Detoxification and Substance Abuse Treatment

A Treatment Improvement Protocol

TIP 45

Substance Abuse and Mental Health Services Administration
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration

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Rockville, MD 20857

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6 Financing and Organizational Issues

In This Chapter...

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 detoxification program should be based on a well-developed strategic planning 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 operations.

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 financial resources to pay for detoxification treatment themselves. Signed contracts with expected payors may be useful to ensure adequate 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 program development process. Before and during the program development process, administrators and planners should work closely with potential referral and payment sources to determine their needs and to see if the detoxification 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 timeframes for reimbursement, and the process for negotiating a contract. Among useful tactics 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 process, public system payors and planners, private insurance plans, contracting agents for private insurance (e.g., managed care organizations [MCOs]), and local employers large enough to have employee assistance programs (EAPs) or managed behavioral health plans that cover detoxification services. Direct contact 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 components 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 shifted 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 epidemiology of substance abuse in the last decade have been dramatic. Between 1993 and 2000, the number of admissions to hospital 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 percent of total detoxification admissions in 2000, while admissions to 24-hour free-standing 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 detoxification 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 detoxification services and should obtain data on current utilization of and demand for detoxification 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 treatment 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 management challenges and opportunities for program 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 priorities, 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 detoxification program requires a fairly sophisticated management and accounting system to meet the reporting needs and performance requirements of each purchaser, to provide information 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 foundations, board members, and local or national corporate donation programs for any assistance that will help to reduce costs, increase revenue, or improve productivity and effectiveness and aid in the success of the organization. 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.

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

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 potential source of funding through establishment of a for-profit subsidiary. Detoxification programs 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 benefits to covered individuals that vary according to whether or not the services are facility-based and according to the level or setting of care. 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 service is facility based.

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

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 payments 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 management 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 medical necessity is not demonstrated to the satisfaction of the plan or if the service is provided 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 hospitals, affiliated with a hospital, or considered as a licensed facility themselves may be eligible for higher rates of reimbursement than are those that are considered to be outpatient programs with no facility license. However, utilization management criteria to authorize payment for admission to and continued stay in a hospital inpatient setting require a significantly greater severity of patient diagnosis than do criteria for admission 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 coverage for hospital-based or freestanding facility-based detoxification programs and others may subject admissions to such programs to

more intensive review than admissions to non–facility-based detoxification programs. Program planners should consider carefully all alternatives; decisions concerning affiliation with a hospital or pursuit of a facility license have far-reaching financial and political 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 substance abuse treatment and detoxification programs. These funds are sent to the State's Single State Agency (SSA) for substance abuse for distribution to counties, municipalities, 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, including 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 approximately 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 requirements are increasingly common.
- **Performance outcome 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 outcome and other performance data. Substance Abuse and Mental Health Services Administration (SAMHSA) and the States are establishing performance outcome 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 financial 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. 2003*a*) but Medicaid supports about 20 percent of national expenditures for substance abuse services (Coffey et al. 2001). The level of expenditure varies greatly by State. Medicaid is an entitlement program with several distinct eligible groups: low-income children, pregnant women, the elderly, and people who are blind or disabled, all or some of whom can be enrolled in a detoxification program population. Some substance abuse treatment programs will want to target pro-

grams to the Medicaid population; if the State's coverage and payment rates are minimal, 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 within the same State. Rates of payment/reimbursement are determined by each State independently and may vary within the State among the various coverage arrangements. If a State decides to include benefits for substance abuse treatment in its Medicaid program, 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 settings for detoxification programs are covered in those States that do provide coverage. Therefore, a State Medicaid program may cover certain substance abuse treatment services but not cover detoxification services. For more information, readers should contact their State Medicaid office.

An important distinction of the Medicaid benefit 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 substance 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 adolescents on Medicaid for physical and behavioral 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 treatment 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 commercial payors by essentially prohibiting acceptance of contract terms with any other purchaser at rates lower than those established 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 systems 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 program financed through general tax revenues. SSI recipients are one of the mandated populations 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 limited income and resources, who meet the living arrangement requirements, *and* who are otherwise eligible. Congress has excluded a primary diagnosis of substance abuse as a qualifying 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 substance abuse treatment services. Medicare may provide Part A coverage to clients in detoxification programs that are based in hospitals certified by Medicare. However, detoxification programs that provide only a structured environment, socialization, and/or vocational rehabilitation are not covered by Medicare. Medicare imposes very strict review requirements for detoxification programs 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 reimbursed under Part B are 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 certain 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, employers, and self-employed persons. In order to be eligible 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 otherwise eligible. A substance abuse diagnosis was excluded by Congress as a qualifying disability 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.

Medicaid supports about 20 percent and Medicare supports about 8 percent of national expenditures for substance abuse treatment services.

State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP) provides funds for substance abuse treatment of children and adolescents in many States. This program provides low-cost health insurance for children of low-income families who are not eligible for Medicaid. States have the option of providing SCHIP benefits under their existing Medicaid program or designing a separate 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 ensure that coverage meets minimum standards. A State's Alcohol and Drug Abuse Agency also may be able to provide information 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.

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

TRICARE

TRICARE is a regionally managed health care program for active duty and retired members of the uniformed services and their families and survivors. TRICARE supplements the healthcare resources of the Army, Navy, and Air Force with networks of civilian healthcare professionals. TRICARE consists of TRICARE 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 program formerly known as CHAMPUS. The TRICARE Extra and Standard benefits include treatment for substance abuse, subject to preauthorization requirements, but programs will need to check to see if detoxification programs are eligible or preauthorized under TRICARE managed care arrangements. 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 provided directly and through tribally contracted and operated health programs. Health services also include health care purchased from more than 9,000 private providers annually. The IHS behavioral health program supports alcoholism and other drug dependency treatment, detoxification, rehabilitation, and prevention 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 substance 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. Departments of Labor, Housing and Urban Development (HUD), and Education (ED). Some Federal sources of funding for substance abuse treatment under these programs may prohibit use of funds for "medical" services. However, services performed by those not in the medical profession (e.g., counselors, technicians, social workers, psychologists) 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 determine 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. Opportunities 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 one quarter of the money allocated to local communities through a competitive grant process. The funding channels 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 "medical" services, States have considerable latitude in the definition of "medical," and have used TANF funds to support the following substance abuse treatment services: screening/assessment, detoxification, outpatient 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 training, 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 individual who is alcohol or drug dependent). In 2002, these funds provided close to $8 million 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 designated housing entities to fund treatment. Funds are channeled to local public housing authorities, which contract with service providers. In addition, special housing programs are available for people who are homeless 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 eligible 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 children, 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 epidemic, funds are available for substance abuse treatment. Over 500,000 people are served through this program each year.

Criminal justice/juvenile justice (CJ/JJ) systems

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

- **State corrections systems** may provide funds for treatment of offenders who are returning to the community, through parole offices, halfway houses, or residential correctional facilities.
- **Community corrections systems** may include a system of presentence diversion or parole services, including drug court, that may mandate substance abuse treatment in lieu of incarceration.
- **Community drug courts** may send low-risk, nonviolent offenders to substance abuse treatment in lieu of incarceration—programs can be under contract to provide this treatment.
- **Correctional residential facilities** serve offenders returning from a State correctional system; the programs may extend contracts for substance abuse treatment to prevent relapse of treated offenders.
- **Juvenile court systems** may provide contracts 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, values, and needs of the CJ/JJ system so they can develop responsive services for this special needs population. For more information, see TIP 21, *Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System* (CSAT 1995*b*), TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* (CSAT 1998*b*), and TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT 2005*b*).

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 offenders 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 juvenile 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 funding 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 provided through Managed Behavioral Healthcare Organizations (MBHOs) (see "Working In Today's Managed Care Environment," p. 157, for a more detailed discussion of managed 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 substance 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 benefits offered by their health plans are inadequate.
- Contracts with EAPs. Some employers have EAPs that can provide direct service contracts for a particular detoxification program.

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 program development, organizational growth, and operations or equipment may be eligible for support. A variety of support may be available from sources in the community, 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.

- **Fundraisers.** People who do fundraising can help the program develop a campaign. Many States and the District of Columbia require that charitable organizations register and report to a governmental authority before they solicit contributions in their jurisdiction.
- **Foundations and local charities.** A program may qualify as a recipient of funds for capital, operations, or other types of support such as board development from foundations, the Community Chest, United Way, or other charities.

- **Alumni.** 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 services.
- **Volunteers.** Some programs use volunteers in various capacities. Sources include local retirement organizations and faith-based agencies.
- **Community groups.** Faith-based agencies and community centers may let the program use rooms 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 implement effective treatment 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 Abuse 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 program for women, enhancing the cultural competence of staff members, or treating underserved populations.

Writing grant applications requires 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 application or proposal. To design a fundable project, 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 agency capabilities. Programs that fail to involve their own staff in the grant application process risk falling into the "implementation trap" when a grant is awarded for projects they are not prepared to perform. SAMHSA offers a variety of resources to assist community-based organizations and others in developing successful grant applications. See the text box on page 157 for sources of information on grants for treatment and detoxification 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 payment sources. Some patients who have coverage may prefer to pay out of their own pockets 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. Information on grants throughout the Federal government is available from http://www.grants.gov.
- The Web site 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 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 offers some useful information.
- The Non-Profit Resource Center, 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 private. Among individuals covered by employer-sponsored benefits in 2003, 95 percent were covered under managed care arrangements (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 behavioral health care (treatment for substance use and mental disorders) covered by a managed behavioral health care organization (Oss and Clary 1999). Although managed care penetration is lower in public programs than in employer-sponsored programs, it is still significant; 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 separated (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 substance abuse treatment facilities had contracts with MCOs and even 39 percent of facilities owned by State and local governments had such contracts (Office of Applied Studies 2002*b*). 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 capitation, network, or staff-model as well as a host of acronyms.

Contracts Are Primary Tools

Managed care arrangements have four fundamental aspects with which all program administrators should be familiar. First, *an arrangement begins with a managed care contract that specifies the obligations of each party.* It should be noted that small community 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 contract provisions. Nevertheless, a clear and detailed understanding of the contract is required to ensure successful performance. One key aspect of any managed care contract is the financial arrangement between the parties, 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 someone 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.

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.

Secondly, by negotiating and signing a managed 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 performance measurement and reporting. All MCOs apply a wide range of standard performance 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 physicians. The staff makes a determination of what services are "medically necessary" and therefore eligible for health plan reimbursements. Utilization management compares a provider's proposed treatment plan with similar or expected plans for individuals with similar conditions and diagnoses. The utilization management approach may vary not just by MCO but by MCO customer, with some customers 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

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 management programs typical in the public sector. Moreover, the process of case management 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 telephone 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 managed 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 utilization 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 utilization 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 contract and to monitor a program's performance under that contract, it is imperative to know what it costs the detoxification program to provide each unit of service that is produced. 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 methodologies 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 service 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 (1998*d*).
- Another estimation approach has been developed by Yates (1996, 1999): the Cost–Procedure–Process–Outcome Analysis.
- Anderson and colleagues (1998) have developed a cost of service methodology.

Resources on Service Costs

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- 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 arrangements 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 relationship 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 negotiate a financial arrangement for the program that is reasonable and fair.

Managed care contracts vary according to two principal dimensions: (1) the method of payment 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 payment (described in Figure 6-1, p. 162) is associated 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 arrangements 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 purchasing and negotiation from the perspective of a purchaser, see TAP 22, *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers* (CSAT 1998*c*).

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 academic 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 substance abuse treatment and, moreover, typically 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 psychology, nursing, medicine, or social work. MCOs explain that this has to do with malpractice insurance issues. This credentialing practice has a disproportionate impact on those substance abuse treatment providers that do not have as many staff with these credentials as do mental health providers, by presenting an obstacle to contracting with these MCOs. However, it is not an insurmountable obstacle. Substance abuse treatment providers often must help MCOs understand the substance abuse treatment environment, the types of providers that deliver ser-

Figure 6-1
Financial Arrangements for Providers

Method of Reimbursement	Cautions/Risks for Programs
Fee-for-Service Agreement. Fee-for-service programs are the least risky to providers. They generally require precertification and utilization management for some or all procedures and services. 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; typically, a standard program session with specific services bundled in. This is referred to as an "all-inclusive rate." Some common bundled services are urine drug screens and group, family, and individual counseling. Thus the payment rate for one visit may include a 50-minute group counseling session and a urine drug screen. The rate for a day of treatment 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 usually 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 sufficient to cover the actual costs to a program of providing the specified services. During negotiations, the MCO has the option of saying that it will not pay for some of the bundled services. All services 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 treatment providers who may not possess credentials that meet the MCO's licensure criteria.

Many managed care plans have separate provider networks for behavioral health services. It is important for detoxification providers to participate in both medical and behavioral health networks, given that detoxification 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 healthcare 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 substance abuse treatment providers for their

Figure 6-1 (continued)
Financial Arrangements for Providers

Method of Reimbursement	Cautions/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/surplus. 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 compared to the assumption used in developing the rate) and the need for a greater intensity of treatment 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 services 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 distinguishes case rate from capitation is that essentially 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 utilization 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 negotiated 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.

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

Organizational Performance Measurement

Performance measurement is becoming an increasingly important component of managed 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 outcomes. MCOs have their own performance measures established by the agencies that accredit them, such as the NCQA. Their customers, employers, or public purchasers may use adequacy of performance on these measures 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 participate in measuring these indicators and report that information to the MCO, and doing so will likely be a condition of the contract. The MCO may reward good performance 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 prescribed by the organizations that accredit them. Not all MCOs are diligent about this provider evaluation process. Only a few MCOs have implemented sophisticated measurement 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 success, affecting a program's ability to remain a viable, respected network provider. Some performance management systems implemented by MCOs also use financial incentives and/or disincentives keyed to performance.

Regardless of the specific measures implemented by particular MCOs, well-managed organizations will also develop and use their own internal performance measures and constantly strive to improve their own performance. 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 treatment initiation
- The percentage of clients who remain in documented 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 important 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 measurement is an integral component of external and internal accountability as well as continuous clinical improvement.

One of the primary independent entities involved in the construction of national performance measures for substance abuse treatment 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 services
   - 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 funding, SAMHSA began integrating performance measurement into the SAPT Block Grant as of fiscal year 2004. Each State will expect programs to understand and be able to measure the required indicators accurately and in a timely way.

One of the most important performance measures in the future for detoxification programs is likely to be linkages to substance abuse treatment following detoxification (Mark et al. 2002). Research has shown that patients who receive continuing care following detoxification have better outcomes in terms of drug abstinence and readmission rates than those who do not receive continuing care. This focus on linkages 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 treatment following detoxification.

Recordkeeping and management information systems

Like indemnity insurers, MCOs also require detailed records of services provided to clients in order for them to pay for services received. The program's accounting system needs to track counselors' time spent on the phone, on paperwork, and directly with clients. Clinical records should reflect accurately the claims records submitted to the MCO. Periodically, payors and MCOs may audit the clinical records to ensure that the services billed for actually have been provided. Failure to adequately document clinical services can result in nonpayment and put a contract in jeopardy. On the other hand, individuals' private information and identity must be handled in a confidential manner pursuant to the Health Insurance Portability and Accountability Act (HIPAA) and Federal confidentiality requirements for persons with substance abuse.

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

Managing multiple contracts requires sophisticated management, a fiscal management information system (MIS), and constant scrutiny. The need for information is even more crucial for capitation-based arrangements 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 program and the insured entity or payor. The MIS also should be able to analyze key performance data for internal and external reports. The MIS must pass useful data to staff members responsible for managing benefits and providing services.

Program data will need to meet State data requirements as well as requirements by each payor, while respecting confidentiality.

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

Managing payment from multiple funding streams

Especially in the public arena, multiple contracts 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 contracts and grants. For example, a contract with a drug court may specify that Medicaid should be billed as payor number one and the drug court as payor number two. Any unpaid portion might then be billed 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 payors with the most restrictive array of services; later, the more flexible funds can be used to cover the remaining services. A clearly documented strategy for managing payment that is communicated effectively to the accounts payable staff is critical and will help programs be 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 environment or level of care for the appropriate length of time. Although technically, utilization management focuses on a single type of service and case management focuses on the coordination of the appropriate array of services needed by a specific individual, in practice 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 substance 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 utilization 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 contracts, 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 familiar 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 network provider; the program will have to ensure that it is an accepted network provider before it can participate in the utilization 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 program can be of value to a client, a purchaser, and/or an MCO if it can reduce repeated detoxification, repeated treatment, and readmissions, 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 effectively 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 contract. 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 recognizes model, effective, and promising programs. 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 inadequate 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 community 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 community. 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 purchasers 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 consider 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, negotiations, payments, appeals, and priority populations. A successful working relationship with an MCO, a health plan, other purchasers, 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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