

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

Report on Technical Assistance to New Jersey

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Consultation between Chris Hansen/Woodrow Odom and the State of New Jersey Written Report

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Introduction and Purpose of TA

The State of New Jersey requested technical assistance (TA) on issues regarding the establishment of provider incentives for the ATR voucher program, including use of incentives with a sliding fee scale. Assistance with these issues was provided by Chris Hansen and Woodrow Odom, technical experts from Johnson, Bassin & Shaw, Inc. (A summary of the consultants' professional experience appears at the end of this report.)

Methodology

The TA took place by telephone on May 7, 2004. The TA was informal and entailed the discussion of questions related to the issues identified in the Purpose of the TA. Participants included the consultants (Chris Hansen and Woodrow Odom) and representatives from the New Jersey Division of Addiction Services—Jeffrey Clayton (Director, Planning and New Initiatives) and Catherine Vahey (New Initiatives/Program Specialist, Planning and New Initiatives).

The notes summarized in this report are paraphrased and are not verbatim. The consultants advised State personnel on the limitations of their advice, including their inability to advise on compliance with the RFA or to provide material assistance in writing the proposal or budget. New Jersey was also advised that a report of this TA call would be posted on the SAMHSA Web site.

Content of TA Discussion

Issue #1: Developing incentives related to a sliding fee scale

Background: New Jersey plans to cast a wide net in terms of client eligibility for its ATR program. The assumption is that enough clients will be able to pay a portion of their clinical treatment and recovery support services costs to make this incentive discussion viable.

New Jersey: New Jersey wants to require clients to be charged a fee for ATR services, and the fee would be on a sliding scale. The same scale would be used statewide. Traditionally, we have allowed providers to collect the fees, and we require them to plow

those fees back into the program. But in the South Jersey Initiative (our current voucher program), the fees are deducted from the payment. Is either of these approaches possible? We see deduction of the fees as a disincentive for providers to collect them. However, if we just let providers keep the fees under a general supplementation requirement, there are questions about whether providers would make good judgments on where to spend the money. What do you think?

Consultant: I think either solution could work. It really depends on what you want to accomplish. You want incentives that will encourage the kind of behavior you want from providers. Allowing them to keep client fees gives providers an incentive to be aggressive in collecting fees, but not much else. I doubt that is your main goal.

Issue #2: Development of quality-based provider incentives

New Jersey: *Our goals are probably two: (1) to increase the value of the grant by stretching ATR funds to provide greater capacity, and (2) to enhance treatment quality.*

Consultant: In terms of treatment quality, I suggest you consider incentives that are based on measures relating more directly to quality of care. Rather than letting providers determine how they are going to use the fees collected from clients based on a sliding scale (and some will undoubtedly make poor choices), think about what quality means and how you can encourage providers to improve quality. For example:

- The seven domains are SAMHSA's measures of quality of care, and a good starting point. You could use improvement on these measures (change over the episode of care) as a means of determining how much you would pay as an incentive to improve quality of care.
- You might also consider premiums for hard-to-treat patients or training incentives. That would be more targeted than just letting providers keep the fees and spend them as they see fit.

I have another suggestion. You are determining fees according to a statewide fee schedule. Suppose you had staff at the assessment locations ask the financial questions and determine the client amount of co-pays, if any? Then, when you create the voucher, you would put the co-pay amount on the voucher and deduct that amount from the standard rate of reimbursement. This would give the following advantages:

- The provider would have some incentive to collect the co-pays. However, if they chose not to collect them, it would be their problem.
- More important, when a client is sent to several different providers for services, your assessment center could compute the co-pays and take into account all the services that will be charging co-pays. This would allow you to assure that clients do not have more co-pays than they can afford.

- Since providers cannot charge more than the co-pay stated on the voucher, they can't overcharge the clients.

Next, take the money you deduct from the rates for the co-pays and put it into your incentive pool. Pay the providers from the incentive pool based on a formula that takes into account provider performance on the seven domains (or whichever domains are relevant to that provider's work), plus other factors that are important. Be sure to inform providers that the incentive payments are part of the voucher reimbursement—not an administrative payment.

Issue #3: Assuring prompt assessments

New Jersey: *How can we assure that clients get assessed promptly? Can we pay a premium for assessments that are done the same day?*

Consultant: We can't respond to questions about what would be allowed or not. You will have to address that question to SAMHSA. It sounds reasonable to give an incentive to assessors for doing rapid assessments. You could also justify paying more for assessments on a cost basis. Providers have greater costs if they do same-day assessments, because they cannot schedule as tightly. So cost-based rate setting would suggest that providers who do same-day assessments should have higher rates than those who do not.

Issue #4: Other issues regarding use of incentives

New Jersey: *Do incentives have to be paid out on a client-by-client basis, or can they be paid in aggregate?*

Consultant: As a compliance question, that should be addressed to SAMHSA. The RFA says very little about incentives, and other States are considering variations of both methods. I think your analysis should come down to what best encourages providers to help you meet your goals. If both options are equal in that regard, then do whichever is administratively simpler, which is probably the aggregate approach.

You might also think about provider psychology: If the incentives are patient-by-patient, providers will complain about receiving no incentives for the client who gets great service but is uncooperative. On an aggregate basis, the fact that everyone gets "bad clients" and doesn't earn incentives on them is easier to swallow.

New Jersey: *When we withhold incentive money, it means that providers are getting less than 100 percent of cost. That bothers us.*

Consultant: Basically, if you form an incentive pool by deducting from what you think is a fair reimbursement, you are holding onto a provider's due and you should pay out your incentives quickly. The providers' cash flow will suffer if you do not. But think

carefully about what “cost” means. Most States set rates on an average unit cost: The total cost of a service divided by the total number of units delivered for that cost. There are fixed costs that any provider has, as well as variable costs. The marginal cost of the last unit of service delivered is smaller than the overall average unit cost, and it is much smaller than the cost of the first unit delivered. Providers can tolerate larger deductions from the average if their fixed costs have already been met. This means that rapid incentive payments will be more important to small providers than to big ones.

New Jersey: I thought we had to wait until completion of treatment before we paid incentives.

Consultant: No, you can pay any time you want. If the seven domains are the basis for incentives, you have those measures every 2 months and could pay as soon as the measures are in. You could choose to collect those measures every month, in which case you could pay incentives monthly. For retention, you can pay for each month the client stays in care. But be careful about providers who don’t get around to sending in their discharges. Base your incentives on treatment activity, not on discharges.

Consultants’ Background

Chris Hansen

Chris Hansen is a Senior Researcher with Johnson, Bassin & Shaw, Inc. Mr. Hansen has had an extensive career as an expert in substance abuse and management information systems, first at the State of Washington and now nationally. He has been a clinician, a treatment facility director, a program administrator, a research investigator, a software industry executive, and a consultant in substance abuse and information systems. He has managed State-level programs for adolescent treatment, women’s services, childcare, Native American services, prevention, and workplace programs. He has led development of more than 40 State-level data systems in substance abuse and other human services fields. His information technology experience with voucher systems includes documents, negotiable instruments, electronic benefit transfer cards, and electronic vouchers in the Women, Infants, and Children and Farmers Market nutrition programs, Medicaid, job training, childcare, and developmental disabilities.

Mr. Hansen is the technical lead for Access to Recovery technical assistance to States in the Information Technology domain.

Woodrow Odom, J.D.

Woodrow Odom, J.D., has more than 24 years of experience in health care and social service financing, management, administration, assessment, and programming. He is currently the lead for the Financing and Reimbursement domain of CSAT’s Performance Partnership Grant (PPG) Technical Assistance Coordinating Center. In that position, he oversees all project activities that address topics related to the cost and financing of the

State treatment system, including the reimbursement for treatment and recovery services; assures the substantive and technical quality and consistency of the multiple simultaneous activities within and across domains; and, as necessary, applies his expertise as leader or staff on particular work assignments, including delivery of on-site technical assistance as appropriate or requested by the CSAT Task Order Officer (TOO).