

**Detoxification and Substance Abuse Treatment**

**A Treatment Improvement Protocol**

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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Substance Abuse and Mental Health Services Administration

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# Preparing and Developing a Program

Developing a detoxification program is a major financial challenge, whether the program requires building an entirely new organization or is part of an existing treatment entity. The process of program development requires careful planning, especially to ensure adequate

financial support for the operation. The decision to develop a detoxifi­ cation program should be based on a well-developed strategic plan­ ning process (see chapter 2) and a clear understanding of what a detoxification program entails. Because the new program will incur major costs for office space, furniture, staff, computers, and other equipment before clients can be provided with services and payment can be received, significant amounts of initial capital may be needed.

As soon as the administrator or planner identifies a market need for detoxification services, potential fiscal support and other resources should be identified and checked to see if such support is likely and sufficient. Both implementation and initial operating costs must be covered. It may be possible to find strategic partners who will provide resources, work with the program planner, provide office space, or help obtain funding. Community organizations that see a need for establishing detoxification and treatment services are likely partners. Locally based foundations and businesses also may be approached for assistance with developing a program, especially if a case can be made to the potential funder that ongoing costs can be covered from opera­ tions.

It is important to have documented assurance from major referral and payment sources that they will refer patients with information on payment sources; that is, by the referral source, by a third party, or

by patients who have the documented finan­ cial resources to pay for detoxification treat­ ment themselves. Signed contracts with expected payors may be useful to ensure ade­ quate cash flow and to establish a budget for the new program's fee structure.

Identifying and recruiting strategic partners is one of the most important steps in the pro­ gram development process. Before and during the program development process, adminis­ trators and planners should work closely with potential referral and payment sources to determine their needs and to see if the detoxi­ fication program will fit those needs.

Programs also will need to learn whether referral sources are open to new partners, the types of contracts they utilize, their time­ frames for reimbursement, and the process for negotiating a contract. Among useful tac­ tics to employ is holding focus groups and strategy meetings with individuals from potential referral sources; these groups can suggest the types of services they need and for which they will reimburse. Potential referral sources will be more invested in the program if they are involved throughout the planning process. All potential stakeholders should be informed regularly of the developing plans and milestones achieved.

Program planners should follow up on all potential leads for both funding sources and potential referral sources. Relationships with referral sources are important to build and maintain. Obviously, referral sources need to be carefully assessed to ensure that they can provide patients who have needs and resources appropriate for the services the program will provide. Leads for potential sources of funding and referrals may include the contacts made during a focus group pro­ cess, public system payors and planners, pri­ vate insurance plans, contracting agents for private insurance (e.g., managed care organi­ zations [MCOs]), and local employers large enough to have employee assistance programs (EAPs) or managed behavioral health plans that cover detoxification services. Direct con­ tact with the EAPs or managed behavioral

health plans may be necessary to ensure both private sector demand for services and appropriate reimbursement of the services.

Forming strategic alliances with other compo­ nents of the treatment environment can be both an important source for referrals and a resource for clients with needs other than detoxification. Vertical alliances facilitate referrals up and down the continuum of care. An alliance with a larger organization can increase leverage when negotiating with an MCO.

## The Dramatically Changing Pattern of Utilization of Detoxification Services

The settings for detoxification services have changed dramatically over the last decade, as have patients' primary substances of abuse. As the setting for detoxification services has shift­ ed from inpatient to outpatient, the primary substance abuse problem of clients has shifted from alcohol and cocaine/crack to heroin and other opioids. This shift has created significant opportunities in the market for detoxification services for community-based and entrepreneurial providers that are not part of hospitals, or for freestanding detoxification facilities that are owned by hospitals.

Changes in practice patterns and in the epi­ demiology of substance abuse in the last decade have been dramatic. Between 1993 and 2000, the number of admissions to hospi­ tal inpatient settings for detoxification of patients with a primary problem of alcohol abuse declined by 79.6 percent. During the same period, the total admissions to inpatient hospital detoxification services declined by

69.3 percent, from 23.5 percent of total detoxification admissions **in** 1993 to 8.8 per­ cent of total detoxification admissions in 2000, while admissions to 24-hour free-stand­ ing detoxification units increased by the same

14. 7 percentage points, from 60.5 percent of total admissions in 1993 to 75.1 percent of total admissions for detoxification services **in**

2000. During this same period, the number of alcohol admissions to free-standing clinics decreased by 32.0 percent and the number of cocaine/crack admissions decreased by 42.5 percent. Concurrently, heroin admissions (to free-standing clinics) increased substantially from just under a quarter of total detoxifica­ tion admissions in 1993 to just over a third of total admissions in 2000.

Of course, these statistics reflect national trends and regional differences in patterns of both practice and substance abuse. Changes in specific geographic areas will vary.

Prospective programs should carefully research their own local market for detoxifi­ cation services and should obtain data on current utilization of and demand for detoxi­ fication in their local area before proceeding with program development.

## Funding Streams and Other Resources in the Substance Abuse Treatment Environment

Substance abuse treatment and detoxification services in the United States are financed through a diverse mix of public and private sources, with substantially more being spent by the public sector. Public sources account for 64 percent of all substance abuse treat­ ment spending, a much higher percentage than public expenditure for the rest of health care (Coffey et al. 2001). The existence of diverse funding streams presents both man­ agement challenges and opportunities for pro­ gram independence and stability. However, a program with only one major funding source is financially and clinically vulnerable to changes in its major source's budget and pri­ orities, and this situation should be avoided. Diversification of funding sources should be a major goal for detoxification programs.

Usually, each funding stream has different approval and reporting requirements.

Because of this, any new or existing detoxifi­ cation program requires a fairly sophisticated management and accounting system to meet

the reporting needs and performance require­ ments of each purchaser, to provide informa­ tion that meets their requirements, and to generate the appropriate bills/invoices.

Detoxification program administrators must be knowledgeable about efficient business practices, the use of data-based performance measures, accounting, budgeting, financing, and financial and clinical reporting.

It also is important to reach out to other potential sources of support such as founda­ tions, board mem-

bers, and local or national corporate donation programs for any assistance that will help to reduce costs, increase revenue, or improve productivity and effectiveness

Identifying and recruiting strategic partners is one of the most important steps in the program development process.

and aid in the suc- cess of the organiza­ tion. Searching for support does not end with ensuring initial funding. Planners must make good use of the Internet to uncover potential cash and in-kind donations that can

supplement major funding sources, discussed below.

Entrepreneurial, for-profit programs may be able to attract private capital. Not-for-profit entities that are similarly entrepreneurial may be able to take advantage of this poten­ tial source of funding through establishment of a for-profit subsidiary. Detoxification pro­ grams in particular, as opposed to some other areas of substance abuse treatment, may be attractive candidates for private financing because of their potential to serve privately insured and self-pay patients. However, acceptance of private capital usually carries with it requirements for rapid growth in rev-

enues and profitability that may be difficult to meet and may limit operational flexibility, at least in the short term. In the longer term, successful detoxification programs may be able to generate profits.

Funding streams associated **with** public and private health insurance often provide bene­ fits to covered individuals that vary according to whether or not the services are facility-

based and accord­ ing to the level or setting of care.

The Substance Abuse Prevention and Treatment Block Grant program is the cornerstone of Federal funding for substance abuse treatment and detoxification programs.

Complexity arises because coverage and reimbursement depend both on whether a service is considered to be a medical service or a substance abuse treatment service and whether a ser­ vice is facility based.

Many public and private benefit plans still classify substance abuse detoxification as a medical rather than a substance abuse treatment service. In general, and especially for employer-based

coverage, benefits under a medical plan are provided at higher reimbursement rates with fewer limits and restrictions than are benefits for substance abuse treatment (Merrick et al. 2001). Requirements for out-of-pocket pay­ ments by those covered under these plans typically are lower under the medical portion of a plan than under the substance abuse treatment portion. However, it is important to note that benefit plan features are **but** one component of coverage; utilization manage­ ment procedures continue to play a very important role in a patient's access to specific

services. Any episode of detoxification may be denied reimbursement under a plan if medi­ cal necessity is not demonstrated to the satis­ faction of the plan or if the service is provid­ ed at a higher level of care than is judged medically necessary.

It is important to decide whether to make a new detoxification program hospital-based, facility-based, or office-based. Services that are considered hospital- or facility-based, like those in hospital outpatient departments, often are eligible for higher payment rates **than** office-based services to reflect their greater capital and other overhead costs.

Similarly, hospital inpatient services often are reimbursed at a higher payment rate than outpatient services, but medical necessity determinations also require patients to need more intensive services. Sometimes, patient copayments or coinsurance rates may be higher for office-based services than facility­ based services. This is true for Medicare as well as for other health insurance plans.

Detoxification programs that are parts of hos­ pitals, affiliated with a hospital, or consid­ ered as a licensed facility themselves may be eligible for higher rates of reimbursement than are those that are considered to be out­ patient programs with no facility license.

However, utilization management criteria to authorize payment for admission to and con­ tinued stay in a hospital inpatient setting require a significantly greater severity of patient diagnosis than do criteria for admis­ sion and continued stay in a freestanding or outpatient program. On the other hand, often there are high barriers to obtaining a facility license to open a freestanding 24-hour facility or licensed outpatient detoxification facility. Programs that are part of or affiliated with hospitals also must contend with overhead cost allocations from the hospital as well as with oversight from hospital administrators who may know little about substance abuse treatment or detoxification. In addition, some health insurance plans actually exclude cov­ erage for hospital-based or freestanding facil­ ity-based detoxification programs and others may subject admissions to such programs to

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more intensive review than admissions to non-facility-based detoxification programs. Program planners should consider carefully all alternatives; decisions concerning affilia­ tion with a hospital or pursuit of a facility

license have far-reaching financial and politi­ cal ramifications and should be made with as much information as possible.

Following is a discussion of the key funding streams and resources that are available for programs providing detoxification services.

### *SAPT Block Grant*

The Substance Abuse Prevention and Treatment (SAPT) Block Grant program is the cornerstone of Federal funding for sub­ stance abuse treatment and detoxification programs. These funds are sent to the State's Single State Agency (SSA) for substance abuse for distribution to counties, municipali­ ties, and designated programs. Some of the funds are subject to required set-asides for special populations. Each program should check to see if the clients it intends to serve are eligible for block grant funding, either for set-asides or for other funds. Each State maintains its own criteria for eligibility and the criteria and definitions vary greatly among States. Multistate providers will need to check specifically in each State in which they operate.

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides funding for substance abuse treatment and prevention through the block grants as well as a large variety of other mechanisms, includ­ ing both discretionary grants and contracts. A portion of the SAMHSA Web site is devoted to various funding opportunities.

The most recent available data indicate that the SAPT Block Grant accounts for approxi­ mately 40 percent of public funds nationally expended for prevention and treatment of substance abuse (U.S. Department of Health and Human Services 2003). Funds from the block grant may come directly from the SSA or be channeled through regional or county

intermediary agencies. Services may be paid for through grants, contracts, fee-for-service, and/or managed care arrangements. The Children's Health Act of 2000 mandated a gradual transition from SAPT Block Grants to Performance Partnership Grants (PPGs). Providers should follow developments through their SSA, which include

* **Changes in reimbursement.** Treatment purchasing systems may evolve over time; managed care arrangements and require­ ments are increasingly common.
* **Perforn1ance outcmne data.** In accordance with Federal legislation, PPGs eventually will replace SAPT Block Grants and will provide more flexibility for States as well as require more accountability based on out­ come and other performance data. Substance Abuse and Mental Health Services Administration (SAMHSA) and the States are establishing performance out­ come measures for funding programs under the block grants. All data for core measures are collected from States receiving PPG dollars.

***Medicaid***

Medicaid, administered by the Centers for Medicare and Medicaid Services (CMS) in conjunction with the States, provides finan­ cial assistance to States to pay for medical care of specifically defined eligible persons. Medicaid is being used by many States as a vehicle for experimentation with public sector managed care in an effort to expand medical coverage to the uninsured. About 2 percent of total Medicaid expenditures nationally are for substance abuse treatment services (Mark et al. 2003a) but Medicaid supports about 20 percent of national expenditures for sub­ stance abuse services (Coffey et al. 2001). The level of expenditure varies greatly by State.

Medicaid is an entitlement program with sev­ eral distinct eligible groups: low-income chil­ dren, pregnant women, the elderly, and peo­ ple who are blind or disabled, all or some of whom can be enrolled in a detoxification pro­ gram population. Some substance abuse treatment programs will want to target pro-

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grams to the Medicaid population; if the State's coverage and payment rates are mini­ mal, however, other funders should be explored in greater depth.

The reason for substantial variation in State Medicaid expenditures and coverage is that substance abuse treatment and rehabilitation is an optional benefit under Medicaid that States have the discretion to include or not include in their Medicaid program. Medicaid may pay for substance abuse treatment either directly through fee-for-service arrangements or through a managed behavioral health care or other MCO with which it contracts. More than one type of arrangement may exist with­ in the same State. Rates of payment/reim­ bursement are determined by each State inde­ pendently and may vary within the State among the various coverage arrangements. If a State decides to include benefits for sub­ stance abuse treatment in its Medicaid pro­ gram, it can choose the precise services and levels of care that will be reimbursed. The services provided under managed care may differ from those under fee-for-service arrangements. Although most States offer some coverage for detoxification services under their Medicaid program (Office of the Inspector General 1998), not all types or set­ tings for detoxification programs are covered in those States that do provide coverage.

Therefore, a State Medicaid program may cover certain substance abuse treatment ser­ vices but not cover detoxification services.

For more information, readers should contact their State Medicaid office.

An important distinction of the Medicaid ben­ efit structure since its inception has been the exclusion of coverage for services provided in an Institute for Mental Disorders (IMD), defined as a facility with more than 16 beds that treats mental disorders, including sub­ stance abuse, for individuals between the ages of 21 and 64 (Rosenbaum et al. 2002).

Although services furnished by outpatient detoxification programs are not excluded, detoxification programs should be aware of

the IMD exclusion in their program planning process.

The Medicaid Early Periodic Screening Detection and Treatment (EPSDT) mandate requires States to screen all children and ado­ lescents on Medicaid for physical and behav­ ioral health disorders. Further, EPSDT requires that any needed medical treatment is provided to children, even if the service is not in the State's Medicaid plan submitted to CMS. Although the procedures and screening tools vary by State, and there is significant variation in their identification of substance abuse issues, the EPSDT program is an important entrance to substance abuse treat­ ment for children and adolescents (Semansky et al. 2003).

When available, Medicaid coverage offers the following advantages:

* It can provide significant treatment funding for certain high-risk groups, such as low­ income mothers and adolescents.
* Client copays traditionally have not been required so the program receives the entire negotiated fee without having to collect funds from clients. (However, some States have changed this provision due to budget crises.)
* A Medicaid contract can provide a useful lower limit for rate negotiations with com­ mercial payors by essentially prohibiting acceptance of contract terms with any other purchaser at rates lower than those estab­ lished for Medicaid.
* Certification as a Medicaid provider also can position the program to receive patients from other public sector referral sources, making it possible to obtain patients from sources such as social services, indigent care funds, and criminal justice systems.
* The criminal justice and juvenile justice sys­ tems and drug court administrators typically favor providers that are eligible for Medicaid reimbursement because treatment of some offenders can then be billed to Medicaid in some States.

### *Medicaid link* to *Supplemental Security* Income

Supplemental Security Income (SSI) is a pro­ gram financed through general tax revenues. SSI recipients are one of the mandated popu­ lations for Medicaid, but specific provisions vary by State. SSI disability benefits are payable to adults or children who are blind or have certain other disabilities that make it impossible for them to work, who have limit­ ed income and resources, who meet the living arrangement requirements, *and* who are oth­ erwise eligible. Congress has excluded a pri­ mary diagnosis of substance abuse as a quali­ fying disability under the Social Security Administration's programs, but if there is another primary disability that qualifies the person for SSI, a secondary substance abuse diagnosis remains acceptable. Many SSI recipients with a mental disorder diagnosis have a co-occurring substance abuse diagnosis.

### *Medicare*

Medicare provides coverage to individuals over age 65, people under the age of 65 with certified disabilities, and people with end­ stage renal disease. Medicare supports about 8 percent of national expenditures for sub­ stance abuse treatment services. Medicare may provide Part A coverage to clients in detoxification programs that are based in hos­ pitals certified by Medicare. However, detoxi­ fication programs that provide only a struc­ tured environment, socialization, and/or vocational rehabilitation are not covered by Medicare. Medicare imposes very strict

review requirements for detoxification pro­ grams based in hospitals and detoxification programs that are considered to be partial hospitalization programs, and for patients in those detoxification programs. Alternatively, Medicare may provide Part B coverage to clients in detoxification programs with

Medicare-certified medical practitioners; however, clients whose services are reim­ bursed under Part Bare required to pay 50 percent of Medicare-approved amounts. For more information, contact the Social Security Administration, Medicare provider enrollment department, or State Medicare services.

### *Medicare link* to *Social* Security Disability Insurance

The Social Security Administration provides Social Security Disability Insurance (SSDI) to individuals and cer-

Medicaid supports about 20 percent and Medicare supports about

8 percent of national

expenditures for substance abuse treatment services.

tain members of their family if they have worked long enough and paid Social Security taxes. Recipients of SSDI benefits are covered by Medicare following a 2-year waiting period. SSDI is a program financed with Social Security taxes paid by workers, employ­ ers, and self­ employed persons.

In order to be eligi­ ble for a Social Security benefit, the worker must earn sufficient credits based on taxable work. Disability benefits are payable

to disabled workers, disabled widow(er)s, or adults disabled since childhood, who are oth­ erwise eligible. A substance abuse diagnosis was excluded by Congress as a qualifying dis­ ability for SSDI, **but** a secondary substance abuse diagnosis is acceptable if the person is qualified by another primary diagnosis, such as mental illness, which often co-occurs.

### *State Children's Health* Insurance Program

The State Children's Health Insurance Program (SCHIP) provides funds for sub­ stance abuse treatment of children and ado­ lescents in many States. This program pro­ vides low-cost health insurance for children

of low-income fami­ lies who are not eli­ gible for Medicaid. States have the option of providing SCHIP benefits under their existing Medicaid program or designing a sepa­ rate children's health insurance program entirely separate from Medicaid. If the program is part of Medicaid, then the substance abuse benefits will mirror those under Medicaid. If the State designs its own program, CMS has promulgated a set of rules to

Substance abuse treatment and detoxification services in the United States are funded through a diverse mix of public and private sources.

ensure that coverage meets minimum stan­ dards. A State's Alcohol and Drug Abuse Agency also may be able to provide informa­ tion on resources available for treatment of transition-age youth who have exceeded the maximum age for the SCHIP program in the State. For more information see the State SCHIP program office.

### *TR/CARE*

TRICARE is a regionally managed health care program for active duty and retired members of the uniformed services and their families and survivors. TRICARE supple­ ments the healthcare resources of the Army,

Navy, and Air Force with networks of civilian healthcare professionals. TRICARE consists of TRI CARE Prime, where Military Treatment Facilities are the principal source of health care; TRICARE Extra, a preferred provider option; and TRICARE Standard, a fee-for-service option that replaced the pro­ gram formerly known as CHAMPUS. The TRICARE Extra and Standard benefits include treatment for substance abuse, sub­ ject to preauthorization requirements, but programs will need to check to see if detoxifi­ cation programs are eligible or preauthorized under TRICARE managed care arrange­ ments. TRICARE is run by managed care contractors, each of whom may have different authorization procedures.

### *Indian Health Service*

The Indian Health Service (IHS) is an agency within the Department of Health and Human Services that operates a comprehensive health service delivery system for approximately 1.6 million of the Nation's estimated 2.6 million American Indians and Alaska Natives. Most IHS funds are appropriated for American Indians who live on or near reservations.

Congress also has authorized programs that provide some access to care for Indians who live in urban areas. IHS services are provid­ ed directly and through tribally contracted and operated health programs. Health ser­ vices also include health care purchased from more than 9,000 private providers annually. The IHS behavioral health program supports alcoholism and other drug dependency treat­ ment, detoxification, rehabilitation, and pre­ vention services for individuals and their families.

### *Department of Veterans* Affairs

The Department of Veterans Affairs provides the Civilian Health and Medical Program of the Veterans Administration to eligible beneficia-

ries. Medically necessary treatment of sub­ stance abuse is a covered benefit; beneficiaries are entitled to three substance use disorder treatment benefit periods in their lifetimes.

### *Social Services*

Funding for substance abuse treatment, which may include detoxification services, also may be available through arrangements with agencies funded by the U.S. Depart­ ments of Labor, Housing and Urban Development (HUD), and Education (ED). Some Federal sources of funding for sub­ stance abuse treatment under these programs may prohibit use of funds for "medical" ser­ vices. However, services performed by those not in the medical profession (e.g., coun­ selors, technicians, social workers, psycholo­ gists) and services not provided in a hospital or clinic (including 24-hour care programs) may be considered nonmedical. The precise definition of "medical" under some of these Federal programs may be determined by each State individually, so administrators need to check with their State authorities to deter­ mine exactly which services may be funded through these sources. Even if funding for detoxification services is not available through these programs, programs may be able to link their clients to them for support for services that enable them to initiate and complete treatment successfully. Oppor­ tunities include the following:

* + **Temporary** Assistance **to Needy Families (TANF).** Under the TANF programs, each State receives a Federal block grant to fund treatment for eligible unemployed persons and their children, usually women with dependent children. Services that overcome barriers to employment (e.g., substance abuse treatment) are eligible for formula grants-with onequarter of the money allo­ cated to local communities through a com­ petitive grant process. The funding chan­ nels vary by State. Funds may be directed through Private Industry Councils,

Workforce Investment Boards, Workforce Development Boards, and similar bodies at the State and community levels. Although States may not use TANF funds for "medi­ cal" services, States have considerable lati­ tude in the definition of "medical," and have used TANF funds to support the fol­ lowing substance abuse treatment services: screening/assessment, detoxification, outpa­ tient treatment, non-hospital residential treatment, case management, education/ prevention, housing, employment services, and monitoring (Rubinstein 2002). Even if these funds are not available for substance abuse treatment in a State or program, the program's clients may be able to access this source of assistance for employment train­ ing, child care, and other support needs.

* Social Services Block Grant. Under Title XX of the Social Security Act, the Administration for Children and Families provides a block grant to each State for the purpose of furnishing social services. Funds may not be used for medical services (except initial detoxification of an individu­ al who is alcohol or drug dependent). In 2002, these funds provided close to $8 **mil­** lion for substance abuse treatment in 14 States (Administration for Children and Families 2002).
* **Public housing.** HUD funds substance abuse treatment of public housing residents under the Public Housing Drug Elimination Program. HUD awards grants to public housing authorities, tribes, or tribally desig­ nated housing entities to fund treatment. Funds are channeled to local public housing authorities, which contract with service providers. In addition, special housing pro­ grams are available for people who are home­ less and have substance use disorders.
* **Vocational rehabilitation.** Federal ED funds support services that help people with disabilities participate in the workforce. Treatment of substance use disorders is eli­ gible for funding. Funds are channeled to

the State agencies responsible for vocational rehabilitation.

* + **Children's protective services.** Title IV of the Social Security Act provides funding for foster care and services to prevent child abuse and neglect. Eligible services include substance abuse treatment for parents who are ordered by a court to obtain treatment and are at risk for losing custody of their children. Medicaid also covers these chil­ dren, as they are a mandatory eligibility group.
  + **Ryan White.** The Federal Ryan White CARE Act, enacted in 1990, provides health care for people with HIV disease. Under Title I of the Ryan White CARE Act, which provides emergency assistance to Eligible Metropolitan Areas that are most severely affected by the HIV/AIDS epidem­ ic, funds are available for substance abuse treatment. Over 500,000 people are served through this program each year.

### *Criminal justice/juvenile* justice (CJIJJ) systems

Both State and local CJ/JJ systems purchase substance abuse treatment services. The man­ ner in which these systems work varies across locales. The following are common components of these systems:

* + **State corrections syste111s** may provide funds for treatment of offenders who are returning to the community, through parole offices, halfway houses, or residential cor­ rectional facilities.
  + **Connum1ity corrections systen1s** may include a system of presentence diversion or parole services, including drug court, that may mandate substance abuse treatment in lieu of incarceration.
  + **Connumrity drug courts** may send low-risk, nonviolent offenders to substance abuse treatment in lieu of incarceration-pro­ grams can be under contract to provide this treatment.
* **Correctional residential facilities** serve offenders returning from a State correction­ al system; the programs may extend con­ tracts for substance abuse treatment to pre­ vent relapse of treated offenders.
* **Juvenile court** systems may provide con­ tracts to programs with expertise in treating adolescents to treat juvenile offenders in correctional facilities or who are otherwise involved in the criminal justice system.

Providers should understand the culture, val­ ues, and needs of the CJ/JJ system so they can develop responsive services for this spe­ cial needs population. For more information, see TIP 21, *Combining Alcohol and Otlier Drug Abuse Treatment With Diversion for Juveniles in the Justice System* (CSAT

1995b), TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT 1998b), and **TIP** 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT 2005b).

### *Byrne Formula Grant* Program

The Byrne Formula Grant Program awards grants to States to improve the functioning of the criminal justice system. Grants may be used to provide rehabilitation of offend­ ers who violate State and local laws. One of the 26 Byrne Formula Grant purpose areas is providing programs that identify and meet the treatment needs of adult and juve­ nile offenders who are drug and alcohol dependent. However, the availability of Byrne Formula Grant funds depends on annual Congressional appropriations and declines have been proposed for funding in recent years.

### *County and local* governments

County and local governments often contract for the delivery of substance abuse treatment services using locally available funds. The annual availability of these funds depends in part on State fiscal conditions.

### *Schools*

Local public schools may be a source of fund­ ing for assessments; however, they rarely pay for ongoing treatment. Some services may be reimbursable under the special entitlements for children with disabilities.

### *Private Payors*

Private sources of revenue include a range of entities from large MCOs to local or self­ insured national employers. Most health plans offered by large employers operate under managed care arrangements.

Sometimes, a health plan may cover some substance abuse treatments under the mental health benefit portion of their plan; others may provide coverage through the medical component. In many cases, substance abuse treatment benefits, when offered, are provid­ ed through Managed Behavioral Healthcare Organizations (MBHOs) (see "Working In Today's Managed Care Environment," p.

157, for a more detailed discussion of man­ aged care arrangements). Because substance abuse coverage is a minor cost to employers, accounting for about 0.4 percent of the cost of health insurance overall (Schoenbaum et al. 1998), it may be difficult to get employers' attention, despite the high profile that sub­ stance abuse problems sometimes present. In general, three broad categories of private funding may be distinguished:

* + Contracts with health plans, MCOs, and MBHOs.
  + Direct service contracts with local employers. Local employers may contract directly with substance abuse services providers if the hen-

efits offered by their health plans are inade­ quate.

* Contracts with EAPs. Some employers have EAPs that can provide direct service con­ tracts for a particular detoxification pro­ gram.

### *Contributions*

By developing relationships with people in the community, an administrator can find new sources for support of capital and operations. Even if a source is reluctant to provide funds to support treatment

services directly, other aspects of pro­ gram development, organizational growth, and opera­ tions or equipment may be eligible for support. A variety of support may be available from sources in the com­ munity, ranging from financial support to donations of time, expertise, used or low-cost furniture and equipment, and space for a variety of activities. Some potential sources include

Many public and private benefit plans still classify detoxification as a medical rather than a substance abuse treatment service.

* **Fm1draisers.** People who do fundraising can help the program develop a campaign. Many States and the District of Columbia require that charitable organizations regis­ ter and report to a governmental authority before they solicit contributions in their jurisdiction.
* **Foundations and local charities.** A pro­ gram may qualify as a recipient of funds for capital, operations, or other types of sup­ port such as board development from foun­ dations, the Community Chest, United Way, or other charities.
  + **Ahuuni.** Graduates from a program may donate money to the program or provide support for clients.
  + **Internships.** Local colleges and universities may need internship slots for their students who are planning careers in human ser­ vices.
  + **Volm1teers.** Some programs use volunteers in various capacities. Sources include local retirement organizations and faith-based agencies.
  + **Commmrlty groups.** Faith-based agencies and community centers may let the program userooms for meetings, alumni groups, recovery support groups, or classes. Community groups can contribute reading materials, clothes, toys for clients' children, furniture, or computers.
  + **Local stores and vendors.** Local businesses may contribute useful supplies such as snacks, office supplies, or even computers.

### *Research funding*

In addition to SAMHSA's other roles, such as technical assistance, helping communities use research findings to in1plement effective treat­ ment programs, and funding of prevention and treatment, the institutes of the National Institutes of Health conduct research on best practices in substance abuse treatment.

The Research Assistant (http://www.theresearchassistant.com) may be a helpful source for information. For current funding opportunities, visit the National Institute on Drug Almse Web site (http://www.nida.nih.gov) and the National Institute on Alcohol Abuse and Alcoholism Web site (http://www.niaaa.nih.gov).

### *Grants*

Government agencies and private foundations offer funding through competitive grants.

Grant money usually is designated for discrete projects, such as creating a videotape on family issues, providing childcare services in a pro-

gram for women, enhancing the cultural com­ petence of staff members, or treating under­ served populations.

Writing grant applicationsrequires special skills. A program can hire a consultant to write the application or use its own planning or research staff, if available. Successful grant applications address areas of genuine need, propose ideas worthy of support, express these ideas well, and explicitly follow the requirements of the request for applica­ tion or proposal. To design a fundable pro­ ject, the program may need to establish links with other resources. Each donor agency or foundation has its own application format and requirements that should be followed exactly. It is especially important when using a consultant to have program staff closely involved in the process of developing a grant application to ensure that affirmations in the application are completely aligned with agen­ cy capabilities. Programs that fail to involve their own staff in the grant application pro­ cess risk falling into the "implementation trap" when a grant is awarded for projects they are not prepared to perform. SAMHSA offers a variety ofresources to assist commu­ nity-based organizations and others in devel­ oping successful grant applications. See the text box on page 157 for sources of informa­ tion on grants for treatment and detoxifica­ tion programs.

### *Self-pay patients*

Some patients pay for some or all of a course of treatment themselves, without seeking reimbursement from a third-party payor.

These patients may have no or inadequate third-party coverage for substance abuse treatment and are not eligible for public pay­ ment sources. Some patients who have cover­ age may prefer to pay out of their own pock­ ets due to concerns about the confidentiality of their information with their employer or others.

***Where* To *Get Information* on *Grants***

* SAMHSA provides information about the grants it provides at [http://www.samhsa.gov/grants/block-grants.](http://www.samhsa.gov/grants/block-grants) Information on grants throughout the Federal government is available from [http://www.grants.gov.](http://www.grants.gov/)
* The Web site [http://www.cybergrants.com](http://www.cybergrants.com/) provides information about corporate foundations.
* The National Center on Addiction and Substance Abuse at Columbia University's Web site at [http://www.casacolumbia.org](http://www.casacolumbia.org/) provides links to several helpful sites.
* *The Substance Abuse Funding Week* provides public and private funding announcements for alcohol, tobacco, and drug abuse programs. It is available by subscription in print.
* The Grantsmanship Center at [http://www.tgci.com](http://www.tgci.com/) offers some useful information.
* The Non-Profit Resource Center, [http://www.nprcenter.org/,](http://www.nprcenter.org/) has information on a variety of funding sources.

# Working in Today's Managed Care Environment

All healthcare providers, including those who provide substance abuse treatment services, increasingly operate in a world in which care is managed in all sectors, both public and pri­ vate. Among individuals covered by employ­ er-sponsored benefits in 2003, 95 percent were covered under managed care arrange­ ments (Kaiser Family Foundation and Health Research and Educational Trust 2003). The penetration of managed care into employer­ sponsored health plans is relatively new; as recently as 1993, 46 percent were covered by indemnity plans. It is estimated that more than 160 million Americans have their behav­ ioral health care (treatment for substance use and mental disorders) covered by a managed behavioral health care organization (Oss and Clary 1999). Although managed care penetra­ tion is lower in public programs than in employer-sponsored programs, it is still sig­ nificant; in 2002, 58 percent of the Medicaid population was enrolled in managed care arrangements (CMS 2002). Many States also operate MCOs not connected with Medicaid for provision of substance abuse treatment services.

Behavioral health care carve-outs, so named because management of substance abuse treatment and mental health benefits are sep­ arated (carved out) from the provision and management of other healthcare services, are now the dominant approach to managed care for mental health treatment. However, this is not the case for substance abuse; many behavioral health carve-outs retain substance abuse coverage in the medical MCO. The "carve-in" approach, which theoretically integrates traditional medical services with services for substance use and other mental disorders, is re-emerging but as of 2004 was still relatively rare. Even when health plans carve-in substance abuse services, they often use a subcontracted specialty vendor or a separate internal division with specialty expertise to manage the carve-in benefits.

MCOs are becoming more prevalent in the public sector. In 2002, 51 percent of all sub­ stance abuse treatment facilities had con­ tracts with MCOs and even 39 percent of facilities owned by State and local govern­ ments had such contracts (Office of Applied Studies 2002b). By 1998, all but four States had implemented some form of managed behavioral health care in their public sector treatment programs. However there is wide variation among States and large counties in the extent and form of reliance on managed

care and in the vendors who operate such programs on behalf of government or private entities.

A distinct terminology has evolved in the managed care industry-terms such as capi­ tation, network, or staff-model as well as a host of acronyms.

## Contracts Are Primary Tools

Managed care arrangements have four funda­ mental aspects with which all program admin­

istrators should be familiar. First, *an arrangement begins with a managed care contract that specifies the obliga­ tions of each party.*

It is estimated that more than 160 million Americans

have their behavioral health care (treatment for substance use and mental disorders) covered by a managed behavioral health care organization.

It should be noted that small communi­ ty providers may have little or no negotiating leverage in the contracting process; their only decision may be whether or not to accept what is offered, including the rate of payment and all other con­ tract provisions.

Nevertheless, a clear and detailed understanding of the contract is required to ensure successful perfor­ mance. One key aspect of any man­ aged care contract

is the financial arrangement between the par­ ties, including the basis for payment and the amount of risk assumed by each party, if any. Of course, some managed care contracts are not risk-based. It is important to have some­ one with expertise and experience in managed care contracts and financing examine any

proposed contract and make certain that the financial components of the arrangement are well understood by the program staff who have financial responsibilities.

Secondly, by negotiating and signing a man­ aged care contract, a detoxification program or its parent agency becomes a member of that MCO's managed care network. MCOs generally have a network of contracted and credentialed providers who supply services at a negotiated rate to members who are enrolled in the plans. Each organizational member of the network must satisfy the MCO's minimum requirements for licensure of staff, programs, and facilities to be eligible for a managed care contract.

The third fundamental aspect of managed care arrangements is the requirement for per­ formance measurement and reporting. All MCOs apply a wide range of standard perfor­ mance measures to each of their contracted providers and may have financial or referral incentives or disincentives associated with measured performance.

Finally, the fourth aspect involves utilization management and case management. These tasks generally are performed by MCO staff, typically nurses or social workers, with supervision from Ph.D. clinicians or physi­ cians. The staff makes a determination of what services are "medically necessary" and therefore eligible for health plan reimburse­ ments. Utilization management compares a provider's proposed treatment plan with simi­ lar or expected plans for individuals with sim­ ilar conditions and diagnoses. The utilization management approach may vary not just by MCO but by MCO customer, with some cus­ tomers preferring that utilization be highly scrutinized and meet the test of medical necessity and others preferring that the MCO use a light touch in managing utilization. If a treatment plan from a detoxification program does not meet criteria for medical necessity, it is likely to be denied and referred to a higher level clinician for review, delaying approval and payment. It makes sense to obtain each MCO's protocols, as well as any specific

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arrangements and benefit plans for customers whose employees or enrollees are in the detoxification program's client population.

Case management programs operated in the private sector often are utilization review programs rather than the clinical case man­ agement programs typical in the public sec­ tor. Moreover, the process of case manage­ ment in the private sector often differs from the one found in traditional public sector mental health or substance abuse treatment agencies. Instead, it primarily involves tele­ phone contact, usually with a nurse, in high­ risk or high-cost cases. Case management usually is not performed onsite or in person in MCOs unless under contract to a public agency that requires this. If a detoxification program client has a public sector and a man­ aged care case manager, the detoxification program will have to interact with both to obtain initial and continuing approvals of treatment in what is called a case or utiliza­ tion management program.

In general, programs will be required to obtain utilization management approval and/or case management approval for any proposed treatment plan before they can bill the MCO. Programs will have to bear the cost of pursuing denials and requesting exceptions as well. The more the program's staff can develop a relationship with the MCO's utiliza­ tion management and case management staff, the more they will learn about the internal criteria and protocols that drive approval or denial decisions and the more latitude they will have to request special arrangements for a particular client. Most MCOs and MBHOs have Web sites with provider portals. Once a program identifies the name of the managed care plan from which payment is to be requested staff should be sure to check its Web site. Some managed care plans offer electronic data interchange **with** network providers to facilitate claims submission.

## Elements of Financial Risk in Managed Care Contracts

### *Cost of services*

To assess and negotiate a managed care con­ tract and to monitor a program's perfor­ mance under that contract, it is imperative to know what it costs the detoxification program to provide each unit of service that is pro­ duced. The cost of services includes staff time spent with clients, administrative time spent on meetings and paperwork, and capital and operating expenses. Only when the actual cost of delivering a unit of a particular service is known can an agency negotiate a reasonable rate for specific services when negotiating contracts and a fiscally prudent arrangement. Determining the cost of services often entails many challenges but is absolutely essential in the current environment of accountability.

See the text box on page 160 for a list of resources from the literature. Following are the recognized but evolving cost methodolo­ gies developed specifically for substance abuse services:

* The first systematic cost data collection method, the Drug Abuse Treatment Cost Analysis Program (DATCAP) (French 2003a, b), was developed in the early 1990s by economists at Research Triangle Institute (French et al. 1997). The Treatment Services Review used with DATCAP provides unit ser­ vice costs (French et al. 2000).
* The Uniform System of Accounting and Cost Reporting for Substance Abuse Treatment Providers is a cost estimation method developed about the same time by CSAT (1998d).
* Another estimation approach has been developed by Yates (1996, 1999): the Cost-Procedure-Process-Outcome Analysis.
* Anderson and colleagues (1998) have devel­ oped a cost of service methodology.

***Resources* on *Service Costs***

Anderson, D.W., Bowland, B.J., Cartwright, W.S., and Bassin, G. Service-level costing of drug abuse treatment. *Journal of Substance Abuse Treatment* 15(3):201-211, 1998.

Center for Substance Abuse Treatment. *Measuring the Cost of Substance Abuse Treatment Services: An Overview.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998.

Center for Substance Abuse Treatment. *Uniform System of Accounting and Cost Reporting for Substance Abuse Treatment Providers.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998.

Center for Substance Abuse Treatment. *Summary Report on Assessment and Measurement of Treatment Costs.* Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 2000.

Dunlap, L.J., and French, M.T. A comparison of two methods for estimating the costs of drug abuse treatment. *Journal of Maintenance in the Addictions* 1(3):29-44, 1998.

Flynn, P.M., Porto, J. V., Rounds-Bryant, J., and Kristiansen, P.L. Costs and benefits of methadone treatment in DATOS-Part 1: Discharged versus continuing patients. *Journal of Maintenance in the Addictions* 2(1/2):129-150, 2003.

French, M.T. *Drug Abuse Treatment Cost Analysis Program (DATCAP): Program Version.* 8th ed. Miami, FL: University of Miami, 2003.

French, M.T. *Drug Abuse Treatment Cost Analysis Program (DATCAP): User's Manual.* 8th ed. Miami, FL: University of Miami, 2003.

French, M.T., Dunlap, L.J., Zarkin, G.A., and Karuntzos, G.T. The costs of an enhanced employee assistance program (EAP) intervention. *Evaluation and Program Planning* 21(2):227-236, 1998.

French, M.T., Dunlap, L.J., Zarkin, G.A., McGeary, K.A., and McLellan, A.T. A structured instru­ ment for estimating the economic cost of drug abuse treatment. The Drug Abuse Treatment Cost Analysis Program (DATCAP). *Journal of Substance Abuse Treatment* 14(5):445-455, 1997.

French, M.T., Roebuck, M.C., McLellan, A.T., and Sindelar, J.L. Can the Treatment Services Review be used to estimate the costs of addiction and ancillary services? *Journal of Substance Abuse* 12(4):341-361, 2000.

French, M.T., McCollister, K.E., Sacks, S., McKendrick, K., and De Leon, G. Benefit-cost analysis of a modified therapeutic community for mentally ill chemical abusers. *Evaluation and Program Planning* 25(2):137-148, 2002.

French, M.T., Salome, H.J., and Carney, M. Using the DATCAP and ASI to estimate the costs and ben­ efits of residential addiction treatment in the State of Washington. *Social Science* & *Medicine* 55(12):2267-2282, 2002.

Yates, B.T. *Analyzing Costs, Procedures, Processes, and Outcomes in Human Services.* Applied social research methods series v. 42. Thousand Oaks, CA: Sage, 1996.

Yates, **B.T.** *Measuring and Improving Cost, Cost-Effectiveness, and Cost-Benefit for Substance Abuse Treatment Programs: A Manual.* NIH Publication No. 99-4518. Rockville, **MD:** National Institute on Drug Abuse, 1999.

Zarkin, G.A., and Dunlap, L.J. Implications of managed care for methadone treatment. Findings from five case studies in New York State. *Journal of Substance Abuse Treatment* 17(1-2):25-35, 1999.

Zarkin, G.A., Dunlap, L.J., and Homsi, G. The substance abuse services cost analysis program (SAS­ CAP): A new method for estimating drug treatment services costs. *Evaluation and Program Planning* 27(1):35-43, 2004.

* + The Substance Abuse Services Cost Analysis Program (Zarkin et al. 2004) is an emerging treatment services cost estimation method.
  + Variants of these methods have been applied to several treatment studies (Flynn et al. 2003; Koenig et al. 1999; Mojtabai and **Zivin** 2003).

Three major categories of financial arrange­ ments may be distinguished in managed care contracts: (1) fee-for-service agreements, (2) capitation agreements, and (3) case rate agreements. Program administrators need to understand the differences among these types of arrangements so they can manage financial risk. Sometimes, administrators may think that the contract itself is the goal. However, the existence of a contract is no guarantee of a referral; it only enables referrals that are medically necessary. The closer the relation­ ship the program staff can develop with a given MCO, the easier it will be for them to understand their clinical criteria, to obtain

more than intermittent referrals, and to nego­ tiate a financial arrangement for the program that is reasonable and fair.

Managed care contracts vary according to two principal dimensions: (1) the method of pay­ ment and the corresponding type of risk assumed by the provider, and (2) the amount of payment. Each of the three major types of financial arrangements or methods of pay­ ment (described **in** Figure 6-1, p. 162) is asso­ ciated with major financial risks that providers should be aware of in negotiating each type. Risk, of course, is a continuous variable, so that no arrangement is devoid of any risk whatsoever. The key is to ensure that a program has the tools and capabilities to manage the risks it assumes. Many managed care systems rely on fee-for-service arrange­ ments with providers, so that most providers are paid on a discounted fee-for-service basis, based on a schedule of fees described in the contract. Capitation agreements usually are reserved for very large networks of

providers, who in turn pay individual providers on a fee-for-service basis.

For more information on managed care pur­ chasing and negotiation from the perspective of a purchaser, see TAP 22, *Contracting for Manao*e*-*,*ed Substance Abuse and Mental Health Services: A Guide for Public Purchasers* (CSAT 1998c).

## Networks, Accreditation, and Credentialing

To join an MCO's network of providers and negotiate a contract specific MCO minimum standards for staff credentials and program accreditation must be met. These minimum standards generally are not negotiable because they have their basis in that MCO's accreditation requirements. The provider credentialing requirements vary by MCO and by customer within the MCO and often include primary verification of specific aca­ demic degrees or specific levels of licensure for staff, as well as verified minimum levels of malpractice insurance. Some MCOs may use what are called independent Credentialing Verification Organizations (CVOs) for this process. These CVOs verify the credentials of providers on behalf of MCOs to ensure, for example, that their licenses are valid and up to date.

MCOs sometimes are not familiar with sub­ stance abuse treatment and, moreover, typi­ cally include only those types of providers that are licensed by a given State to engage in private practice in their provider networks. Usually such providers are licensed in psy­ chology, nursing, medicine, or social work.

MCOs explain that this has to do with mal­ practice insurance issues. This credentialing practice has a disproportionate impact on those substance abuse treatment providers that do not have as many staff with these cre­ dentials as do mental health providers, by presenting an obstacle to contracting with these MCOs. However, it is not an insur­ mountable obstacle. Substance abuse treat­ ment providers often must help MCOs under­ stand the substance abuse treatment environ­ ment, the types of providers that deliver ser-

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| ***Figure 6-1 Financial Arrangements for Providers*** | |
| **Method of Reimbursement** | **Cautious/Risks for Programs** |
| **Fee-for-Service Agreement.** Fee-for-service pro­ grams are the least risky to providers. They gen­ erally require precertification and utilization management for some or all procedures and ser­ vices. The client's benefit plan document or the public payor's contract dictate the services that may be approved. In a fee-for-service contract, a rate is received for the services provided; typical­ ly, a standard program session **with** specific ser­ vices bundled in. This is referred to as an "all­ inclusive rate."  Some common bundled services are urine drug screens and group, family, and individual counsel­ ing. Thus the payment rate for one visit may include a SO-minute group counseling session and a urine drug screen. The rate for a day of treat­ ment could include, for example, one-fifth of a 25- minute psychologist visit, one-half of a urine drug screen, one-half of a vocational training session, and two sessions of group counseling. The assumption is that these services will occur at a specified frequency during the course of the client's treatment. Psychiatric services can be incorporated into the bundled services, but usual­ ly they are negotiated separately and treated as an additional service. | When negotiating a fee-for-service contract, an administrator needs to ensure that the rate is suf­ ficient to cover the actual costs to a program of providing the specified services. During negotia­ tions, the MCO has the option of saying that it will not pay for some of the bundled services. All ser­ vices should be costed out prior to negotiation, so actual costs of treatment components are known and can be compared to the reimbursement offered. Programs must understand that even if a fee-for-service contract is successfully negotiated, referrals may or may not follow. |

vices, and the qualifications and standards they must meet so that the MCO can modify its policies appropriately. MCOs often are more willing to contract with organizations that have a facility license from their State than with individual substance abuse treat­ ment providers who may not possess creden­ tials that meet the MCO's licensure criteria.

Many managed care plans have separate provider networks for behavioral health ser­ vices. It is important for detoxification providers to participate in both medical and behavioral health networks, given that detoxi-

fication benefits may be considered either medical or behavioral benefits.

In addition to the credentials of the staff and practitioners, the program itself may have to be accredited by one of the major national health­ care accrediting organizations. These include the Commission on Accreditation of Rehabilitation Facilities, the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations. In general, accreditation from CARF is considered most important by sub­ stance abuse treatment providers for their

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| --- | --- |
| ***Figure 6-1 (continued) Financial Arrangements for Providers*** | |
| **Method of Reimbursement** | **Cautious/Risks for Programs** |
| **Capitation Agreement.** A managed care company may establish a stipulated dollar amount to cover treatment costs for a group of people using one per-person rate for everyone, which is the MCO's capitation rate. The MCO may then subcapitate a stipulated dollar amount to a treatment provider or organization, and the MCO and the treatment provider negotiate an agreement in which the provider is paid a fixed amount per subscriber per month, rather than billing on a fee-for-service basis. The provider agrees to provide all or some of the treatment services for an expected number of managed care "covered lives" (e.g., for 100,000 subscribers). Usually only large service providers have the assets and volume of services to engage in capitated agreements. | The two critical elements are the per member/per month (pm/pm) rate and the utilization rate. If many more people than are predicted require treatment, the provider may not be able to cover service delivery costs, much less make a profit/sur­ plus. The key is to have reliable information on the historical use rates of a given managed care plan's enrollees. If the provider bears in mind these caveats, this regular, guaranteed payment can be an excellent arrangement but carries with it the risks of both "overutilization" (when com­ pared to the assumption used in developing the rate) and the need for a greater intensity of treat­ ment than the capitation rate can cover. In some cases a program may want to accept a somewhat speculative capitation rate in order to join a panel and then renegotiate that rate after the program has collected data that show that it needs a higher rate to cover its costs. In any case, it is crucial to track actual dollars against the budget in real time to avoid unexpected deficits. |
| Case **Rate Agreement.** The case rate is a fixed rate per client paid for delivery of specific ser­ vices to specified types of consumers. For this fee, a provider such as a clinic covers all the services that a client requires for a specific period. In essence, the MCO is saying, "You provide the client what he needs from this set of services and I will pay you this set amount." What usually dis­ tinguishes case rate from capitation is that essen­ tially all of the case rate clients are anticipated to be receiving some service; that is, at least case management. Usually those receiving services under capitation are a small minority of those covered. The case rate may be "risk-adjusted" to compensate for the higher costs of serving clients who predictably need more services than average. | A case rate agreement removes some of the utiliza­ tion risk from the service provider. However, the risk remains that clients will need services more frequently or at higher levels than the case rate covers. It is essential that programs track costs by specific client in order to assess the adequacy of a proposed case rate. However, it is a mistake to consider a case rate as a cap for any specific patient; the goal is to ensure that the *average* cost per case is lower than the negotiated case rate, not that the cost for each case is less than the negotiat­ ed rate. Once again, it is crucial to track actual average dollars per case against the contracted case rate in real time to avoid unexpected deficits. |

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programs. However, providers that wish to offer inpatient detoxification services general­ ly must obtain accreditation from JCAHO to meet the requirements of most MCOs.

## Organizational Performance Measurement

Performance measurement is becoming an increasingly important component of man­ aged and fee-for-service care in both the public and private sectors. SAMHSA's SAPT Block Grants now require the collection of measures of program performance and out­ comes. MCOs have their own performance measures established by the agencies that accredit them, such as the NCQA. Their cus­ tomers, employers, or public purchasers may use adequacy of performance on these mea­ sures in their decisions to acquire or retain their plans for their employees. NCQA has established a set of measures specifically relating to substance abuse and mental

health treatment services for all the MCOs that it accredits, including new measures of the identification of enrollees with substance abuse diagnoses, the rate of initiation of treatment, and a measure of treatment engagement. Programs will be asked to par­ ticipate in measuring these indicators and report that information to the MCO, and doing so will likely be a condition of the con­ tract. The MCO may reward good perfor­ mance with an additional fee.

Similarly, MCOs evaluate the performance of the members of their provider network. Each MCO has its own measures and procedures for implementation, some of which are pre­ scribed by the organizations that accredit them. Not all MCOs are diligent about this provider evaluation process. Only a few MCOs have implemented sophisticated mea­ surement systems, and some of the methods used today may be crude but they still are required. Nevertheless, regardless of how simple or complex they may be, the results of

external performance measures implemented by MCOs can be extremely important to a program's financial and organizational suc­ cess, affecting a program's ability to remain a viable, respected network provider. Some performance management systems implement­ ed by MCOs also use financial incentives and/or disincentives keyed to performance.

Regardless of the specific measures imple­ mented by particular MCOs, well-managed organizations will also develop and use their own internal performance measures and con­ stantly strive to improve their own perfor­ mance. Among these should be measures of both process and outcomes, such as

* The percentage of clients who complete a defined treatment regimen that meets their individual needs
* The percentage of clients who drop out of treatment in the first 7 days following treat­ ment initiation
* The percentage of clients who remain in doc­ umented but less intensive treatment 30 days after discharge from the program
* The percentage of clients who are employed or attending school 6 months after discharge from the program

When using performance measures, it is impor­ tant for programs to account for differences among clients that may affect measured results, such as a client's previous history of abuse or medical conditions. Nevertheless, it is equally important to recognize that employing mea­ surement is an integral component of external and internal accountability as well as continu­ ous clinical improvement.

One of the primary independent entities involved in the construction of national per­ formance measures for substance abuse treat­ ment is the Washington Circle Group.

NCQA's new substance abuse performance measures on identification and initiation of treatment and treatment engagement were developed by the WCG over a 4-year period.

They have identified four major "domains" for substance abuse treatment measures:

1. Prevention/Education
2. Recognition or Identification of Substance Abuse
3. Treatment
   * Initiation of alcohol and other plan ser­ vices
   * Linkage of detoxification and alcohol and other drug plan services
   * Treatment engagement
   * Use of interventions for family members and significant others
4. Maintenance of Treatment Effects

These and other substance abuse performance measures are now used in NCQA's MCO accreditation process. The WCG and others have defined a variety of such measures and administrators should think of these measures as ways to improve their own performance, as an essential element in the reporting system, and as a means for documenting success to their customers and other stakeholders.

Performance measurement is becoming increasingly important outside of managed care contracts as well as inside them. For example, as mentioned in the previous section on fund­ ing, SAMHSA began integrating performance measurement into the SAPT Block Grant as of fiscal year 2004. Each State will expect pro­ grams to understand and be able to measure the required indicators accurately and in a timely way.

One of the most important performance mea­ sures in the future for detoxification programs is likely to be linkages to substance abuse treat­ ment following detoxification (Mark et al.

2002). Research has shown that patients who receive continuing care following detoxification have better outcomes in terms of drug absti­ nence and readmission rates than those who do not receive continuing care. This focus on link­ ages is a likely result of research indicating **that** many people who undergo detoxification do not

receive subsequent substance abuse services from the formal treatment system and that the lack of substance abuse treatment following detoxification has been getting worse instead of better (Mark et **al.** 2002). **It** is incumbent on providers of detoxification services to ensure that clients are linked to substance abuse treat­ ment following detoxification.

### *Recordkeeping and manage­*

**ment *information systems***

Like indemnity insurers, MCOs also require detailed records of

services provided to clients in order for them to pay for ser­ vices received. The program's account­ ing system needs to track counselors' time spent on the phone, on paper­ work, and directly with clients. Clinical records should reflect accurately the claims records submitted to the MCO. Periodically, payors and MCOs may audit the clini­ cal records to ensure that the ser­ vices billed for actu­ ally have been pro­ vided. Failure to adequately docu- ment clinical ser-

Performance measurement is becoming an increasingly important compo- nent of managed and fee-for-service care in both the public and private sectors.

vices can result in nonpayment and put a con­ tract in jeopardy. On the other hand, individ­ uals' private information and identity must

be handled in a confidential manner pursuant to the Health Insurance Portability and Accountability Act (HIPAA) and Federal con­ fidentiality requirements for persons with substance abuse.

Managing multiple contracts requires sophis­ ticated management, a fiscal management information system (MIS), and constant scrutiny. The need for information is even more crucial for capitation-based arrange­ ments that place risk on the service provider than it is for fee-for-service arrangements. In essence, the MIS needs to be capable of two­ way information transfer between the MCO and the program. Data such as membership, benefits, copays, deductible amounts, and other financial information must be passed

between the pro­ gram and the insured entity or payor. The MIS also should be able to analyze key per­ formance data for internal and exter­ nal reports. The MIS must pass use­ ful data to staff members responsi­ ble for managing benefits and pro­ viding services.

Successfully addressing the needs of the utilization and case management staff at MCOs is a critical element in the relationship withanMCO.

Program data will need to meet State data requirements as well as require­ ments by each payor, while respecting confiden­ tiality.

### *Managing payment from* multiple funding streams

Especially in the public arena, multiple con­ tracts with and grants from several funding streams and payors may be used to support services for a single client. These contracts will specify order of payment. The provider needs to manage the funds carefully and appropriately to be in compliance with con­ tracts and grants. For example, a contract with a drug court may specify that Medicaid

should he billed as payor number one and the drug court as payor number two. Any unpaid portion might then he hilled to the block grant agency as payor of last resort, if it is an eligible service under the block grant. Some providers have successfully used the strategy of first using the reimbursement of those pay­ ors with the most restrictive array of services; later, the more flexible funds can he used to cover the remaining services. A clearly docu­ mented strategy for managing payment that is communicated effectively to the accounts payable staff is critical and will help pro­ grams he successful in this important area.

## Utilization and Case Management

All MCOs use methods to manage the service utilization of their members and ensure that they are receiving the most appropriate array of services in the most appropriate environ­ ment or level of care for the appropriate length of time. Although technically, utiliza­ tion management focuses on a single type of service and case management focuses on the coordination of the appropriate array of ser­ vices needed by a specific individual, in prac­ tice the same individual professionals may be responsible for both types of management.

Utilization and case management staff at an MCO authorize specific services for purposes of payment. A wide variety of specific criteria and protocols may be used to determine whether services may be authorized for sub­ stance abuse, typically including the American Society of Addiction Medicine (ASAM) patient placement criteria (ASAM 2001) and other level of care or diagnosis­ based criteria sets.

Successfully addressing the needs of the uti­ lization and case management staff at MCOs responsible for authorizing care is a critical element in the relationship with an MCO and in maintaining the program's clinical and financial viability. To do so, program staff must understand what their counterparts do and be well trained in conducting professional

relationships over the telephone, be familiar with the criteria and protocols employed by the MCOs with which the program has con­ tracts, and have easy access to the multitude of clinical and service information required by an MCO to help them complete a review and authorize services. Excellent records are essential. Program staff also should be famil­ iar with each MCO's appeal or exceptions process for those occasions when the outcome of a first-level review is unsatisfactory.

Utilization management cannot proceed if the program is not recognized as an eligible net­ work provider; the program will have to ensure that it is an accepted network provider before it can participate in the uti­ lization management or case management process.

## Strengthening the Financial Base and Market Position of a Program

The following strategies may strengthen the market position of a detoxification program to facilitate both larger numbers of patients and greater revenues per patient:

* + Achieve recognition for the quality and effectiveness **of** services. If a program has a reputation for providing effective care, then managed care enrollees and other potential clients will want to use it. A pro­ gram can be of value to a client, a purchas­ er, and/or an MCO if it can reduce repeated detoxification, repeated treatment, and re­ admissions, and thus manage unnecessary costs and interventions. Effective substance abuse treatment provided promptly may reduce medical care and hospitalization costs in the long run. A program that effec­ tively manages the care of high-utilization substance abuse clients by also providing psychiatric treatment, case management, and housing support is a good candidate for "preferred" or "core" status with one or several MCOs or MBHOs. Of course, the

additional costs of these services need to be a component of a program's rate and con­ tract. Having highly reputable, recognized, and efficient providers is a major marketing and regulatory advantage for the health plan, as well as for the program. **All** these program characteristics can be marketing advantages. Programs also may apply to SAMHSA's National Registry of Evidence­ based Programs and Practices, which recog­ nizes model, effective, and promising pro­ grams. Check SAMHSA's Web site to find out how to apply for this status, which is a major achievement and marketing asset.

* **Serve specific populations.** Providing low­ cost, high-quality treatment to a population no other program serves (e.g., adolescents, clients with HIV/AIDS, clients with co­ occurring mental disorders, pregnant women, women with young children, clients who are deaf) also is a possible marketing advantage. Treating these clients can result in client referrals from a larger geographic area and multiple sources. Such clients may bring with them higher reimbursement rates too, but this also may simply reflect higher costs to provide care to the population. Using special capabilities to attract clients is a good idea, but not at the cost of inade­ quate payment for services.
* **Develop economies of scale.** Adding clinic sites or increasing the number of branch clinics may permit spreading some fixed costs (e.g., management, information, financial systems, executive staff) among a larger number of patients, thus driving down a program's per capita costs. However, larger size requires greater administrative coordination, which itself can be costly.
* **Gain connum1ity visibility and support.** Having governmental, community agency executives, or political figures (e.g., the mayor, council members) as board members raises the program's profile in the commu­ nity. Of course, programs should be sure to include board members who have specific

skills and connections that will advance the purposes of the detoxification program.

* + **Form alliances with other treatment providers.** Setting up coalitions to compete with or work with MCOs and other pur­ chasers such as Medicaid may be useful. However, consultation with an attorney is strongly advised prior to developing such a coalition or other collaboration with local treatment providers as the laws regarding antitrust and other matters related to such relationships are complex. For programs serving publicly funded clients, technical assistance may be available through SAMHSA; the SSA can provide details.

# Preparing for the Future

Major forces that shape and limit provider financing are unlikely to change substantially in the near future. Careful strategic planning

and assurance of funding from reputable and varied referral sources are essential for new and existing programs. As a buffer against shrinking budgets, all programs should con­ sider broadening their funding streams and referral sources, expanding the range of clients they can serve, and promptly referring clients for other services not provided on site. Partnerships can be a critical factor to the financial success of a program. To operate effectively, administrators and other staff must thoroughly understand the managed care and community political environment including its terminology, contracts, negotia­ tions, payments, appeals, and priority popu­ lations. A successful working relationship with an MCO, a health plan, other pur­ chasers, or with another agency or group of agencies depends on day-to-day interactions in which staff members serve as informed, professional advocates for their clients and the program.

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