REVIEW OF PAYMENT RATES FOR SUBSTANCE USE DISORDER RESIDENTIAL SERVICES COVERED BY SECTION 97

PUBLIC COMMENTS AND RESPONSES

– PREPARED FOR –

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

– PREPARED BY –

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PROJECT BACKGROUND

As part of its ongoing effort to review the adequacy of payment rates for MaineCare providers, the Maine Department of Health and Human Services (DHHS) contracted the national consulting firm Burns & Associates, a division of Health Management and Associates, to conduct a rate study for Substance Use Disorder (SUD) Treatment Facility services covered by Appendix B of Section 97 of the MaineCare Benefits Manual.

The rate review encompassed several tasks, including:

- A detailed review of the treatment models, MaineCare service requirements, billing rules, and DHHS' policy objectives
- Meetings with service providers
- Development and administration of a provider survey that was emailed to all providers to collect information regarding service designs and costs
- Review and analysis of provider cost reports
- Identification of other data sources to inform the development of the rate models, including cross-industry wage and benefit standards and rates paid for comparable services in other states
- Analyses of claims data

Based on this work, detailed rate models were developed. The models included the specific assumptions regarding the costs of delivering each service, such as the wages, benefits, and caseloads for direct support staff and clinicians, program occupancy, and agency overhead.

The proposed rate models were presented on March 29, 2021 to providers who were then given three weeks to provide written comments on the models. In response to public comments and the availability of updated data from other benchmark sources, a number of changes were made to the rate models:

- Incorporated more recent Bureau of Labor Statistics wage data and Bureau of Economic Analysis wage inflation data that became available after publication of the proposed rates.
- Increased the program support rate from 11 percent of the total cost to 13 percent.
- Increased the registered nurse staffing in Detoxification programs to allow for 24-hour coverage and reduced the assumed nurse-to-resident ratio from 1:16 to 1:8.
- Developed a Detoxification rate for programs that serves individuals with lower medical support needs that do not require 24-hour nursing coverage.
- Increased licensed alcohol and drug counselor staffing in Extended Care and Residential Rehabilitation Type I programs by reducing the staff-to-resident ratio from 1:6 to 1:5.

The cumulative effect of these changes is presented in the table below.

Service Description	Current Rate	Proposed Rate (03/26/2021)	Final Rate	Increase Compared to Current Rates	
Detoxification (Non Hospital)	$217.48	$254.44	$385.55	$168.07	77.3%
Detoxification (Non Hospital) - Low RN Support	$217.48		$238.12	$20.64	9.5%
Halfway House Services	$106.09	$158.52	$165.67	$59.58	56.2%
Extended Care	$116.89	$121.60	$137.21	$20.32	17.4%
Residential Rehab. Type I	$224.44	$267.90	$287.91	$63.47	28.3%
Residential Rehab. Type II	$119.65	$158.52	$165.67	$46.02	38.5%
Adolescent Residential Rehab.	$187.67	$244.65	$254.78	$67.11	35.8%

The remainder of this document provides DHHS' response to each specific comment.

ACROSS SERVICES

1. ***One commenter stated that a medical director position should be added to this rate to support the requirement to conduct physical assessments on all detoxification clients.***

   Assessment and other functions likely to be performed by a medical director are considered program support and are therefore incorporated in the program support component of the rate models. Additionally, there is not an expectation that every facility should have its own medical director.

   In response to feedback from providers, however, the assumed program support rate increased from 11 percent to 13 percent.

2. ***One commenter requested that room and board be included in the rate models.***

   In general, federal law prohibits the use of Medicaid funding for room and board costs and the state has not established supplemental payments for these costs. Room and board related expenses were therefore excluded from the rate study.

DETOXIFICATION

3. ***One commenter stated that there should be an overnight shift differential for direct support professionals of $1.50 per hour and $5 per hour for registered nurses.***

   The wage assumptions in the rate models are intended to reflect a typical wage. It is expected that for any given worker, some will earn more (for example, for experienced staff or those earning a shift differential) and others will earn less (for example, for new staff). The wage assumptions exceed the wage levels paid by providers based on their cost reports, which incorporate any shift differentials.

4. ***One commenter suggested the rate models should assume 24-hour registered nurse staffing at a ratio of one registered nurse for every 8 residents rather than the 1:16 ratio assumed in the rate models.***

   In response to this comment, the rate model has been revised to provide for 24-hour coverage by a registered nurse at an assumed ratio of one nurse for every 8 residents.

EXTENDED CARE

5. ***One commenter stated that the caseload ratio for licensed alcohol and drug counselors should be one LADC for every five residents rather than the one-to-six ratio assumed in the rate model.***

   In response to this comment, the rate model has been revised to reflect a one-to-five ratio for LADCs.

RESIDENTIAL REHABILITATION TYPE I

6. ***One commenter stated that the assumed staffing level for licensed alcohol and drug counselors in the rate model should be increased, suggesting that 60 percent of direct support staff hours should be covered by an LADC.***

   In response to this comment, the rate model has been revised to reflect a one-to-five staffing ratio for LADCs. Based on a 12-person program (the average size of existing programs), this translates to about 96 hours of LADC staffing per week, which is consistent with the average current staffing reported by providers.

7. ***One commenter noted that a certified clinical supervisor (CCS) is not included in the staff assumed in the rate model but is a requirement of the program.***

   It is understood that a CCS-credentialed staff is a requirement for this service. However, the credential is a secondary requirement as staff must already have an underlying credential such as and LADC or LCSW. In general, providers reported the CCS designation is held by the program director or a licensed social worker. Depending on the specific role of the staff person who is a CCS, they will be one of the staff specifically delineated in the rate model or they may be included in the program support component of the model.

8. ***One commenter asked whether the registered nurse that is assumed in the rate model is a programmatic requirement.***

   The rate model assumptions are not mandates. Provider requirements are found in Section 97 Chapter II and Chapter III Appendix B of the MaineCare benefits manual.

9. ***One commenter stated that the 92 percent occupancy rate assumed in the rate model cannot be consistently achieved given admission delays and early client departures.***

   The rate models assume a 92 percent occupancy rate for *staffed* beds. The rate model does not include a provision for unstaffed capacity because the provider is not incurring its single largest expense: wages and benefits for direct support staff. To validate this assumption, claims data between March 1, 2018 and February 29, 2020 were reviewed. Claims were segmented into six-month periods. Within each period, the staffed capacity was defined as the smallest number of residents for which the program was occupied for at least half the days in the period. For example, for one halfway house

during a six-month period, there were 83 days when there was one participant, 72 days when there were two participants, and 27 days when there were three participants (there were two days without participants). For this program, the assumed staffed capacity was two residents since there were two or more participants in the program for 99 of the 184 days during the period.

Based on this methodology, the staffed occupancy rate ranged from 89 percent to 94 percent during each six-month period. Additionally, a review of the average occupancy rate during a participant's time in a program found rates that ranged from 92.4 percent to more than 99 percent. As a result, no changes were made to this assumption.