



Substance Abuse Task Force

August 25, 2008

10:00-3:00

NC Hospital Association

Meeting Summary

Attendees:

Task Force/Steering Committee: Patrice Alexander, Burt Bennett, Bob Bilbro, Dwayne Book, Sherry Bradsher, Soyna Brown, Tony Burnett, Chris Collins, April Conner, Grace Crockett, Anne Doolen, Tony Foriest, Robert Gwyther, Paula Harrington, Carol Hoffman, Verla Insko, Jinnie Lowery, Kevin MacDonald, Nidu Menon, Martin Nesbitt, Will Neumann, Martin Pharr, William Purcell, James Ragan, Starleen Scott-Robbins, Tom Savidge, Jane Schairer, Flo Stein, Cynthia Wifford

Interested Persons: Sue Butler, Karen Chapel, Ted Clodfelter, Becky Ebert, Scarlette Gardner, Denise Harb, John Kemp, Tom Lucking, Tom McLellan, Shawn Parker, Mary Powell, Will Savery, Kathleen Thomas, Shealy Thompson, Katheryn Wellman, Ellen Wilson,

Staff: Kimberly Alexander-Bratcher, Mark Holmes, David Jones, Julia Lerche, Pam Silberman, Berkeley Yorkery

LEGISLATIVE UPDATE

Flo Stein, Chief, Community Policy Management, Division MH/DD/SAS, NC Department of Health and Human Services

- Flexible Funding for LMEs: The integrated payment and reporting system (IPRS) has been simplified and made more flexible.
 - Collapsed categories
 - Changes the hierarchy of payment
- Expanded Substance Abuse CASPS (cross area service programs): Another \$2 million to go with \$6 million from last year of flexible funding from legislature. These funds are being used for a new management system
- Division to work with LMES to:
 - Figure out why LMEs and providers are not earning their money.
- Crisis Services
 - Announce locations for where 19 new mobile crisis teams should be placed. New psychiatry staff (~30) will be hired. Add psychiatry and SA beds in community hospitals. Select LMEs and providers to development DD crisis services

- Gap Analysis: Starting by looking at the gap analyses done each year by all LMEs.
- Discharge Plan: Problem of people being seen in their communities after they are released from inpatient services and the ADATCs.
 - Sec. is producing a bi-monthly report on how LMEs are doing with care management
 - ADATC utilization has gone up significantly (most between 85-92%).
- Veterans Services: The Legislature named veterans a target population.
 - Walter Reed is closing and North Carolina is one of the receiving states for active duty personnel. This is a year away, but Womack at Fort Bragg is one of the receiving hospitals. North Carolina is also gaining military personnel due to base closings in other states (100,000 new active duty in next year). DOD takes care of the care of active duty military. Tricare is the health care insurance for veterans and reservists but many do not sign up for it. There is a nationwide shortage of Tricare providers
 - NC is looking into a Traumatic Brain Injury (TBI) waiver to help provide services for returning vets with TBI.
 - NC has a large number of guardsmen and reservists who return to their local communities in need; need to ensure local communities are ready to provide appropriate services.

PERFORMANCE-BASED CONTRACTS

Tom McLellan, PhD, CEO, Treatment Research Institute

The current model for treating addiction is based on the old assumption that substance abuse was an acute problem. Research has shown that substance abuse is a chronic disease, therefore the system needs to change from an acute care model to a continuous management model to better meet the needs of patients. In the old system, patients were put in treatment and were expected to be cured when they finished treatment. If the patient was not cured, treatment was a failure. Treating substance abuse as a chronic disease requires a system change away from a treatment model to a management model. Under a continuing care model, patients receiving ongoing management of their addiction with varying levels of treatment available including screening/brief interventions, detoxification, residential recovery-oriented treatment/intensive outpatient programs/outpatient continuing care, tele/internet continuing care, AA/mutual help.

This is not the type of system currently in place. To get to a continuing care model, the following must be available: attractive treatment choices at all levels of care; patient/family participation in treatment planning and treatment changes; and regular clinical information to track progress and to guide care changes. Additionally, for treatment to work patients need to be retained at appropriate levels of care, need to be prepared to do well at the next level of care and the effectiveness of treatment needs to be evaluated throughout and after treatment.

Components of care that meet FDA standards of effectiveness are out there, however, they are not widely used, often because they are not currently funded. Therapies such as

cognitive behavioral therapy, community reinforcement and family training and individual drug counseling as well as various medications that help reduce substance use all meet FDA standards for evidence-based care. One way to help patients get to these types of services even though they are not well funded is the use of a computer assisted system for patient assessment and referral (CASPAR).

State systems can help drive the change to a continuum of care model through performance-based contracts with providers. The state purchases 80% of substance abuse services so how the state chooses to purchase services sets the stage for how the system will function. A performance-based contract system should be structured so that providers can stay open, so the majority of providers' budgets must be readily available, 85-90%. But the rest of the budget can be used as an incentive by the state to get better results. Under performance based contracting, providers are told they can make the rest of their budgets (and possibly up to more than 100% of their budget) if they provide results. In this way, the state is able to hold programs/providers responsible for outcomes during treatment. To do this, assessments and evaluation should take place from the beginning of outpatient care so that progress can be monitored. A small number (10 or fewer) of measures should be used for evaluation.

Experience with this type of contracting in other states has shown that performance-based contracting can encourage providers to work together, adopt better business practices, provide incentives for counselors, adopt more evidence-based treatments and improve patient outcomes.

FLEXIBLE FUNDING: LMES AND PROVIDERS WORKING TOGETHER SUCCESSFULLY
Tom Lucking, Consultant, Behavioral Health Research Program, UNC Chapel Hill

There are different ways to fund substance abuse services in North Carolina including grants, unit cost reimbursement (UCR) and non-Medicaid state (IPRS) funding. These options are all available in North Carolina.

Utilization control and expense issues are different for substance abuse services than other services because there is little risk of over-utilization. This is because patients are largely ambivalent about treatment and, thus, do not enter treatment without needing it. Additionally, patients often want lower doses of treatment than are needed. Although substance abuse services are sometimes plagued by cost-containment issues, these are almost always due to the provider delivering inappropriate care or care at too high a cost.

Grants available for substance abuse services purchase capacity, not services. The advantages of grant funding are that they are good for providing start up funding to organizations. This makes grants a good option in areas lacking provider capacity. Grant funding is also an attractive option in areas where the demand for services is too low to maintain a service provider without some sort of subsidy support. However, if grant funding is used in situations it is not well suited for, can reinforce inefficient performance, unaccountable purchasing, and providers skimping to make more of a profit.

Unit cost reimbursement (UCR) funding, often referred to as “fee-for-service,” is used to purchase services. Public substance abuse systems typically use UCR for annual allocations (i.e., \$131.93/day not to exceed \$300,000/per year). UCR funding helps to stabilize the system and support more expensive services. UCR funding provides incentives for providers to be efficient, productive, and to attract, engage, and retain patients. However, UCR funding also involves higher transaction costs, can reinforce inappropriate levels of care, and can make providing services quite difficult to new providers.

Developing a blended system using both payment methods may lead to the most effective systems. Grant funding can be used to help increase capacity in areas in need and to support providers as they are building their practices. UCR funding is more appropriate once a provider system is in place and stable because UCR funding can provide performance incentives

In North Carolina, Local Management Entities (LMEs) and providers must use flexible funding to work together successfully. Most of North Carolina’s substance abuse funding is non-Medicaid IPRS which is more flexible than either grants or UCR. LMEs can use this funding to set up a system with non-UCR temporary funding and UCR funding available.

DISCUSSION OF POTENTIAL RECOMMENDATIONS

Currently, LMEs have the authority to pay providers either under a grants basis or fee-for-service basis. LMEs are also paid with single source funding, which gives LMEs more flexibility to pay for MH, DD and SA services. However, there is a concern that with single source funding, some LMEs may not push to spend the funding on SA services (and the funding may be used for MH or DD purposes). LMEs have a reporting requirement to DMHDDSAS to ensure that they report on services paid using single source funding. However, not all LMEs are submitting utilization and XX reports as required by the state.

- DMHDDSAS should develop a system of accountability to ensure that LMEs report on how single stream funding is spent, such as withholding some or all of state payments for failing to submit timely reports.

Regardless of whether providers are paid under a grant or fee-for-service system, the state can build incentive payments to incentivize providers to provide the “right” services. The incentives should be targeted to the 2 or 3 areas where the state needs the greatest improvement.

- DMHDDSAS, in collaboration with the LMEs, should develop performance-based payment systems to incentivize providers to: 1) engage people with substance abuse problems, 2) keep people in active treatment for longer periods of time (active engagement), and 3) provide care management for people in recovery.
- DMHDDSAS should require the use of standardized assessment tools and outcome measures at the local level.