Maximizing Systems for a Change

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Informing the Design of Statewide Substance Use Disorders Service Systems for Optimal Performance in the Era of Healthcare Reforms

SAAS
STATE ASSOCIATIONS OF ADDICTION SERVICES

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GLOSSARY

ACA	Affordable Care Act
ACO	Accountable Care Organization
ACT	Assertive Community Treatment
AHP	Advocates for Human Potential, Inc.
AHRQ	Agency for Healthcare Research and Quality
ASAM	American Society of Addiction Medicine
CHC	Community Health Center
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
EHR	Electronic Health Records
FFS	Fee-For-Service
FDA	Food and Drug Administration
FY	Fiscal Year
FQHC	Federally Qualified Health Centers
GPRA	Government Performance and Results Act
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Health and Human Services
HIE	Health Information Exchange
HIT	Health Information Technology
HMO	Health Maintenance Organizations
IPA	Independent Practitioner Association
MBHO	Managed Behavioral Healthcare Organization

GLOSSARY continued

MCO	Managed Care Organization
MHPAEA	Mental Health Parity and Addiction Equity Act
MH/SUD	Mental Health and Substance Use Disorder
MSO	Management Services Organization
NIDA	National Institute on Drug Abuse
NOM	National Outcome Measure
NQF	National Quality Forum
ONDCP	Office of National Drug Control Policy
PCMH	Patient-Centered Medical Homes
PPC-2R	Patient Placement Criteria for the Treatment of Substance-Related Disorders
SAAS	State Associations of Addictions Services
SAMSHA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SMHA	State Mental Health Authorities
SMI	Serious Mental Illness
SPF	Strategic Prevention Framework
SSA	Single State Agency
SUD	Substance Use Disorder
TEDS	Treatment Episode Data Set
USPSTF	U. S. Preventive Services Task Force

EXECUTIVE SUMMARY

Today's substance use disorder (SUD) delivery system is highly fragmented and idiosyncratic. Services are financed primarily by grants awarded by governmental organizations, secondarily by self-pay clientele and grants awarded by foundations, and finally by public and private health insurers. The SUD system has struggled to accommodate the many differing accountabilities required by these funding sources while maintaining its essential core of values and practices. Additionally, the field has historically operated principally within a behavioral healthcare system, which itself has been fragmented and tangentially related to the broader healthcare system. Behavioral healthcare has also suffered from unequal insurance coverage and reimbursement as well as onerous utilization management practices when compared to general medical benefits.

There are two pieces of legislation fundamentally transforming the way the SUD delivery system will operate in the future. They are the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act (ACA). Both Acts provide an opportunity for the SUD system to reestablish its boundaries and design systems within a framework moving rapidly toward reformed, more accessible, affordable, and effective services for all Americans.

In this report, *Maximizing Systems for a Change*, we explore the powerful catalysts shaping healthcare services and demanding new business models, access mechanisms, quality practices, and financing paradigms. Many of these catalysts have a "multiplier" or compounding effect, so that, for example, the impact of the new Parity Law is magnified by the Affordable Care Act.

This report discusses why and how a *systems change* approach is necessary to help SUD providers understand and adapt to changes taking place in the most beneficial ways possible. The report proposes an actual scope of work that all States can consider and conduct with limited external support and facilitation. Having framed the current environment, the report offers a series of global recommendations for action at the State level that are based on what is taking place nationally. We believe it's in every stakeholder's best interest to act now and to be thorough in this process. Making hasty changes or waiting too long to act will likely have negative and potentially dire unintended long-term consequences.

Implementation needs to occur in every State, and statewide systems need to be developed based on a *systems change* plan that reflects local causes and conditions. However, there is no one-size-fits-all solution. What is true in Florida is not true in Oregon or New York or Iowa, although all States are being driven by the same forces. Additionally, there may be an overwhelming temptation to attempt massive transformation yourself. This is rarely effective. We know that people who assess their own substance use problems and act based on that assessment rarely achieve optimal results. It takes a trained and experienced professional and a reliable sponsor to frame and support the path to recovery. It is equally necessary to have the support of peers, family, and the broader community through which to enact and maintain change.

Similarly, SUD providers need support from the outside to ensure they take actions that are based on the broadest perspective possible. But, more importantly they need each other. Drawing strength from the entire SAAS membership enables everyone to make more intelligent decisions that ensure full and effective participation in the unfolding system. SUD providers are in a system within a system that is changing rapidly and ongoing support and dialogue from peers and outside experts will be essential to success of your reform efforts.

BACKGROUND

With the passage of MHPAEA and the ACA, the stage has been set for a profound transformation of the U.S. healthcare system. The transformation will affect healthcare providers of all types in both the public and private sectors. Before addressing why these changes are occurring and making recommendations for action to address the changes, this paper offers a systems perspective from which to view and manage the change process.

Purpose

The State Associations of Addictions Services (SAAS) subscribes to the concept that SUD prevention, treatment, and recovery unfold within a complex, dynamic system. To understand the enormous changes underway, it is important to understand the complex system that is undergoing change. By gaining an understanding of how complex and adaptive systems work, we can better see how SUD providers fit into it, and will be affected by changing systems. It is also important to track and measure changes over time in order to make adjustments and continually adapt within a rapidly changing environment.

Complex and Adaptive Systems

While many of SAAS's provider association members and their individual providers struggle to make sense of the countless changes going on around them, we wish to set recent changes and reforms within the larger context of a business environment or *ecosystem*. The concept of a system in human organizations suggests that a set of elements or relationships can come together to form a whole that has different properties than those of the individual component parts. The word **system** comes from the Latin word *systēma*, which means "a whole compounded of several parts or members" (Backlund, 2000). The term *system* may also refer to a set of rules that governs structure and/or behavior with most systems sharing common characteristics that include:

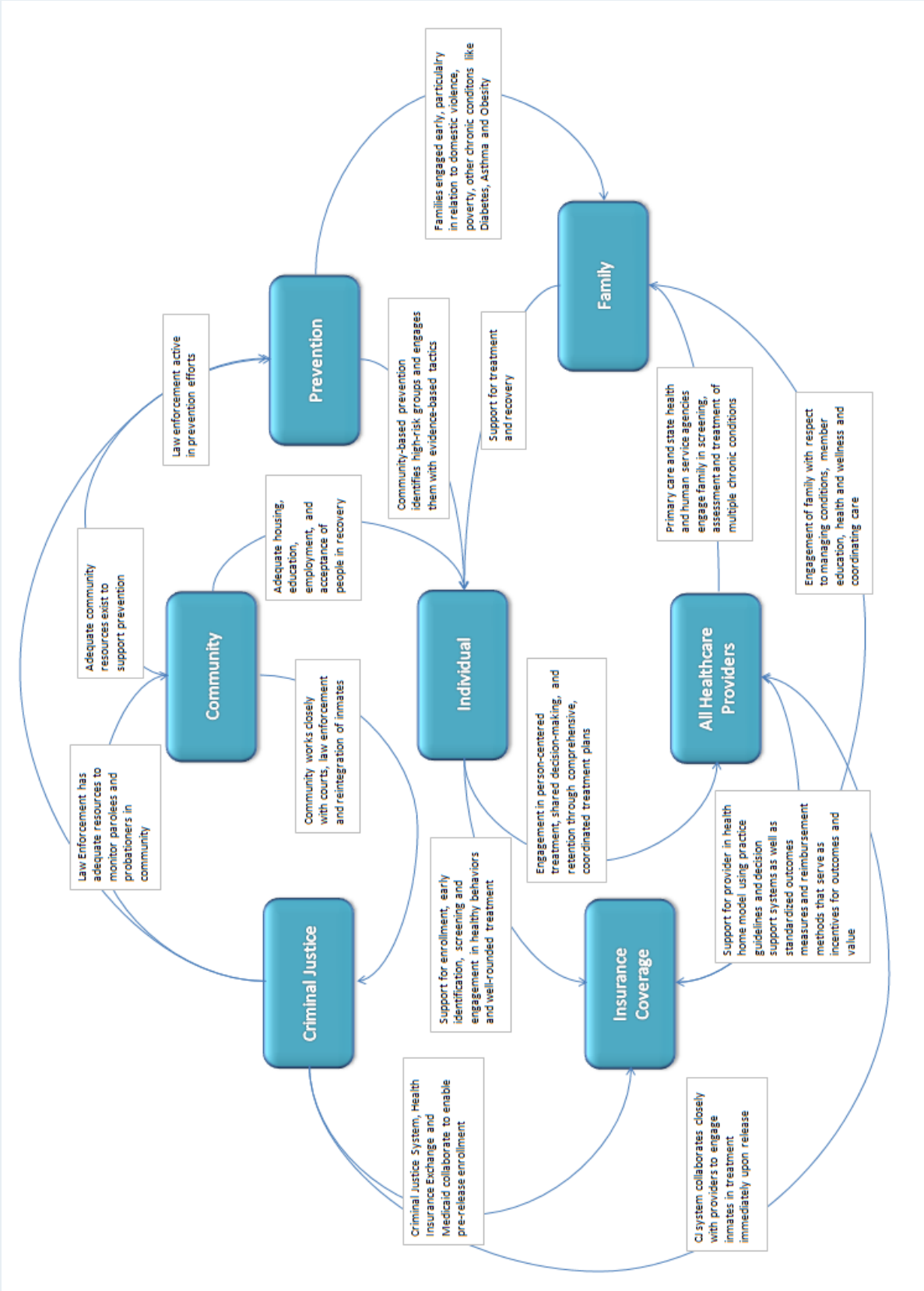
- **Structure** — is defined by components and their composition;
- **Behavior** — involves inputs, processes, and outputs of material, energy, information, or data;
- **Interconnectivity** — consists of the various parts of a system that have functional as well as structural relationships to each other; and
- **Functions or groups of functions** — include activities, actions, processes, and operations within the modeled system or subject area.

Therefore, a complex system is a system comprised of interconnected parts that as a whole exhibit one or more properties that are not obviously discernable from the properties of the individual parts (Chu, 2011).

Our current system has evolved over decades to meet the needs of Americans under the existing behavioral healthcare financing paradigm. As this paradigm shifts in response to the ACA, Medicaid expansion, and health insurance exchanges—many new important system design initiatives must be fully developed, funded, and implemented.

SAAS believes it is critical to view this new evolving system in a dynamic fashion and to understand that the behavior of complex systems change with time. We also understand this approach must deal with factors such as internal feedback loops and time delays that affect the behavior of entire systems. We believe a systemic view is trans-disciplinary and integrative and suggest that our approach emphasize the importance of interrelationships within the system. It is from these dynamic interrelationships between distinct entities that the new properties of our system will emerge. Within this framework, systems of care are understood as complex, adaptive systems that are sensitive to local conditions. Take for example the dynamic interactions within the SUD system. The figure below shows variable elements within this system that must be considered for optimal operations.

Figure 1. *Systems Dynamics:* View of a SUD System



Critical parameters for system design must account for dynamic factors that change over time, thus influencing the system and calling for nimble responses. We believe system design parameters must include and address factors such as:

- **Business Rules** — federal/State legislation, regulations, and enforcement
- **Financing** — public, commercial, and private-pay
- **Infrastructure** — workforce, structure, governance/leadership, information technology, telecommunications, etc.
- **Triggers** — activation events, referrals, admissions, arrests, incarcerations, discharges, etc.
- **Inputs** — volume, demand upon the system, census, prevalence, need, admissions, etc.
- **Process** — business rules, roles and responsibilities, decision-making, touch-points/hand-offs, timing, data required/produced, etc.
- **Throughput within the system** — engagement, enrollment, initiating treatment, etc.
- **Outputs and performance measures** — access, episodes/encounter data, admissions, average length of stay, quality of care, experience of care, behavior and symptom change, satisfaction, quality of life, cost, value, etc.
- **Constraints** — process, procedure, financing, eligibility, etc.
- **Waste** — waiting lists, procedural "motions" through the system, conveyance that add no value, over-processing, re-admissions, etc.

Too often, poorly articulated systems fail to take into consideration all of the ways process and system variables need to be aligned. Sadly, results include waste, inefficiency, benign neglect, fraud/abuse, missed opportunities, as well as significant human consequences such as lost lives, disability, broken homes, domestic violence, or lost opportunities to live a meaningful and productive life in recovery.

Tracking the Change

In June of 2011, The Commonwealth Fund presented an Issue Brief entitled *Delivery System Reform Tracking: A Framework for Understanding Change*. Authors postulated that "significant delivery system reforms will simultaneously affect the structures, capabilities, incentives, and outcomes of the delivery system. With so many changes taking place at once, there is a need for a new tool to track progress at the community level" (Tollen et al., 2011).

In this brief's overview, Tollen and other authors outline that the primary goal of a delivery system's tracking tool is to understand whether progress is being made in a given community, and that in order to do this, it is necessary to have a notion of what progress would look like—such as what is a reformed delivery system, and how will we know it when we see it? As stated by the Institute of Medicine, "we believe that the United States needs a healthcare system that is safer, more effective, more patient-centered, timelier, more efficient, and more equitable than the traditional non-system that dominates American healthcare today"(Institute of

Medicine, 2001). In short, Tollen and the other authors point out that **a reformed system is one in which the various elements—including primary care physicians, specialists, hospitals, ambulatory surgery centers, etc.—can manage health and economic outcomes by measuring, planning, and executing changes to improve performance and are held accountable for delivering high-quality, affordable care while providing a positive patient experience**. They say that some of the data elements necessary for a delivery system reform tracking tool are already being collected by different stakeholders, and these elements must be brought together into a unified whole to create a detailed picture of delivery systems change. Furthermore, there are significant holes in the information that is currently collected about the delivery system for which additional information is needed.

Tollen and the other authors propose that a robust delivery system monitoring tool must track changes in the structure, functions, and outcomes of the healthcare system as well as evaluate progress. To do so, it is important to understand structural and functional elements associated with improved performance through questions such as:

- How does organizational structure relate to outcomes? Which organizational types are most successful?
- How do payments and other incentives affect capabilities and outcomes?
- How does the market environment influence delivery system change, and how does delivery system change influence the market environment?
- Is it easier or more difficult to develop reformed care systems in highly competitive or more consolidated markets?
- How effective are different policy options for improving performance and facilitating spread and growth?

To measure change over time, Tollen and other authors propose a four-part framework to organize the information that would be included in a tracking tool. To identify delivery system change within a defined geographic area and to determine whether that change represents progress toward reform, they suggest it is important to have information regarding the following areas:

- **Structure:** What does it look like? How is the delivery system organized? How does it change over time?
- **Capabilities:** What can it do? Does the delivery system have the tools and processes in place that allow it to manage total spending and health outcomes?
- **Incentives:** With what incentives is it provided? Do incentives in the external environment encourage the delivery system to contain costs and improve health outcomes?
- **Outcomes:** What does it actually do? Does the delivery system succeed at containing costs and improving health outcomes?

IDENTIFYING AND IMPLEMENTING SYSTEM DESIGN CHANGES

SAAS has prepared this report as a guide for its association members and other SUD delivery system stakeholders such as federal officials, State substance abuse authorities, mental health agencies, Medicaid managers, and others. Our purpose is to ensure that SUD system design is addressed in statewide planning and design initiatives. The following section provides system stakeholders and managers with important steps in the design process.

Conducting Analyses

Prior to and/or during substantive design recommendations and efforts, SUD system managers are urged to conduct a number of important, objective, analytical exercises. Making significant changes to the SUD system in your State without reasonably valid data and analysis is strongly discouraged. We recognize that much of the data required for these analyses is difficult to access, assemble, and/or analyze on your own so we encourage seeking expert support from consultants, research universities, public health epidemiology, your Medicaid agency, and in-State health benefit insurers and issuers. Key elements of analysis include:

- **Community Asset and Accessibility Analysis** — system managers are encouraged to study State data such as Treatment Episode Data Set (TEDS), National Outcomes Measures (NOMs), and data from the Government Performance and Results Act (GPRA). Data can also be gathered from SAMHSA, the National Institute on Drug Abuse (NIDA), and other research resources to evaluate access and availability, coordination of care, or variables that pertain to the current array or continuum of care in your State. This analysis should attempt to inventory all SUD services including those provided by public, private and hospital-based entities. This inventory should also take into consideration types and levels of service including co-occurring, prevention and recovery support services. A comprehensive inventory of services organized along a contemporary continuum of care can be compared to actual utilization, encounter and episode data, and any data testifying to unmet needs. The core questions to address with this kind of analysis revolve around the adequacy of the current system across each level of care and service and can identify any issues related to workforce shortages and workforce development.

- **Financial/Investment Analysis** — system managers are encouraged to conduct a financial analysis to address costs across the continuum of care; cost efficiencies; questions of value (i.e., where outcomes are contrasted with costs); medical cost-offset analysis working in cooperation with Medicaid, any willing health plans and managed care plans or employers; and a total economic burden cost analysis that considers all available medical and social costs associated with SUD.

- **Quality of Care** — across all facets of the SUD system, managers are advised to collect and to study all available health, behavior, symptom, quality of life, and other outcomes data, satisfaction data, or other indicators of quality.

Provider Participation

Encouraging provider participation will contribute to the success of your system design efforts and subsequent implementation. Early engagement in the overall process not only helps to build buy-in and a sense of ownership in the outcome, but it also enhances the entire process and final outcome. Local providers understand the system perhaps better than any other stakeholder because they exist at the nexus of connecting consumers and communities with existing resources and can speak directly from experience to what is lacking. By including consumer groups, State personnel, health insurers, and mental health and primary care providers, change manager will gain a significantly broader perspective about what is required for coordination and facilitation. To engage provider participation, we suggest you consider stages or phases of involvement and feedback where incremental processes can build upon the product of prior work.

Managing Complexity

System design initiatives of this magnitude require evaluating, articulating, and implementing complex, multi-level processes while aligning with a wide range of social and healthcare networks across large tracts of geography and population. This can be an overwhelming undertaking. On the one hand, SAAS urges system managers to remain aware and respectful of complexities. Failure to account for complex relationships can result in tragic unintended consequences. On the other hand, we want to encourage a bird's eye view from where the simplicity and elegance of system design can be appreciated. As complex as your system is today, it can become more refined, efficient, and adaptive. For best results, we suggest simultaneously cultivating a bird's and worm's eye view.

Linking Strategies

System design initiatives have much to gain by conducting activities in full view of other system-wide reforms. For example, the State of Illinois has designated a Governor's Healthcare Reform Implementation Council that includes a system design work group comprised of stakeholders from across the healthcare and health insurance sectors. By cooperating and communicating openly, interest groups are much better able to adapt to changes taking place in other domains and to leverage lessons learned from others' efforts.

Setting Goals

When setting goals throughout system design initiatives, it is essential to set clear and unequivocal goals for the system. These goals will likely differ from those of a single provider or the State agency. However, the goals should be specific, achievable, and linked directly to the primacy of design changes vis-a-vis healthcare reform. The following are examples your initiative may want to consider:

Sample System Design Initiative Goals

GOAL 1: Design a simplified healthcare delivery system with greater portability between payers and funding sources.

GOAL 2: Create greater uniformity in the availability of services across the State.

GOAL 3: Increase consistency of services offered in the service delivery system.

GOAL 4: Create transparency and accountability throughout the system.

GOAL 5: Reduce administrative costs in order to purchase more direct services.

Evaluating and Continuously Monitoring Systems

Lastly, SAAS recommends that any design changes or efforts implemented in the form of a pilot or demonstration project be properly evaluated before making more comprehensive and potentially disruptive changes. Evaluators must be confident that they have reviewed valid and reliable data through the prism of logical business and clinical models before reaching conclusions about what does and doesn't work.

Framework for Action: A Roadmap to State-Specific System Design

In order to develop a legitimate system design initiative with a clear mandate, vision, mission, goals, and objectives, SAAS recommends the following seven steps:

1. Multi-Stakeholder System Survey

Prior to engaging stakeholders in strategic planning exercises, SAAS recommends developing and conducting a Web-based survey that requires the participation of a significant number of your State's SUD prevention and treatment providers. Independent and unbiased consultants can conduct surveys and prepare reports of findings. Respondent's names should not be disclosed, and they should be reassured that their participation will remain anonymous and confidential.

2. Key Informant Interviews

SAAS suggests using a skilled consultant to conduct a series of telephone interviews with members of the SUD prevention and treatment community. Each interviewee should be asked the same questions and in the same manner. Responses should be properly recorded and aggregated for analysis. Recommendations can then be developed and documented based on patterns and trends in responses.

3. Strategic Planning

Having conducted both steps above, stakeholders are advised to schedule a meeting to review data, findings, and expert recommendations based specifically on the findings. We believe it is best to schedule 6 to 8 hours for this purpose in a central and neutral location. We also urge members or anyone else considering this approach to engage an experienced expert facilitator.

4. Prioritizing

All of the previous steps will generate a great wealth of ideas and suggestions for a system design. However, the number of ideas can become unwieldy and counter-productive when taken as a collective body and the question becomes how everything will be addressed. To avoid succumbing to the desire to accomplish it all with the result of accomplishing nothing, we suggest immediately establishing clear priorities. We strongly recommend that the same consultant responsible for harvesting data to this point be retained to conduct an inclusive and democratic priority-setting exercise where a limited number of recommendations reflect the will of the majority.

5. Developing Guiding Principles

Throughout this process, the core values and deeply held beliefs of the system should be harvested. Documenting these principles now makes promoting them easier later. We recommend you draw from the collective wisdom and experience of your stakeholders as well as from the array of principles attributable to systems of care today. SAMHSA's *Guiding Principles and Elements of Recovery-Oriented Systems of Care: What do we know from the research?* suggests the following principles that can guide the systems design and implementation efforts (Sheedy et al., 2009). Systems of care should be:

- Self-organizing and enabled to transcend old paradigms;
- Reflected in State policy and the wide variety of financing mechanisms resulting from healthcare reform;
- Structured and stabilized by services and professionals that are guided by a philosophy and supported by an infrastructure;
- Committed to evidence-based and community-based approaches to prevention, screening, early intervention, referral, case management, and treatment;
- Primarily person-centered and engage the family and community;
- Individualized and responsive to age, gender, language, and culture;
- Strengths-based and committed to peer recovery support services;
- Consisting of comprehensive services addressing housing, medical, psychological, social, educational, and vocational needs;
- Accessible and available across an array of qualified prevention, treatment, and recovery supports that are anchored in the community;
- Least restrictive, normative, and clinically appropriate;
- Adequately and flexibly financed;
- Measurably accountable and demonstrate quality, economic value as well as improved clinical, functional, and quality of life outcomes;
- Highly collaborative, coordinated, and integrated; and
- Enabled by the meaningful use of interoperable health information technologies.

Your system's principles might also feature some of the following:

- Support for the Strategic Prevention Framework (SPF);
- A public health understanding of substance use and abuse, chronic disease, and co-morbid conditions;
- Best practices in prevention
- A cost-containment value proposition emphasizing outcomes, value, and accountability;
- A strong position that SUD prevention and treatment should be integrated with mental health and primary care while preserving uniqueness and distinct capabilities;
- Statement of support for the ACA's emphasis on the accountable and coordinated treatment of chronic disease;
- ONDCP positions on treatment instead of incarceration;
- the Department of Health and Human Services' efforts to de-stigmatize substance use disorders; and
- A statement of support for the MHPAEA.

6. Action Planning

Having prioritized a realistic and manageable number of strategies, SAAS recommends your system design initiative develop a strategic framework consisting of equal measures of the following:

- **Policy Actions.** These speak to the need for the system and its champions to publicly support existing policies and propose measures that will benefit the field and its consumers.
- **Project Actions.** These address the need to develop demonstration projects or pilot projects in order to validate and verify that a particular approach, will produce positive results for the field and its consumers.
- **Research and Technical Assistance Actions.** These are actions that need to be taken to develop greater clarity, understanding, quantitative/qualitative information, and otherwise equip the field with targeted training, education, and preparation.

7. State-specific Report

Lastly, your system and stakeholders will be in a position to assemble all of the preceding steps and deliverables into a cogent and highly strategic report of system design recommendations. Work with your subject matter experts to develop an implementation plan with estimated scopes of work and timelines that enable you to answer your State's difficult business questions, such as *"How do you suggest we accomplish all of these objectives?"*

System Design Priorities 2012-2015

In order to implement parity and healthcare reform, given the opportunities and constraints noted in the preceding sections, SAAS proposes three broad system design priorities—one related to policy development, one to program development, and a third to research and technical assistance. Within each broad priority area, SAAS makes three recommendations for action. In total, there are nine recommendations and corresponding rationale for change.

POLICY DEVELOPMENT – PRIORITY 1: IMPLEMENT PARITY FULLY

RECOMMENDATION

MHPAEA and its purposes and principles must be understood, accepted, and implemented to the fullest extent possible in each State. Where State parity laws exist, they must be monitored and implemented; when possible, they should be modified and strengthened, as MHPAEA only establishes a parity floor and not the ceiling. Plans, issuers, and payors of all kinds must be held accountable for compliance. In addition, providers and the public must be educated about their rights under parity. Acting on this recommendation requires leadership by SAAS members on a state-by-state basis to convene, educate, and engage in strategy, planning, and educational meetings with key system participants such as State insurance commissioners, State Medicaid directors, private insurers, other provider stakeholders, and consumer organizations.

RATIONALE

Policy change, even to the extent that it is legislated, enacted, and interpreted through regulation, is no assurance of implementation. The 2008 MHPAEA legislation has a precedent in the Mental Health Parity Act of 1996, which established parity in aggregate lifetime and annual dollar limits. At that time, it was considered a sufficient vehicle to end the principal barriers of access to MH/SUD services in large group health plans. However, another more robust iteration of the parity principle was required by 2008. The newest version extends parity beyond aggregate and annual limits to include parity for financial requirements such as copayments and deductibles, to treatment limitations such as visit limits, to non-quantitative treatment limitations such as inclusion of MH/SUD providers, to provider networks, and other provisions.

Because the 2008 law is so essential in expanding coverage for SUDs, the parity requirement must be implemented as fully and quickly as possible under all insurance plans covered by parity; however, not all plans are covered. In the small group health insurance market, employers with 50 or fewer employees are not covered. Also, self-funded, non-federal governmental health plans can opt-out of MHPAEA, and many have. These circumstances demand a state-by-state effort to raise the understanding of the complexity and fundamental nature of this aging federal legislation. While an interim final regulation was issued by HHS, there are still ambiguities about whether and how parity applies to the various Medicaid MCO programs. CMS is also expected to issue further guidance to clarify this matter.

Nonetheless, there is no reason to wait for 2014 to make changes. States have implemented State-specific parity laws since passage of the 1996 federal law. State parity laws may be more comprehensive and extensive than the current federal law. For example, Illinois recently enacted a parity law that exceeds MHPAEA in several ways. First, it specifically recognizes providers that are licensed or certified through the Illinois Department of Human Services in accordance with the Illinois Alcoholism and other Drug Abuse and Dependency Act. Additionally, in a significant victory for advocates, the law specifically identifies residential treatment services under the definition of inpatient treatment, and now requires parity in coverage of residential treatment. The new law also sets forth a definition for SUDs and requires medical necessity determinations to be made in accordance with ASAM patient placement criteria.

At the core of parity legislation are the truisms that behavioral health is essential to overall health; that prevention works; that treatment is effective; and that people can and do recover. The historical marginalization and criminalization of SUDs can be reversed by simultaneously fortifying our position as a specialty while mainstreaming treatment of those with SUDs.

POLICY DEVELOPMENT — PRIORITY 2: DEVELOP FINANCING AND REIMBURSEMENT

RECOMMENDATION

Develop a payment system for SUD providers based on equitable reimbursement for services rendered consistent with ASAM levels of care. In addition and in concert with this effort, define and operationalize payment models that include 1) recalibrated fee-for-service , 2) a pay-for-performance model, 3) episode or case rates, 4) partial global payments, and 3) a shared savings approach.

Acting on this recommendation requires identifying existing information and data about where ASAM level of care criteria have been utilized in a reimbursement scheme and/or developing and testing a methodology for such an application. It will also require providing analysis of how these payment approaches have been applied in other healthcare environments, including their strengths and weaknesses as well as when and how to apply them. This information then needs to be distributed to providers and developed into provider training and tools.

RATIONALE

In the 2011 Health Affairs article, *The Looming Expansion and Transformation of Public Substance Abuse Treatment under the Affordable Care Act,* Jeffrey Buck articulates the need for systems of payment and administration that are more characteristic of health plans and funding sources such as Medicaid, Medicare, and private health insurance. Current SUD providers are seldom integrated with other behavioral or general health service systems. They make limited use of information technology, even for administrative, claims, and/or billing purposes. Thus, they are ill-prepared to manage the changes that the ACA will bring about.

In order to begin preparations for reform, it is necessary to redefine services using a medical model framework. The ASAM patient placement criteria provide such a framework. In addition, it is necessary to develop cost analyses on the various categories, types of services, and associated procedure codes so that provider organizations can determine if reimbursement is equitable and makes sense from a business perspective or to understand what alternatives and/or supplemental strategies are needed for adequate financial performance. Ideally, the approach must account for the diversity of funding sources and their usual reimbursement practices. Additionally, the process must also examine how services can be provided while producing adequate revenue under different financing approaches that include recalibrating payment levels in fee-for-service, pay-for-performance, episode payments, global reimbursements, or shared savings approaches.

POLICY DEVELOPMENT – PRIORITY 3: DEFINE ESSENTIAL HEALTH BENEFITS

RECOMMENDATION

It is important to promote the inclusion of a full continuum of SUD services in each state's *Essential Health Benefits,* a position supported by the Coalition for Whole Health. Also see the recently released Institute of Medicine report on *Essential Health Benefits* for detailed discussion on this important definition (Institute of Medicine, 2011).

SAAS members are encouraged to provide input into the *Essential Health Benefit* process. Regulations are likely to be issued in 2012. Therefore it is necessary to clarify and develop consensus around SAAS's policy positions, requiring education, training, and technical assistance for our field so that as a collective community of providers we can weigh in effectively.

RATIONALE

How *Essential Health Benefits* are defined will have a great deal to do with the specific ways in which health plans issued through *Exchanges* are implemented. The benefit design impacts almost every aspect of health insurance, including the scope of benefits; what can be afforded; what consumers need to know; how quality is defined; and how, by whom, and according to what standards medical necessity is to be determined.

If SUD providers are going to gain influence in this process, they must understand benefit design to some extent. In addition, they need to understand how the role of specialty services in healthcare evolved and where specialty services are headed. Particularly with the addition of 20 million formerly uninsured enrollees in Medicaid in 2014, plan administrators will need to be able to serve a more acute and historically uninsured population. Such individuals often overwhelm primary care physicians who already have difficulty referring to behavioral health specialists. Plans need SUD specialists who are capable of dealing with a less healthy population in their provider networks. They also need a benefit that is sufficiently comprehensive and enables provision of services that have greater depth. Ideally, the Medicaid State Plan benefit and the *Essential Health Benefits* provided through *Exchanges* health plans will be sufficiently comparable in breadth and depth so enrollees are able to move seamlessly between them.

PROGRAM DEVELOPMENT — PRIORITY 4: DEVELOP CLINICAL OUTCOME MEASURES

RECOMMENDATION

Providers are encouraged to support the establishment of standard clinical outcomes measures for SUD treatment that can be integrated across healthcare systems and healthcare professionals. SUD providers have historically measured outcomes consistent with federal Block Grant requirements (e.g., TEDS, GPRA, and NOMs). However, they must now prepare to collect and report measures common to commercial managed care (e.g., HEDIS), Medicaid, and other measures such as those being promulgated by the National Quality Forum (NQF).

RATIONALE

The outcome measures that have evolved to date meet the expressed demands of funding sources, but are not sufficient to serve in the more connected healthcare system and insurance-driven financing environment of the future. Either the SUD treatment community will develop new or modified measures that will be accepted by ACOs, Medicaid, *Exchange* insurance plans, medical home programs, CHCs, and other entities, or such measures will be imposed. In the latter case, measures could well be insufficient and/or counter-productive, given the limited degree to which SUD treatment is understood and integrated within other healthcare organizations. The community must define what information needs to be collected and shared, what outcomes can be expected, and how organizations can operationalize and automate the entire process using certified information systems.

PROGRAM DEVELOPMENT — PRIORITY 5: PILOT PRIMARY CARE INTEGRATION AND MULTIPLE CHRONIC CONDITION PROJECTS

RECOMMENDATION

Develop bi-directional, co-location pilot projects involving SUD, MH, and primary care that focus on the clinical and programmatic dimensions of integration. Projects should be based on state-of-the-art practices that explicitly screen for, assess, and treat SUDs with the full participation of SUD providers on the treatment team.

RATIONALE

One of the greatest challenges for healthcare reform is the extent to which integration can be achieved and to what extent better integration and care coordination can address and improve clinical and financial outcomes as a result. There are differing levels of acuity and complexity among the SUD population, in terms of the substance related disorder and the comorbidity of other illnesses. For some individuals, the amount and level of comorbidity is less and is often best treated within the primary care setting. For others, there is a more significant level of comorbidity with patients suffering from chronic conditions that may include obesity, diabetes, asthma, chronic pain and opiate withdrawal, HIV and AIDS, chronic obstructive pulmonary disease, mental illness, and others. In such cases, clinical complexity often requires treatment from other specialists that augment the work of the primary care physician. Thus, the SUD treatment community must not only have the capability to engage with and participate within a team model with primary care physicians, but also with other specialists. Having the expertise and experience to do so is vital to the field and is of considerable importance in the health reform experiment.

Under SAMHSA direction, several national mental health and substance abuse organizations have developed primary care integration “tool kits” for implementing more fully integrated services. These must be disseminated widely, and the opportunity for much broader deployment is at hand. Not only is having the capacity and operating models for how to treat multiple chronic conditions similar to being able to coordinate and collaborate with primary care, but it is also more complex. At times, it may require the participation of hospitals and inpatient settings, and not just ambulatory practices.

Developing and deploying both the clinical models as well as the programmatic dimensions of collaboration, information sharing, and other dimensions of practice are important. To the extent SUD treatment organizations can collaborate with both the specialty medical sector and primary care, they will add great value to their partner organizations and patient mix.

Without leadership from the SUD treatment community to develop, refine, and apply models for integrated treatment on a relatively widespread basis, there will be little if any validation of the basic rationale for reform for this population. Without this level of leadership, there will be a significant missed opportunity.

PROGRAM DEVELOPMENT — PRIORITY 6: DEVELOP AND APPLY INTEGRATION PRACTICES WITH NEW ORGANIZATIONAL PARTNERS

RECOMMENDATION

Develop capacity to implement integration programs with CHCs, PCMH programs, health homes, and ACO model programs.

RATIONALE

Just as the SUD community needs clinical and program models to implement integration, they also require organizational models that enable their engagement with CHCs, PCMHs, ACOs, and health homes. Under Section 2703 of the ACA, health homes are a new model for integration and many are being implemented around the country. Effective in 2011, Medicaid offers a temporary 90 percent federal match rate for these "person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral healthcare, and long-term community-based services and supports"(The Henry J. Kaiser Family Foundation, 2011).

The health home model of service delivery expands on the primary care case management and more traditional medical home models that many States have developed in their Medicaid programs. Medicaid already provides primary care case management projects for 8 million enrollees in 31 States. The health home model envisions additional linkages to social, behavioral, and medical communities to better meet the needs of people with multiple chronic illnesses. To be eligible, Medicaid beneficiaries must have at least one chronic condition and be at risk for another, including "asthma, diabetes, heart disease, obesity, mental condition, *and substance abuse disorder*."

Health homes must coordinate and provide access to a range of services that include preventive and health promotion services; mental health and SUD services; comprehensive care management, care coordination, and transitional care across settings; chronic disease management; individual and family supports, including referrals to community and social supports; and long-term supports and services. As prescribed by the ACA, CMS guidance requires States to consult and coordinate with SAMHSA in designing their approaches to health homes.

In addition, health homes must coordinate and integrate all clinical and non-clinical services and supports required to address the person's health-related needs and reflect that activity in care plans. They must use health information technologies to link services and facilitate communication among individuals, caregivers, providers, and practices involved. They must also collect and report evaluation data and operate a continuous quality improvement program.

Funding available from SAMHSA and CMS provides opportunities to apply the tools and practices that have been developed, and the experience of doing so will enable refinement and information for future application. The more States develop and implement projects focusing on integration, the richer the results.

While the health home is a Medicaid funded program, its principles and practices are also embedded in the best practices ACOs seek to achieve. Ideally, ACOs join physicians and clinics or hospitals in groups that pool their resources with the goal of trimming spending while boosting quality of care. By partnering with primary care organizations, they are able to share savings with their funders if they deliver care for less than the historical cost of care. ACOs will be (and some are already) funded by commercial insurers and Medicare. Development of well-integrated service models will be of interest to ACOs and other PCMH programs. SUD treatment programs that can demonstrate expertise, experience, and technical capability with integrated primary care programs should bring this capability to the attention of ACOs, CHCs, and other PCMH programs.

Successful coordination of care in the context of health reform will require a systemic approach in which strategies are inclusively planned, communicated clearly, and facilitated at all levels.

RESEARCH, EDUCATION, COMMUNICATION — PRIORITY 7: COST-BENEFIT ANALYSIS

RECOMMENDATION

Conduct a cost/benefit analysis that examines the relative value (i.e., outcomes/costs) of all ASAM levels of care in each State. Identification of the most efficient and effective services will help inform notions of *Essential Health Benefits* at the State level and for the insurance offered in 2014 through *Health Exchanges*.

RATIONALE

Fragmentation of the SUD field is problematic from many perspectives. One problem is the ability to reasonably project expenditures and to relate these expenditures to benefits. Lack of uniform definitions of levels of care across States and jurisdictions makes evaluation challenging and introduces considerable risk to insurance-based financing, which is the dominant form of financing that will drive SUD treatment in the future.

In order to better prepare for that future, agreeing on a framework for defining and delivering care is critical. ASAM's levels of care provide a necessary framework. Though application of ASAM criteria is not universal, there are sufficient numbers of sites that could be engaged in more systematic analysis. In the possession of such information, SUD providers and provider systems are in a far better position to compete successfully for participation in the evolving healthcare system. In the absence of such information, providers are at the mercy of other more established organizations that may have different views on the costs and benefits of services.

RESEARCH, EDUCATION, COMMUNICATION – PRIORITY 8: PROVIDE BUSINESS SKILLS TECHNICAL ASSISTANCE

RECOMMENDATION

Develop and deploy technical assistance for provider marketing and business development.

RATIONALE

Delivery of healthcare services is occurring within an increasingly competitive environment. Regardless of profit or non-profit, government or non-government status, the ability to lead, plan, develop, and administer healthcare organizations is an increasingly critical determinant for success. When dominant sources of funding for services were categorical grants and contracts from government agencies, the need for these skills was less apparent. This is no longer true. Being able to align interests, ensure mutual value, and communicate with all of one's constituencies is critical.

Some of the necessary skills for those leading organizations are healthcare business skills such as strategic planning, financial planning and analysis, capital (i.e., reserve) development and deployment, competitive positioning, product innovation and development, market analysis, market research, marketing communications, to name a few. Many of these skills were unnecessary a decade ago, and thus they are typically lacking in the SUD delivery community.

In order to compete in the current environment and marketplace, SUD organizations must increase their business planning and marketing capacities, or they are unlikely to grow. Without growth, they are unlikely to survive. The need for SUD services is not declining, and neither is the need for competitive and vital organizations to meet these needs.

RESEARCH, EDUCATION, COMMUNICATION – PRIORITY 9: PROVIDE TRAINING IN APPROACHES TO ORGANIZATIONAL GROWTH

RECOMMENDATION

Conduct targeted executive training in joint venture and affiliation models, together with a review of merger and acquisition activities that have taken place in healthcare over the past three decades.

RATIONALE

SUD organizations are large in number but small in scope for many reasons. Today's environment requires larger organizations that can derive the benefits of size. All industries cycle through periods of expansion and contraction where businesses are large or small depending on the market and the need. This is also true for behavioral health organizations.

With the 1974 passage of the Health Maintenance Organization Act, dramatic shifts in the healthcare market began to take place. In reaction to what was happening with insurers and the growth of HMOs, providers reacted by organizing themselves in new ways. A variety of network models formed, such as Independent Practice Organizations and Specialty Preferred Provider Networks. Today, some of these organizations consist of large numbers of both hospitals and outpatient clinics in multiple locations. Some have become so large they are now dictating terms and pricing of contracts with insurers, though this point has only recently been reached after years of being at the other extreme. Organizations that support providers and the many new management functions required of them are being formed as well (e.g., Management Services Organizations).

Today, SUD organizations have options available to assist them in meeting the demands of the current environment. Knowing what these options are, the pros and cons of each, and how to institute them can be provided through training. In addition, there are other related options to address current environmental circumstances. These include mergers and acquisitions, organizational strategies not limited to the for-profit community. They are used extensively in the healthcare insurer marketplace, including the Blue Cross and Blue Shield organizations that are historically non-profit organizations. The interaction between the public and private sectors is also important to understand and should be included in recommended training.

Implementation Scope of Work

The purpose of this section is to articulate and elucidate an implementation plan for the nine initiatives and actions we have suggested. This plan will help readers identify timeline implications, dependencies between tasks, roles, milestones, resource requirements and other critical factors. Notably, SAAS is also suggesting that SUD providers and their associations take a lead role in managing the implementation and execution of system design recommendations. We believe that our providers understand the nature and extent of the issues, constraints, and critical success factors that pertain to these initiatives. The involvement of subject matter experts will be necessary to ensure successful implementation.

System Overview

The system consists of substance use disorders prevention, treatment and recovery assets including providers, professionals and facilities at all levels of service. The system is relational and has a scope and span that encompasses and affects all stakeholders including consumers and their families, mental health providers and managers, medical and general healthcare providers, hospitals, health insurers and managed care organizations, publicly-financed healthcare, family and children's services, homelessness and housing agencies, employers and labor, public health, education, corrections, law enforcement, and the judicial system. The proposed system:

- Is structured to implement change,
- Defines the necessary infrastructure requirements,
- Is financed by a variety of sources and payers,
- Is expected to meet access, quality and cost standards, and
- Is interconnected clinically and technologically.

Assumptions and Constraints

SAAS is presupposing that policymakers and stakeholders will want to make a reasonable effort to implement system design recommendations. As a result, we are making the following assumptions:

- **Schedule.** The deadlines and milestones for many of the federal and State health care reforms are approaching rapidly. We propose that agreement on an implementation approach and budget is critically important and must be reached early in 2012.

- **Budget.** Many of the SUD stakeholders do not have the financial resources to fully deploy all of the system design recommendations. SAAS recommends that a frank discussion of budget be chaired by the State and that grants and other funding be made available to manage statewide implementation.
- **Resource availability and skill sets.** SAAS recognizes that additional resources and subject matter experts will be required to effectively deploy these recommendations. We strongly recommend that expert resources be identified and that states and provider associations are ready to execute agreements with them as needed.
- **Software and other technology.** SAAS submits that much of the technology required to conduct activities suggested in this plan is available. However, we are assuming that stakeholders and partners will be willing to share information openly when it is called for and within the bounds of privacy and security laws. In regard to the adoption of electronic health records, we would support the establishment of funding specifically for that purpose.

System Organization

For the recommendations we are making to be considered feasible, we would require the approval and participation of many other stakeholders. Primarily, SAAS believes that many Federal and State agencies would need to be organized in such a way as to support our progress and success. The participation of health plans, other health care providers such as primary care providers, among others is also crucial. SAAS believes system design changes will be most successful if SUD providers are engaged in dynamic communication with other stakeholder groups, including other agencies. Specifically, SAAS suggests the following:

1. Participate fully in conferences and summits of State leadership, State agencies, community organizations, SUD prevention, SUD treatment providers, mental health providers, public health, schools, and primary care providers.
2. Address funding, communication, cooperation, rules and regulations and other factors that are impeding our progress.
3. Attend any open meetings concerned with Health Care Reform implementation to define your role, your recommendations and positions, implementation of system design changes, and pilot or demonstration projects that prove viability and reliability of the field.
4. Participate in any Outcomes and Quality committees – potentially involving representatives from Medicaid, public health, commercial insurers, mental health and primary care –to promote the development of core outcomes measures that include and transcend programs and funding sources. For example, if managed care organizations use HEDIS measures, the SUD system must begin to follow suit, eventually producing TEDS, NOMS and HEDIS data. We believe that SAMHSA and states should support that evolution. Otherwise, the risk is that requirements for multiple systems, data and measures will become untenable for providers with inadequate or immature information systems (IS) and limited resources for development.

5. Examine adjacent health care sectors to explore viable solutions to management and administrative operations challenges. Review potential for the development of Administrative Services Only funders (ASOs), Management Services Organizations (MSOs), Preferred Provider Organizations (PPOs), Specialty Preferred Provider Networks and other management/technical services cooperative or consortia models.

Management Overview

This section of the Project Implementation Plan provides a description of how an implementation can be managed and identifies the major tasks involved.

Description of Implementation

SAAS is recommending that the implementation be conducted over a period of no fewer than 12-18 months. The actions and strategies we are proposing are reasonable in scope and duration and require the skills of different individuals which will require deploying and managing multiple teams simultaneously. The implementation can be carefully managed and monitored with frequent progress reporting.

Project Participants

SAAS suggests that system design implementations include comprehensive participation across a wide range of agencies and stakeholders. We recommend the development of project teams to include:

Executive Sponsors
Project/Program Managers
Government Project Officer
Consultants and Subject Matter Experts
Medicaid Behavioral Health
Corrections, Probation & Parole
Mental Health
Public Health
Information Management and IT
Training and Technical Assistance
Epidemiology and Health Informatics
Department/Office of Insurance
Managed Care, Health Plans, ACO, CCO other Payor Liaisons

Others can be added as identified and necessary.

Major Tasks

In most cases, the priorities we identified in the preceding sections can be construed as a task with subtasks. We have identified tasks required to implement SAAS recommendations below. The following task list represents the 12-18 months' implementation timeline assuming considerable resources are allocated in the spirit of public/private partnership:

POLICY DEVELOPMENTS

Task 1

Promote the comprehensive implementation of the *Mental Health Parity and Addiction Equity Act* and the need for timely issuance of final federal regulations, guidance for consumers and providers, as well as enforcement of parity-compliant health insurance regulations at the state level.

1.1 Advocate for the broadest and most appropriate definitions of covered services (per ASAM levels of care), covered providers, and covered conditions (per ICD-9 and DSM-IV).

1.2 Promote the Coalition for Whole Health definitions and descriptions of *Essential Health Benefits* in the context of MHPAEA.

1.3 Develop consumer-friendly parity and equity promotional material and conduct community outreach to raise level of awareness

Task 2

Define the current SUD prevention, treatment and recovery system in your state and develop a promotional/informational packet for legislators, stakeholders, health care providers, and the general public. Include public and private providers and stakeholders to draw a thorough picture of the system of care.

2.1 Develop training materials and deliver webinars/seminars.

Task 3

Develop a proposed reimbursement policy that supports equitable reimbursement for SUD services and providers across all payors in the state. Attempt to standardize and harmonize reimbursements that transcend state- and county-funded programs, commercial health insurers, Medicaid managed care plans and other plans; explore fee-for-service, pay-for-performance, shared savings and global payment methods.

3.1 Conduct research into viable models accounting for methods like Usual, Customary and Reasonable (UCR) rates of reimbursement, Diagnosis Related Groupings (DRG), case rates, Relative Value Scale (RVS) and Global Payments. Compare and contrast findings, make recommendations.

3.2 Disseminate findings and recommendations.

3.3 Convene stakeholder group meetings to review recommendations and develop consensus positions.

Task 4

Standardize SUD professional credentials and scope of practice across all funding streams and payors.

4.1 Conduct research into existing credentialing requirements

4.2 Compare and contrast, developing findings and recommendations

4.3 Convene stakeholders to develop consensus position

Task 5

Conduct Capacity and Gap Analysis, mapping statewide assets and needs to meet demand by 2014.

Task 6

Define breadth and scope of SUD workforce requirements across Medicaid, Medicare, private insurance and state programs including those that remain in force for the uninsured following January 1, 2014.

PROGRAM DEVELOPMENTS

Task 7

Standardize and align clinical outcomes measures that integrate State and Federal Block Grant requirements for the Treatment Episode Data Set (TEDS) and National Outcomes Measures (NOMs) with commercial managed care and Medicaid managed care plan measures like HEDIS and any new SUD quality and outcomes measures such as those being developed and promoted by the National Quality Forum (NQF).

7.1 Collect measures and assign study to cross-section of stakeholder representatives

7.2 Develop findings and recommendations

7.3 Convene stakeholder and interest groups and develop consensus position

7.4 Disseminate recommendations

7.5 Develop policy and regulatory framework to implement and enforce recommendations

Task 8

Develop access measures that span market segments and funding streams capable of measuring a baseline and establishing new system benchmarks for access statewide.

Task 9

Develop a state-level policy and position that unequivocally recognizes SUDs as a chronic medical condition on a par with other treatable medical conditions.

Task 10

Market and promote the policy across organizational boundaries focusing on sectors like public health, disease control, law enforcement, judiciary, corrections, education, and mental health such that all state agencies can articulate a common vision for the prevention and treatment of SUDs as well as state-specific goals and objectives that transcend any single department or agency.

Task 11

Establish SUD as a *sub-specialty* discipline, taking the following actions:

11.1 Clearly define *Addiction Equity* where state insurance law and regulations are concerned.

11.2 Articulate the manner in which guidelines such as the ASAM patient placement criteria will be implemented and enforced in the state's commercial health plans and any Medicaid managed care plans.

11.3 Clearly define *scope of practice* to recognize SUD-specific education, training, experience, certifications, and State licensure.

11.4 Clearly define SUD prevention, treatment and recovery in the context of *Essential Community Providers* and *Essential Health Benefits*.

11.5 Align SBIRT initiatives, funding, process, and assets in primary care, emergency rooms, and other community-based organizations.

11.6 Identify existing and prospective patient-centered medical home models, healthcare homes, accountable care organizations (ACOs), and Coordinated Care Organizations (CCOs)

11.7 Develop and launch a statewide primary care outreach strategy that supports the effective identification of SUD needs in primary care settings while familiarizing the medical community with statewide networks of qualified SUD providers and mechanisms that facilitate the proper coordination of care between disciplines.

11.8 Build bi-directional, co-location pilot projects including mental health, primary care, and SUD providers.

11.9 Establish inventory of appropriate screening and assessment tools.

11.10 Develop viable model for information sharing and exchange to support integration efforts, patient centered medical homes, healthcare homes and ACOs.

11.11 Measure and analyze the impact of collaboration and integration on utilization patterns, cost trends, access to and quality of care, and clinical/medical outcomes.

RESEARCH, EDUCATION, COMMUNICATION DEVELOPMETS

Task 12

Measure and establish a baseline for the cost-effectiveness of prevention and treatment available in the current system designed for people with SUD and co-occurring disorders in contrast to untreated and unmitigated SUD.

12.1 Develop valid actuarial/research approach, carefully framing key questions and considerations.

12.2 Define societal and medical cost off-set.

12.3 Identify test and control groups with sufficient data and conduct analysis with the participation of large commercial payors. Use primary and secondary diagnosis codes and service codes including prescription drug data.

12.4 Conduct a Medicaid cost-impact study with a similar emphasis on medical cost-offset, prescription drug costs, and hospital Emergency Room utilization and admissions.

Task 13

Develop a 3-year Technical Assistance Plan.

13.1 Build a business and marketing training plan. Identify subject matter experts and trainers.

13.2 Develop guides, aids and resources.

13.3 Identify business and executive mentors and coaches from within the state to ensure cultural relevancy and promote networking while building skills and confidence of SUD providers. Identify providers from across the state that are perceived to be leaders in terms of market share and market maturity, embodying the objectives of the plan in terms of new business models and integration with partners.

13.4 Identify 3-5 viable business models, emulating approaches taken by primary care and other specialty groups in the private insurance and healthcare market.

13.5 Develop proof of concept methodology and resources, including coaching through proof of concept process.

13.6 Disseminate models and train providers statewide.

Implementation Plan Management and Performance Monitoring

SAAS suggests that professional project management be included in any implementation planning effort over the course of 12-18 months. Project Management consists of the following activities:

- Develop final implementation plan for stakeholder review.
- Coordinate and conduct Kick-off Meeting with key stakeholders.
- Request pertinent documentation and data.
- Introduce and familiarize personnel and consultants to team roles and responsibilities, developing organizational and communication charts.
- Review goals and objectives.
- Review plan (critical path, milestones, tasks, schedule, and resource requirements).
- Discuss perceived issues and risks.
- Review assumptions concerning responsibilities and accountability.
- Review communications, liaisons, problem escalation, progress monitoring, and status reporting.
- Review planned deliverables.
- Provide ongoing project management, oversight, communication, monitoring, and status reporting.

Conclusion

Despite the rhetoric, change in the healthcare system is occurring that will have dramatic impact on how SUD providers operate. MHPAEA and the ACA provide the new paradigm in which the SUD delivery system will define its own new features, functions, and contours. Together these and other system catalysts require systems thinking and understanding, systems planning, and decision-making, systems design, and system-wide action. In this report, we have explored critical catalysts, discussed important new organizations that will be key players in the evolving system, and made nine important recommendations. We have laid it out for you, now it is up to you find the collective will to take these steps in your State. Let the vision of what's possible motivate your efforts and see it for the tremendous opportunity that it is.

References

Backlund, A. (2000). The definition of system. *Kybernetes* Vol. 29 nr. 4, pp. 444–451.

Bergthold, L. (2010). Essential Benefits, *Health Affairs Blog*. http://healthaffairs.org/blog/2010/10/29/what-is-an-essential-benefit/ (accessed 9/25/11)

Buck, J.A. (2011). The Looming Expansion and Transformation of Public Substance Abuse Treatment under the Affordable Care Act, *Health Affairs*, 30, no.8:1402-1410

Coalition for Whole Health, *Recommendations on Coverage of Mental Health and Substance Use Disorder Services in the Essential Health Benefit Package*, http://alcoholreports.blogspot.com/2011/07/coalition-for-whole-health.html (accessed 9/25/11)

Centers for Medicare & Medicaid Services (CMS), *Medicaid Managed Care*, www.cms.gov/ (accessed 9/25/11)

Chu, D. (2011). *Complexity: Against Systems*. Theory in Biosciences, Springer Verlag.

Executive Office of the President of the United States. (2011). *National Drug Control Strategy*, p. 1 & 2, http://www.whitehouse.gov/ondcp/2011-national-drug-control-strategy (accessed 10/11/11)

Executive Office of the President of the United States. (2011). *National Drug Control Strategy*, Appendix One, http://www.whitehouse.gov/ondcp/2011-national-drug-control-strategy (accessed 10/11/11)

Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, D.C., and National Academies Press.

Institute of Medicine. (2011). *Essential Health Benefits – Balancing Coverage and Costs*. Perspectives on Essential Health Benefits: A Workshop Report Are available at http://www.iom.edu/EHB (accessed 10/11/11)

Kaiser Family Foundation, The Henry J. (2011). *Medicaid's New "Health Home" Option*. This publication (#8136) is available on the Kaiser Family Foundation's website at www.kff.org (accessed 10/11/11)

Patient Protection and Affordable Care Act. (2011). *Establishment of Exchanges and Qualified Health Plans,* Federal Register*,* Vol. 76, No. 136, Friday, July 15, 2011, Proposed Rules

Rocha, L.M. (1999). *Complex Systems Modeling: Using Metaphors From Nature in Simulation and Scientific Models*. *BITS: Computer and Communications News*. Computing, Information, and Communications Division. Los Alamos National Laboratory.

SAMHSA, Block Grants, http://www.samhsa.gov/grants/blockgrant/ (accessed 9/25/11)

SAMHSA, Eight Strategic Initiatives, http://www.samhsa.gov/about/strategy.aspx (accessed 9/25/11)

Sheedy, C. K., and Whitter, M., (2009). *Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research?* (DHHS Publication No. SMA 09-4439). Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Tollen, L., Enthoven, A., Crosson, F.J., Taylor, N., Audet, A.M., Schoen, C., and Ross, M. (June 2011). *Delivery System Reform Tracking: A Framework for Understanding Change,* The Commonwealth Fund, pub. 1510, Vol.10.

The White House, President Barack Obama, Health Reform in Action, *The Affordable Care Act,* http://www.whitehouse.gov/healthreform/healthcare-overview (accessed 10/11/11)

Appendix: Catalysts of Change

Today's Catalysts of Change

The basic challenge for the field is to find opportunities for growth within a rapidly changing environment. Some have compared this challenge to asking mechanics to fix a plane's engine while flying at twenty-thousand feet. In the following sections, we explore some of the most important catalysts impacting the environment for mental health and substance use disorder (MH/SUD) providers today. In order to participate successfully in the profound transformation taking place, providers must be oriented to the factors that are driving change along with cultivating an understanding of how regulators and policy makers are shaping the change process. To begin with, we look at the impact of recent healthcare legislation, including the MHPAEA, changes to Medicaid, and the ACA that have resulted in the creation of health insurance exchanges and other new entities. We then examine in greater detail *Essential Health Benefits* and what types of SUD services should be covered under new legislation as well as look at the impact that two organizations are having on how MH/SUD providers implement these changes. Lastly, overarching themes and concluding thoughts summarize what are the most important catalysts of change, their impact on the healthcare system, and how SUD providers can best prepare.

Mental Health Parity and Addiction Equity Act (MHPAEA)

One of the major catalysts of change is the MHPAEA of 2008. Under this federal law, most group health plans will now provide coverage for MH/SUDs comparable to the coverage they provide for all other medical conditions. Insurers are prevented from including additional barriers within the policy—such as financial requirements, treatment limitations, lifetime limits, or annual limits within the policy—for treatments of MH/SUDs if no such stipulations exist for other health conditions. MHPAEA applies to group health insurance policies and health maintenance organization (HMO) plans that cover 51 or more employees.

On February 2, 2010, interim final rules concerning the implementation of MHPAEA were published that provide explicit requirements for insurers. MHPAEA further solidifies and expands behavioral health coverage within health policies, thus normalizing the treatment of historically stigmatized disorders. Rather than practicing in a unique stand-alone system of financing where 80 percent of revenues are public dollars administered through categorical grants and contracts, substance abuse providers have become eligible for reimbursement by many public and private health insurance plans along with becoming eligible business and clinical partners within the broadening scope of a transforming healthcare system.

Medicaid

In concert with parity, Medicaid is expanding coverage for addiction disorders but will do so in a dramatic way in 2014 as the ACA is fully implemented. One of Medicaid's historical limits on the SUD provider community is the fact that it does not cover residential services in facilities with more than 16 residents because these are considered "institutions for mental disease,'' which are prohibited from being funded. Nonetheless, Medicaid is already one of the larger sources of

healthcare funding for SUDs, and Medicaid is growing rapidly as a result of the declining economy. Additionally, it is transforming from an indemnity insurance program into a managed care program.

Over 71 percent of Medicaid enrollees are now served by managed care organizations (MCOs), and this percent has increased in all but one year over the past two decades and is unlikely to abate soon (Centers for Medicare & Medicaid Services, 2011). Even as MCOs have become the managers of healthcare benefits to an ever-larger population, they and their Managed Behavioral Healthcare Organization (MBHO) intermediaries have impacted SUD providers. Their presence constrains the use of higher intensity services such as inpatient treatment and requires extensive administrative performance in delivery of lower intensity services (e.g., outpatient) that have low rates of reimbursement. This results in a substance abuse system of providers with low (if any) reserves, or concomitant opportunities for reinvestment. Still, coverage and usage is expected to grow significantly.

Affordable Care Act (ACA)

Further catalyzing change is the ACA, which became the law of the land in 2009. This law is dedicated to reforming healthcare and achieving the broad goals of improving access, increasing quality, and constraining costs that threaten to expand beyond 17 percent of the gross domestic product consumed today.

The ACA contains many important provisions and creates several new organizational entities. Among these entities are health insurance exchanges (HIEs), which will begin operations in all States in 2014. HIEs are organizations designed to create insurance marketplaces that will make it easier for low and moderate-income individuals to obtain public subsidies and to purchase private health insurance in a competitive, comparison shopping, web-based (online) environment. HIEs cover both individual and small group markets for insurance. *Exchanges* must provide evidence by 2013 that they will be ready to fully operate by 2014. If this does not occur, the Department of Health and Human Services (HHS) will step in to provide a federal *Exchange* (Federal Register, 2011).

HIEs will be responsible for ensuring that health plans offering policies sold by the Exchanges contain '*Essential Health Benefits*.' These benefits are typically defined as the types of services that would "typically" be covered through insurance plans or by employers. *Essential Health Benefits* are covered in Section 1302 of the ACA, but the law contains relatively little guidance about what "*essential*" really means, other than outlining the following broad categories of services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- MH/SUD services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services

- Preventive/wellness services and chronic disease management
- Pediatric services, including oral and vision care

Both the National Institute of Medicine and the Whole Health Coalition have addressed this issue, and in the next section we have summarized the Coalition's recommendations to HHS that these requirements be operationalized for the behavioral healthcare community. At the time of publication Federal regulations are unpublished. Given that "mental health and substance abuse services" are specifically mentioned, we expect they will be defined more fully within the regulations. Because HIEs are anticipated to make coverage available to 30+ million new individuals and small employer groups, the demand for substance use services will grow significantly.

There are two other important, new organizations that will influence change throughout the healthcare system. These organizations are being created in a response to one of the key assumptions of the ACA, which is 'care must be integrated and coordinated with primary care in a leadership position.' For those treating SUDs, this means coordinating with primary care providers and their practice organizations in particular. One of these new organizational entities is the Accountable Care Organization (ACO), also known as an Integrated Care or Coordinated Care Organization. The other organizational model that may be new for many SUD providers is the Patient-Centered Medical Home (PCMH). These organizations are expected to become part of a new, more person-centered and integrated healthcare system. This system will include care teams that coordinate treatment and ensure access to appropriate and necessary services, including treatment for SUDs.

Proposed federal regulations were recently published defining how ACOs will operate under Medicare, which are likely to shape the final form of how coordinated care organizations will operate. This in turn will determine, at least in part, how primary care organizations can reassume a central role and leadership position within the healthcare system, as well as how primary care will integrate with specialty care. Both 'PCMH' programs and 'Health Homes' are currently being piloted by the Center for Medicaid and Medicare Services (CMS) to help operationalize care coordination, thereby shaping future practices. Other new organizations that fit the PCMH model are community health centers (CHCs) and federally qualified health centers (FQHCs). Each will be important potential partners for SUD treatment organizations.

Policy makers can support agreed upon goals through well-thought out reimbursement policies with aligned incentives and by identifying appropriate measures to gauge the success of systemic changes.

Essential Health Benefits

The Coalition for Whole Health notes that the "ACA requires plans in the *Exchanges*, as well as Medicaid expansion plans, to cover a set of '*Essential Health Benefits*' that include MH/SUD services, including behavioral health treatment." By including MH/SUD as essential services, Congress recognizes that SUDs and mental illnesses are treatable health conditions, as accepted by the American Medical Association, other public health and medical standards, and decades of scientific research.

For an addiction and mental health system to be accessible, accountable, efficient, equitable, and of high quality, the Coalition for Whole Health believes the *Essential Health Benefits* package must include the following benefits:

Assessment. Individualized assessment tools must drive the quality of care. Targeted MH/SUD services must be included in a distinct treatment plan and the beneficiary must be involved in the treatment planning process. The Coalition for Whole Health supports provisions that require the use of standardized assessment tools under the ACA.

Patient Placement Criteria. Evidence-based patient placement criteria can help effectively place individuals into the optimal level of MH/SUD care for the amount of time deemed medically necessary. For example, the *Patient Placement Criteria for the Treatment of Substance-Related Disorders—Second Edition, Revised* (PPC-2R) of the American Society of Addiction Medicine (ASAM) is a widely used tool for decision making that takes into account both clinical and practical considerations of care.

Outpatient Treatment. Parity provisions of the ACA require that outpatient treatment services be provided as long as medically necessary with no limits on duration or frequency. Patients must be allowed to access treatment, to manage relapses, and to receive outpatient treatment services that should include evidence-based (e.g., individual, group, and family) therapies.

Intensive Outpatient Services. These should be time-limited treatment programs that offer therapeutically intensive, coordinated, and structured clinical services as a step down or alternative to inpatient acute services for both MH and SUD populations. These services stabilize acute crises and clinical conditions by utilizing recovery principles that help return individuals to less intensive outpatient, case management, peer support, and/or other recovery-based services. Coverage of these services is an integral part of most private MH/SUD benefit packages and should include: substance use intensive outpatient treatment, partial hospitalization, dual-diagnosis partial hospitalization, intensive outpatient services for persons with co-occurring MH/SUD conditions, and intensive case management.

Residential Services. Residential MH/SUD services are a key component of an optimally functioning service delivery continuum and help offset the costs associated with emergency department visits, hospital admissions, and readmissions. Placement in a residential or inpatient setting should be based on the individual needs of the patient. Patients should be regularly assessed to ensure they are at all times placed within the appropriate treatment setting for the appropriate duration and receive the appropriate level of care given their needs and severity of their illness. To the greatest extent possible, the use of uniform patient placement criteria should drive placement decisions.

Laboratory Services. These should include coverage for laboratory tests regardless of whether offered by MH/SUD specialists; general medical professionals (e.g., primary care providers); or persons in non-behavioral, non-primary care medical/surgical specialties (e.g., laboratory services, including drug testing).

Emergency Services. These should include the following:

1. Crisis services in MH/SUD and medical settings (e.g., 24-hour crisis stabilization, mobile crisis services) as well as those provided by peers;
2. 24/7 crisis services, including “warmlines” and “hotlines”; and
3. Hospital-based detoxification services.

Prescription Drugs. Medications that are approved for mental illness, alcohol, drug, and tobacco treatment, have been shown to be effective, and must be a covered *Essential Health Benefit*. All Food and Drug Administration (FDA) approved medications should be covered for SUDs and matched to the assessed individual’s clinical need and personal preference. The full continuum of FDA approved medications for MH/SUD must be covered and parity in access to medications prescribed for the treatment of MH/SUDs must be enforced. Coverage should be continued as long as medically necessary with no limits.

Rehabilitative and Habilitative Services and Devices.

Rehabilitative services that should be covered include:

1. Psychiatric rehabilitation services;
2. Behavioral management;
3. Comprehensive case management in physical health or MH/SUD settings (e.g., individualized service planning with periodic review to address changing needs, treatment matching, navigation between all needed services, etc.);
4. Assertive Community Treatment (ACT) Teams;
5. Peer provided telephonic and Internet-based recovery support services, including those delivered by recovery community centers;
6. Recovery supports, including those delivered by peer run mental health organizations; and
7. Skills development, including supported-employment services.

Habilitative services that should be covered include**:**

1. Personal care services;
2. Respite care services for caregivers;
3. Transportation to health services; and
4. Education and counseling on the use of interactive communication technology devices.

Case Management. Both medical and behavioral health authorities have identified case management as an effective service for improving health outcomes among people with chronic medical, mental health, and SUD conditions. Comprehensive case management secures access to and retention in services that promote compliance with recommended treatment protocols throughout an episode of care.

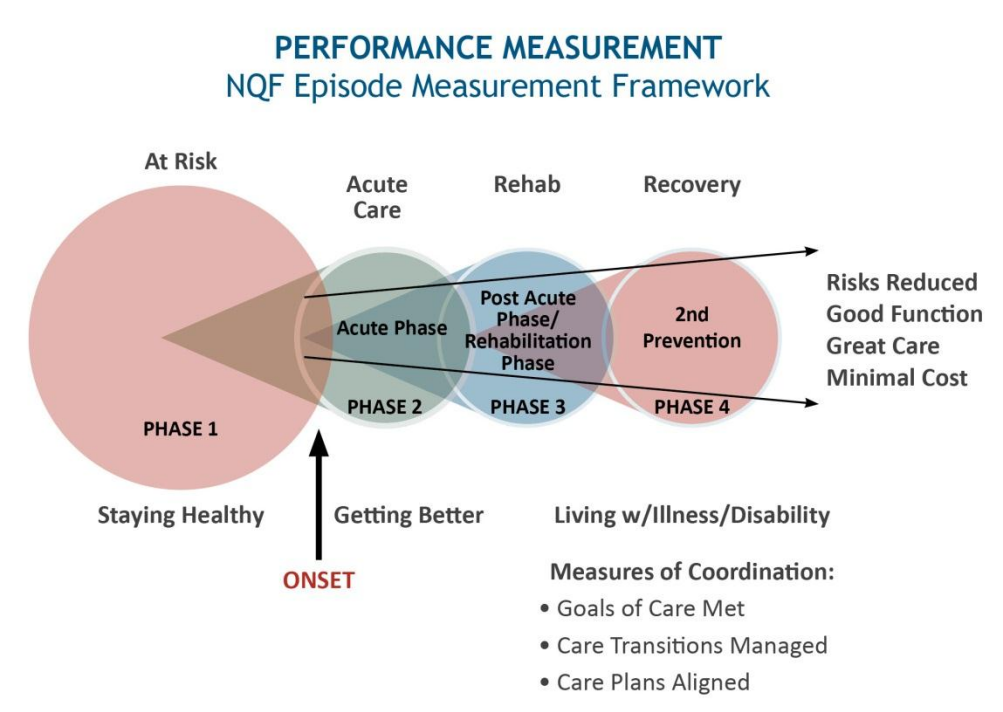
Recovery Supports. Twenty-three States provide Medicaid reimbursement for peer-delivered mental health and/or addiction recovery support services. Ongoing recovery supports for at least one year following an active phase of treatment have been shown to improve and sustain treatment and health outcomes for individuals with SUDs. Recovery support services should include:

1. Peer provided recovery support services for addiction and mental health conditions;
2. Recovery and wellness coaching;
3. Recovery community support center services;
4. Support services for self-directed care; and
5. Community support programs as well as other continuing care for MH/SUDs.

Preventive/Wellness Services and Chronic Disease Management. The ACA requires all group health plans and health insurance issuers that offer group or individual health insurance to include, without cost-sharing, a minimum level of preventive health services, including services that have a rating of A or B by the U. S. Preventive Services Task Force (USPSTF). Mandatory USPSTF recommendations include depression screening for adults and youth ages 12 to 18, alcohol screening and counseling, tobacco screening, and cessation interventions for adults. These and other preventive services (e.g., drug screening, counseling, etc.) are a critical component of prevention and should be included in the preventive and wellness services and chronic disease management as an *Essential Health Benefit*. Health promotion is also a significant part of comprehensive prevention and wellness plans that should be included in preventive and wellness services and chronic disease management.

Screening, Brief Intervention, and Referral to Treatment (SBIRT). This is a preventive intervention that has been shown to be very effective in hospitals, health clinics, and primary care settings in reducing MH/SUD prevalence and future emergency room visits. SBIRT targets people who are at-risk of developing SUD issues. Medical benefits must support and encourage SBIRT through full reimbursement in all primary care settings, including emergency rooms.

Coverage for Youth. While most services previously mentioned apply to youth, there are additional MH/SUD services that are only appropriate for youth and families. Specific attention should be paid to ensure the needs of transition-age youth are met. In addition, maternal and newborn services should be covered. Examples include pre-natal/peri-natal screening and interventions for maternal depression, SUDs, as well as referrals to treatment, health education, targeted case management, and maternal, infant, and early childhood home visiting programs. Pediatric services should include screening for substance use, suicide, and other mental health problems, early intervention services, service planning, caretaker coaching on children's social/emotional development and support, therapeutic mentoring, skill building, intensive home-based treatment, and targeted case management.



The National Quality Forum (NQF) uses the model of performance measurement shown in this diagram, which facilitates the evolution of on-target, well-coordinated systems of care.

Other Catalysts

At the federal level, Medicare and Medicaid are driving change due to their influence in financing; however, there are two other influential organizations at the apex of healthcare reform changes. The first is the Office of National Drug Control Policy (ONDCP), which is influential in shaping policies that influence funding for substance abuse treatment. The second is the Substance Abuse and Mental Health Services Administration (SAMSHA), which provides considerable funding for SUD prevention and treatment programs across the country. To gain a clearer picture of the magnitude of changes that are on the horizon, it is important to understand each organization's influence.

Office of National Drug Control Policy (ONDCP)

President Obama released the Administration's inaugural *National Drug Control Strategy* in May of 2010 based on the premise that drug use and its consequences pose a threat not just to public safety, but also to public health. The *2010 Strategy* represented the first comprehensive effort to rebalance federal drug control policy in nearly 40 years (Executive Office of the President, 2011). In the *2011 Strategy* the Obama Administration states, "The approach to the drug problem is borne out of the recognition that drug use is a major public health threat, and that drug addiction is a preventable and treatable disease. Overall, the economic impact of illicit drug use on American society totaled more than $193 billion in 2007, the most recent year for which data are available" (Executive Office of the President, 2011). Almost $32 billion in medical costs per year are due to illicit drug use, which is a burden that our communities, employers, and small businesses cannot afford to bear (Executive Office of the President, 2011, Appendix 1).

The *2011 Strategy* continues efforts to coordinate an unprecedented government-wide public health approach to reduce drug use and its negative consequences in the United States. Responding to this call to action and the issues of drug abuse, the ONDCP recognizes the importance of aligning and prioritizing all aspects within the broadest definition of the "system" as evidenced by the most recent National Drug Control Policy five-year plan (i.e., 2010-2015). This plan coincides with implementation of most of the healthcare reforms that have been discussed above. The *Strategy's* policy priorities include the following:

- Reduce Prescription Drug Abuse
- Address Drugged Driving
- Prevent Drug Use Before it Begins
- Focus on Special Populations (i.e., college/university students, women/families, military/veterans and their families, Native Americans and Alaskan Natives)

The 2011 *Strategy* articulated seven objectives that support overall goals and presented 106 specific action items, the implementation of which is necessary to achieve the *Strategy's* goals and the Administration's vision of a balanced approach to drug policy in the United States. The *Strategy's* two main goals and sub-measures that are impacting SUD providers include (Executive Office of the President, 2011):

ONDCP National Strategic Goals

GOAL 1: Curtail illicit drug consumption in America through the following:

- Decrease the 30-day prevalence of drug use among 12 to 17 year-olds by 15 percent;
- Decrease lifetime prevalence of 8th graders who have used drugs, alcohol, or tobacco by 15 percent;
- Decrease 30-day prevalence of drug use among young adults ages 18 to 25 by 10 percent; and
- Reduce the number of chronic drug users by 15 percent.

GOAL 2: Improve the public health and public safety of the American people by reducing the consequences of drug abuse through the following:

- Reduce drug-induced deaths by 15 percent;
- Reduce drug-related morbidity by 15 percent; and
- Reduce the prevalence of drugged driving by 10 percent.

In addition, the ONDCP's operating principles reflect many of the broader SUD prevention, treatment, and recovery principles. Several important, overlapping principles include:

- Early identification of SUDs saves lives and money;
- Addiction treatment must be an integrated, accessible part of mainstream healthcare;
- New data systems and analytical methods to address gaps should be developed and implemented;
- A national prevention system must be grounded at the community level;
- Prevention efforts must encompass the range of settings in which young people grow up;
- Criminal justice agencies and prevention agencies must collaborate;
- Preventing drugged driving must become a national priority on par with preventing drunk driving; and
- Curbing pharmaceutical abuse while preserving medical benefits of pharmaceuticals.

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA recognizes the powerful evolution that is taking place due as a result of the ACA and MHPAEA and is enhancing access to prevention, treatment, and recovery support services for persons with or at risk of MH/SUDs as well as enhancing access to behavioral health services for millions of Americans. In light of changing healthcare systems, laws, knowledge, and conditions in States, SAMSHA's Block Grants have made changes to help States prepare for 2014 when more people will be insured through Medicaid or third party insurance. These new laws will improve the nation's ability to close service gaps that have existed for decades for far too many individuals and their families. Overall, the nation's healthcare system is focusing more and more on quality and accountability; therefore, SAMHSA acknowledges the importance that providers must follow suit and begin to envision their future in terms of focused interventions and efforts that align well with efforts to implement and measure accountability.

How these changes impact SUD providers can be illustrated through proposed changes in the Medicaid program that will significantly affect how State Mental Health Authorities (SMHAs) and Single State Agencies (SSAs) use their limited resources. Case in point is that more than 39 percent of individuals with a serious mental illness (SMI) or a serious emotional disturbance as well as 60 percent of individuals with SUDs were poor and uninsured in 2009. Traditionally, their treatment and recovery support services were supported wholly or in part by SAMHSA Block Grant funds and State General Funds. With proposed changes to the system, a substantial proportion of this population (i.e., potentially as many as six million people) will gain health insurance coverage in 2014 and will have some but not all preventive, treatment, and support services covered by Medicaid or private insurance.

SAMHSA seeks to ensure that SMHAs and SSAs are prepared and ready to address the changing priorities and needs prompted by these reforms. Changes to the new Block Grant application allow for a diverse range of goals that each State has for health reform. While certain changes do not occur until 2014, State authorities need to consider critical questions such as the following:

1. What are the possible changes in what services they purchase?
2. What system improvements are necessary to operate in a new healthcare environment?
3. How will States prepare their providers to offer effective care?

Proposed changes to SAMSHA's fiscal year (FY) 2012/2013 Block Grants seek to get State behavioral healthcare systems ready for the impending changes. Under this new approach, States and territories will have the opportunity to use block grant dollars for prevention, treatment, recovery supports, and other services that supplement services covered by Medicaid, Medicare, and private insurance (SAMSHA, 2011). SAMHSA Block Grant funds will be directed toward four purposes that include:

1. Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
2. Fund priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and for treatment or services that demonstrate success in improving outcomes and/or supporting recovery;
3. Fund primary prevention (i.e., universal, selective, and indicated prevention activities) and services for persons not identified as needing treatment; and
4. Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services while planning the implementation of new services on a nationwide basis.

To achieve these purposes, SAMHSA plans to make adjustments in staff functions as well as technical assistance to support States through the many transitions of health reform. In addition, SAMHSA's Strategic Initiatives are changing in response to health reform. Eight new Strategic Initiatives are designed to improve delivery and financing of prevention, treatment, and recovery support services that advance and protect the nation's health and include (SAMSHA, 2011):

1. **Prevention of Substance Abuse and Mental Illness** — Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This initiative focuses especially on the nation's high risk youth, youth in tribal communities, and military families.
2. **Trauma and Justice** — Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems along with addressing the behavioral health needs of people involved or at risk of involvement in the criminal and juvenile justice systems.

3. **Military Families** — Supporting America's service men and women—active duty, national guard, reserve, and veterans—together with their families and communities by leading efforts to ensure needed behavioral health services that are accessible and with successful outcomes.
4. **Recovery Support** — Partnering with people in recovery from MH/SUDs to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce barriers to social inclusion.
5. **Health Reform** — Broadening health coverage to increase access to appropriate high quality care, and to reduce disparities that currently exist between the availability of services for substance abuse, mental health disorders, and other medical conditions.
6. **Health Information Technology** — Ensuring the behavioral health system, including States, community providers, peer and prevention specialists, fully participates with the general healthcare delivery system in the adoption of Health Information Technology (HIT) and interoperable Electronic Health Records (EHR).
7. **Data, Outcomes, and Quality** — Realizing an integrated data strategy that informs policy and measures program impact leading to improved quality of services and outcomes for individuals, families, and communities.
8. **Public Awareness and Support** — Increasing understanding of MH/SUDs to achieve the full potential of prevention, help people recognize MH/SUDs, seek assistance with the same urgency as any other health condition, and make recovery the expectation.

To achieve these goals, SAMHSA needs to use FY 2011, 2012, and 2013 to work with States to plan for and transition the Block Grants towards these four purposes and strategic priorities. This transition includes fully exercising SAMHSA's existing authority regarding States' use of Block Grant funds, and a shift in SAMHSA staff functions to support and provide technical assistance for States receiving Block Grant funds as they move through these changes. For instance, coordination between primary care and specialty care—including behavioral health—is a necessity.

Case in point is the following statistics:

> ***News and Numbers*, Agency for Healthcare Research and Quality (AHRQ)**
>
> Nearly 12 million visits made to U.S. hospital emergency departments in 2007 involved individuals with a mental disorder, substance abuse problem, or both (Bergthold, 2010). These visits account for one in eight of the 95 million visits to emergency departments by adults that year. Of these, two-thirds involved those with a mental health disorder, one quarter was for those with a substance abuse problem, and the rest involved those dealing with both a MH/SUDs. Overall, people with SMI have elevated rates of hypertension, diabetes, obesity, and cardiovascular disease, leading to morbidity and mortality disparities where those with SMI die on average at 53 years of age. These health conditions are exacerbated by unhealthy lifestyle practices such as lack of physical activity, poor nutrition, smoking, substance abuse, and side effects of necessary medication. Many of these health conditions are preventable through routine primary care screening, monitoring, treatment, and care management/coordination strategies.

Overarching Themes

Between the language-of-the-law and practice of healthcare delivery, there is a considerable gap, and the challenge lies in discerning the details of both. Multiple parties mediate between legislators, executives, and regulators that include different levels of government, payers entrusted with allocating resources, provider organizations delivering care, and ultimately the interaction between individual providers and healthcare consumers. Successful implementation of these new provisions require agreement on what must be changed within our existing system of care to achieve this broad vision while making the most efficient use of very limited resources to accomplish our aims. The pace of change is dizzying as the vision is expansive, resources are few, the current system's inertia is considerable, and deadlines are fixed and approaching rapidly.

Some of the common themes, requirements, and challenges identified by federal, State, and local programs focus on six broad areas that include the following:

Engage Consumers, Patients, and Families:

- Provide access to education and support.
- Provide access to call centers, Web resources, and other tools to facilitate entry to care.
- Develop health promotion and disease prevention messages and materials such as SAMHSA's key messages that include prevention works, people recover, behavioral health is essential to health, and treatment is effective.

Deliver Care within a Medical Care System Model:

- Develop a population health database that responds to and produces prevalence, incidence, and global health information.
- Promote clinical continuum, prevention treatment, rehabilitation, and recovery support.

- Promote use of evidence-based practices.
- Promote treatment of co-occurring disorders and implement best practices for chronic disease management.
- Promote care coordination and PCMHs.
- Promote quality assurance and quality improvement practices.

Improve Provider Capability to Administer Services within a Managed Health System:

- Promote operational sophistication, particularly information technology capability to undergird service processes and meaningful use of information.
- Promote efficiency in responding to MCO and MBHO administrative requirements such as utilization review, care management, provider profiling, and credentialing.
- Promote organizational strategies for developing more robust provider business models, including the formation of specialized provider networks.
- Promote improvements to common administrative practices such as billing.

Build Systems of Care in a Multi-System Environment:

- Explore issues of integration and consolidation as a larger business trend to achieve efficiency and enable reinvestment among provider types and organizations.
- Ensure integration of MH/SUD care delivery within CHCs, CMHCs, and ACOs.
- Facilitate business models that enable collaboration, including mergers and acquisition, and make sure these are not restricted by organizational auspice (e.g., public, private, or non-profit).
- Incorporate more comprehensive delivery capabilities such as pharmacy services.
- Serve diverse populations such as veterans, military families (i.e., TriCare), or individuals involved in corrections/justice systems.
- Ensure and maintain connectedness with related community systems and issues of housing, employment, and education.

Accommodate Payment Models and Shape Financing:

- Recalibrate fee-for-service (FFS) payment methods by instituting pay-for-performance, creating episode-based payments, and adopting global payments.
- Provide education on pay-for-performance such as provider profiling and performance monitoring.

Develop the Workforce through Training and Technical Assistance:

- Promote scope of practice, licensing, etc.
- Develop multi-year training and technical assistance plans to address the five sections above.
- Develop enhanced recruitment and retention capabilities.

Recovery-Oriented Systems

In considering system redesign themes, it is vital not to lose sight of what works well today. The adage “if it isn’t broken, don’t fix it” is very appropriate to our situation. For instance, SAAS believes it is essential that a SUD system design effort leverage existing core elements of recovery-oriented systems of care. This body of knowledge has evolved over decades to encompass mission-critical factors upon which successful implementation, positive recovery

outcomes, and notions of value depend. SAAS strongly recommends providers and States avail themselves of the following elements in the assessment and planning of their local system design:

- Integration (i.e., mental health, primary care)
- Capacity (i.e., entry, accessibility, availability, choice)
- Consumer Involvement
- Cultural Relevance and Competence
- Quality Monitoring
- Patient Satisfaction
- Care Monitoring/Tracking
- Clinical Outcomes
- Cost-Effectiveness
- Technology Infrastructure
- Advocacy Needs
- Training Needs
- Workforce (i.e., capacity, education, scope of practice)
- Funding
- Governance and Leadership
- Management and Operations

Concluding Thoughts on Catalysts of Change

The recent laws, regulations, and agencies discussed in this report are the most important catalysts of change impacting SUDs providers. In addition, reforms demand much in the way of adaptation and innovation from the provider community if it is to transition successfully and thrive in the coming years and decades. Important aspects of that adaptation include consensus regarding how reforms will impact the current system; State-specific innovations to address these impacts; and business-savvy responses from the provider community. There are inherent challenges related to organizing services, developing reasonable reimbursement models, measuring accountability, as well as overcoming the barriers that have historically existed between healthcare, SUD providers, and the broader healthcare delivery system, particularly general hospitals, specialists, and primary medical care providers—all of whom can and should become strong partners for our field.

In a recent article, Jeffrey Buck (2011) comments on the profound effects these changes are going to have on substance abuse treatment services stating, "Overall, requirements for expanded substance abuse coverage, along with the expansion of Medicaid eligibility, will greatly increase public support of substance abuse treatment services. However, these and other changes also will have profound effects on the character of substance abuse treatment in America, affecting the relative importance of funding sources, the numbers and types of substance abuse treatment providers, their workforce, and the kinds of services they offer. Also affected will be the size and nature of substance abuse treatment services in the Medicaid program and the role and orientation of State substance abuse agencies."

Together, the ACA (and other recent healthcare reforms) coupled with declines in State general revenue spending is changing how substance abuse services are provided. Buck specifies several features that characterize the current direction of the national healthcare policy that include: 1) near-universal coverage, 2) systems of payment and administration characteristic of health plans, 3) integrated models of care centered in primary care settings, and 4) expanded use of health information technology. What makes these features important is that they are antithetical to the common practices of publicly funded specialty substance abuse providers, specifically:

- Providers now primarily rely on funding sources other than Medicaid, Medicare, or private insurance.
- Services are seldom integrated with other behavioral or general health service systems.
- Providers make limited use of information technology, even for administrative and billing purposes.

Buck proposes that “as a consequence, changes now under way will result in a different system of substance abuse treatment over the next ten years. These changes will be driven chiefly by the consequences of the expected relative increase in Medicaid’s funding of these services at parity. Changes will also reflect the greater participation of non-specialty providers, particularly health centers, in the substance abuse service system.” Buck says these changes can be summarized as:

- Consolidation
- Medicalization
- Integration
- Deinstitutionalization

Whether one agrees with every purported trend or not, SAAS recommends actions and reactions that are both deliberate and strategic. In order to make the most of the opportunities made possible by sweeping changes, we need to cultivate a shared understanding, develop or acquire new skill sets, make full use of evidence-based practices, implement cutting-edge technology, and form dynamic partnerships.