Chemical and Mental Health Services Administration, Alcohol & Drug Abuse Division:

Recommendations for a new rate methodology for the Consolidated Chemical Dependency Treatment Fund

A Report

Mandated by Minnesota Session Laws, 2009, Chapter 79, Article 7, Section13.

February 2011

Minnesota Department of **Human Services**

Legislative Report

Chemical and Mental Health Services Administration, Alcohol & Drug Abuse Division: Recommendations for a new rate methodology for the Consolidated Chemical Dependency Treatment Fund

A Report to the Chairs of the Senate and House Health and Human Services Committees

Chemical and Mental Health Services Administration, Minnesota Department of Human Services

February 2011

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Chemical and Mental Health Services Administration, Alcohol & Drug Abuse Division:

Recommendations for a new rate-setting methodology for the Consolidated Chemical Dependency Treatment Fund

Report to the 2011 Legislature

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I. Executive Summary

Department of Human Services (DHS) was instructed by the Minnesota Legislature and the federal Centers for Medicare and Medicaid Services (CMS) to act regarding rate-setting for Minnesota's chemical dependency treatment services purchased for eligible persons. CMS requires a statewide methodology. The Minnesota Legislature, through *Minnesota Session Laws, 2009, Chapter 79, Article 7, Section 13,* required DHS to recommend a uniform rate-setting methodology that includes broad stakeholder input, a graduated reimbursement scale that accounts for acuity and complexity, and can replace county-negotiated rates for state-purchased chemical dependency treatment services. In addition, the legislature instructed DHS to propose legislation necessary to implement the new proposed rate-setting methodology.

DHS examined rate-setting processes in 25 states, consulted more than 400 stakeholders during 2010 and presented draft recommendations in public meetings across Minnesota. Draft materials were adjusted after stakeholder discussion sessions yielded additional, valuable information.

DHS recommends the following steps:

1. Commissioner sets addiction-only and co-occurring rates for non-residential and residential program types.
2. Commissioner sets rate enhancements for programs serving special populations, clients with their children or persons with physical health issues (Appendix B).
3. Commissioner applies specific methodology for setting rates in the state fiscal years 2012 and 2013.
4. Commissioner enters into provider agreements that describe program standards for each rate and rate enhancement.
5. Commissioner requires Consolidated Chemical Dependency Treatment Fund providers to provide financial statements and audit results annually.
6. Commissioner rebases rates in state fiscal 2014, and every two years thereafter, based on actual costs.
7. Legislature amends Minnesota Statutes 254B to authorize new rate-setting methodology and to remove its provisions related to county contracting and rate-setting.

II. Introduction

Minnesota Department of Human Services' Alcohol and Drug Abuse Division (herein referred to as "the division") purchases publicly-funded substance abuse treatment services through the Consolidated Chemical Dependency Treatment Fund (CCDTF). The CCDTF combines federal, state and county dollars to purchase services through 87 county and 11 tribal contracting and placing entities. County and tribal agencies are responsible for negotiating CCDTF rates with providers. This system has resulted in widely diverse rates and rate-setting methods.

CCDTF Rate Summary 1-1-2009

Rate Description	Highest Rate	Lowest Rate	Difference	Mean Rate
Outpatient	$ 229.50	$ 16.54	$ 212.96	$ 41.29
Medicated Assisted Therapy (MAT)	$ 229.50	$ 9.74	$ 219.76	$ 41.36
In-Patient -High Adolescent	$ 400.97	$ 36.50	$ 364.47	$ 220.86
Room & Board Adolescent	$ 170.34	$ 23.45	$ 146.89	$ 80.31
In-Patient -High Adult	$ 349.50	$ 51.11	$ 298.39	$ 191.61
Room & Board Adult	$ 212.28	$ 8.14	$ 204.14	$ 55.92
In-Patient -Medium Adult	$ 375.26	$ 59.16	$ 316.10	$ 134.93
In-Patient -Low Adult	$ 253.00	$ 10.20	$ 242.80	$ 76.46
Hospital	$ 328.68	$ 144.81	$ 183.87	$ 262.10

In January 2009, the federal Centers for Medicare and Medicaid Services (CMS) notified the division that it had improperly delegated authority over the Consolidated Chemical Dependency Treatment Fund 1915(b)(4) Waiver to counties and tribes. CMS had determined that DHS could no longer allow counties and tribes to contract with CCDTF treatment providers and that DHS must establish "a uniform, statewide rate-setting methodology." In the same letter, CMS requested that DHS provide its plans for resolution.

In response to CMS, the division proposed to solicit from stakeholders input on a new rate-setting methodology, analyze current payment rates, examine other states' methodologies and consider performance measures and patient acuity. The result would be the creation and implementation of a new statewide rate methodology to be effective July 1, 2011. The proposal was approved by CMS.

In 2009, Minnesota passed legislation that modified Minnesota Statutes 254B.03 and directed Department of Human Service to develop a uniform rate methodology for the CCDTF. The division initiated a process to determine how best to comply with statutory requirements. This internal process included a review of rate-setting processes in other states. In January 2010, the division contracted for technical assistance to assist the division in development of a statewide rate-setting method.

III. Discussion

Division staff examined rate-setting processes in 25 states. These states were surveyed to learn how they establish rates, the mechanism they use for payment and whether they purchase treatment services from a consolidated funding pool as Minnesota does.

The inquiry revealed great variation among the states' methods of payment for treatment services. Ten of the 25 states use a fee-for-services method as the CCDTF does, though no other state reported having a fund that consolidates multiple sources of funding such as Minnesota's CCDTF. Of the 25 states, 15 of them set rates by contracting directly with providers or through a third-party administrator. The survey showed significant variety among the states' methods, with nine different types of payment incentives or withholdings employed to influence treatment providers' practices and achieve desired client outcomes. No state provided the division with an appropriate model for setting rates.

On Sept. 15, 2009, more than 100 individuals representing treatment providers, county and tribal placing authorities and managed care organizations met with the division and began the public input process. Participants were informed of the instructions to DHS by the Minnesota Legislature and CMS, and were told that the goal of a restructured rate-setting system was to end the variety of rate-setting methods of the 87 counties and 11 reservations, which has resulted in different and inequitable rates for like treatment services. Participants were encouraged to share their knowledge and expertise about current rate-setting and what a new structure must include.

Stakeholders volunteered for four identified work groups. The first was charged with providing direction and coordination of the input from the remaining panels. The other three groups were each given a specific focus: basic rate-setting, rate modifications based on client acuity and complexity, and performance incentives. Stakeholder work groups met with the division each month beginning September 2009 and ending in January 2010.

The original four work groups identified critical issues and gave suggestions for addressing these issues. The work groups recommended the division keep the new rate-setting system as simple as possible, use existing treatment rule components, get outside assistance and continue drafting the new system so it could return to the stakeholders with "something to react to."

Subsequent planning meetings were attended by division staff and a core design group of three stakeholders: a treatment provider, a county placing authority and a managed care executive.

Division staff began work with Thomas Lucking, EdS, hereinafter "the consultant," in January 2010. The division, assisted by the consultant, began a process, enumerated below.

1. Develop policy decisions and desired program standards

A key issue was the importance of preserving access to providers for all clients, including smaller providers that could not afford the kinds of administrative infrastructures usually associated with hospital systems. Rate-setting, care management and billing systems would therefore need to be simple and straightforward. However, maintaining administrative simplicity is difficult because each possible rate variation adds geometrically to billing variations that could overcome the capacities of all but those organizations with the most capable administrative infrastructures.

The division staff and the core design group addressed the needs for simplicity and variation by developing a conceptual model that considered various intensity levels of treatment service. The model includes types of adult and adolescent services: outpatient, residential, medication-assisted and hospital treatment. Intensity levels for residential services establish the number of treatment hours per week and may include additional services for persons with co-occurring mental health disorders. Symptom complexity is addressed with the addition of service features, with possible enhanced rates for specialized populations, medical, and services for clients with children.

2. Obtain recent cost information from providers

On March 2, 2010, the consultant and the division met with provider organizations to discuss rate-setting and cost surveys. The consultant prepared a treatment provider cost survey. Subsequently, the cost survey was distributed to all treatment providers with the request that providers submit to the division up to two sets of costs: actual and the (projected) costs of a potential, future program design.

In order to collect data on as many providers as possible, the division extended the submission deadline and offered technical assistance to any provider that desired it. Surveys were returned by 34 agencies, providing information on more than 120 programs. The completed surveys were sufficient to identify cost trends for core services and allow for modeling to identify or construct rates for some other services.

3. Data analysis and rate-setting methodology

Costs, particularly the reasonable costs of services delivered efficiently, inform this rate setting process. However other factors also play an important role. In an established delivery system, history is an influence, as is concern for those service features which need to be reinforced or discouraged. Additionally the system of rates must have the capacity to address services for the most complex cases. For these reasons the rates are not an arithmetic formula, but a hybrid in which cost data and policy considerations inform each other.

SETTING OUTPATIENT SERVICE RATES:

Cost data from outpatient treatment programs were adjusted for a standard of efficient care in which the cost of the counseling staff is at least half of the cost of the program operation. The average cost per hour was determined. The initial rate was set at approximately 10 percent higher than the average cost for efficient care allowing for fluctuation because no program operates at peak efficiency all of the time. The rate-setting process needs to allow for such unpredictable variables as staff turnover and fluctuation in client flow.

That initial rate pays individual counseling and group counseling the same amount. Clearly the cost per client of individual counseling is higher. Offering the same rate for each discourages individual counseling. While group counseling is important and effective with the chemical dependency treatment population, there are times when individual counseling is the best way to serve a client. Providers should not have to take a large financial loss to provide the service. To provide a reasonable rate for individual counseling sessions, certain assumptions were made (these are estimates and not meant to reflect any specific program):

- Counselors spend 50 percent of their time coordinating with other service providers on behalf of their clients; planning treatment strategies; staff meetings; consultation; supervision; and charting

- Counselors spend 50 percent of their time providing direct services to clients

    - Counselors spend 40 percent of their direct service time in group sessions (approximately eight hours per week)
    - Counselors spend 60 percent of their direct service time providing individual counseling.

Using these assumptions rates were developed for individual and group counseling that would produce the same income to the program as if the initial rate had been used for both services.

SETTING RESIDENTIAL SERVICE RATES:

Historically, residential chemical dependency treatment programs have had rates for room and board separate from their treatment services rates; however, how both rates were determined varied from program to program.

Additional methods had to be employed to account for this variability.

- The treatment rates and room and board rates were added together to equal total cost of treatment for each provider

- A single room and board rate was established by adding to the Group Residential Housing (GRH) rate the cost of any staffing expectations that are higher than GRH, yielding a new, standard room and board rate.
- The standard room and board rate was then subtracted from the averaged total cost of treatment. This process was repeated for each level of care, to provide a treatment services rate for each level.

SETTING ENHANCEMENT RATES:

The additional costs for the co-occurring disorders treatment and medical services enhancements are primarily in staffing costs. The additional costs were based on the increased staffing required, particularly for the additional mental health professionals and nursing staff required in such a program. Information from the Minnesota Department of Employment and Economic Development was used to determine the usual wage of the additional professional staff. The program standards in Appendix B were used to determine the amount of staff time for the added professionals. The percentage increases for these enhancements are higher for outpatient programs than residential programs. This is because staff costs are a higher percent of total program costs in outpatient programs. Residential programs have higher fixed costs not associated with the additional staffing requirements for the enhancements.

The additional cost for the special populations (Appendix B) programs is an estimate based on information from few programs, with adjustments for staff training and staff turnover. These programs commit more resources to staff training in order to develop treatment strategies specific to the strengths and challenges of being a member of the specific population. These specialty staff are then valuable to larger organizations that can afford to pay more to attract staff expertise in serving special populations. Other costs include participation in culturally specific ceremonies and events, translation of materials, and development of materials that are culturally appropriate.

The additional cost for programs serving clients with their children is based on actual costs above the basic rate, for those costs specifically related to the care of the children who accompany the clients to treatment.

A rate enhancement for rural non-residential programs was considered. That rural non-residential programs might need a rate enhancement seems logical because the programs cannot take advantage of economies of scale, due to their locations in areas of low population. Unfortunately, no rural non-residential providers participated in the cost study. Cost data show that historic rates for programs in rural areas (fewer than 15,000 people living within a 30-mile radius of the provider) were not higher than the average outpatient treatment rate.

4. Solicit input from affected parties

To update interested parties and to solicit input on the work done to date, the division presented a set of draft rates and program standards in multiple settings. The members of the original work groups and the core design group were invited to a public meeting on Sept. 21, 2010. Following the meeting, all treatment programs were invited to participate in a series of public forums, during which the draft rates and program standards would be reviewed. The objective of the forums was to gain provider feedback regarding the drafts' impact and consider the effect the proposed changes might have on the treatment provider infrastructure and the Minnesotans who depend on it.

The feedback gathered at the various meetings informed the division that the proposed draft program standards added requirements for providers. Further, those additional requirements added costs that weren't considered in the 2010 survey of provider rates.

Considering this feedback, the division reduced the draft program standards to those already in applicable law or rule, or, if not in regulation, to those directly related to operating costs. The division tried as much as possible to define the program types and complexity variations that exist in the treatment delivery system today.

IV. RECOMMENDATIONS

<u>Recommendations</u>

1. Commissioner sets addiction-only and co-occurring rates for each of the following program types:

   Non-residential Services – Individual

   Non-residential Services – Group

   Non-residential Services, Medication Assisted Therapy – Methadone-PLUS Per Diem

   Non-residential Services, Medication Assisted Therapy – All Other-PLUS Per Diem

   Residential Services, High Intensity

   Residential Services, Medium Intensity

   Residential Services, Low Intensity

   Hospital Inpatient – Per Diem

2. Commissioner sets addiction-only rates for each of the following program types:

   Non-residential Services, Medication Assisted Therapy – Methadone Per Diem

Non-residential Services, Medication Assisted Therapy – All Other Per Diem

Room and Board Rate

3. Commissioner sets rate enhancements for the following program attributes:

   Special Populations

   Clients with Children

   Medical Services

4. Commissioner sets state fiscal year 2012 and 2013 chemical dependency program rates for each program type, based on average costs as reported by efficient programs and adjusted to accommodate normal business fluctuations such as variations in staffing and client utilization.

5. Commissioner enters into provider agreements that describe program standards for each rate and rate enhancement.

6. Commissioner requires Consolidated Chemical Dependency Treatment Fund providers to provide financial statements and audit results annually.

7. Commissioner rebases rates for state fiscal 2014 and subsequent years based on actual costs.

8. Legislature amends Minnesota Statutes 254B to authorize new rate-setting methodology and to remove its provisions related to county contracting and rate-setting.

V. APPENDICES

APPENDIX A

CCDTF Rate Summary 1-1-2009

Rate Description	Highest Rate	Lowest Rate	Difference	Mean Rate
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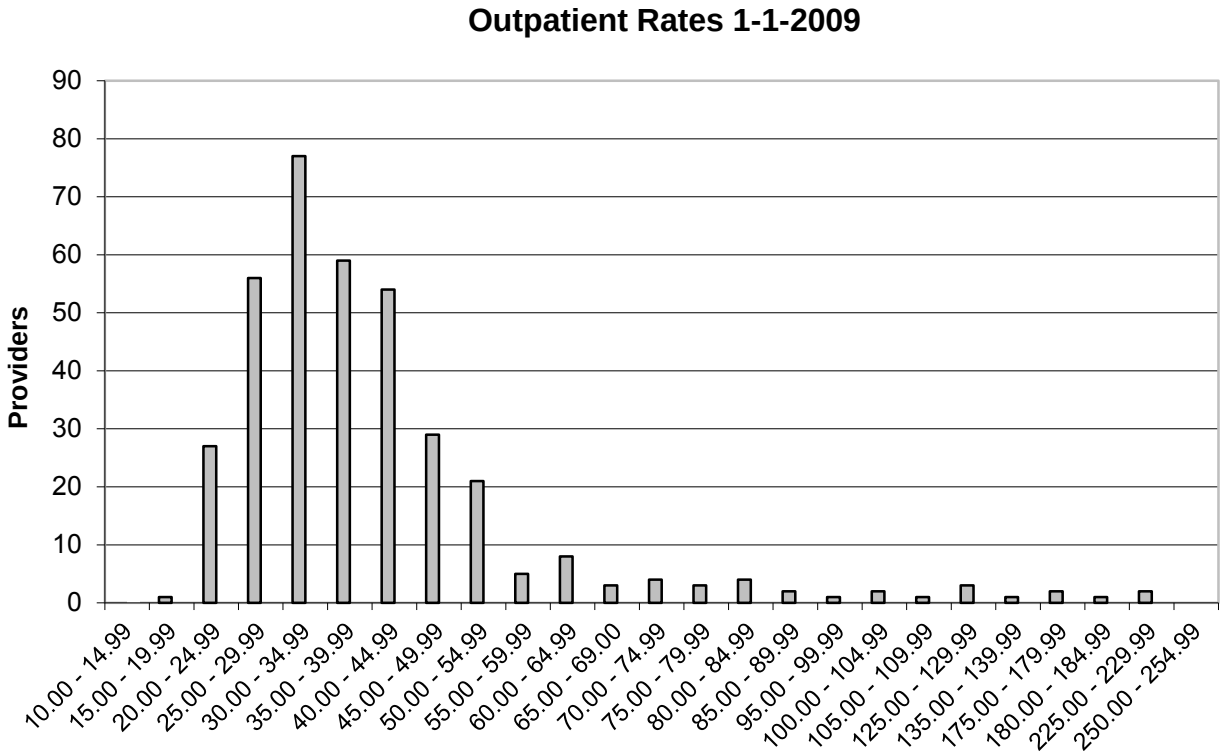
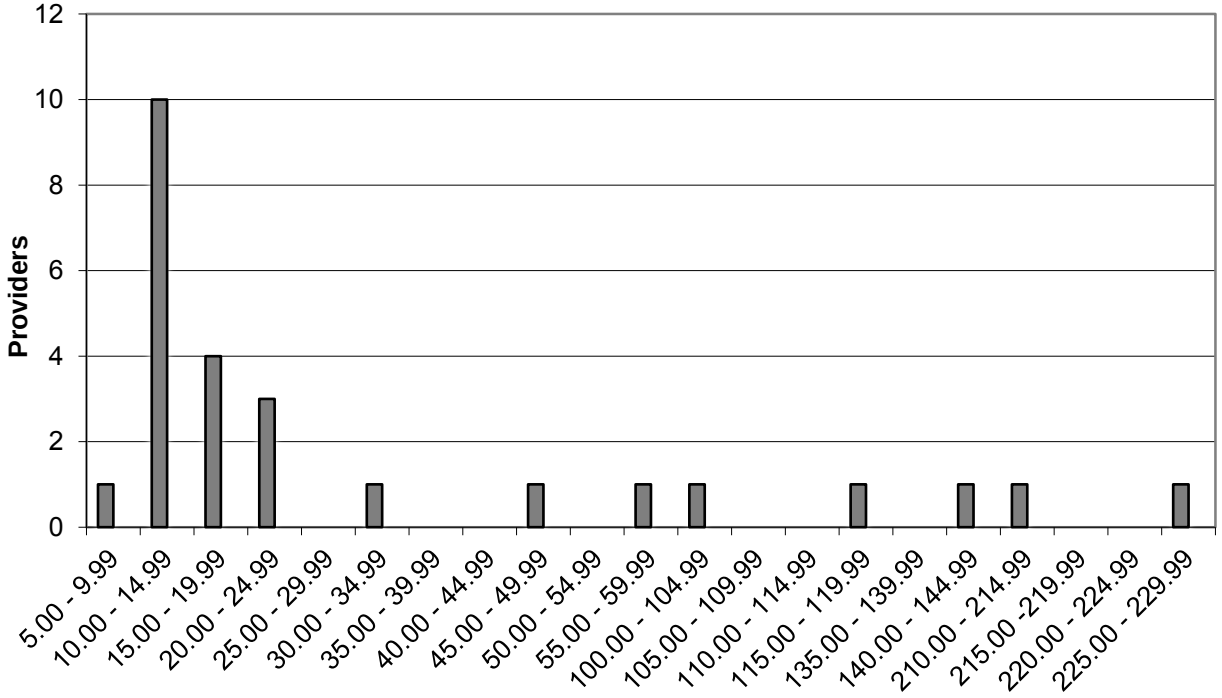
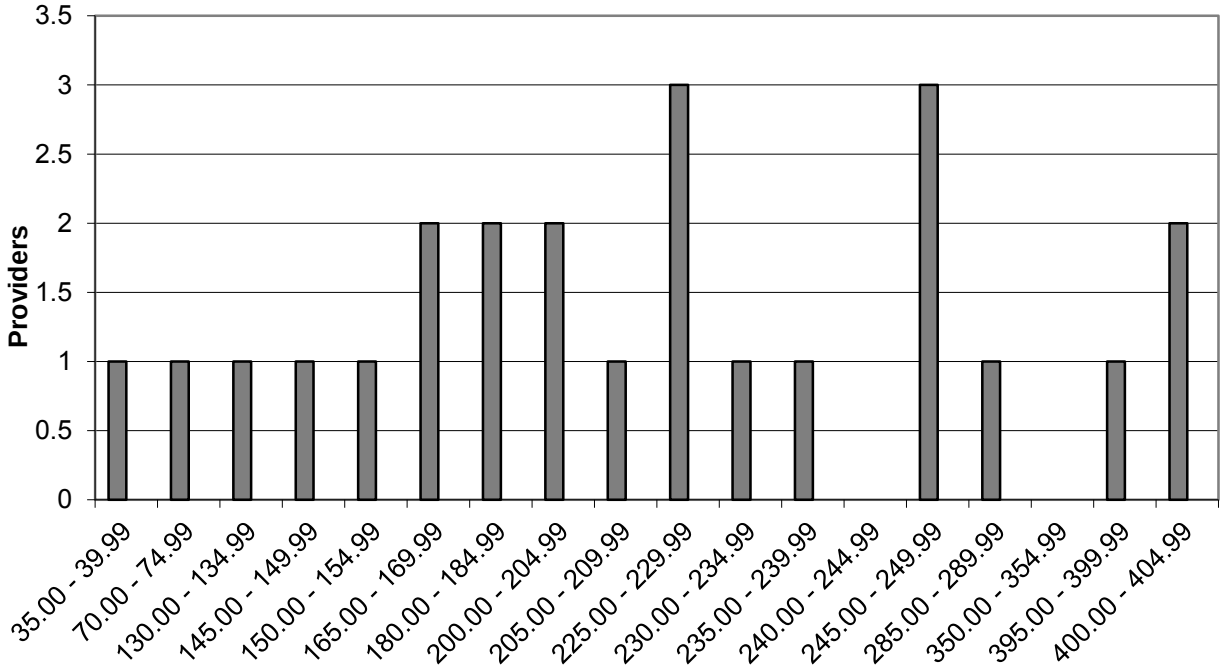


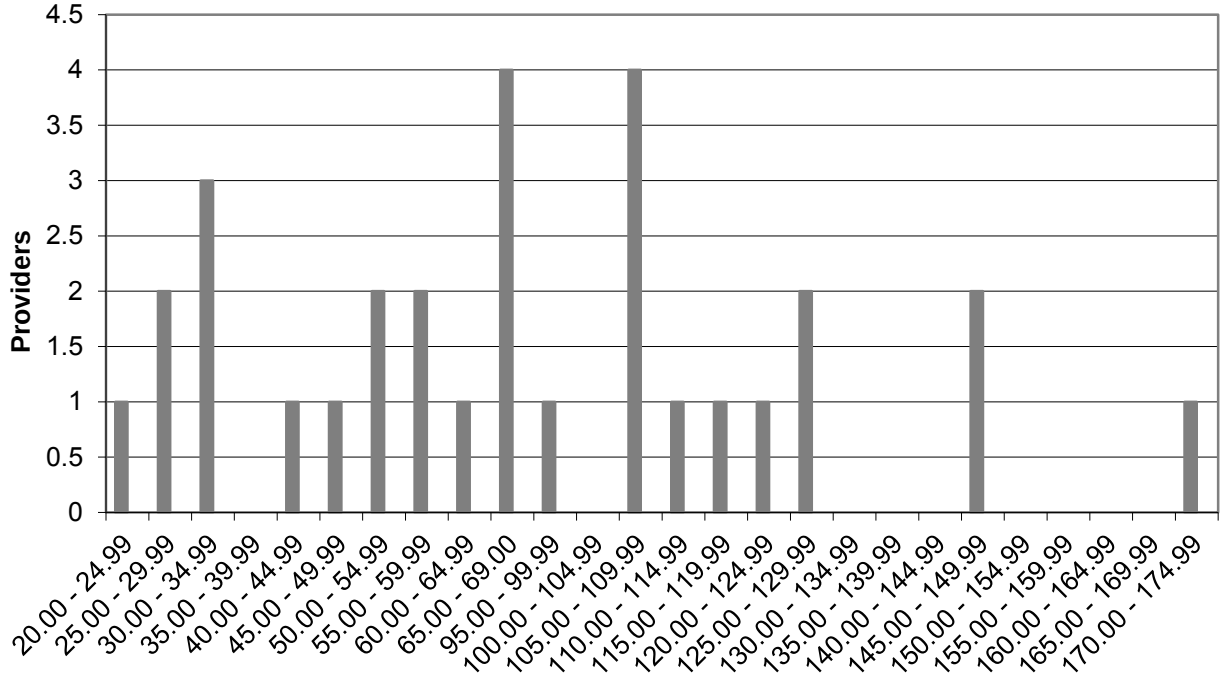
Medication Assisted Therapy Rates 1-1-2009

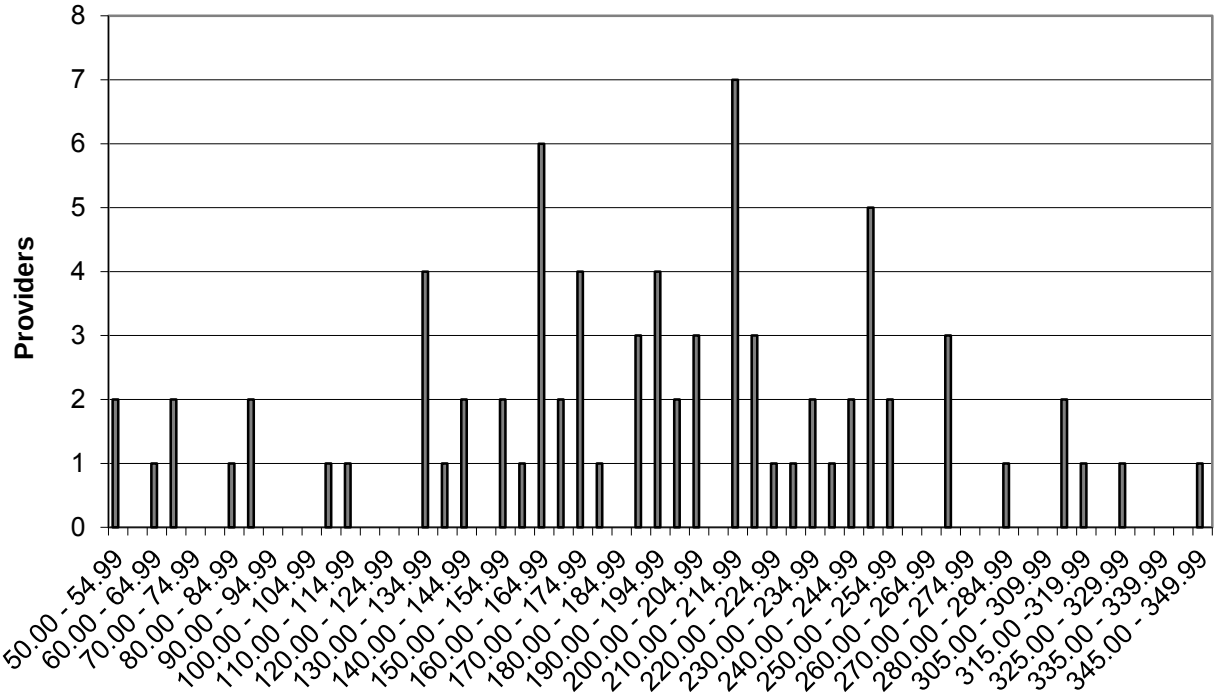


Adolescent High Inpatient Rates 1-1-2009

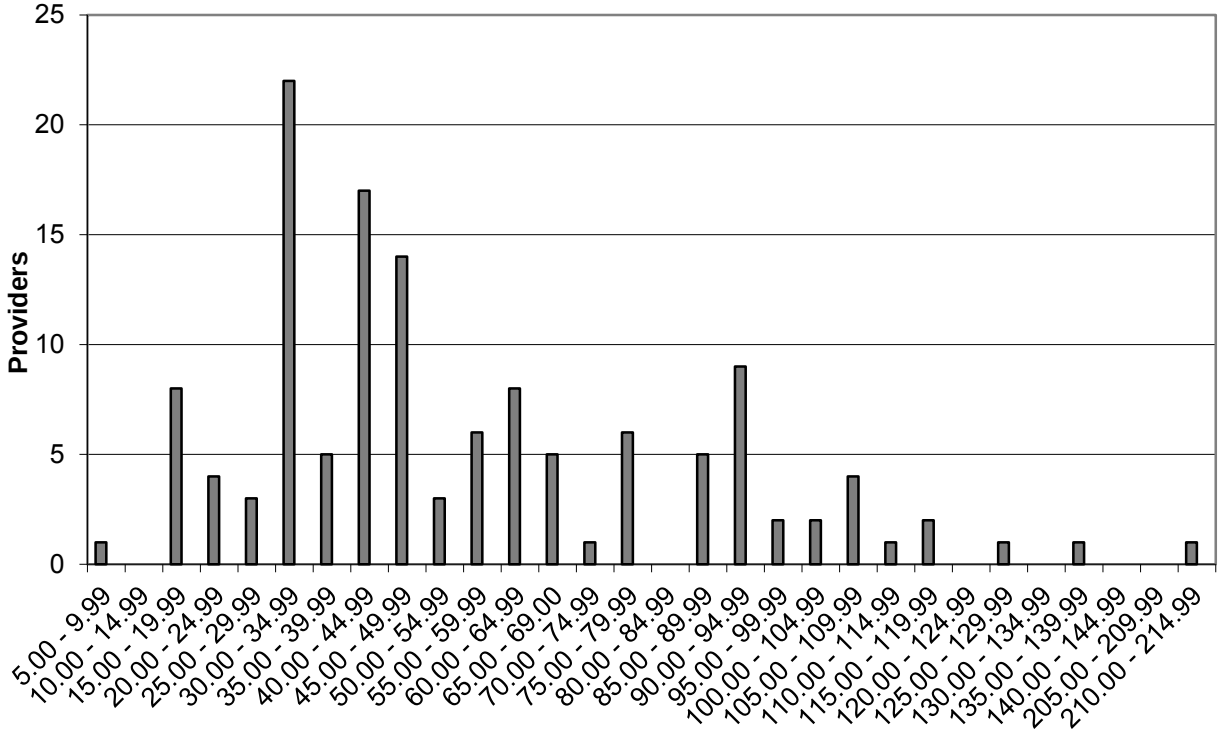


Adolescent Room and Board Rates 1-1-2009





Adult Room and Board Rates 1-1-2009



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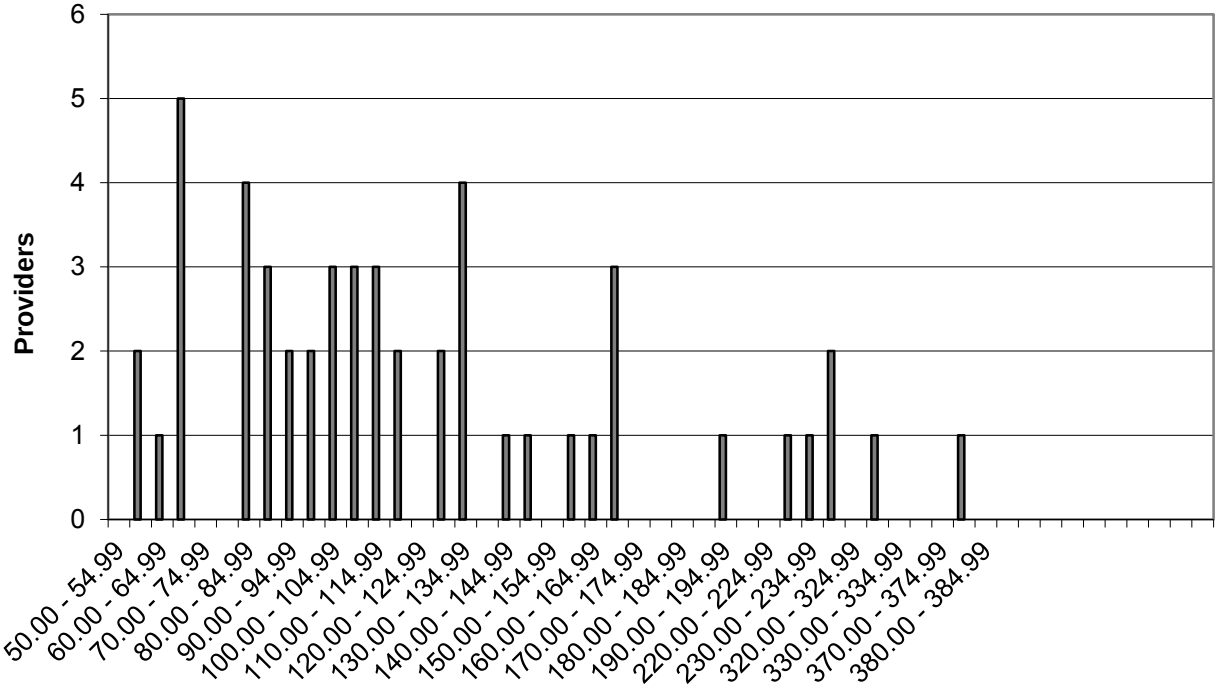
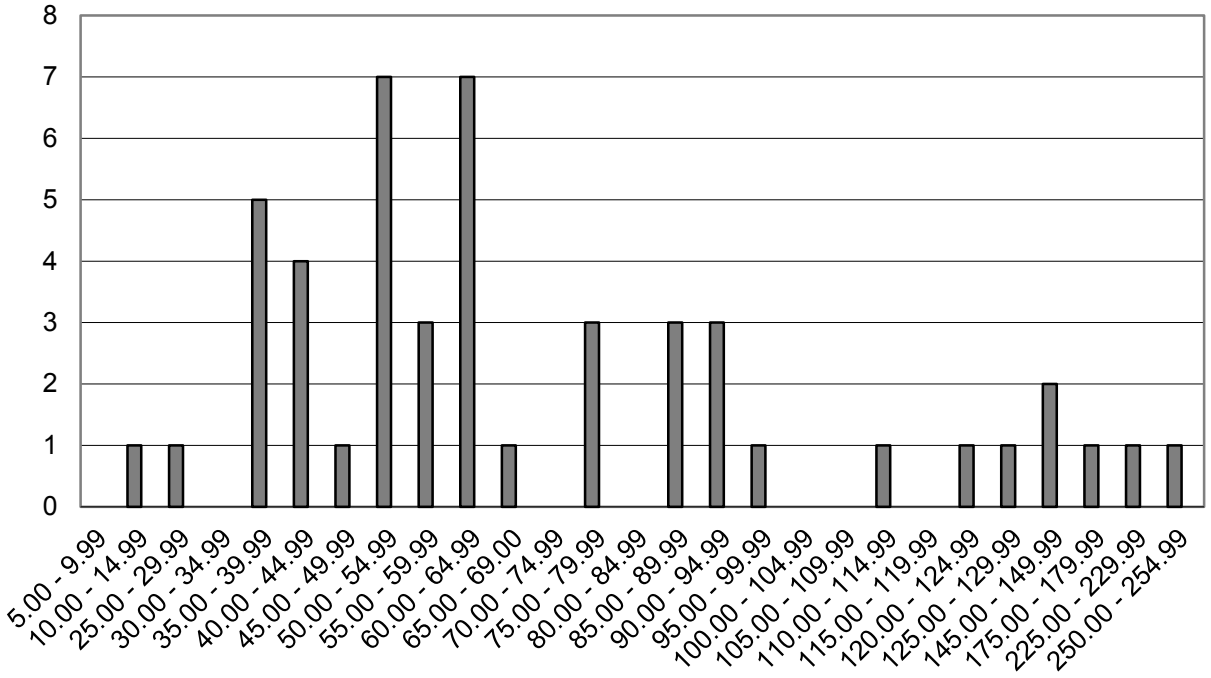
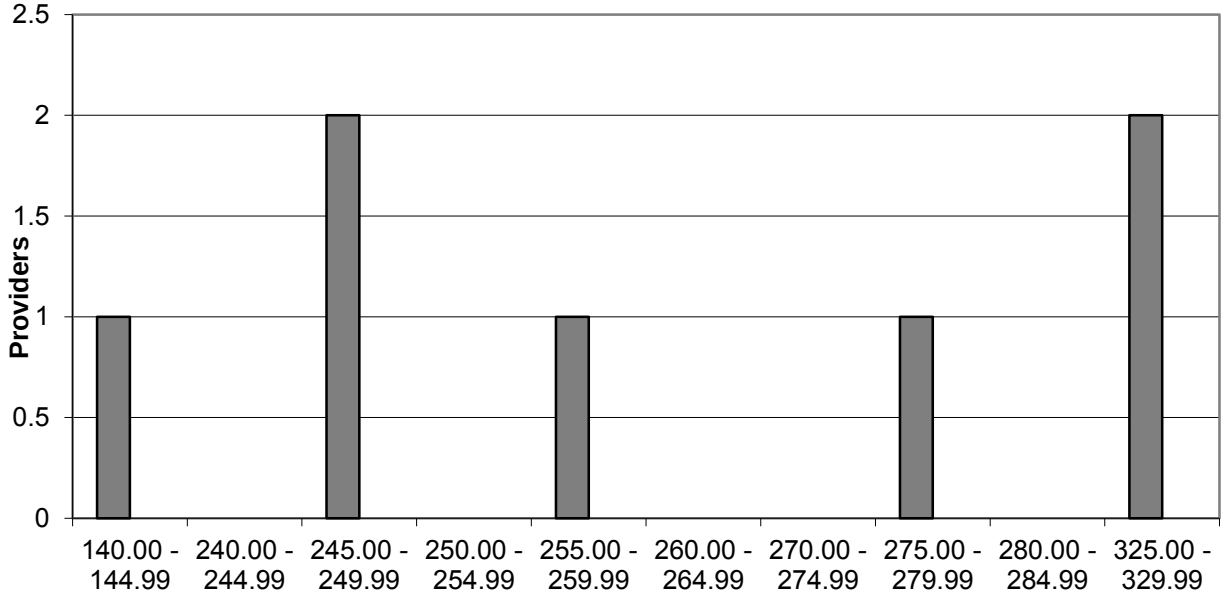


Adult Low Inpatient Rates 1-1-2009



Hospital Rates 1-1-2009



APPENDIX B

Program Standards

1. **Outpatient Treatment Services**: A licensed chemical dependency treatment program that meets the minimum requirements of Rule 31 or applicable tribal license that does not require clients to reside in the same facility.

2. **Medication Assisted Therapy**: A program licensed under Minnesota Rules, parts 9530.6405 through 9530.6505 (Rule 31) and part 9530.6500 or applicable tribal license.

3. **Medication Assisted Therapy Plus**: A program licensed under Minnesota Rules, parts 9530.6405 through 9530.6480 (Rule 31) and part 9530.6500 or applicable tribal license, which provides at least 9 hours of treatment service per week.

4. **Residential Treatment Services --- High**: A licensed chemical dependency treatment program that meets the minimum requirements of Rule 31 or applicable tribal license, and provides at least 30 hours of treatment services per week and room and board to its clients. For purposes of establishing a rate, treatment services mean those services listed in Minnesota Rules, part 9530.6430. For purposes of placement decisions may also include room and board provided by a facility with a contract with the Commissioner in conjunction with outpatient treatment services providing at least 30 hours of treatment services.

5. **Residential Treatment Services --- Medium:** A licensed chemical dependency treatment program that meets the minimum requirements of Rule 31 or applicable tribal license and provides at least 15 hours of treatment services per week and room and board to its clients. For purposes of establishing a rate, treatment services means those services listed in Minnesota Rules, part 9530.6430. For purposes of placement decisions may also include room and board provided by a facility with a contract with the Commissioner in conjunction with an outpatient treatment service providing at least 15 hours a week of treatment services.

6. **Residential Treatment Services --- Low**: A licensed chemical dependency treatment program that meets the minimum requirements of Rule 31 or applicable tribal license and provides at least 5 hours of treatment services per week and room and board to its clients. For purposes of establishing a rate, treatment services mean those services listed in Minnesota Rules, part 9530.6430. For purposed of placement decisions may also include room and board provided by a facility with a contract with the Commissioner in conjunction with an outpatient treatment service providing 5 hours a week of treatment services.

7. **Hospital Based Treatment Services**: A licensed chemical dependency treatment program that meets the requirements in Rule 31 or applicable tribal license provided within a facility licensed as a hospital under Minnesota Statutes, 144.50 to 144.56.

8. **Room and Board**: A facility that provides meals and a place to reside for people who are participating in chemical dependency treatment and is not governed by Minnesota Rules, part 9530.6505. The facility must meet the following requirements:

   A. Admits only persons age 18 or older unless licensed according to Minnesota Rule, chapter 2960;

   B. The program must have a policy and procedure manual and make it available to staff members and clients;

   C. Employees must be 18 years or older and have demonstrated at least one year of freedom from a chemical use problem at the time of employment and must sign a statement attesting to that fact;

   D. Register as a board and lodging or lodging establishment with special services and meets the back ground study requirements of Minnesota Statutes 157.17;

   E. Provide and document 24 hour on site supervision by an awake staff capable of implementing the facility's behavioral or medical emergency procedures;

   F. Have written behavioral procedures that the staff must follow when responding to a client who exhibits behavior that is threatening to the safety of the client and written procedures for obtaining medical interventions when needed for a client. The program is responsible for ensuring that staff are trained on the behavioral and medical procedures;

   G. Facilities providing medication services must meet requirements in MN Rule, part 9530.6435, subpart 3, A and B, and subpart 4, A and B;

   H. Have rules prohibiting the resident from using or bringing into the facility mood altering substances and develops a plan that provides consequences for infractions of those rules;

   I. Admit only individuals who are participating in a chemical dependency treatment program unless the facility is licensed according to Minnesota Rules, chapter 2960 or the individuals who are not participating in a treatment program have completed chemical dependency treatment and are compliant with the facility rules regarding mood altering substances;

   J. Staff is required to report alleged or suspected abuse and neglect according to Minnesota Statutes 245A.65 and 626.557 if they have obtained a release of information. Staff is required to have the training required in Minnesota Statutes 245A.65;

   K. Have abuse prevention plans that meet the requirements of Minnesota Statutes section 245A.65;

   L. Provider must have at least one staff person on the premises who has a current American Red Cross standard first aid certificate or an equivalent certificate and at

least one staff person on the premises who has a current American Red Cross community, American Heart Association, or equivalent CPR certificate. A single staff person with both certificates satisfies this requirement;

M. Obtain a release of information and document coordination and communication between the treatment facility and the room and board. A copy of the release must be located on site;

N. Men and women can only share a facility when the sleeping and bathroom spaces are separated by a door that is locked, alarmed or supervised by awake staff;

O. Have policies and procedures that protect client funds and property and prohibit financial exploitation. The policies and procedures must include a method for clients to safeguard their own funds and property or for the facility to safeguard client funds and property. If the facility holds any client funds or property, there will be procedures for documenting and accounting for funds and property. The policies and procedures must prohibit staff from borrowing from or lending funds to clients; purchasing from or selling items or personal services to clients. Facilities must retain client's property for seven days after discharge, before disposing of the property;

P. Have a grievance procedure in a place visible to the clients. On admission, the program must explain the procedure to the client. The procedure must require that:

- Staff help the client develop and process a grievance;
- Telephone numbers and addresses for the Minnesota Department of Human Services/Alcohol and Drug Abuse Division, the office of the Ombudsman for Mental Health and Developmental Disabilities and the Minnesota Department of Health must be available to the clients; and
- The program is obligated to respond to the client's grievance within three days of a staff member receiving the grievance, and must permit the client to bring the grievance to the highest level of authority in the program if not resolved by other staff members.

Q. The facility's policy and procedure manual must include a policy on fraternization consistent with the facility's program abuse prevention plan; and

R. Comply with applicable building, fire and safety codes, health rules and zoning ordinances.

9. **<u>Co-occurring Programs</u>:** Programs serving individuals with co-occurring mental health problems and meet the following requirements:

A. Minnesota Rules, part 9530.6495.

B. At least 25 percent of the employed or contracted co-occurring counseling staff are mental health professionals, as defined by Minnesota Statutes, 245.462, subd. 18, clauses (1) through (6).

C. Up to 50 percent of the mental health counseling staff may be composed of graduate students in one of the behavioral sciences or related programs and are formally assigned by an accredited college or university to an agency or facility for clinical training; and hence, may provide services to a person with mental illness and addiction under the weekly supervision of a mental health professional.

D. Persons may also be credentialed as mental health professionals under 256B.02, subd. 7, through a tribal facility providing services to American Indian people.

E. Providers are required to develop a plan that addresses cross training of staff in providing co-occurring treatment. Counseling staff must receive eight hours of continuing education on co-occurring disorders, annually.

F. Admission criteria include clients with mental health symptoms regardless of whether a diagnostic assessment has been completed.

G. Clients scoring "positive" on a standardized mental health screen must receive a diagnostic assessment, as defined in Minnesota Statutes, 245.462, subd. 9 or 245.4871, subd.11, within 10 days of admission. In cases where a diagnostic assessment is available and has been completed within 180 days preceding admission, the mental health professional only needs to update the assessment. If the client's mental health status has changed markedly since their recent mental health diagnostic assessment, a new diagnostic assessment is required.

H. The program shall have a policy that addresses standards for case review. The purpose of these meetings is to review the client's treatment plan and seek consultation. The co-occurring staff including the mental health professional must attend case review. Each client must be reviewed by the team at least one time per month.

I. The treatment plan must be signed by the Mental Health professional and the Alcohol and Drug counselor.

J. Education will be provided to families and/or significant others that addresses mental health disorders, substance abuse and the interaction between the two disorders. In addition, the program must provide information to the families or those selected by the client on family support groups and counseling services in the community. Programs must also advise families or interested persons regarding the availability of appropriate community resources, such as case management services, crisis management, and educational programs.

K. Residential programs serving children with co-occurring mental health problems are exempt from A through G above, but must meet the requirements of Minnesota Rules, parts 2960.0580 through 2960.0700.

10. **Clients with Children Program:** Is licensed under Minnesota Rules part, 9530.6405 through 9530.6480 (Rule 31) and part 9530.6490 (clients with children) or applicable tribal license. Programs must directly provide or contract for childcare while the parent is receiving treatment services. Staff members who work with the children must be trained in strategies for working with children of substance abusing parents.

11. **Special Populations**: This category of programs are:

    A. Designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background, including physical disabilities, deaf and hard of hearing, seniors, gay, lesbian, bisexual and transgender persons;

    B. Governed with significant input from individuals of that specific background;

    C. That employ individuals to provide individual or group therapy, at least 50 percent of whom are of that specific background, except that programs serving individuals with physical disabilities are exempt from this requirement; and

    D. Does not include programs specializing in providing treatment services to Caucasians, men, women, adolescents, and religious preferences.

12. **Medical Services**: Are delivered by appropriately credentialed medical staff to assess and address the client's health care needs. The required intensity of medical care will be calculated at a minimum of two hours per week per client. Any one client will get the amount of care he or she needs.

13. **Adolescent Program:** Is licensed under Minnesota Rules, parts 9530.6405 through 9560.6485 (programs serving adolescents) or is licensed under Minnesota Rules, chapter 2960 or applicable license.

APPENDIX C

Rate Reform Grid

ADULT Service Rates		COMPLEXITY			
Treatment Settings Descriptions	Addiction Only Basic Rate	Co-occurring	Special Populations	Clients with their Children	Medical Services
Non-Residential Treatment Rates- acuity addressed in intensity					
Individual (one hour increments)					
Group (one hour increments)					
Medication Assisted Therapy-Methadone-per diem					
Medication Assisted Therapy-all other-per diem					
Medication Assisted Therapy-Methadone-PLUS-per diem (minimum 9 hours counseling services per week)					
Medication Assisted Therapy-all other-PLUS (same as above) per diem					
Residential Treatment Rates * - acuity addressed in intensity					
High Intensity (Minimum 30 hours/week)					
Medium Intensity (Minimum 15 hours/week)					
Low Intensity (Minimum 5 hours/week)					
Hospital Inpatient Per Diem Rates					
Room and Board Rates					

*Residential Medication Assisted Therapy Program - appropriate dosing amount will be added to the appropriate residential rate when a residential provider is supplying and administering medication otherwise administered in an MAT program.

Rate Reform Grid

ADOLESCENT Service Rates		COMPLEXITY			
Treatment Settings Descriptions	Addiction Only Basic Rate	Co-occurring	Special Populations	Clients with their Children	Medical Services
Non-Residential Treatment Rates - acuity addressed in intensity					
Individual (one hour increments)					
Group (one hour increments)					
Residential Treatment Rates - acuity addressed in intensity					
High Intensity (Minimum 15 hours/week)					
Hospital Inpatient Per Diem Rates					
Room and Board Rates					