

# **CASE-RATES FOR METHADONE TREATMENT**

11/2/2006

## **EXECUTIVE SUMMARY**

Case rates offer advantages for flexible, prepaid funding of certain services for clients. The DCF staff members and workgroup charged with developing case rates for methadone treatment services recommends a methadone case rates structured as follows:

- Use the case rate to reward both efficiency and effectiveness, with effectiveness measured by retention.
- Establish financial eligibility according to the standard of medical indigence being proposed by the managing entity workgroup: at or below 250 percent of the federal poverty guideline and the lack of Medicaid or other third party coverage for methadone treatment.
- Establish a monthly cost of treatment based on an efficient benchmark. This benchmark can be calculated by multiplying an efficient daily rate by the average number of days per month, 30.44.
- Encourage client retention beyond the first 30 days of methadone treatment. At present, statistics show that nearly 20% of new methadone clients fail to complete their initial 30 days of treatment.
- Reward retention by paying differential rates according to the length of stay in treatment. The case rate would start at a lower monthly amount and increase at certain junctures as the client continued in treatment.
- Estimated monthly case rate payments would continue in anticipation of services on a month-to month basis until the client ceases treatment, transfers to another payment source or is no longer medicated with methadone.
- Consider more refined client retention incentives once DCF was able to generate reliable, client-by-client encounter data across fiscal years and the payment system demonstrates its capacity to manage the payment variations required by these incentives.

# GOALS

## Reward efficiency

DCF would pay a uniform case rate that was selected for efficiency.

## Reward retention

Retention is important because research has shown a powerful relationship between patient retention and favorable outcomes for methadone treatment.<sup>1</sup> In fact, retention has been widely enough accepted as a desirable goal that researchers have used it as a proxy for treatment success.<sup>2</sup> Persons retained in treatment for at least one year have been proven to enjoy better outcomes than those discharged within the first year.<sup>3</sup> Yet the relationship between improved outcomes and retention is not a strict function of a 12-month time period. Instead, it begins within the first year of treatment and appears to continue in a linear fashion beyond the first year.<sup>4</sup>

## CURRENT PAYMENT SYSTEM

DCF pays providers a single rate per “dose.” This single rate bundles all medical, counseling, and other costs into a single unit cost . Since clients receive a single dose of methadone per day, either on-site at the clinic or off-site, each “dose” is also a day in treatment. The current rates paid are summarized in Table 1 below.

**Table 1: Current DCF rates with providers considered for case rates**

Provider	District	Rate
DACCO	SunCoast through CFBHN	\$9.90/dose (day) plus a 4.5 % ME fee for a total of \$10.37
PAR	Direct contract between SunCoast and PAR	\$8.90/dose (day) for a small contract to establish a Medicaid contract
	District 8	\$11.38/dose (day)
	District 10	New rate
River Region	District 4	\$12.00/dose (day)

Additional Rates:

- The Medicaid rate is \$67.50 per week or \$9.64/dose (day)
- The ATR rate is \$12.27/dose (day), up to a maximum of 160 doses.

<sup>1</sup> Villafranca S W, McKellar JD, Trafton JA, and Humphries K:. Predictors of retention in methadone programs, *Drug and Alcohol Dependence*, Columbe 83, Issue 2, 27 July 2006: 218-224.

<sup>2</sup> Bell J, Burrell T, Indig D, Gilmour S: Cycling in and out of treatment; participation in methadone treatment in NSW, 1990-2002, *Drug and Alcohol Dependence*, 2006 Jan 4; 81(1): 55-61.

<sup>3</sup> Joe GW, Simpson DD, Broome KM, 1999; Joe GW, Brown BS, Treatment retention and follow-up outcomes in the drug abuse treatment outcome study (DATOS), *Psychology of Addictive Behaviors*, 1997. 11: 239-260.

<sup>4</sup> Zahng Z, Friedmann PD, and Gersten DR, Does retention matter? Treatment duration and improvement in drug use, *Addiction*, 2003 May, 98(5): 673-84.

Managing entities present another consideration. District 1 currently operates through a managing entity under a prepaid plan. Carving out a case rate for methadone services would modify the current funding relationship between the network and the district and not further the goals of case rates. Therefore, District 1 is excluded from consideration for case rate. Also, Methadone providers DACCO and PAR provide services through a contract with Central Florida Behavioral Health Network (CFBHN). The SunCoast Region pays the providers on a fee-for-service basis and adds a 4.5 percent for managing entity services. (See the critical issues section of this report.)

### **Cost study**

A 2003 article that presented the results of a series of federally-funded cost studies included eleven methadone treatment programs.<sup>5</sup> Viewed as a general indicator of cost, the study suggests that the amounts paid by Florida fall within the broad, normal range for methadone services nationwide. The weekly costs of the eleven programs ranged from \$42 per week (or \$6 per day) to \$166 per week (or \$23.71 per day). The mean cost was \$91 per week (or \$13 per day) and the median cost was \$86 per week (or \$12.29 per day). This data should be interpreted as broad indicator of costs because it compared several different types of programs at different times. While the cost data was gathered over a 10-year period ending in 2002, and subsequent inflation may make some of the rates artificially low by today's standards, the study calculations were based on economic costs, a method that can result in higher unit costs than other cost-analysis methods.

## **THE NEED FOR RELIABLE LENGTH OF STAY DATA ACROSS FISCAL YEARS**

The workgroup analyzed data from the One Family data system in an attempt to find approximate length of stay data. However, at this writing, the group is not confident that the system can identify an approximate length of stay from the One Family system (See Attachment I). Data obtained directly from one of the providers, Operation PAR, Inc., appears to be more reliable (See Attachment II). However, it includes length of stay data for those discharged only, not those remaining in treatment, so it presents a partial picture.

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<sup>5</sup> Roebuck MC; French MT; McLellan, A T.; DATStats: results from 85 studies using the Drug Abuse Treatment Cost Analysis Program (DATCAP), *Substance Abuse Treatment* 25 (2003) 51–57

## **CRITICAL ISSUES**

The issues listed below are important to consider as the methadone case rate moves forward.

### **Moving from individual provider rates to a uniform state-wide rate**

Moving from multiple, cost-based rates to a single statewide rate is a significant change by itself.

### **Administrative activities and streamlining**

Case rates sometimes help to streamline administrative costs by simplifying client billing. However, apart from ATR, DCF does not pay its methadone providers through client-by-client invoicing. Consequently, case rates would not streamline administrative activity in this case because encounter data would still need to be submitted and reducing the number of individual invoices is not possible.

### **Relationship to managing entities**

Methadone clients and providers are often separate from the remainder of the service network. Is the managing entity really managing the provider contract and payment to the provider? Is the managing entity coordinating care between methadone clients and other providers and systems of care? If not, it would be difficult to justify paying an additional rate to the managing entity.

### **Data and payment systems**

As of this writing, the data system has not yielded reliable length of stay data across fiscal years. Developing and monitoring a case rate system may be impossible without such data. Unfortunately, purchasers have had to abandon otherwise effective case-rates system because of payment systems being unable to meet the payment variation required by the payment system and because of incomplete encounter data.

### **Efficiency and retention**

Case rates often reinforce efficiency by rewarding brief lengths of stay. However, as noted above, longer lengths of stay are strongly associated with success for methadone treatment. Reinforcing both through the same payment mechanism is challenging, and more refined ways of doing so may need to await more refined data and payment systems.

## **Provider responsibility and case mix**

Certain client characteristics, such as unemployment, are related to retention problems, and certain provider characteristics, especially dosing practices and client satisfaction, are related to longer retention.<sup>6</sup> As a result, case mix might become an issue if the baseline utilization data used to establish incentives were to be based on the experience of all clients. This is because DCF only pays for the less-stable medically indigent group, and this less stable group could be expected to have shorter lengths of stay. On the other hand, providers could be held accountable for rates of retention because of the impact of provider practices on retention rates

## **Provider characteristics and responsibility**

Even though case mix and the decisions of clients are important, research has documented that provider treatment characteristics, especially dosing practices and client satisfaction, have powerful impacts on client retention rates.

## **Transfer of clients from DCF to self-pay or other payment sources**

DCF can extend its resources when clients make the transfer from DCF-covered care to self-pay or payment from another source, such as Medicaid. Also, unemployed clients who become stabilized with methadone are often able to maintain steady employment, and stable employment supports other positive outcomes. Therefore, DCF has clinical and financial reasons to encourage providers to help clients become employed and transfer from DCF payment to other coverage as soon as possible. On the other hand, some medically-indigent clients may need extended DCF support.

# **CASE RATE METHOD**

## **Differential monthly rates according to lengths of stay**

### **Summary of the method**

The rate would start at a lower monthly amount and increase at certain junctures as the client stayed in treatment. The examples that follow are for illustration purposes only because the setting of differential rates, the rate amounts, and junctures for changing rates would require refined and reliable length of stay data.

Beginning at the close of month one:  $\$8.00 \times 30.44 = \$243.52/\text{month}$

Beginning at the close of month six:  $\$9.00 \times 30.44 = \$273.96/\text{month}$

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<sup>6</sup> Villafranca, op cit

Beginning at the close of month nine  $\$10.00 \times 30.44 = \$304.40/\text{month}$

Beginning after one year and thereafter  $\$11 \times 30.44 = \$334.84/\text{month}$

- Payments would be made on a monthly basis at the statewide bundled case rates based on the continuous duration of a length of stay in treatment.
- Programs would receive no payment for a client's initial 30 day treatment period. For those retained beyond the initial 30 days, DCF would pay a prorated cost of the first month's treatment at the end of the first reporting month, and begin prepaid estimated case rate payments on monthly basis.
- Programs would continue to receive monthly case rates in anticipation of services as long as the client remains in treatment or until the client is transferred to another payment source.
- If a client leaves methadone treatment during a month where a case rate was paid in anticipation of services, providers must adjust their next DCF invoice to deduct the unearned pro-rata share of that client's case rate.
- Cases would be reviewed semi-annually to verify that DCF was still the most appropriate funding source.

### **Advantages**

- Retention would be reinforced.
- This method would support efficiency, especially for clients who stayed for short lengths of time.
- The overall costs could still be predicted and contained even though the exact mix of rates could not be predicted. This is because providers could contain costs by controlling the number of admissions, as they do now when the rates increase and service units purchased decrease. Fortunately, longer retention would also reduce the need for readmissions.

### **Disadvantages**

- This method would increase administrative activity, and it would place heavy demands on the payment and data systems.
- Providers would not have an incentive to move clients from a DCF to self-pay status, since higher DCF payments occur later in treatment.

**ATTACHMENT I  
UTILIZATION DATA FOR FLORIDA-PURCHASED  
METHADONE TREATMENT**

**Financial Analysis of Methadone Dosing Reported to the One Family Data System**

A query was run on client service event information reported to the One Family data system. The purpose of the query was to identify distinct clients reported as receiving methadone doses during FY 05/06. A total of 2,327 clients were shown to have received 391,592 total methadone doses from reported funding sources.

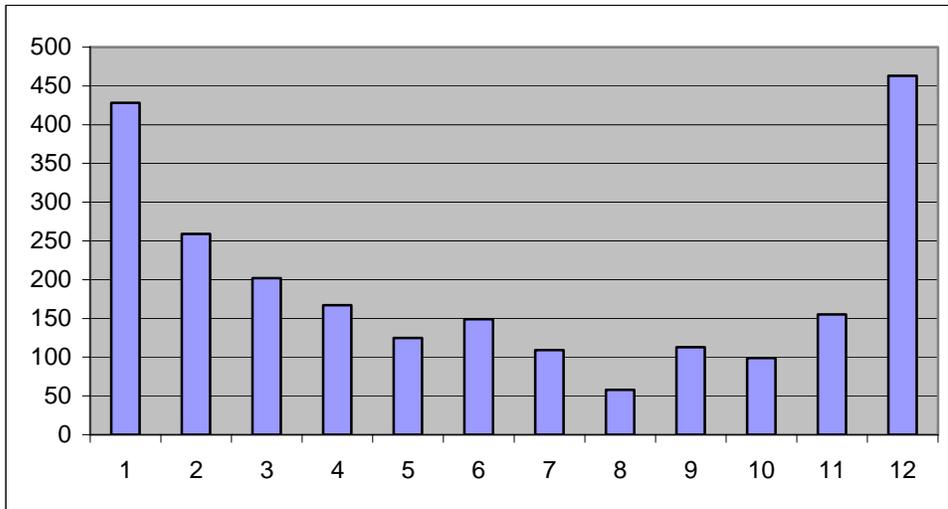
Client length of stay is not currently shown in the One Family system. To estimate the duration of individual client services, the number of methadone doses reported in 30 day increments was used as a proxy for length of stay. The results are shown as follows:

<b>Methadone Doses (Days) Reported In One Family Data System</b>			
<b>Range of Reported Doses in FY 05/06</b>	<b>Number of Clients</b>	<b>% of Population</b>	<b>Average Doses/Client</b>
< 30 Doses	428	18.4	12
30-59 Doses	259	11.1	44
60-89 Doses	202	8.7	75
90-119 Doses	167	7.2	103
120-149 Doses	125	5.4	135
150-179 Doses	149	6.4	165
180-209 Doses	109	4.6	192
210-239 Doses	58	2.5	224
240-269 Doses	113	4.9	256
270-299 Doses	99	4.2	284
300-329 Doses	155	6.7	318
330-365 Doses	463	19.9	347
<b>Totals</b>	<b>2327</b>	<b>100.0</b>	<b>168</b>

The following chart shows the population of reported methadone clients in FY 05/06. On the horizontal axis, the reported doses have been converted to an approximation of the number of continuous months of methadone treatment. The vertical axis shows the number of clients in the dosing range. The information is presented only to represent the current apparent trends of client retention in dosing treatment. The numbers could be distorted slightly by methadone clients being carried forward from FY 04/05 services. In addition, the numbers are likely to be distorted more by clients starting treatment near the end of the fiscal year. For example, clients admitted during the last month of the fiscal year would be included in the “< 30 Doses” row, suggesting that they remained in treatment for very short lengths of stay, even though a high proportion

probably remained in treatment well beyond the close of the fiscal year. In the same way, clients admitted during the second to last month of the fiscal would appear in the “30-59 doses” column, also suggesting very short lengths of stay, even though a high proportion probably remained in treatment beyond the close of the fiscal year.

Although the actual lengths of stay are likely to be significantly longer than the table above suggest, the average doses per year was 168, less than six months of treatment, suggesting volatility.



**ATTACHMENT II  
DATA FROM OPERATION PAR, INC**

Methadone  
Client Discharges  
For Period 7/1/05-6/30/06

<u>Average Length of Stay</u>	<u># Clients</u>	<u># days</u>	<u></u>
0 - 30 days	605	8,255	19.42%
31 - 60 days	179	8,036	5.74%
61 - 90 days	245	19,263	7.86%
91 - 120 days	144	14,989	4.62%
121 - 180 days	234	34,782	7.51%
181 - 240 days	144	29,756	4.62%
241 - 300 days	112	30,144	3.59%
301 - 365 days	115	37,760	3.69%
> 365 days	1,338	1,184,811	42.94%
<b>Totals</b>	<u>3,116</u>	<u>1,367,796</u>	<u>100.00%</u>
 Average per client		438.96	

These lengths of stay were for clients who were discharged during the period. The table does not include those remaining in treatment. This is an important difference. For example, the table indicates that 19.42% of those discharged dropped out during the initial 30 days. While this is important information, it does not reveal the percentage of all clients, including those still in treatment after 6/30/06, who dropped out within the first 30 days. In addition, the numbers apparently include private pay clients, most of whom would be employed, and this group could be expected to have higher rates of retention than a sample of clients made up of DCF-funded clients only, a group that could be expected to have higher rates of drop out.

Yet the table does reveal that engagement is especially important during the first 30 days, after which rates of drop-out per thirty day period diminish greatly.