

**Pre-Application Technical Assistance Reports for the
Access to Recovery Grant Program**

**Report on Technical Assistance to the States of
Wisconsin, California, Louisiana, Florida, and Missouri
Summary Report on Developing Incentives**

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Consultation between Barry Brauth and the States of Wisconsin, California, Louisiana, Florida, and Missouri Written Report

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Introduction and Purpose of TA

The States of Wisconsin, California, Louisiana, Florida, and Missouri (the States) individually requested assistance with assessing the role that financial incentives could play in their planned voucher proposal for the Access to Recovery (ATR) grant program. Under Task Order with the Center for Substance Abuse Treatment (CSAT), the American Institutes for Research (AIR) and Johnson, Bassin, and Shaw (JBS) contacted Barry Brauth of New York State's Office of Mental Health to assist the States.

Methodology

During the first two weeks of May 2004, the consultant conducted telephone conference calls with representatives from the various States. The calls all lasted approximately 1 hour with one State requiring telephone and e-mail follow-up. (For the background and experience of the consultant, see the last section of this report.)

Content of TA Discussion

Each of the States provided brief overviews of their current delivery systems and their thinking about modifications to make the systems ATR compatible. From the States' questions, certain themes kept recurring:

- 1) None of the States wanted to withhold any portion of providers' reimbursement fees to use as an incentive payment. All the States already had fee schedules in place for their non-ATR business and could not see paying less for services funded through ATR.
- 2) All of the States felt that they already paid providers for good services and did not want to pay more just for them doing what they were supposed to do.
- 3) All of the States felt that some providers performed better than others and did want to incentivize outcomes but did not know how to do it.

- 4) The States complained of the difficulty of making quarterly rate adjustments. They did not feel that there would be enough data on individual providers upon which to base adjustments. They felt that at least one year of outcome data would be necessary. They also felt that their payment systems would have trouble with handling differential rates for each provider.
- 5) All of the States struggled against inflationary reductions to their reimbursement rates with providers complaining that the fees became more outdated each year, i.e., one State was paying \$45 a day for residential treatment. State legislatures and budget divisions however made the implementation of cost of living adjustments (COLA's) almost impossible.
- 6) All of the States were interested in incentivizing provider behaviors, such as treatment providers making referrals to recovery support providers or providers putting more effort in post treatment follow-up.

Recommendations

A set of recommendations was developed which complied with the needs and constraints facing the States:

- 1) Pay financial incentives but pay them as enhancements on top of 100 percent fees.
- 2) Base eligibility for incentives on a full year of outcome data that collapses performance in the seven domains into a single aggregate score. Providers meeting the minimum score would get the enhanced rates (enhancement); those not meeting the score would not.
- 3) Pay the enhancement as a COLA to the next year's rates. This could either be done as an actual adjustment to the rates or as just a prepaid lump sum based on the first year's billing. For example, a provider bills for \$10,000 in claims the first year. They qualify for the State's 3 percent COLA. The State does not have the capacity to differentially increase rates so they pay a \$300 prepaid COLA. At the end of the second year, the process will be repeated. By rewarding providers for achieving outcomes with COLAs, the State is keeping high quality providers financially whole and using financial incentives as a strategy for getting the other arms of State government to participate in annual COLAs, but only for high quality providers.
- 4) In developing the algorithm used to weight the seven domains, particular emphasis should be placed on social support and service access by heavily weighting referrals to recovery support providers.
- 5) An additional method for implementing an incentive may be to phase in an evolution of the rate from mostly base payment with a small COLA (incentive) to decreasing base and increasing incentive. In this way the State builds in both a carrot and stick for good performance, moving the system incrementally in the direction of paying for outcomes rather than services. This process also creates a mechanism for obtaining the commitment of State budget offices and legislatures in building COLAs into substance abuse rates. The following table provides an example of how this process could be implemented:

Incremental Base Modifications

	Year 1	Year 2	Year 3
Base Payment	\$100	\$98	\$95
Incentive Rate	3%	8%	15%
Base Payment plus Incentive	\$103	\$106	\$109

Outcomes

The States are taking the recommendations under consideration.

Background of Consultant for the TA Teleconferences

This TA is provided by Mr. Barry Brauth, who is employed with the New York State Office of Mental Health (OMH). Mr. Brauth has for over 25 years worked in various positions in administering both medical and behavioral health programs. After receiving his Master's degree in public administration, Mr. Brauth moved to Albany for a position as a Federal Programs Coordinator for the New York State OMH. There he developed rate and reimbursement strategies that resulted in hundreds of millions of dollars in increased Medicare and Medicaid revenue for New York State mental health programs.

In the early 1980's, Mr. Brauth joined Blue Cross of Northeastern NY as the senior policy advisor to the President. There he designed client tracking systems which were used to profile providers and to develop innovative insurance and funding mechanisms such as case payment and prudent purchasing arrangements.

Except for a period of employment with Value Behavioral Health as director of Utilization and Data Analysis in 1996, Mr. Brauth has worked with the OMH since 1986. His responsibilities with OMH have included development of a patient classification schema and rate setting alternative to the Medicare psychiatric Diagnostic Related Groupings. This alternative rate setting methodology reimbursed hospitals based on case mix, length of stay, recidivism, and linkage to outpatient services. The project required the development of a sophisticated client information system that was later used for planning, utilization monitoring, and the development of managed care proposals.

Mr. Brauth's current position is Director of Financial Planning. He is responsible for developing fiscal initiatives and reimbursement methodologies that promote mental health programs that are stable, accountable, and outcome oriented.