

# Purchasing Managed Care Services for Alcohol and Other Drug Treatment:

## Essential Elements and Policy Issues

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*Foreword of TAP 16: Purchasing Managed Care Services for Alcohol and Other Drug Treatment: Essential Issues and Policy Issues*

## Foreword

Today, the U.S. health care system is undergoing a period of rapid change that will profoundly affect how alcohol and other drug (AOD) treatment is funded and delivered. Our AOD treatment systems are

changing fast, as substance abuse treatment is increasingly being provided through managed care arrangements. More than 30 States are actively involved in health care reform plans, many of which include efforts to treat publicly funded AOD clients through managed care initiatives. This move to managed care creates tremendous challenges for both State substance abuse agencies and for local treatment providers, who all need to be ready to function well in this new, more competitive environment.

Managed care promises many positive benefits, from cost savings to increased focus on outcomes and on providing appropriate treatment that is targeted to each individual's need. But the change to managed care also carries very significant risks for our clients in the publicly funded system—people who are often poor, have little political clout, and have serious needs and problems not typically covered in private managed care plans.

Managed care is essentially a system for providing acute care, while substance abuse is a complex, chronic, and recurring condition. The length and intensity of treatment are both important for successful recovery of those with AOD problems. Many managed care organizations have little experience with AOD treatment among populations like ours, with their challenging and comprehensive long-term needs.

Another serious risk is that managed care plans could exclude current AOD treatment providers, who are experienced with these difficult populations but may lack the infrastructure and the resources required by managed care organizations (MCOs). These providers, who have worked long and hard to provide services to poor and uninsured clients with multiple needs, deserve the opportunity to continue their services in this competitive new environment.

Nothing is more important at this particular time than the specific contract stipulations that will be made between the States and MCOs regarding AOD services. Personnel in State agencies will need to work through a wide range of issues as they prepare to purchase, manage, monitor, evaluate, and develop MCO standards for providing managed care services to those with AOD problems. Managed care initiatives need to be well designed, carefully developed, closely monitored, and strongly enforced.

States can do much to establish workable, positive contracts with managed care providers that will be comprehensive and equitable for all. Carefully developed contracts can benefit AOD clients now being served in the publicly funded system, as well as supporting our existing AOD treatment providers as they move into the new system. Such contracts can also provide for our particular concerns regarding these clients, including their need for ready access to care, for outreach, for adequate, long-term benefits, and for the special services needed by pregnant women, parolees and probationers, adolescents, and ethnic or cultural groups.

This document is intended to provide guidance to those in State AOD and Medicaid agencies who will be undertaking essential roles as planners and managers of managed care contracts. To address critical issues in this emerging area, the Center for Substance Abuse Treatment (CSAT) sought the advice and direction of a publication development panel made up of experts from States that are already well advanced in developing State managed care plans for AOD clients. The guidelines and recommendations presented in this document are the result of their efforts.

On behalf of CSAT, I wish to express my grateful appreciation to the publication development panel and its chair, Jeffrey N. Kushner, and to Stephen Moss, Ph.D., the consultant and writer. I also wish to extend special thanks to the many dedicated individuals who reviewed this document and provided their comments and expert advice.

The expertise of all of us working together will be needed as we learn to operate successfully in this new managed care environment and seek to preserve the right of publicly funded AOD clients to receive adequate, appropriate, and effective treatment. Within this context, CSAT is pleased to publish this document as part of our mission, in partnership with State and local governments and

community-based programs, to improve the access and effectiveness of addiction treatment and recovery services on a nationwide scale.

We hope this manual will encourage and guide State agencies and treatment providers as they take an active and influential role in shaping and managing our evolving health care system.

Susan L. Becker  
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## Introduction

State alcohol and other drug (AOD) authorities find themselves in the midst of revolutionary changes now occurring in the health care and AOD treatment fields. Regardless of the eventual outcome of national health care reform efforts, States are continuing to enact legislation that is rapidly transforming the service delivery landscape. More than 30 States are in the process of legislating some form of health care reform, and most of these reform efforts include the delivery of AOD treatment services with some form of managed care at their core.

Because many managed care organizations (MCOs) have little experience with AOD treatment among noncommercial populations, the State AOD directors must assume a primary role during this turbulent time. State directors must advocate aggressively for the needs of uninsured and publicly insured populations.

Directors can best achieve this role by maintaining their access to the expertise of today's publicly funded treatment providers. These treatment providers, after years of providing services to these challenging and disempowered populations, have developed a wealth of knowledge and experience about how to reach out to and treat these groups.

Managed care consists of a set of health care management tools that have the capacity *both* to increase the overall quality of a treatment system dramatically *and* to wreak havoc. Managed care initiatives must be well-conceptualized, carefully developed, closely monitored, and strongly enforced. A strong managed care contract must be developed to deal with a set of particular components. Such a contract must:

- Specifically address all key treatment issues
- Specify expectations
- Identify means to monitor compliance
- Offer strategies to enforce both the spirit and the letter of the contract

Public AOD treatment systems have been largely exempt from the impact of the managed care movement that has swept through the rest of the health care industry. This exemption is quickly evaporating. In this new environment, the AOD field must seize the opportunity to frame the debate. State AOD authorities and others involved in the field need to ensure that they play an active and knowledgeable role as new AOD treatment paradigms are being created.

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## Goal

The goal of this document is to help prepare State AOD directors and others (e.g., Medicaid authorities, MCOs, AOD treatment providers, AOD policy makers, and purchasers of managed care services) to:

- Actively participate in the development and management of managed AOD treatment systems in the context of State health care reform initiatives
- Provide guidance to contract effectively with, manage, monitor, evaluate, and/or develop standards for an MCO
- Increase conceptual and pragmatic understanding of how effectively to develop and manage a contract with an MCO that will best achieve system goals
- Provide some model contract language for State agencies to use and build upon with MCOs
- Describe potential strengths and weaknesses of managed care system and identify strategies for using managed care to achieve specified goals
- Describe state-of-the-art managed care practices for AOD treatment
- Provide an overview of financing, contracting, and network management issues
- Identify data needed to monitor access, quality, cost, problems, and outcomes of a managed care system

## Objectives

- Provide an overview of current managed care systems as they relate to public AOD treatment systems
- Identify critical issues to focus upon when working with MCOs

Describe necessary and effective mechanisms for appeal, grievance, and consumer protections

# Chapter 1–Managed Care

# Overview

Substantial confusion about the meaning of the term "managed care" exists among both the general public and alcohol and other drug (AOD) treatment professionals. For purposes of this document, managed care can be described as "an organized system of care which attempts to balance access, quality, and cost effectively by using utilization management, intensive case management, provider selection, and cost-containment methodologies." Tension naturally exists between the fiscal objective of conserving funds and the clinical goal of providing appropriate, quality services in a timely manner to all those who need them.

## Managed Care Models

Since its inception, the managed care industry has moved—and is moving—through several "generations." A basic understanding of the generations of managed care can be helpful in understanding managed care behavior and the maturity of systems (Center for Substance Abuse Treatment 1994; Waxman 1994).

1. The first generation of managed care focused on reducing costs by *restricting access to services* through such means as overly rigid utilization review, limited benefits, and large copayments.
2. The second-generation managed care organizations (MCOs) *manage benefits*. They focus on the development of provider networks, selective contracting, increased treatment planning, and a less rigid utilization review process.
3. Third-generation MCOs focus on *managing the care of enrollees* by emphasizing treatment planning and carrying out more active management of clients through the course of their treatment(s). This involves enhancing the breadth and "seamlessness" of the continuum of care and actively using the least restrictive treatment settings that are clinically appropriate. The MCO may provide highly individualized clinical management for individuals who are at high risk for multiple readmissions or who are particularly challenging to treat.
4. A fourth generation—now being aspired to—is for MCOs to manage by outcomes. This model seeks to focus primarily on the outcomes of treatment and allows great provider autonomy regarding how these outcomes are achieved. To the extent that the field moves toward this

"outcomes management" model, research and clinical findings will be fed back to treatment programs, which will in turn provide new data for further analysis. This will create a *self-correcting treatment system*.

Numerous variations of managed care are rapidly evolving across the country. However, States are most likely to consider only the handful of managed care models that best meet their needs at this time. The most probable models of managed care include health maintenance organizations (HMOs), the managed behavioral healthcare organizations (MBHCOs), and regional integrated service networks (RISNs). Since most State development will be built upon these models, or variations of these models, State AOD directors need a basic understanding of their strengths and weaknesses.

### **Health Maintenance Organizations**

Health maintenance organizations are healthcare organizations that provide and/or ensure the delivery of an agreed-upon set of health maintenance and treatment services to a group of persons for a prepaid amount of money.

The most common form of an HMO is a staff model in which treatment professionals are salaried employees. Other models include:

- A "group model" (contracts for services of treatment professionals in a group practice)
- A "group network" (treatment professionals in a group practice who also accept other patients)
- An "individual practice association" (in an IPA, the management organization administers the plan and contracts with independent treatment professionals who are generally paid a fixed sum of money per person)
- A "preferred provider organization" (in a PPO, the payer directly contracts with individual providers at reduced fees and a guaranteed volume)

For AOD treatment, a theoretical advantage of the HMO model is that AOD treatment is integrated with physical medicine and thus is more in the mainstream of general health care. Many believe that this strengthens AOD treatment services by increasing the understanding of how medical costs are related to AOD-related problems, thus

highlighting the high medical costs associated with these problems. In reality, however, HMOs have often provided a very narrow range of mental health and AOD services. The primary care physician—usually the gatekeeper—is often insufficiently trained in screening for, or diagnosing, AOD disorders.

In HMO settings, mental health and AOD treatment services (i.e., behavioral health services) are often overwhelmed by the physical medicine departments. Behavioral health services are often also undervalued, because these disorders are not well understood by health care administrators. Behavioral health services account for only a small percentage (e.g., 3 percent) of the total HMO expenditures, with AOD treatment services accounting for as little as 1 percent. Since AOD treatment services represent such a small part of the total services, they are often relegated to the background and sometimes are not even tracked. As a result, more than half of all HMOs now contract with specialized firms to enrich their behavioral health treatment services and to remain competitive (Levin et al. 1984; Levin 1993; Frank and Salkever 1991).

### **Managed Behavioral Healthcare Organizations**

This general shortcoming in the HMOs led to widespread criticism and to the rise of MBHCOs. These firms provided all, or specified components of, AOD and mental health care to an enrolled population for a prepaid capitated payment. They offered a range of "products" dedicated to managing mental health and AOD treatment needs. This MBHCO industry rapidly expanded from the last half of the 1980s until about 1992. This dramatic growth created a highly competitive environment that resulted in the active involvement of venture capitalists, frequent acquisitions and mergers, and general instability in the industry. During this growth period, financial concerns often took precedence over the quality of care provided to individuals.

The early 1990s brought a period of consolidation that resulted in the domination of about a dozen major MBHCOs. These organizations aggressively established—and continue to establish—contracts with corporations, governments, and HMOs around the country. These companies now collectively cover approximately 80 million lives (Oss 1993).

In an MBHCO, AOD and mental health treatment needs are not overshadowed—as can happen in an HMO—by the dominance of medical needs. However, these services are not naturally integrated with the medical care system. This lack of a natural bridge for linking individuals with necessary medical services can create incentives to shift costs to the medical sector (Christianson 1989). In addition, AOD treatment can be overshadowed by the mental health sector.

## **Regional Integrated Service Networks**

Regional integrated service networks (RISNs) are a group of mental health and/or AOD providers who have formally organized into a functional entity to provide, manage, and/or oversee the delivery of specified behavioral health care to a defined population. The creation of these networks is a fairly recent phenomenon, but is gaining momentum as increasing numbers of providers and provider organizations attempt to respond to the growth of managed care.

These networks—variations of provider-based PPOs—can vary dramatically in terms of their comprehensiveness, sophistication, and marketability. While RISNs may collectively include a full range of needed services, they may lack the capital, technical expertise, and/or experience to participate successfully in the competitive managed care industry. To compensate for this, networks have the option of purchasing administrative services only (ASO) from an appropriate partner to strengthen the network.

In developing the network, State AOD authorities and other policymakers need to make a decision regarding whether or not to join with mental health providers and form a comprehensive behavioral health network tailored to the unique needs of the State. The advantage of doing so is that combined AOD and mental health services are the norm in existing managed behavioral health companies. The majority of the purchasing market is therefore looking for an integrated product. A disadvantage for AOD treatment providers in such networks is that AOD services are usually the smaller component both in terms of programs and in management. The particular circumstances in a given State should dictate whether an RISN should be formed and what its ideal composition should be.

## **Public Sector and Managed Care**

Virtually all Federal and State health care reform initiatives envision the integration of public and private behavioral healthcare systems. Public behavioral healthcare funding streams—from Medicaid, Medicare, the Department of Veterans Affairs, CHAMPUS, State organizations, and other public payers—are now being redirected to purchase privatized behavioral healthcare services. MCOs are increasingly entering this new market niche. These public-private integration efforts will most likely result in rapid growth of privatized service capacity for publicly funded populations.

Until recently, public purchasers and private sector MCOs have been fairly cautious in terms of forming any kind of working alliance. The MCOs were generally focused on surviving in the highly competitive private sector. They

often believed that employed enrollees and their families are generally more stable, more predictable, and easier to treat effectively as compared to public program beneficiaries, who were seen as less stable, more difficult to treat, and more expensive to cover (Christianson 1989). Public purchasers were not sure that the models and expertise developed by those serving private-sector clients would easily generalize to more vulnerable and impaired populations.

However, in examining the experience of MCOs in the private sector, government policy-makers have become increasingly interested in experimenting with alternative healthcare delivery systems. The hope is that these alternatives will help contain costs and improve quality of care. As a result, more than 30 States are now in various stages of developing health care reform measures. These almost always incorporate managed care concepts or the direct purchase of managed care services.

Despite this movement, community-based, public-sector providers are often skeptical about the ability and incentives of private-sector MCOs to provide appropriate services for vulnerable populations. They believe that most MCOs are not highly experienced in treating publicly insured clients and lack well-established links with key community-based agencies. Such MCOs would therefore be less effective in successfully serving this difficult treatment population.

Most MCOs, on the other hand, believe that their systems of care can be adapted to meet the needs of these populations effectively. They anticipate the integration of public and private health care systems. Eager to enter this evolving market, they are showing dramatically increased interest in serving publicly insured populations.

The strong interest of MCOs in providing services for public program beneficiaries, combined with the strong interest of public payers in using MCOs to help achieve cost-containment and system development goals, will soon result in greater blending of the "private" and "public" systems of care. The collective challenge to overall health care reform is:

1. To integrate the best of what the community-based public sector treatment systems and the managed care industry have to offer, and
2. To build collaboratively the system of care that will take AOD treatment into the next century.

## **Current Managed Care/Medicaid Initiatives**

Currently, State Medicaid agencies all over the country are developing innovative managed care systems. The Medicaid system now has about 12 percent of its 30 million beneficiaries currently covered in some form of managed care, and these numbers are expanding rapidly. These systems are directly affecting, or will be affecting, the delivery of AOD treatment services. State AOD agencies are in a key position to engage actively with State Medicaid systems and become collaborators in developments occurring now and in the foreseeable future.

Two Federal Government Medicaid waivers—allowing States to experiment with new models of care—continue to create opportunities for States to pilot innovative managed care models. The "1115" waiver, the most comprehensive, is used to establish pilot or demonstration projects, usually through a Request for Proposal (RFP) process. The "1915(b)" waiver allows the State to "lock in" Medicaid beneficiaries to certain provider classes and to create central intake systems.

The Medicaid projects—designed to provide more carefully managed, clinically appropriate, and cost-effective care to lower income and more clinically challenging populations—are at the cutting edge of the State healthcare reform movement. The manner by which the government and managed care entities decide and implement the delivery, management, payment, and measurement of care for Medicaid populations is the crucial question. The answer will broadly impact both the direction of healthcare reform and the publicly insured clients themselves.

Massachusetts, Minnesota, Oregon, and Tennessee are some of the most well-known examples of States that are implementing major managed care programs. State programs are described below.

## **Massachusetts**

Massachusetts has one of the most extensive managed care initiatives in the country. In 1992, the State Medicaid agency contracted with a national MBHCO that specializes in servicing the public sector. This MBHCO would manage mental health and AOD treatment services for about 400,000 recipients in Massachusetts. An active collaborative relationship has evolved between the MBHCO, Medicaid, and the State AOD authority.

The project is widely viewed as being both fiscally and clinically successful. Since its inception, the MBHCO has halved AOD treatment costs—largely through eliminating unnecessary hospitalizations, improving overall access, developing useful profiles of program performance, adding new levels of care, and expanding methadone treatment services. It has currently implemented intensive office-based and community-based case management services for the most challenging clients—the addicted, dually diagnosed

individuals and/or pregnant women with AOD problems. An independent evaluation detailing the strengths and weaknesses of this project, mandated by the Health Care Financing Administration, is now available (Callahan et al. 1994).

## **Minnesota**

Minnesota has the longest experience in handling the interface of managed care with AOD treatment. Two initiatives—the *Consolidated Fund* and the *Chemical Dependency Treatment Accountability Plan*—are now up and running.

The *Fund* consolidates a variety of AOD treatment funds into a single consolidated fund. The *Plan* collects data on patient demographics, severity of illness, and treatment placement. It then looks at outcomes by measuring abstinence, utilization of health care services, encounters with the law, on-the-job productivity, and family impact. In an attempt to optimize cost-efficiency and quality outcomes, it will provide better parameters for improving client match to the appropriate setting, treatment modality, and clinical intensity.

## **Tennessee**

In January 1994, by Executive Order, Tennessee implemented a Medicaid waiver that totally replaced its Medicaid system with *TennCare*. Under this system, the State minimized its healthcare management responsibility and reduced its costs by contracting on a capitated basis with competing MCOs.

The cost savings have allowed the State to provide total health care with no tax increase to all Medicaid-eligible individuals (about 800,000), plus another 350,000 people who were formerly uninsured or uninsurable.

To be eligible to contract with *TennCare* and compete for subscribers, each MCO had to establish a comprehensive healthcare provider network, including AOD services. Some MCOs chose to manage AOD services themselves, while others subcontracted behavioral health (mental health and AOD) to an MBHCO that, in turn, established a provider network.

The minimum AOD benefit package which *TennCare* requires MCOs to provide includes two episodes of treatment per lifetime. This minimum has, in reality, become a maximum for most MCOs. Discussions are ongoing about whether to increase or remove this benefit limit, since many people have already exhausted it.

This system will also examine the cost offsets of providing comprehensive AOD coverage. Monitoring, evaluation, and

data-reporting to the State by the MCOs is just beginning and reliable data are not yet available. Anecdotal data on AOD treatment show a shift occurring in primary treatment modalities– from inpatient hospital treatment under Medicaid to precertified outpatient services under *TennCare*.

## **Oregon**

In 1993, the Oregon legislature enacted a bill that includes AOD treatment in the Oregon Health Plan, a plan designed to provide health care to the uninsured and poor. Oregon's vision was to integrate AOD treatment services fully into a comprehensive set of services that are managed and coordinated via primary care and case management.

These comprehensive services would include medical, surgical, and AOD/mental health services, so that the needs of the whole person can be met. The stated goal was to include AOD treatment services in the plan to reduce the inappropriate use and cost of medical and surgical services.

It was understood by all parties involved with this legislation that AOD treatment services, if provided appropriately, would reduce the other health and social costs that inevitably occur when AOD problems are left untreated. The Oregon Department of Human Resources is the buyer and sets standards, capitation rates, and other requirements for the management of the Plan. The Oregon Office of Alcohol and Drug Abuse Programs (SSA) is charged with implementation of the AOD budget, including development of contract standards, placement/discharge criteria, and screening instruments.

MCOs, mostly HMOs, are the managers of the Oregon Health Plan operating within defined geographic boundaries across the State. These MCOs determine the procedures, amounts and methods of payments, and providers to be used in their geographic area. The State has required that the MCOs must initially plan to refer at least 50 percent of their plan members who need AOD treatment to identified "essential community providers." This is intended to ensure that public safety, welfare, and other public costs are protected during the transition into and implementation of managed care. Essential community providers are programs that previously received funds from the Single State Agency (SSA).

## **Concerns About Managed Care**

Implementing a managed care system is extremely threatening to the status quo. Concerns about managed care abound because of past performance and perceived structural shortcomings. Many fear the potential of an MCO for causing harm to the AOD treatment system and to the vulnerable populations that system serves.

It is important to understand the breadth of concerns that have been raised about managed care. These concerns serve as a collective example of what can happen if a managed care initiative is poorly executed (see table 1). This understanding can be critical to State AOD authorities as they attempt to develop stipulations in their managed care contracts that will effectively guard against such abuses.

In assessing the implementation of managed care, it is essential to understand that MCOs are *vendors* of a service who have negotiated service contracts with a government agency, private company, or other entity. These service contracts are designed to achieve specified financial, administrative, system development, and clinical goals. Consequently, both the contracting agency and the MCO share the successes and failures of a particular initiative.

## The Potential of Managed Care

Managed care, having demonstrated the capacity to contain costs in the private sector, is increasingly being proposed as a possible solution to the many challenges that face public sector purchasers of behavioral health care. It is seen as having the capacity to:

- Develop incentives that increase accountability
- Build an integrated continuum of treatment services
- Contain costs
- Improve outcomes
- Introduce much-needed innovation

Managed care techniques—*when properly applied*—offer many new opportunities to State AOD systems. Managed care's powerful tools and methodologies can be applied to develop new systems, reallocate finite resources, expand access, improve quality of care, and/or to "jump-start" a treatment system to help it keep pace with the rapidly evolving healthcare system. Any enlightened, systemwide reform should proceed based on an appreciation of how managed care strengths can be used to achieve reform goals and to reform service delivery systems.

Each State and region differs in its specific financial, political, and systems development reform needs. Nevertheless, quality AOD treatment has basic components that cut across these individual circumstances. These components are described below.

### **Table 1. Common Criticisms of Managed Care**

- Emphasizes short-term cost-cutting at the expense of long-term outcomes and savings
- Has fiscal incentives to delay, deny, or restrict care
- Is used as a means to diminish or eliminate AOD treatment services, or to undertreat AOD clients
- Refuses to purchase longer-term residential care (e.g., recovery homes, therapeutic communities)
- Overemphasizes cost containment and underemphasizes quality of care, program content, staffing, and clinically oriented concerns
- Sets arbitrary limits on the duration, type, or access to treatment
- Utilizes gatekeepers who are poorly trained and/or inexperienced in AOD treatment services
- Restricts methadone maintenance as a treatment option for opioid-addicted individuals
- Is inexperienced in managing special populations (e.g., ethnic/racial minorities, criminal justice referrals, injection drug users)
- Relies excessively on outpatient treatment models
- Uses overly restrictive interpretations of "medical necessity" that contradict or otherwise neglect basic tenets of AOD treatment
- Is based on the needs of the employed and not the unemployed/underemployed
- Makes referral decisions based on general policies and procedures rather than on individual client needs
- Lacks national standards and is unregulated
- Has inadequate grievance procedures

### **Managed Care Needs Assessment**

Many State AOD authorities need to decide which path to pursue regarding their relationship with managed care. The AOD authority must first consider carefully the current strengths and weaknesses of the AOD treatment network, the current status of managed care for publicly funded beneficiaries within the State, and the future desired design of the service delivery system. State situations vary widely on many important dimensions. These include:

- Treatment needs
- Client needs

- Stage of managed care development
- Staff and financial resources
- Political support for AOD treatment services
- Relationship with the State Medicaid agency
- Extent of sparsely populated areas
- Affiliation with other State agencies

### **Conducting an Inventory of the Current System**

To achieve maximum benefit, the AOD authority should perform a careful and critical inventory of the current system. It should minimally include:

1. An examination of the resources available to the State
2. Unmet treatment needs
3. Regional and statewide gaps in a full continuum of care
4. Cultural and ethnic capacities
5. Sufficiency of linkages to housing, social, educational, health care, and other services
6. Adequacy of fiscal oversight and accountability
7. Effectiveness of outreach efforts
8. The quality of screening, assessment, and placement processes
9. Maturity and utilization of quality improvement methodologies
10. Breadth and sophistication of the management information system
11. Status of followup data on treatment outcomes

### **Establishing Priorities**

Establishing priorities for system development is a key step when considering a managed care initiative. Questions that can be asked include:

Is there a preference for uniformity or diversity in services for a specified modality of treatment?

Is there a preference for a larger number of smaller programs which are joined into a network of services, or for a smaller number of larger programs that have multiple levels of care and services?

What are the priorities for program expansion or reduction?

Is rapid development or slower, more measured development more appropriate?

What services are currently provided at public cost? Which agencies fund these services and is there a consensus in goals?

Are there currently achievable savings in the AOD treatment system?

Can medical/surgical costs be substantively reduced by increased access to AOD treatment?

To what degree are payers, legislators, and the citizens of the State supportive of addiction treatment?

Who are the key policymakers and what relationships exist? What commitments will they make to AOD services?

The ramifications of the answers to these questions should be carefully assessed to facilitate achievement of desired goals.

### **Choosing the Optimal Approach**

The AOD authority must decide between two options. One is whether to support the development of a comprehensive, "one-stop shopping" approach to service—where a client can receive a variety of medical, educational, and social services onsite along with AOD treatment.

The second option is to support the development of more free-standing, specialty AOD treatment programs—where a client is referred to other community resources for medical care and for educational, social, and other services. The unique set of circumstances in each State should strongly guide the decisionmaking about these options.

To the extent possible, the State should consider whether its long-term goals for the treatment network are consistent with any proposed managed care plan. If the managed care plan does not promote the treatment goals of the State, the State should seek to modify the managed care plan instead of the treatment goals.

### **Achieving Maximum Benefits**

Managed care systems offer a set of specific clinical technologies that can, in the right circumstances and with careful planning, reshape treatment systems to achieve specified goals (see table 2). Managed care is a flexible and powerful tool—with clear strengths and weaknesses—that can be adapted to a variety of circumstances and used to transform systems in desired directions. Misused, poorly managed, or poorly implemented managed care programs can cause great damage. State AOD authorities and other purchasers of AOD treatment services will benefit from doing a thorough needs assessment and then carefully considering the degree and manner in which managed care would be the most appropriate vehicle to implement reform initiatives (H. Bartlett, New York State Office of Mental Health and Substance Abuse Services, personal communication, 1994).

Much of the current expansion of publicly funded AOD treatment across the country results from the expansion of Medicaid AOD treatment services. However, it is important to understand that managed care is only one of the tools available to effect desired changes in the treatment network. There are many ways to change the quantity, quality, and mix of treatment types available in any State. This can be done through regulations, legislation, licensing, oversight, monitoring, and a variety of direct funding and contract schemes. To best achieve the prevention and treatment goals established by the State, it is important to ensure that these efforts work in concert with a managed care plan.

### **Using Contracts To Achieve Goals**

Given the impact that managed care can have, it is imperative that, once a decision is made to use managed care, a strong and well-thought-out contract be carefully developed, closely monitored, and strongly enforced. The contract *must* specifically address all key areas, clearly specify expectations, outline valid and efficient means to monitor compliance, and have strategies to enforce this

compliance. The MCO should submit a written description of how it intends to comply with contract specifications. A well-designed contract will maximize the chance that a given managed care initiative will achieve its desired goals.

For publicly funded treatment, Single State Agencies for AOD abuse treatment are probably in the best position to monitor stipulations of the AOD abuse contract. SSAs should approach State financing agencies and insist on developing and monitoring AOD contract stipulations with MCOs. It is the SSAs' responsibility to manage the MCO vendors effectively, so they ensure compliance with both the letter and the spirit of the contract.

The managing team overseeing the contract must be strong, and any gaps in their knowledge, experience, or skills must be filled through collaboration with others or through consultation services, which are widely available. There should be no confusion whatsoever about the fact that the MCO will be held accountable for achieving specified goals.

The remainder of the MCO contract should focus on key issues relating to AOD treatment and managed care. These include:

- Access to treatment
- Comprehensiveness of care
- Financial considerations
- Consumer protections

The following four chapters in this book discuss how these arenas should be addressed by managed care providers. Three of these chapters contain sample contract language.

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**Table 2. Possible Goals/Objectives for Managed Care**

<b>Increase Access to Treatment</b>	<b>Improve Service Efficiency</b>
Increase service capacity	Maximize cost-efficiency of service delivery system
Eliminate waiting lists	Reduce inappropriately long stays in any level of care
Build a more comprehensive and seamless continuum of care	Improve utilization of the most appropriate levels of care
Expand geographic access	Increase the "seamlessness" of service between levels of care
Expand outreach	Reduce the delivery of AOD services in hospital

settings

Facilitate earlier identification of AOD problems

Eliminate unnecessary paperwork and processes

Increase access for cultural/linguistic minorities

### **Improve Access to Wraparound Services**

Improve all access to the full range of wraparound services that are critical to the recovery process (e.g., employment, vocational, and child care services)

### **Improve Quality of Care**

Implement state-of-the-art, continuous quality improvement technologies

Improve efficiency of systems to triage and monitor client flow

Increase the clinical focus on complex clinical cases

Influence wraparound services to create greater access for individuals with AOD problems

Increase the accountability for client outcomes

### **Improve Outcomes Measurement**

Expand the capacity to track and monitor individual case progress

Measure relapse rates

Improve the care practices of providers

Measure injection drug use

### **Improve Medical Linkage**

Measure overall health status

Improve linkages between individuals with AOD problems and primary care

Measure overall level of functioning

Improve screening for AOD problems in medical settings

Measure criminal activity

Reduce health care costs by reducing frequency of untreated AOD problems

Measure client satisfaction

Improve screening for medical problems by AOD treatment providers

## Chapter 2–Access to Treatment

Maintaining and improving overall "access" to the treatment system is arguably the most important issue to monitor when first implementing managed care into public treatment systems. Access generally refers to the capacity of a treatment system to facilitate entry into the appropriate treatment, as well as the continuance of that treatment, for all individuals who need it.

The extent of access to appropriate treatment in a managed care system depends on the amount of resources devoted to alcohol and other drug (AOD) treatment services. To understand how much access can be implemented for AOD clients, a key variable will be the resources that are made available.

Most treatment systems have access problems that influence whether or not an individual can obtain and continue to utilize treatment services. Uninsured and publicly insured individuals often lack the resources and the knowledge to negotiate their way through overly bureaucratic systems. Every effort must be made to facilitate their entry into the treatment system. Potential barriers to treatment must be carefully analyzed and steps taken to lessen or eliminate these barriers.

In a managed care environment, access to treatment can be hindered in a variety of overt and covert ways. It is imperative that key measures of access be closely monitored to ensure that access is not intentionally or inadvertently restricted.

### Factors Affecting Access

Access in AOD treatment refers to a variety of diverse factors. Some of the most important factors include:

- Understanding of AOD problems by gatekeepers
- Structured outreach activities
- Timeliness of the first face-to-face meeting after an initial contact
- Geographic proximity to appropriate services
- User-friendliness of the intake and referral systems
- Absence of financial barriers
- Cultural, ethnic, and gender-sensitive treatment
- Adequacy of AOD treatment funding and resources

### Understanding of AOD Problems by Gatekeepers

All too often, gatekeepers into treatment are not sufficiently trained or experienced to assess needs effectively and to triage individuals into appropriate AOD treatment. It is crucial that such gatekeepers

(e.g., clinicians, primary care physicians) be well-trained, sensitive to the bio-psychological aspects of addiction, and monitored regularly.

### **Structured Outreach Activities**

Structured outreach activities maximize access to a treatment system by providing systematic efforts to identify individuals in need of AOD treatment. Such outreach activities might be directed to pregnant addicted women, homeless AOD abusers, injection drug users, or others whose impact on society is high and who are less likely to seek out treatment on their own.

### **Timeliness of Treatment**

Immediate and convenient initial access to qualified providers is a hallmark of any quality treatment system. A key component of high-quality treatment is how efficiently a person in need can obtain appropriate AOD treatment. The motivation to address AOD problems is often fleeting, and a delay in access can easily result in a crucial missed opportunity to initiate treatment. Contracts with managed care organizations (MCOs) should ensure rapid access to all levels of treatment.

Detoxification should be understood as an emergency care service. Individuals should have very easy access (i.e., same day or the next morning) to detoxification evaluation and treatment services 7 days a week.

While screening can occur over the telephone, evaluations should be face to face. Standards should assure 24-hour telephone intake, immediate referral capacity, and rapid access to appropriate treatment. Noncrisis treatment should generally be available in 1 to 3 days (Zwick and Berman 1992). It may be decided that some subpopulations (e.g., pregnant women, injection drug users) should receive higher priority or more immediate access within the system.

### **Geographic Proximity**

Appropriate treatment services must be within reasonable distance for the population served. The maximum distance in time or miles should be determined for each level of care. Since most publicly insured recipients do not have reliable transportation, services should be accessible via public transportation whenever possible. Special plans may be required in rural areas, including the use of volunteers or members of self-help groups to provide transportation. Any outpatient services should be especially easy to access.

### **"User-Friendliness" of Systems**

The "user-friendliness" of a system describes the overall ease with which an individual can negotiate the various steps of a treatment system. To assure access, when policies and procedures are being developed for an MCO plan, it is essential that ease of use should assume the highest priority. Those who utilize the services offered are in an excellent position to rate their access to that service. For example, information regarding the time to first appointment, ease of telephone access, ease of understanding how to use the system, clarity of written materials, and staff attributes can easily be incorporated into standardized client satisfaction surveys, program/MCO records, and ongoing focus groups.

### **Absence of Financial Barriers**

Uninsured and publicly insured individuals are overwhelmingly poor and disenfranchised. Any financial barriers (e.g., copayments) can be a barrier to access and should be avoided.

### **Cultural/Ethnic/Gender Sensitivities**

Treatment that does not meet the cultural, ethnic, and gender needs of clients is poor treatment and will result in poor outcomes. Such non-responsive treatment restricts the access of those with cultural, ethnic, and gender needs.

### **Adequacy of AOD Treatment Funding and Resources**

Quality AOD treatment requires a comprehensive continuum of treatment services. Many State systems do not support such a continuum, because they lack the resources, commitment, and/or understanding of the value of AOD treatment within such a framework. Any managed care initiative should include an analysis of the AOD treatment continuum and the costs associated with needed expansion. Such information is vital to inform the planning process.

### **Avoiding Obstacles and Promoting Access**

Numerous factors can influence— both directly and indirectly— whether or not an individual obtains and continues to utilize necessary AOD treatment services (see table 3). When poorly implemented, managed care can dramatically reduce access to services. When well implemented, it can substantially increase access to care.

Depending on the structure of the contract, MCOs may have strong financial incentives to create obstacles or to otherwise restrict care. All too often, MCOs receive set amounts of dollars which are insufficient to maintain the array of services needed for supporting stability of the patient. When developing contracts with MCOs, it is essential (1) to guard against incentives to undertreat these vulnerable populations, and (2) to build strong incentives to promote access (Frank 1994; Christianson 1989).

### **Managed Care in Rural Areas**

Implementing managed care programs in rural or frontier communities requires careful planning. Such planning needs to address the unique clinical challenges of rural America.

### **The Challenges**

In rural America, mental health and AOD treatment services have been rationed for decades because of poor accessibility and the lack of human and fiscal resources. Access to quality treatment in rural communities and regions is often limited by a range of challenges. These include:

- Geographic distance
- Concerns about confidentiality
- Community prejudice
- Lack of properly trained providers
- Inadequate support services
- Limited benefits
- A conservative values orientation

Often, the public mental health system is the only provider in rural communities.

Several factors contribute to the difficulty of developing an effective managed care system in rural and frontier States. Poverty and unemployment rates are generally higher. Public transportation is lacking. A disproportionate number of populations are at risk for behavioral health disorders.

Additionally, managed care initiatives have primarily happened in more urban centers, which allow a certain economy of scale. The implications of managed care for rural areas are less clear.

### Guidelines for Developing Services

It is important to develop and analyze a baseline inventory of practitioners who are providing AOD treatment services. If that inventory identifies shortages, potential MCO providers can be asked to propose strategies to bring in or recruit professionals in a Request for Proposal (RFP) process.

Managed competition models based upon competition among independent provider groups may not be the most effective model for rural areas. It has been suggested by some that a "managed cooperation model might more effectively improve access and quality of care." This model would create a rural "Authority" that would use subsidies and exclusive franchises to achieve goals. The approach would be flexible, fostering cooperation where needed and competition in areas where sufficient diversity exists. Initiatives involving cooperation would facilitate the development of networks. The managed component would improve the interface between urban and rural areas, coordinate access to tertiary care, and assist in recruiting needed professionals.

When managed care is implemented in rural settings, it is likely that the experience of the company and leadership is more urban than rural in its perspective. It is essential that any implementation in rural areas actively utilize local professional and client groups in adapting managed care principles to rural and frontier settings.

**Table 3. Factors Influencing Access to Treatment**

<b>Obstacles to Access</b>	←→	<b>Factors Promoting Access</b>
Not identifying individuals in need of treatment	←→	Effective screening, assessment, AOD training
Not reaching clients in the locations in which they enter the "system" (i.e., courts, criminal justice system)	←→	Satellite sites, systematic linkage, training
Long waiting periods for appropriate service	←→	Services within 72 hours, depending on severity of clinical need
Multiple steps, places, and people needed to access services	←→	Widely available and simplified intake processes
Arbitrary service limits	←→	Individualized treatment plans
Automatic "fail first" policies (e.g., the client must fail a less intense level of treatment before a more intense level is made available)	←→	Individualized comprehensive assessment used to guide appropriate placement
Geographic inaccessibility	←→	Geographically well distributed sites located on transportation lines
Resource-intensive review and appeal procedures	←→	Highly efficient, publicly known utilization review processes
Excessive and clinically inappropriate exclusionary criteria	←→	Restricted ability to exclude specified types of hours/day of operation
Cultural, gender, and/or ethnic insensitivities	←→	Priority placed on cultural

Restrictive copayments	←	→	competence development
Unknown, untimely, or non-objective appeals processes	←	→	Elimination of copayments
Lack of transportation			Widely known, timely, objective appeals
Patient placement criteria that are nonstandardized, financially driven, and/or subjectively applied	←	→	Transportation available as needed
			Patient placement criteria that are collaboratively developed, clinically driven, objective, and standardized

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## Utilization Patterns As Measures of Access

It is imperative that the managed care industry and the AOD treatment field develop standard access measures, so that data and findings can be easily compared. It is impossible to overstate the importance of consistent data and standardized units of analysis for purchasing, monitoring, and improving care. Accurately managing these data is critical to determining the success of any managed care intervention.

The utilization patterns of various treatment services provide a range of quantifiable measures of access within a managed care system. Also influenced by the quality and outcomes of treatment, these utilization data are easily obtained from medical claims encounter data. They allow systematic comparison of different plans and the ongoing monitoring of overall access.

A review of the literature (Shadle and Christianson 1989; Levin 1993; Mercer 1990, pp. 1-13) suggests that certain measures represent the current state of the art and should be standardized across the managed care spectrum. These state-of-the-art measures include the following:

- Potential purchasers should be aware that AOD treatment often cannot be separated from mental health treatment in MCOs.
- Contracts should ensure that AOD treatment can be analyzed as a discrete entity or it will be impossible to accurately measure access, utilization, quality, or other important variables.
- All levels of care should be separately analyzed, with aggregate totals compiled as needed.
- The utilization rates of clinical subpopulations (e.g. pregnant women, ethnic minorities) should be capable of being discretely analyzed as separate entities.

Recommended annual utilization (unduplicated) profile measures (per level of care) are shown in table 4. Exhibit 1 provides sample contract language regarding actions MCOs should take to provide access to treatment.

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### Table 4. Utilization Rates

(Per Level of Care Per Year)

- Admissions per 1,000 covered lives (unduplicated)

- Total days or units per 1,000 covered lives
- Mean length of stay (LOS) or mean number of treatment units
- Average cost per case

EXAMPLE

	MCO #1	MCO #2	1996
Admissions/1,000	25	50	?
Total Days/1,000	150	150	?
Mean LOS	6	3	?
Mean Cost/Episode	\$750	\$450	?

**Example:** You are a State AOD director and you are comparing the utilization rates of two MCOs that are competing for a contract. In this example, MCO #1 historically has half the admission rate of MCO #2. However, MCO #1 allows its clients to stay in treatment twice as long, resulting in both MCOs averaging the same amount of treatment days per 1,000 clients. MCO #1 pays an average of \$125/day, while MCO #2 pays an average of \$150/day. Using these data as a starting point, you continue to request outcome data, readmission rates, customer satisfaction results, and continuing care profiles to inform your decisionmaking.

**Exhibit 1. Sample Contract Language Pertaining to Treatment Access**

*The MCO shall regularly report on specified utilization data for all levels of care, including, but not limited to, the number of enrolled members, unduplicated admissions per 1,000 covered lives, day/units per 1,000 covered lives, mean length of stay/number of treatment units, and mean cost per case.*

*The MCO shall provide emergency, urgent, and nonurgent care within specified, clinically responsive timeframes. Emergent care should be offered immediately or within 4 to 6 hours, depending on the situation. Urgent care should be available within 24 hours. Noncrisis treatment should generally be available in 1 to 3 days (Zwick and Berman 1992).*

*The MCO shall develop an outreach plan with specified objectives and regularly report on its success at reaching those goals.*

*The MCO shall make and report on systematic efforts to identify, or encourage the identification of, beneficiaries with AOD problems and refer them for evaluation and treatment.*

*The MCO shall ensure systematic screening for AOD disorders in those settings most likely to deal with individuals at high risk for AOD problems. These may include standard screening tools as part of initial contact with the system, during routine physical exams, at initial prenatal contact, when "trigger conditions" suggest a high possibility of AOD problems, or when there is evidence of serious overutilization of medical, surgical, trauma, or emergency services.*

## Chapter 3–Comprehensiveness of Treatment

Comprehensiveness in the context of alcohol and other drug (AOD) treatment is a very broad umbrella term that may encompass numerous key aspects of service delivery. For purposes of this discussion, "comprehensiveness" refers to the capacity to:

- Provide a full continuum of AOD treatment services
- Base treatment on ongoing bio-psychosocial assessments
- Utilize standardized patient placement criteria (PPC)
- Facilitate appropriate linkages with medical, psychiatric, and/or social support services
- Meet the cultural, gender, ethnic, and other specialized needs of those served
- Utilize a network of providers experienced in serving the covered population

### Full Continuum of AOD Treatment

The managed care organization (MCO) shall ensure that enrollees have access—directly or through functional affiliations—to a full continuum of prevention, treatment, and rehabilitation services. These services include:

- Prevention/pre-treatment
- Screening, assessment, diagnosis, intervention, and referral
- Outpatient counseling
- Psychiatric services
- Structured day treatment
- Short- and long-term residential treatment services
- Opioid substitution therapies, such as methadone treatment
- Freestanding and outpatient detoxification
- Hospital-based detoxification
- Case management services

When such services do not exist in the community, the MCO shall create these services.

The need for a full continuum of care is critical. However, continuing care (often called aftercare) needs to be clearly distinguished from acute, or initial, care. This distinction is important. Irrespective of the care received in the initial recovery phases, the extent to which the individual gets periodic services for the first 6 months to a year after treatment is strongly related to the probability that the person will continue recovery.

Continuing care services should be widely available and strongly supported by all MCO systems. Also, there may be value in trying to create a separate entity of the benefit package, ideally 6 months of weekly outpatient visits, that cannot be eroded by other services and are available for relapse prevention on an "as needed" basis (Hoffmann 1993).

## **Assessment**

Standardization of assessment processes is an essential developmental step that is urgently needed in the AOD treatment field. Such standardization will:

- Improve the overall quality of assessments
- Allow less trained staff to perform adequate assessments
- Provide a consistent data base to compare the effectiveness of different treatment protocols upon different types of people with AOD problems

Any transition to managed care should include consideration of more standardized assessments.

The requirement for standardization must be balanced, however, with the requirement for the flexibility to meet the needs of the particular population being served. Assessment instruments may necessarily vary across different types of treatment settings, clinical needs, and geographic situations. However, they all should contain a core set of State and nationally standardized data elements. The policies of the MCO should aggressively facilitate such standardization. In addition, these assessment data should be retrievable for review as agreed upon by the contract with the MCO.

There are difficult tradeoffs when determining the location, type, and number of assessment sites. MCOs use a variety of models to assess and triage individuals into and within the treatment continuum. These may include:

- Assessment and triage capacity at all treatment sites
- Walk-in and call-in access
- 24-hour hotlines
- Central intakes
- Local community-based assessment sites
- Employee assistance program (EAP) triage centers

All models have advantages and disadvantages. In many ways, implementation is more important than the model. It is important to analyze local needs, clients served, previous experience, and

current patterns of service delivery. Based on these factors, one can develop the assessment and entry systems that are most likely to achieve desired goals for a given State, region, or system.

## Screening

It has been estimated that 75 to 85 percent of individuals with AOD problems *never* receive formal AOD treatment. To achieve middle-term savings through early identification and intervention, state-of-the-art models of AOD treatment must provide comprehensive screening for problems throughout the health and human services system. Ideally, systematic screening for AOD problems will be available or done in psychiatric settings, correctional settings, medical settings, and in a broad range of social service settings.

Early intervention and referral to outpatient AOD services should be seen as a hallmark of quality AOD treatment. Infrequent use of the simple, inexpensive screening devices that are available for AOD problems leads to insufficient early case identification. This failure to identify AOD problems early results in missed treatment opportunities, increased AOD treatment costs at a later stage, and increased overall medical costs.

## Prevention

As the managed care field matures, increasing attention is being focused on longer term outcomes, demand reduction, and cost savings. A number of technologies are being increasingly used. These include:

- Prevention
- Wellness training
- Early identification
- Pretreatment
- Targeted outreach
- Brief interventions
- Other clinical technologies

Many expect that the focus of managed behavioral health care will substantially move in this direction, especially among systems that are financially "at risk." These systems will be motivated to become proactive in reducing the likelihood that clients will subsequently need more intensive and costly care.

Increasing the capacity of a system to screen for AOD problems is essential in being able to offer targeted prevention efforts and to intervene earlier in the course of an individual's substance use disorder.

The sources of referral for individuals with AOD problems is one key component of any managed care system that needs to be understood. These referral sources should be systematically monitored as closely as possible. Common referral sources for the publicly insured—the courts, child protection agencies, welfare systems—must be borne in mind when developing and monitoring systems.

Although health maintenance organizations (HMOs) and other capitated systems have economic incentives to promote wellness, the results are mixed. In situations where managed care is provided

through HMOs, physicians are the source of referral about 40 percent of the time. This is despite the fact that physicians are often ill trained to screen for and diagnose substance use disorders. Therefore, physicians should be thoroughly trained in screening technologies, in conducting brief interventions, and in the use of standard AOD screening tools (Levin 1993).

As one component of continual improvement activities, the physicians should also be systematically monitored for their rate of referrals to AOD caregivers for evaluation and treatment. AOD providers should be monitored for their response to the referrals in a timely, professional, and collaborative manner.

Contracts with MCOs should emphasize the importance of early identification and screening of AOD problems, and purchasers of managed care should closely monitor performance. Many standardized screening tools are available. Brief intervention techniques (mild clinical interventions that can be provided at a variety of settings by trained individuals) hold promise for the less severely impaired. The Center for Substance Abuse Treatment (CSAT) has recently developed a Treatment Improvement Protocol (TIP) on simple screening instruments for alcohol and drug abuse and infectious diseases; this TIP is an excellent resource for States to use when implementing screening systems (CSAT 1994).

## **Patient Placement Criteria (PPC)**

Some believe that the short-term financial incentives to cut and/or contain costs can create a powerful conflict of interest regarding quality care for the purchasers of managed care. They would prefer to see the government—preferably State alcohol and drug authorities—establish criteria on the environment, intensity, and duration of services. Others believe that this approach would be too restrictive, too intrusive, and would undermine the capabilities of the MCO to innovate and improve systems of care. Most would agree that the best case scenario would be that such criteria—and the implementation of these criteria—be created and continually refined through an active collaboration between the MCO, the State financing authority, consumer advocacy groups, and the State alcohol and drug authority.

A standard set of written patient placement criteria for a State is a reasonable goal. In this way, the placement process can be more understandable and acceptable to providers and clients alike. Standardized criteria also help create a level playing field in which competing MCOs will operate. In a collaborative system, the standards can be openly discussed and amended as understanding increases. All gatekeepers should be trained in the use of the PPC adopted and used in the State.

There are many different routes to follow in implementing statewide patient placement criteria. Insurance statutes can be used to govern how MCOs determine AOD benefits. Regulations can be developed to govern eligibility for funds or licenses. Contracts can be written between providers, MCOs, and/or the State.

The Patient Placement Criteria developed by the American Society of Addiction Medicine (ASAM) have stimulated much discussion and action in the field. Many States have adapted these criteria to fit individual State circumstances. CSAT recently sponsored a Treatment Improvement Protocol (TIP) on Patient Placement Criteria, which should be available in 1995. A review of these publications would be helpful for State planners and AOD providers.

## **Core Set of Wraparound Services**

Wraparound services are services provided to individuals and families to enhance, supplement, and support AOD treatment services. They are an essential adjunct to treatment and are often a key to successful outcomes, although they are not usually considered treatment services. They are usually not—but can be—funded under AOD treatment benefits. It is imperative that any MCO managing the care of these beneficiaries ensure effective access to these wraparound services. Successful linkages to primary care, mental health care, and social services are essential to coordinated care and positive outcomes.

Most healthcare reform discussions separate social and public health services from general healthcare services. At the same time, there is a possibility that some of the dollars spent on treatment-related social services will be mixed with healthcare dollars and that certain services, such as housing and transportation, will fall into a financial vacuum. Thus, it may be important to identify and publicly fund certain wraparound services as separate from health care and as an MCO's responsibility.

One can divide wraparound services into (1) those that are essential to access and (2) those that contribute to positive outcomes. At a minimum, essential wraparound services include child care and transportation.

Wraparound services that contribute to positive outcomes include:

- Primary health care
- Screening and referral for HIV disease, tuberculosis (TB), and other infectious diseases
- Mental health services
- Legal aid
- Vocational training
- Education services
- Supportive living arrangements
- Domestic violence services
- Financial assistance
- Liaison services with Immigration and Naturalization services
- Other social services

Often, MCOs rooted in the private sector are not well linked to many of these wraparound services. The contractor should identify the most salient services for its population and determine the most effective way to ensure access. The contractor should also contractually ensure that:

1. The MCO provides and covers certain services that have not been considered traditional healthcare services, such as transportation and child care, or
2. The MCO develops effective linkage mechanisms to these services

## Medical Linkage

In the United States, \$1 of every \$7 spent on health care is related to complications of AOD problems. More than 70 medical conditions and diseases are attributable, in whole or in part, to alcohol abuse. These conditions and diseases include cancer, cardiovascular disease, trauma, birth complications, and acquired immunodeficiency syndrome (AIDS) (Merrill et al. 1993).

It is therefore crucial that medical care be closely integrated with AOD treatment. In behavioral healthcare carveouts, there must be a clearly established and functionally feasible linkage with

primary care services (e.g., with adjoining primary care clinics and primary care physicians). In HMOs, there must be close monitoring of the expertise of the gatekeepers and the effectiveness of the internal referral systems. In all cases, the primary care linkage to AOD treatment programs must be considered a priority and must be systematically measured as well as possible.

In Minnesota, AOD system developers wanted to create financial incentives for providing clients with efficacious levels of AOD treatment the first time they enter treatment. The Minnesota system developers found it essential to insert legislative language that directed decision makers and their numbers-crunchers and/or actuaries to look at cost offsets in creating these financial incentives. They incorporated the following language into law as a factor to be considered when developing a universal standard benefit set:

In developing the universal standard benefits set, the commissioner shall take into account factors including, but not limited to, cost savings resulting from the inclusion of healthcare services that will decrease the utilization of other health care services.

Assuming that this would not be fully understood by the actuaries, they followed it up by inserting specific actuarial assumptions into the commissioner's quasi-rulemaking directive to the actuary "for public and private plans." In Oregon, the medical/surgical capitation rate was reduced in anticipation of offsets resulting from AOD treatment.

## Special Populations

In any given pool of enrollees, there are "special populations" that require responsive treatment facilities, staff, outreach, and case management. Such populations include, but are not limited to:

- Women—especially pregnant women
- Intravenous drug users
- People exposed to human immunodeficiency virus
- Those with coexisting AOD and psychiatric disorders ("dually diagnosed")
- The criminally involved
- The elderly
- Cultural and ethnic minorities
- Adolescents
- People with multiple disabilities

Underserved populations require targeted outreach efforts to assist them in getting into and staying in care. Contractual financial incentives often discourage such outreach, and many MCOs are not sufficiently community-based to provide this outreach effectively. This type of outreach may be best achieved by a separate party (e.g., the AOD authority). A thoughtful decision must be made regarding who is best positioned to reach out effectively to these populations.

## Provider Network

Incorporating managed care into a publicly funded AOD treatment system will have a dramatic impact on the providers in that system. Some will adapt quickly to the new environment and prosper, some will fight to remain viable, and others will not survive the transition. Mergers, new affiliations, and new system developments will radically change the service-delivery landscape. The MCOs may be inclusionary or exclusionary in how they implement systems development. However, the MCOs should only be able to use licensed facilities.

It is therefore crucial that State AOD authorities do their best to support the initial inclusion of these existing licensed programs and assist them in adapting to the new environment. Extensive training may be required to assist some providers. Information regarding managed care should be systematically forwarded to them. Trainings and educational forums can be provided or strongly encouraged. (Note: Appendix C, "Managed Healthcare Organizational Readiness Guide and Checklist," which is a tool to help analyze a provider's capacity to function successfully in a managed care environment, can be used by both programs and State systems to identify their strengths and weaknesses.)

Needed consultative or technical assistance services can be arranged. Strategic planning processes—both at the system and provider levels—can be implemented. Within the limits of resource capabilities, State AOD authorities should provide leadership in designing and implementing strategies that will enable publicly funded AOD providers to participate successfully in the managed care system.

### **"Any Willing Provider"**

Many States are now adopting or considering "any willing provider" legislation in an attempt to lessen the exclusionary power of MCOs. This type of legislation—mandating that all providers who are willing to meet specified standards and accept a given rate will not be excluded from a managed care network—is highly controversial. Fundamentally, the advantage of such legislation is that it can prevent a provider or group of providers from being formally excluded from a managed care network. The disadvantage is that it can substantially restrict the capacity of an MCO to accomplish clinical goals and that *de facto* exclusion could still probably occur. State AOD authorities must examine the individual circumstances of their particular State to decide whether or not to support such initiatives.

### **Essential Community Providers**

The financial and societal consequences of undetected, untreated, or inadequately treated AOD problems are enormous. During a transition to managed care, it is essential to the public safety, welfare, and economy of a State that the treatment offered to the uninsured or publicly insured populations not be dramatically reduced or made less available. Measures must be implemented to ease the inevitable problems of such a transition and to ensure that the provider systems in place are not abandoned in a wholesale and reckless manner.

Many MCOs are not highly experienced in treating addictions among the type of clientele that is characteristic of publicly funded programs. For this reason, many believe that new systems should encourage the initial inclusion of the local, publicly funded AOD treatment programs that have been serving this population. Traditionally, these publicly funded programs have operated for years with insufficient funding. They are at a distinct disadvantage relative to providers who have been funded in the private sector for treating the commercial population.

However, these publicly funded providers offer major strengths and advantages. These providers have:

- Developed strong community linkages with key supportive services
- Demonstrated sensitivity and commitment to the needs of the publicly insured individual

- Demonstrated that they are capable of being, by necessity, highly cost-efficient in the delivery of clinical services

The loss or functional exclusion of such services in the name of reform would represent a substantial step backwards in attempting to meet the needs of the publicly insured population.

As healthcare delivery systems are transformed, planners need to be creative in combining the community-based strengths of the publicly funded system with the technical and managerial strengths of the managed care industry. One way to facilitate a successful transition to managed care—while still protecting the public good—is to encourage contractually the inclusion of community-based providers as "essential community providers" for a designated transitional period.

Exhibit 2 provides sample contract language relating to the comprehensiveness of treatment.

## **Exhibit 2. Sample Contract Language Pertaining to Comprehensiveness of Treatment**

**Individualized Care** *The MCO shall support the delivery of individualized care with a comprehensive continuum of services that provide the most appropriate intensity of care in a cost-effective manner.*

**Full Continuum of Services** *The MCO shall ensure that enrollees have access—directly or through functional affiliations—to a full continuum of prevention, treatment, and rehabilitation services. These services include prevention; screening, assessment, diagnosis, intervention and referral; outpatient counseling; psychiatric services; structured day treatment; short- and long-term residential treatment services; opioid substitution therapies, such as methadone treatment; freestanding and outpatient detoxification; hospital-based detoxification; and case management services. When such services do not exist in the community, the MCO shall create these services.*

**Assessment** *The MCO shall base treatment on a comprehensive biopsychosocial assessment.*

*The MCO shall utilize a core of retrievable standard data elements in all assessments. Assessment instruments shall be approved by the State AOD authority and shall be consistent with specified patient placement criteria.*

**Screening** *The MCO shall ensure that effective screening is conducted for AOD problems and shall facilitate the development of new community-based treatment settings in areas with the highest rate of problems.*

**Prevention** *The MCO shall provide members with contractor-specified prevention and education programs on AOD use; these programs shall have a special focus on risk factors for AOD problems and on specified vulnerable populations.*

**Standardized Patient Placement Criteria (PPC)** *The MCO shall use standardized admission, continuing care, and discharge criteria that are consistent with emerging national clinical norms to guide decisionmaking regarding the appropriate intensity of care (e.g., ASAM/ASAM- modeled criteria).*

*The MCO shall ensure that its policies, practices, and procedures encourage strong linkages with appropriate specified supplementary and supportive services, agencies, and organizations. Performance will be monitored systematically, using contractor-specified performance measures.*

*The MCO shall operate a structured case management program that includes a process to identify complex cases at all levels of care. Specialized or dedicated case management staff shall proactively coordinate care and follow client progress through the continuum of care. Patient placement criteria shall be developed by the State AOD authority and utilized by the MCO to assure consistency and openness regarding placement decisions.*

**Outreach** *The MCO shall ensure that the unique needs of specified populations are identified and met in a clinically appropriate manner.*

*The MCO shall provide, or contract for when necessary, specialty AOD care when clinically appropriate and legitimately unavailable within the MCO's range of services.*

*The MCO shall develop processes of outreach to contractor-identified special populations at risk for AOD use disorders who may have difficulty accessing care.*

*The MCO shall actively collaborate with the courts to place appropriately those clients who are diverted into treatment.*

*The MCO shall develop criteria to ensure that chemically dependent individuals have access to cost-effective treatment options that address their specific needs. These include, but are not limited to, the need for: treatment that takes into account severity of illness and comorbidities; provision of a continuum of care from primary inpatient to outpatient care, aftercare, and long-term care; the safety of the individual's domestic and community environment; gender-appropriate and culturally appropriate programs; and access to appropriate social services.*

**Wraparound Services** *The MCO shall ensure that providers develop affiliation agreements and policies that support smooth, clinically sound transitions of recipients from one service environment to another.*

*The MCO shall ensure that all clients are provided with documented access to a core set of contractor-specified wraparound services which are then individualized according to client need.*

*The MCO shall regularly report on (1) its efforts to expand and refine systemic relationships with contractor-specified wraparound services; and (2) measurable success in ensuring client entry into specified wraparound services.*

*The MCO shall provide, measure, and regularly demonstrate effective linkages for its enrolled population among a broad range of contractor-specified primary care and public health services.*

## Chapter 4–Financial Considerations

Fee-for-service reimbursement is a system in which payment is based on actual services rendered. Until recent years, this system has been the mainstay of most reimbursement for privately funded alcohol and other drug (AOD) treatment services. However, fee-for-service reimbursement has inherent incentives—both financial and clinical—to overutilize services and to overtreat clients. Because every additional unit of service generates additional revenue, there is little incentive to monitor treatment more tightly or to lower costs. The result can often be waste and inefficiency.

Most individuals who work in the AOD treatment field want to provide quality care to those whom they treat. To the degree that financial incentives strongly encourage *both* high quality *and* cost-efficient treatment, most provider systems will deliver treatment that is good for clients, for taxpayers, and for health care in general. Effective reimbursement systems attempt to tap these good intentions.

### Capitation 23

Capitation is a method of reimbursement in which a fixed sum of money is paid per enrollee by the purchaser to the provider. This sum of money is expected to cover specified services for every enrollee for a defined period of time. Capitation agreements attempt to create a system in which those delivering care are financially motivated to deliver the highest quality care and to achieve the best outcomes in the most clinically and cost-efficient way possible.

A shift in the financing of behavioral health care toward capitation models is rapidly evolving. This represents a major policy shift from retrospective to prospective reimbursement systems. Payment is gradually moving away from fee-for-service and toward risk-based payments—either per case fees or capitation payments. Often, these risk-based payments are linked to performance on specified measures (Oss 1992, 1993).

The essential components of a capitation contract include:

- Prepaid care to cover all clinical and administrative costs

- A contracted provider who is at full or partial risk

- Financial incentives to manage care wisely

- Payments tied to a specific risk pool

- Increased emphasis on outcomes rather than on amount or level of treatment

Capitation creates clear financial incentives to minimize hospital use through the development of a comprehensive continuum of treatment services. This continuum of services has the advantage of facilitating the treating and maintenance of enrollees within their community, where they will receive ongoing support for recovery (Christianson 1989). Capitation requires establishing clear performance criteria in such areas as accessibility, treatment appropriateness, customer satisfaction, individual outcomes, and outcomes for the enrolled population as a whole. Capitation thus focuses attention on the achievement of specified *results* rather than on the mechanisms of *process*.

Capitation engenders strong emotions for those in the field. Christianson (1989) summarized the polarization around the issue when he wrote, "Proponents of capitated financing foresee cost savings and better integration of a relatively fragmented service delivery system. Skeptics fear that capitated arrangements will lead to access barriers, the channeling of patients to inappropriate providers, and cost-shifting."

Most agree that capitated reimbursement models can, if implemented properly, create increased clinical accountability for individual and aggregate outcomes. This level of clinical accountability cannot easily be duplicated in a fee-for-service environment. Fiscal and clinical incentives encourage the capitated party to consider all available options for meeting client needs in the most efficacious way. These fiscal and clinical incentives can foster innovation by encouraging the use of treatment settings that are not traditionally purchased in fee-for-service financing (Dangerfield and Beitt 1993).

However, depending on the nature of financial incentives built into the contract, capitation can create strong short-term incentives to underprovide care as a cost-cutting measure. Monitors of a capitated system must therefore develop an expanded set of concerns, skills, and systems to maintain the integrity of the treatment system and to ensure appropriate access to treatment (Schaller et al. 1986). In many situations, the State AOD authority is well positioned to be such a monitor.

## **Risk Management**

Risk management refers to a health care organization's desire to minimize the financial risk of delivering services in a capitated system. The financial risk may be borne by the provider, by the managed care organization (MCO), or by the entity that is purchasing the managed care service, or the risk may be shared in agreed-upon ways. Adverse selection—having an unfair and disproportionate number of expensive-to-treat enrollees—is avoided whenever possible. Management of this risk is a key challenge in most managed care systems.

In any pool of enrollees, there will be subgroups who utilize treatment services differently. Some groups will be more expensive to manage and some will be less expensive. It is essential to understand the clinical and treatment characteristics of the populations served. For example, in the behavioral health field, it has been estimated that 40 percent of all mental health/AOD expenditures are made on behalf of just 2 percent of the population (Frank 1994). In most cases, this is related to individuals with severe mental health problems who have AOD problems that exacerbate the condition.

When provider organizations compete to attract enrollees in &nbsp;capitated systems of care, there are strong financial incentives to limit, discourage, or disenroll those individuals who can be expected to incur higher costs. Providers who attract a disproportionate share (i.e., adverse selection) of such persons face serious financial risk unless they are protected by some form of adjustable capitation payment, shared risk, or stop-loss mechanisms. Reinsurance or other "stop loss" provisions are ways to protect against unforeseen costs. Providers under such an arrangement are protected from financial loss beyond a certain predetermined level (Mechanic 1993).

## Benefit Package

The benefit description (i.e., what treatment services must be available in the plan) needs to be clearly defined. Any capitation payment must be substantial enough to support delivery of these defined services. If there are services that fall outside of the domain of the MCO, certain requirements will be needed. These include:

A mechanism must be provided for the client to receive these services.

Some assurances are needed that there will be timely access to these services.

Assurances are needed that these services will be coordinated with the MCO.

Capitated health care systems must incorporate effective checks and balances to ensure that short-term incentives to undertreat do not overwhelm the longer term incentives. For positive outcomes, checks and balances are critical because they support longer term goals—to build quality services and improve overall health status. To offset short-term incentives to undertreat, important balances include (1) sufficient funding for the services required, (2) clear performance indicators, and (3) longer contracts (e.g., 25 years) that increase the incentive for MCOs to seek longer term positive outcomes.

Before the advent of managed care, financial exposure was limited by such means as placing maximum individual limits on the amount, duration, and/or type of treatment. Such limits are largely unnecessary in a managed care environment. However, use of such limits still prevails, despite the fact that they can result in denials of treatment that are clinically unsound and financially counterproductive.

The contracting agency makes the final determination regarding the benefit package that the MCO must implement. Depending on the situation, the MCO may or may not be able to influence this decision significantly. Thus, service coverage within a managed care system may include a number of benefit limitations that need careful examination. These benefit limitations may include:

Restrictions on the number of available hospital days or ambulatory visits

Copayments, deductibles, or other enrollee-paid fees

Supplemental benefits available only for an additional monthly charge

Mandatory periods of time (e.g., 90 days) between treatment episodes

Limitation of sufficient resources (e.g., facilities and/or personnel)

Annual or lifetime payment limitations

Arbitrary "fail first" policies

In developing or evaluating the terms of a managed care contract, it is imperative that the benefit package be closely examined. Attempts should be made to minimize or eliminate any arbitrary limits of care that are not well grounded in clinical practice.

## **Cost-Shifting**

Cost-shifting occurs when the care of a particular condition is "shifted" inappropriately to another treatment facility, State agency, or other entity. Cost-shifting is a common problem in any systems development. It is imperative that developers aggressively consider how to minimize incentives for shifting costs. What incentives will there be for the MCO to transfer care (and therefore cost) to other State agencies? How will care and responsibility for individuals be determined between the MCO and other agencies? What kind of interagency agreements should be developed to guide these decisions? How will possible cost shifts between the MCO and medical services be monitored?

With today's healthcare reform of publicly supported clients, many MCOs are now placed in the position of becoming the provider of services to the indigent (i.e., the provider of last resort). There are no other resources or providers to whom MCOs can shift costs. State AOD agencies need to consider contract benefits and responsibilities from this perspective.

## **Actuarial Analysis**

In any capitated situation, it is essential to understand the case mix (i.e., the clinical characteristics) of the pool of enrollees and to determine the likely per-person cost of treating each group. Actuarial companies are companies that specialize in analyzing past utilization data for specified groups and then, using assumptions when necessary, estimating likely future costs for treating each group.

There is considerable "art" in the science of actuarial prediction. Good actuarial work needs to be thoroughly attuned to the real world, so that any assumptions are grounded in logic and represent the field as it is currently practiced. Actuarial analysis is only as good as its sources, and therefore depends on the quality of the historic cost data, the accuracy of the demographic data, and on the validity of its assumptions.

An actuarial analysis is the basic tool used by insurance firms to determine how much to charge for a policy that would pay for a defined benefit package. State agencies need to estimate how much the State should expect to pay for the services it proposes to contract through a managed care firm. States employ actuaries to prepare such analyses. The final analysis combines a variety of estimates, calculations, and assumptions as the basis for computing the cost per covered person per month, the "PMPM" (per member per month).

Whenever possible, actuarial analysts will base estimates on concrete data and, when necessary, will make assumptions to compensate for missing, incomplete, or inaccurate data. During negotiations, actuaries will usually tend to estimate conservatively and err on the side of a high PMPM. In order to stretch limited funds, it is usually in the interest of the State purchaser and the State AOD authority to lower the PMPM to the lowest level that can still support a quality care system.

In working with actuaries, it is thus very important to provide them with appropriate assumptions. To the extent possible, one should try early in the discussion to define what assumptions the actuaries are actually using. Model building for PMPM should accompany or precede actuarial analysis. Such model building will force explication of what the payer wants, in what volume, and for what populations.

The importance of providing assumptions for the actuaries cannot be emphasized enough. Experience in healthcare reform at the State level has shown that battles about benefit packages ultimately end up in actuarial wars between competing sets of numbers. These competing numbers are used by opponents as reasons to reduce benefits for appropriate and cost-effective services.

It is important to understand the actuarial process and to question aggressively the actuaries who establish the capitation rates. The critical question is whether the rates being proposed are sufficient to guard against undertreatment. If the capitation rate is insufficient, undertreatment of substance abuse problems will result.

During the actuarial process, it is important for decision makers and actuaries to be knowledgeable about the many cost offsets related to AOD treatment. This knowledge can be a driving force for creating financial incentives to provide efficacious levels of treatment.

Overall actuarial studies should be tailored to the options that the State is considering for controlling costs (C. Hansen, Washington State Division of Alcohol and Substance Abuse, personal communication, 1994).

## **Chapter 5–Consumer Protections**

The relatively recent emergence of behavioral healthcare companies has resulted in this type of health care being largely unregulated by both States and the Federal government. Although States and the Federal government regulate health maintenance organizations (HMOs), health insurers, and alcohol and other drug (AOD) treatment providers, few such regulations govern the activities of managed care firms. While many firms act in good faith and provide quality services to those served, some do not and thereby damage the overall reputation of the industry.

In the absence of such regulation, several problems have occurred at different times in the implementing of managed care programs. These include:

- Failure to have adequate staff with specific skills and training in AOD diagnosis and referral

- Failure to use acknowledged AOD patient placement criteria

- The use of financial arrangements that create incentives to undertreat

Inadequate grievance procedures

Inadequate emergency procedures

Incomplete coverage for approvals in the evenings and weekends

Inappropriate shifting of costs to public funding sources

Without consumer protections in place, this combination of factors can potentially lead to inadequate and sometimes dangerous care. In response to this, the Model Managed Care Consumer Protection Act was established to provide reasonable protections to consumers. It sets a standard that allows responsible managed care firms to continue to carry out their functions, but creates much-needed consumer protections for those firms whose policies or fiscal incentives can lead to less than adequate care (President's Commission on Model State Drug Laws 1993, pp. D75-D95; D. Gates, Pennsylvania Health Law Project, personal communication, March 1994).

## **Focal Points for Consumer Protection**

The following are some key consumer protection areas that should be incorporated into a contract with a managed care entity. Exhibit 3 provides sample contract language pertaining to consumer protection.

### **Openness of Systems**

MCOs differ substantially regarding how available, specific, and/or valid their patient placement criteria are to providers and enrollees. Public access and input to these processes can lead to improved quality, accountability, and provider/consumer relations.

### **Out-of-Plan Services**

It is important that enrollees have reasonable access to appropriate treatment services. Systems need to be set in place to ensure this access if providers cannot, at a given time, offer these services within the formal system.

### **Consumer-Friendly Materials**

Written information from MCOs is sometimes difficult to obtain and challenging to read. It is essential that all necessary materials be readily available and be written in clear and simple language(s).

### **Disenrollment Protections**

The extent to which services are covered and the amount of that coverage vary greatly. Limits on coverage can include maximum number of days, number of visits, or dollar amounts.

MCOs often have incentives to disenroll or to encourage disenrollment of individuals perceived as expensive or difficult to treat. Additionally, in highly competitive markets, MCOs sometimes use dubious procedures as they compete for enrollment.

In general, contracts should make disenrollment by the provider or MCO very difficult. This can be done by requiring that the provider or MCO take multiple and monitored steps in disenrollment, while making disenrollment by the consumer a relatively easy, single-step process (Boyer 1993; President's Commission on Model State Drug Laws 1993). All disenrollments should be documented and reviewed by the financing agency and/or the State AOD authority.

## Appeals

Legitimate differences of opinion regarding the clinically appropriate level, length, or intensity of care for a given problem are inevitable. Every MCO must have a user-friendly vehicle for handling appeals and grievances.

## Staffing and Gatekeeping

The training, experience, qualifications, and overall sensitivity of "gatekeepers" is crucial when addressing the needs of individuals with AOD problems. Gatekeeping is a central component within the managed care environment. MCOs should be required to provide ongoing training of gatekeepers.

The MCO should be able to demonstrate knowledge of all relevant Federal/State laws and governing provisions regarding AOD treatment. Such relevant laws and regulations include the Americans with Disabilities Act and confidentiality regulations.

### Exhibit 3. Sample Contract Language Pertaining to Consumer Protection

#### **Openness of Systems**

*The MCO shall use and disclose the patient placement criteria (e.g., ASAM) used by clinicians, make other contractor-specified information publicly available, and regularly elicit formal comment from involved agencies and enrollees.*

*The MCO shall systematically meet with other specified organizations (e.g., State agencies, healthcare organizations, provider organizations, and consumer groups) to maximize the integration of necessary care across organizational boundaries.*

*The MCO, or the contractor of the MCO, shall establish a community advisory board composed of carefully selected representatives (e.g., consumers, providers, relevant agencies, people in recovery, public health and mental health providers, and criminal justice representatives) who regularly meet with the MCO to monitor and suggest policy evolution.*

*The MCO shall clearly inform all enrollees of any functional limitation in benefits or care.*

#### **Out-of-Plan Services**

#### **Appeals**

*The MCO, the contractor, or both will establish an efficient grievance procedure to handle complaints and grievances which cannot be resolved in the internal process. The MCO shall ensure that internal appeal and grievance processes are widely known, easy to use, timely, and not overly demanding of provider and enrollee resources. A mechanism will be in place for an AOD-credentialed, nonfinancially involved third party (e.g., State authority) to hear grievances that cannot be resolved at the MCO level. Enrolled individuals will have direct access to this third party as needed (e.g., an 800 line).*

*The MCO shall develop a system to track and report on the frequency and severity of client complaints and grievances by region, provider, service type, and resolution of problem.*

#### **Staffing and Gatekeeping**

*The MCO shall ensure that all reviewers, other staff, or subcontractors involved in the determination of care shall be clearly qualified—by virtue of specified training, experience, and/or certification—to make informed decision regarding clinically appropriate AOD treatment.*

*Utilization review decisions will be clinically based on "best practice" and consistent with emerging*

*national patient placement standards (e.g., ASAM criteria).*

*The MCO will ensure that enrollees have reasonable geographic access to all appropriate services in the benefit package. Services may be delivered by a nonparticipating provider when not available in the enrollee's area from a participating provider or when the enrollee is out of the area.*

*Clinical decisionmaking will not be subject to any arrangements which create direct financial incentives for an individual staff person to deny or reduce care or create any conflict of interest.*

### **Consumer-Friendly Materials**

*The MCO will ensure that consumers are provided with all necessary materials to utilize the system effectively and that these materials are written in clear and simple language(s).*

*The MCO will ensure that admission to different levels and types of service is individually determined and based on the clinical judgments of qualified AOD treatment professionals*

*The MCO shall work with the State authority and other MCOs to develop a common or core set of patient placement criteria.*

### **Disenrollment Protections**

*The MCO shall not disenroll consumers based on previous claims, change class or premium status based on claims, or use any incentives to disenroll unwanted consumers. Additionally, it will seek additional enrollees in an ethical manner.*

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## Appendix A–Glossary

**Access:** Degree to which appropriate treatment is available, timely, geographically feasible, culturally sensitive, and affordable.

**Actuarial Study:** Analysis of past utilization data for specified groups in order to estimate future costs for each group. Built upon assumptions where necessary, the final analysis combines all estimates to compute the cost per covered person per month (PMPM).

**Administrative Services Only (ASO):** Health care organization provides administrative support services only for a self-funded plan or startup MCO.

**Adverse Selection:** Situation where a health care organization has a disproportionate share of high utilizing, high risk recipients and/or expensive-to-treat enrollees.

**Average Length of Stay (ALOS):** Duration of treatment in a 24-hour treatment setting, usually expressed in days.

**At Risk:** Situation where a health care organization is vulnerable to providing or paying for more service delivery than is paid through premiums or per capita payments.

**Beneficiary:** A subscriber or dependent eligible for health care services (also: enrollee, member).

**Benefit Package:** Contractually defined set of services in which the costs, in full or in part, are borne by the insurer.

**Capitation:** A method of health care financing and delivery which pays a fixed amount of money per member for a specified set of services for a specified time.

**Carveout:** Within the managed care industry, it generally refers to a situation where mental health and/or AOD treatment is separated from physical medical care and managed as a separate entity.

**Case Mix:** The overall clinical and diagnostic profile of a defined population which influences intensity, cost, and scope of services typically provided.

**Case Rate:** A predetermined "package rate" for delivery of a specified set of procedures or services to a specified population.

**Closed Panel:** PPO (see below) in which enrollees can only use a specified group of providers in order to receive benefits.

**Coinsurance:** Percentage of covered expenses the insured party must pay for health care services above and beyond the deductible.

**Community Rating:** A method of establishing a capitation rate which is based on the average cost of actual or anticipated health care used by all enrollees in a given geographic region, community, or defined population.

**Copayment:** A form of cost-sharing in which the enrollee pays a fixed amount of money per unit or time of treatment service (e.g., \$2 per visit, \$20 per inpatient day) designed to reduce utilization of a treatment service.

**Cost-Based Reimbursement:** Method of reimbursement in which third parties pay providers for services provided based upon the documented costs of providing that service.

**Cost Sharing:** Health insurance practice which requires the insured person to pay some portion of covered expenses (e.g., deductibles, coinsurance, copayments) in an attempt to control utilization and allow lower premium payments.

**Covered Days:** Maximum number of days for which an insurer will reimburse for services rendered. Days may be limited per episode of illness, per year, per lifetime, or per length of policy.

**Deductible:** A fixed amount of money that the member must pay for specified medical services before the insurer will pay for further services within a defined period of time.

**Enrollee:** See beneficiary.

**Exclusive Provider Organization (EPO):** A "closed panel" PPO in which patients may only use a specified group of providers in order to receive benefits.

**Experience Rating:** A method of establishing health insurance premiums in which a premium for a specified population is based on the average cost of actual or anticipated health care used by members of that population. Variables such as age, gender, and health status affect that rating.

**Federally Qualified HMOs:** An HMO that has applied for and met Federal HMO requirements and laws.

**Fee-for-Service:** A common and traditional method of reimbursement for services rendered.

**First-Dollar Coverage:** Health insurance coverage that has no deductible. Copayments and coinsurance may be present.

**Freestanding Facility:** Usually refers to an autonomous treatment service that is not physically connected to a hospital or to other services (e.g., a freestanding detoxification unit).

**Gatekeeper:** A person or entity at the entry point of treatment who either provides all care, triages enrollees to appropriate care, and/or has the power to authorize or deny the delivery of care.

**Group Model HMO:** An HMO which contracts for services of treatment professionals in an existing group practice, usually with financial incentives for treatment efficiency.

**Health Maintenance Organization (HMO):** Organization which provides, or ensures the delivery of, a specified set of prevention, treatment, and rehabilitation services to enrollees for a prepaid amount of money.

**Holdback:** A portion of a fee which is withheld pending the achievement of a specified outcome or result. Often used in a risk situation, it can be used to strengthen the capacity to enforce a contract provision.

**Hold Harmless:** A clause sometimes included in a managed care contract which protects the MCO from all costs related to patient claims of injury, regardless of potential malpractice, negligence, or policies of the MCO.

**Incentives:** Financial incentives (and disincentives) used in managed care contracts to increase the likelihood of specified processes or results.

**Indemnity Benefits:** Insurance benefits based on payment of a defined amount of money for a specified range of covered services, usually incorporating maximum limits.

**Individual Practice Association (IPA):** A model in which a management organization is contracted to administer a plan and contract with an association of independent treatment professionals.

**Last-Dollar Coverage:** Insurance coverage without the imposition of arbitrary upper limits or maximums on treatment or dollars spent.

**Length of Stay (LOS):** Length of time patients are treated in a 24-hour treatment setting, usually reported as the average number of days of treatment per discharge.

**Lock-in Feature:** A feature requiring that individual enrollees receive all nonemergency care from the MCO. Care provided outside of the MCO will not be reimbursed by the MCO.

**Medical Necessity:** The decision by an MCO regarding the need for a particular clinical service. Historically, this term has sometimes been interpreted in an overly restrictive way that is insensitive to the full biopsychosocial nature of addiction treatment.

**Member:** An alternative term for enrollee, beneficiary, or recipient of health insurance benefits.

**Open Panel:** Usually refers to an MCO which contracts with a variety of treatment provider subtypes.

**Out-of-Area Coverage:** Payment for services provided outside of a defined geographic area, with costs paid by the MCO or shared with the treating provider.

**Overutilization:** Rendering of a service, or demand for services, which are judged to be unnecessary and/or excessive.

**Penetration:** Generally, a marketing concept which describes what proportion of a given market or population has contracted for services with a specific MCO.

**Per Capita:** Payment for specified health care services based on the number of enrollees covered, regardless of the number actually receiving services or the amount of services delivered (related to capitation, prospective payment, risk).

**Preferred Provider Organization (PPO):** Payer directly contracts with individual providers at reduced fees, usually fee-for-service, with a commitment to guaranteed volume. Enrollees have incentives to utilize these providers.

**Prepaid Group Practice:** A group model HMO in which the group has a set amount of payment to provide service to a defined population; this set amount of payment is determined in advance for the coming year.

**Prepaid Health Plan:** A contract between an insurer and a group of enrollees, whereby the insurer provides a defined set of services for a fixed premium payment.

**Prior Authorization:** A requirement imposed by a utilization review system that, in order to be reimbursed for a treatment, the provider must justify the need for this particular treatment to a utilization review clinician before delivering it (also called pre-authorization, precertification, and predetermination).

**Proprietary:** Generally refers to a for-profit company or to materials "owned" by a company that are not to be shared outside of that company.

**Prospective Reimbursement:** A reimbursement method in which a provider or other health care system has the amount or rate of payment for defined services to a defined population determined in advance for the coming year. That amount is paid regardless of the number of enrollees served or the amount of services delivered.

**Provider-Based PPO:** An organized system of treatment providers forming a preferred provider organization (PPO) for the purpose of providing, managing, and overseeing the delivery of care.

**Quality Assurance:** An organized set of activities intended systematically to ensure quality of care. Deficiencies in care are identified, measured, and systematically remeasured in the context of ongoing staff training and monitoring until an acceptable level of practice is consistently maintained.

**Quality Improvement:** An organized set of activities, programs, and philosophies intended to assure continuous improvement of specified practices focusing on customer definition, customer satisfaction, active utilization of data, non-hierarchical decisionmaking, efficient group process, teamwork, and a respect for the individual.

**Risk:** The situation when a provider or other healthcare organization is in a prospective payment system where reimbursement is a predetermined amount per covered enrollee regardless of amount

of services provided. The provider is thus liable (i.e., at risk) for any losses or profits which result from how service is allocated. When spending exceeds budget, shortages occur and loss is experienced. When spending is less than budget, profits occur. (See also Shared Risk below.)

**Self Insurance:** A practice by which an organization assumes complete financial responsibility for medical and/or behavior health treatment costs for its defined group members. Insurance protection against excessive loss can be purchased.

**Service Area:** A geographic area generally defined by natural geographic boundaries, population distribution, and/or transportation accessibility, whose population is served by a healthcare organization.

**Shared Risk:** A variation of a risk-based reimbursement system (see Risk above) in which any financial profits or liabilities are "shared" between two or more entities in a contractually defined manner, thereby spreading the risk of unplanned financial loss resulting from underestimates of service needs.

**Skimming:** A practice by a healthcare organization which attempts to ensure, by a wide variety of practices and processes, that the most healthy, least difficult, lower risk, and/or least expensive to treat are enrolled within the MCO as a means of controlling costs.

**Stop-Loss Insurance:** Insuring against a specified level of financial risk with a third party.

**Stop-Loss Provision:** A provision in a risk-based contract that (1) caps the amount of money for which a healthcare organization is responsible when spending for services exceeds budgeted amounts, and (2) that identifies a means (e.g., stop loss insurance) to pay for these services.

**Subscriber:** The individual who contracts with a healthcare or insurance plan for a defined set of services. The term "subscriber" does not include other individuals (e.g., family members) who may receive services as a result of this contract.

**Third Party Payor/Administrator:** Generally refers to the organization (e.g., insurer, State agency) that pays for, insures, and/or is responsible for the payment of specified health care expenses.

**Utilization Rates:** Patterns or rates of use of a single service or type of service usually expressed in rates per unit of population for a defined period of time (e.g., 28 hospital days/per 1,000/per calendar year).

**Utilization Review:** Evaluation by an outside party of the appropriateness, necessity, and/or efficiency of a given clinical service for an enrollee.

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## Appendix B–Field Reviewers

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## **Appendix C–Managed Healthcare Organizational Readiness Guide and Checklist: *Special Report***

**James B. Bixler, M.S.**

Managed care has become a primary method of organizing and financing healthcare services in the United States, and the delivery of substance abuse treatment services is being significantly affected.

### **Introduction**

A majority of the Fortune 500 companies and more than half of the health maintenance organizations (HMOs) now use managed care arrangements for purchasing substance abuse treatment. Thirty-six State Medicaid programs were using managed care approaches as of early 1993, and another 13 States planned to implement managed care programs by 1994 (U.S. General Accounting Office 1993). Several States have "carved out" substance abuse as well as mental health services for Medicaid recipients.

Publicly funded substance abuse treatment providers must adapt to meet the challenge of managed care, which will expand as the healthcare system changes in response to market forces and as healthcare reform discussions continue in Washington.

## **Purpose**

The guide and checklist have been prepared to assist publicly funded treatment providers become more competitive in a managed care environment. The document is intended especially for use by treatment providers receiving financial support from State funds, Medicaid, and the Federal Substance Abuse Prevention and Treatment Block Grant.

## **Goals and Objectives**

The goal of the checklist is to assist State substance abuse agencies and publicly supported treatment providers to design and implement strategies that will result in these providers being able to participate successfully in managed care programs.

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### **Objectives Include**

Increased knowledge about key managed care issues

Use of the checklist to assess readiness for participation in managed care

Action planning at the State, regional, and local levels

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## **Background**

The readiness checklist was developed for the technical assistance program of the Center for Substance Abuse Treatment's Division of State Programs. It built upon the Managed Care Readiness Inventory developed in 1993 by the Oregon community mental health providers and the National Community Mental Healthcare Council.

The checklist was first used at a workshop on managed care issues for project directors, part of the Fall Training Institute of the Pennsylvania Office of Drug and Alcohol Problems. Attendees completed the checklist, and the presenter conducted an interactive discussion about the importance of the issues identified.

After this pilot effort, the checklist was refined during its use in workshops conducted in Oregon, Arkansas, and Tennessee. The guide was added to provide additional information and to help treatment providers use the checklist as a freestanding self-assessment instrument.

## **Ways to Use the Guide and Checklist**

The checklist can be very effective as part of a workshop for treatment providers. Such a workshop would include substantial discussion of strategies for meeting the challenges of healthcare reform, changes in the organization and financing of health care, and the expanded use of managed care.

The guide and checklist can also be used:

In meetings of regional or local networks of providers

By providers or networks and their consultants

By providers as a self-assessment tool

The checklist can be an important part of the development of an organization's strategic plan, as a treatment provider or service network decides how to improve service delivery and position itself for a more successful future.

### **Why Prepare for Managed Care?**

The healthcare system is undergoing very rapid change in response to several fundamental economic forces.

1. Healthcare expenditures consumed 13.2 percent of the Gross Domestic Product (GDP) of the United States in 1991 (Letsch 1993) and rose to more than 14 percent in 1993, which means that almost \$1 of every \$7 is spent for healthcare services.
2. The growth rate of healthcare expenditures in 1991 was four times the growth rate of the national economy (Letsch 1993).
3. Some experts estimate that national healthcare expenditures will reach 18&nbsp;to 19 percent of the GDP by 1998.
4. Medicaid expenditures, an important source of payment for substance abuse services, doubled between 1988 and 1992. By 1992, the \$199 billion cost of Medicaid equalled the total cost of the Medicare program (Holahan et al. 1993).
5. State Medicaid expenditures have grown until they are second only to the combined State costs of elementary and secondary education (Holahan et al. 1993).

High inflation in healthcare expenditures has led employers and States to seek ways to limit the growth of their insurance premiums, benefit costs, and Medicaid programs.

Substance abuse treatment services and costs increased during the 1980s for many reasons:

Increased public acceptance of the need for care

Increased benefit coverages in many health plans

State activities to include substance abuse services in State Medicaid programs

A rapid growth in inpatient hospital-based substance abuse and psychiatric units, supported by benefit plans that paid for inpatient treatment and a surplus of hospital beds

Increases in State and Federal funding of community services, such as the Substance Abuse Prevention and Treatment Block Grant program

Some employers perceived that mental health and substance abuse treatment costs were "out of control" and that service delivery was fragmented. Claire Wilson, in a 1993 article on substance abuse

and managed care, wrote: "The skyrocketing utilization and costs of substance abuse treatment during the last 10 years have alarmed corporate benefit managers" (Wilson 1993).

England and Vacarro (1991) identified 21 percent increases in 1990 healthcare expenditures to employers/purchasers as the impetus behind managed care, despite cost containment efforts spanning more than a decade. They said: "Mental health and chemical dependency services, with reported cost increases of up to 60 percent per year, are a prime target for managed care."

These perceptions also were shared by some insurance carriers and HMOs, forcing payers to seek ways to coordinate care and control costs. The result is greater use of HMOs, preferred provider arrangements, increased competition, and—for substance abuse and mental health services—the development of behavioral health managed care organizations (MCOs) (see chart A).

These firms have expanded rapidly in the last 10 years, with the three largest MCOs each reporting more than 10 million persons enrolled, a total of almost 40 million persons for these three firms alone (Oss 1994).

A survey conducted in January 1994 determined that more than 102 million Americans, 45.9 percent of those with health insurance, are enrolled in some type of managed behavioral healthcare program (Oss 1994). The survey did not separate managed care for substance abuse from mental health services; however, almost all behavioral MCOs use an integrated approach. There were:

20.0 million in employee assistance programs (EAPs)

6.6 million in integrated managed behavioral health/EAPs

20.5 million in risk-based behavioral health network programs

15.0 million in nonrisk-based network programs

37.0 million in stand-alone behavioral health utilization review programs (Oss 1994)

### **What Is Managed Care and How Is It Changing?**

Managed care approaches, such as utilization review and second opinions, have been in place for more than a decade for medical-surgical insured health benefits. Their general purpose is to assure payers that consumers receive the appropriate level of care and that excessive, inappropriate, or unnecessary care is not delivered or reimbursed. These practices arose to regulate the functioning of the fee-for-service system, where financial incentives tend to encourage the delivery of more health services and more expensive procedures.

Another way to define managed care is by the organizational structures used to deliver treatment. Health maintenance organizations are "managed care," because clinical management and financial incentives exist within staff HMOs and independent-practice model HMOs to encourage preventive care and to reduce cost increases.

Feldman and Goldman (1993) indicated that the behavioral health managed care industry "arose as a response to the economic imperatives of spiraling unmanaged mental health and substance abuse costs. In light of escalating costs, payers were essentially faced with two alternatives—cut benefits (which many have done) or manage them so as to control costs and ensure quality."

In addition to concerns about costs, purchasers identified several quality-related problems:

Overuse of hospitalization

Purchase of services without any indication of clinical effectiveness—making it difficult to identify good care and good providers

Incentives in traditional benefit plans to use hospitalization rather than outpatient alternatives

Fragmented service delivery and the lack of coverage for case management services in traditional indemnity plans (England and Vacarro 1991).

Without a doubt, the industry has grown rapidly. In general, it has gone through three major phases since the mid-1980s.

1. The first generation of MCOs managed **access** to health care, with a primary focus on utilization review (UR). Access was controlled by limiting benefits and requiring significant co-payments to contain costs. MCOs also introduced such administrative barriers as preadmission certification.
2. The second generation of managed care focused on managing **benefits**. MCOs added fee-for-service provider networks, selective contracting, and treatment planning to the UR function.
3. The current generation of MCOs focuses on managing care, performing utilization management instead of utilization review—with a greater emphasis on treatment planning, delivery of the most appropriate care in the most appropriate setting, and moving patients through a continuum of services.

Managed care organizations expect development of a fourth-generation product in which they manage **outcomes** as part of an integrated services system, moving both public and private patients through a full continuum of treatment services (Waxman 1994).

The impact on treatment providers over the last 10 years has been dramatic. Hospitals that deliver substance abuse care have reduced staff and closed units or have integrated their inpatient care for substance abuse within psychiatric units. Many hospitals have expanded ambulatory substance abuse services. Community agencies have scrambled to learn about managed care and to become members of MCO provider panels.

These changes are likely to continue as the managed care industry increases its focus on Medicaid recipients, State and local governments, and services to other public clients.

### **How Do Managed Care Organizations Select Treatment Providers?**

Behavioral health managed care organizations (MCOs) work for self-insured businesses, HMOs, insurance carriers, unions, State Medicaid agencies, and others. Prior to deciding which providers to select, they first listen to their customers.

Some payers will dictate the qualifications of substance abuse treatment providers. These payers may require hospitals for residential care and require licensed professionals for outpatient treatment. Increasingly, MCOs are recommending that less expensive yet well-qualified community providers be included on the "provider panel." This enables MCOs to lower costs and to offer a more complete range of services.

The selection criteria of MCOs cover several areas:

- Access to care and a provider's response time; i.e., the availability of inpatient and residential beds as needed, and access to outpatient services based on:
  - Emergencies: immediate access

- Urgent services: 1-2 days
- Routine services: 4-6 days

Minimal delays for patients transferring from one service to another, particularly within a single provider

Administrative and clinical responsiveness

Use of brief, problem-centered clinical approaches rather than long-term rehabilitative approaches

Positive practice profiles; i.e., providers who are pragmatic, innovative, team-oriented, consumer-oriented, case management-oriented, and outcomes-oriented

Cultural competence

Willingness to arrange for related social services as needed, e.g., housing or job placements

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### **Sample Selection Criteria**

First Mental Health, and MCO that operates the Medicaid substance abuse and mental health managed care program in Massachusetts as MHMA, Inc., looks for organizations and programs that:

Are consumer-oriented, e.g., have satisfaction surveys and use the information

Have no long waiting lists

Deliver focused treatment, e.g., an average of six outpatient sessions

Are part of a system that promotes clinical continuity, e.g., a consumer can move from service to service without interruption

Direct their attention to outcomes, e.g., functional levels and employment

Have an interest in innovation, with the ability to move rapidly and to be responsive

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### **What Strategies Should a Treatment Provider Consider?**

The specific strategies that a substance abuse provider adopts will depend on the level of readiness of the provider and the State and local managed care environment.

The provider should develop an individualized plan that is specific to the circumstances and locality. The first step can be to complete the readiness checklist and consider potential change strategies within the organization. Providers may find it necessary to make changes in their clinical and management services in order to become more attractive to MCOs and other payers.

### **Short-range Strategies**

**Short-range strategies** could include:

Strengthening relationships with businesses through relationships with EAPs

Maximizing Medicaid reimbursements and positioning the provider organization to expand its participation in Medicaid as managed care arrangements are implemented

Becoming a preferred provider for several managed care organizations

### **Longer Range Strategies**

**Longer range strategies** to be considered might include:

Determining the extent to which the provider organization will address a broad client group by delivering a range of services or by focusing on one or more niche markets, i.e., specialty services for a limited population

Joining or forming a regionally integrated substance abuse and/or behavioral health service network, which can seek preferred provider and other contracts

Marketing to primary care medical group practices and multipractice physician groups, which have an increasingly critical "gatekeeper/service manager" role in healthcare reform

Marketing directly to payers, such as HMOs, insurance carriers, and self-insured businesses

Integrating fully into the healthcare system by becoming part of a physician-hospital organization or an arm of a large physician group practice.

***Use the following checklist to assist you in developing your agency's individualized plan for future challenges.***

## **Managed Healthcare Organizational Readiness Checklist**

Following is a managed care readiness checklist for publicly funded substance abuse treatment service providers, a vital segment of the health services system. The checklist is intended:

1. To identify a program's strengths and weaknesses in specific areas, and
2. To enhance a strategic planning process that will assist your organization to prepare for success in a managed care environment.

Use of the checklist will help treatment providers anticipate the skills that will be needed to prosper in a changing healthcare system.

Use of the checklist cannot substitute for an onsite assessment. However, it is likely to generate productive thought and discussion.

It is not necessary to have a perfect score to secure a contract with a managed care firm for private or public patients. In general, the better prepared your organization, the more likely it is that you will be selected to provide services.

Twelve areas are assessed:

- Adult services
- Adolescent services
- Service characteristics
- Quality assurance and utilization management
- Managed care and employee assistance program experience
- Management information system
- Staff and staff training
- Organizational relationships
- Board and management
- Marketing
- Fiscal analysis
- Business office

There are survey questions for each area. In addition, there is a summary at the end of the checklist.

Please answer each question using a *whole* number, i.e. 1, 2, 3, 4, or 5. One is the lowest score, while 5 is the highest score. Use the following scale for your response.

**Service Comprehensiveness**

No, None, Never	Very Limited, Not Often	Partially, Frequently	Mostly, Regularly	Yes, Fully, Always
1	2	3	4	5

**For adults, do you deliver:**

***Please circle the answer...***

- 1. Centralized screening, assessment, intake, and crisis intervention services?      1   2   3   4   5
- 2. Comprehensive outpatient services?      1   2   3   4   5

- |    |  |   |   |   |   |   |
|----|--|---|---|---|---|---|
| 3. | Intensive outpatient services, or do you have strong network relationships with providers of such services?                  | 1 | 2 | 3 | 4 | 5 |
| 4. | Partial hospitalization/day treatment services, or do you have strong network relationships with providers of such services? | 1 | 2 | 3 | 4 | 5 |
| 5. | Short-term residential treatment, or do you have strong network relationships with providers of such services?               | 1 | 2 | 3 | 4 | 5 |
| 6. | Inpatient treatment, or do you have strong network relationships with providers of such services?                            | 1 | 2 | 3 | 4 | 5 |

**For children and adolescents, do you deliver:**

- |     |  |   |   |   |   |   |
|-----|--|---|---|---|---|---|
| 7.  | Centralized screening, assessment, intake, and crisis intervention services?   | 1 | 2 | 3 | 4 | 5 |
| 8.  | Outpatient services?   | 1 | 2 | 3 | 4 | 5 |
| 9.  | Intensive outpatient services, or do you have strong network relationships with providers of such services?  | 1 | 2 | 3 | 4 | 5 |
| 10. | Partial hospitalization/day treatment services, or do you have strong network relationships with providers of such services?   | 1 | 2 | 3 | 4 | 5 |
| 11. | Short-term residential treatment, or do you have strong network relationships with providers of such services?   | 1 | 2 | 3 | 4 | 5 |
| 12. | Inpatient treatment, or do you have strong network relationships with providers of such services?  | 1 | 2 | 3 | 4 | 5 |
| 13. | Do you have skilled clinical staff assigned to all aspects of the screening and assessment process, including initial telephone contacts?                                  | 1 | 2 | 3 | 4 | 5 |
| 14. | Do your services ensure rapid access (1-2 days) to assessment services and initial placement?  | 1 | 2 | 3 | 4 | 5 |
| 15. | Do your services have a brief intervention focus, e.g., six to eight sessions for outpatient care, for most patients?  | 1 | 2 | 3 | 4 | 5 |
| 16. | Do you have internal case management services for focusing on repeating patients and others who have high utilization patterns?  | 1 | 2 | 3 | 4 | 5 |
| 17. | Do you have ensured linkages with primary healthcare providers for needed healthcare?  | 1 | 2 | 3 | 4 | 5 |
| 18. | Do you adapt standard services to meet the needs of special populations, such as mentally ill substance abusers, injecting drug users, and pregnant addicts?               | 1 | 2 | 3 | 4 | 5 |
| 19. | Are service needs constantly reevaluated, and service plans modified, based on patient progress?   | 1 | 2 | 3 | 4 | 5 |
| 20. | Are admission, treatment, and discharge criteria in place and used consistently by staff?  | 1 | 2 | 3 | 4 | 5 |
| 21. | Do your admission, treatment, and discharge criteria take into consideration the practice standards of managed care firms with which you have (or hope to have) contracts? | 1 | 2 | 3 | 4 | 5 |
| 22. | Do your services ensure rapid linkage to succeeding levels of care?  | 1 | 2 | 3 | 4 | 5 |
| 23. | Do your services emphasize family involvement and use of natural support systems, including self-help groups?  | 1 | 2 | 3 | 4 | 5 |
| 24. | Do your services focus on patient outcomes and satisfaction?   | 1 | 2 | 3 | 4 | 5 |

**Quality Assurance (QA) and Utilization Management (UM)**

- |     |   |   |   |   |   |   |
|-----|---|---|---|---|---|---|
| 25. | Do you have QA and UM procedures that have been shared with clinical staff?   | 1 | 2 | 3 | 4 | 5 |
| 26. | Does the staff you have designated to perform the QA/UM function review clinical activities for consistent use of established admission, treatment, and discharge criteria? | 1 | 2 | 3 | 4 | 5 |
| 27. | Is the information from the QA/UM function received rapidly enough to   | 1 | 2 | 3 | 4 | 5 |

	assist clinicians <i>during</i> an episode of care?					
28.	Does the QA/UM function include maintaining records of managed care appeals, and suggest strategies for improving relationships and/or modifying service delivery to reduce denials?	1	2	3	4	5
29.	Do you have sufficient staff assigned to the QA/UM function?	1	2	3	4	5
30.	To what extent is the QA/UM function designed to "stay ahead" of staff from managed care firms by anticipating their concerns?	1	2	3	4	5
31.	Do clinicians, clinical supervisors, and management all receive and act on regular QA and UM reports?	1	2	3	4	5
32.	Is the QA/UM function tied closely to your management information system?	1	2	3	4	5
33.	To what extent is the QA/UM function focused on patient outcomes?	1	2	3	4	5
34.	Are patient satisfaction surveys a regular function of QA/UM?	1	2	3	4	5
<b>Managed Care and Employee Assistance Program (EAP) Experience</b>						
35.	Do you have contract(s) with managed care firms or EAPs as a preferred provider?	1	2	3	4	5
36.	If yes to #35, are any of your contracts paid on a fee-per-case or a capitation basis?	1	2	3	4	5
37.	Do you offer an employee assistance program which includes crisis intervention, assessment and linkage to service, followup to assure receipt of appropriate services, and coordination of benefits?	1	2	3	4	5
38.	Does your EAP provide consultation to management on policies and procedures, training to managers and supervisors, assistance with specific cases, employee education and orientation programs, critical incident debriefing, and reporting on utilization and effectiveness?	1	2	3	4	5
39.	Has your EAP business increased over the last 2 years?	1	2	3	4	5
<b>Management Information Systems (MIS)</b>						
40.	Do you have an MIS which can retrieve patient information either online or in less than 1 hour?	1	2	3	4	5
41.	Does your MIS have integrated functions for client information; service utilization; financial information, including payer type by client; and client records?	1	2	3	4	5
42.	To what extent does your MIS permit single-source response inquiries from managed care organizations?	1	2	3	4	5
43.	To what extent does your MIS produce information that is used by clinicians, supervisors, and management?	1	2	3	4	5
44.	To what extent does your MIS integrate information from various programs and sites?	1	2	3	4	5
45.	Is your MIS designed so that client and service information can be reported to all major payers?	1	2	3	4	5
46.	Does your MIS generate patient invoices?	1	2	3	4	5
<b>Staff and Staff Training</b>						
47.	Do clinical staff accept shared responsibility with case managers from managed care organizations for clinical decisions?	1	2	3	4	5
48.	Are staff informed concerning the funding and managed care environment, including managed care criteria for admission and discharge?	1	2	3	4	5
49.	Have clinical and supervisory staff resolved concerns about cost, service quality, access, and managed care?	1	2	3	4	5
50.	Do you have an ongoing staff training program that includes brief service intervention skills, patient assessment and reassessment, and	1	2	3	4	5

instructions on how to respond to managed care organizations?

### **Organizational Relationships**

- |     |  |   |   |   |   |   |
|-----|--|---|---|---|---|---|
| 51. | To what extent have you implemented referral and business arrangements with other behavioral healthcare organizations, e.g., mental health and substance abuse programs?                 | 1 | 2 | 3 | 4 | 5 |
| 52. | To what extent have you implemented referral and business arrangements with primary or specialty healthcare organizations, e.g., hospital emergency rooms and physician group practices? | 1 | 2 | 3 | 4 | 5 |
| 53. | To what extent have you been involved in economic arrangements with other healthcare   | 1 | 2 | 3 | 4 | 5 |

### **Board and Management**

- |     |   |   |   |   |   |   |
|-----|---|---|---|---|---|---|
| 54. | Do you have significant experience at contract negotiation and management?  | 1 | 2 | 3 | 4 | 5 |
| 55. | To what extent is the board oriented to service effectiveness and business success?   | 1 | 2 | 3 | 4 | 5 |
| 56. | Are you experienced at strategic planning, modifying plans, and developing contingency plans to meet emerging opportunities and challenges?                 | 1 | 2 | 3 | 4 | 5 |
| 57. | How well informed are board members and top management concerning healthcare reform, managed care, financing options, and interorganizational arrangements? | 1 | 2 | 3 | 4 | 5 |
| 58. | Are mechanisms in place which would allow for prompt shifts in response to business opportunities?  | 1 | 2 | 3 | 4 | 5 |
| 59. | To what extent will the board and management be proactive and entrepreneurial in pursuit of managed care initiatives?                                       | 1 | 2 | 3 | 4 | 5 |

### **Marketing**

- |     |  |   |   |   |   |   |
|-----|--|---|---|---|---|---|
| 60. | Do you have marketing plans that target payers, referral sources, and the general public?  | 1 | 2 | 3 | 4 | 5 |
| 61. | Do you have sufficient staff resources assigned to the marketing function?   | 1 | 2 | 3 | 4 | 5 |
| 62. | To what extent does your service line emphasize acute and primary services (rather than long-term, rehabilitative, and wraparound care)? | 1 | 2 | 3 | 4 | 5 |
| 63. | Have you prepared a managed care capability statement?   | 1 | 2 | 3 | 4 | 5 |
| 64. | To what extent have you made marketing presentations to the large employers in your service area?  | 1 | 2 | 3 | 4 | 5 |
| 65. | Do your costs per episode and lengths of stay compare favorably with the competition?  | 1 | 2 | 3 | 4 | 5 |

### **Fiscal Analysis**

- |     |   |   |   |   |   |   |
|-----|---|---|---|---|---|---|
| 66. | To what extent is your revenue diversified?   | 1 | 2 | 3 | 4 | 5 |
| 67. | Do you have adequate liquid reserves for at least 2-3 months operating expenses?  | 1 | 2 | 3 | 4 | 5 |
| 68. | Have you accumulated (or can you access) venture capital sufficient to respond to a major business opportunity?   | 1 | 2 | 3 | 4 | 5 |
| 69. | Have you maximized Medicaid revenue?  | 1 | 2 | 3 | 4 | 5 |
| 70. | Does your fiscal system, in combination with the MIS, allow analysis of cost-per-unit of service, cost-per-episode of care, and cost by disability type and level of functioning? | 1 | 2 | 3 | 4 | 5 |
| 71. | Can the fiscal staff assist with pricing issues during contract negotiations, especially when capitated contracts are considered?   | 1 | 2 | 3 | 4 | 5 |
| 72. | Can the fiscal staff readily compare actual to anticipated revenue and expense by contract?   | 1 | 2 | 3 | 4 | 5 |

## Business Office

73. Is the business office experienced at fee-for-service invoicing for Medicaid, preferred provider organization (PPO) contracts, insurance, patient fees, etc.? 1 2 3 4 5
74. Does the business office conduct internal service audits to ensure that documentation of services in patient records can withstand an external audit? 1 2 3 4 5
75. To what extent is the business office's invoicing function integrated into your MIS? 1 2 3 4 5
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## Summary of Answers

This section allows you to generate a score for each area. Add together the individual response scores for the questions in each of the 12 sections. Then divide the total by the number of questions in that section to generate a composite score for the section. Enter the composite score on the 1 to 5 scale at right.

	Total	Divide by	Composite	Weakest Position	1	2	3	4	Strongest Position	5
Adult Services Comprehensiveness	6			1	2	3	4	5		
Adolescent Services Comprehensiveness	6			1	2	3	4	5		
Service Characteristics	12			1	2	3	4	5		
QA and UM area	10			1	2	3	4	5		
Managed Care an EAP area	5			1	2	3	4	5		
MIS area	7			1	2	3	4	5		
Staff and Training	4			1	2	3	4	5		
Organizational Relations	3			1	2	3	4	5		
Board and Management	6			1	2	3	4	5		
Marketing	6			1	2	3	4	5		
Fiscal Analysis	7			1	2	3	4	5		
Business Office	3			1	2	3	4	5		
All scores	75			1	2	3	4	5		

This approach will show you the areas in which your organization is well prepared for managed care participation, the areas in which additional work may be needed, and the areas of relative weakness where immediate remedial activities can be targeted.

It may also be helpful to inspect the variations in the scores among the various persons in your organization who complete the checklist. You may find a range of answers and perceptions on a specific question or within one or two sections. It might be illuminating to note the differences, for instance, between management, board members, and clinical staff.

On the following page you will find a list of Common Questions and Answers

## Common Questions and Answers

There were several common questions asked by treatment providers who attended workshops in which the checklist was used. This part of the guide gives answers to a few of those questions.

**QUESTION: *Do I have to pay attention to these managed care issues? I have contracts with the State and revenue from fees, so won't my organization survive intact?***

**ANSWER:** Economic forces are leading to the use of managed care approaches by almost all payers. If you have secured a "niche market," where it is unlikely that other organizations will compete with you, then you may be in a unique situation where the payers will continue to buy your service. However, organizations that deliver basic outpatient and residential substance abuse care cannot ignore managed care.

**QUESTION: *My organization delivers residential treatment. Should I add outpatient services or otherwise diversify?***

**ANSWER:** Managed care organizations frequently shift services from hospital inpatient to community residential facilities. A second strategy of MCOs is to then shift the location of care from brief residential services to intensive outpatient or outpatient care as quickly as possible. The best strategy would be to offer all needed services and plan to shift the balance between services as referral patterns and MCO practices change.

**QUESTION: *What staff qualifications do managed care firms require for outpatient services, and are graduate degrees a necessity?***

**ANSWER:** There is considerable variation. Staff qualifications are frequently determined by the payer rather than the MCO. Some MCOs require State-licensed practitioners, while others accept all staff working within a licensed or State-approved program.

**QUESTION: *How cost competitive is managed care? Will I be asked to accept reimbursement rates below my cost?***

**ANSWER:** Most MCOs attempt to secure discounted rates. It is important to know your costs and establish a level below which you will not negotiate. It is also important to be aware of the costs and rates of your competitors, in order to be able to judge the marketplace.

**QUESTION: *Will managed care require my organization to change our clinical practices?***

**ANSWER:** As you market your services, carefully consider the types of services that managed care organizations want. Most will favor brief and focused counseling models, with rapid step-down to less intensive levels of care.

You may have to modify your service practices in order to secure and maintain business.

**QUESTION: *My staff are concerned about losing clinical control of our services to a gatekeeper or case manager. Is it necessary to give up clinical control if I get a contract?***

**ANSWER:** It's best to think of working with an MCO as a partnership where you exchange information about clients and determine a plan of treatment together. Most MCOs watch the length of treatment episode very carefully, either through a case manager or by reviewing your organization's practice patterns (based on the analysis of your organization's paid claims).

**QUESTION: *We don't do outcome studies. How can I begin to focus on the impact of treatment?***

**ANSWER:** Implementing a consumer satisfaction survey is a good place to begin. It can provide feedback on access, staff, the most (and least) valuable components of services, and the value of care to clients and family members.

**QUESTION:** *Will it be necessary to create new alliances, join networks, establish joint ventures, or merge with another organization to be successful?*

**ANSWER:** It depends on your local situation and your organization's goals. There are many new relationships currently being established to improve the likelihood of doing well as the healthcare system changes. You may find arrangements that strengthen your organization clinically and managerially. No organization should rule out considering these options.

## How Can We Design an Action Program for Change?

The information you gained from completing the readiness checklist is a good start. There are several steps in classic organizational planning. The action planning steps are to:

### 1. Assess Your Current Position

Assess your organization's strengths: What do you have going for you, and what should you be sure to maintain and/or expand?

Assess your organization's limitations: What areas need improvement, and what is your realistic capability to address these areas internally?

Assess the opportunities emerging in the marketplace: What are the commercial and public managed care developments in your State and locality?

Assess the competition and other challenges: What threatens your plans, how quickly will you need to implement changes, and what are your competitors planning which will impact on your future?

### 2. Develop an Achievable Plan

Establish clear long-range goals: What changes are needed in the organization's mission and long-range targets, if any?

Chart 1-2 year objectives: What are the priority actions that will make the greatest difference as you penetrate the managed care market?

Develop targets: What are the numerical targets and the schedule to be used for each priority action?

Involve the staff and board: What steps must be approved and accomplished by the various actors, and what are the resource requirements?

Consider strategic partnerships: What new organizational relationships will strengthen your ability to reach your objectives, and what scarce skills or resources are essential to success?

### 3. Implement the Plan

Assign the tasks: What are the expectations for all of the key persons and organizational units?

Coordinate the work: Manage the process and make the needed adjustments in day-to-day activities.

### 4. Check Progress and Adjust the Targets

Review achievements against the objectives: What was accomplished and what were the deviations from the plan?

Reassess the environment: What has occurred in the business environment, with Medicaid managed care, in healthcare reform, or in your local service system that will impact on your success?

Change the strategic plan: What better strategies have been identified and how should the plan, targets, or timetable be modified based on your experiences?

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*Remember, the key objectives in managed care are to:*

Deliver high quality, consumer-responsive and payer-responsive services

Develop services that are attractive to payers and to MCOs

Secure contracts and other organizational relationships that lead to additional revenue

Expand your market share to secure your future

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## Summary and Conclusion

This guide and checklist were developed for the Center for Substance Abuse Treatment (CSAT) to assist States and publicly funded substance abuse treatment providers to succeed in a managed care environment. The objectives are to increase managed care participation by expanding knowledge, assessing readiness through use of the checklist, and encouraging effective action planning.

Remember, the checklist will be helpful but should not be the only tool your organization uses to prepare for managed care participation. Providers should attend workshops, read, share ideas with colleagues, and participate in State association activities.

Treatment providers seeking additional assistance should contact their State authority or CSAT's Quality Assurance and Evaluation Branch within the Division of State Programs.

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