulf Coast/Aleutian Region	\$294,000	0.0%
Northern and Interior Region	\$40,000	0.0%
Western Region	\$1,000	0.0%

E.2.4. Provider Cost and Wage Survey Review and Validation

After receiving the survey responses, Guidehouse compiled responses and conducted the following quality checks to prepare the data for analysis:

- **Completeness:** Checked the completion status in all worksheets within individual survey workbooks to determine whether follow-up was required to resolve any issues and missing data. Guidehouse followed up with providers individually within a week of receiving the survey responses if clarification or correction was required.
- **Outliers:** Reviewed quantitative data points (e.g., wages, productivity, benefits, number of clients and caseloads, staffing patterns) reported across all organizations to identify potential outliers. If any outlier data points were excluded or assumptions were made for rate model inputs, the assumptions were reviewed with the Department and the Rate Workgroup and are documented as such in this report.

¹ Qualtrics, Survey Distribution Methods, How to Increase Survey Response Rates Available online: <https://www.qualtrics.com/experience-management/research/tools-increase-response-rate/>

It is important to note cost survey processes are not subject to auditing processes, as an established administrative cost reporting process would be. Providers' self-reported data were not audited for accuracy, although outliers were examined and excluded when warranted, and additional quality control checks were conducted to ensure data completeness. The absence of an additional auditing requirement is ultimately a strength rather than a weakness of the cost survey approach, as it allows providers to report their most up-to-date labor costs, a key concern for rate development at a moment of heightened inflation.

The survey data reported by providers was utilized to develop several key rate components including baseline hourly wages, Employee Related Expenses (ERE), and administrative and program support cost factors. **Section G** further outlines how the survey data was utilized for rate setting purposes.

E.3. Claims Data

Guidehouse developed a detailed claims data request to be able to process the Medicaid claims utilization. This request included all detailed claims for services that were in scope for this specific rate study. This data was for state fiscal year 2024. We requested key fields such as provider level detail, including provider name and location, payment information, service identifying fields and units of measure. In addition, the IHS provider identifier was included within the claims data so that the encounter rate expenditures could be separated from the non-IHS expenditures.

E.4. Other Data Sources

Cost assumptions developed throughout the study rely on a wide variety of data sources. The objectives of the rate study aim to establish benchmark rates based on a combination of publicly available resources as well as to understand the necessary cost requirements required to promote access to quality services going forward. As will be detailed in greater depth in the sections that follow, Guidehouse's provider cost and wage survey furnished the majority of our rate assumptions on employee wages, provider fringe benefit offerings, staff productivity, staff-to-client ratios and administrative and program support costs.

While cost surveys are a rich and valuable source of information on provider costs, these tools cannot validate in themselves whether the costs reported are reasonable or adequate in the face of future service delivery challenges. Considering the possibility that historical costs may not be truly representative of the resources required to provide services in the future or are not comparable to or competitive with the industry as a whole, Guidehouse evaluates cost survey data against external data benchmarks whenever feasible. As a result, the cost assumptions used by Guidehouse frequently draw on national and regional standards, at least for comparison purposes, that reflect wider labor markets as well as median costs typical of broader industries, to benchmark Alaska reported information from the provider cost and wage survey. **Table 12** summarizes the additional public data sets used to inform cost assumptions used in Guidehouse's benchmark rate recommendations.

Table 12: Other Data Sources

Source	Description
Bureau of Labor Statistics, Occupational Employment and Wage Statistics (BLS OEWS)	Federal wage data available annually by state, intra-state regions, and metropolitan statistical areas (MSA). Used for wage geographic and industry comparisons and establishing benchmark wage assumptions for most wages.
Bureau of Labor Statistics, Costs for Employee Compensation Survey (CECS)	Federal data on employee benefits cost, analyzing groups of benefit costs including insurance, retirement benefits, paid time off, and other forms of non-salary compensation. Used for reference in establishing benchmark ERE assumptions.
Bureau of Labor Statistics, Provider Price Index (PPI)	Federal index of inflation across multiple industries for Medicaid populations. Updated monthly and includes data series for Residential Developmental Disability Homes, Home Health Care Services, and Nursing Care Facilities. Used for reference to understand annual inflation for provider costs and for recommendations on recurring rate updates.
Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component (MEPS-IC)	Federal data on health insurance costs, including Alaska-specific data regarding multiple aspects of health insurance (employer offer, employee take-up, premium and deductible levels, etc.). Used for reference in estimating health care costs for benchmark Employment Related Expenditures (ERE) assumptions.
Other State Medicaid Fee Schedules and Reimbursement Methodologies	Data from other states on reimbursement levels for similar services as well as overall service design. Used for peer state comparison and well as development of best-practice recommendations for improving supported employment service delivery.

F. Peer State Comparisons

F.1. Overview

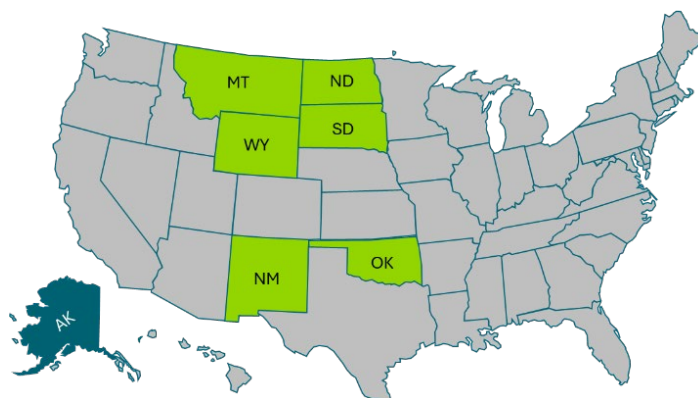
Guidehouse’s recommendations for the current study are comprised of existing approaches used in other states, and Guidehouse’s experience conducting similar studies and analyses in these states. Guidehouse gathered peer state data sources to assist the development of the rate build-up methodologies for comparable behavioral health services included in the rate study. Due to the uniqueness of every state’s Medicaid system, no state waiver or state plan is exactly comparable to similar waivers for a similar population in another state. However, it is helpful to compare waiver rates to similar waivers in other states to understand whether current rates represent an outlier, or whether differences can be explained by distinctive service definitions or economic conditions in the State.

Guidehouse appreciates that Alaska is unique among other states geographically, demographically, and culturally. Therefore, we were selective in identifying these peer states and the services within the states. We not only identified comparable states but then reviewed each service definition prior to comparison to help confirm the applicability and adequacy of comparison. As an example, when comparing residential services, it is important to understand the facility size and services offered within the facility to understand where differences could lie resulting in justifiably varied rates. These services also do not typically have an equivalent Medicare or commercial benchmark to use as a fair comparison, which in turn makes finding a Medicaid equivalent even more important.

F.2. Comparison Approach

First, Guidehouse identified states that had similarities to Alaska by demographics, geography, Medicaid program design, and scope of services offered for the behavioral health population. As seen in the map shown in **Figure 2**, Guidehouse researched the initial peer states marked in light green. Although Alaska is unique in comparison to the lower 48 states, the programs and services identified can serve as an initial benchmark for comparison.

Figure 2: Peer States for Rate Comparison



F.3. Comparison Results

In the realm of healthcare services, reimbursement rates are a critical aspect that significantly influence the accessibility and quality of care provided. Alaska, with its unique geographic and demographic characteristics, presents a distinctive case when it comes to service rates for various healthcare needs. This section aims to provide a comprehensive analysis of Alaska's reimbursement rates for several key services, comparing them to those of peer states.

When it comes to Autism services, Alaska's reimbursement rates fall towards the bottom of the spectrum compared to peer states. This positioning can have several implications for families and individuals seeking these essential services. Lower reimbursement rates may limit the availability of providers who are willing to offer their services within the state, potentially leading to longer wait times and reduced access to quality care. It is essential for Alaska to consider strategies that could raise these rates to ensure that individuals with Autism receive the support and interventions they need.

In stark contrast to Autism services, Alaska's reimbursement rates for Substance Use Disorder (SUD) residential treatment are at the top when compared to peer states. This higher rate of reimbursement is indicative of the state's recognition of the importance of addressing substance use issues through comprehensive residential treatment programs. High reimbursement rates can attract more providers to the state, enhance the quality of care, and provide individuals with the necessary resources to combat substance use disorders effectively.

For short-term crisis services, Alaska's reimbursement rates are positioned towards the middle-top end when compared to its peers. This indicates a balanced approach that ensures these critical services are adequately funded. Reimbursement rates that are competitive yet sustainable help in maintaining a steady influx of providers who can offer immediate, high-quality care during times of crisis. Such positioning ensures that individuals in crisis can receive timely and effective interventions.

Peer support services, which are an essential component of mental health and substance use recovery, also see Alaska positioned towards the top end of reimbursement rates compared to peer states. This favorable positioning reflects the state's commitment to integrating peer support within the broader healthcare system. Higher reimbursement rates for these services can enhance the sustainability of peer support programs, providing individuals with the necessary emotional and experiential support on their journey to recovery.

Alaska's reimbursement rates for psychotherapy are similarly positioned towards the middle-top end compared to peer states. This strategic positioning ensures that there is a viable market for psychotherapists, which in turn helps in maintaining a robust mental health service network. Competitive reimbursement rates are crucial for attracting and retaining qualified psychotherapists, reducing wait times, and improving the overall quality of mental health care.

Alaska presents a mixed landscape in terms of reimbursement rates for various healthcare services. While Autism services lag behind, indicating a need for potential restructuring of the current service model, other areas such as SUD residential treatment, short-term crisis services, peer support, and psychotherapy exhibit comparable reimbursement rates to their peers. However, the current Alaska rates being towards the top of some of these categories does not

automatically mean that they are an appropriate reimbursement amount. Given Alaska's complexities and various economic factors, all rates must be thoroughly evaluated and individually determined to ensure sound reimbursement amounts that enable providers to deliver quality care. To further enhance the accessibility and quality of care, Guidehouse has developed individual rate model build ups to calculate an accurate reimbursement rate.

Autism or Applied Behavior Analysis (ABA) Services

Autism or Applied Behavior Analysis (ABA) services play a critical role in supporting individuals with autism spectrum disorder, helping them develop essential skills and improve their quality of life. However, the reimbursement rates for these services can significantly impact their availability and utilization. In Alaska, the reimbursement rates for Autism (ABA) services are notably lower compared to peer states, which may potentially lead to a series of challenges in service delivery.

When comparing Alaska's reimbursement rates for Autism (ABA) services to those of peer states, it becomes evident that Alaska ranks on the lower end of the spectrum. States delivering similar services typically have higher reimbursement rates, which facilitates better access to and utilization of these essential services. Higher reimbursement rates in peer states enable providers to offer more comprehensive and sustained support to individuals with autism.

The low reimbursement rates in Alaska have been identified as a potential reason for the current low utilization of Autism (ABA) services in the state. Providers have noted that the financial constraints imposed by the low rates make it challenging to maintain high-quality service delivery, which in turn affects the availability and accessibility of these services to the affected population. Consequently, families and individuals in Alaska might face greater difficulty in accessing the support they need. During the rate modeling process, these low rates were thoroughly examined, and efforts were made to develop rates that now align with those of peer states.

The comparison of Autism (ABA) services reimbursement rates between Alaska and peer states underscores the challenges faced by providers and individuals due to low rates. By aligning the rates with those of peer states, Alaska aims to improve service utilization and ensure that individuals with autism can access the support they need. The rate modeling process has built a foundation for better service delivery, addressing the concerns raised by providers and paving the way for enhanced Autism (ABA) services in the state. Current rates for family adaptive behavior treatment guidance by qualified health care professional (with or without patient present) and behavioral identification assessment by qualified health care professional are shown in **Figure 3** and **Figure 4** below to demonstrate the current state of Autism services in Alaska.

Figure 3: Family Adaptive Behavior Treatment Guidance by Qualified Health Care Professional (with or without Patient Present) (97156)

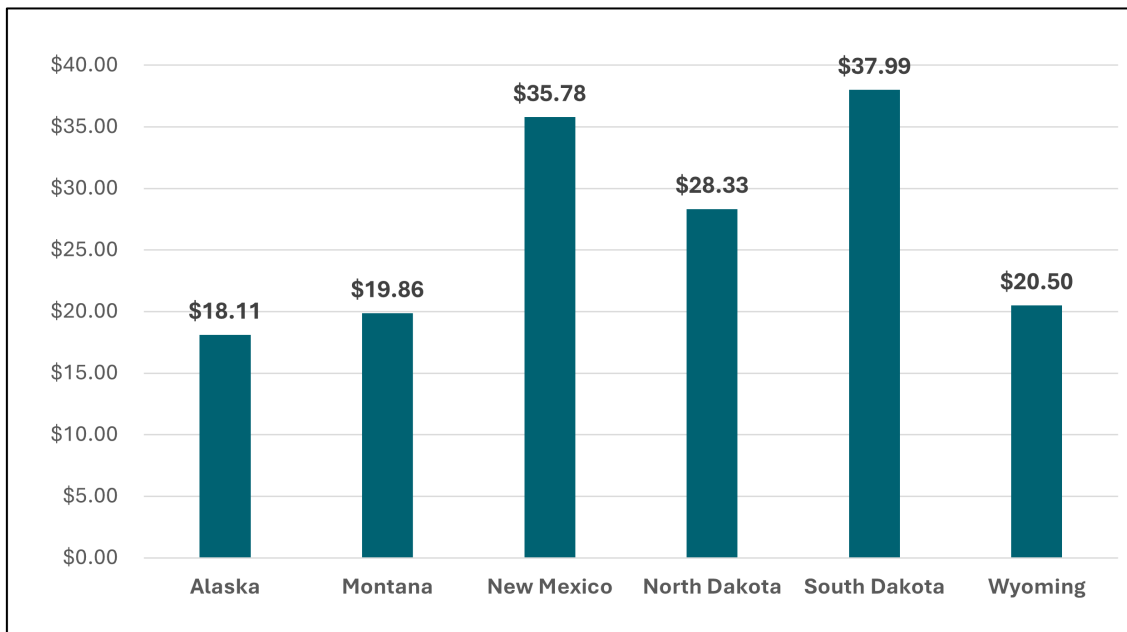
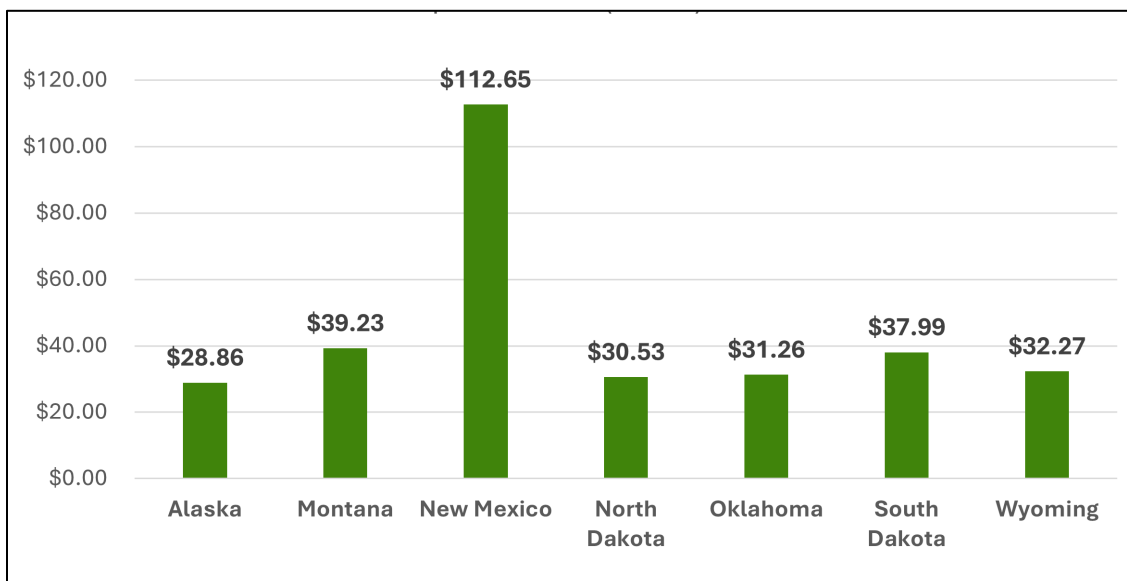


Figure 4: Behavioral Identification Assessment by Qualified Health Care Professional (97151)

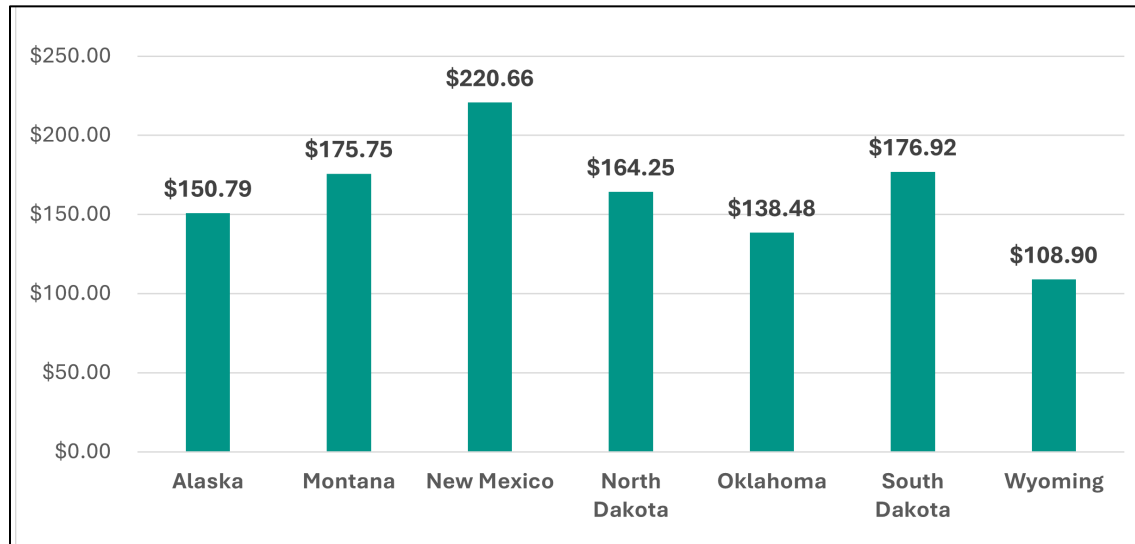


Clinic “UPL” Services

Psychotherapy services across the United States are generally governed by guidelines set by the Upper Payment Limit (UPL). These guidelines help ensure that service rates are consistent and fair. However, the rates for both individual and group psychotherapy services can vary significantly between states.

In Alaska, the rates for individual psychotherapy services are competitive, standing in the middle amongst their peers. Compared to other states, Alaska's rates are on par with many, reflecting a balanced approach in setting these rates. See **Figure 5** below.

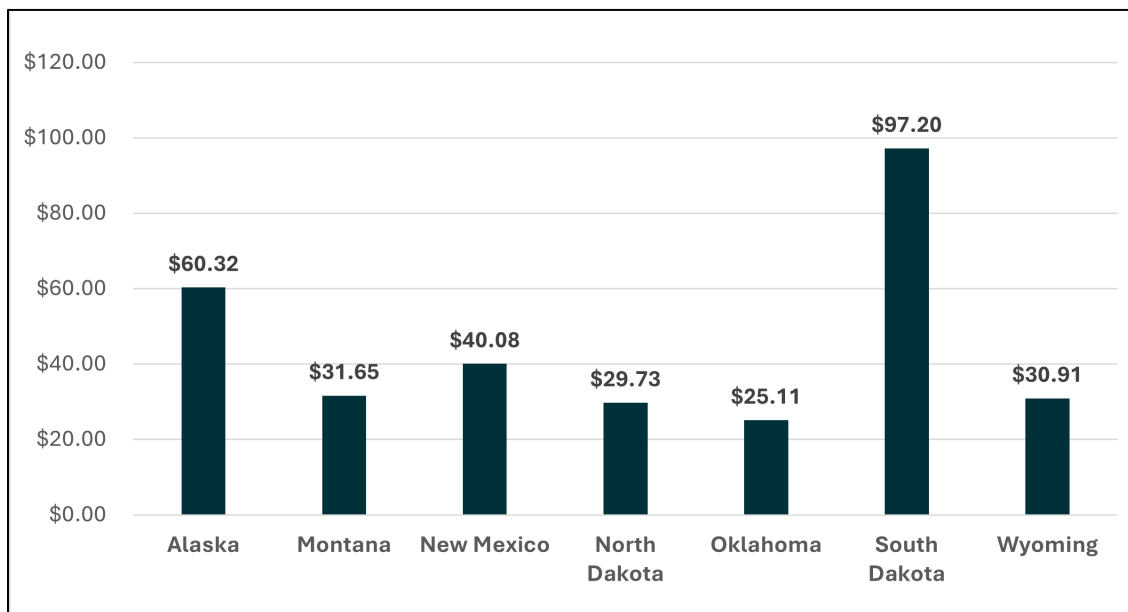
Figure 5: Psychotherapy, Individual (90837)



The story of group psychotherapy service rates in Alaska, however, paints a different picture. Outside of South Dakota, Alaska's group rate is nearly double or triple the amount in some cases of their peer states. See **Figure 6** below.

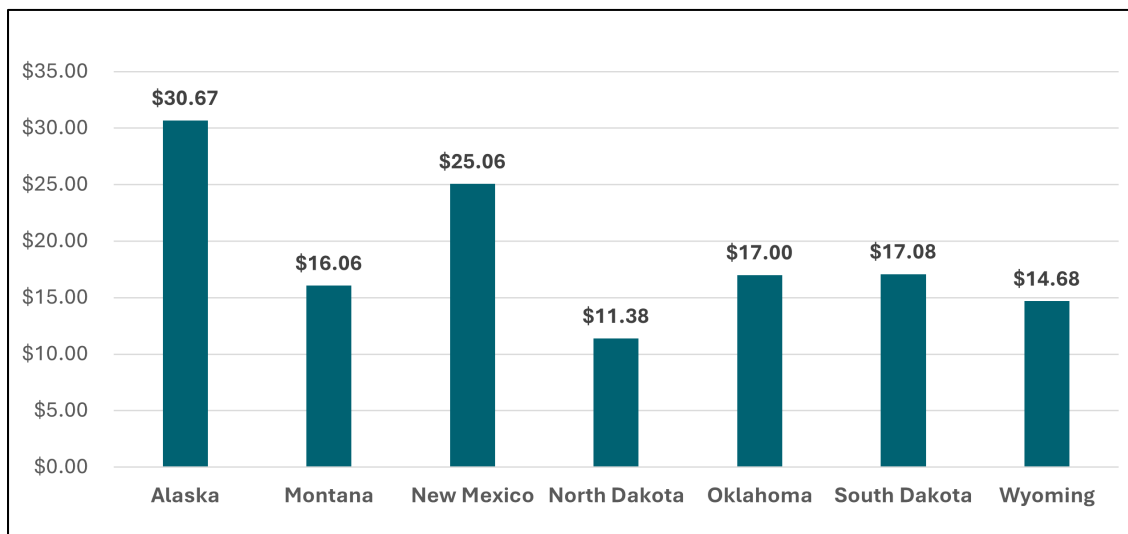
Understanding the significance of these rate differences is crucial. The rate models were designed to determine what an appropriate group size should be to build into the rate structures. This peer state analysis allowed Guidehouse to identify areas where potential recalibration is needed to ensure that rates are fair and justifiable.

Guidehouse's analysis revealed the necessity to evaluate the appropriate group size to build into the rate models. By evaluating the high rates in Alaska, they can pinpoint where adjustments may benefit both providers and patients. Ensuring that rates are not excessively high is vital for maintaining the accessibility and effectiveness of group psychotherapy services.

Figure 6: Group Psychotherapy (Other than Multi-Family Group) (90853)


General Community Services

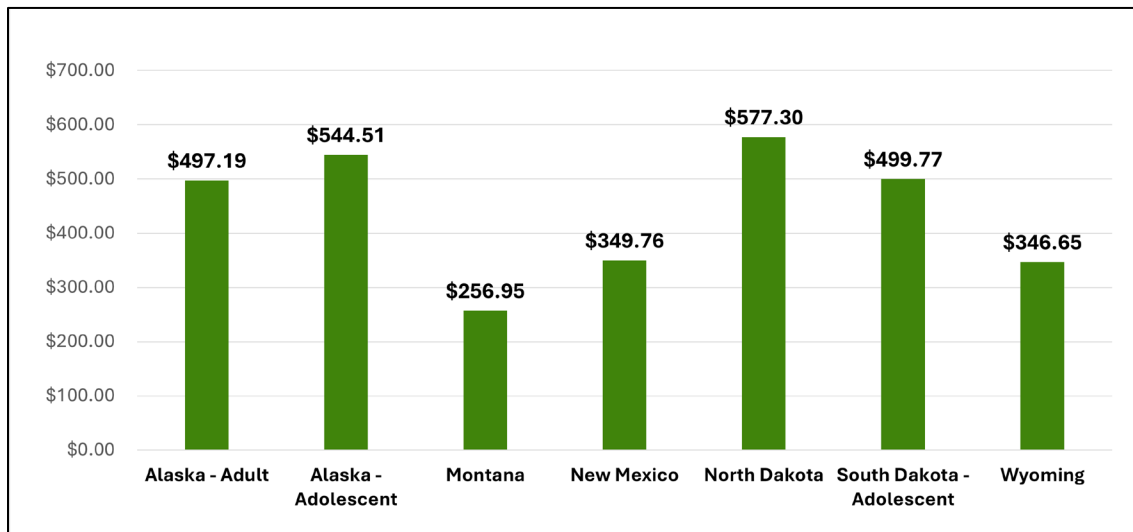
The comparison of Peer Support Services revealed that Alaska's are significantly higher than those of its peer states. This discrepancy indicates that there may be unique factors at play in Alaska that influence the demand and delivery of these services. However, it also raises questions about the alignment and effectiveness of the services currently being offered. When looking through the Alaska Behavioral Health service array the higher rates for peer support services in Alaska suggest a potential need for recalibrating similar types of services. For example, although CRSS is not identical to peer support services, the current rates in Alaska indicate significant differences between the two. This is an area Guidehouse explored during our rate study process to ensure that there is uniform alignment where necessary amongst services. See **Figure 7** for the peer state comparison for Peer Support Services.

Figure 7: Peer Support Services Individual (H0038)


ASAM, Intensive Outpatient, and Partial Hospitalization Services

When examining the peer state results for American Society of Addiction Medicine (ASAM), Intensive Outpatient, and Partial Hospitalization Services, a variety of outcomes emerged. These results proved to be crucial in informing our rate study and provided valuable insights into Alaska's current standing and the necessary adjustments.

In another scenario, the evaluation of ASAM 3.5 (Adult) services placed Alaska in the middle-high range among the peer states. This positioning indicated a relatively balanced approach but also suggested room for refinement to ensure optimal service delivery and reimbursement rates. Being in the middle-high range means Alaska is competitive but might still need minor adjustments to align more closely with the best practices observed in other states. See **Figure 8** for the ASAM 3.5 comparison.

Figure 8: ASAM 3.5, SUD Residential (Adult) (H0047 TG V1)


Crisis Services

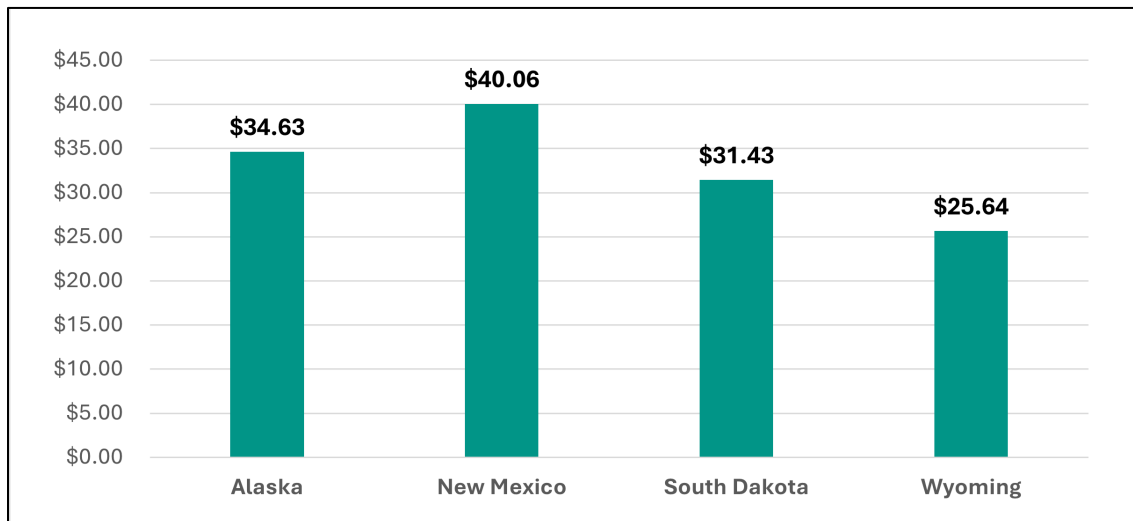
Short-Term Crisis Stabilization services are critical components of mental health care, providing immediate support and intervention for individuals experiencing acute mental health crises. An evaluation of these services in Alaska has revealed that the state's current rates are comparable to those of its peer states, highlighting the effectiveness and efficiency of Alaska's crisis response mechanisms.

One of the significant aspects of the evaluation was the examination of reimbursement rates for Short-Term Crisis Stabilization services. The current reimbursement structure in Alaska has proven to be beneficial in sustaining these services. It ensures that providers are adequately compensated, which in turn encourages the maintenance and improvement of service quality.

The existing reimbursement rates for Short-Term Crisis Stabilization services play a crucial role in the expansion and establishment of other crisis services across the state. The financial stability provided by current reimbursements allows for the development of a comprehensive crisis response system, which includes various services such as mobile crisis teams, crisis residential services, and crisis intervention training.

Moreover, the current reimbursement structure is instrumental in supporting the expansion and establishment of additional crisis services. By providing financial stability and encouraging the development of a robust mental health care infrastructure, Alaska is well-positioned to offer comprehensive and accessible crisis support to its residents. See **Figure 9** below to see the peer state results for this service.

Figure 9: Short Term Crisis Stabilization (H2011)



G. Rate Methodologies and Components

G.1. Overview of Rate Methodologies

Guidehouse employed an independent rate build-up approach to develop payment rates for covered services. The independent rate build-up strategy allows for fully transparent models that consider the numerous cost components that need to be considered when building a rate. The foundation of the independent rate build-up is direct care worker wages and benefits, which comprise the largest percentage of costs for these services while also considering the service design and additional overhead costs that are necessary to be able to provide the service. This approach:

- Uses a variety of data sources to establish rates for services that 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 care and services are available to the general population in the geographic area.” -1902(a)30(A) of the Social Security Act (SSA)
- Relies primarily on credible data sources and reported cost data (i.e., costs are not audited, nor are rates compared to costs after a reporting period and adjusted to reflect those costs)
- Makes additional adjustments to rates to reflect state-specific policy goals – for example, incenting specific kinds of services.

The rate build-up approach is commonly used by states for setting rates and is an approach recognized as compliant with CMS regulations and guidelines. This approach also yields a transparent rate methodology, allowing DOH to clearly delineate the components that contribute to rates and adjust as needed.

The values for each component of the rate models were calculated, and rates were built from the bottom up for each of the services included in the rate study. Guidehouse determined each cost component associated with the direct care provided for a service (for example, direct service professional wages and benefits), identified the corresponding payment amount(s), and added on payment amounts reflecting administration and program support costs required to deliver the service.

Many of the service rate benchmarks we propose follow a series of general assumptions for the components of each rate, adjusted according to the specific context and goals for providing each service. This rate build-up approach is based on a core set of wage assumptions for direct care staff, supplemented by estimates of the cost of other supporting staff, activities and materials needed to support direct care provision. In this section of the report, we describe in detail the methodology for calculating various components used in the rate models. In addition, we describe the data sources used to determine the component.

The section is divided into the following areas:

- Staff Wages
- Employment Related Expenditures (ERE)
- Productivity of Direct Care Staff
- Occupancy
- Supervision
- Staffing Ratios
- No-Show Adjustment
- Administrative Expenses
- Program Support Expenses

G.2. General Cost Assumptions

The methodology for developing a rate for a unit of service – or a rate model – varies across types of services but generally includes certain key components. A rate model starts with the wage for the primary staff person providing a service and then building upon that wage with fixed or variable cost factors to account for additional program support costs.

Typical components of a rate methodology or rate model include:

- Direct Care Compensation Costs
 - Staff Wage Costs
 - Employment Related Expenditures (ERE)
 - Supervision Costs
- Billing Adjustments to Direct Care Compensation Costs
 - Billable vs Non-Billable Time (Productivity) of Direct Service Staff
 - Travel Expense (if applicable)
- Administrative Expenses
- Program Support Expenses

Together, these components sum to a unit rate designed to reimburse a provider organization for all inputs required for quality service delivery. This approach is often called an “independent rate build-up” approach because it involves several distinct rate components whose costs are captured independently through a variety of potential data sources. These costs are essentially “stacked” together into a collective cost per unit that defines the rate needed for cost coverage. Table 13 illustrates the “building block” structure of Guidehouse’s rate development methodology. Although individual rates may incorporate different building blocks, each rate model follows a similar process for identifying the component blocks for inclusion, based on the service requirements and specific adjustments needed to align overall costs with the appropriate billing logic and units of service.

Table 13: Overview of Rate Components*

Direct Care Cost	Calc	Indirect Cost	Calc	Other Rate Model Adjustments	Calc	Result
Cost for Direct Care Services - Wages (Provider Survey & BLS) - Benefits (GH ERE Model & MEPS) - Adjusted by billable time, as applicable (Provider Survey, State documentation) Supervisory Direct Care Cost - Wages (Provider Survey & BLS) - Benefits (GH ERE Model & MEPS) Adjusted by supervisor hours	+	Admin Cost: Average of ratio derived for each provider based on unique admin and direct care costs for all services Program Support Wages and Direct Care-Related Costs: Ratio of program staff salaries and wages and costs related to training, development, technology and activities Supply Cost: Ratio of total supply cost to total direct care cost for services across all providers Transportation Cost: Ratio of total transportation and vehicle costs to total direct care cost for services across all providers Percentages are calculated to reflect indirect cost components relative to direct care costs, not as a percentage of the total rate.	+	Staff Mileage Acuity Adjustments Stipend Values	=	Service Rate Per Unit of Measurement
	(Plus)		(Plus)		(Equals)	

*Varies based on service categories

G.2.1. Staff Wages

Wages for direct care staff form the largest component of any rate model, as many of the services for which Guidehouse developed rate models depend substantially on the labor time of the qualified, dedicated staff who provide care for behavioral health services. To best understand the landscape of wages in Alaska, we used data from the cost and wage survey reported by provider organizations.

As part of the cost and wage survey, each responding provider reported average hourly or “baseline” wages in addition to overtime, shift differential and other forms of supplemental pay, as well as inflationary trends in wages and other wage or salary-related information. The staff types with the highest number of Full-Time Equivalents (FTE) reported in the survey were Residential Workers, Case Managers, Behavioral Specialist/Technician, and Behavioral Health Aides, with almost 800 FTEs between the four job categories. Direct Care Personnel, Technicians, Aides, and similar staff types are often the foundation of direct care in the study population, as evidenced by the number of positions reflected in the survey responses. However, there are additional staff that are commonly considered when building out models to account for the appropriate credentialing and licensing required to provide some of these services. The baseline wages represented in **Table 14** do not include inflationary factors or supplemental pay and are representative of the time period requested within the survey, April 2024-June 2024.

Table 14: Average Hourly Wage Reported in Cost and Wage Survey, Weighted by FTEs

Staff Type List	Survey Average FTE Weighted Hourly Wage	FTEs ²
Residential Worker	\$20.96	265.00
Case Manager	\$26.97	222.50
Behavioral Specialist/Technician	\$25.76	166.87
Behavioral Health Aide	\$21.23	114.10
Clinical Non-Licensed	\$31.38	99.10
Licensed Professional Counselor	\$42.78	96.53
Behavioral Health Manager/Supervisor/Director	\$45.27	78.56
Therapist/Social Worker	\$34.40	70.43
Program Manager/Director	\$39.73	69.00
Counselor	\$37.90	67.64
Clinical Specialist	\$33.37	61.55
Registered Nurse (RN)/Nurse	\$48.68	54.31
Licensed Clinical Social Worker (LCSW)	\$45.12	51.22
Nurse Practitioner	\$74.76	49.15
Floor Supervisor	\$27.58	45.00
Clinical Director	\$54.92	37.65
Licensed Clinician	\$19.18	36.20
Clinical Supervisor	\$46.67	36.05
Certified Peer Support Specialist	\$21.47	34.00
Certified Nurse Assistant (CNA)	\$28.58	31.49
Other Manager/Supervisor/Director	\$36.46	29.00
Care Coordinator	\$27.49	20.06
Admissions Manager	\$25.13	15.00
Physician	\$153.87	14.23
Licensed Addiction Counselor	\$29.84	13.84
Medical Director	\$193.05	12.01
Certified Medication Assistant/Medication Aide	\$25.69	11.00
Detox Director/Supervisors	\$48.42	11.00
Psychologist	\$65.02	8.80
Psychiatrist	\$148.12	7.86
Licensed Practical Nurse (LPN)	\$37.41	6.30
Physician Assistant (PA)	\$73.28	5.78

² Removed Occupations that have less than 5 FTEs from the tables above

For all staff types, Guidehouse applied a weighting of reported wages by the number of FTEs, then compared that wage to mean benchmark wages reported by the Bureau of Labor Statistics, Occupational Employment and Wage Statistics (BLS OEWS). Guidehouse first looked at the BLS OEWS specific to Alaska. However, given stakeholder feedback on the difficulty of hiring qualified behavioral healthcare workers in the current marketplace, Guidehouse also looked at the national BLS OEWS wages. Guidehouse, in agreement with DOH and the provider workgroup opted to choose the survey-weighted average wages over the BLS wages within our rate models. This decision was consistent with feedback from the provider workgroup, which emphasized that BLS data often underrepresents actual wage costs in Alaska. The survey wages more accurately reflect the unique labor market conditions and hiring challenges providers face across the state. As BLS wages are not current, we applied inflation by using the BLS wage trends for Outpatient Mental Health and Substance Abuse centers to be able to compare the BLS wages to the wages reflected in the provider cost and wage survey. Therefore, the May 2023 BLS wages were inflated by **2.1 percent** to match the same time period of data request in the provider cost and wage survey. **Table 15** shows the BLS Job Type used for each of the direct care jobs listed within the survey with the Alaska specific mean wage compared to the national mean wage to illustrate that for almost every job type comparison the Alaska wages are higher than the national.

Table 15: Bureau of Labor Statistics Alaska and National Comparison

Survey Staff Type List	BLS Job Type	Alaska Survey Average Hourly Wage	Alaska Mean Hourly Wage BLS ³	National Mean Hourly Wage BLS ⁴	Alaska BLS vs. National BLS Percent Difference	Alaska Survey vs. Alaska BLS Percent Difference
Behavior Analyst	Substance Abuse, Behavioral Disorder, and Mental Health Counselors	\$39.61	\$38.01	\$29.50	28.8%	4.2%
Behavioral Health Aide	Community Health Workers	\$21.23	\$29.08	\$25.83	12.6%	-27.0%
Behavioral Specialist/Technician	Psychiatric Technicians	\$25.76	\$23.01	\$21.43	7.4%	12.0%
Care Coordinator	Healthcare Support Workers, All Other	\$27.49	\$30.65	\$27.21	12.6%	-10.3%
Care Coordinator	Mental Health and Substance Abuse Social Workers	\$27.49	\$30.65	\$27.21	12.6%	-10.3%
Case Manager	Healthcare Support Workers, All Other	\$26.97	\$30.65	\$27.21	12.6%	-12.0%

³ Inflated by 2.1%

⁴ Inflated by 2.1%

Survey Staff Type List	BLS Job Type	Alaska Survey Average Hourly Wage	Alaska Mean Hourly Wage BLS ³	National Mean Hourly Wage BLS ⁴	Alaska BLS vs. National BLS Percent Difference	Alaska Survey vs. Alaska BLS Percent Difference
Case Manager	Mental Health and Substance Abuse Social Workers	\$26.97	\$30.65	\$27.21	12.6%	-12.0%
Certified Fitness Coach	Healthcare Support Workers, All Other	\$31.13	\$30.04	\$23.07	30.2%	3.6%
Certified Medication Assistant/Medication Aide	Medical Assistants	\$25.69	\$25.78	\$21.28	21.1%	-0.3%
Certified Nurse Assistant (CNA)	Nursing Assistants	\$28.58	\$23.11	\$19.44	18.9%	23.7%
Certified Peer Support Specialist	Healthcare Support Workers, All Other	\$21.47	\$30.04	\$23.07	30.2%	-28.5%
Clinical Non-Licensed	Healthcare Support Workers, All Other	\$31.38	\$30.04	\$23.07	30.2%	4.5%
Clinical Specialist	Healthcare Support Workers, All Other	\$33.37	\$30.04	\$23.07	30.2%	11.1%
Counselor	Substance Abuse, Behavioral Disorder, and Mental Health Counselors	\$37.90	\$38.01	\$29.50	28.8%	-0.3%
Detox Technician	Psychiatric Technicians	-	\$23.01	\$21.43	7.4%	-
Driver/Transportation	Shuttle Drivers and Chauffeurs	\$23.90	\$20.54	\$18.12	13.4%	16.4%
Licensed Addiction Counselor	Mental Health and Substance Abuse Social Workers	\$29.84	\$31.26	\$31.35	-0.3%	-4.5%
Licensed Clinical Social Worker (LCSW)	Substance Abuse, Behavioral Disorder, and Mental Health Counselors	\$45.12	\$38.01	\$29.50	28.8%	18.7%
Licensed Marriage and Family Therapist (LMFT)	Marriage and Family Therapists	\$45.50	\$36.53	\$33.73	8.3%	24.6%
Licensed Practical Nurse (LPN)	Licensed Practical and Licensed Vocational Nurses	\$37.41	\$36.45	\$29.84	22.2%	2.6%

Survey Staff Type List	BLS Job Type	Alaska Survey Average Hourly Wage	Alaska Mean Hourly Wage BLS ³	National Mean Hourly Wage BLS ⁴	Alaska BLS vs. National BLS Percent Difference	Alaska Survey vs. Alaska BLS Percent Difference
Licensed Professional Counselor	Substance Abuse, Behavioral Disorder, and Mental Health Counselors	\$42.78	\$38.01	\$29.50	28.8%	12.5%
Nurse Practitioner	Nurse Practitioners	\$74.76	\$61.93	\$63.08	-1.8%	20.7%
Physician	Physicians, All Other	\$153.87	\$139.52	\$122.05	14.3%	10.3%
Physician Assistant (PA)	Physician Assistants	\$73.28	\$72.89	\$64.06	13.8%	0.5%
Psychiatrist	Psychiatrists	\$148.12	\$81.58	\$126.12	-35.3%	81.6%
Psychologist	Clinical and Counseling Psychologists	\$65.02	\$53.65	\$52.33	2.5%	21.2%
Registered Nurse (RN)/Nurse	Registered Nurses	\$48.68	\$53.61	\$46.37	15.6%	-9.2%
Residential Worker	Residential Advisors	\$20.96	\$20.92	\$19.74	6.0%	0.2%
Therapist/Social Worker	Substance Abuse, Behavioral Disorder, and Mental Health Counselors	\$34.40	\$38.01	\$29.50	28.8%	-9.5%

G.2.2. Inflation Factors

We also consulted federal data in tandem with survey data to understand how wages and costs have trended over recent years. Inflationary metrics were calculated based on the most recent data available at the time of rate development and data collection. As inflation is an ever-changing metric we encourage state agencies to review these metrics and potentially adjust closer to the true rate implementation date. **Table 16** includes the most recent growth rate from each source, which includes:

- **BLS Producer Price Index (PPI).** The BLS publishes a PPI for Medicaid populations including psychiatric and substance abuse hospitals which are specific to the populations and services in scope for this study. The most recent PPI data from Calendar Year (CY) 2023 – January 2024 through August 2024 Produces an annual growth rate of 3.2 percent.
- **BLS Current Employment Statistics (CES).** The BLS also publishes CES data which looks at wages rather than overall industry costs compared to PPI. Across relevant employee categories (e.g., Outpatient Mental Health and Substance Abuse Centers), CY2023 to CY2024 trends show an annual growth rate in earnings of 2.1 percent.

- **Cost and Wage Survey.** Responding provider organizations recorded the average growth rate of earnings between CY2021 and CY2022, CY2022 and CY2023, and CY2023 and CY2024Q2 for their staff. The mean growth rate was roughly 3.0 percent in annual wages reported in the survey between CY2021 and CY2024 Q2 which aligns with industry trends such as the BLS PPI and CES.

Table 16: Sources of Growth Rates in Relevant Costs and Wages

Source	Time Period	Growth Rate
Bureau of Labor Statistics (BLS) Producer Price Index (PPI) for Psychiatric and Substance Abuse Hospitals	Avg. CY2023-Avg.CY2024 ⁵	3.2%
Bureau of Labor Statistics (BLS) Current Employment Statistics (CES) Average for Outpatient Mental Health and Substance Abuse Centers	CY2023-CY2024	2.1%
Alaska Behavioral Health Provider Cost and Wage Survey	CY2021-CY2024Q2	3.0%

To align potential growth in costs during CY2024 and to account for economic and labor conditions that may reflect the future cost of service delivery, our wage assumptions include the growth rate from the Bureau of Labor Statistics (BLS) Current Employment Statistics (CES) Average for Outpatient Mental Health and Substance Abuse Centers of **2.1 percent**. Applying an inflationary impact to wages accounts for the difference in the survey time period versus when the rates may go into effect. If rate implementation is at a later date, this assumption may need to be revisited.

G.2.3. Overtime and Other Supplemental Pay

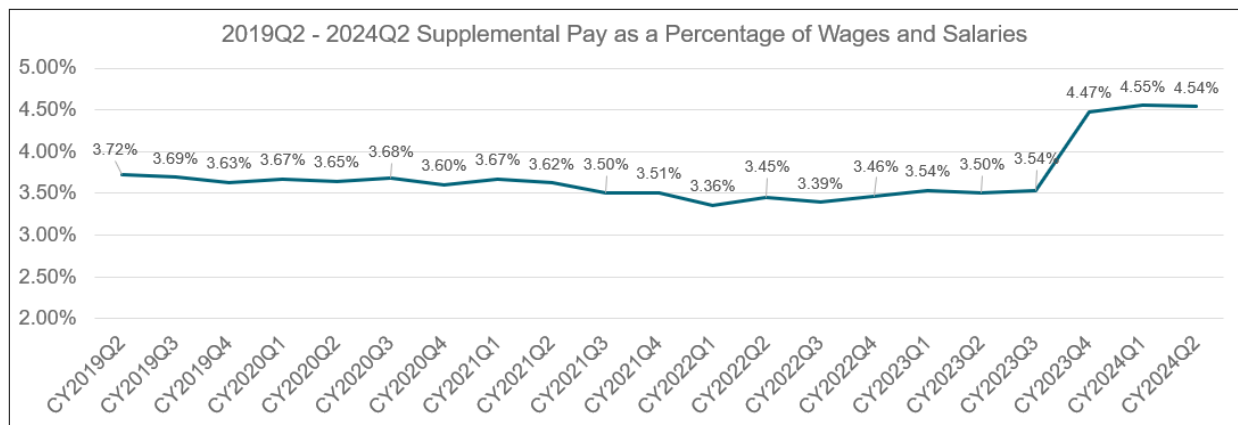
Supplemental pay is inclusive of costs such as overtime wages, shift differentials, holiday pay, and non-production bonuses on top of compensation from regularly earned wages. Guidehouse asked providers to report the supplemental pay within their organization in the provider cost and wage survey. In analyzing survey results, Guidehouse calculated a supplemental pay percentage of 1.73 percent by dividing total supplemental pay reported by total wages for each provider (excluding outlying providers for which this percentage was over 15 percent).

We again consulted federal data from the BLS Employer Costs for Employee Compensation (ECEC) quarterly data series for the Health Care and Social Assistance Industry, which divides costs into hourly wages as well as expense categories related to mandatory taxes and benefits, insurance, retirement, paid time off, supplemental pay, and other benefits. In the second calendar year quarter of 2024 (CY2024 Q2) – the same time period as requested in the cost and wage survey – supplemental pay for the selected labor category equaled 4.54 percent of the average hourly wage, which is a deviation from the previous four years which hovered around 3.5 percent. To account for the recent change in supplemental pay Guidehouse used the two-year average supplemental pay

⁵ The 2024 Average PPI value for Psychiatric and Substance Abuse Hospitals is for the January through August 2024 time period as that was the most recent data available at the time of the calculation.

percentage of **3.87 percent** to account for most recent pay rates, as supplemental pay information collected through the survey deviates from the most recent historical *and* industry trends and comes from a potentially unrepresentative sample. **Figure 10** shows the national supplemental pay percentages over the last 5-year period where there is a notable increase in the recent years. The BLS ECEC data includes all supplemental cost components integral to overall compensation, and the data provides consistent and periodic trends that can be used to project a future state. As illustrated within the figure, there is an increase in supplemental pay starting in CY2023Q4.

Figure 10: Supplemental Pay Over Time



G.2.4. Final Wage Adjustments

Our benchmark wage assumptions are computed by adding supplemental pay as a function of wage and labor costs and then inflating the survey weighted average hourly wages with supplemental pay to reflect growth in costs, as demonstrated in **Table 17**.

Table 17: Calculation of Wage Adjustment Factors

Result	Calc	No. 1: Baseline Q2 CY2024 Weighted Average	Calc	No. 2: Supplemental Pay	Calc	No. 3: Inflation Adjustment
Preliminary Benchmark Hourly Wage	= (Equals)	Alaska Provider Cost and Wage Survey April 2024-June 2024 Hourly Wage Weighted based on Number of FTEs	+ (Plus)	2022Q2-2024Q2 Two-year Average BLS Supplemental Pay as a Percentage of Wages	= (Equals)	BLS 2023-2024 Average Wage Trend for Outpatient Mental Health and Substance Abuse Centers Inflation

For example, using the Behavioral Health Aide weighted baseline wage from the survey of \$21.23 (as discussed above), Guidehouse added a 3.87 percent supplemental pay factor which amounts to \$0.82, or a total of \$22.05. From the supplemental pay adjusted wage we then added a 2.10 percent inflation adjustment of \$0.46, which brought the projected total hourly wage to \$22.52 for Behavioral Health Aides. **Table 18 and Table 19** completes this equation for each job type and also includes the number of FTEs for each job type as reported in the cost and wage survey.

Table 18: Benchmark Wage Recommendations- Direct Care

Job Type	FTEs	Baseline Wage	Survey FTE- Weighted Hourly Wages (Baseline + 3.87% Supp. Factor)	Supplemental Pay Adjusted Hourly Wage (Supp. Adjusted Hourly Wage + 2.10% Inflation)
Behavior Analyst	3.0	\$39.61	\$41.15	\$42.01
Behavioral Health Aide	114.1	\$21.23	\$22.05	\$22.52
Behavioral Specialist/Technician	166.9	\$25.76	\$26.76	\$27.32
Care Coordinator	20.1	\$27.49	\$28.55	\$29.15
Case Manager	222.5	\$26.97	\$28.01	\$28.60
Certified Fitness Coach	2.0	\$31.13	\$32.33	\$33.01
Certified Medication Assistant/Medication Aide	11.0	\$25.69	\$26.68	\$27.24
Certified Nurse Assistant (CNA)	31.5	\$28.58	\$29.69	\$30.31
Certified Peer Support Specialist	34	\$21.47	\$22.30	\$22.77
Clinical Non-Licensed	99.1	\$31.38	\$32.60	\$33.28
Clinical Specialist	61.6	\$33.37	\$34.66	\$35.38
Counselor	67.6	\$37.90	\$39.36	\$40.19
Driver/Transportation	4.0	\$23.90	\$24.82	\$25.35
Licensed Addiction Counselor	13.8	\$29.84	\$30.99	\$31.65
Licensed Clinical Social Worker (LCSW)	51.2	\$45.12	\$46.87	\$47.85
Licensed Marriage and Family Therapist (LMFT)	2.0	\$45.50	\$47.26	\$48.25
Licensed Practical Nurse (LPN)	6.3	\$37.41	\$38.86	\$39.68
Licensed Professional Counselor	96.5	\$42.78	\$44.44	\$45.37
Nurse Practitioner	49.2	\$74.76	\$77.65	\$79.29

Job Type	FTEs	Baseline Wage	Survey FTE- Weighted Hourly Wages (Baseline + 3.87% Supp. Factor)	Supplemental Pay Adjusted Hourly Wage (Supp. Adjusted Hourly Wage + 2.10% Inflation)
Physician	14.2	\$153.87	\$159.83	\$163.18
Physician Assistant (PA)	5.8	\$73.28	\$76.12	\$77.72
Psychiatrist	7.9	\$148.12	\$153.85	\$157.09
Psychiatrist (Adolescent Services)	5.0	\$151.55	\$157.41	\$160.72
Psychiatrist (Adult Services)	4.3	\$174.43	\$181.18	\$184.98
Psychologist	8.8	\$65.02	\$67.54	\$68.96
Registered Nurse (RN)/Nurse	54.3	\$48.68	\$50.57	\$51.63
Residential Worker	265.0	\$20.96	\$21.77	\$22.23
Therapist/Social Worker	70.4	\$34.40	\$35.74	\$36.49

In addition, **Table 19** displays the wage build up for supervision positions with the same supplemental pay and inflation applied.

Table 19: Benchmark Wage Recommendations – Supervisory Jobs

Job Type	FTEs	Baseline Wage	Survey FTE- Weighted Hourly Wages (Baseline + 3.87% Supp. Factor)	Supplemental Pay Adjusted Hourly Wage (Supp. Adjusted Hourly Wage + 2.10% Inflation)
Admissions Manager	15.0	\$25.13	\$26.11	\$26.65
Behavioral Health Manager/Supervisor/Director	78.6	\$45.27	\$47.02	\$48.01
Clinical Director	37.7	\$54.92	\$57.04	\$58.24
Clinical Supervisor	36.1	\$46.67	\$48.47	\$49.49
Counselor Director/Supervisor	3.0	\$44.41	\$46.13	\$47.10
Detox Director/Supervisors	11.0	\$48.42	\$50.29	\$51.35
Floor Supervisor	45.0	\$27.58	\$28.65	\$29.25
Licensed Clinical Social Worker (LCSW) Supervisor	1.0	\$58.00	\$60.24	\$61.51
Medical Director	12.01	\$193.05	\$200.52	\$204.73
Nurse Manager/Supervisor/Director	3.66	\$48.18	\$50.04	\$51.09

Job Type	FTEs	Baseline Wage	Survey FTE- Weighted Hourly Wages (Baseline + 3.87% Supp. Factor)	Supplemental Pay Adjusted Hourly Wage (Supp. Adjusted Hourly Wage + 2.10% Inflation)
Other Manager/Supervisor/Director	29.0	\$36.46	\$37.87	\$38.66
Program Manager/Director	69.0	\$39.73	\$41.27	\$42.14

G.2.5. Employee-Related Expenses

Total compensation includes wages as well as employment-related expenses (ERE) – for example, Behavioral Health Aides earn not only their wages over the course of the year, but also receive benefits such as days off, health insurance, and employer retirement contributions. These ERE or fringe benefits include legally required benefits, paid time off, and other benefits such as health insurance.

- **Legally required benefits** include federal and state unemployment taxes, federal insurance contributions to Social Security and Medicare, and workers’ compensation. Employers in Alaska pay a federal unemployment tax (FUTA) of 6.00 percent of the first \$7,000 in wages and state unemployment tax (SUTA) of a 1.00 percent employer rate and a 0.50 percent rate for employees for a total rate of 1.50 percent for healthcare and social service industry of the first \$49,700 in 2024 wages.⁶ Generally, if an employer pays wages subject to the unemployment tax, the employer may receive a credit of up to 5.40 percent of FUTA taxable wages, yielding an effective FUTA of 0.60 percent. Employers pay a combined 7.65 percent rate of the first \$168,600 in wages for Social Security and Medicare contributions as part of Federal Insurance Contributions Act (FICA) contributions. Per the cost and wage survey, employers in Alaska pay an average effective tax of 1.40 percent toward workers’ compensation insurance.
- **Paid time off (PTO) components of ERE** include holidays, sick days, vacation days, and personal days. The average aggregate number of paid days off per year, per the cost and wage survey, was 32.5 days total. As PTO benefits only apply to full-time workers, the daily value of this benefit is multiplied by a part time adjustment factor, which represents the proportion of the workforce which works full-time for the provider organizations responding to the cost and wage survey.
- **Other benefits in ERE** include retirement, health insurance, and dental and vision insurance. Other benefits are also adjusted by a part time adjustment factor, as well as a take-up rate specific to each benefit type which represents the proportion of employees who actually utilize the benefit.

Not all providers who responded to the provider cost and wage survey have historically offered a “full” or competitive benefits package. To determine competitive contributions for benefits which

⁶ Alaska Unemployment Insurance Tax Rates For New (Industry) Employers, 2024. Available online: [2024_Industry_rates.pdf](#)

are not legally required, Guidehouse analyzed paid time off components in aggregate and data on other benefits only from providers *who contribute to their full-time employees' benefits*. Analyzing these contributions and take-up rates for providers offering “other benefits” yielded median annual contributions per employee.

We compared benefits information reported in the survey to the publicly available Medical Expenditure Panel Survey (MEPS). MEPS is a set of large-scale surveys of families and individuals, their medical providers, and employers across the United States. MEPS is the most complete source of data on the cost and use of health care and health insurance coverage. During this comparison we found the average monthly premium reported in the State of Alaska was \$1,027.93 after applying an inflation factor. This came in slightly lower than the average of \$1,165.75 reported in the survey. Guidehouse ultimately decided to use the survey information over the MEPS data. The provider survey data was a better source for health insurance costs than the Medical Expenditure Panel Survey (MEPS) for behavioral health services in Alaska because MEPS does not account for the unique rural and frontier areas within Alaska. In contrast, the provider survey captured current, localized cost data directly from behavioral health providers operating in Alaska, offering a more accurate and relevant reflection of actual insurance reimbursement rates and service delivery costs within the state’s unique context. However, reported information in the survey was largely in line with costs identified in the MEPS data, corroborating the accuracy of the benefits data submitted by providers and confirming the applicability of the MEPS data as an appropriate benchmark for identifying health insurance costs. This assumption is in line with our other assumptions of vision insurance, dental insurance, and other benefits which come from information reported through the cost and wage survey.

Table 20 lists the components of ERE and calculates an example ERE percentage for a Behavioral Health Aide using our wage recommendations. Calculating each ERE component as a percentage of the annual wage assumption for Behavioral Health Aides, or \$44,161 per year, yielded a competitive fringe benefit package of **42.02 percent** of wages.

Table 20: Components of ERE for a Behavioral Health Aide

Component	Calculation	Value
Annual Wage	\$44,161 (\$21.23 x 2080 hours)	\$44,161 (\$21.23 x 2080 hours)
FUTA	0.60% of up to \$7,000	\$42 (0.10%)
SUTA	1.50% of up to \$49,700	\$662 (1.50%)
FICA	7.65% of up to \$168,600	\$3,378 (7.65%)
Workers' Compensation	1.40%	\$620 (1.40%)
Legally Required Benefits	-	\$4,703 (10.65%)
Daily Wage	\$21.23 x 8 hours	\$169.84

Component	Calculation	Value
Part-Time Adjustment Factor	76.57%	76.57%
Paid Time Off	32.5 days	32.5 days
Paid Time Off	\$169.84 x 76.57% x 32.5 days	\$4,229 (9.58%)
Insurance Take-up Rate	Dental 52.59%, Vision 63.86%, Health 68.23%, Other 79.66%, Retirement 87.85%	Dental 52.59%, Vision 63.86%, Health 68.23%, Other 79.66%, Retirement 87.85%
Retirement	5.14%	\$1,527 (3.46%)
Health Ins.	\$1,166/mo.	\$7,308 (16.55%)
Dental Ins.	\$50/mo.	\$242 (0.55%)
Vision Ins.	\$20/mo.	\$119 (0.27%)
Other Benefits	\$59/mo.	\$429 (0.97%)
Other Benefits	-	\$13,854 (31.37%)
Total ERE per Behavioral Health Aide	Legally Required Benefits + Paid Time Off + Other Benefits	\$18,557 (42.02% of Annual Wage Assumption)

As wages rise, costs of contributing to certain legally required benefits and other benefits do not necessarily become more expensive. As wages increase, the proportion of ERE to wages decreases; therefore, we developed individual ERE percentages based on job type.

As an example of how the ERE percentage decreases with a higher wage within **Table 21** we display the numbers for the following job types:

- Residential Worker
- Behavioral Health Aide
- Licensed Addiction Counselor
- Registered Nurse

Similarly, the ERE percentage was calculated for other job types utilizing the benchmark hourly wages.

Table 21: Examples of Employee-Related Expenses Across Job Types

Metric	Residential Worker	Behavioral Health Aide	Licensed Addiction Counselor	Registered Nurse (RN)
Hourly Wage	\$20.96	\$21.23	\$29.84	\$48.68
Annual Wage	\$43,591	\$44,161	\$62,067	\$101,260
Legally Required Benefits	\$4,643 (10.65%)	\$4,703 (10.65%)	\$6,407 (10.32%)	\$9,956 (9.83%)
Paid Time Off Benefits	\$4,174 (9.58%)	\$4,229 (9.58%)	\$5,943 (9.58%)	\$9,696 (9.58%)
Retirement Plan	\$1,507 (3.46%)	\$1,527 (3.46%)	\$2,146 (3.46%)	\$3,502 (3.46%)
Health Insurance	\$7,308 (16.77%)	\$7,308 (16.55%)	\$7,308 (11.77%)	\$7,308 (7.22%)
Dental Insurance	\$242 (0.56%)	\$242 (0.55%)	\$242 (0.39%)	\$242 (0.24%)
Vision Insurance	\$119 (0.27%)	\$119 (0.27%)	\$119 (0.19%)	\$119 (0.12%)
Other Benefits	\$429 (0.98%)	\$429 (0.97%)	\$429 (0.69%)	\$429 (0.42%)
Total ERE per Staff	\$18,423 (42.26%)	\$18,557 (42.02%)	\$22,595 (36.41%)	\$31,252 (30.86%)
Hourly Wage with ERE	\$29.81	\$30.15	\$40.70	\$63.71

G.2.6. Direct Care Staff Productivity

While direct care staff can only bill for the time during which they are delivering services, they perform other tasks as part of their workday. Productivity factors account for this “non-billable” time. Non-billable time includes time spent traveling to a member’s home to deliver services, maintaining records, or participating in training. The productivity factors upwardly adjust compensation (wages and ERE) to cover the full workday.

Consider a simple example to illustrate this process:

A direct care staff person is paid \$16 per hour and works an 8-hour day. The cost to the provider for the day is \$128 (\$16 * 8 hours). However, if half of the staff member’s 8-hour day (4 hours) was spent on activities that are non-billable, the agency would only be able to bill Medicaid for 4 hours of the staff member’s time. Therefore, a productivity adjustment would have to be made to allow the provider to recoup the full \$128 for the staff cost. The adjusted wage rate per billable hour would need to be \$32 in this example. This means the productivity adjustment needs to be 2.0.

While this is an exaggerated example (a typical productivity adjustment is around 1.4-1.6 for many of the services in scope for this study), it demonstrates the importance of including a productivity factor to fully reimburse providers for the time spent.

Provider organizations reported the average number of billable hours (out of an assumed 8-hour workday) through the cost and wage survey, which then translated into a productivity factor for staff delivering each service. For example, for Community Recovery Support Service, providers reported an average of 5.49 billable hours per each direct care staff member’s 8-hour day, meaning

68.59 percent of their day is typically spent on client-facing, billable activities. Dividing 8 by 5.49 (or equivalent, 1 divided by 68.59 percent or .6859) yields a productivity adjustment of 1.46, which is then multiplied by ERE-adjusted wages to get productivity-adjusted compensation.

For similar services within the behavioral health service array, productivity percentages were standardized across like services to ensure consistency where appropriate. This approach allows for a uniform evaluation of service delivery efficiency and effectiveness, facilitating a more accurate comparison and analysis of provider performance. In addition, the provider cost and wage survey did not indicate differences in billable time between group and individual services. However, this did not align with our understanding of the services or communication from the providers within the workgroups. Therefore, to account for the additional notetaking and record keeping required for group services the productivity percentages were reduced by 5 percent for all group services. A reduction in the productivity percentage in turn increases the productivity factor that is applied within the rate methodology and ultimately increases the direct care assumptions. **Table 22** displays the productivity percentages calculated by each service grouping with the corresponding reduced group percentages using the information provided within the cost and wage survey.

Table 22: Productivity by Service

Service Grouping	Productivity	Service Description
ASAM, Intensive Outpatient, and Partial Hospitalization Program Service	59.20%	Ambulatory Withdrawal Management without Extended Monitoring ASAM 1 WM
ASAM, Intensive Outpatient, and Partial Hospitalization Program Service	59.20%	Ambulatory Withdrawal Management with Extended On-Site Monitoring ASAM 2 WM
ASAM, Intensive Outpatient, and Partial Hospitalization Program Service	68.60%	Intensive Outpatient Services (IOP) – Group
ASAM, Intensive Outpatient, and Partial Hospitalization Program Service	68.60%	Intensive Outpatient Services ASAM 2.1 – Group
ASAM, Intensive Outpatient, and Partial Hospitalization Program Service	68.60%	Outpatient Services ASAM – Group (Adolescent)
ASAM, Intensive Outpatient, and Partial Hospitalization Program Service	68.60%	Outpatient Services ASAM – Group (Adult)
ASAM, Intensive Outpatient, and Partial Hospitalization Program Service	73.60%	Intensive Outpatient Services (IOP) – Individual
ASAM, Intensive Outpatient, and Partial Hospitalization Program Service	73.60%	Intensive Outpatient Services ASAM 2.1 – Individual
ASAM, Intensive Outpatient, and Partial Hospitalization Program Service	73.60%	Outpatient Services ASAM 1.0 – Individual
Assessment, Evaluation, and Screening Service	63.40%	Behavioral Health Screen
Assessment, Evaluation, and Screening Service	63.40%	Medical Evaluation for Recipient
Assessment, Evaluation, and Screening Service	63.40%	Medical Evaluation for Recipient when Methadone is used for opioid use disorder treatment
Assessment, Evaluation, and Screening Service	63.40%	Medical Evaluation for Recipient NOT Receiving Methadone Treatment
Assessment, Evaluation, and Screening Service	63.40%	Treatment Plan Development or Review

Service Grouping	Productivity	Service Description
Assessment, Evaluation, and Screening Service	63.40%	Treatment Plan Review for Methadone Recipient
Assessment, Evaluation, and Screening Service	72.50%	Methadone Administration and/or service (as prescribed by a physician)
Assessment, Evaluation, and Screening Service	80.00%	Oral Medication Administration, direct observation;
Assessment, Evaluation, and Screening Service	80.00%	off premises (one billable service per day)
Assessment, Evaluation, and Screening Service	80.00%	Oral Medication Administration, direct observation;
Assessment, Evaluation, and Screening Service	80.00%	on premises (one billable service per day)
Autism (ABA) Service	58.20%	Adaptive Behavior Treatment by Protocol, administered by technician under direction of qualified health care professional to multiple patients
Autism (ABA) Service	58.20%	Group Adaptive Behavior Treatment with Protocol Modification, administered by QHP face to face with multiple patients
Autism (ABA) Service	58.20%	Multiple-Family Group Adaptive Behavior Treatment Guidance, administered by QHP (without the patient present), face to face with multiple sets of guardians/caregivers
Autism (ABA) Service	63.20%	Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to one patient
Autism (ABA) Service	63.20%	Adaptive behavior treatment with protocol modification, administered by qualified health care professional to one patient
Autism (ABA) Service	63.20%	Behavioral identification assessment by qualified health care professional
Autism (ABA) Service	63.20%	Family adaptive behavior treatment guidance by qualified health care professional (with or without patient present)
General Community Service	63.60%	Community Recovery Support Services (CRSS) – Group
General Community Service	63.60%	Therapeutic BH Services - Group
General Community Service	68.60%	Community Recovery Support Services (CRSS) – Individual
General Community Service	68.60%	Home-Based Family Treatment HBFT Level 1
General Community Service	68.60%	Home-Based Family Treatment HBFT Level 2
General Community Service	68.60%	Home-Based Family Treatment HBFT Level 3
General Community Service	68.60%	Peer Support Services - Family (w/o patient present)
General Community Service	68.60%	Peer Support Services - Family (with patient present)
General Community Service	68.60%	Peer Support Services - Individual
General Community Service	68.60%	Peer-Based Crisis Services (PBCS)
General Community Service	68.60%	Therapeutic BH Services - Family (w/o patient present)
General Community Service	68.60%	Therapeutic BH Services - Family (with patient present)
General Community Service	68.60%	Therapeutic BH Services - Individual
General Community Service	75.70%	Screening, Brief Intervention, and Referral for Treatment (SBIRT)

G.2.7. Occupancy

For some services, such as residential or day programs, an “occupancy rate” is used to further adjust the cost assumptions behind the rate. These adjustments are made for many of the same reasons as staff time is adjusted for “productivity”. Namely, if provider costs are divided over all billable units, the rate must account for the fact that not all time which is hypothetically billable when determining the rate can actually be billed by providers. Program absences or unoccupied days occur for a variety of reasons including non-attendance to a day program due to sickness, absences from a residence due to clients visiting their families, hospitalizations, short vacancies in a home before a new resident replaces a former resident or a provider holding a bed waiting for an incarcerated individual. In order to cover a provider’s incurred costs across the year, rates will typically include some combination of an occupancy factor and/or retainer days policy (also known as a “bed hold”) to allow reimbursement otherwise lost to absences. A retainer days policy addresses this issue by allowing providers to bill under a limited number of days and conditions even when the service was not provided. Conversely, with an occupancy adjustment approach, providers are allowed to bill only when the service is actually provided. However, an occupancy adjustment is added to the rate models to build in the anticipated amount of average lost annual revenue due to bed absences. So long as vacancies or absences are reasonably low and reflect efficient operations, a rate that includes an occupancy factor is more responsive to the actual relationship between provider revenue and costs. Occupancy adjusters of **80-85 percent** have been included within residential models.

G.2.8. Supervision

While direct care staff deliver services, other staff are often present to supervise, usually multiple staff at one time. Wages for supervisors are often higher, but proportionate, to the wages of the direct care staff they supervise and are therefore included in independent rate models as a separate component or add-on to the primary staff wage. The supervision cost component captures the cost of supervising direct care staff. It should be noted that supervision costs are distinct from administrative costs related to higher-level management of personnel. Supervision is time spent in direct oversight of and assistance with care provision and is frequently conducted by staff who are themselves providing direct care as a part of their role.

The cost and wage survey includes questions regarding the number of direct care staff supervised by one supervisor and the total number of hours a supervisor spends, on average, directly supervising staff; for most service groups, the average number of staff supervised by one supervisor ranged from two to five, except for community-based services for which the supervisor “span of control” was higher. For example, for Community Recovery Support Services (CRSS) the supervisor span of control was 5.5 staff to one supervisor on average. Taking into consideration this additional element accounts for the costs of employing supervisors to help assure appropriate delivery of services. In **Table 23** below are the average supervisor assumptions for each service type.

Table 23: Supervisor Span of Control and Hours

Service Type	Supervisor Span of Control Survey Results	Hours of Supervision per Week Survey Results	Supervisor Span of Control in Rate Models	Hours of Supervision per Week in Rate Models
Adaptive Behavior Treatment by Protocol, Administered by Technician Under Direction of Qualified Health Care Professional to Multiple Patients	5.50	17.50	4.56	20.85
Adaptive Behavior Treatment by Protocol, Administered by Technician Under Direction of Qualified Health Care Professional to One Patient	4.75	16.75	4.56	20.85
Adaptive Behavior Treatment with Protocol Modification Administered by Qualified Health Care Professional to One Patient	4.67	16.67	4.56	20.85
ASAM 1 WM and ASAM 2 WM	-	-	4.75	4.35
ASAM Level 1.0 Outpatient Services – Adolescents and Adults (ASAM Level 1) Group	7.13	5.38	7.86	4.76
ASAM Level 1.0 Outpatient Services – Adolescents and Adults (ASAM Level 1) Individual	7.14	5.57	7.86	4.76
ASAM Level 2.1 Intensive Outpatient Services – Adolescents and Adults (ASAM Level 2.1) - Group	8.80	5.60	7.86	4.76
ASAM Level 2.1 Intensive Outpatient Services – Adolescents and Adults (ASAM Level 2.1) - Individual	8.25	6.00	7.86	4.76
Behavioral Health Screen - AK Screen Tool	5.25	2.86	5.25	2.86
Behavioral Identification Assessment by Qualified Health Care Professional	4.50	17.50	4.56	20.85
Community Recovery Support Services (CRSS) - Group	5.64	4.36	5.52	4.50
Community Recovery Support Services (CRSS) - Individual	5.40	4.63	5.52	4.50
Family Adaptive Behavior Treatment Guidance by Qualified Health Care Professional (With or Without Patient Present)	4.50	17.50	4.56	20.85
Group Adaptive Behavior Treatment with Protocol Modification, Administered by QHP Face To Face with Multiple Patients	4.00	30.00	4.56	20.85
Homebased Family Treatment Services Level 1 (HBFT Level 1)	3.00	5.67	4.33	8.56
Homebased Family Treatment Services Level 2 (HBFT Level 2)	5.00	10.00	4.33	8.56
Homebased Family Treatment Services Level 3 (HBFT Level 3)	5.00	10.00	4.33	8.56

Service Type	Supervisor Span of Control Survey Results	Hours of Supervision per Week Survey Results	Supervisor Span of Control in Rate Models	Hours of Supervision per Week in Rate Models
Intensive Outpatient Services (IOP) - Group	8.33	3.00	7.86	4.76
Intensive Outpatient Services (IOP) - Individual	7.50	3.00	7.86	4.76
Medical Evaluation for Recipient NOT Receiving Methadone Treatment	3.00	1.00	3.00	1.00
Medical Evaluation for Recipient Receiving Methadone Treatment	1.00	1.00	1.00	1.00
Methadone Administration and/or Service	2.00	3.00	2.00	3.00
Multiple-Family Group Adaptive Behavior Treatment Guidance, Administered by QHP (Without the Patient Present), Face to Face with Multiple Sets of Guardians/Caregivers	4.00	30.00	4.56	20.85
Oral Medication Administration, Direct Observation; Off Premises	2.00	-	4.75	4.35
Oral Medication Administration, Direct Observation; On Premises	1.00	-	4.75	4.35
Peer Support Services (Individual and Family)	3.00	3.50	3.00	3.50
Peer-Based Crisis Services (PBCS)	3.00	3.50	3.00	3.50
Screening, Brief Intervention, And Referral for Treatment (SBIRT)	2.00	1.17	2.00	1.17
Therapeutic BH Services - (Individual, Group, Family, Family Group)	5.81	6.03	5.81	6.03
Treatment Plan Development or Review and Treatment Plan Review for Methadone Recipient	3.00	1.00	3.00	1.00

G.2.9. No-Show Adjustment

Provider time and revenue lost due to missed appointments is a problem to be contended with across health care. However, client “no-shows” are particularly challenging in behavioral health. Mental health and SUD appointment no-shows not only adversely impact clinical outcomes but have a large impact on overall healthcare productivity and the ability to bill for providers time. During the workgroup sessions, stakeholders noted substantial additional loss due to clients not showing up for scheduled appointments as well as lost time related to staff driving into the community to deliver a service where the patient is not there. Although it was not possible to quantify lost productivity due to client no-show rates solely through the information reported through the provider survey, with further stakeholder and DOH input, Guidehouse determined that a no-show adjustment was appropriate.

Based on a combination of provider experience, workgroup feedback and literature review, Guidehouse estimated that a **10-25 percent** no-show rate was a reasonable assumption for the setting and population served in Alaska. We inserted an additional no-show factor into the

proposed rate models, augmenting the standard productivity adjustment. This adjustment is distinguished from the billable time adjuster to differentiate between other standard non-billable time elements and productive time lost to missed appointments, thereby allowing the State to implement alternative no-show targets and assumptions down the road as needed.

G.2.10. Staffing Ratios

Just as one supervisor may oversee the work of multiple direct care staff simultaneously, one direct care staff may deliver a service to multiple clients simultaneously. As services are reimbursed per-client, this means the costs associated with direct service can be split across multiple units of service in cases when the ratio of staff to clients (“staffing ratio”) is more than one-to-one.

Staffing needs of each service typically vary and require examination to assign the appropriate staff wage rate assumptions. The cost and wage survey asks for the average staffing ratios of each service, and analysis of survey results across provider organizations as well as careful readings of service definitions informed assumptions of staffing ratios. And while some services genuinely call for individualized or 1:1 (meaning one staff member to one client) staffing ratios, many allow for appropriate delivery of services to small groups. Depending on the provider, some surveys indicated groups up to 10 in size. However, in discussion with providers and to promote quality outcomes Guidehouse found that group sizes of three are deemed more reasonable. To ensure consistency across the behavioral health service array, staffing ratios for similar services are standardized. This approach allows for a uniform assessment of service delivery efficiency and effectiveness, facilitating a more accurate comparison and analysis of provider performance. By maintaining consistent staffing ratios, we can better align our rate-setting methodology with the overarching goals of quality and access in behavioral health services. **Table 24** shows the services that are intended to be provided in a group setting with the average size reported in the survey compared against the size built into the final rate models.

Table 24: Staffing Ratios by Service

CPT & Modifier	Service Description	Average Group Size Reported in the Survey	Group Size within Rate Models
97154	Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to multiple patients	2.0	3.0
97158	Group Adaptive Behavior Treatment with Protocol Modification, administered by QHP face to face with multiple patients	2.0	3.0
97157	Multiple-Family Group Adaptive Behavior Treatment Guidance, administered by QHP (without the patient present), face to face with multiple sets of guardians/caregivers	3.0	3.0
H0007HQHAV1	Outpatient Services ASAM – Group (Adolescent)	2.0	3.0

CPT & Modifier	Service Description	Average Group Size Reported in the Survey	Group Size within Rate Models
H0007HQHBV1	Outpatient Services ASAM – Group (Adult)	2.0	3.0
H0015HQB1	Intensive Outpatient Services ASAM 2.1 – Group	4.0	3.0
H0015HQB2	Intensive Outpatient Services (IOP) – Group	-	3.0
H2021HQB1	Community Recovery Support Services (CRSS) – Group	4.0	3.0
H2019HQ	Therapeutic BH Services - Group	4.0	3.0

G.2.11. Staffing Ratios within Residential Settings

Residential services account for staffing ratios by determining the appropriate staffing levels for one staff number to set number of residents. The primary objective of these ratios is to ensure appropriate support and maintain optimal staff-to-client ratios, taking into consideration the acuity and specific needs of individuals within each service. However, the staffing ratios are not necessarily the only staff included when determining a residential rate as we understand that specific services require a multidisciplinary team of professionals.

Total hours required for daytime and nighttime all need to be considered to ensure there is adequate staffing for the number of residents. The annual primary hours represent the total number of staffed service delivery hours. Substitution hours represent the hours needed to cover non-productive hours due to staff training, paid time off, and resident absences from day programs. The training hour assumptions assume a staff turnover rate of 50 percent and required annual training hours per staff as 30 hours. The *PTO-Related Substitution* assumes 32 days of paid time off, consistent with the paid time off reported by providers in the provider cost and wage survey

The calculation for the hour requirement follows the same pattern; however, staffing levels vary by setting. **Table 25** provides an example of a facility that needs a daytime staffing ratio of 1:6, but a nighttime staffing of 1:12. To determine the number of staff needed for a facility, we take the facility size divided by the staffing ratio. In the example below, since the facility size is for 12 residents, we identify the need for two daytime staff and one nighttime staff. We also assume most residential settings need to be staffed 24 hours a day, 365 days in a year, resulting in 8,760 total yearly hours per staff. If the setting has higher intensity residents, increased hours would be required to account for multiple staff working simultaneously.

Table 25: Residential Facility Staff Calculation: Facility Size = 12 Beds

Time	Staffing Ratio	Actual Staff Needed
Day	1:6	2
Night	1:12	1

In the case of the example residential setting with a 1:6 daytime staffing and 1:12 nighttime staffing, the Behavioral Technician hours are split amongst the residents differently depending on the time of day. As demonstrated in **Table 26**, we take the total daytime hours divided by the six residents and the total nighttime hours, divided by the twelve residents, resulting in 1,217 total hours per resident in a year.

Table 26: Residential Facility Service Staffing Hours: Facility Size = 12 Beds

Time Type	Tech Hours - Day	Tech Hours - Night	Total Hours - Daily
Sunday	16	8	24
Monday	16	8	24
Tuesday	16	8	24
Wednesday	16	8	24
Thursday	16	8	24
Friday	16	8	24
Saturday	16	8	24
Total Weekly Hours	112	56	168
Annual BH Technician Total	5,840	2,920	8,760
Staffing Ratio	1:6	1:12	-
Hours Per Resident	973	243	1,217

Substitution hours required for the current staffing levels are then calculated in **Table 27** as follows:

Table 27: Residential Service Substitution Hours Calculation

Home Size	Staffed Hours	FTE = Staffed Hours ÷ 2080	Substitute Training Hours	Substitute PTO Hours	Total Substitution Staff Hours
12	1,217	.58	26.3	150	176

These hourly calculations feed into each of the residential models based on setting and variation in resource need intensity defined by that setting. Detailed staffing ratios, hour assumptions and additional staffing resources for each service are included within **Appendix A**.

G.2.12. Administrative Expenses

Administrative expenses reflect costs associated with operating a provider organization, such as costs for administrative employees' salaries and wages along with non-payroll administration expenses, such as licenses, property taxes, liability and other insurance. Rate models typically add a component for administrative expenses so as to spread costs across the reimbursements for all services an organization may deliver; our recommended rates reflect this methodology by establishing a percentage add-on for each service rate.

To determine an administrative cost percentage, Guidehouse calculated the ratio of administrative costs to direct care wages and benefits by summing administrative costs reported in the cost and wage survey, then dividing by total direct care wages and benefits inflated according to new wage

and fringe assumptions for direct care workers and other direct care workers for the time period captured in the survey.

Administrative costs include several categories:

- **Payroll Administrative Expenses:** *Employees and contracted employees who perform administrative or maintenance activities earn salaries and benefits, which count toward payroll expenses in the calculation of total administrative costs.*
- **Non-Payroll Administrative Expenses:** *Costs including office equipment and overhead comprise non-payroll administrative expenses, net of bad debt and costs related to advertising or marketing.*
- **Facility and Utilities for Administrative Use:** *Rent, mortgage, and depreciation for administrative space factors into total administrative costs, as do utilities and telecommunication expenses relating to administrative use.*

Direct care costs include the salaries, wages, taxes, and benefits for direct care employees. After dividing administrative costs by direct care costs for each provider, Guidehouse calculated an average ratio of **43.8 percent**. Our recommended rate models incorporate the ratio of 43.8 percent, which adds a dollar amount to a unit rate by multiplying the rate components of productivity-adjusted direct care staff and supervisor compensation by the average administrative percentage.

G.2.13. Program Support Expenses

Program support expenses reflect costs associated with delivering services, but which are not related to either direct care or administration but still have an impact on the quality of care. These costs are specific to the program but are not billable, and may include:

- **Program Support Wages and Direct Care-Related Costs:** Employees and contracted employees who perform program support activities earn salaries and benefits, which count toward direct care-related expenses in the calculation of total program support costs. These may also include costs for staff training and development, activities costs, and expenses for devices and technology, all of which are related to the quality of care but not specifically billable.
- **Supplies:** This includes the costs of program supplies used by client in, for example, day programs.
- **Client Transportation:** When client transportation is “bundled” into a service, this means the service definition includes transportation of the client to and from the location of service delivery. These costs may include costs relating to actually transporting the client (e.g., mileage); vehicle licensing, acquisition, registration, leasing, and insurance; vehicle maintenance and repair; and vehicle depreciation.
- **Building and Equipment:** When services are delivered in a facility, certain costs for the direct care facility may be included such as utilities and telecommunications; building maintenance and repairs; facility janitorial, landscaping, and other costs not part of rent; and non-administrative equipment costs and depreciation.

Similar to the calculation for administrative costs, the program support percentage is calculated based on cost data reported in the provider survey. Program support costs reported by providers were calculated in relation to direct care costs reported in the provider survey. The largest components of this percentage are program support wages and direct care-related costs, which comprise **11.1 percent** of the direct care costs, and building and equipment costs **8.6 percent** of direct care costs. Supplies accounted for **4.0 percent** and client transportation accounted for an additional **2.1 percent**. The combination of these 4 program support numbers, Guidehouse arrived at an overall program support percentage of **25.8 percent**. However, this depends on the service – a service which does not include client transportation would not include the transportation component as well as for residential services where room and board is paid for separately does not include the additional building and equipment percentage. **Table 28** below illustrates the Program Support variables.

Table 28: Program Support Variables

Program Support Factor	Total Program Support (Additive)	Percentage per Program Support Category
Baseline (<i>Program Support Employees and General Program Costs</i>)	11.1%	-
Baseline +1 (<i>Baseline + Program Supplies, Training, and Activity Costs</i>)	15.1%	4.0%
Baseline + 2 (<i>Baseline +1 plus Transportation</i>)	17.2%	2.1%
Baseline + 3 (<i>Baseline + 2 plus Building and Equipment</i>)	25.8%	8.6%

The combination of these rate components supports the building block methodology. Full rate models with the individual rate components for each service are represented within **Appendix A**.

G.3. Service-Specific Rate Components

To create consistency and standardization where appropriate Guidehouse created service groupings for “like” services. **Table 29** displays how Guidehouse categorizes the individual services into the service groupings for rate development purposes only.

Table 29: Guidehouse Behavioral Health Service Groupings

Health Service Group	Services
ASAM (Including Partial Hospitalization and Outpatient)	• Outpatient Services – 1.0 • Intensive Outpatient Services (IOP and 2.1) • Ambulatory Withdrawal Management • Partial Hospitalization (2.5 and PHP) • ASAM Residential Levels 3.1-4.0
Assessment/Evaluation	• Alcohol and/or Drug Assessment • BH Health Screen • Integrated MH & Substance Use Intake • Medical Evaluation • Methadone Administration • Oral Medication Administration • Treatment Plan Development/Review

Health Service Group	Services
General Community	• Community Recovery Support Services • Home-Based Family Treatment • Peer Support Services (including Crisis) • SBIRT • Therapeutic BH Services
Residential	• Adult Mental Health Residential • Children's Residential Treatment • Therapeutic Treatment Home
UPL Clinic	• Comprehensive Medication Assessment • Mental Health Intake Assessment • Psychiatric Assessment • Psychotherapy (Individual, Family, Group)
Autism (ABA) Services	• Adaptive Behavior Treatment (Individual, Family, Group) • Behavioral Identification Assessment
Crisis	• Crisis Residential • Crisis Stabilization
Other Services	• Assertive Community Treatment • Day Treatment for Children
Case Management	• SUD Care Coordination • Intensive Case Management • Case Management

G.3.1. General Community Services

General community services represent the various 1115 waiver and state plan services that are the 15-minute services that take place in the community or in an individual's home. Given the consistency of the style of these services there are standardized rate components incorporated. General community services include the following five services:

- **Community Recovery Support Services:** The Community Recovery Support Services (CRSS) category includes services that support members in improving or maintaining their recovery journey
- **Home-Based Family Treatment:** Home-Based Family Treatment (HBFT) Services are specialized therapeutic programs aimed at supporting families by providing mental health treatment directly in their homes. The primary goal of HBFT is to strengthen the family unit, prevent out-of-home placements, and promote long-term stability and well-being.
- **Peer Support Services (including peer-based crisis):** Category is for all services that have a certified peer support specialist as the primary provider of the service
- **Therapeutic BH Services:** Therapeutic Behavioral Health Services play a crucial role in providing support and treatment for individuals experiencing mental health challenges. These services encompass a range of therapeutic interventions designed to address behavioral issues, improve emotional well-being, and enhance the overall quality of life for patients.

- Screening, Brief Intervention, And Referral for Treatment (SBIRT): Screening, Brief Intervention, and Referral for Treatment (SBIRT) is an evidence-based approach in behavioral health aimed at identifying, reducing, and preventing problematic use of alcohol and other substances. SBIRT consists of three main components: screening to assess the severity of substance use and identify the appropriate level of treatment, brief intervention to increase insight and awareness regarding substance use and motivation toward behavioral change, and referral to treatment to ensure individuals receive access to specialty care when necessary.

Across the services standardized rate components are as follows for these set of services:

- Administrative Percentage: 23.7% or 25.8%
- Program Support Percentage: 43.8%
- Group Sizes (where applicable): 3.0
- Productivity Percentage: 68.6% (individual with or without family present), 63.6% (group), 75.7% for SBIRT
- No-Show Adjustment: 10.0-25.0%

However, depending on the service the primary driving reason for a difference in benchmark rates is the job type that is included within the models. Providers reported their primary jobs that deliver services. In reviewing those results Guidehouse used the primary job type reported to inform the final rate models. **Table 30** displays the job types for each of General Community services.

Table 30: General Community Job Types

Service Type	Job Type
Peer Support Services	Certified Peer Support Specialist
Community Recovery Support Services	Behavioral Specialist/Technician
Therapeutic BH Services	Behavioral Specialist/Technician
Home-Based Family Treatment	Clinical Specialist and Case Manager
Screening, Brief Intervention, And Referral for Treatment (SBIRT)	Licensed Addiction Counselor

Leveraging the different rate components the benchmark rates for General Community Services are included in **Table 31**.

Table 31: General Community Benchmark Rates

Service	Service Description	Unit	Current Rate	Benchmark Rate
H0038	Peer Support Services - Individual	15 Minutes	\$30.67	\$25.61
H0038V2	Peer-Based Crisis Services (PBCS)	15 Minutes	\$22.34	\$25.61
H0038V1	Peer-Based Crisis Services (PBCS)	15 Minutes	\$22.34	\$25.61
H0038HR	Peer Support Services - Family (with patient present)	15 Minutes	\$30.67	\$25.61
H0038HS	Peer Support Services - Family (w/o patient present)	15 Minutes	\$30.67	\$25.61
H2021V1	Community Recovery Support Services (CRSS) – Individual	15 Minutes	\$23.44	\$26.36
H2021V2	Community Recovery Support Services (CRSS) – Individual	15 Minutes	\$23.44	\$26.36
H2021HQP1	Community Recovery Support Services (CRSS) – Group	15 Minutes	\$6.14	\$9.46
H2021HQP2	Community Recovery Support Services (CRSS) – Group	15 Minutes	\$6.14	\$9.46
H1011V2	Home-Based Family Treatment HBFT Level 1	15 Minutes	\$26.39	\$35.34
H1011TFV2	Home-Based Family Treatment HBFT Level 2	15 Minutes	\$26.90	\$35.34
H1011TGV2	Home-Based Family Treatment HBFT Level 3	15 Minutes	\$29.69	\$35.34
H2019HS	Therapeutic BH Services - Family (w/o) patient present)	15 Minutes	\$30.53	\$30.14
H2019HR	Therapeutic BH Services - Family (with patient present)	15 Minutes	\$30.53	\$30.14
H2019HQ	Therapeutic BH Services - Group	15 Minutes	\$14.33	\$10.81
H2019	Therapeutic BH Services - Individual	15 Minutes	\$30.53	\$30.14
99408	Screening, Brief Intervention, and Referral for Treatment (SBIRT)	15-30 Minutes	\$58.04	\$55.83

G.3.2. Assessment, Evaluation, and Screening Services

Services Included:

- Behavioral Health Screen - AK Screen Tool
- Medical Evaluation for Recipient NOT Receiving Methadone Treatment
- Medical Evaluation for Recipient Receiving Methadone Treatment
- Treatment Plan Development or Review
- Treatment Plan Review for Methadone Recipient
- Methadone Administration and/or Service
- Intensive Outpatient Services (IOP) – Group
- Oral Medication Administration, direct observation; off premises (One billable service per day)
- Oral Medication Administration, direct observation; on premises (One billable service per day)

Across the services standardized rate components are as follows for these set of services:

- Administrative Percentage: 23.7%
- Program Support Percentage: 43.8%
- Productivity Percentage: 63.4%
 - Methadone Administration and/or Service and Oral Medication Administration services have higher productivity rates due to the nature of these services.
- Supervision:
 - Supervisors varied across services and included Clinical Directors, Clinical Supervisors, Nurse Managers, or Physicians as a supervisor rate component. The final assumptions were informed using the provider cost and wage survey.
- No-Show Adjustment: 5.0% -15.0%

Similar to most services, the job type is a large factor in the final rate determination. However, the assessment/evaluation rates also have a time element to consider. Unlike services that include an expected time estimate such as 15 minutes or an hour, these services have a unit of measure as a single evaluation or assessment. Therefore, we asked providers within the provider cost and wage survey and confirmed assumptions during the provider workgroup meetings related to the average length for each of these assessments or evaluations to be able to build an accurate representation of time into the models. The job type and time estimates are displayed in **Table 32**.

Table 32: Assessment/Evaluation Job Tyes and Unit of Measure Time Estimates

Service Type	Job Type	Time
Behavioral Health Screen - AK Screen Tool	1 screening (45 Minutes)	Licensed Clinical Social Worker (LCSW)
Medical Evaluation for Recipient NOT Receiving Methadone Treatment	1 evaluation (2 Hours)	Registered Nurse (RN)/Nurse
Medical Evaluation for Recipient Receiving Methadone Treatment	1 evaluation (2 Hours)	Registered Nurse (RN)/Nurse
Treatment Plan Development or Review	Per Assessment (1 Hour)	Licensed Clinical Social Worker (LCSW)
Treatment Plan Review for Methadone Recipient	Per Assessment (1 Hour)	Certified Nurse Assistant (CNA)
Methadone Administration and/or Service	Administration Episode (15 Minutes)	Registered Nurse (RN)/Nurse
Oral Medication Administration, direct observation; on premises (One billable service per day)	1 day	Registered Nurse (RN)/Nurse
Oral Medication Administration, direct observation; off premises (One billable service per day)	1 day	Registered Nurse (RN)/Nurse

Leveraging the different rate components, the benchmark rates for the Assessment and Evaluation Services are included in **Table 33**.

Table 33: Assessment and Evaluation Benchmark Rates

Service	Service Name	Unit	Current Rate	Benchmark Rate
T1023	Behavioral Health Screen - AK Screen Tool	1 screening (45 Minutes)	\$135.13	\$144.77
H0002	Medical Evaluation for Recipient NOT Receiving Methadone Treatment	1 evaluation (2 Hours)	\$652.86	\$413.10
H0002HF	Medical Evaluation for Recipient Receiving Methadone Treatment	1 evaluation (2 Hours)	\$652.86	\$417.88
T1007V1 & T1007V2	Treatment Plan Development or Review	Per Assessment (1 Hour)	\$147.89	\$192.54
T1007	Treatment Plan Review for Methadone Recipient	Per Assessment (1 Hour)	\$97.45	\$127.30
H0020	Methadone Administration and/or Service	Administration Episode (15 Minutes)	\$39.29	\$44.02
H0033HK	Oral Medication Administration, direct observation; on premises (One billable service per day)	1 day	\$112.76	\$117.34
H0033HK	Oral Medication Administration, direct observation; off premises (One billable service per day)	1 day	\$130.80	\$122.93

G.3.3. Autism (ABA) Service Methodologies

The Autism or ABA services include a combination of assessments and treatment by a technician under supervision or by a qualified health professional. The services include:

- Behavioral identification assessment by qualified health care professional
- Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to one patient
- Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to multiple patients
- Adaptive behavior treatment with protocol modification administered by qualified health care professional to one patient
- Family adaptive behavior treatment guidance by qualified health care professional (with or without patient present)
- Multiple-Family Group Adaptive Behavior Treatment Guidance, administered by QHP (without the patient present), face to face with multiple sets of guardians/caregivers
- Group Adaptive Behavior Treatment with Protocol Modification, administered by QHP face to face with multiple patients

Across the services standardized rate components are as follows for these set of services:

- Staff Types:
 - Technician: For services delivered by a technician, we assume a Behavioral Specialist/Technician as the primary staff type.
 - Qualified Health Care Professional: For services that require a qualified health care professional, we assume a Behavioral Analyst as the primary staff type.
- Administrative Percentage: 23.7%
- Program Support Percentage: 43.8%
- Group Sizes (where applicable): 3
- Productivity Percentage: 63.2% (individual with or without family present), 58.2% (group)
- Supervision: Services delivered by a technician assume approximately 21 hours per week of supervision with a supervisor span of control of approximately 1:5.
- No-Show Adjustment: 10%

Table 34 displays the proposed benchmark rates compared to the current rates.

Table 34: ABA Benchmark Rates

Service	Service Description	Unit	Alaska Current Rate	Benchmark Rate
97151	Behavioral identification assessment by qualified health care professional	15 minutes	\$28.86	\$40.67
97153	Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to one patient	15 minutes	\$21.93	\$30.96
97154	Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to multiple patients	15 minutes	\$8.76	\$11.11
97155	Adaptive behavior treatment with protocol modification administered by qualified health care professional to one patient	15 minutes	\$28.86	\$40.67
97156	Family adaptive behavior treatment guidance by qualified health care professional (with or without patient present)	15 minutes	\$18.11	\$40.67
97157	Multiple-Family Group Adaptive Behavior Treatment Guidance, administered by QHP (without the patient present), face to face with multiple sets of guardians/caregivers	15 minutes	\$7.24	\$14.72
97158	Group Adaptive Behavior Treatment with Protocol Modification, administered by QHP face to face with multiple patients	15 minutes	\$11.54	\$14.72

G.3.4. ASAM, Intensive Outpatient, and Partial Hospitalization Services

The ASAM services in combination with the intensive outpatient and partial hospitalization services are structured in a hierarchical fashion to encourage step down between services as patients continue to improve. There is a distinction between non-residential and residential services in the ASAM continuum of care for addiction treatment, where levels are used to indicate the intensity of services needed taking into account the setting of care. Therefore, standardization of rate components is important to build into these models as the intensity of treatment and team structure adjusts based on the acuity and need of the population.

The variability in service location requires additional considerations for staffing. The program’s provider manual, the ASAM continuum of care, and the Medicaid website identify rigorous service criteria that we leveraged to appropriately capture the specifics of each individual level of service⁷. In the next sections we outline the different rate assumptions that were developed to differentiate between the acuity of the population between each level.

⁷ Medicaid Innovation Accelerator Program, Overview of Substance Use Disorder (SUD) Care Clinical Guidelines: Available online: <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/asam-resource-guide.pdf>

The ASAM, Intensive Outpatient and Partial Hospitalization rate models represent the following services:

- Ambulatory Withdrawal Management without Extended Monitoring ASAM 1 WM
- Outpatient Services ASAM 1.0 – Individual
- Outpatient Services ASAM – Group (Adolescent & Adult)
- Intensive Outpatient Services ASAM 2.1 – Individual & Group
- Intensive Outpatient Services (IOP) – Individual & Group
- Ambulatory Withdrawal Management with Extended On-Site Monitoring ASAM 2 WM
- Partial Hospitalization Program ASAM 2.5
- Partial Hospitalization Program (PHP)
- Clinically Managed Residential Withdrawal Management ASAM 3.2 WM
- SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adolescent, age 12 – 17)
- SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adolescent, age 18 – 21)
- SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adult)
- SUD Clinically Managed Population Specific High-Intensity Residential ASAM 3.3 (Adult)
- ASAM Level 3.5 Clinically Managed High-intensity Residential Services Adult (ASAM Level 3.5 Adult)
- ASAM Level 3.5 Clinically Managed High-intensity Residential Services Adolescent age 12-17 (ASAM Level 3.5)
- ASAM Level 3.5 Clinically Managed High-intensity Residential Services Adolescent age 18-21 (ASAM Level 3.5)
- Medically Monitored High Intensity Inpatient ASAM 3.7 (Adult)
- Medically Monitored High Intensity Inpatient ASAM 3.7 (Adolescent, age 18 – 21)
- Medically Monitored High Intensity Inpatient ASAM 3.7 (Adolescent, age 12 – 17)
- Medically Monitored Inpatient Withdrawal Management ASAM 3.7 WM
- Medically Managed Intensive Inpatient ASAM 4.0
- Medically Managed Intensive Inpatient Withdrawal Management ASAM 4.0 WM

G.3.4.1. Outpatient, ASAM 2.1 and Intensive Outpatient

The outpatient services are the first level in the continuum therefore the rate components are similar to those found within the General Community services. However, we have incorporated a team-based structure to incorporate a Behavioral Specialist/Technician in combination with a Licensed Addition Counselor. Rate components are as follows:

- Administrative Percentage: 23.7%
- Program Support Percentage: 43.8%
- Group Sizes (where applicable): 3.0
- Productivity Percentage: 73.6% (individual), 68.6% (group)
- Supervision: Services assume approximately 5 hours per week of supervision with a supervisor span of control of approximately 1:8.
- No-Show Adjustment: 10.0% - 25.0%

Table 35 displays the benchmark rates for this set of services. Within the table you will observe that there is an incremental increase from the outpatient services to the intensive outpatient services to account for the enhanced need.

Table 35: ASAM 1.0 and Outpatient Benchmark Rates

Service	Service Description	Unit	Alaska Current Rate	Benchmark Rate
H0014V1	Ambulatory Withdrawal Management without Extended Monitoring ASAM 1 WM	15 Minutes	\$32.76	\$37.63
H0014CGV1	Ambulatory Withdrawal Management with Extended On-Site Monitoring ASAM 2 WM	15 Minutes	\$32.76	\$37.63
H0007V1	Outpatient Services ASAM 1.0 – Individual	15 Minutes	\$28.00	\$31.02
H0007HQHAV1	Outpatient Services ASAM – Group (Adolescent)	15 Minutes	\$9.21	\$11.04
H0007HQHBV1	Outpatient Services ASAM – Group (Adult)	15 Minutes	\$9.21	\$11.04
H0015HQV1	Intensive Outpatient Services ASAM 2.1 – Group	15 Minutes	\$10.67	\$13.46
H0015HQV2	Intensive Outpatient Services (IOP) – Group	15 Minutes	\$10.67	\$13.46
H0015V1	Intensive Outpatient Services ASAM 2.1 – Individual	15 Minutes	\$32.33	\$37.65
H0015V2	Intensive Outpatient Services (IOP) – Individual	15 Minutes	\$32.33	\$37.65

G.3.4.2. ASAM 2.5 and Partial Hospitalization

Partial Hospitalization and ASAM 2.5, Partial Hospitalization are the intermediate step down from the residential setting. The criteria details that this service should operate usually 5 days a week with at least 4 hours a day of intensive treatment. In addition, there is a team-based structure with group and individual treatment included. ASAM 2.5 Partial Hospitalization Program (PHP) involves intensive treatment during the day while allowing patients to return home in the evenings. Patients receive structured therapeutic activities, counseling, and medical support, making it suitable for individuals who need substantial care but not 24-hour supervision.

Non-Residential standardized rate components are as follows:

- Team Structure: Behavioral Specialist/Technician, Licensed Addiction Counselor (individual and group time), Case Manager, Psychiatrist
- Administrative Percentage: 23.7%
- Program Support Percentage: 43.8%
- Group Sizes (where applicable): 3.0
- Productivity Percentage: 72.0%
- Supervision: Clinical Director Oversight

Table 36 displays the benchmark rates for ASAM 2.5 and Partial Hospitalization.

Table 36: ASAM 2.5 and Partial Hospitalization Benchmark Rates

Service	Service Description	Unit	Alaska Current Rate	Benchmark Rate
H0035V1	Partial Hospitalization Program ASAM 2.5	Daily	\$546.01	\$691.97
H0035V2	Partial Hospitalization Program (PHP)	Daily	\$546.01	\$691.97

G.3.4.3. ASAM 3.1-4.0

The residential SUD services are organized in a hierarchical fashion where the need of the population primarily decreases from level to level, with the exception of some specialized populations. Therefore, facility sizes are similar between the levels but the staffing ratios and staff assumptions vary to account for the increased need. Clinically managed, medically monitored and medically managed categorization inform the rate assumptions with the medically monitored and medically managed including a more robust team of nurses to account for the additional medical complexities. In addition, levels 3.1 and 3.5 have minimum treatment hours included in the rate assumptions that follow the existing service descriptions established by the state.

SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adolescent, age 12 – 17), (Adolescent, age 18 – 21), and (Adult): ASAM 3.1 offers low-intensity residential treatment for individuals with substance use disorders. Patients receive age-appropriate therapeutic activities, counseling, and support in a residential setting. Guidehouse alongside DOH and

conversations with providers opted to align the benchmark rates for adult and adolescent SUD Clinically Managed Low-Intensity Residential ASAM 3.1 services.

Clinically Managed Residential Withdrawal Management ASAM 3.2 WM: ASAM 3.2 WM offers residential withdrawal management services with clinical oversight. Patients reside in a treatment facility where they receive continuous support and supervision to manage withdrawal symptoms safely.

SUD Clinically Managed Population Specific High-Intensity Residential ASAM 3.3 (Adult): ASAM 3.3 provides high-intensity residential treatment for adults with substance use disorders. This level involves structured therapeutic activities, counseling, and medical care tailored to specific populations, offering comprehensive support for recovery.

ASAM Level 3.5 Clinically Managed High-intensity Residential Services Adult (ASAM Level 3.5 Adult), (Adolescent age 12-17), and (Adolescent age 18-21): ASAM 3.5 provides high-intensity residential treatment. This level includes structured therapeutic activities, intensive counseling, and medical care, offering comprehensive support for individuals with severe substance use disorders. Guidehouse alongside DOH and conversations with providers opted to align the benchmark rates for adult and adolescent Clinically Managed High-intensity Residential ASAM 3.5 services.

Medically Monitored High Intensity Inpatient ASAM 3.7 (Adult), (Adolescent, age 18 – 21), and (Adolescent, age 12 – 17) and 3.7 Withdrawal Management: ASAM 3.7 offers medically monitored high-intensity inpatient treatment for adults. This level involves 24-hour medical supervision, intensive therapeutic activities, and counseling to address severe substance use disorders.

Medically Managed Intensive Inpatient ASAM 4.0 and Withdrawal Management ASAM 4.0 WM: ASAM 4.0 offers medically managed intensive inpatient treatment for individuals with severe substance use disorders. Patients receive 24-hour medical supervision, comprehensive therapeutic activities, and intensive counseling to support recovery. Additionally withdrawal management patients benefit from 24-hour medical supervision to safely manage withdrawal symptoms, along with comprehensive therapeutic support.

Residential standardized rate components are as follows:

- Team Structure: Behavioral Specialist/Technician, Licensed Addiction Counselor, Case Manager, Registered Nurse, Licensed Clinical Social Worker, Peer Support
- Administrative Percentage: 15.1%,
 - Residential services have a separate room and board component that is paid for outside of these rates. Therefore, we reduce the program support amount to remove the percentage that is attributed to building and equipment costs.
- Program Support Percentage: 43.8%
- Occupancy Percentage: 85.0%

Table 37 displays the facility size for reach of the ASAM residential services.

Table 37: ASAM Residential Facility Sizes

Service	Service Description	Facility Size
H0010V1	Clinically Managed Residential Withdrawal Management ASAM 3.2 WM	16 Person
H2036HAV1	SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adolescent, age 12 – 17)	12 Person
H2036CGHAV1	SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adolescent, age 18 – 21)	12 Person
H2036HFV1	SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adult)	12 Person
H0047HFV1	SUD Clinically Managed Population Specific High-Intensity Residential ASAM 3.3 (Adult)	8 Person
H0047TGV1	ASAM Level 3.5 Clinically Managed High-intensity Residential Services Adult (ASAM Level 3.5 Adult)	12 Person
H0047HAV1TF	ASAM Level 3.5 Clinically Managed High-intensity Residential Services Adolescent age 12-17 (ASAM Level 3.5)	12 Person
H0047CGV1HATF	ASAM Level 3.5 Clinically Managed High-intensity Residential Services Adolescent age 18-21 (ASAM Level 3.5)	12 Person
H0009TFV1	Medically Monitored High Intensity Inpatient ASAM 3.7 (Adult)	12 Person
H0009CGV1HATF	Medically Monitored High Intensity Inpatient ASAM 3.7 (Adolescent, age 18 – 21)	12 Person
H0009TFHAV1	Medically Monitored High Intensity Inpatient ASAM 3.7 (Adolescent, age 12 – 17)	12 Person
H0010TGV1	Medically Monitored Inpatient Withdrawal Management ASAM 3.7 WM	12 Person
H0009TGV1	Medically Managed Intensive Inpatient ASAM 4.0	8 Person
H0011V1	Medically Managed Intensive Inpatient Withdrawal Management ASAM 4.0 WM	8 Person

The primary drivers for rate differentials are due to the staffing ratios and team structure included to support service delivery. **Appendix A** illustrates the full rate model. The benchmark rates are in **Table 38** below.

Table 38: ASAM 3.1 – 4.0 Residential Benchmark Rates

Service	Service Description	Staffing	Minimum Treatment Hours	Unit	Alaska Current Rate	Benchmark Rate
H0010V1	Clinically Managed Residential Withdrawal Management ASAM 3.2 WM	1:8 Day 1:16 Night	-	Daily	\$330.06	\$343.29
H2036HAV1	SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adolescent, age 12 – 17)	1:6 Day 1:12 Night	5 Hours	Daily	\$386.61	\$398.07
H2036CGHAV1	SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adolescent, age 18 – 21)	1:6 Day 1:12 Night	5 Hours	Daily	\$386.61	\$398.07
H2036HFV1	SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adult)	1:6 Day 1:12 Night	5 Hours	Daily	\$437.72	\$398.07
H0047HFV1	SUD Clinically Managed Population Specific High-Intensity Residential ASAM 3.3 (Adult)	1:4 Day 1:8 Night	15 Hours	Daily	\$672.62	\$726.08
H0047TGV1	ASAM Level 3.5 Clinically Managed High-intensity Residential Services Adult (ASAM Level 3.5 Adult)	1:6 Day 1:12 Night	20 Hours	Daily	\$497.19	\$588.63
H0047HAV1TF	ASAM Level 3.5 Clinically Managed High-intensity Residential Services Adolescent age 12-17 (ASAM Level 3.5)	1:6 Day 1:12 Night	15 Hours	Daily	\$544.51	\$531.16

Service	Service Description	Staffing	Minimum Treatment Hours	Unit	Alaska Current Rate	Benchmark Rate
H0047CGV1HATF	ASAM Level 3.5 Clinically Managed High-intensity Residential Services Adolescent age 18-21 (ASAM Level 3.5)	1:6 Day 1:12 Night	15 Hours	Daily	\$544.51	\$531.16
H0009TFV1	Medically Monitored High Intensity Inpatient ASAM 3.7 (Adult)	1:6 Day 1:12 Night (With 24 Hour Nursing Care)	-	Daily	\$982.82	\$1,074.09
H0009CGV1HATF	Medically Monitored High Intensity Inpatient ASAM 3.7 (Adolescent, age 18 – 21)	1:6 Day 1:12 Night (With 24 Hour Nursing Care)	-	Daily	\$982.82	\$1,074.09
H0009TFHAV1	Medically Monitored High Intensity Inpatient ASAM 3.7 (Adolescent, age 12 – 17)	1:6 Day 1:12 Night (With 24 Hour Nursing Care)	-	Daily	\$982.82	\$1,074.09
H0010TGV1	Medically Monitored Inpatient Withdrawal Management ASAM 3.7 WM	1:6 Day 1:12 Night (With 24 Hour Nursing Care)	-	Daily	\$982.82	\$1,074.09
H0009TGV1	Medically Managed Intensive Inpatient ASAM 4.0	1:4 Day 1:8 Night (With 24 Hour Nursing Care)	-	Daily	\$1,638.04	\$1,641.53
H0011V1	Medically Managed Intensive Inpatient Withdrawal Management ASAM 4.0 WM	1:4 Day 1:8 Night (With 24 Hour Nursing Care)	-	Daily	\$1,638.04	\$1,641.53

G.3.5. Residential Service Methodologies

Adult Mental Health Residential and Children’s Residential Treatment are 1115 waiver services for behavioral health providers. Both services require a 24/7 rate development model where a multidisciplinary team of professionals is included to account for a combination of Residential Workers, Therapist/Social Workers, Case Managers, Certified Medication Assistant/Medication Aides, Nurse Practitioners and Registered Nurses.

G.3.5.1. Adult Mental Health Residential (AMHR)

Adult Mental Health Residential Services (AMHR) in Alaska provide structured living environments and support for adults with serious mental health disorders. These services aim to stabilize mental health conditions, enhance life skills, and promote community integration. Different levels of care are designed to meet the varying needs of individuals, ranging from intensive supervised settings to more independent living environments.

Residential Rate Assumptions:

- Facility Size: 12
- Staffing Ratios: 1:6 staffing ratio during the day and a 1:12 ratio at night.
- 24/7 Staffing Type: Residential Worker
- Program Support Percentage: 15.1%,
 - Residential services have a separate room and board component that is paid for outside of these rates. Therefore, we reduce the program support amount to remove the percentage that is attributed to building and equipment costs.
- Administrative Percentage: 43.8%
- Occupancy Adjuster: 85.0%
- Additional Dedicated Treatment Time:
 - Level 1: 8 hours per week – This higher allocation reflects the intensive therapeutic needs of Level 1 residents, requiring more frequent and longer sessions to address their complex mental health issues.
 - Level 2: 5 hours per week – Level 2 residents require less intensive therapy, hence the reduced allocation. This ensures that resources are appropriately matched to the residents' needs.
- Support Staff:
 - Case Manager- 5 hours a week
 - Certified Medication Assistant/Medication Aide: 1 hour per day – Ensures proper administration and monitoring of medication, which is critical for the residents' health and stability.
 - Nurse Practitioner: 3 hours per week – Provides medical oversight and addresses health issues that may impact mental health treatment.
 - Registered Nurse: 2 hours per week – Supports the nurse practitioner and helps with more routine healthcare needs.

Each component of the rate structure is thoughtfully designed to match the needs of the residents and ensure the effective operation of the services.

- **Difference in Therapist/Social Worker Time:** Level 1 requires more intensive therapeutic interventions due to the residents' higher acuity levels, necessitating more hours of professional time. Level 2 residents, having less intensive needs, benefit from fewer hours while still receiving adequate support.
- **Staffing Ratios:** Reflect the activity levels and intervention needs at different times of the day and night, ensuring residents receive appropriate care without unnecessary staffing expenses.
- **Other Staff Roles:** The inclusion of medical professionals and medication aides addresses the comprehensive health needs of residents, promoting overall stability and enhancing mental health outcomes.
- **Occupancy Factor:** Ensures financial viability while allowing for operational flexibility and maintaining high-quality care standards.

Adult Mental Health Residential Services (AMHR) Level 1

AMHR Level 1 offers intensive, 24-hour supervised residential care for adults with severe mental health conditions. Key features include:

- **24/7 Supervision:** Continuous support and monitoring by trained staff.
- **Individualized Treatment Plans:** Tailored plans addressing mental health, medical, and psychosocial needs.
- **Therapeutic Services:** Regular access to therapeutic interventions, including individual and group therapy.
- **Life Skills Training:** Programs to develop daily living skills such as personal hygiene, meal preparation, and financial management.
- **Medication Management:** Assistance with medication adherence and monitoring for side effects.
- **Community Integration:** Activities and support to promote social skills and community participation.

Adult Mental Health Residential Services (AMHR) Level 2

AMHR Level 2 provides a less intensive, yet still supportive residential environment for adults with mental health disorders who require some level of supervision and assistance. Key features include:

- **Partial Supervision:** Staff are available for support and supervision, but residents have more independence.
- **Individualized Care Plans:** Development of personalized care plans to address ongoing mental health and daily living needs.
- **Supportive Services:** Access to counseling, peer support, and case management services.

- Rehabilitation Programs: Opportunities for vocational training, education, and employment support.
- Medication Assistance: Help with medication management, including reminders and monitoring.
- Enhanced Life Skills Training: Continued focus on developing independent living skills.
- Community Activities: Encouragement to engage in community-based activities and build social networks.

The AMHR model is designed to provide comprehensive, efficient, and sustainable care for individuals with mental health challenges. The carefully considered staffing ratios, professional time allocations, and cost structures ensure that residents receive the support they need while maintaining the operational integrity of the services. See **Table 39** for AMHR Rates.

Table 39: Adult Mental Health Residential Rates

Service	Service Description	Staffing	Minimum Treatment Hours	Facility Size	Alaska Current Rate	Benchmark Rate
T2016V2	Adult Mental Health Residential Services (AMHR) Level 1	1:6 Day 1:12 Night	8 Hours	12 Person	\$656.97	\$603.57
T2016TGV2	Adult Mental Health Residential Services (AMHR) Level 2	1:6 Day 1:12 Night	5 Hours	12 Person	\$524.45	\$561.92

G.3.5.2. Children's Residential Treatment

Children's Residential Treatment Services in Alaska provide essential support, nurturing environments, and treatment interventions for children in need. These services are structured around two primary levels of care—CRT Level 1 and CRT Level 2. Both levels assume the primary role of residential workers, as confirmed by survey results.

Residential Rate Assumptions:

- Facility Size: 12
- Staffing Ratios: 1:6 staffing ratio during the day and a 1:10 ratio at night to account for minimum licensing requirements
- 24/7 Staffing Type: Residential Worker
- Program Support Percentage: 15.1%,
 - Residential services have a separate room and board component that is paid for outside of these rates. Therefore, we reduce the program support amount to remove the percentage that is attributed to building and equipment costs.
- Administrative Percentage: 43.8%

- Occupancy Adjuster: 85.0%
- Additional Dedicated Treatment Time by Licensed Clinical Social Worker:
 - Level 1: 10 hours per week
 - Level 2: 15 hours per week
- Support Staff:
 - Case Management: Each home assumes 5 hours per week of case management time to coordinate services, manage care plans, and liaise with external agencies.
 - Nurse Practitioner: There is an assumption of 1 hour per week of nurse practitioner time for medical assessments and health care coordination.

Rate model development may include the minimum staffing ratios due to licensing requirements. However, this staffing ratio is for the primary job type of residential workers. There are additional staff that are included with direct care hours in addition to the extensive indirect costs to account for additional program support and administrative staff. Additional direct care hours are included for Licensed Clinical Social Workers, Case Managers, Certified Medicaid Assistants and Nurse Practitioner time. **Appendix A** illustrates the cost assumptions and the total dollars the model assumes per resident a year.

This structured approach ensures that children in need receive the appropriate level of care, supervision, and therapeutic support, helping them to achieve better outcomes and improved well-being. See **Table 40** for CRT Rates.

Table 40: Children's Residential Treatment Service Benchmark Rates

Service	Service Description	Staffing	Minimum Treatment Hours	Facility Size	Alaska Current Rate	Benchmark Rate
T2033V2	Children's Residential Treatment CRT Level 1	1:6 Day 1:10 Night	10 hours	12 Person	\$334.16	\$506.40
T2033TFV2	Children's Residential Treatment CRT Level 2	1:6 Day 1:10 Night	15 hours	12 Person	\$464.51	\$590.21

G.3.5.3. Therapeutic Treatment Homes (TTH)

Alaska's Therapeutic Treatment Homes (TTH) service is a unique service that offers a supportive, family-like setting where trained caregivers deliver individualized care plans to address each child's unique needs.

The TTH service in Alaska is dedicated to ensuring that children in need receive the highest level of care within a nurturing and stable home environment. The goal is to help these children develop essential life skills, improve their emotional and mental health, and ultimately reintegrate into their communities successfully. The service includes highly trained staff, therapeutic interventions, and a comprehensive support system involving case managers, social workers, and program directors.

Unlike the traditional 24/7 residential models TTH includes a stipend that is paid to the foster parent to provide care for the child in their home. In addition, to the stipend payment there are costs to the provider to operate the service and incorporate adequate oversight and training to the foster parents.

The final rate model includes the following key components:

- Staffing Considerations:
 - Licensed Clinical Social Worker: 240 annual hours per person
 - Program Manager/Director Supervision: 104 annual hours per person
 - Case Manager: 240 annual hours per person
- Administrative Costs: 43.8%
- Program Support: 15.1%
- Occupancy Percentage: 85%
- Stipend Assumption: \$150 per month

Focus groups were an impactful data point as the providers described the hands-on approach to ensuring that the foster parents are receiving adequate training, there is a 24/7 call line in case of issues and proper oversight of the homes to determine safety requirements have been met. The components of the rate model are carefully crafted to support the various aspects of the TTH service, ultimately contributing to the well-being and development of the children served. **Table 41** displays the benchmark rate for TTH.

Table 41: Therapeutic Treatment Homes (TTH) Service Rates

Service	Service Description	Alaska Current Rate	Benchmark Rate
H2020V2	Therapeutic Treatment Homes (TTH)	\$321.77	\$306.80

G.3.6. Crisis Services

G.3.6.1. Crisis Residential and Stabilization Services (CSS)

This report provides a comprehensive overview of the rate model components utilized to calculate the Crisis Residential and Stabilization Services in Alaska, with a specific focus on a 12-bed facility. The objective of this model is to ensure that the facility is adequately staffed and resourced to provide high-quality care and support to its residents.

Rate Model Structure:

- Facility Size: 12-bed
- Staffing Ratio: 1:6 during daytime hours and 1:12 during nighttime hours

- Team Structure (All staff have the same staffing ratios of 1:6, 1:12):
 - Certified Peer Support Staff:
 - Clinical Specialist
 - Registered Nurse
 - Case Manager
- Additional Support Staff:
 - Nurse Practitioner Time: Allocated 10 hours per day for prescribing duties.
 - Clinical Supervisor: Allocated 7 hours per week to oversee clinical operations and provide supervision.
- Program Support Percentage: 23.7%,
- Administrative Percentage: 43.8%
- Occupancy Adjuster: 85.0%
 - The rate model assumes an occupancy rate of 85%. This assumption helps to account for periods when there may be vacancies, ensuring that the facility can maintain financial stability and continue to provide uninterrupted services despite fluctuations in occupancy.

The rate model for the Crisis Residential and Stabilization Services in Alaska is comprehensively structured to ensure optimal care and support for residents. The detailed staffing assumptions, combined with the financial add-ons, are designed to cater to the unique needs of a 12-bed facility. This model serves as a robust framework for delivering high-quality services while maintaining operational efficiency and financial sustainability. See **Table 42** below for an overview of the components in the rate model:

Table 42: Crisis Residential and Stabilization Services (CSS) Rate

Service	Service Description	Unit	Alaska Current Rate	Benchmark Rate
S9485V1 & S9485V2	Crisis Residential and Stabilization Services (CSS)	Daily	\$982.82	\$1,577.43

G.3.6.2. 23-Hour Crisis Observation and Stabilization (COS), Short-Term Crisis Intervention, and Short-Term Crisis Stabilization

This report provides a comprehensive overview of the rate model components utilized to calculate the 23-Hour Crisis Observation and Stabilization (COS) in Alaska, with a specific focus on a 12 bed facility. The objective of this model is to ensure that the facility is adequately staffed and resourced to provide high-quality care and support to its residents. The rate model structure follows a similar staff and team structure at a higher intensity.

Rate Model Structure:

- Facility Size: 12-bed
- Staffing ratios: Maintained at 1:3 during daytime hours and 1:6 at night. Due to the frequent turnover of patients throughout the day and the heightened acuity often present upon admission, adjustments to staffing ratios have been implemented to ensure adequate support during periods of increased crisis.
- Team Structure (All staff have the same staffing ratios of 1:3, 1:6):
 - Certified Peer Support Staff:
 - Clinical Specialist
 - Registered Nurse
 - Case Manager
- Additional Support Staff:
 - Nurse Practitioner Time: Allocated 24 hours per day split across 12 residents for prescribing duties
 - Clinical Supervisor: Allocated 7 hours per week to oversee clinical operations and provide supervision.
- Program Support Percentage: 23.7%,
- Administrative Percentage: 43.8%
- Occupancy Adjuster: 80.0%
 - The stabilization services have adjusted occupancy levels to reflect more consistent patient movement in and out of the crisis unit.

Short-Term Crisis Intervention and Short-Term Crisis Stabilization are essential components of the crisis response continuum. These services leverage the hourly build-up model used in 23-Hour Crisis Observation and Stabilization (COS) to determine their rates. By breaking down the hourly rates into smaller increments, these services can derive their 15-minute rates, ensuring that the billing is accurate and reflective of the actual time spent on crisis intervention and stabilization. Rates for the 23-Hour Crisis and Short-Term Crisis are included in **Table 43**.

Table 43: 23-Hour Crisis Observation and Stabilization (COS), Short-Term Crisis Intervention, and Short-Term Crisis Stabilization Rates

Service	Service Description	Unit	Alaska Current Rate	Benchmark Rate
S9484V1 & S9484V2	23-Hour Crisis Observation and Stabilization (COS)	Hourly	\$126.89	\$142.05
S9484U6, S9484U695, S9484U6FQ, S9484U6GT	Short-Term Crisis Intervention	15 Minutes	\$37.05	\$35.51
H2011, H201195, H2011FQ, H2011GT	Short-Term Crisis Stabilization	15 Minutes	\$34.63	\$35.51

G.3.7. Other Service Methodologies

B.3.7.1. Day Treatment for Children

Day Treatment for Children programs in Alaska integrate mental health services with educational resources from local school districts. These programs are designed to provide comprehensive care for children facing mental health challenges, ensuring they can continue their education while receiving necessary therapeutic support.

To develop an effective rate model, several assumptions and components were considered:

- **Group Therapy Duration:** The duration of 3 hours and 45 minutes per day ensures that children receive adequate therapeutic intervention while allowing for educational activities. The group size of 5 ensures individualized attention within a group setting.
- **Individual Therapy Duration:** The 15 minutes per day of individual therapy allows for focused, personalized intervention without overwhelming the child or the counselor. It provides a balance between group interaction and individual support.
- **Productivity:** 75%
- **Additional Staff:** Case Manager and Psychiatrist
 - Both case management and psychiatrist time are included in the rate model, with each contributing 1 hour per day split among the group of 5 children. This ensures that comprehensive care plans are developed and monitored, and that children receive appropriate psychiatric evaluations and interventions.
- **Administrative Percentage:** 43.8%,
- **Program Support Percentage:** 15.1%

By combining mental health services with educational resources, Day Treatment for Children programs in Alaska provide a holistic approach to care, ensuring that children can thrive both academically and emotionally. The carefully considered rate components ensure that these programs are financially sustainable while maintaining high standards of care. See **Table 44** for Day Treatment for Children Rates.

Table 44: Day Treatment for Children Rates

Service	Service Description	Unit	Alaska Current Rate	Benchmark Rate
H2012	Day Treatment for Children (combined mental health and school district resources) (Not to exceed six hours per school day)	1 Hour	\$46.38	\$52.11

H. Fiscal Impact Estimates

The fiscal impact analysis aims to use historical utilization to project prospective costs for the overall behavioral health services and specifically the portion related to state share. These scenarios assume consistent utilization from the prior year, based on the information that was available at the rate of the rate evaluation. However, it is important to note that if there are substantial shifts in utilization due to rates adjusting or additional providers entering the system these numbers may change. In addition, we created four distinct scenarios to display the combined impacts of a “hold harmless” approach and additional inflation depending on when the rates may go into effect.

H.1. Utilizing State Fiscal Year 2024 Claims Data

One of the foundational elements of our fiscal analysis is the use of claims utilization data from state fiscal year 2024 as this was the most recent full year available at the time of the rate evaluation. By leveraging this data, we can project future costs under the new benchmark rates with a high degree of accuracy. This historical claims data provides insights into patterns of service use and expenditure, allowing us to forecast future financial impacts in a structured and evidence-based manner. It is important to note that substantial changes in utilization due to things like provider capacity, access changes and policy decisions will not be reflected in the underlying data.

H.2. Comparative Analysis with Existing Rates

To strengthen our benchmark rate recommendations, we compared them with the latest Alaska behavioral health rates. Since our data covers an earlier period, we updated expenditures using the new rates effective November 2024. This approach allows us to accurately show the fiscal impact based on the most current rates and reflect potential changes.

H.3. Incorporating Federal Medical Assistance Percentages (FMAP)

Our analysis also takes into account the Federal Medical Assistance Percentages (FMAP) for various programs including Medicaid Expansion, Title 19, Title 21, and Indian Health Service (IHS). It is imperative to consider these variables as they significantly influence the fiscal landscape. We have accounted for IHS members and IHS providers within our projections, ensuring that their unique circumstances are adequately represented and evaluated. The current FMAP included is

52.42 percent for the general Medicaid population, 65 percent for Title 21, 90 percent for Medicaid Expansion and 100 percent for HIS. The combination of these FMAP percentages provide insights into the state share portion of the fiscal impact, illustrating the population mix depending on the service.

H.4. Geographic Differential Adjustments

An additional layer added to our analysis is the geographic differential adjustments as initially discussed in **Section C.2.3**. Recognizing the diverse economic conditions across Alaska, we make these adjustments on a borough/census basis. These adjustments are driven by the costs and purchasing power of different areas throughout the state, thus allowing us to tailor our fiscal projections to reflect local economic impacts. By incorporating these geographic differentials, we allow for benchmark rates that are representative of the economic pressures within the remote regions of the state.

H.5. Behavioral Health Service Mix

We develop benchmark rates on the individual service level but for ease in interpretation Guidehouse grouped like services into service groupings. As discussed throughout the report these service groupings were also used to help build consistent rate assumptions in these like services. Before evaluating the fiscal impact of the benchmark rates it is important to understand the service mix by these service groupings, as increases or decreases in services that account for a larger portion of behavioral health expenditures will have a larger impact on the overall state expenditures.

Looking at **Figure 11** below we show the current total service mix (Federal and State) using SFY 2024 total expenditures. Indian Health Services (IHS) account for half of the total SFY 2024 expenditures. Due to claims data limitations we are unable to determine the individual services included in the IHS encounter rate but we are still able to observe the total dollars attributed to the encounter rate.

**Figure 11: Behavioral Health Service Grouping SFY2024 Medicaid Expenditures
(Including IHS Providers and IHS Members)**

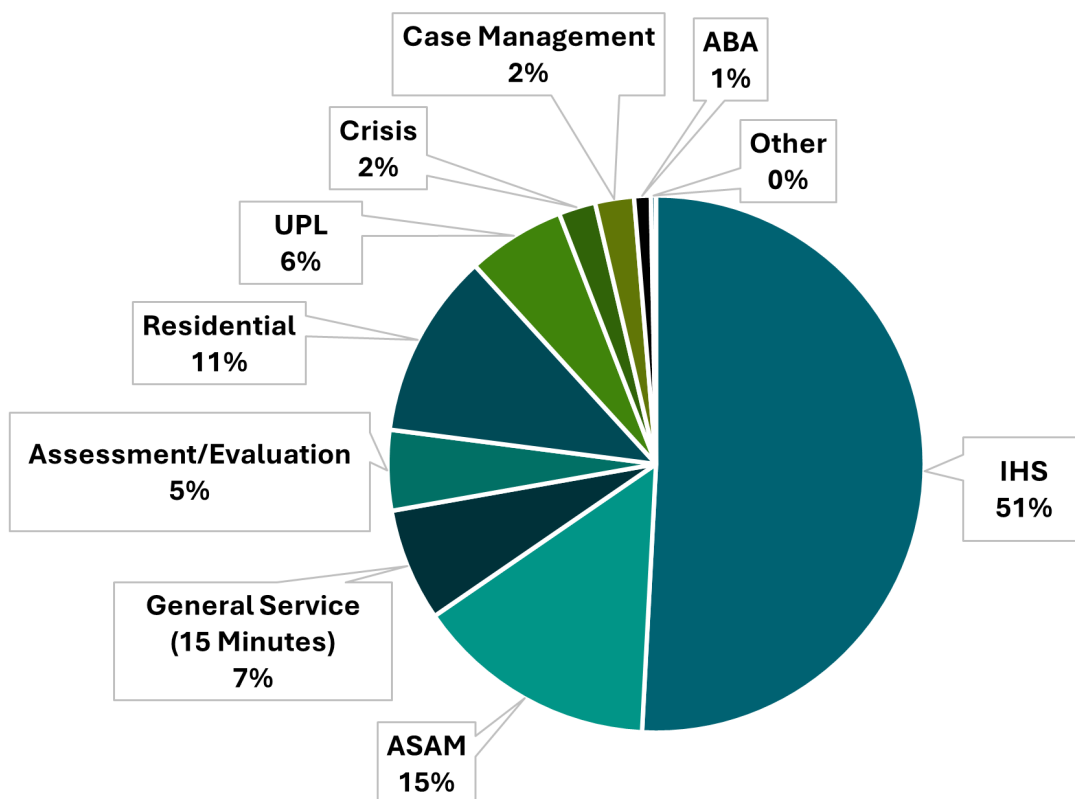
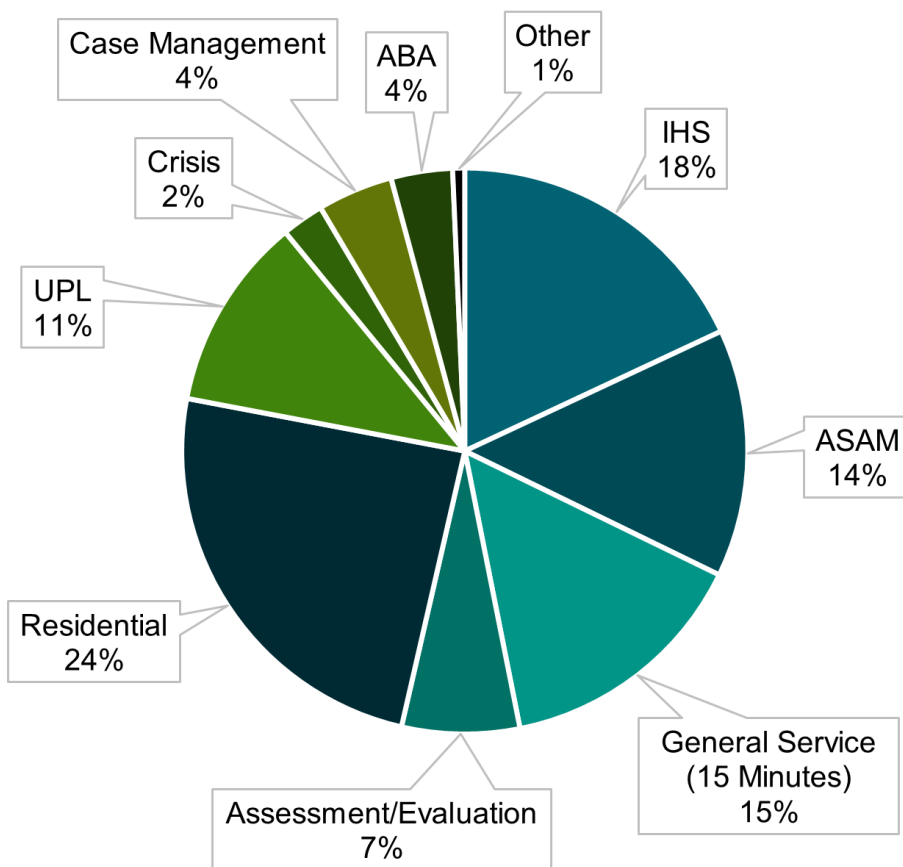
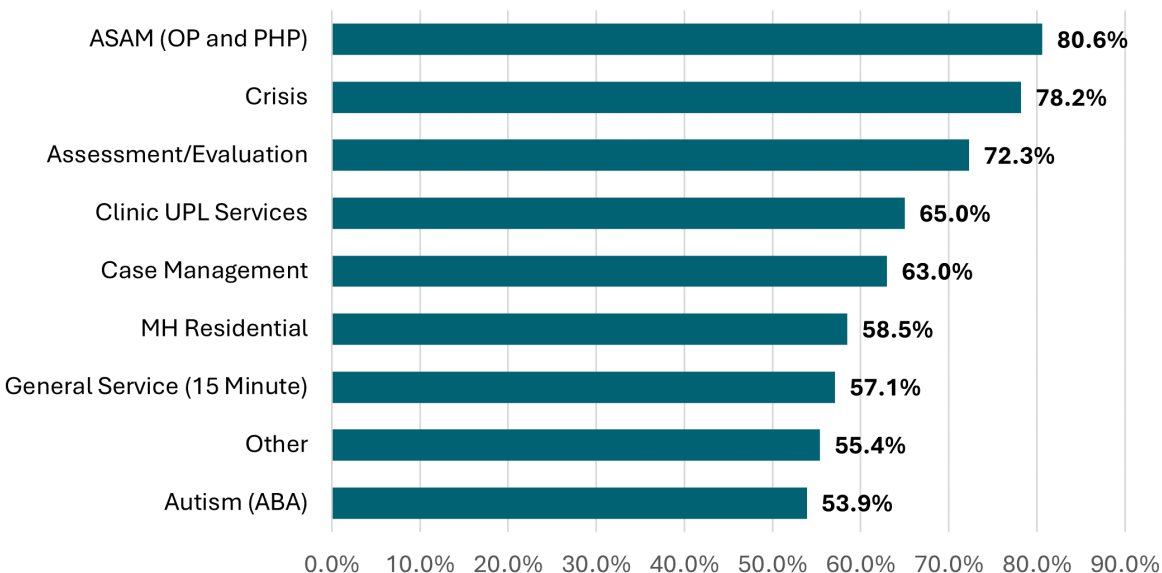


Figure 12 displays the service mix based solely on the state share for SFY 2024. Examining this portion highlights that residential services make up the largest share of state spending, so increases in these services have a greater fiscal impact. Conversely, while Autism services have seen significant benchmark rate increases, they represent only about 4% of total expenditures per **Figure 12**; thus, higher rates here have less effect on overall state costs. Non-IHS members can access services through IHS providers where the provider will still receive the encounter daily rate. However, the 100 percent federal match does apply, resulting in a cost to the state. Therefore, the encounter rate still represents 18% of the total as this is the state share for the non-IHS members visiting IHS provider sites.

Figure 12: Behavioral Health Service Grouping SFY2024 State Share Medicaid Expenditures (Excluding IHS Members)



The fiscal impact scenarios all combine historical claims data, application of the most current Alaska behavioral health rates and FMAP considerations to understand the state share impact. FMAP is particularly important in the behavioral health space due to the larger number of Medicaid expansion members that utilize these services. **Figure 13** illustrates the weighted average FMAP associated with members utilizing each service. The elevated average FMAP is attributable to services that are more frequently used by Medicaid Expansion members, particularly within the ASAM (IOP and PHP) service grouping.

Figure 13: FMAP Percentage by Service Grouping


This comprehensive approach ensures that our fiscal projections are accurate, inclusive, and regionally tailored, thereby supporting informed decision-making and sustainable financial planning in the realm of behavioral health services. We have created four scenarios of fiscal impact outlined in the sections below.

H.6. Fiscal Impact Scenarios

In the sections below we outline four different fiscal impact scenarios that show a combination of a “hold harmless” approach with inflationary metrics based on the time of rate implementation. These scenarios are reflective of the impact of rate changes based on Medicaid service utilization and do not reflect the additional administrative overhead costs to the state for recommendations that require additional investment from the state in the form of technology, state employee FTEs and infrastructure. For the sake of analysis, Guidehouse chose a simple rate corridor, a “hold harmless” provision, as a straightforward proof of concept and an illustration of one potential solution to the challenge of rate volatility. In the scenario explored by Guidehouse, rates would be increased to the benchmark, but services otherwise seeing rate decreases would be held harmless, meaning that rates would be frozen at their current level for a certain amount of time to allow providers to adjust to full implementation of benchmark rates. As the underlying wage data utilized in this rate study was for April 2025 to June 2024, cost elements will start to become old and are not necessarily reflective of the time period when rates would go into effect. Therefore, we included multiple scenarios with two scenarios reflecting the 2.1 percent CES inflation for outpatient mental health and substance abuse centers applied to the wage data to reflect a rate implementation period of July 2025, projected one year forward, compared to an additional 3.2 percent inflation based on the PPI category of psychiatric and substance abuse hospitals for an implementation in July 2026. However, depending on when the rates ultimately go into effect DOH should reevaluate this inflationary metric to determine the appropriateness.

H.6.1. Scenario 1: Not Held Harmless, No Additional Inflation (Rates Effective 7/1/2025)

This baseline scenario models the fiscal impact if rate decreases are allowed to flow through ("not held harmless") and the baseline inflationary adjustment is applied to the wages to move underlying wage data forward from June 2024 to July 2025. It represents a conservative, cost-containment approach, capturing the net impact of redistributing rates based on current utilization and cost structures without additional fiscal growth factors. The total fiscal impact is \$13.14 million, with a 7.2% overall increase and a 7.0% increase to the state share.

The essence of this scenario lies in its stringent approach to fiscal management. By allowing rate decreases, it emphasizes the redistribution of current funds without seeking additional budget allocations. This scenario ensures that spending aligns closely with existing cost structures and utilization patterns, minimizing the potential for budgetary excess. It provides a clear picture of how conservative fiscal policies can affect state and overall expenditures, ensuring that increases in funding are carefully controlled and justified through existing financial parameters. These can be seen by service grouping below in **Table 45**.

Table 45: Scenario 1- Not Held Harmless, No Additional Inflation (Rates Effective 7/1/2025)

Service Grouping	Projected Total Fiscal Impact (State & Federal Share)	Projected Total Fiscal Impact (State & Federal Share) % Change	Projected Total Fiscal Impact (State Share)	Projected Total Fiscal Impact (State Share) % Change
ASAM, Intensive Outpatient, and Partial Hospitalization Services	\$5,279,000	10.7%	\$1,077,000	11.2%
Assessment, Evaluation, and Screening Services	\$1,768,000	7.5%	\$526,000	8.1%
Autism (ABA) Services	\$2,343,000	41.3%	\$1,092,000	41.3%
Case Management	\$0	0.0%	\$0	0.0%
Crisis Services	\$1,361,000	18.1%	\$282,000	17.1%
General Community Services	\$375,000	1.5%	\$123,000	1.1%
Other Services	\$66,000	5.0%	\$31,000	5.2%
Residential Services	\$1,951,000	4.9%	\$1,010,000	6.1%

Service Grouping	Projected Total Fiscal Impact (State & Federal Share)	Projected Total Fiscal Impact (State & Federal Share) % Change	Projected Total Fiscal Impact (State Share)	Projected Total Fiscal Impact (State Share) % Change
Clinic “UPL” Services	\$0	0.0%	\$0	0.0%
Total	\$13,143,000	7.2%	\$4,141,000	7.0%

H.6.2. Scenario 2: Not Held Harmless, With 3.2% Inflation (Rates Effective 7/1/2026)

This scenario builds on the first by incorporating a 3.2 percent PPI inflation factor to move the rates forward an additional year to rate implementation in July 2026. This approach represents an effort to adjust rates in line with rising costs while still allowing decreases to take effect. The result is a higher total fiscal impact of \$15.55 million (8.5% increase overall, 8.4% for the state share), indicating the influence of inflationary adjustments on the budget and additional needs for funding if rate implementation happens further in the future.

Incorporating inflation into rate adjustments acknowledges the real-world economic pressures that affect costs across the board as well as considering time of rate implementation. This scenario aims to have rates keep up with consistent rising costs ensuring that rates remain realistic and sustainable. By allowing for rate decreases while factoring in inflation, the approach seeks to maintain the rebalancing efforts discussed within the findings section of the report. This scenario highlights the importance of considering economic trends and cost increases in fiscal planning, demonstrating the delicate balance between fiscal conservatism and necessary adjustments. In addition, this scenario increases the Clinic “UPL” services by inflation, however dependent on the upper payment limit these services may not be able to receive the full amount of inflation as they are restrained by the UPL. These can be seen by service grouping below in **Table 46**.

Table 46: Scenario 2- Not Held Harmless, With 3.2% Inflation (Rates Effective 7/1/2026)

Service Grouping	Projected Total Fiscal Impact (State & Federal Share)	Projected Total Fiscal Impact (State & Federal Share) % Change	Projected Total Fiscal Impact (State Share)	Projected Total Fiscal Impact (State Share) % Change
ASAM, Intensive Outpatient, and Partial Hospitalization Services	\$5,587,000	11.3%	\$1,142,000	11.9%
Assessment, Evaluation, and Screening Services	\$1,829,000	7.7%	\$549,000	8.4%
Autism (ABA) Services	\$2,343,000	41.3%	\$1,092,000	41.3%

Service Grouping	Projected Total Fiscal Impact (State & Federal Share)	Projected Total Fiscal Impact (State & Federal Share) % Change	Projected Total Fiscal Impact (State Share)	Projected Total Fiscal Impact (State Share) % Change
Case Management Services	\$265,000	3.2%	\$98,000	3.2%
Crisis Services	\$1,365,000	18.2%	\$284,000	17.2%
General Community Services	\$659,000	2.6%	\$247,00	2.2%
Other Services	\$91,000	6.9%	\$42,000	7.0%
Residential Service	\$2,709,000	6.8%	\$1,317,000	8.0%
Clinic “UPL” Services	\$705,000	3.2%	\$251,000	3.2%
Total	\$15,553,000	8.5%	\$5,022,000	8.4%

H.6.3. Scenario 3: Held Harmless, No Additional Inflation (Rates Effective 7/1/2025)

In contrast to Scenarios 1 and 2, this scenario applies a "hold harmless" provision, meaning providers whose rates would otherwise decrease are maintained at current levels. This approach emphasizes provider stability and minimizes disruption but increases the fiscal impact since no downward adjustments offset increases elsewhere. With a baseline inflationary adjustment being applied wage data is moved forward from June 2024 to July 2025, the fiscal impact rises to \$17.54 million (9.6% overall, 9.6% state share), illustrating the cost of maintaining rate floors.

The "hold harmless" approach prioritizes the stability of providers by ensuring that those facing potential rate decreases remain unaffected. This scenario is designed to minimize disruption and maintain consistent funding levels across the board. However, this stability comes at a cost, as the lack of downward adjustments means that increases in funding are not counterbalanced, leading to a significant rise in the fiscal impact. This scenario underscores the trade-offs between stability and cost containment, demonstrating the financial implications of maintaining rate floors without accounting for broader economic factors or cost reductions. These can be seen by service grouping below in **Table 47**:

Table 47: Scenario 3- Held Harmless, No Additional Inflation (Rates Effective 7/1/2025)

Service Grouping	Projected Total Fiscal Impact (State & Federal Share)	Projected Total Fiscal Impact (State & Federal Share) % Change	Projected Total Fiscal Impact (State Share)	Projected Total Fiscal Impact (State Share) % Change
ASAM, Intensive Outpatient, and Partial Hospitalization Services	\$6,087,000	12.3%	\$1,213,000	12.6%

Service Grouping	Projected Total Fiscal Impact (State & Federal Share)	Projected Total Fiscal Impact (State & Federal Share) % Change	Projected Total Fiscal Impact (State Share)	Projected Total Fiscal Impact (State Share) % Change
Assessment, Evaluation, and Screening Services	\$2,041,000	8.6%	\$602,000	9.3%
Autism (ABA) Services	\$2,343,000	41.3%	\$1,092,000	41.3%
Case Management Services	\$0	0.0%	\$0	0.0%
Crisis Services	\$1,367,000	18.2%	\$284,000	17.3%
General Community Services	\$2,235,000	8.7%	\$939,000	8.5%
Other Services	\$66,000	5.0%	\$31,000	5.2%
Residential Service	\$3,402,000	8.6%	\$1,554,000	9.4%
Clinic “UPL” Services	\$0	0.0%	\$0	0.0%
Total	\$17,541,000	9.6%	\$5,714,000	9.6%

H.6.4. Scenario 4: Held Harmless, With 3.2% Inflation (Rates Effective 7/1/2026)

This scenario combines the "hold harmless" provision with a 3.2 percent PPI inflation factor to move the rates forward an additional year to rate implementation in July 2026. This approach represents a comprehensive approach to adjusting provider rates. The fiscal impact of this scenario is the highest among all considered, with a total increase of \$20.09 million, an 11.0 percent overall increase, and an 11.2 percent increase in the state share.

The "hold harmless" provision is designed to protect providers from financial losses that might arise from changes in rate calculations or funding mechanisms, ensuring that providers are not adversely affected by any adjustments. Inflation, measured at 3.2 percent, acknowledges and responds to the reality that operating costs for providers will naturally increase, ensuring that the rates remain relevant and sufficient to cover growing expenses. In addition, this scenario increases the Clinic “UPL” services by inflation, however dependent on the upper payment limit these services may not be able to receive the full amount of inflation as they are restrained by the UPL.

The significant fiscal impact of this scenario reflects a commitment to both stability and responsiveness, providing a safety net for providers while ensuring their rates keep pace with

inflation. This approach positions the state to better absorb and adapt to future economic changes, fostering a resilient and sustainable healthcare system. These can be seen by service grouping below in **Table 48**.

Table 48: Scenario 4- Held Harmless, With 3.2% Inflation (Rates Effective 7/1/2026)

Service Grouping	Projected Total Fiscal Impact (State & Federal Share)	Projected Total Fiscal Impact (State & Federal Share) % Change	Projected Total Fiscal Impact (State Share)	Projected Total Fiscal Impact (State Share) % Change
ASAM, Intensive Outpatient, and Partial Hospitalization Services	\$6,421,000	13.0%	\$1,282,000	13.3%
Assessment, Evaluation, and Screening Services	\$2,110,000	8.9%	\$627,000	9.6%
Autism (ABA) Services	\$2,343,000	41.3%	\$1,092,000	41.3%
Case Management Services	\$265,000	3.2%	\$98,000	3.2%
Crisis Services	\$1,371,000	18.3%	\$286,000	17.4%
General Community Services	\$2,579,000	10.1%	\$1,089,000	9.9%
Other Services	\$91,000	6.9%	\$42,000	7.0%
Residential Service	\$4,205,000	10.6%	\$1,879,000	11.4%
Clinic “UPL” Services	\$704,000	3.2%	\$251,000	3.2%
Total	\$20,090,000	11.0%	\$6,645,000	11.2%

H.6.5. Overall Fiscal Impact

Together, these four scenarios offer a range of policy choices and fiscal implications, from minimal adjustment to full protection and inflation indexing. Scenario 1 results in a limited fiscal impact; however, it may compromise provider stability. Scenario 2, with modest inflation adjustments, balances cost and provider needs but still carries fiscal implications. Meanwhile, Scenario 3 and Scenario 4 illustrate the highest investment levels, prioritizing provider rate stability and responsiveness to cost inflation in future implementation, but at a larger fiscal cost.

This analysis supports transparent decision-making by highlighting the trade-offs between fiscal responsibility, provider stability, and responsiveness to cost growth. Policymakers must weigh these considerations carefully, balancing the need to manage budgetary constraints while ensuring providers can continue to operate effectively and deliver necessary services. Each scenario demonstrates different levels of investment and protection, offering a clear framework for understanding the fiscal and operational impacts of rate adjustments and inflation indexing. **Table 49** shows the total fiscal impact with the corresponding state share.

Table 49: Fiscal Impact (No Geographic Adjustment)

Scenario	Description	Projected Total Fiscal Impact (State & Federal Share)	Projected Total Fiscal Impact (State & Federal Share) % Change	Projected Total Fiscal Impact (State Share)	Projected Total Fiscal Impact (State Share) % Change
Scenario 1	Not held harmless with no additional inflation (Rates Eff 7/1/2025)	\$13,143,000	7.2%	\$4,141,000	7.0%
Scenario 2	Not held harmless with 3.2% inflation (Rates Eff 7/1/2026)	\$15,553,000	8.5%	\$5,022,000	8.4%
Scenario 3	Held harmless with no additional inflation (Rates Eff 7/1/2025)	\$17,541,000	9.6%	\$5,714,000	9.6%
Scenario 4	Held harmless with 3.2% inflation (Rates Eff 7/1/2026)	\$20,090,000	11.0%	\$6,645,000	11.2%

The following **Table 50** incorporates the geographic adjustments previously discussed in the fiscal impact section. These values do not include a geographic adjustment for Clinic “UPL” services, as the method by which these service rates are established may result in conflicts with providers exceeding the maximum allowable UPL rates. The geographic adjustments accounts for 18 distinct regions across the state, utilizing the EPI database referenced earlier in the report. The application of the geographic differential accounts for roughly a 2.1 percent increase in Scenario 1 as compared to the original fiscal impact with no geographic differential.

Table 50: Fiscal Impact (With Geographic Adjustment)

Scenario	Description	Projected Total Fiscal Impact (State & Federal Share)	Projected Total Fiscal Impact (State & Federal Share) % Change	Projected Total Fiscal Impact (State Share)	Projected Total Fiscal Impact (State Share) % Change
Scenario 1	Not held harmless with no additional inflation (Rates Eff 7/1/2025)	\$16,476,000	9.0%	\$5,414,000	9.1%

Scenario	Description	Projected Total Fiscal Impact (State & Federal Share)	Projected Total Fiscal Impact (State & Federal Share) % Change	Projected Total Fiscal Impact (State Share)	Projected Total Fiscal Impact (State Share) % Change
Scenario 2	Not held harmless with 3.2% inflation (Rates Eff 7/1/2026)	\$18,925,000	10.3%	\$6,310,000	10.6%
Scenario 3	Held harmless with no additional inflation (Rates Eff 7/1/2025)	\$20,979,000	11.5%	\$7,029,000	11.8%
Scenario 4	Held harmless with 3.2% inflation (Rates Eff 7/1/2026)	\$23,570,000	12.9%	\$7,976,000	13.4%

Overall, these scenarios are intended to be illustrative to show the lower and upper bounds depending on state decisions. All scenarios are dependent on budgetary considerations and the time of rate implementation. As discussed in the recommendations section there are recommendations that could ultimately impact reimbursement rates such as service definition review that are not included within these fiscal impact scenarios and therefore the overall impact could change depending on the implementation of specific Guidehouse recommendations. In addition, current rate recommendations were developed based on historical provider costs with generous assumptions for indirect costs, no show adjustment inclusion and smaller than reported group sizes that resulted in the benchmark rates displayed in this report. As DOH continues to review and evaluate their services the fiscal impact scenarios may be adjusted dependent on DOH decisions and the potential for a phased implementation approach for specific recommendations.

Finally, there are recommendations that require investment from the state such as cost reporting and behavioral health administrative updates that are not based on Medicaid service reimbursement. **Section C.2. Recommendations** outlines how Guidehouse arrived at these cost estimates based on cost components such as department staff time, technology and initial development while also considering leveraging resource already established in Recommendation LT-R4 in the LTSS Rate Evaluation. The cost estimated for these recommendations are included in **Table 51**.

Table 51: State Administrative/Overhead Costs

#	Recommendation	Projected Min: State	Projected Max: State	Projected Min: Fed & State	Projected Max: Fed & State
BH-R4	Behavioral Health Cost Reporting	\$148,000	\$224,000	\$296,000	\$447,000
BH-R8	Behavioral Health Administrative Rate Review*	\$9,000	\$18,000	\$18,000	\$35,000

I. Benchmark Rates

The behavioral health services reviewed by Guidehouse for the rate evaluation are listed in **Table 52** below. Services covered under the state's upper payment limit were not included in the rate assessment due to restrictions related to the clinic UPL. The report also includes recommendations for the Department of Health to examine the units of measure for Case Management, Intensive Case Management, SUD Care Coordination, and Assertive Community Treatment, therefore rates were not established by Guidehouse during the rate evaluation at this time.

Table 52: Behavioral Health Benchmark Rates

Service Grouping	Service	Service Description	Unit	Current Rate	Benchmark Rate	% Difference
Autism	97154	Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to multiple patients	15 minutes	\$8.76	\$11.11	26.8%
Autism	97153	Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to one patient	15 minutes	\$21.93	\$30.96	41.2%
Autism	97155	Adaptive behavior treatment with protocol modification administered by qualified health care professional to one patient	15 minutes	\$28.86	\$40.67	40.9%
Autism	97151	Behavioral identification assessment by qualified health care professional	15 minutes	\$28.86	\$40.67	40.9%
Autism	97156	Family adaptive behavior treatment guidance by qualified health care professional (with or without patient present)	15 minutes	\$18.11	\$40.67	124.6%
Autism	97158	Group Adaptive Behavior Treatment with Protocol Modification, administered by QHP face to face with multiple patients	15 minutes	\$11.54	\$14.72	27.6%

Service Grouping	Service	Service Description	Unit	Current Rate	Benchmark Rate	% Difference
Autism	97157	Multiple-Family Group Adaptive Behavior Treatment Guidance, administered by QHP (without the patient present), face to face with multiple sets of guardians/caregivers	15 minutes	\$7.24	\$14.72	103.3%
ASAM	H0014CGV1	Ambulatory Withdrawal Management with Extended On-Site Monitoring ASAM 2 WM	15 Minutes	\$32.76	\$37.63	14.9%
ASAM	H0014V1	Ambulatory Withdrawal Management without Extended Monitoring ASAM 1 WM	15 Minutes	\$32.76	\$37.63	14.9%
ASAM	H0047HAV1TF	ASAM Level 3.5 Clinically Managed High-intensity Residential Services Adolescent age 12-17 (ASAM Level 3.5)	Daily	\$544.51	\$531.16	-2.5%
ASAM	H0047CGV1HATF	ASAM Level 3.5 Clinically Managed High-intensity Residential Services Adolescent age 18-21 (ASAM Level 3.5)	Daily	\$544.51	\$531.16	-2.5%
ASAM	H0047TGV1	ASAM Level 3.5 Clinically Managed High-intensity Residential Services Adult (ASAM Level 3.5 Adult)	Daily	\$497.19	\$588.63	18.4%
ASAM	H0010V1	Clinically Managed Residential Withdrawal Management ASAM 3.2 WM	Daily	\$330.06	\$343.29	4.0%
ASAM	H0015HQP2	Intensive Outpatient Services (IOP) – Group	15 Minutes	\$10.67	\$13.46	26.1%
ASAM	H0015V2	Intensive Outpatient Services (IOP) – Individual	15 Minutes	\$32.33	\$37.65	16.5%
ASAM	H0015HQP1	Intensive Outpatient Services ASAM 2.1 – Group	15 Minutes	\$10.67	\$13.46	26.1%
ASAM	H0015V1	Intensive Outpatient Services ASAM 2.1 – Individual	15 Minutes	\$32.33	\$37.65	16.5%
ASAM	H0009TGV1	Medically Managed Intensive Inpatient ASAM 4.0	Daily	\$1,638.04	\$1,641.53	0.2%
ASAM	H0011V1	Medically Managed Intensive Inpatient Withdrawal Management ASAM 4.0 WM	Daily	\$1,638.04	\$1,641.53	0.2%
ASAM	H0009TFHAV1	Medically Monitored High Intensity Inpatient ASAM 3.7 (Adolescent, age 12 – 17)	Daily	\$982.82	\$1,074.09	9.3%
ASAM	H0009CGV1HATF	Medically Monitored High Intensity Inpatient ASAM 3.7 (Adolescent, age 18 – 21)	Daily	\$982.82	\$1,074.09	9.3%
ASAM	H0009TFV1	Medically Monitored High Intensity Inpatient ASAM 3.7 (Adult)	Daily	\$982.82	\$1,074.09	9.3%
ASAM	H0010TGV1	Medically Monitored Inpatient Withdrawal Management ASAM 3.7 WM	Daily	\$982.82	\$1,074.09	9.3%
ASAM	H0007HQP1	Outpatient Services ASAM – Group (Adolescent)	15 Minutes	\$9.21	\$11.04	19.9%
ASAM	H0007HQP2	Outpatient Services ASAM – Group (Adult)	15 Minutes	\$9.21	\$11.04	19.9%
ASAM	H0007V1	Outpatient Services ASAM 1.0 – Individual	15 Minutes	\$28.00	\$31.02	10.8%
ASAM	H0035V2	Partial Hospitalization Program (PHP)	Daily	\$546.01	\$691.97	26.7%

Service Grouping	Service	Service Description	Unit	Current Rate	Benchmark Rate	% Difference
ASAM	H0035V1	Partial Hospitalization Program ASAM 2.5	Daily	\$546.01	\$691.97	26.7%
ASAM	H2036HAV1	SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adolescent, age 12 – 17)	Daily	\$386.61	\$398.07	3.0%
ASAM	H2036CGHAV1	SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adolescent, age 18 – 21)	Daily	\$386.61	\$398.07	3.0%
ASAM	H2036HFV1	SUD Clinically Managed Low-Intensity Residential ASAM 3.1 (Adult)	Daily	\$437.72	\$398.07	-9.1%
ASAM	H0047HFV1	SUD Clinically Managed Population Specific High-Intensity Residential ASAM 3.3 (Adult)	Daily	\$672.62	\$726.08	7.9%
Assessment and Evaluation	T1023	Behavioral Health Screen - AK Screen Tool	1 screening	\$135.13	\$144.77	7.1%
Assessment and Evaluation	H0002	Medical Evaluation for Recipient NOT Receiving Methadone Treatment	1 evaluation	\$652.86	\$413.10	-36.7%
Assessment and Evaluation	H0002HF	Medical Evaluation for Recipient Receiving Methadone Treatment	1 evaluation	\$652.86	\$417.88	-36.0%
Assessment and Evaluation	H0020	Methadone Administration and/or Service	Administration Episode	\$39.29	\$44.02	12.0%
Assessment and Evaluation	H0033HK	Oral Medication Administration, direct observation; off premises (One billable service per day)	1 day	\$130.80	\$122.93	-6.0%
Assessment and Evaluation	H0033HK	Oral Medication Administration, direct observation; on premises (One billable service per day)	1 day	\$112.76	\$117.34	4.1%
Assessment and Evaluation	T1007V1 & T1007V2	Treatment Plan Development or Review	Per Assessment	\$147.89	\$192.54	30.2%
Assessment and Evaluation	T1007	Treatment Plan Review for Methadone Recipient	Per Assessment	\$97.45	\$127.30	30.6%
Crisis	S9484V1 & S9484V2	23-Hour Crisis Observation and Stabilization (COS)	Daily	\$126.89	\$142.05	11.9%
Crisis	S9485V1 & S9485V2	Crisis Residential and Stabilization Services (CSS)	Daily	\$982.82	\$1,577.43	60.5%
Crisis	S9484U6, S9484U695, S9484U6FQ, S9484U6GT	Short-Term Crisis Intervention	15 Minutes	\$37.05	\$35.51	-4.2%
Crisis	H2011, H201195, H2011FQ, H2011GT	Short-Term Crisis Stabilization	15 Minutes	\$34.63	\$35.51	2.5%
General Community	H2021HQV1	Community Recovery Support Services (CRSS) – Group	15 Minutes	\$6.14	\$9.46	54.1%

Service Grouping	Service	Service Description	Unit	Current Rate	Benchmark Rate	% Difference
General Community	H2021HQP2	Community Recovery Support Services (CRSS) – Group	15 Minutes	\$6.14	\$9.46	54.1%
General Community	H2021V1	Community Recovery Support Services (CRSS) – Individual	15 Minutes	\$23.44	\$26.36	12.5%
General Community	H2021V2	Community Recovery Support Services (CRSS) – Individual	15 Minutes	\$23.44	\$26.36	12.5%
General Community	H1011V2	Home-Based Family Treatment HBFT Level 1	15 Minutes	\$26.39	\$35.34	33.9%
General Community	H1011TFV2	Home-Based Family Treatment HBFT Level 2	15 Minutes	\$26.90	\$35.34	31.4%
General Community	H1011TGV2	Home-Based Family Treatment HBFT Level 3	15 Minutes	\$29.69	\$35.34	19.0%
General Community	H0038HS	Peer Support Services - Family (w/o patient present)	15 Minutes	\$30.67	\$25.61	-16.5%
General Community	H0038HR	Peer Support Services - Family (with patient present)	15 Minutes	\$30.67	\$25.61	-16.5%
General Community	H0038	Peer Support Services - Individual	15 Minutes	\$30.67	\$25.61	-16.5%
General Community	H0038V2	Peer-Based Crisis Services (PBCS)	15 Minutes	\$22.34	\$25.61	14.6%
General Community	H0038V1	Peer-Based Crisis Services (PBCS)	15 Minutes	\$22.34	\$25.61	14.6%
General Community	99408	Screening, Brief Intervention, and Referral for Treatment (SBIRT)	15-30 Minutes	\$58.04	\$55.83	-3.8%
General Community	H2019HS	Therapeutic BH Services - Family (w/o patient present)	15 Minutes	\$30.53	\$30.14	-1.3%
General Community	H2019HR	Therapeutic BH Services - Family (with patient present)	15 Minutes	\$30.53	\$30.14	-1.3%
General Community	H2019HQ	Therapeutic BH Services - Group	15 Minutes	\$14.33	\$10.81	-24.6%
General Community	H2019	Therapeutic BH Services - Individual	15 Minutes	\$30.53	\$30.14	-1.3%
Other Services	H2012	Day Treatment for Children (combined mental health and school district resources)	1 Hour	\$46.38	\$52.11	12.4%
Residential	T2016V2	Adult Mental Health Residential Services (AMHR) Level 1	Daily	\$656.97	\$603.57	-8.1%
Residential	T2016TGV2	Adult Mental Health Residential Services (AMHR) Level 2	Daily	\$524.45	\$561.92	7.1%
Residential	T2033V2	Children's Residential Treatment CRT Level 1	Daily	\$334.16	\$506.40	51.5%
Residential	T2033TFV2	Children's Residential Treatment CRT Level 2	Daily	\$464.51	\$590.21	27.1%
Residential	H2020V2	Therapeutic Treatment Homes (TTH)	Daily	\$321.77	\$306.80	-4.7%