REVIEW OF PAYMENT RATES FOR INTENSIVE OUTPATIENT SERVICES

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 ensure a continuum of care for MaineCare enrollees, the Maine Department of Health and Human Services (DHHS) is in the process of studying payments and service delivery models for Intensive Outpatient (IOP) services. DHHS contracted the national consulting firm Burns & Associates, a division of Health Management Associates, to assist with this effort.

The rate review encompassed several tasks, including:

- A detailed review of the treatment models, MaineCare service requirements, billing rules, and DHHS' policy objectives for the current IOP services
- Review of published IOP standards and service requirements in other states
- 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
- 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 clinicians' wages, benefits, and caseloads; building costs; and agency overhead.

The proposed rate models were presented on March 26, 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 data, a number of changes were made to the rate models:

- All rates models were changed to reflect per diem billing units rather than weekly units. With the exception of the Eating Disorder Partial Hospitalization Program rate model, which assumes a five-day-a-week program, the rate models are now based on three-day-a-week programs, which both supports programs that meet this minimum requirement and provides additional funding for programs that operate more than three days per week.
- Added an attendance factor or 90 percent to all 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.
- Added paid time off to the benefit calculation rate for all positions.
- Made two changes to the in the Substance Use Disorder IOP rate model:
    - Increased the licensed alcohol and drug counselor staffing assumption from half-time to full-time for a five-day program, which translates to 0.6 of an FTE for a three-day program.
    - Increased the psychiatrist staffing assumption from two hours per week to four hours.
- Made two changes to the Mental Health and Co-Occurring IOP rate model:
    - Added a second therapist position.
    - Eliminated the quarter-time therapeutic support (i.e., occupational or physical therapist) position.

- Made three changes to the Developmental Disability and Behavioral Health IOP rate model:
    - Added a quarter-time registered nurse position.
    - Increased the staffing assumption for a therapeutic support position (i.e., occupational or physical therapist) from a quarter-time position to a half-time position.
    - Increased the assumed wage for the behavioral health professional.
- Aligned the Geriatric IOP rate model with the Mental Health and Co-Occurring IOP. Although no comments were received on the proposed Geriatric IOP model, DHHS reviewed the program design and determined the staffing and support should be similar for both programs.
- Made two changes to the Eating Disorder IOP:
    - Added a quarter-time cook position to provide meal preparation support.
    - Added funding for food costs.
- Made several changes to the Eating Disorder Partial Hospitalization Program rate model:
    - Increased the number of lead therapists from one to three.
    - Increased the staffing assumption for a nutritionist/ dietician support from a half-time position to a full-time position.
    - Added a half-time cook position to provide meal preparation support.
    - Added funding for food costs.
    - Increased the staffing assumption for a mental health rehabilitation technician from a half-time position to a full-time position.
    - Increased the clinic space for 100 square feet per participant to 250 square feet.

ACROSS SERVICES

1. ***Commenters expressed concern about the proposed requirement that programs operate five days per week. These commenters additionally stated that daily rates more effectively compensate providers who serve individuals with greater needs because, for example, a provider will be paid more for serving an individual on five days than for serving an individual on three days. Other commenters expressed support for a weekly rate coupled with a daily rate that can be billed when the minimum weekly contact requirements are not met.***

   In response to these comments and to support flexibility for providers in designing programs to meet the needs of their clients, the rate models have been revised to reflect daily billing rates. The assumptions in the rate models were revised to reflect a three-day-per week program primarily by lowering the full-time equivalent assumptions for the direct care positions. For programs that operate more than three days per week, the rate models support greater staffing. For example, a rate model for a three-day program that includes 0.6 full-time equivalent position would fund a full-time position for a five-day program. It is assumed that program support and administrative functions will be similar regardless of whether a program operates three or five days per week so the assumptions for these positions were generally not reduced. Additionally, as discussed in the response to comment 11, an attendance factor has been added to the rate models.

2. ***One commenter requested the timeline for implementing the rate models, noting that regulations will need to be developed, funding will need to be appropriated, and billing processes will need to be established.***

   Acknowledging the work to be done to establish these programs, particularly because all but the substance use disorder IOP will be new to MaineCare, it is DHHS' intent to implement these rates effective April 1, 2022.

3. ***Commenters asked whether providers' programs will be required to include the staff assumed in the rate model and whether they will need to manage to the assumed caseloads.***

   In general, the rate model assumptions are not meant to be prescriptive. However, DHHS is in the process of developing service standards for the IOP programs that would be added to MaineCare and, as part of that process, will consider whether any minimum staffing requirements are needed to support the efficacy of the program. These standards will be subject to the usual rulemaking process, which includes an opportunity for public comment.

4. ***One commenter noted that the rate does not account for productivity factor such as training, paid time off or turnover factors.***

   As discussed in the response to comment 5, the rate models have been revised to include paid time off in the calculated benefit rate.

   The rate models do not include productivity factors. Rather, the models reflect the full cost of a full-time worker or the appropriate portion of a full-time worker that is then spread over the assumed program caseload. The caseload assumptions are intended to reflect both the direct and indirect responsibilities of staff (that is, if staff did not have indirect responsibilities, the caseloads would be larger).

5. ***One commenter stated that the benefit rate calculation is too low and should be increased to include paid time off and employer-funded retirement contributions. This commenter also observed that the assumptions related to unemployment insurance costs do not account for turnover.***

   The proposed rate models did not include paid time off in the benefit rates because the caseload assumptions were intended to reflect paid time off (that is, the caseloads would be higher if staff did not have paid time off). However, in response to this comment, the benefit rate has been changed to add paid time off to the calculation, resulting in an increased benefit rate for all positions.

   As the commenter notes, there is not a specific assumption for a retirement contribution, but the rate model includes $100 per employee per month for undefined other benefits, which would include retirement. The total benefit package is in line with the results of the provider survey and the benefit packages incorporated in rate studies for other MaineCare programs and services.

   As the commenter noted, the assumptions for unemployment insurance takes into account the taxable wage base. For example, the federal unemployment insurance rate only applied to the first $7,000 in wages paid to a given employee, so the rate model only includes the cost of the tax on $7,000 in wages. As the commenter states, the cost will be higher if there are multiple staff in the position due to turnover. However, other benefits costs will generally be lower as a result of turnover; for example, there is often a waiting period for health insurance and discretionary other benefits. These savings will be greater than the cost of unemployment insurance so no adjustments were made to the rate models.

6. ***One commenter indicated that all IOP services should include the cost of a program director.***

   The program director position is funded in the 11 percent allocated for program support. There is not the expectation that each program has a full-time program director.

7. ***One commenter stated that the cost of $15 per square foot is not sufficient in some parts of the state, such as Portland. Another commenter observed that the assumed costs is slightly less than assumed in the rate study for children's residential services (MaineCare Section 97, Appendix D) occurring concurrently with this rate study.***

   Only two respondents to the provider survey reported information related to program square footage so the rate models incorporated the same assumption included in other recent MaineCare rate studies. The children's residential real estate assumption was not considered as part of this comparison since this is a different type of real estate. In response to these comments, commercial real estate listings were researched. Costs varied across the state and, as the commenter suggested, costs in Portland were generally higher. The overall average, however, was slightly less than $15 per square foot. The rate model assumption is therefore unchanged.

8. ***One commenter stated that the rates models should be rounded to four decimal points instead of two decimal points.***

   The rounding conventions incorporated in these rate models follow the conventions included in previous rate studies: dollars rounded to the nearest penny, percentages rounded to the nearest tenth of a percent, and work hours rounded to the nearest one-hundredth of an hour (less than a minute). This approach is intended to support transparency by allowing a reader to calculate the value at each step in the rate model. The rounding conventions neither favor nor disfavor the final rate; they may produce a slightly higher or slightly lower final rate, but the difference is generally within one-tenth of one percent.

SUBSTANCE USE DISORDER IOP

9. ***One commenter expressed support for the proposed rate. Another commenter stated the proposed rate is not sufficient for adolescents with substance use disorder due to higher no-show rates and transportation issues in rural areas.***

   The support for the Substance Use Disorder IOP rate, which represents an increase of more than 50 percent compared to the current rate, is appreciated. It is hoped that the higher rate will allow for the expansion of services across the state.

   Neither the current nor the proposed rate differentiates between adults and children. However, as discussed in the response to comment 11, an attendance factor has been added to the rate.

10. ***One commenter asked whether the medication management that is currently billed separately under MaineCare sections 65 and 92 is included in the rate.***

    Medication management is included in the SUD IOP rate and the service is intended to be performed by the psychiatrist. Medication management cannot be billed for an individual while they are participating in an IOP program. The rate model includes an assumption that a psychiatrist is part of the IOP program, incorporating four hours per week per 10 individuals. Medication management may also be delivered by other staff, who would be incorporated in the program support component of the rate model.

11. Two commenters stated that the assumption of 10 billable patients is too high due to the high no show rate.

The program caseload assumption is meant to support the number of staff needed to operate the program, but the number are scalable. For example, the rate model includes a quarter-time peer support specialist for a ten-person program; for a 20-person program, the model would support a half-time position.

In response to this comment, an attendance factor has been added to the rate model. Specifically, an analysis of claims data shows that individuals receive an average of 2.7 days of service per week, so the attendance factor was set at 90 percent (equal to 2.7 days of service for a three-day-a-week program).

Although these comments related specifically to the substance use disorder rate model, the attendance factor has been added to all IOP models.

12. One commenter asked whether the lead therapist will be required to be a licensed clinical social worker.

The rate model funds the lead therapist based on a wage assumption for a licensed clinical social worker (LCSW), which was the most commonly reported position by respondents to the provider survey. However, the rate study does not represent a change to the qualifications for the lead therapist. Section 65.02-42 of the MaineCare Benefits Manual states the position may also be a licensed alcohol and drug counselor (LADC), physician (MD or DO), licensed clinical psychologist, licensed clinical professional counselor (LCPC), licensed marriage and family therapist (LMFT), registered professional nurse certified as a psychiatric nurse, or advanced practice psychiatric and mental health registered nurse (APRN).

13. One commenter requested clarification on the role of the psychologist as this position is not utilized in their current service model.

The psychologist position is intended to provide program oversight. Per Regulations for Licensing/Certifying Substance Abuse Programs, 14-118 CMR chapter 5, section 11, covered services must be provided under the direction of a physician (MD or DO) or psychologist. Similar to the response to comment 12, although the rate model assumes that oversight will be provided by a psychologist, providers are not required to have a psychologist.

14. One commenter indicated the two hours per week for a psychiatrist/MD is insufficient given the job responsibilities which include admissions, case reviews, medication management, crisis management, and discharge work program.

Only one of five programs reported through the survey reported having a psychiatrist attached to their program. In response to this comment, however, the psychiatrist time has been increased to 0.1 of a full-time equivalent, or four hours per week.

MENTAL HEALTH AND CO-OCCURRING IOP

15. One commenter questioned the role of the quarter-time therapeutic support position.

In response to this comment, the quarter-time therapeutic support position has been removed from the rate model.

DEVELOPMENTAL DISABILITY AND BEHAVIORAL HEALTH IOP

16. ***One commenter stated that the assumed hourly wage for a psychologist is too low. The commenter stated that the rate model assumption is based on the typical wages paid to school psychologists who typically have master's degree rather than doctoral degrees.***

    The rate model wage assumption is tied to the Bureau of Labor Statistics classification of "clinical, counseling, and school psychologists". Thus, while school psychologists are included in this classification, they do not represent the entirety of the classification; a review of national BLS data shows that less than half of the psychologists in the classification work in the educational sector (industry-level data is not available at the state level). Further, the BLS documentation notes that most psychologists in this classification do have a doctoral degree.

    The rate model wage assumption is based on the 50th percentile (median) wage from the BLS dataset for this classification. DHHS continues to believe that median wages are an appropriate market-based benchmark as this is the wage at which half the individuals in the occupation earn more and half earn less across both the public and private sectors.

17. ***One commenter stated that the quarter-time therapeutic support position is not sufficient to deliver the service and suggested a full-time staff person is required to support a caseload of ten patients.***

    In response to this comment, the therapeutic support position has been increased to half-time, or 20 hours per week.

18. ***One commenter indicated that a quarter-time registered nurse should be added to this service, consistent with the other IOP rate models.***

    In response to this comment, a quarter-time registered nurse has been added to the rate model.

EATING DISORDER IOP AND PARTIAL HOSPITALIZATION PROGRAM

19. ***One commenter questioned whether pre-admission and post discharge assessments that are currently billed separately are included in the IOP and PHP rates.***

    Pre-admission and post discharge supports are not included the IOP or PHP rates, and they will continue to be able to be billed as separate services.

20. ***One commenter stated that the IOP and PHP eating disorder services are a specialty area making staff positions hard to fill. The commenter suggested that the rate model wage assumptions therefore be based on the 75th percentile of Bureau of Labor Statistics wage data rather than the 50th percentile.***

    As noted in response to comment 16, the rate model wage assumptions are based on the median (50th percentile) wages from the BLS dataset. DHHS continues to believe that median wages are an appropriate market-based benchmark as this is the wage at which half the individuals in the occupation earn more and half earn less across both the public and private sectors.

21. ***One commenter noted the rate models do not fund a full-time psychologist or psychiatrist, which would require providers to hire part-time or contract staff.***

    As the commenter stated, the rate models do not presume that a full-time psychologist or psychiatrist is required for a program with ten participants. The rate model does not presume how the provider

delivers this staffing, but the commenter is correct that it could be achieved through part-time or contract staff or full-time staff that support other programs operated by the provider.

22. ***One commenter indicated that a three-day eating disorder IOP is not sufficient for clients with significant mental health issues so the program should be structured for five days per week.***

    As noted in the response to comment 1, the rate models have been revised to reflect a three-day-a-week program with per diem rate. If more intensive supports are necessary – such as a five-day program – the per diem rate ensures that providers receive additional funding to compensate for the higher costs.

23. ***One commenter stated the rate model for the partial hospitalization program does not have sufficient staff for a five-day-a-week program. The commenter suggested that therapist staffing be increased from one full-time position to three, and that the dietician and the mental health rehabilitation technician positions be increased from half-time to full-time.***

    In response to this comment, the Partial Hospitalization Program model has been revised by increasing the number of therapists from one to three and increasing the dietician and mental health rehabilitation technician positions from half-time to full-time.

24. ***One commenter stated that the assumption of 100 square feet of program space per individual is too low to accommodate individual and group meetings spaces as well as shared meal preparation and eating spaces. The commenter suggested approximately 250 square feet would be more appropriate.***

    In response to this comment, the program space for the Partial Hospitalization Program has been increased from 100 square feet per participant to 250 square feet.

25. ***One commenter stated that the 11 percent program support rate included in the eating disorder IOP and PHP rate models is not sufficient to cover tasks such as clinical supervision, intake, a cook, and client meals.***

    In response to this comment, a half-time cook and food expenses have been added to the Partial Hospitalization Program rate model and a quarter-time cook and food expenses have been added to the IOP model. The other costs are incorporated in the 11 percent included in the rate models for program support.