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# FEASIBILITY OF SUBSTANCE ABUSE PREVENTION RATES

WASHINGTON STATE
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH AND RECOVERY SERVICES

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Government Human Services Consulting

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# 1

# Introduction

## Purpose

The Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery (DBHR) engaged Mercer Government Human Services Consulting (Mercer) to conduct a study on the feasibility of establishing substance abuse primary prevention service rates. This report summarizes the findings of the study.

## Background

DBHR is assessing the feasibility of using fee-for-service (FFS) rates as part of its planning process to improve the effectiveness and efficiency of primary substance use prevention services. Currently, DBHR uses cost reimbursement contracts to fund prevention services. To understand the rate-setting process and how the implementation costs of prevention services are addressed in a FFS payment system, DBHR authorized this study.

The study focused on the following tasks:

- Analyzing data from other states on the implementation cost ranges for the eight most frequent DBHR supported evidence-based substance abuse prevention programs or services categories (see Table 1 below.)

**Table 1: Evidence-Based Primary Prevention Substance Abuse Programs**

| Evidence-Based Primary Prevention Substance Abuse Programs | |
|---|---|
| LifeSkills Training | Guiding Good Choices |
| Mentoring: Big Brothers/Big Sisters | Nurturing Parenting Programs |
| Project ALERT | Parenting Wisely |
| Second Step | Strengthening Families Program: For Parents and Youth 10-14 |

- Describing the rate development strategies and process used by other states to establish FFS rates for primary care substance abuse prevention services. The task includes describing the rational, steps, barriers and strategies to address potential barriers. Mercer also interviewed prevention experts during this phase to understand their perspectives on the fit of FFS rates with the goals of prevention services.

- Reviewing the information from the state interviews with Mercer's actuaries to recommend a process that DBHR can use to establish a rate schedule for primary substance abuse prevention services.

## Methodology

To obtain data from states on their implementation costs, DBHR utilized the National Prevention Network (NPN) member list and polled via email 14 Single State-Agencies that fund prevention services. The states were selected based on their response to a previous DBHR survey, in which DBHR asked the same NPN contacts if their states had established FFS rates for substance abuse prevention services.

Mercer provided follow-up telephone and email contact to the 14 responding states in order to clarify the information provided, request additional information, or schedule an interview. Five states were selected for interview based upon their responses and availability. These included: Alabama, Illinois, Louisiana, South Dakota and Tennessee.

Mercer prepared a draft interview guide (Appendix A) for review and approval by DBHR, and conducted interviews with these states. The interview guide identified the type of evidence based practice (EBPs) offered by the states, payment strategies, the process for developing rates or payments and the strengths and barriers identified by the states in determining rate schedules. Implementation barriers and successes were also addressed in the guide.

Mercer interviewed three substance abuse prevention experts to discuss rate development strategies and the impact of FFS rates on the delivery of prevention services. Two of the experts developed evidence-based prevention programs and the third expert currently evaluates prevention services in Washington State. The list of states and experts interviewed is included as Appendix B.

## Organization of the Report

Section 2 of this report provides a summary and an analysis of findings from the states and expert interviews. Section 3 discusses the feasibility of establishing rates for primary substance abuse prevention services. This section also provides recommendations for a process that DBHR can use to establish a billing rate schedule, including steps, potential barriers and strategies.

## Acknowledgements

Mercer would like to extend its appreciation to the states and prevention experts that participated in the interviews and to DBHR for the opportunity to participate in this exciting project.

# 2

# Summary of Findings

This section of the report provides a summary and an analysis of findings from the state survey responses, interviews of the NPN State contacts and expert interviews. It should be noted that only two states have implemented FFS reimbursement systems and that a few other states are in the early stages of implementation of FFS rates. Thus, the findings below should be reviewed with the understanding that use of FFS rates for substance abuse prevention services is limited. As more states implement some type of FFS rate, additional information will become available.

## Task 1 Findings: Information on Implementation Cost Ranges for the Eight Most Frequent DSHS/DBHR Supported Evidence-Based Substance Abuse Prevention Programs

Twelve states responded to the DBHR request and Mercer's follow-up telephone and email contacts. However, the information on implementation of cost ranges was very limited. In general, implementation costs are not separately funded or identified. Typically, states reported that some start-up costs may be included in annualized contracts as line items, but not necessarily categorized as an implementation cost.

For example, Illinois includes start-up costs in their contracted budgets for items such as one-time purchase of computers and other reasonable costs as determined by state and federal administrative rules. To facilitate statewide implementation of prevention services, South Dakota also provided planning grants to implement community-based prevention coalitions and subsequently selected coalitions that were able to meet the goals outlined in the planning grants.

One consistent area where several states report support of EBP implementation is provider training. They either fund training directly or include funding in prevention contracts. Training includes certification programs for individual staff as well as orientation and training on specific EBP prevention programs.[1]

[1] DBHR, with the National Association of State Alcohol and Drug Abuse Directors (NASADAD), asked for state requirements for certification and training, as well as rate information in October 2011. The results informed this report.

## Task 2 Findings: Rate Development Strategies and Process Used by Other States to Establish Rates

Four states reported development of FFS rate for prevention services: Louisiana, New Jersey, South Dakota and Tennessee. Even though Illinois does not have established prevention rates, the state established reportable hours of services per full-time employee (FTE) that each provider must submit to obtain reimbursement. Alabama is considering development of a FFS rate structure, but currently uses annual cost-reimbursement contracts. Alabama, Illinois, Louisiana, South Dakota, and Tennessee participated in interviews to discuss rates for evidence-based substance abuse prevention services. New Jersey provided information on their rates and barriers to implementation via email.

## Use of Eight Most Frequent DBHR Evidence-Based Primary Prevention Substance Abuse Programs

The first step in Mercer's analysis was to determine if any of the states utilizing some type of rate methodology for prevention services also fund any of the top eight prevention EBPs that are in use in Washington State. Table 2 identifies the EBPs delivered in states either moving toward or utilizing FFS type rates.

**Table 2: Eight Most Frequent DBHR Evidence-Based Primary Prevention Substance Abuse Programs provided by Other States**

| Eight Most Frequent Prevention EBPs in Washington State | AL | IL | LA | NJ | SD | TN |
|---|---|---|---|---|---|---|
| LifeSkills Training | X | X | X | X | X | X |
| Guiding Good Choices | | | | X | | |
| Mentoring: Big Brothers/Big Sisters | | X | | | | X |
| Nurturing Parenting Programs | | | | | X | |
| Project ALERT | X | X | X | X | X | X |
| Parenting Wisely | | | | | | |
| Second Step | X | | X | X | X | |
| Strengthening Families Program: For Parents and Youth 10-14 | | X | X | X | | X |

The most frequent of the top eight Washington State EBPs in use by the states responding to this study are Life Skills Training and Project Alert. Second Step and Strengthening Families tied for the second most available EBP models in the participating states.

## Rate Methodologies

The next phase of the feasibility study was to identify the rate methods developed by the states. Table 3 describes the types of rates or other methods used by the states.

### Table 3: Description of Rate Methodologies

| State | Rate Method | Description |
|---|---|---|
| Illinois | Established reportable hours standards for FTEs in their annual contracts (does not have specific FFS rates) | Established a set amount of reportable hours per FTE during contract year (number of reportable hours under development for FY 2013; previously was 1,160 reportable hours per FTE) |
| Louisiana[2] | Rates per enrollee per EBP session | Universal: $75 per enrollee<br>Selective: $100 per enrollee<br>Indicated: $150 per enrollee |
| New Jersey | Per session rate of $1,488 and a booster session rate of $688 for Strengthening Families | Calculated a per session cost of $1,488 for 14 initial sessions in the program cycle, using previous contract line items costs for facilitators, program staff, food, facility costs, incentives plus a 20% administrative cost. Established separate booster session cost of $688. Combined initial and booster sessions to equal the total average cost. The rates were not implemented due to state contracting requirements. |
| South Dakota | Fifteen minute units of service rates include all direct and indirect costs of delivering a unit of service except resource development, and a maximum of 5% for ancillary costs plus a maximum of 5% for administrative costs, totaling 10% of direct service costs. | Reimbursement is based on submission of utilization data for each prevention strategy by code into the state's KITS data system, which is operated and maintained by KIT Solution, LLC. |

[2] Louisiana utilizes the Institute of Medicine (IOM, 1994) definitions of prevention strategies: Universal prevention strategies for the general public or individual not engaged in substance use; Selective prevention for a high risk population due to membership in a particular group, i.e. children of alcoholics; and Indicated prevention strategies are designed to prevent the onset of substance abuse in individuals who do not meet DSM-IV criteria for addiction, but who are showing early danger signs, such as falling grades and consumption of alcohol and other gateway drugs. Downloaded 5.14.2012.
http://www.kitsco.com/casupport/WebHelp_Prevention101/Institute_of_Medicine_IOM_for_Prevention.htm

| State | Rate Method | Description |
|---|---|---|
| Tennessee | $30 per hour per person FFS all inclusive rate for any EBP model (except environmental), to be implemented July 1, 2012. | Established an all-inclusive rate based on outpatient group therapy rate with an adjustment for travel. Reimbursement is based on submission of per person per hour utilization by state service code into the TNWITS data system. |

## *Illinois*

Illinois' contracts require at least one full time prevention coordinator and other prevention staff that must provide an established number of reportable hours (The reportable hours per FTE need to be finalized for FY 2013. In 2012, the reportable hours were 1,160). Providers are required to report on the number of prevention activity hours and the number of participants monthly utilizing the OnTrack information technology system. Reportable hour activities are defined in the contract and are standard across all services. These include items for time spent implementing and delivering program activities within an approved work plan (i.e., reviewing program materials, meeting with community members to plan the implementation program, consulting with individuals that are directly related to planning or implementing a work plan activity, basic training for a new worker, and attendance at mandatory meetings.) The state tracks utilization of reportable hours and amends provider contracts based on utilization. While this is not a FFS rate method, it does provide a method for tracking utilization and allowable activities.

## *Louisiana*

Louisiana established FFS cost bands per person, per lesson for EBPs at three prevention levels:

- Universal Direct: up to $75.00 or less per enrollee, targeted to the general public
- Selective: up to $100.00 or less per enrollee, targeted to high risk populations
- Indicated: up to $150.00 or less per enrollee, targeted individuals who do not meet DSM-IV criteria for addiction, but who are showing early danger signs

One 35-45 minute session is equivalent to a service delivery unit. Each EBP has a prescribed number of lessons or sessions. In addition to lessons, a pre-test and a post-test session are funded. For example, the LifeSkills Elementary, Level 1 program consists of one pre-test session, eight lesson sessions and one post-test session, totaling ten 35-45 minute sessions. A Prevention Management Information System service ticket must be completed by the provider for each lesson in order to obtain reimbursement. Payment is based upon attendance.

The FFS rates are calculated to include the following provider expenses:

- Training and certification of program facilitators/teachers in the EBP they deliver.
- EBP facilitators'/teachers' manual and student guide for each individual registered to participate in the EBP lessons/sessions.
- Facilitators/teachers to deliver EBP lessons and pre/post-test sessions.
- Participation and documentation of provider staff/ participant activities.
- EBP program process and outcome evaluation (including an independent external evaluation of the pre/post data).

Louisiana initially utilized cost reimbursement contracts and migrated to the cost bands for prevention services established by SAMHSA: $100 (Universal), $200 (Selective) and $500 (Indicated). When SAMHSA removed cost bands, the State established rates utilizing data from previous cost reimbursement contracts and provider budgets.

It is important to note that Louisiana's Office of Behavioral Health (OBH) partnered with the Department of Education to use the infrastructure within school systems. Prevention services are provided in the schools rather than OBH contracting with providers to deliver prevention outside the schools. Thus, resources for office space and related administrative costs to deliver prevention services are provided through the local schools.

Louisiana continues to use annual contracts. The contract describes the number of lessons in the curriculum and requirements for the pre- and post-tests by EBP. Louisiana also funds a statewide evaluator separately from provider contracts at a cost of $1.12 per child participating in prevention services. Louisiana developed quality improvement (QI) tools that are program specific to help monitor fidelity to the EBP.

## *New Jersey*

New Jersey developed a rate schedule for Strengthening Families in 2008. Although this was not implemented due to contract rules, the method included a per session cost for 14 initial sessions in the program cycle, using costs for facilitators, program staff and food and facility costs, incentives and a 20% administrative cost. They also established a separate booster session cost and then combined the initial and booster sessions to obtain a total average cost. Currently, New Jersey utilizes an annualized contract with a specified dollar amount to deliver services to a pre-determined number of individuals/families.

## *South Dakota*

South Dakota established specific codes for 15 minute units of services within an annualized contract for prevention services beginning in 1997, thus this state has over 14 years' experience with use of a FFS rate system. The units of services are listed below:

- H0024 Information Dissemination: $12.75/unit
- H0025 Education: $12.75/unit

- H0026 Community based: $13.75/unit
- H0027 Environmental: $12.00/unit

A Resource Development code (RESD) covers curriculum costs, purchase of media time/space, data collection and training. No set rate is associated with this code, but costs are negotiated within each prevention contract.

South Dakota also covers ancillary and administrative costs beyond the 15 minute rate schedules and RESD. The salary costs included in the rates are based on a statewide average cost. Ancillary costs include incidental funds for community coalition meetings and incentives. Administrative costs cover invoice/voucher preparation, management oversight, and fiscal compliance accountability. Ancillary and administrative costs to support prevention functions cannot exceed 5% each of the total direct prevention service costs, totaling a maximum of 10% of direct services costs. There is also a travel allocation for one statewide training meeting and up to two regional training meetings funded separately from the FFS unit costs. However, local travel to carry out services including travel to coalition meetings is contained in the 15 minute unit service rates. South Dakota also pays $2,000 per contractor to participate in the KITS, the information technology (IT) solution utilized for billing and reporting for substance use treatment services. KITS allows for person level encounter reporting, which is very useful for reporting purposes, calculating costs and tracking performance.

To set the rates, South Dakota established a financial work group that included providers. They analyzed budgets of the larger agencies to extract out resources that were budgeted for prevention. They also surveyed agencies on the salaries of prevention staff and determined an average salary for statewide use. The work group then reviewed productivity assumptions to determine the amount of time per FTE that could be spent weekly on direct services and other functions. Utilizing the guidelines described above for ancillary and administrative costs, the typical costs included in the rates are: staff, employee benefits, considerations for paid time off, travel costs for direct services, supply costs, administrative/overhead costs, and occupancy costs. Once all this information was gathered, South Dakota determined rates by units of service. The rates do not include preparation for model programs that had developed modules.

## *Tennessee*

Tennessee established an all-inclusive $30 per person per hour FFS rate for all substance abuse prevention EBPs except environmental prevention models, which will become effective July 1, 2012. Providers can select any recognized EBP. The FFS rate was developed after tracking data from two years' of cost reimbursement contracts. The state decided to pay a slightly higher rate than outpatient group therapy rates in order to include travel costs in the rate. The participant has to attend the session in order for the provider to receive payment. Tennessee will utilize provider contracts with a total dollar amount and the contracts will be adjusted upward or downward depending on utilization across providers. Providers will be required to submit monthly person level encounter data to the Tennessee Web-based Information Technology System (TNWITS), which then generates an invoice for payment. This

system was previously established through an Access to Recovery Grant for use with substance use treatment services. It took six months preparation to develop the interface between TNWITS and the State's Edison billing system. Implementation strategies include a six month provider group to review the use of the FFS rates and impact on provider operations and service utilization. The state intends to track any differential costs based on the EBP model and make adjustments in the future. For example, some EBP models require food or other resources that may exceed the cost of the $30 per person per hour FFS rate.

## Summary Description of Rate Methodologies

The reporting states with FFS type rates (or reportable hours) continue to have annual contracts with a total budget cap. Also, most of the states developed the rates to support the actual delivery of prevention services (i.e., rate components include staff and travel to the session). Other contract resources beyond the FFS rates support ancillary and administrative costs, such as purchase of the curriculum and annual meetings. When reported, the ranges of administrative and ancillary costs were between 10% and 20%. One state also paid for information technology costs separately from other costs. Only one state is implementing an all-inclusive rate session with no additional payments and will track the adequacy of the rate to cover all costs.

## Rationale and Process for Establishing Rates

The states reported the following reasons for establishing rates:

- Administrative directive from the governor, agency head or senior management level to increase accountability.
- Efficient use of scarce prevention resources.
- Limited availability of good utilization and outcome data.
- Incentivizing use of EBP prevention models by funding adequate rates.

Most states reported concerns about their ability to identify what they were paying for through cost reimbursement contracts. In some instances, prevention resources were supporting staff that may not have actually delivered prevention services. Prevention resources had become too diluted to have desired outcomes. Person level attendance/utilization was difficult to track. One state also expressed concerns that participation in sessions may have been low and that use of allowable incentives to encourage participation was limited because providers received funding for the session regardless of attendance.

The states reported they require providers to implement EBP prevention models as a way of promoting good outcomes. Monitoring often focuses on fidelity to the EBP model rather than tracking person level outcomes. They discussed the difficulty in obtaining reliable outcome data, often due to the complexity of establishing effective evaluation protocols. (The interviews with prevention experts also supported the approach of using EBP prevention models to promote good outcomes. The experts also validated the complexity of measuring prevention outcomes.) As a result, most states emphasize monitoring fidelity to EBPs as an effective approach to promoting good outcomes. Use of FFS rates provides information on utilization that allows

states to monitor the number of sessions and consistency with the EBP session requirements, as a basic monitoring strategy. States reported that session attendance information should be supplemented with other quality management approaches. Two states defined standards in the provider contract and developed a report template to monitor the standards. However, the states varied in the availability of resources to actually provide fidelity monitoring beyond review of utilization data. One state developed QI processes to monitor fidelity with program and monitoring templates specific to EBPs.

## Technical Process for Establishing Rates

The technical process for establishing rates typically involved reviewing historical data from cost reimbursement contracts and establishing "direct service" rates inclusive of cost components for direct delivery of the prevention model (i.e., staff, travel to session). States reported they also established separate "line item" costs for administration and ancillary activities, or developed an in-kind method to support infrastructure costs. One state utilized the Substance Abuse and Mental Health Services Administration (SAMHSA) concept of "cost bands" to establish direct service rates by type of EBP – universal, selective and indicated prevention models. Another state selected the most similar direct treatment service (outpatient group counseling) as the rate foundation, adding costs for travel. Only one state developed a rate specific to the EBP practice, Strengthening Families, but did not implement it because the rate model did not fit into state contracting requirements.

## Information System for Payment and Reporting

The states that were interviewed uniformly reported the need to have information technology that would support FFS payment and reporting. The states using FFS type rates all had existing systems that either could manage billing and reporting or had to modify existing systems to accommodate prevention services. One state required a six month planning process to develop an interface for the prevention FFS rates with the state's payment information system. The states also had to develop prevention specific billing codes.

The use of person level encounter billing was required by all states that implemented or are implementing FFS type rates. This method was viewed as crucial by the states to obtain useful information on individual attendance and provider performance.

## Provider Participation and Impact

The importance of involving providers early on in the process of migration to FFS rates was discussed by most states. The limited availability of prevention resources coupled with an administrative or political mandate to improve accountability for prevention expenditures offers an incentive for providers to actively participate in planning. States reported both formal and informal methods for involvement of providers.

The most frequently mentioned steps included:

- Data collection on provider costs for delivering prevention services, including the costs that should be included in the rates and the costs that should be financed through a line item budget.
- Assessment of provider information technology capacity.
- Educational sessions to assist providers with the change in "culture" from line item contracts to FFS and the related call for increased accountability.
- Training on the rate structure, documentation and billing and coding.
- Methods to address provider certification as prevention specialists and EBP certification.
- Strategies to support EBP fidelity and monitoring.
- Evaluation strategies.

States also reported that the process was often difficult for providers that relied on cost reimbursement contracts to establish annualized agency budgets and for providers that did not have the technical capacity to project income or submit FFS type bills (claims). One state noted that the procurement process for providers eliminated applicants that did not have the technical capacity to utilize a FFS model. The states interviewed discussed the importance of monitoring provider stability and having resources available to support costs beyond the actual service components of the FFS rate. As a result, most of the states also had "line item" resources to support ancillary and administrative costs that are not components of the FFS rates. They also had administrative processes to adjust the contract upwards or downwards, depending on the sessions provided.

A barrier to establishing FFS rates involved provider advocacy with state legislators against the move away from cost reimbursement contracts. One state reported that an effective strategy to mitigate legislators' concerns was emphasizing that funding was not being reduced in the legislator's area. Rather, utilization of FFS rates would promote greater accountability and potentially result in increased services to constituents.

Another issue raised was questioning the value of implementation of FFS rates when health care reform is now focusing on outcomes of service rather than use of FFS payments (although the transition from FFS rates must be carefully constructed). However, the long-term nature of measuring outcomes of prevention, (i.e., does a specific intervention result in prevention of addictive disorders over an age span), makes it challenging to rely solely on outcomes as a way of monitoring effectiveness and efficiency. In most of the states interviewed, the transition to FFS rates occurred along with the requirement to offer evidence-based prevention models. Interviews with prevention experts suggested that use of EBPs is an important strategy in promoting good outcomes. (See Expert interview summaries section of this report.) Thus, use of FFS rates is one strategy that the states found useful in monitoring whether the services were actually delivered as well as provided consistently with the EBP session requirements.

## Administrative Barriers

States reported the administrative barriers in the use of FFS rates focused in the following areas:

- State contracting operations and requirements.
- IT capacity of providers to bill FFS claims and the state's capacity to accept claims.
- IT capacity to generate reports.
- Identification of components comprising the rate.

One state was not able to move forward with FFS rates due to its contracting operations. The contracting structure would need significant overhaul to accommodate use of FFS rates.

Of the other states interviewed, most had developed IT that could be modified to address FFS claims and reporting. However, careful assessment of the IT capacity was recommended to ensure the state can process FFS claims as well as generate meaningful reports that can be used to monitor utilization and fidelity to EBPs.

Determining the components of FFS rates was a challenge that most states overcame. However, this requires ongoing review to determine the appropriateness and adequacy of the rates. States must identify the components (staffing, travel, supervision time, etc.) to include in the rate and those that will be paid outside the rate. For example, if providers are required to conduct their own evaluation of the program, evaluation costs could be included in the FFS rate. If a state selects a statewide evaluator, then payment for the evaluator would likely not be included in the rate. For example, in Louisiana the State partners with the Department of Education and infrastructure costs for scheduling and hosting the prevention sessions are provided through the school systems, thus those costs are not included in the FFS provider rate.

## Successes

Two states that successfully implemented FFS rates and have enough experience to report favorably on their efforts are Louisiana and South Dakota. Illinois also successfully implemented a "reportable hours" method with defined contract standards. Each of these states report success with these strategies including greater accountability, improvements in reporting on EBPs and increased efficiency, especially in targeting prevention resources to defined populations and programs. These states plan to continue using their FFS rates and reportable hours' methodologies. Common themes and strategies discussed by the states included:

- Implementation throughout different areas/regions of the state may evolve differently.
- The availability of specific cost information is crucial to establishing adequate rates.
- The state can decide the components to include in the FFS rate and the components that may be better paid through a cost reimbursement method.
- Standardized contract templates and monitoring tools are very useful to the implementation of EBPs.

- Quality measures linked to specific EBPs are helpful with monitoring, reporting and fidelity measurement.
- The capacity to adjust contracts based on FFS claims allows for efficient use of resources. Under- and over-utilization can be accommodated by shifting resources across contracts.
- Evaluation resources can be paid for through the FFS rates, independent of the rates, or using both methods.

## Substance Abuse Prevention Expert Interviews

Three substance abuse prevention based experts from academia were selected for interview:

- Laura Hill, PhD, Associate Professor, Department of Human Development, Associate Director for Health Promotion Research, & Evaluation, Health & Wellness Services, Washington State University, prevention researcher.

- Flavio Marsiglia, Professor of Cultural Diversity and Health and Director of the Southwest Interdisciplinary Research Center (SIRC), Arizona State University. Prevention researcher and developer of kiR, a life skills curriculum for children in grades 6 to 9 that has been proven effective for reducing drug use and establishing anti-drug attitudes. kiR is identified as a model program by the Center for Substance Abuse Programs at SAMHSA.

- Steven Schinke, MSW, PhD, Professor, Columbia School of Social Work. Dr. Schinke is studying the effects of computer-based intervention programs to reduce drug abuse among adolescent girls and to prevent school abuse among young adults.

None of the experts had experience with FFS payment methodologies for prevention services, but expressed interest in understanding how rates would be constructed. With regard to establishing rates, monitoring fidelity to EBPs and tracking outcomes, the experts shared the following recommendations:

- When establishing rates, it is important to look at fidelity and adaption to fidelity in real world settings. In one student study in the State of Washington,[3] while 80% of facilitators adhered to the curriculums of EBP prevention programs, 70% of these same facilitators slightly modified the program to fit different circumstances, mostly compressing the material, due to time constraints.

- The adequacy of the rate to accommodate real world settings in delivery of EBPs and to support the actual costs of delivering specific EBP models were raised as key issues for rate development.

[3] Dr. Laura Hill, Washington State University reported that a student conducted this study.

- The shift to universal interventions with large group participants should be assessed. It is important to review the relative effectiveness of small versus large group interventions. Smaller groups may be more resource intensive, but may have a bigger effect. Thus the cost per case prevented should be considered in selecting and financing different prevention models when this information is available.

- Use of EBPs is an effective method to promote better outcomes. The difficulty of outcomes measurement in prevention is largely due to the data requirements needed over time to track cases prevented. One of the experts found that intervention often postpones substance use, but may not prevent it. Thus, funders are at times reluctant to pay for interventions that postpone use, even though postponement may have an important positive effect on overall health and outcomes in the future.

- When conducting outcome evaluations, focus on small geographical areas, (i.e., neighborhoods), where it may be easier to collect data over time.

- Use of computer based prevention models is one strategy that promotes fidelity. Computer assisted models are self-administered, self-contained and fidelity inherent. The individual cannot advance the program until completing each session. It is not necessary to train or certify prevention staff to deliver the program. If students have access to computers, it is a cost effective prevention delivery model.

With these findings in mind, the next section of the report will address the feasibility of establishing rates for prevention services in Washington State.

# 3

# Feasibility of Setting Prevention Rates

While the number of states moving forward with establishing rates for prevention services is very small, the positive results reported by the states interviewed are encouraging. This section of the report will focus on considerations for establishing FFS prevention rates.

## Decision Analysis – Mandate for Change and Administrative Capacity

The first step in determining feasibility of implementing FFS rates is to conduct a decision analysis for key areas that other states reported as instrumental in their rate setting process.

***Is there a mandate to improve the efficiency and effectiveness of prevention services?***
With budget reductions and fewer resources available for prevention, is there a need to target prevention services? Improve efficiency? Track effectiveness? Without a mandate, it may be difficult to garner resources necessary to set rates and address potential administrative infrastructure changes.

***Are there DBHR and other state staffing resources available to initiate a rate setting process?***
Staff resources are needed for data collection, decision and policy analysis, provider collaboration, and public education about the changes.

***Are there regulations governing provider contracting that would have to change to implement FFS rates?***
Review of administrative rules and regulations, as well as the current contracting requirements is necessary to determine needed changes and the timeframe for accomplishing changes.

***Does DBHR's information system have capacity to accept claims for FFS or does the system require updates or changes? What steps are needed to establish FFS billing codes for prevention services? What is the timeline for making system changes and implementing billing codes?***
Adoption of FFS rate structure depends on having an information system that can process provider claims and issue payments, as well as report on utilization.

Once these key areas are addressed, the next step is to determine the FFS rate setting process.

## Decision Analysis – Rate Setting Process

***Who will be involved in the rate setting process?***
Typically, it is necessary to identify key staff and resource staff to assist with problem solving administrative infrastructure issues, provider collaboration and data collection required to establish rates. Also, if changes to administrative rules or information technology are necessary, key contacts in those areas should be included in the planning process. Establishing ways for providers and stakeholders to offer information and feedback during the rate setting process is an important strategy to achieve checks and balance on the rate components.

***What is the time frame for introduction of FFS rates?***
Depending on the decisions made in the above sections related to infrastructure changes, introduction of FFS rates will depend on the resources available for data collection and verification. It is likely that DBHR will need at least one year to address potential administrative changes and establish rates. The actual timeframe will depend on multiple factors identified in the decision analysis questions.

Once these decisions are addressed, the next step is to set rates.

## Decision analysis – Rate Setting Parameters

***Does DBHR want to set rates for each individual EBP model or create a single rate for similar EBP models?***
Establishing rates for individual EBPs captures the specific costs of the model. For example, if the Strengthening Families model requires a meal at each session, meal costs would be calculated into the rate. Another advantage of establishing rates for specific EBPs allows the state to provide incentives through higher rates for desired services, or for smaller group sessions, if smaller sessions are more desirable in use of the EBP model. Alternatively, similar to the Louisiana model, three rates could be established for the type of prevention model, universal, selective or indicated.

The large number of EBPs in use for substance prevention services may make it too labor intensive to set rates for each individual EBP. However, DBHR may want to consider setting rates for the most frequent EBPs or establish rates for the different categories of EBPs, similar to Louisiana. DBHR could also decide to pay a higher rate for EBP programs that meet fidelity requirements according to an agreed upon method for assessing fidelity.

***What components does DBHR want to include in the rate?***
Most FFS rates for treatment and rehabilitation services are all-inclusive meaning that all costs of the service are part of the rate. For example, personnel costs including taxes, insurance, training, paid time off, supervision, and certification. Evaluation, curriculum materials, travel, and agency administrative costs could also be included in the rate. Louisiana and Tennessee have

all-inclusive rates. South Dakota has cost reimbursement contracts that support administrative and other costs beyond basic service delivery costs contained in the FFS rate. As part of the rate setting process, DBHR will need to determine the components of each rate and whether to have cost reimbursement contracts that support certain non-rate components. DBHR should also evaluate if there are components of the rate that will be funded form other State funds (e.g., statewide evaluator funded separately).

***Does DBHR want to establish separate rates for practitioners with similar qualifications, education and training?***
Many FFS rates for treatment services pay according to the practitioner's qualifications. Separate procedure and bill codes are used for bachelor-level staff, master-level staff, peer, nurses and psychiatrists. Similarly, DBHR could choose to pay a higher rate for certified prevention specialists than for staff that are not certified.

These decision points will need to be thoroughly vetted as part of the rate setting process. The section that follows identifies the typical rate setting steps.

## Typical Rate Setting Steps

Establishing cost based FFS rates follows typical steps and activities as listed below:

- Identify allowable costs and or allowable activities related to the service, based on state and federal funding rules.
- Review the service description for all requirements, including certification, training and qualifications of staff.
- Discuss the rate components and assumptions.
  - Determine the unit of service (e.g., 15 minutes, hour, or day).
  - Develop direct, indirect, productivity and administrative assumptions.
  - Identify what constitutes a billable service.
- Review provider costs/budget data for past two years, if available.
- Model rates based on service delivery expectations.
- Compare rates to other states, where applicable.
- Finalize rate recommendations for the service.
- Develop billing guidance to ensure consistency.
- Orient providers to the rates and billing requirements.

With implementation of FFS rates for EBPs, it is important that the staffing requirements match the fidelity model. Financial decisions should consider the following factors:

- Productivity (extracting time for supervision, vacation, holiday, sick leave, provider training, and documentation, etc.).
- Wages to pay practitioners.
- Employee related expenses (e.g., health insurance, workers compensation, federal and state unemployment taxes, federal insurance, and other benefits such as retirement, etc.).

- Certification and fidelity maintenance costs.
- Rate structure/number of rates.
- Costs of travel, training and other expenses incurred specifically to carry out the service.
- Cost of supervision.
- General and administrative allowances.
- Evaluation costs if evaluation is a required function.

Throughout the rate setting process, the following approaches are typically addressed:

- Ensuring compliance with state and federal regulations and requirements (e.g., staff qualifications, licensing or certification requirements, allowable costs).
- Ensuring the service is designed to achieve results, both for the individual service and the prevention system of care.
- Ensuring the rate assumptions incent behaviors that meet program objectives and state/federal requirements (e.g., payments rates priced too low will hinder provider recruitment and availability; payments priced too high may attract provider base but are not efficient).
- Designing reports that track utilization and cost information.

In summary, addressing these decision points and following the key steps and considerations outlined above, lead to sound rates.

## Conclusion

Two states have successfully implemented FFS rates. Other states are planning to utilize similar strategies. The development of FFS rates is a technical process. However, implementation of FFS rates may require administrative and infrastructure changes. Involving providers in the rate setting process and collaborating on billing and documentation requirements are essential steps in transition from cost reimbursement contracts. Successful implementation of FFS rates for prevention services requires a thoughtful planning process with defined time frames. The planning process will need to address the decision-analysis points and the key steps in the rate setting process outlined in this report.

# APPENDIX A

## Interview Guide for Feasibility Study for Substance Abuse Prevention Services Rates

State: _____ Date: _____

Contact person: _____

Telephone: _____

Script of introductory remarks: Hello, I am [Name] from Mercer Government Human Services Consulting. I am calling on behalf of the Washington State Division of Behavioral Health and Recovery to discuss your email response to Michael Langer about payments for prevention services. Thank you for providing the information and agreeing to speak with me. This interview should take between 15 to 20 minutes.

1. Does your state provide any of the following evidence-based substance abuse prevention services?

| Service | Yes | No |
|---|---|---|
| LifeSkills Training | | |
| Guiding Good Choices | | |
| Mentoring: Big Brothers/Big Sisters | | |
| Nurturing Parenting Programs | | |
| Project ALERT | | |
| Parenting Wisely | | |
| Second Step | | |
| Strengthening Families Program: For Parents and Youth 10–14 | | |

2. You mentioned that you have established prevention rates. (Attach the rate information provided by the state as a resource during the call.) If yes, they have rates, ask or confirm if the rates apply to these prevention models listed above. If no, ask for the services for which the rates were developed.

3. Can you describe the process used to establish the rates?
   Prompts include:

   - What prompted your state to establish specific prevention services rates? (For example, stakeholder feedback, national prevention initiative/state prevention enhancement, provider accountability.)

   - What, if any, data did you have available in your state to establish the rates? (For example, provider cost reports, provider surveys, etc.)

   - Are the rates used for the entire prevention system (all services) or are they specific to certain types of services? (For example, direct programming versus coalition work versus environmental strategies.)

   - What steps did you take to establish the rates? (For example, data collection process, provider input, determination of billing codes.)

   - What barriers did you encounter during the rate setting process? (For example, provider concerns, lack of utilization data for prevention services, technical method for determining rates, lack of state infrastructure to utilize a fee-for-service type payment methodology.)

4. Can you describe the type of rate paid for these services and the components of the rate?

   - Type of rate: case rates, per diems, hourly or 15-minute rates, rates differing by qualifications of staff providing the service.

   - Staffing costs, employee benefits, considerations for paid time off, specific considerations for training for each service or other requirements of the service, travel and training costs, supply costs, admin/overhead, occupancy costs, etc.

   - How do you handle start-up costs?

   - Are there any supplemental payments in addition to the rates, or were there any supplemental payments during the initial implementation of the rates?

5. Is there specific staffing, certification, licensing or other requirements necessary for a provider to receive the established prevention rates?

   - Provider agency certification, individual staff certification, licenses, education?

6. How is fidelity to the evidence-based prevention program or adherence to other necessary requirements enforced? Are there programmatic and/or financial implications if a provider does not adhere to these standards?

   - For example, withholding on payment rates, periodic audits, reduced rate if fidelity is not met or other requirements are not met, other, etc.

   - Any other corrective action for providers?

7. Once you established the rates, what steps did you take to implement them, both from a policy and a financial perspective?

   - Policy: State agency infrastructure changes, billing system changes, policy development, provider education, stakeholder education

   - Financial: Payment mechanisms in early years to support providers in the transition, phase-in of revised rates, etc.

8. Has your state developed any reports to track utilization and fidelity? Would you be able to provide a sample report?

9. Are the rates working as expected? Have there been any notable successes or challenges?

   - Provider stability? Better reporting? More/less utilization? Other?

10. If you were going to establish rates again, what would you do differently? Looking back, would you do it again? Any advice for other states that are about to establish rates for prevention services?

11. How has having rates benefited the state and the prevention system/field?

12. What have been the drawbacks to having established rates?

# APPENDIX B

## State and Expert Interviews

### National Prevention Network State Contacts

**Alabama –** Dr. Maranda Brown, Department of Mental Health, Division of Substance Abuse Services

**Illinois –** Kim Fornero, Bureau Chief, Bureau of Community-Based and Primary Prevention Department of Human Services/Division of Community Health

**Louisiana –** Leslie H. Brougham Freeman, PhD, LPP, Director, and Bill Blanchard, Program Manager, Prevention Services, Louisiana Department of Health and Hospitals, Office of Behavioral Health – Addictive Disorders Prevention Services

**South Dakota –** Prevention Program Manager/SPF-SIG Coordinator/NPN, Community Behavioral Health, Department of Social Services

**Tennessee –** Angela McKinney-Jones, Director of Prevention Services, Division of Alcohol and Drug Abuse Services

### Prevention Experts

**Laura Hill, PhD** – Associate Professor, Department of Human Development and Associate Director for Health Promotion, Research & Evaluation, Health & Wellness Services, Washington State University

**Flavio Marsiglia, PhD** – Professor of Cultural Diversity and Health at the Arizona State University (ASU) School of Social Work and Director of the Southwest Interdisciplinary Research Center (SIRC)

**Steven Schinke, PhD** – D'Elbert and Selma Kennan Professor at Columbia University School of Social Work and developer of computer-based prevention programs

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