FINAL
REPORT

MaineCare Children's Outpatient Mental Health Services — An Assessment of Administrative Costs and Their Drivers

Report No. SR-CMH-08

a report to the
Government Oversight Committee
from the
Office of Program Evaluation & Government Accountability
of the Maine State Legislature

February
2009

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ABOUT OPEGA & THE GOVERNMENT OVERSIGHT COMMITTEE

The Office of Program Evaluation and Government Accountability (OPEGA) was created by statute in 2003 to assist the Legislature in its oversight role by providing independent reviews of the agencies and programs of State Government. The Office began operation in January 2005. Oversight is an essential function because legislators need to know if current laws and appropriations are achieving intended results.

OPEGA is an independent staff unit overseen by the bipartisan joint legislative Government Oversight Committee (GOC). OPEGA's reviews are performed at the direction of the GOC. Independence, sufficient resources and the authorities granted to OPEGA and the GOC by the enacting statute are critical to OPEGA's ability to fully evaluate the efficiency and effectiveness of Maine government.

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Report Highlights

OPEGA Report No. SR-CMH-08

MaineCare Children's Outpatient Mental Health Services — An Assessment of Administrative Costs and Their Drivers

What questions was this OPEGA review intended to answer?

- How much of the funding for outpatient services for children is expended on the administrative costs of DHHS and providers versus direct delivery of services?
- What are the primary factors driving the administrative costs?

What was OPEGA's overall conclusion?

Of the approximately $18.5 million spent on outpatient children's mental health services (CMH services) in FY 2008, we estimate about 73%, or $13.5 million is associated with the cost of directly delivering the services to children. Approximately 19% ($3.4 million) can be attributed to providers' administrative costs, and the remaining 8% ($1.4 million) represents the administrative cost of program management performed by the Department and its contracted Administrative Service Organization (ASO).

Primary drivers of administrative costs for DHHS are the contract with the ASO and costs incurred by the Office of MaineCare Services in processing provider claims. Providers surveyed reported that certain administrative requirements imposed upon them by the State, and the ASO in particular, represented significant efforts for them.

The State has moved to standardized reimbursement rates for CMH outpatient services and providers are working to adapt by managing their costs to a supportable level. By lowering or raising the standard rate, the State affects the level of costs providers can afford to bear.

The provider network will continue to adapt to the implementation of care management efforts and standardized rates. We encourage DHHS and the Legislature to closely monitor whether the current standard rate, or administrative requirements on providers, should be further adjusted to achieve additional savings or to address any unintended changes in the availability and quality of services.

What actions has OPEGA suggested?

OPEGA suggested the Legislature consider taking action to:

- ⇨ Assess the cost-effectiveness of the contract DHHS has entered with the ASO, APS Healthcare.
- ⇨ Formally monitor the effects of the current standard rate and administrative requirements of the care management effort on the CMH network to ensure any unintended changes in the availability or quality of services can be addressed promptly.
- ⇨ Determine whether to revive the currently inactive Children's Mental Health Oversight Committee authorized by 34-B MRSA §15004-2.
- ⇨ Monitor developing actions by DHHS and the Service Center to begin collecting federal reimbursement for appropriate costs not reimbursed in prior years.

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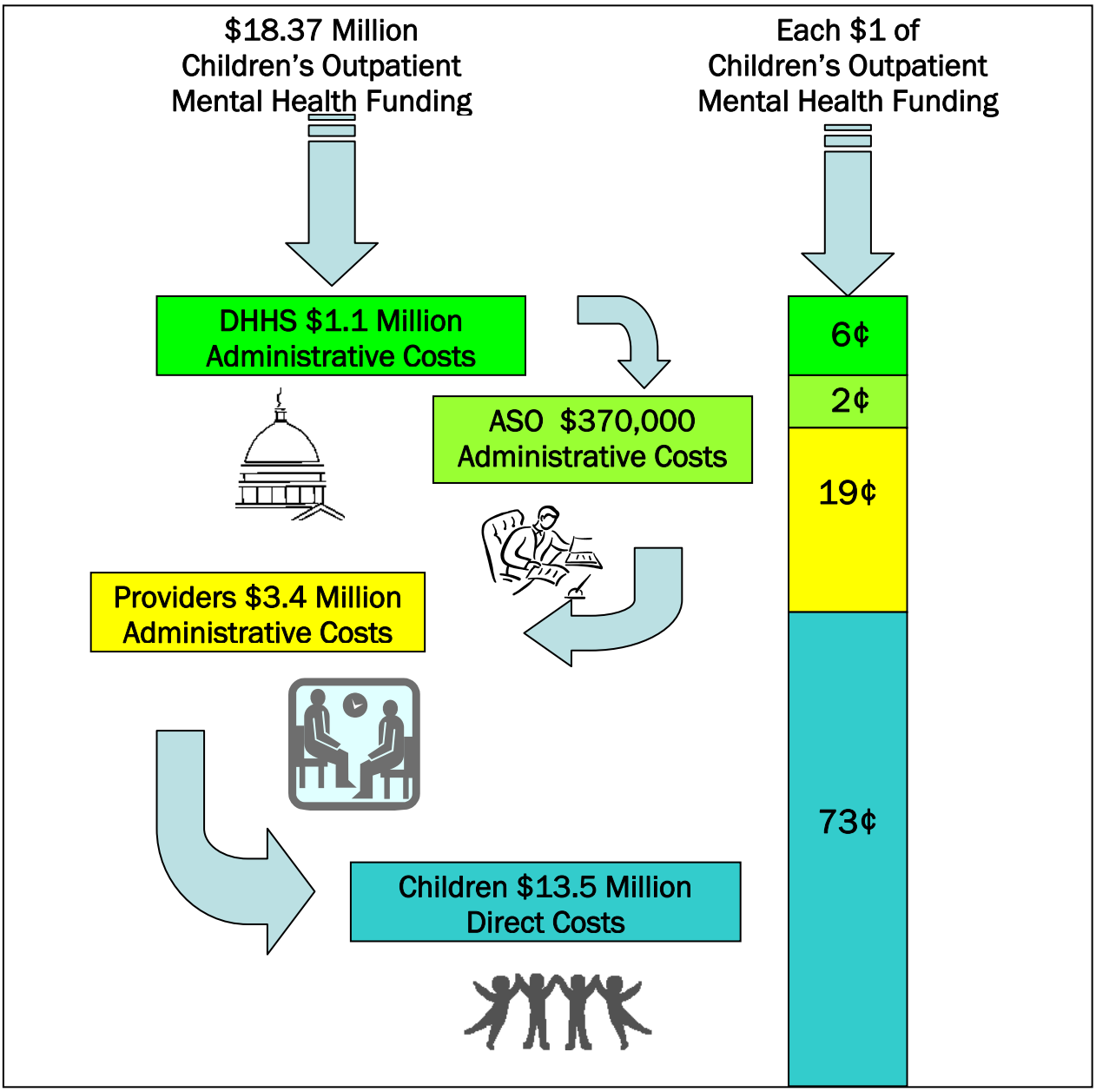
February 2009

Estimated Portion of Each FY 2008 Dollar that Went to Direct Services and Administrative Costs for MaineCare Children's Outpatient Services



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FULL REPORT

MaineCare Children's Outpatient Mental Health Services — An Assessment of Administrative Costs and Their Drivers

Purpose

OPEGA's review focused on administrative costs associated with outpatient mental health services for children.

The Maine Legislature's Office of Program Evaluation and Government Accountability (OPEGA) has completed a review of administrative costs associated with Children's Outpatient Mental Health Services provided by the Department of Health and Human Services (DHHS) through MaineCare. OPEGA conducted this review at the direction of the joint legislative Government Oversight Committee (GOC) of the 123rd Legislature, in accordance with 3 MRSA §§991-997.

Over the past three years, OPEGA and the Government Oversight Committee have heard a number of questions from legislators about children's mental health services (CMH) in general, and about the administrative costs associated with their delivery. This report attempts to address some of those questions within the context of a specific CMH program: outpatient services. This program was selected by the GOC because its services are provided to a larger number of children than any other service (see Table 1). Almost $17 million of State and federal funds was paid to providers for outpatient children's mental health services delivered in FY 2008. These services were delivered to approximately 13,000 individual children throughout Maine.

Table 1. Children's Behavioral Health Services by Type for FY 2008

Service Provided	FY08 Total Costs All Funds*	FY08 Count of Children** (unduplicated)	FY08 Count of Providers** (unduplicated)
Office Based Outpatient	$16,868,595	12406	62
Case Management	$25,664,159	7276	49
Crisis Services	$8,232,946	5990	15
Medication Management	$3,867,640	4609	20
Flex Funds	$1,193,398	4190	3
Child & Family Behavioral Health Treatment Services	$11,344,233	2094	40
Homeless Youth	$241,192	2030	4
Respite Care	$2,157,656	1783	4
Intensive Temporary Residential Treatment (room & board portion only)	$3,846,436	518	32
Assertive Community Treatment	$3,070,660	394	6

*DHHS provided the total General Fund costs for each service. OPEGA estimated the federal match portion by applying the blended federal match rate of 66% to the General Fund costs that were accounted for as eligible for matching. Flex Funds, Respite Care and Intensive Treatment are not matched by federal dollars.

**Children and provider count data in this Table also provided by DHHS. Counts are unduplicated within each service but individual children may receive more than one service and would be included in the count for each service they received. Similarly, providers may have offered multiple services. Also note that due to timing issues this data does not exactly match the data analyzed by OPEGA later in this report.

Within outpatient services, the GOC focused OPEGA's work specifically on administrative costs associated with the service, in keeping with the Committee's interest in areas where costs could perhaps be reduced without affecting services to citizens. The resulting scope questions approved by the GOC on October 7, 2008 were:

> *How much of the funding for outpatient services for children is expended on the administrative costs of DHHS and providers versus direct delivery of services? What are the primary factors driving the administrative costs?*

OPEGA conducted research to identify a national standard or common definition for "administrative costs" in a health service setting, but found that there is little agreement on this point. For the purposes of this review, OPEGA considered "administrative costs" to be those costs associated with managing the services, but not specifically associated with the actual physical delivery of those services. For example, most indirect and overhead costs would be considered administrative, while salaries of counselors delivering the services, and some portion of building costs associated with the space in which they provide the services would be considered direct costs.

Scope and Methods

The scope of our review was limited to children's outpatient services governed by Section 65F of the MaineCare Benefits Manual and provided during FY 2008.

Given the scoping direction from the Government Oversight Committee, OPEGA's work was bound primarily to children's outpatient mental health services. Although our work indicated that some such services are provided through a General Fund-only program, that program had been dwindling over the recent years and as of FY 2008 had an annual budget of approximately $200,000. The majority of children's outpatient services, approximately $17 million annually, are delivered through MaineCare and therefore supported by General Fund dollars with a federal match. Our work focused on these MaineCare services.

The outpatient mental health services for children at the center of our review were those governed by Section 65A.02.F of the MaineCare Benefits Manual, commonly referred to as 65F services. Section 65F was effective during the period of our review, but since the end of FY 2008 changes have been made to the Manual. Outpatient services are now covered under section 65.06-3 and have been grouped together with services previously covered under other sections[1].

In performing this review, we recognized the complexity of the MaineCare system and the regularity with which its parameters can change. In order to keep our work

[1] From DHHS's website: "Effective October 29, 2008, four Sections of the MaineCare Benefits Manual: Sections 58, Licensed Clinical Social Worker, Licensed Clinical Professional Counselor and Licensed Marriage and Family Therapist Services, Section 65, Mental Health Services, Section 100, Psychological Services and Section 111, Substance Abuse Treatment Services Chapters II & III, were consolidated into one Section of the MaineCare Benefits Manual, now known as Section 65, Behavioral Health Services. The final rule consolidates all Outpatient Services under one Section of the MaineCare Benefits Manual, ensuring better coordination of services. Emergency Services, which used to be covered as a stand alone service, has been incorporated into Outpatient services. Comprehensive Assessment, which was incorporated into Outpatient Services, is covered as a stand alone service and coded for reimbursement in Chapter III…"

confined to a relatively stable time period and to keep our results current, we focused on costs, processes, and results associated primarily with FY 2008. Our work included:

- interviewing key employees of DHHS and the Department of Administrative and Financial Services (DAFS) Service Center to understand the work DHHS offices perform to administer children's outpatient mental health services and the costs attributable to their efforts;
- surveying a sample of 12 providers representing organizations of various sizes located across the State;
- interviewing representatives of the three primary support organizations in Maine for parents of children who use behavioral health services;
- obtaining and analyzing an extract of paid claims from the Maine Claims Management System (MECMS) for CMH services provided during FY 2008;
- obtaining and reviewing data from APS Healthcare, the Administrative Service Organization (ASO) contracted to perform utilization review for children's outpatient services;
- working with the legislative Office of Policy and Legal Analysis (OPLA) and Office of Fiscal and Program Review (OFPR) to understand legislative history and recent fiscal initiatives;
- reviewing pertinent State and federal regulations, including the MaineCare Benefits Manual;
- reviewing reports from similar audits in other states; and
- reviewing State Single Audit Reports and obtaining additional information from the State Auditor.

OPEGA conducted research that included interviews and surveys of key stakeholder groups. We also analyzed paid claims data from MECMS for FY 2008.

We initially expected our work to include reviewing the appropriateness of the allowance for administrative costs built into the standard rate paid to providers of children's outpatient services. However, Deloitte Consulting LLP (Deloitte) was contracted by DHHS in the fall of 2008 to assess the rates paid for all behavioral health services for both children and adults. In order to avoid duplication of effort, OPEGA did not perform any additional analysis of the standard rate, and instead relied on Deloitte's work to the extent necessary and prudent.

Overview of Children's Mental Health Outpatient Services

DHHS's Administration of Outpatient Services

The Federal Early and Periodic Screening, Diagnosis and Treatment (EPDST) law is Medicaid's comprehensive and preventative child health program for individuals under the age of 21 and requires states to serve that population, but does not mandate how states provide the services. Maine provides the behavioral health services considered required under this law through DHHS's Division of Children's Behavioral Health Services (CBHS). The Division's responsibilities for

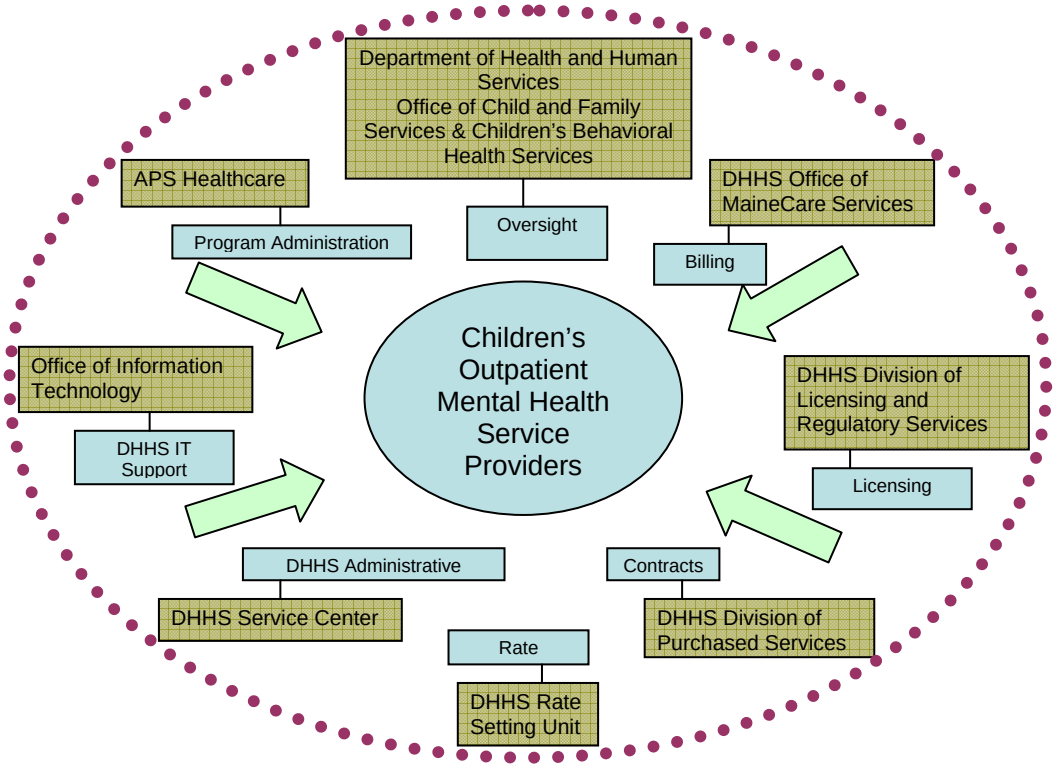
children's outpatient services are guided by statute, 34-B MRSA §15001-§15004, and agency rule, Chapter 101, MaineCare Manual.

DHHS's Division of Children's Behavioral Health Services oversees children's outpatient services. The services are delivered in the community by a network of licensed mental health service providers.

CBHS does not deliver outpatient mental health services to children directly. Services are delivered by licensed mental health service providers in the community, and the Division serves mostly an oversight function. Other offices and divisions within DHHS are involved to varying degrees in the provision of children's outpatient mental health services. Figure 1 illustrates the entities involved in the administration of children's outpatient services.

An additional administrative function was fairly recently established through the partial implementation of a care management initiative authorized by the Legislature in PL 2007, Chapter 240, Part CC. This function is provided by an Administrative Service Organization (ASO), known as APS Healthcare (APS), that is under contract with DHHS. The care management initiative was expected to achieve significant savings, but OPEGA found that, as of yet, there has been no detailed review of contract costs in comparison to savings or other outcomes being derived from APS services. See Recommendation 1 in the Recommendations section of this report for further discussion.

Figure 1. Entities Involved in Administration of Children's Outpatient Services



An ASO has recently been established to manage care and help control costs. OPEGA recommends a cost-effectiveness review of the contract with the ASO be undertaken. See Recommendation 1 for additional information.

Statute created the Children's Mental Health Oversight Committee to provide additional oversight in this complex program area, but the Committee is currently inactive. See Recommendation 3 for more information.

In addition to the oversight provided by DHHS's Division of Children's Behavioral Health Services, statute creates a Children's Mental Health Oversight Committee (34-B MRSA §15004-2). This Committee is statutorily required to meet every 2 months or more often, as the Committee determines necessary, to perform several significant statutorily required duties. During this review, OPEGA observed that the Committee appears to have stopped meeting and no longer receives reports from DHHS or makes reports to joint standing committees of the Legislature as

required in statute. It appears that a number of the Oversight Committee's seats have gone unfilled for some time, and as a result the Committee has ceased to function. See Recommendation 3 in the Recommendations section of this report for additional discussion.

Description of Outpatient Services

Outpatient mental health services usually take the form of therapeutic counseling and are provided in an outpatient setting such as an office or school.

Children's outpatient mental health services are provided to MaineCare eligible children who have developmental disabilities or delays, Pervasive Developmental Disorder (PDD), autism or mental health diagnoses. These services usually take the form of therapeutic counseling, and are distinct from other types of counseling because they are provided in an outpatient setting. The child is not admitted to a residential facility or hospital, and instead participates in the counseling in a setting such as an office or often a school.

Outpatient services can include a number of potential therapies including individual therapy, group therapy, family therapy, anger management, and play therapy. Maine does not require certain therapies be used for certain diagnoses, instead leaving this decision up to the counselor and the child in each specific situation. However Maine has been conducting a pilot program in Evidenced Based Treatment (EBT): treatment methods that have been scientifically proven effective and which are required by some other states. The pilot uses part of a grant award to fund EBT training specific to trauma-focused cognitive behavioral therapy for clinicians in western Maine.

Outpatient services do not require a referral from a primary care physician, and in fact, families can learn about and access them through many different avenues:

MaineCare eligible families may access outpatient services for their children through multiple avenues. No referral from a primary care physician is needed.

- Families may call DHHS Family Information Specialists who may point them to the services.
- Families may contact support organizations (such as NAMI, Maine Parent Federation, and GEAR) who may connect them with services.
- A primary care or emergency room physician may refer a patient.
- Crisis services, schools, other state departments may connect a child with services.
- Families may learn about the availability of services through 211 or online, and may then choose to access the services.

Outpatient Provider Network

Children's outpatient mental health services have historically been provided primarily by licensed mental health clinics. In August of 2008, individual practitioners were also allowed to begin billing MaineCare directly as authorized by PL 2005, Chapter 203.

OPEGA analyzed MECMS data for CMH claims paid for services rendered during FY 2008, and found that claims for outpatient services were paid to 63 unique provider billing IDs. This count appears to include some providers more than

In FY 2008 DHHS paid claims to 63 providers for children's outpatient services. About half of these 63 provided only outpatient services, while the other half also provided some additional mental health services for children.

once as providers can choose whether to bill all services by various subsidiaries and physical office locations under one provider ID or under separate IDs. Eliminating this double counting results in 57 apparently unique provider entities.

About half of these providers billed only for outpatient services (32 of the 63), while the others also billed for additional mental health services for children. Additional services vary by provider, and may include services such as in-home behavioral treatment, medication assessment and treatment, or crisis intervention and resolution. Table 2 includes brief descriptions of the other CMH services offered by outpatient providers.

Table 2. Types of Services Also Offered by Some Children's Outpatient Providers

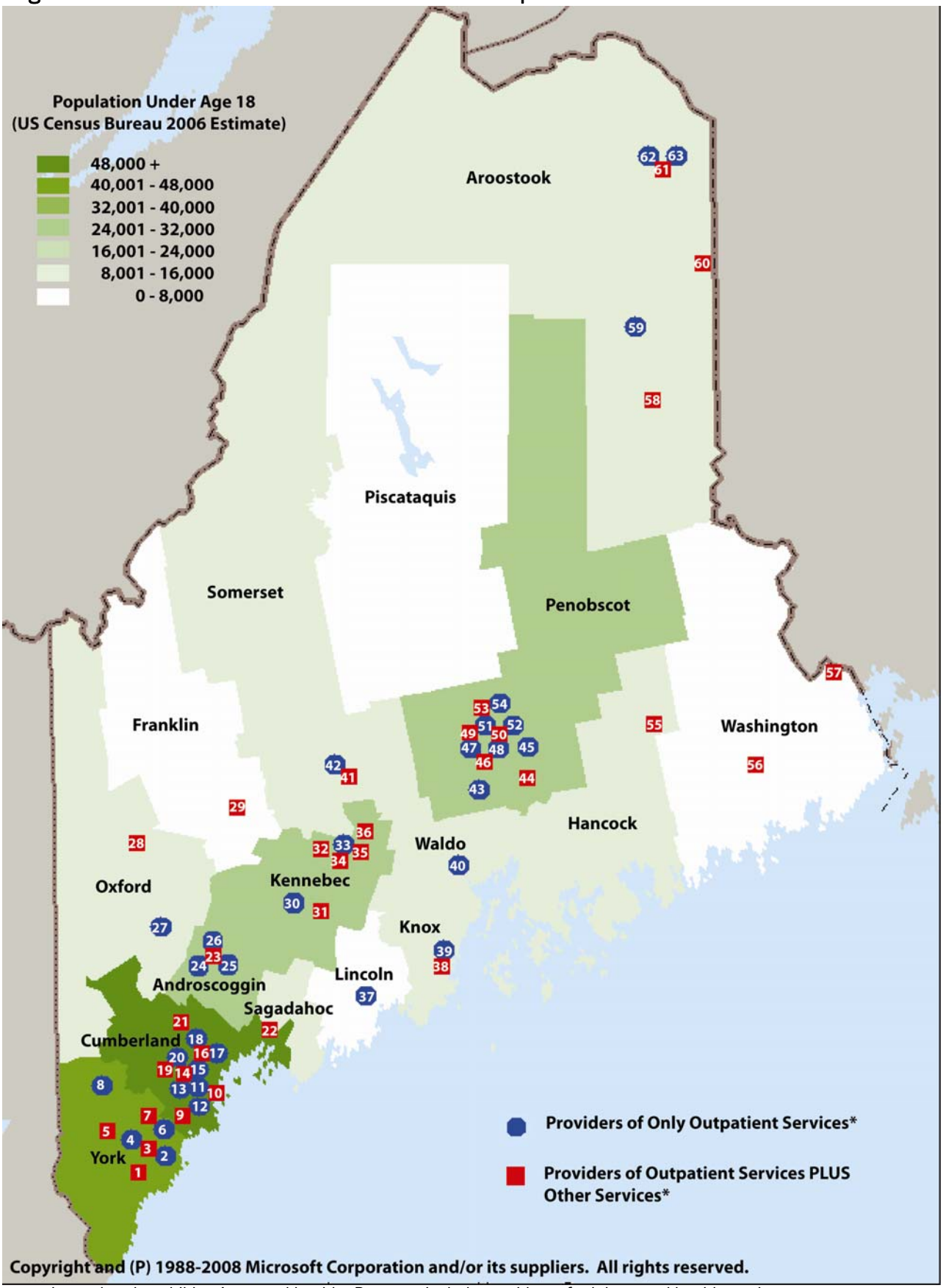
In-Home Behavioral Treatment	Offers strategies to help the family manage symptoms, improve functioning in community, and prevent hospitalization.
Medication Assessment and Treatment	Provides prescription, administration or monitoring of medications for treatment and management of symptoms of any child with behavioral or emotional health needs.
Child Assertive Community Treatment	Provides 24/7 intensive treatment by a team of mental health professionals with goal of improving safety and functioning of the child in least restrictive environment.
Crisis Intervention and Resolution Services	Responds to a child in crisis when there is concern that a child is showing dangerous behaviors or thinking.
Day Treatment	Structured therapeutic program to help children with mental health needs function better in life activities.
Home Based Services	Intense home/community counseling by a team to prevent child's removal from home, or to help a child re-enter home after treatment for a mental health need (repealed during FY 2008).

Providers of outpatient services vary greatly in the volume of services they provide, from as little as $3000 in FY 2008 to as much as $3.9 million.

Outpatient service providers vary greatly in the quantity of services they deliver and the volume of their claims. The provider with the most outpatient claims for services delivered in FY 2008 was Possibilities Counseling Services Inc., with paid claims of $3,949,428 for a total of 2,342 individual children. A near second was Sweetser/Shoreline with paid claims of $3,011,575 for services to 2,464 children. On the other end of the spectrum, Danzig Counseling Services P.A., Oxford County Mental Health Services, and Searsport Counseling Associates each had paid claims of less than $3,000 in FY 2008 for fewer than 5 individual children. See Appendix A for a complete summary of the volume of services by provider.

The map in Figure 2 illustrates the provider network for children's outpatient services. This map and its legend in Table 3 were generated based on available provider data in MECMS. MECMS claims data does not include a field indicating the physical location of the provider branch or office where the child actually accessed the services. Instead, MECMS only records the single primary address given by the provider, which may represent a central office or corporate location and may not even be a site where services are delivered. Given that some providers are large entities with many service locations, this single address for claims makes it difficult to tell where children may not have access. DHHS was unable to provide another source of relevant information on provider service locations for CMH outpatient services.

Figure 2. Providers of Children's Mental Health Outpatient Services In FY 2008



*Refers to services related to children's mental health. Does not include providers of adult mental health services.
Note: Includes only provider IDs that billed MECMS for outpatient services. Additional services may have been provided under other provider IDs.

Table 3. Legend to Accompany Map of Providers of Children's Mental Health Outpatient Services in FY 2008

	York County	
1	Peds Clinic, Inc.	Kennebunk
2	KidsPeace National Centers of New England	Biddeford
3	Counseling Services, Inc.	Biddeford
4	Counseling and Psychotherapy Center of ME	Biddeford
5	Saco River Health Services	Waterboro
6	Support Solutions, Inc.	Saco
7	Sweetser/Shoreline	Saco
8	Adventure Counseling	Limerick
	Cumberland County	
9	Transitions Counseling, Inc.	Scarborough
10	Drug Rehabilitation, Inc.	S. Portland
11	KidsPeace National Centers of New England	S. Portland
12	Food Addiction & Chemical Dependency Consultants	S. Portland
13	Portland West, Inc	Portland
14	Community Counseling Center	Portland
15	PROP Child Development	Portland
16	Spurwink Corporation	Portland
17	Back on Track, Inc.	Portland
18	Casco Bay Substance Abuse	Portland
19	Smart Child and Family Services	Windham
20	Danzig Counseling Services P.A.	Windham
21	Christopher Aaron Counseling Center	Gray
22	Providence Service Corp of ME	Brunswick
	Androscoggin County	
23	Tri-County Mental Health Services	Lewiston
24	KidsPeace National Centers of New England	Lewiston
25	Richardson Hollow Associates Inc.	Lewiston
26	Possibilities Counseling Services, Inc.	Auburn
	Oxford County	
27	Community Concepts Inc.	South Paris
28	Oxford County Mental Health Services	Rumford
	Franklin County	
29	Evergreen Behavioral Services	Farmington
	Kennebec County	
30	KidsPeace National Centers of New England	Manchester
31	Crisis and Counseling	Augusta
32	Care & Comfort	Waterville
33	Maine Children's Home for Little Wanderers	Waterville
34	HealthReach Network	Waterville
35	Kennebec Valley Mental Health Center	Waterville
36	Michael Lane Behavioral Health	Waterville
	Lincoln County	
37	Umbrella Mental Health Services, PA	Damariscotta
	Knox County	
38	Mid-Coast Mental Health Association	Rockland
39	Harbor Schools of Maine, Inc.	Rockport
	Waldo County	
40	Searsport Counseling Associates	Belfast
	Somerset County	
41	Youth & Family Services, Inc.	Skowhegan
42	Resilience Incorporated	Skowhegan
	Penobscot County	
43	Dirigo Counseling Clinic, LLC	Hampden
44	Care Development of Maine	Brewer
45	KidsPeace National Centers of New England	Orono
46	New Life Mission	Bangor
47	Manna, Inc.	Bangor
48	Full Circle Wellness Center, Inc.	Bangor
49	Charlotte White Center	Bangor
50	Northeast Occupational Exchange, Inc.	Bangor
51	Allies, Inc.	Bangor
52	Phoenix Mental Health Services L.L.C.	Bangor
53	Community Health and Counseling Svcs.	Bangor
54	Behavioral Health Center	Bangor
	Hancock County	
55	Washington County Psychotherapy	Ellsworth
	Washington County	
56	Washington County Psychotherapy	Machias
57	Washington County Psychotherapy	Calais
	Aroostook County	
58	Kindred Spirits: Growth & Learning, LLC	Oakfield
59	Life By Design	Houlton
60	Northern Lighthouse, Inc.	Mars Hill
61	Aroostook Mental Health Services, Inc.	Caribou
62	Aroostook Counseling & Evaluation Svcs.	Caribou
63	New Day Counseling Services, LLC	Caribou

Note: Some providers appear more than once on this table and in the accompanying map because they bill MaineCare under multiple provider IDs. The map and table are based on the provider address associated with the provider ID in MECMS. Many providers may have multiple physical service locations that are not shown. In addition, OPEGA's analysis included only provider IDs that billed DHHS for outpatient services. Some providers may also bill for non-outpatient CMH services under separate provider IDs that were not included in our analysis. See the discussion of data limitations at the bottom of page 6 for additional information.

MaineCare Reimbursement Rates for Children's Outpatient Services

Reimbursement rates for children's outpatient providers were historically negotiated on an individual provider basis, but the rates were made standard as of FY 2009.

Children's outpatient providers used to be reimbursed based on individually negotiated rates, but starting with FY 2008 rates were capped and for FY 2009 rates were officially standardized to a set rate per hour. The standard rate has its roots in a budget initiative DHHS proposed for the 2008-2009 biennium. DHHS proposed a rate of $76.09 per hour for children's outpatient services. That rate was derived from a cost-based calculation done by the Department.

Instead of adopting the rate standardization initiative for FY 2008, the Legislature passed an across-the-board percentage reduction in the rates for children's outpatient services. This reduction set the maximum rate for children's outpatient services at $88.08 per hour. The Legislature subsequently passed an initiative in the first supplemental budget for FY 2009 to further reduce and standardize the rate at $84.00 per hour[2] ($21 per quarter hour billing unit).

Estimated Administrative Costs

DHHS's Estimated Administrative Costs

OPEGA identified all substantial activities performed by DHHS staff and other State agency offices that support the delivery of outpatient services and estimated the cost of each function. Table 4 describes the primary administrative activities of each unit.

While assessing DHHS's administrative costs OPEGA found the Department was not receiving all federal matching dollars for which it was eligible. See Recommendation 4 for additional information.

Our work in estimating the administrative costs associated with children's outpatient services included review of the Department's Cost Allocation Plan (CAP). The Plan allocates costs to federal programs, determining how much DHHS can bill the federal government for its share of costs. We noted that the CAP did not include DHHS's Rate Setting Unit that performs work related to outpatient services and is, therefore, eligible for federal matching. This omission results in less federal matching dollars but should be remedied by actions being taken by the DHHS Service Center. See Recommendation 4 in the Recommendation section of this report for additional discussion.

[2] A different standard rate was set for independent clinicians when they were authorized to begin billing directly in August 2008. This rate is $55 per hour. OPEGA attempted to determine how many independent clinicians have enrolled to bill directly since August, but most of the practitioners were already enrolled as providers for other MaineCare services and so could not be identified as newly enrolled. A reliable estimate of the amount they have been paid at their standard rate could also not be obtained since they have only been authorized to bill since August and they have up to one year from the date of service to submit their claims.

Table 4. Functions Performed by DHHS and Support Offices in Relation to Children's Outpatient Services

Unit	Function Related To Outpatient Services
Office of Child and Family Services	Provides management oversight of Child Behavioral Health Services Division.
Division of Children's Behavioral Health Services	Performs oversight of the children's outpatient services program. Provides information and referrals to families of children with developmental disabilities, autism or mental health diagnoses.
Division of Purchased Services	Drafts the abbreviated contracts for MaineCare providers based on information from the appropriate DHHS program office, Rate Setting and Licensing.
Rate Setting Unit	Communicates rates to new providers and assists in any reconsideration of the standard rates.
Office of MaineCare Services	Works with other DHHS offices on the policies included in the MaineCare Benefits Manual. Manages MECMS claims processing, including setting up provider profiles and handling questions about claims.
Division of Licensing and Regulatory Services	Processes applications, arranges fire inspections, performs on site surveys, creates and monitors corrective plans as needed. Investigates complaints, develops licensing regulations.
Statewide Office of Information Technology	Provides and supports computer and telephone services for the Executive Branch, including all of DHHS.
DHHS Service Center	Provides accounting and financial, payroll, and human resources services for DHHS.
Note: These descriptions apply only to the functions these offices perform related to children's outpatient mental health services. The offices may perform different or additional functions related to other programs.	

OPEGA estimates DHHS's administrative costs associated with children's outpatient services to be $1.1 million in FY 2008. An additional $370,000 is attributable to the cost of the Department's ASO.

OPEGA also reviewed output data from a number of DHHS offices and finally estimated that the total cost associated with all DHHS administrative functions was about $1.4 million for FY 2008. This includes approximately $1.1 million of the Department's own internal costs, the vast majority of which stem from the Office of MaineCare Service's provider relations and processing of claims through the MECMS system. DHHS administrative costs also include approximately $370,000 from its contract with APS Healthcare as described below.

The ASO's Role and Estimated Administrative Costs

APS Healthcare is contracted to be Maine's Administrative Service Organization. APS is licensed as a medical utilization review company in Maine and performs the utilization management functions of eligibility verification, prior authorization (if required), utilization review, and retrospective review for a number of both adult and children's behavioral health services. Only two of their services, registration and utilization review, are relevant to children's outpatient mental health services.

When a child receives outpatient services, the provider must register that child through APS to be eligible to be paid by MaineCare. The registration process is different than a prior approval process or pre-registration process in that it may be done after the child has already received some services. However, the provider can not receive payment for those services until the registration is completed

either through APS's web-based system or through a paper form faxed to APS. When the child is registered for outpatient services, they are assigned an authorization number good for 180 days (6 months) of service or 32 billing units (32 quarter hours, or 8 hours of therapy), whichever comes first.

APS Healthcare is the contracted ASO for children's mental health services. For outpatient services specifically, APS provides registration and utilization review services.

A utilization review, also known as a continued stay request, must occur if more than the initial 32 billing units are required or if the treatment extends beyond 6 months. Utilization review requires providers to submit information about the child and treatment plan, and to request authorization to provide additional treatment. The reviews are intended to increase coordination of services, encourage communication among different providers for the same client, and encourage providers to provide only the level of service needed. APS is expected to review each request within 24 hours of receipt. The request may be approved, modified or denied, although APS reports that denials are rare.

APS estimates that registration and utilization review for children's outpatient services represent a significant share of their work. OPEGA analyzed output data provided by the company and confirmed that approximately 10.2% of their annual activity is related to children's outpatient. This 10.2% represented about $370,000 of the total $3.6 million encumbered on the contract in FY 2008. We would estimate the costs associated with children's outpatient to be approximately $500,000 for FY 2009 when APS's contract increases to $5 million.[3]

Outpatient Providers Administrative Costs and Drivers

Outpatient CMH services are currently paid via a standard reimbursement rate that disregards the actual administrative costs of providers and may, in fact, determine how much providers can afford to spend on these types of costs. We have used assumptions built into DHHS's cost-based rate calculation (see Table 5) for indirect[4] and direct costs to estimate the total amount of FY 2008 administrative or indirect costs for outpatient providers. Table 6 illustrates the calculation of our estimate.

DHHS contracted Deloitte Consulting LLP in fall 2008 to assess the reasonableness of MaineCare rates for children's mental health services. Their assessment of the rate for outpatient services supported DHHS's cost-based rate calculation.

The consulting firm Deloitte Consulting LLP (Deloitte) was contracted by DHHS in the fall of 2008 to assess the reasonableness of MaineCare reimbursement rates for all behavioral health services for both children and adults. OPEGA avoided duplicating the work Deloitte was hired to perform, but did review their results and noted that they supported the reasonableness of DHHS's original cost-based rate calculation for children's outpatient services. We did not participate in their effort, or in their meetings with providers, so we can not evaluate the validity of their work or the extent to which they considered providers' input about actual costs providers were experiencing.

[3] APS initiated work halfway into FY 2008 and had a lesser amount encumbered under its contract that year.

[4] For the purposes of this report OPEGA will use the terms "indirect costs" and "administrative costs" interchangeably. See the Methods and Scope section of this report for additional information about how administrative costs were defined for this review.

Table 5. DHHS 2007 Calculation of Cost-based Rate for Children's Outpatient Services

Direct care salary (LCSW/LCPC)	$43,000
Direct care benefits	$12,900
Direct support (supervision, etc.)	$6,370
Direct other (occupancy, etc.)	$7,363
TOTAL DIRECT COSTS	$69,633
Indirect (25% of direct costs)	$17,408
TOTAL COST (per direct care FTE)	$87,041
Units of Service per year (44 weeks X 26 billable hours per week)	1,144
Rate per hour	$76.09

Note: The calculation is presented here as provided by DHHS. The reasonableness of this calculation was recently confirmed in an independent review by Deloitte.

Table 6. Estimate of Administrative Costs Paid in FY08 Based on DHHS's Cost-Based Rate Development

DHHS Cost-Based Assumptions		% of Total Cost		FY08 Paid Claims		Estimated FY08 Direct & Indirect Costs
Total Direct Costs	$69,633	80%	x	$16,957,338	=	$13,565,870
Total Indirect Costs (25% of direct costs)	$17,408	20%	x		=	$3,391,468
TOTAL COSTS (per direct care FTE)	$87,041	100%				$16,957,338

Note: DHHS cost-based assumptions were detailed earlier in Table 5.

OPEGA estimates that about $3.4 million of the total $16.9 million paid to outpatient providers in FY 2008 was likely attributable to providers' administrative costs.

Our estimate of $3,391,468 in administrative (or indirect) costs is based on the assumption that providers' total costs were made up of 20% indirect costs as the Department's calculation infers. Given that the FY 2008 reimbursement rate was capped at $88.08 — a rate which exceeds the DHHS's cost-based rate of $76.09 by a significant amount—some providers were reimbursed for costs exceeding the assumptions above.

If providers used the dollars represented by the difference in the rates to cover indirect costs, then actual administrative costs are higher than what we have estimated. Conversely, if the majority of providers have had direct costs higher than what is included in DHHS's cost-based assumptions, then administrative costs may be lower than what we have estimated. We note that the current standard rate being paid to mental health clinics is $84 – so the potential degree of variance in provider administrative costs being covered in the standard rate remains.

The 12 providers surveyed by OPEGA reported a number of administrative burdens specific to requirements associated with providing children's outpatient to MaineCare members. The majority of the burdens reported were related to the ASO, but the following additional burdens were noted:

Twelve outpatient service providers were surveyed about their administrative burdens in serving MaineCare eligible children. The providers described burdens such as late payments, duplicative licensing requirements, and changes to claim submission requirements as unique to MaineCare.

- increased costs associated with not receiving payment of claims in a timely manner;
- licensing requirements and data collection that seem duplicative or that require submittal of duplicative data to multiple entities (for example, licensing and APS care management both require data about treatment plans, but they require slightly different content in a different format); and,
- changes to MaineCare requirements mean providers are constantly asking administrative and technical staff to update data submission forms, codes, and processes.

The providers almost unanimously described the reporting required by APS as an administrative burden that consumes significant resources. Although a few noted that APS reporting requirements have been amended to make them somewhat less burdensome, most still noted concerns in the following areas:

- APS requires multiple pages of data be reported as part of utilization review, consuming significant staff resources for providers. The reports must be completed outside of session, and so are not on billable time, and require information that can often not be completed by an administrative employee and must be prepared by clinicians.
- There seems to be an increase in the need for repeated billing of claims since APS initiated care management. This is a hardship for providers because it delays their receipt of funds, but it also consumes resources in researching the reason for claim rejection then resubmitting the claim. Providers have observed the issue often seems to be that authorization was granted by APS, but somehow not communicated to DHHS to allow payment.

Almost unanimously, the 12 providers we surveyed cited the reporting requirements associated with the ASO as a burden that increased their administrative costs.

- Some providers felt that the frequency with which utilization reviews (also known as Continued Stay Reviews, or CSR's) must be done is what creates the administrative burden for outpatient services. They described quality assurance (QA) procedures used by private insurers that are far less frequent and onerous, and wondered whether APS is taking their QA efforts too far, to the point where they do not yield enough value to justify the imposition on scarce resources.

A number of providers suggested that these issues, and some of those not related to APS, could be resolved with a more streamlined state-wide electronic medical record (ERM) system that would allow every provider to access and submit information on MaineCare patients. Providers suggested that if all provider entities and all DHHS offices had access, then the duplication of reporting would be eliminated and communication and coordination about members' care would be improved. Those surveyed also indicated that DHHS has taken valuable steps in the past to identify administrative burdens on providers, such as the Administrative Burden Reduction Working Group authorized by PL 2007, Chapter 240, Part AAAA.

OPEGA shared the provider perspectives we obtained with DHHS. DHHS acknowledged that a utilization review effort like that being performed by APS is requiring more of providers than they have had to do in the past. However, they

DHHS acknowledged that the ASO provides more oversight and thus has more requirements than providers are used to. They noted the ASO's cost containment role and described ongoing efforts to address the issues raised by providers.

maintain that Maine is moving to the industry standards of practice, and that Maine's ASO is in line with what other states are doing. DHHS notes that continuing with a system where providers were not required to justify the number of visits and types of treatments MaineCare members were receiving, and the associated costs, was not sustainable for the State.

The Department also described the efforts being made to reduce administrative burdens for providers by both DHHS and APS. They mentioned the APS Provider Advisory Group and noted that the several pages of documentation previously required by the provider for a utilization review had been reduced to a one page form as of August 2008. They also indicated that the Administrative Burdens Working Group was still on-going and was making progress in implementing suggestions arising from that process as appropriate.

OPEGA observes that there are some differences in perspectives between providers and DHHS on the administrative burdens and this is not entirely unexpected given the cultural shift that a care management effort creates. However, we have not researched the specific points made to us by either group and are not in a position to validate them. Such validation could naturally be undertaken during the cost-effectiveness review of the contract with APS that we suggest in Recommendation 1 and/or the on-going monitoring of changes in the provider network that we recommend in Recommendation 2.

Potential Effects of Utilization Reviews and Standard Rates

Impact on Costs of Outpatient Services

Since reimbursement rates for outpatient providers are now standardized, the State essentially drives the level of administrative costs providers can afford to bear by adjusting the rate up or down.

Recent implementations of utilization reviews and a standardized rate are primarily State efforts to contain costs while also achieving equity among providers and improving outcomes for children. Utilization reviews by the ASO are intended to help assure that children receive only the services that are necessary and appropriate for their situations. A standard rate that applies to every provider helps ensure that the State's costs are driven by the amount and quality of services it is acquiring rather than by the cost structures of individual providers.

Since the rate is standard regardless of each individual providers' actual delivery costs, one could expect that providers will work to manage their costs to a level that allows them to function within the current rate. The result is a scenario in which, by lowering or raising the standard rate, the State affects the level of costs both it and providers can afford to bear. Theoretically, the level the standard rate is set at should represent a fair price for the service in the marketplace that also takes into account providers' costs in complying with any administrative requirements imposed upon them.

Providers we surveyed reported that between 29% and 100% of their clients for children's outpatient services were MaineCare members with most of them having more than 80%. Changes in rates and administrative requirements can not help but

to have a major impact on individual providers that can be expected over time to affect the provider network as a whole.

Two of the twelve providers indicated that rate reductions experienced in recent years have been a hardship and have required them to reduce the amount of outpatient services they provide or alter the way they provide them. Others have explored mergers or joint purchasing efforts. These adaptations on the part of providers are good examples of how a standard rate is likely to impact the provider network.

Impacts on Availability and Quality of Outpatient Services

Standardized rates are a recent development for outpatient services with the potential to significantly impact the provider network. The rates should be closely monitored to ensure they are adequate to maintain the availability and quality of outpatient services. See Recommendation 2.

If rates are pushed so low that it is not possible to deliver the services without losing money, Maine will likely see providers leaving the network – potentially resulting in lengthy waiting lists or shortages of providers in certain geographic areas. Conversely, an overly generous rate would likely result in many new providers entering the network and potentially creating excess capacity. Quality of service may also be affected if affordability impacts providers' ability to recruit and retain highly qualified clinicians or the range of therapies they can offer.

No systemic issues with either availability or quality of children's outpatient services were brought to OPEGA's attention. In our discussions with parent support groups, we heard that families are mostly satisfied with the outcomes of their children's therapy sessions, although there was some frustration expressed about individual counselors who were not perceived as being flexible enough in their selection of therapeutic methods.

These groups also indicated that outpatient services are actually more readily available than some other CMH services. They commented, however, that parents will travel a great distance, if necessary, to get the services their children need, and that in some cases the willingness to travel is not enough. These groups cited issues with the number of Washington County providers for certain other mental health services. They also noted that access can still be an issue even in areas where there are technically enough providers, because some providers will not take MaineCare patients. Reasons given for this were that providers felt MaineCare paid less than other payers or took longer to pay.

Monitoring the adequacy of the outpatient provider network is made more complex because DHHS does not maintain an actual "wait list" or similar metric for these services.

Three of the 12 providers we surveyed indicated they are usually able to see a child within a week of the request for an appointment, while the others responded that the time lag is usually somewhere between 2 and 4 weeks. Some providers noted difficulty in maintaining enough qualified clinicians as a driving factor in this wait time.

We asked DHHS for wait list or related data collected regarding areas where children may not be able to access outpatient services immediately. DHHS reported that it discontinued provider reporting on waiting list data in 2008 after determining that it was not a reliable measure for various reasons. Instead, need in specific geographic areas is determined through a "thorough knowledge of the geographic area in terms of what children and families are saying works for them" that exists with DHHS regional staff.

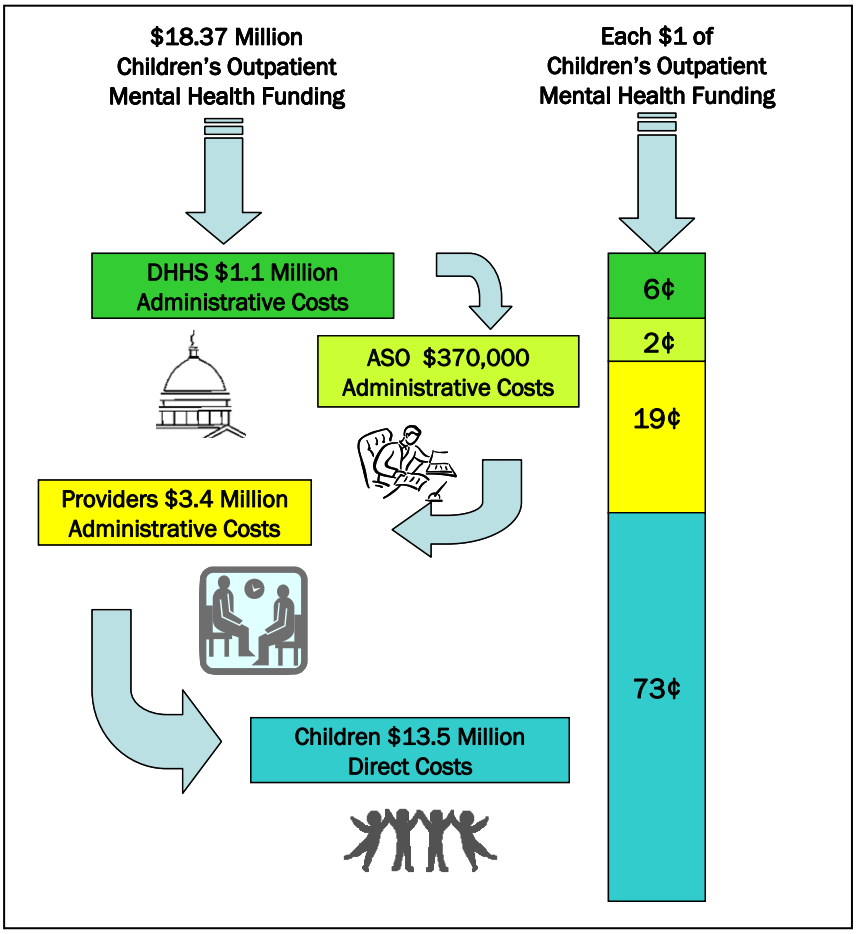
Since the outpatient provider network is still in the process of responding to recent changes in rates and administrative requirements, close monitoring will be required over the short term to ensure that any availability or quality issues that arise can be addressed quickly. See Recommendation 2 in the Recommendations section of this report for further discussion.

In Summary

Of the approximately $18.5 million spent on outpatient children's mental health services in FY 2008, we estimate about 73%, or $13.5 million is associated with the cost of directly delivering the services to children. Approximately 19% ($3.4 million) can be attributed to providers' administrative costs, and the remaining 8% ($1.4 million) represents the administrative cost of program management performed by the Department and its contracted Administrative Service Organization. Figure 3 illustrates the breakdown by each $1 of spending.

OPEGA estimates approximately 73% of the total dollars spent on outpatient services for children in FY 2008 went to direct delivery of those services. The remaining 27% is attributable to costs to administer the services, both within DHHS, on the part of it's ASO, and by providers.

Figure 3. Estimated Portion of Each FY 2008 Dollar that Went to Direct Services and Administrative Costs



Administrative costs within DHHS related to outpatient CMH services appear to be relatively low, primarily because the services are now delivered under a standard rate by a relatively stable network of providers. Primary drivers of administrative costs for DHHS are the contract with the ASO and costs incurred by the Office of MaineCare Services in processing provider claims.

Providers surveyed reported that certain administrative requirements imposed upon them by the State, and the ASO in particular, represented significant efforts for them. They described the ASO's reporting requirements as potentially more onerous than necessary, as duplicative of data that is required to be reported to other DHHS offices, and as having a net effect of straining their resources by requiring clinicians to spend more time completing forms and less time delivering billable services. Some providers even indicated that given this additional administrative burden the standard rate no longer covered the costs associated with offering outpatient services, and that they were no longer accepting new outpatient clients as a result.

Providers seem to be working to adapt to the newly standardized rates, but they also expressed concerns about what they perceive to be unnecessary burdens imposed by the ASO.

DHHS maintains that implementation of an ASO utilization review moves Maine toward industry standard practices and will provide overall benefit to the State in controlling costs and improving outcomes for children. They note that APS's reporting requirements are consistent with ASO efforts in other states and that APS is continually working with providers to identify and implement administrative efficiencies. OPEGA has not validated either perspective. Nonetheless, given the cost of the APS contract and the significant savings being attributed to its services, we believe it would be prudent to conduct a more detailed review of the contract to assure that the State's desired outcomes for the care management effort are being achieved in the most cost-effective manner possible.

OPEGA recommends the Legislature and DHHS closely monitor whether the standard rate should be adjusted to achieve additional savings or to address any unintended consequences that may arise.

As a result of the State's move to standardized reimbursement rates for CMH outpatient services, providers now receive the standard rate regardless of their actual individual delivery costs. While providers are working to adapt to the rate by managing their costs to a supportable level, the result is a scenario in which, by lowering or raising the standard rate, the State affects the level of costs providers can afford to bear. The provider network will continue to adapt to the implementation of care management efforts and standardized rates. We encourage DHHS and the Legislature to closely monitor whether the current standard rate, or administrative requirements on providers, should be further adjusted to achieve additional savings or to address any unintended changes in the availability and quality of services.

Recommendations

1

More Detailed Review of Contract with APS Would be Prudent

When the 123rd Legislature passed PL 2007, Chapter 240, Part CC, it expected estimated savings of $6 million in General Fund and just over $16 million total during FY 2008. Expected savings for FY 2009 were $8.5 million in General Fund and about $23 million total. Table 7 shows the detail of savings booked as part of that public law. We also note that the Governor's Proposed Biennial Budget for 2010 – 2011 includes several budget initiatives related to PL 2007, Chapter 240, Part CC.

Table 7. Savings Estimates Excerpted from PL 2007, Chapter 240, Part CC

SECTION TOTALS	2007-08	2008-09
GENERAL FUND	($6,000,000)	($8,500,000)
FEDERAL EXPENDITURES FUND	($10,348,774)	($14,732,479)
SECTION TOTAL - ALL FUNDS	($16,348,774)	($23,232,479)

DHHS has contracted with APS Healthcare to serve as the ASO. The contract became effective September 1, 2007 and ends on July 31, 2009 unless extended. The cost of the contract for all services is approximately $3.6 million in FY08, $5 million in FY09 and $406,688 in FY10. Seventy-five percent of the contract is paid for with Federal funds with the State funding the other 25%.

OPEGA inquired about whether and how actual savings realized from APS's contract were being tracked. DHHS provided a Cost Impact Analysis for the ASO prepared for DHHS by the Muskie School of Public Service. This analysis bases cost savings on changes in trends in MaineCare spending for behavioral services as a whole and by individual services. We note that there are a number of factors that could contribute to changes in the total cost of behavioral services, and outpatient CMH services specifically, from one year to another including:

- changes in MaineCare eligibility that may affect how much outpatient treatment children may receive annually;
- changes in the number of MaineCare eligible children seeking outpatient services;
- implementation of standardized rates; and
- changes in provider requirements or environmental factors that may affect the number of providers willing to offer the services.

Consequently, savings shown in this analysis cannot be directly attributed to the efforts of the ASO.

In addition, our survey of providers indicated that many providers have concerns about the administrative burdens imposed by APS, not just related to outpatient services, but for all behavioral health services. These concerns may be mostly the frustrations of dealing with new procedures, but they do raise the question of whether the benefits (cost savings and improved outcomes) of the contract with

APS actually exceed the total costs associated with their work: not just their contract costs, but also the costs imposed on the provider network.

Given the cost of the APS contract, the significant savings expected from the ASO and providers' concerns about associated administrative burdens (which OPEGA has not validated), we believe it would be prudent to conduct a more detailed review of the contract to assure that the State's desired outcomes for the care management effort are being achieved in the most cost-effective manner possible.

Recommendation for Legislative Action:

The Legislature should consider directing OPEGA (or some other entity) to perform an in depth evaluation of the contract and services provided by APS. Such an evaluation should review the detail of results APS has achieved, the administration of the contract with APS, and the costs that the provider network has absorbed as a result of APS's requirements.

Outpatient Provider Network Needs Ongoing Monitoring

Maine's relatively recent move to a standard rate for outpatient services has changed the interaction between the State and the provider network. There is no longer negotiation to ensure that individual providers' rates are adequate to cover their specific expenses. With this new dynamic, it will be increasingly important for the State to actively and consistently monitor the health of the provider network: following the evolution of the network, staying alert for any access or quality issues, and monitoring the implementation of efforts to improve efficiencies and reduce administrative burdens.

In our discussions with DHHS, they mentioned several avenues that currently exist for monitoring the quality of services provided – some of them more objectively based than others. Adequately assessing the geographic availability of outpatient services for children, however, is currently a difficult task due to a lack of objective data and processes for collecting it.

Recommendation for Legislative Action:

The Legislature should consider two potential approaches for monitoring the health of the outpatient provider network, the quality of service children are receiving and on-going efforts to increase efficiencies in providers' administrative requirements. One would be for the Joint Standing Committee on Health and Human Services to establish a formal and regular process specifically focused on monitoring these items. As an alternative, the Legislature could assign this formal oversight to the now inactive Children's Mental Health Oversight Committee. Although the Committee has been inactive for some time (see Finding 3), its statutorily set membership seems well suited to carry out this sort of monitoring.

With either approach, the Health and Human Services Committee and DHHS should agree upon the data to be collected and reported that will allow for a sufficient understanding of changes in the provider network and meaningful,

objective measures of availability and quality of services. Data collection processes and procedures should have adequate controls built in to assure that data collected is complete and reliable.

Continued Need for Children's Mental Health Oversight Committee Should be Determined

The Children's Mental Health Oversight Committee required by 34-B MRSA §15004-2 appears to have stopped meeting and no longer receives reports or makes reports to joint standing committees of the Legislature as required in statute. It appears that a number of the Committee's seats have not received legislative appointments for some time, and as a result the Committee has ceased to function. Statute contains a number of specific duties for the Committee, some of which no longer appear relevant.

Recommendation for Legislative Action:

The Legislature may want to consider either removing the Children's Mental Health Oversight Committee from statute, or else taking steps to revive the Committee and ensure its effectiveness. An active Oversight Committee could potentially assist the Department and the Legislature in monitoring how changes in the newly standardized rates are impacting the provider network and tracking the implementation of initiatives to reduce administrative burdens on providers.

If the Legislature decides to reactivate the Committee it should review, and update as appropriate, the Committee's current statutory responsibilities. The Legislature should also consider adding the Committee to the list of committees in 5 MRSA Chapter 379 so that the Secretary of State's office can monitor and report on the Committee's annual activity and vacant seats as it does for all other committees listed in that chapter.

DHHS Cost Allocation Plan Should Include Rate Setting Unit

The DHHS Rate Setting Unit performs work related to federal programs but had none of their costs allocated to Medicaid in the Department's FY 2008 Cost Allocation Plan. This results in less federal matching dollars for the Department and requires the Unit to be fully funded by the General Fund. Issues with the CAP have been noted previously by the Department of Audit, and the DHHS Service Center has been working actively over the past few years to make improvements to the plan and maximize federal reimbursements. The Service Center estimates that allocating the Rate Setting Unit's applicable costs to Medicaid could result in additional federal reimbursement of approximately $110,000, but not more than $148,000 annually.

Recommendation for Legislative Action:

DHHS and the Service Center are taking steps to ensure the Rate Setting Unit's costs are allocated to federal programs as appropriate to maximize federal revenue in future fiscal years. The Joint Standing Committee on Health and Human Services (HHS) may want to follow up on the status of this action during the second session of the 124th Legislature to make sure the State has collected all appropriate federal reimbursement associated with the Rate Setting Unit. In addition, by the second session the State Department of Audit will likely have completed its thorough audit of DHHS's new CAP plan. Although that audit may not touch on the Rate Setting Unit specifically, the HHS Committee may want to invite the State Auditor before the Committee to report on the Department's new CAP as a whole.

Agency Response

In accordance with 3 MRSA §996, OPEGA provided the Department of Health and Human Services an opportunity to submit comments on the draft of this report. The response letter can be found at the end of this report.

Acknowledgements

OPEGA would like to thank the management and staff of the Department of Health and Human Services and the DHHS Service Center who worked with us throughout this audit. We would also like to thank:

- the providers and family advocates who took the time to share their perspectives with us;
- the APS Healthcare representatives who willingly shared output data and information about their processes;
- the legislative Office of Fiscal and Program Review and the Office of Policy and Legal Analysis for assisting us in understanding the context and legislative history associated with children's mental health; and
- the State Auditor's Office for providing additional context on relevant Single Audit findings and the related federal programs.

Appendix A: Detail of Services Delivered During Fiscal Year 2008 by Providers of Outpatient CMH Services

Map ID	Provider	Service Categories													
		Outpatient Clinical Services		In-Home Behavioral Treatment		Medication Assessment and Treatment		Child Assertive Community Treatment		Crisis Intervention / Resolution Services		Day Treatment		Home Based Services	
		#*	$	#*	$	#*	$	#*	$	#*	$	#*	$	#*	$
1	PEDS Clinic, Inc.	48	$21,447			10	$4,638								
2	KidsPeace National Centers of New England	5	$4,955												
3	Counseling Services, Inc.	868	$721,552	61	$200,884	564	$295,996	207	$1,715,414	357	$441,437			112	$471,612
4	Counseling and Psychotherapy Center of Maine	5	$4,360												
5	Saco River Health Services	23	$23,430	37	$518,333										
6	Support Solutions, Inc.	18	$17,286												
7	Sweetser/Shoreline	2464	$3,011,575	49	$198,870	686	$378,802			544	$1,153,410				
8	Adventure Counseling	19	$9,396												
9	Transitions Counseling, Inc.	279	$306,006			1	$357								
10	Drug Rehabilitation, Inc.	55	$67,822	2	$2,708	15	$5,928								
11	KidsPeace National Centers of New England	21	$34,285												
12	Food Addiction & Chemical Dependency Consultants	46	$80,608												
13	Portland West, Inc	41	$17,401												
14	Community Counseling Center	358	$586,352			184	$127,712								
15	PROP Child Development	84	$166,053												
16	Spurwink Corporation	625	$949,332	42	$31,619	297	$162,791								
17	Back on Track, Inc.	57	$25,755												
18	Casco Bay Substance Abuse	7	$4,184												
19	Smart Child and Family Services	63	$92,880	5	$15,370										
20	Danzig Counseling Services P.A.	1	$114												
21	Christopher Aaron Counseling Center	96	$114,616	30	$255,939										
22	Providence Service Corp of Maine	64	$135,761	460	$2,793,200										
23	Tri-County Mental Health Services	1175	$1,092,378	100	$339,325	595	$353,847	18	$60,823	358	$316,184				
24	KidsPeace National Centers of New England	14	$11,869												
25	Richardson Hollow Associates Inc.	62	$22,505												
26	Possibilities Counseling Services, Inc.	2342	$3,949,428												
27	Community Concepts Inc.	61	$52,761												
28	Oxford County Mental Health Services	3	$1,718							134	$174,419				
29	Evergreen Behavioral Services	253	$255,709			207	$103,343			97	$124,984	6	$27,529		
30	KidsPeace National Centers of New England	5	$7,014												
31	Crisis and Counseling	24	$23,858			8	$2,505			595	$917,826				
32	Care & Comfort	317	$387,026	150	$740,781										

*Indicates the number of individual children served in FY 2008.

Source: OPEGA analysis of MECMS claims data for FY 2008.

Note: Some providers appear more than once on this table because they bill MaineCare under multiple provider IDs. In addition, OPEGA's analysis included only provider IDs that billed DHHS for outpatient services. Some providers may also bill for non-outpatient CMH services under separate provider IDs that were not included in our analysis.

Appendix A (cont.): Detail of Services Delivered During Fiscal Year 2008 by Providers of Outpatient CMH Services

Map ID	Provider	Service Categories													
		Outpatient Clinical Services		In-Home Behavioral Treatment		Medication Assessment and Treatment		Child Assertive Community Treatment		Crisis Intervention / Resolution Services		Day Treatment		Home Based Services	
		#*	$	#*	$	#*	$	#*	$	#*	$	#*	$	#*	$
33	Maine Children's Home for Little Wanderers	63	$51,110												
34	HealthReach Network	130	$153,760			53	$45,213								
35	Kennebec Valley Mental Health Center	1269	$897,301	282	$1,047,553	923	$1,283,090								
36	Michael Lane Behavioral Health	59	$18,258			11	$904								
37	Umbrella Mental Health Services, PA	36	$33,911												
38	Mid-Coast Mental Health Association	296	$180,729	8	$7,281	425	$408,993			152	$157,209				
39	Harbor Schools of Maine, Inc.	13	$10,658												
40	Searsport Counseling Associates	5	$2,531												
41	Youth & Family Services, Inc.	144	$117,532	17	$53,276										
42	Resilience Incorporated	5	$4,498												
43	Dirigo Counseling Clinic, LLC	8	$6,107												
44	Care Development of Maine	228	$224,768	243	$1,166,180	418	$371,791	33	$324,387						
45	KidsPeace National Centers of New England	20	$15,854												
46	New Life Mission	185	$212,225	46	$351,922	10	$1,530								
47	Manna, Inc.	57	$95,479												
48	Full Circle Wellness Center, Inc.	95	$99,437												
49	Charlotte White Center	253	$248,448	23	$61,612	87	$84,615								
50	Northeast Occupational Exchange, Inc.	500	$403,455	27	$116,241	15	$4,333			9	$1,321	154	$377,544		
51	Allies, Inc.	17	$24,574												
52	Phoenix Mental Health Services L.L.C.	388	$389,630												
53	Community Health and Counseling Services	590	$604,880	79	$317,344	310	$263,856	60	$514,130	256	$372,581				
54	Behavioral Health Center	62	$51,569												
55	Washington County Psychotherapy	39	$13,917	9	$32,176	46	$47,071								
56	Washington County Psychotherapy	70	$121,127			4	$1,077								
57	Washington County Psychotherapy	83	$105,768			1	$135								
58	Kindred Spirits: Growth & Learning, LLC	7	$6,598	15	$40,314										
59	Life By Design	201	$202,358												
60	Northern Lighthouse Inc.	11	$4,184	8	$18,712										
61	Aroostook Mental Health Services, Inc.	431	$308,421	69	$133,018	101	$83,528			213	$817,918				
62	Aroostook Counseling & Evaluation Svcs	109	$73,884												
63	New Day Counseling Services, LLC	47	$74,934												

*Indicates the number of individual children served in FY 2008.

Source: OPEGA analysis of MECMS claims data for FY 2008.

Note: Some providers appear more than once on this table because they bill MaineCare under multiple provider IDs. In addition, OPEGA's analysis included only provider IDs that billed DHHS for outpatient services. Some providers may also bill for non-outpatient CMH services under separate provider IDs that were not included in our analysis.

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Safe, Healthy and Productive Lives

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February 23, 2009

Beth Ashcroft, Director
Office of Program Evaluation and Government Accountability
#82 State House Station
Augusta, ME 04333-0082

Dear Ms. Ashcroft:

The Department of Health and Human Services appreciates having the opportunity to respond to the Office of Program Evaluation and Government Accountability's report entitled "MaineCare Children's Outpatient Mental Health Services – An Assessment of Administrative Costs and Their Drivers". The Department was given the opportunity to comment on a preliminary draft of the report, and we were pleased to note that some revisions were made as a result of the Department's comments. We appreciate the courtesy and professionalism which OPEGA brings to their work, and we hope the comments we are providing here will provide additional information and perspective that will be helpful to legislators.

On page 14 of the report, OPEGA states: "there are some differences in perspectives between providers and DHHS on the administrative burdens and this is not entirely unexpected given the cultural shift that a care management effort creates. However, we have not researched the specific points made to us by either group and are not in a position to validate them." We think it is unfortunate that OPEGA has adopted this stance, and we believe it diminishes the value of the report. In several instances, the Department provided information and documentation that would have enabled OPEGA to make a determination concerning specific issues identified in the report. For example:

- OPEGA has reported (on page 13) the providers' contention that the "multiple" pages of information required for continuing stay reviews of children's outpatient services is extremely burdensome, even after the Department provided a copy of the actual one-page form that is required. It is impossible to perform a utilization review function without requiring some information from providers, and a minimal amount of information is currently being required.
- The report contains the allegation that "changes to MaineCare requirements mean providers are constantly asking administrative and technical staff to update data submission forms, codes and processes." There have been two instances of such changes in MaineCare requirements for outpatient services that were necessitated by the need to replace local codes with HIPAA-compliant billing codes (as part of the conversion to a new claims processing system). We do not mean to understate the significance of these changes for providers, but two instances certainly do not amount to a "constant" problem. We believe this may be a view held by providers of multiple services and is outside the scope of this review.

- Regarding rates for children's outpatient services, the report notes that the Department contracted with Deloitte to assess the reasonableness of MaineCare reimbursement rates for behavioral health services. Further, the report correctly points out that Deloitte's analysis supported the reasonableness of the cost-based standard rates that were originally developed and proposed by the Department in 2007. However, in the face of all the data that has been developed, the extensive and well documented process of discussion with providers that has occurred, and the comprehensive analysis that was done by a firm with national scope and expertise in the area of rate-setting, the report concludes (on page 11) that OPEGA "did not participate in [Deloitte's] effort, or in their meetings with providers, so we can not evaluate the validity of their work or the extent to which they considered providers' input about actual costs providers were experiencing."

It is difficult to understand why OPEGA has been willing to report subjective provider concerns that excessive administrative burdens are being imposed or that rates may be either too high or too low, and reluctant to draw a conclusion based on the voluminous objective data that is available on the issues that have been raised. It is not enough to say (as the report does on page 19) that OPEGA has not validated provider concerns about administrative burdens when there is clear evidence that at least some of the most prominent concerns described in the report are certainly not valid. Without validating claims and counter-claims, the OPEGA report gives unwarranted credibility to assertions and allegations that are not supported by facts.

The Department does not object to the recommendations contained in the report, but we would offer the following comments regarding those recommendations:

- Recommendation 1 calls for a more detailed review of the contract with the Administrative Services Organization (ASO). While such a review may help to answer questions raised in the report, the primary reasons that OPEGA has presented for recommending this review is to assess the costs and benefits of this initiative in light of provider concerns about the administrative burdens it imposes. In response to this recommendation, we would note that the decision to implement a utilization management initiative for behavioral health services was a policy decision made by the Legislature based on the need to control escalating costs. It only began operating in December of 2007. For the first three months providers registered their clients and services and received automatic authorizations. Actual clinical reviews generally began 3 to 12 months (depending on the service) after the initial registration became effective (less for inpatient and PNMI services). Claims for services are generally submitted and processed one to three months after the service is provided. In other words, the initial year of operation is an implementation period and the impact of an ASO initiative manifests itself over time. We therefore suggest that it is too soon to effectively evaluate the ASO initiative, and that such an evaluation should wait until the initiative has been fully operational for a reasonable period of time and more data is available.

  On the other hand, we would welcome a review if the Legislative Committee would like to focus on the question of administrative burdens, how the burdens imposed by the Maine ASO compare to burdens imposed by other utilization management programs in the public and private sectors, and what the Department and the ASO have done to mitigate administrative burdens on Maine providers.

- Recommendation 2 calls for monitoring of the outpatient provider network. In response to this recommendation, the Department would note that the Children's Cabinet already exists and has general responsibility for monitoring children's services. If the Children's Mental Health Oversight Committee is to be re-activated, it will be important to coordinate roles and functions in order to prevent duplication.

  In addition, the recommendation calls for collecting complete and reliable data to support monitoring of the availability and quality of services. The lack of waiting list data for children's outpatient services is one of the specific issues mentioned earlier in the report. We would note that collecting waiting list data from the large number of outpatient service providers in Maine would only result in the compilation of duplicated, inaccurate and outdated data. In order for waiting list data to be meaningful, it must be collected and maintained in a central location on a "real time" basis. Doing this requires a substantial commitment of resources and imposes significant burdens on providers. Our only point here is that before imposing new data collection requirements, there should be a determination that there is a clearly identified problem or need to be addressed. In this instance, the report itself notes (on page 15) that "no systemic issues with either availability or quality of children's outpatient services were brought to OPEGA's attention".

Thank you for the consideration of our comments.

Sincerely,

Brenda Harvey

Brenda M. Harvey
Commissioner

BMH/klv

cc: Geoff Green, Deputy Commissioner, DHHS
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