

# Optimizing System Design

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A Report Prepared for the Governor's Health Care Reform  
Implementation System Design Work Group



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## Executive Summary

This report presents the recommendations of the Illinois Alcoholism and Drug Dependence Association (IADDA) for successful implementation of health reform in the State of Illinois. Legislative changes at both the State and National level present unprecedented opportunities to better meet the needs of Illinois residents with substance use disorders. Capitalizing on these opportunities requires a thoughtful approach to systemic change in which all stakeholders are fully engaged. To accomplish this, IADDA has embarked on a vision and goal-setting process known as the Prevention and Treatment Horizon (PATH). This dynamic process has yielded the following:

1. **A framework for design and action**, which includes the many elements that affect SUD treatment in Illinois and will have an impact on the success of systemic changes.
2. A carefully considered set of nine **recommendations for system design** that IADDA's membership has developed, analyzed, and refined over the past year.
3. **A detailed implementation plan** to implement reforms that includes timeframes, management strategy, and a performance monitoring process.

**FRAMEWORK FOR DESIGN AND ACTION.** The framework presented in this report recognizes that dynamic factors will influence system design. Because they change over time, they must be taken into account to allow for flexible responses in areas such as business rules, financing, and systemic constraints. It also stresses the need to define, measure, and track system change in order to determine whether or not the reformed system is meeting the desired ends. IADDA envisions a robust delivery system monitoring tool that is capable of tracking changes in outcomes and providing input on how structural and functional elements are contributing to system performance.

The design framework also takes into account the catalysts of change that will have a profound impact on how changes are implemented. These include both legislative changes and organizational catalysts (notably the Office of National Drug Control Policy and the Substance Abuse and Mental Health Services Administration). Especially important will be the definition of the *Essential Health Benefits* that must be addressed by qualified health plans operating within the State Exchanges required by the Affordable Care Act. IADDA endorses the recommendations made by the Coalition for Whole Health In regard to Essential Health Benefits.

The pace of change will be rapid, and consensus must be reached quickly on how the State plans to meet such challenges as changes in reimbursement, new requirements for transparency and accountability, the use of evidence-based practices, the adoption of technology, and the formation of new entities and partnerships to achieve coordinated care.

**RECOMMENDATIONS FOR SYSTEM DESIGN.** IADDA unites on the following key recommendations.

RECOMMENDATIONS FOR POLICY DEVELOPMENT	
<p><b>Policy Strategy 1. Recognition and Equality</b></p>	<ul style="list-style-type: none"> <li>▪ Promote the policy across organizational boundaries, within the contexts of Public Health, Disease Control, Law Enforcement, Judiciary, Correctional system, Education, and Mental Health, such that all State agencies are dedicated to same ideal and objectives.</li> <li>▪ Promote the comprehensive implementation of the State’s new <i>Parity and Equity Law</i> and the need for timely issuance of final regulations and guidance for consumers and providers, as well as enforcement of Medicaid and commercial health insurance regulations.</li> </ul>
<p><b>Policy Strategy 2. Financing and Reimbursement</b></p>	<ul style="list-style-type: none"> <li>▪ Develop reimbursement models that transcend commercial health insurers and Medicaid-managed care plans and that apply regardless of whether the organizations use fee-for-service, pay-for-performance, shared savings, or global reimbursement strategies.</li> <li>▪ Support the establishment of standard clinical outcomes measures that transcend State and Federal Block Grant requirements for the Treatment Episode Data Set (TEDS) and National Outcomes Measures (NOMs) and align with commercial managed care and Medicaid managed care plans measures like the Healthcare Effectiveness Data and Information Set (HEDIS) and new measures such as those being promulgated by the National Quality Forum (NQF).</li> </ul>
<p><b>Policy Strategy 3. Scope of Practice</b></p>	<ul style="list-style-type: none"> <li>▪ Support the standardization of professional credentials across funding streams and markets.</li> <li>▪ Define licensure and certification requirements and scopes of practice per the new Parity Law.</li> <li>▪ Develop a shared understanding of the workforce requirements in a system financed by Medicaid, Medicare, and private insurance.</li> </ul>

## RECOMMENDATIONS FOR POLICY DEVELOPMENT

<p><b>Pilot Project 1.</b> <b>Measuring the Impact of Medicaid Reforms</b></p>	<ul style="list-style-type: none"> <li>▪ Develop statewide implementation plans for the expansion of Medicaid eligibility among childless adults (including those eligible for the State’s Coordinated Care Organizations) on a regional and/or incremental basis.</li> <li>▪ Measure the impact of expanded eligibility on the SUD system of care, noting where and when access and quality are adversely affected and developing corrective action plans. IADDA recommends developing access and quality measures that span market segments and funding streams, capable of measuring performance in relation to a baseline and benchmarks.</li> </ul>
<p><b>Pilot Project 2.</b> <b>Modeling Specialty Integration</b></p>	<ul style="list-style-type: none"> <li>▪ IADDA recommends specific actions be taken immediately to establish SUD as a sub-specialty discipline that can and will be integrated into the broader healthcare and medical sectors while preserving its distinctiveness.</li> </ul>
<p><b>Pilot Project 3.</b> <b>Conducting an IT Assessment and Gap Analysis</b></p>	<ul style="list-style-type: none"> <li>▪ Assess and establish a baseline of the current state of the adoption of health Information Technology (IT) among SUD providers and conduct a gap analysis between the baseline and the expected future-states of HIPAA 5010 standards, conversion to ICD-10 diagnosis codes, interoperability, capacity for Meaningful Use of health information, and Health Information Exchange (HIE).</li> <li>▪ Establish a timeline, resource requirements, and budget for improving upon the rate of adoption of certified health information systems among our members in accordance with privacy laws specific to SUD (42 CFR).</li> </ul>
<p><b>Priority 1 (Research). Conduct a SUD Cost/Benefit Analysis</b></p>	<ul style="list-style-type: none"> <li>▪ Identify test and control groups with sufficient data and conduct analysis in Illinois with the participation of large commercial payer such as Blue Cross. Using primary and secondary diagnosis codes and service codes (including prescription drug data), payers can play an important role in conducting a comprehensive evaluation of costs and benefits specific to Illinois populations.</li> <li>▪ Conduct a Medicaid cost-impact study analyzing the benefits and value of SUD prevention and treatment with an emphasis on medical cost-offset, prescription drug costs, and hospital Emergency Room utilization and admissions.</li> </ul>

## RECOMMENDATIONS FOR POLICY DEVELOPMENT

<p><b>Priority 2 (Technical Assistance). Develop Information Packages and Assess Resources</b></p>	<ul style="list-style-type: none"> <li>▪ Develop training material and webinars/seminars for providers.</li> <li>▪ Conduct Capacity Assessment and Gap Analysis, mapping our assets in the context of expected demand by 2014.</li> </ul>
<p><b>Priority 3 (Technical Assistance). Develop Readiness and Capacity for Third-Party Reimbursement and Managed Care</b></p>	<ul style="list-style-type: none"> <li>▪ Develop a 3-5 year Technical Assistance plan that efficiently and effectively informs SUD providers.</li> </ul>

**Implementation Plan.** As health reform moves forward, IADDA proposes to engage fully with stakeholders, including other State agencies, through conferences and summits, open meetings of the System Design Work Group, and committees established to monitor outcomes and ensure quality. It also intends to examine adjacent health care sectors to explore viable solutions to management and administrative operations challenges and to review the potential for various models of coordinated care.

Finally, this report contains IADDA’s delineation of specific implementation tasks related to each of the recommendations cited above. An implementation timeline is included for these tasks. IADDA proposes to coordinate schedules and ensure the quality of all products throughout the implementation process.

IADDA looks forward to the State’s review of these recommendations and to a collaborative, informed, and accountable effort to ensure the highest quality SUD prevention and treatment services to the residents of Illinois.

## BACKGROUND

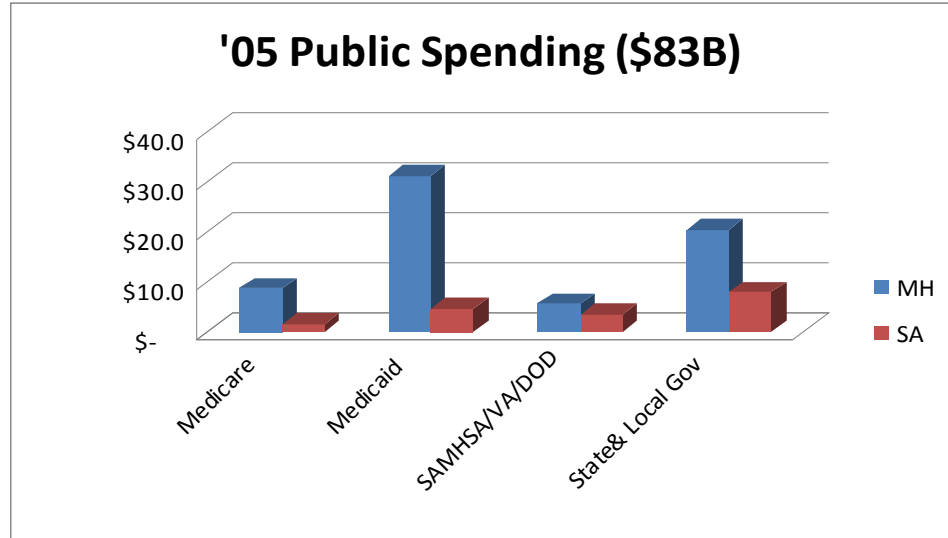
As a result of the Affordable Care Act (ACA) of 2010, the substance use disorder community is experiencing major changes to the larger health care system in which it operates. To ensure that health reform is implemented in a way that maximizes benefits to Illinois residents, on July 29, 2010, Governor Quinn issued Executive Order 10-12, which establishes the Health Care Reform Implementation Council. The purpose of the Council is to recommend steps needed to improve the health of Illinois residents by increasing access to care, reducing disparities, controlling costs, and improving the affordability, quality, and effectiveness of healthcare. The Council was also asked to solicit feedback from stakeholders on how to implement the ACA in Illinois.

Perhaps the most significant challenge for the Council is the establishment of an *Illinois health insurance exchange*, a new organizational entity that is enabled under the federal Affordable Care Act and scheduled for full-scale operation in 2014. The Illinois Exchange will be a critical vehicle for advancing the goal of expanding access to high quality and affordable healthcare. The exchange will directly impact those with substance use disorders, their families, and the providers who serve them.

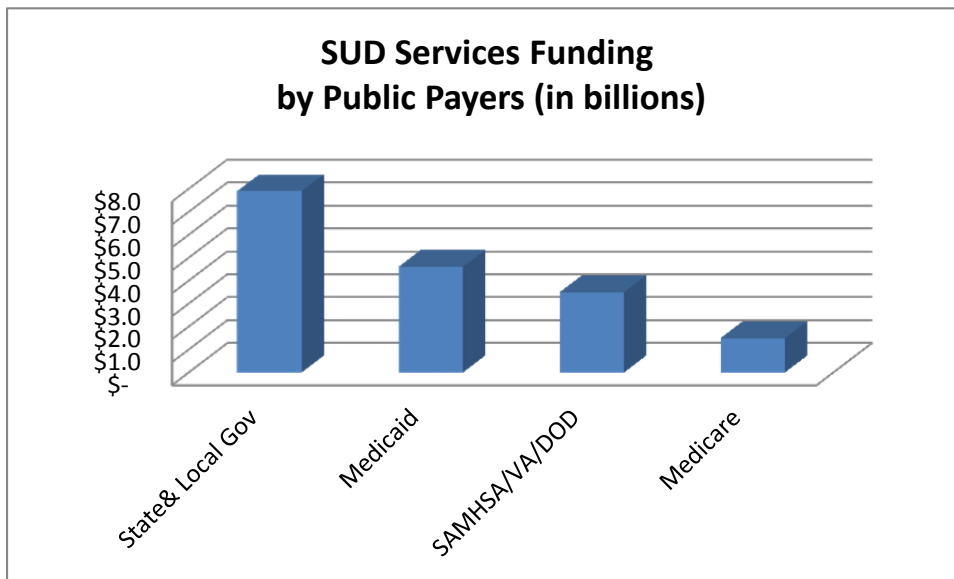
Another major challenge for the Council is reforming *Medicaid* service structures and incentives. The Implementation Council established the *Health Care Reform Implementation Design Work Group* to identify options, set priorities, and take advantage of appropriate funding under ACA to implement Medicaid program reforms. The Design Group convened in the spring of 2011 and defined plans to hold public meetings, develop a set of criteria for evaluating options, and apply those criteria to various new models. This document contains the recommendations of the Illinois Alcoholism and Drug Dependence Association (IADDA), which represents providers of substance use disorder (SUD) services throughout the State. It is presented by IADDA to the Design Group for its consideration.

The recent Deloitte Consulting report on current health coverage in Illinois underscores the importance of Medicaid as a payer of health care services. The report indicates that Medicaid covers over one in five Illinois citizens and 28% of the Chicago population (Deloitte Consulting, 2011). Clearly, changes to Medicaid will have large-scale impacts in the State.

National data augment the Deloitte findings particularly as they apply to those with substance use disorders. Nearly 80 percent of funding for SUD treatment came from public rather than private sources (Mark et al., 2011). 1 In 2005, spending for substance use disorders and mental health combined was \$83 billion nationally. About \$17.5 billion was for SUD treatment. Based on: Mark, Levit, Vandivort-Warren, Buck, and Coffey, 2011.



Among all public payers, Medicaid is the second largest payment source of all SUD services (26% or \$4.6B), exceeded only by contributions by state and local government (45% or \$7.9B). Clearly, Medicaid reforms will have a significant and disproportionately large impact on SUD services.



In 2005, spending for SUD and mental health combined was \$83 billion nationally. About \$17.5 billion was for SUD treatment. Based on: Mark, Levit, Vandivort-Warren, Buck, and Coffey, 2011.

Another major development that will affect SUD treatment in Illinois is the Illinois Mental Health Parity Act, signed into law by Governor Pat Quinn on August 18, 2011. The law requires that health insurance policies sold in the State offer SUD treatment benefits on a parity basis with medical surgical benefits. Insurers will have to eliminate any policy barriers that affect access to care for mental health and substance use disorders – such as financial requirements, treatment limitations, lifetime limits, or annual limits – wherever these barriers do not apply to other health conditions. In addition, policies must specifically identify State-licensed or certified SUD treatment providers, including residential service providers, as covered providers. Finally, the new law requires determinations of medical necessity for the treatment of substance use disorders to be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine (ASAM).

When making a determination of the medical necessity for a treatment modality for serious mental illness or substance use disorders, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. Medical necessity determinations for substance use disorders shall be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine.

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Members of the Illinois Alcoholism and Drug Dependence Association (IADDA) are preparing for a future based on these profound changes. They recognize that in order for the potential benefits of these systemic changes to be fully realized, they must be implemented strategically within an inclusively-designed systemic approach to change. To this end, IADDA has engaged stakeholders in a visioning and goal-setting process known as the Prevention and Treatment Horizon (PATH), which has provided input toward the following aim:

PATH is an adaptive network of structures, processes, and relationships grounded in core values and principles that effectively provide Illinoisans with access to services and supports across administrative and funding boundaries.

The PATH process articulated principles that are critical to an effective, recovery-oriented system of prevention, treatment, and recovery services design.

## PRINCIPLES GUIDING SYSTEM DESIGN

The Illinois system that emerges from the design process must be:

1. Self-organizing and able to transcend old paradigms;
2. Reflected in State policy and the wide variety of financing mechanisms resulting from health care reform;
3. Structured and stabilized by services and professionals who are guided by a shared philosophy and supported by a well-defined infrastructure;
4. Committed to evidence and community-based approaches to prevention, screening, early intervention, referral, case management, and treatment;
5. Primarily person-centered, engaging the family and community in prevention, treatment, and recovery;
6. Individualized and responsive to age, gender, language, and culture;
7. Strengths-based and committed to peer recovery support services;
8. Consisting of comprehensive services that address physical, psychological, social, and educational needs;
9. Accessible and available across an array of qualified prevention, treatment, and recovery supports;
10. Anchored in the community;
11. Offer care that is normative, clinically appropriate, and offered in the least restrictive environment;
12. Adequately and flexibly financed,
13. Measurably accountable;
14. Highly collaborative, coordinated, and integrated;
15. Enabled by the meaningful use of interoperable health information technologies.

IADDA believes the change process must be carefully articulated, tested, implemented and refined to achieve the widely shared vision of a better life for all those who struggle with substance use disorders. To this end, they have requested AHP Healthcare Solutions to prepare this report to convey IADDA's recommendations on implementation. It covers three broad areas, including:

1. A *framework for design and action*, which includes the many elements that affect SUD treatment in Illinois and will have an impact on the success of systemic changes.
2. A carefully considered set of nine *recommendations for system design* that IADDA's membership has developed, analyzed, and refined over the past year.
3. A detailed *implementation plan* to implement reforms that includes timeframes, management strategy, and a performance monitoring process.

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## Framework for Design and Action

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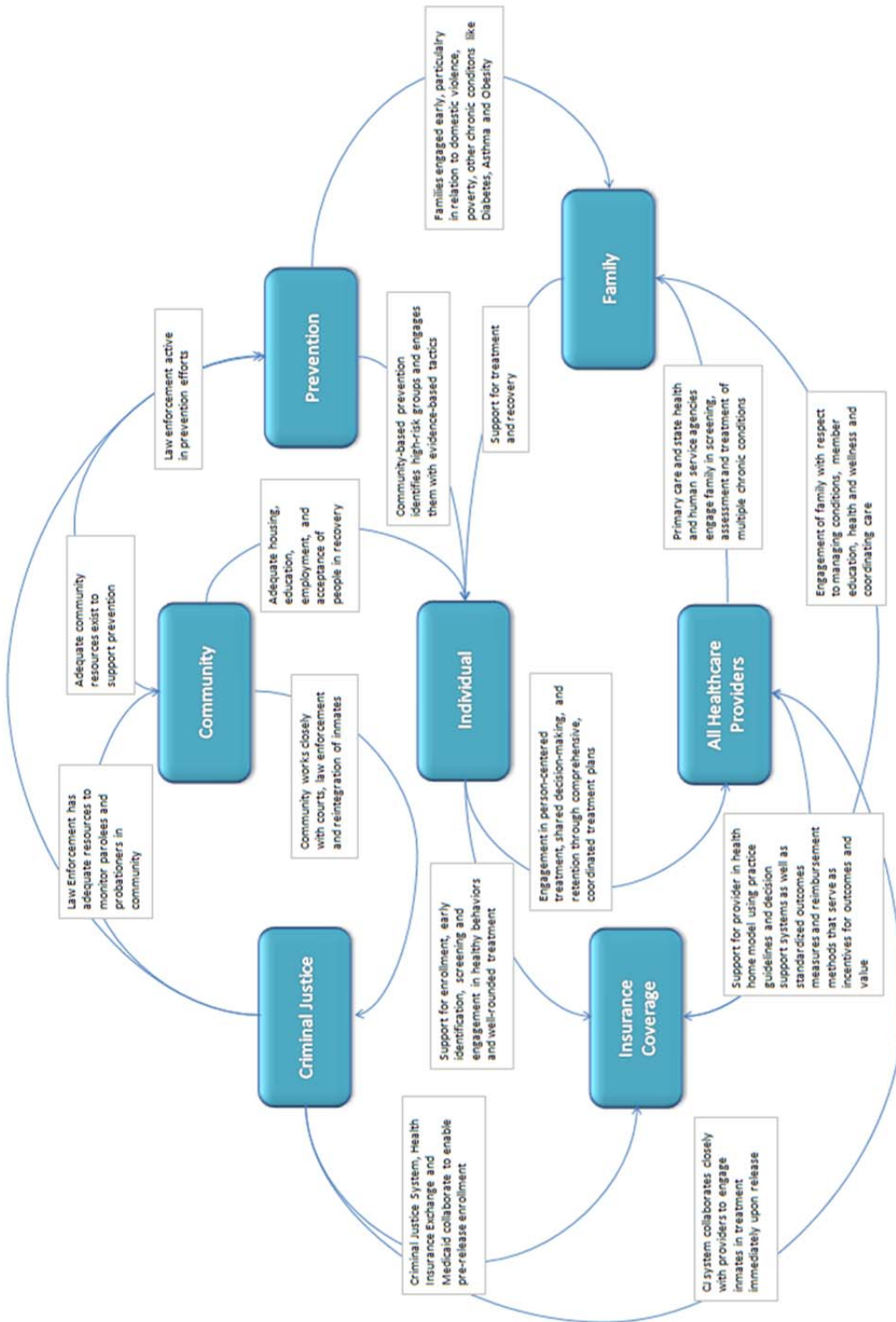
### Modeling Systems Change

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The Illinois substance use disorders system is both a unique and highly complex system that partakes of many elements, including persons with substance use disorders, their families, the communities in which they live and work, the justice and health systems, the other institutions and providers who serve them, and the public and private funders of these services, which exist at multiple levels of government and with different mandates and purposes.

In order to improve the effectiveness of the system that exists today and which is flawed in many ways, we must understand its inputs, throughputs, outputs, and outcomes. The systemic view proposed in this paper is trans-disciplinary and integrative. It assumes that the systemic is dynamic, changing constantly as its elements change. This understanding of the system also emphasizes the importance of interrelationships among all the elements in the system. For example, internal feedback loops and time delays affect its behavior.

We suggest that it is from these dynamic interrelationships that new properties of our system will emerge. Systems of care are complex, adaptive entities that are sensitive to local conditions. They are *complex* in that they are made up of multiple, interconnected elements and *adaptive* because there is action, reaction, and learning among these elements over time. A brief depiction of many of the components of the current system is provided in the illustration below.



Critical parameters for system design must account for dynamic factors that change in time, influencing the system and calling for nimble responses.

## DYNAMIC FACTORS THAT INFLUENCE SYSTEM DESIGN

- Business Rules (federal and State legislation, regulations and enforcement)
- Financing (public, commercial, and private-pay)
- Infrastructure (workforce, structure, governance and leadership, information technology, telecommunications, etc.)
- “Triggers” (activation events, referrals, admissions, arrests, incarcerations, discharges, etc.)
- Inputs (volume, demand upon the system, census, prevalence, need, admissions, etc.)
- Process (business rules, roles and responsibilities, decision-making, touch-points and hand-offs, timing, data required/produced, etc.)
- Throughput within the system (engagement, enrollment, initiating treatment, etc.)
- Outputs and Performance Measures (access, episodes and encounter data, admissions, average length of stay, quality of care, experience of care, behavior and symptom change, satisfaction, quality of life, cost, value, etc.)
- Constraints (process, procedure, financing, eligibility, etc.)
- Waste (waiting lists, procedural “motions” through the system, conveyance that adds no value, over-processing, re-admissions, etc.)

With respect to system design, failure to account for all process and system variables can lead to adverse consequences such as: waste, inefficiency, benign neglect, fraud and abuse, missed opportunities, and human consequences such as death, disability, broken homes, domestic violence, and lost opportunities to live a meaningful and productive life in recovery. IADDA and its members have worked diligently for decades to build the best possible system of care and are keenly aware of the process variables and system dynamics discussed in this section. Our aim with this report is to raise the level of awareness among our peers in other dimensions of the system of health care delivery and identify how we can make a good system even better.

## Defining, Measuring, and Tracking System Change

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Managing a systems design and change management process requires asking a lot of questions about the system in place and how it can be changed, over what period of time, and toward what ends. As IADDA began its assessment and planning process, some of the many questions raised included the following:

### Key Questions in Designing a System to Deliver Treatment for Substance Use Disorders (SUD)

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**Structure:** What does the new system look like? How is the delivery system organized? How does it change – and how should it change -- over time?

**Capabilities:** What can it do? Does the delivery system have the tools and processes in place that would allow it to manage total spending and health outcomes?

**Incentives:** What incentives are built into the system? Do incentives in the external environment encourage the delivery system to contain costs and improve health outcomes?

**Outcomes:** What does it actually do? Does the delivery system succeed at containing costs and improving health outcomes?

The primary purpose of any delivery system tracking tool is to understand whether progress is being made in a given community. It is necessary, therefore, to have some notion of what progress would look like. In other words, what is a reformed delivery system, and how will we know it when we see it? We agree with the Institute of Medicine, which has stated that the United States needs a health care system that is safer, more effective, more patient-centered, timelier, more efficient, and more equitable than the traditional non-system that dominates American health care today (IOM, 2001).

In short, a reformed system is one in which the various elements—primary care physicians, specialists, hospitals, ambulatory surgery centers, etc.—can manage health and economic outcomes by measuring, planning, and executing changes to improve performance and are held accountable for delivering high-quality, affordable care and a positive patient experience.

Some of the necessary data elements for a delivery system reform tracking tool are already being collected by different stakeholders. We propose that all these elements must be brought together into a unified whole to create a detailed picture of delivery system change. Further, there are significant holes in the information that is currently collected about the delivery

system, and our framework outlines the additional information needed. We hope the brief will serve as a call for continued development of valid measures that will support efforts to track progress.

A robust delivery system monitoring tool must track changes in the outcomes of the health care system. While tracking outcomes is essential to evaluate progress, it is also important to understand the structural and functional elements associated with better performance. These additional elements, along with outcome measures, allow for the exploration of many important questions, such as:

- How does organizational structure relate to outcomes? Which organizational types are most successful?
- How do payment and other incentives affect capabilities and, ultimately, outcomes?
- How does the market environment influence delivery system change, and how does delivery system change influence the market environment?
- Is it easier or more difficult to develop reformed care systems in highly competitive or more consolidated markets?
- How effective are different policy options for improving performance and facilitating spread and growth?

## Today's Catalysts of Change

To be effective, the Illinois approach to implementing health reform must take into account the major catalysts of change, which include the legal framework that governs change as well as key organizations that have important roles to play in the change process. Strategies will need to take into account factors that influence change at the national, State, county, and local level in order to maximize investments and efficiencies.

The challenge for the field of behavioral health is to find opportunities for growth and improvement within a rapidly changing health care environment that is increasingly recognizing the importance of behavioral health but does not necessarily understand or appreciate the complex system in which the field exists today. In order to participate successfully in the profound transformation taking place, participants must be grounded in the principal factors that are driving change together with understand what and how regulators and policy managers are shaping this process.

## Mental Health and Addiction Parity Legislation

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One of the major catalysts of change is the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. The Act requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. MHPAEA applies to group health insurance policies and health maintenance organizations (HMO) plans that cover 51 or more employees. On February 2, 2010, interim final regulations implementing MHPAEA were published. MHPAEA solidifies and expands behavioral health coverage within affected health insurance policies, normalizing the treatment of a historically stigmatized disorder. It also transforms the pattern of reimbursement for SUD providers. Rather than practicing in a unique stand-alone system of financing where 80 percent of revenues are public dollars administered through categorical grants and contracts, SUD providers by law have become eligible for reimbursement by many public and private health insurance plans.

The Illinois Mental Health Parity Act exceeds the Federal law in several ways. The State law specifically recognizes those community-based providers that are licensed or certified through the Illinois Department of Human Services in accordance with the Illinois Alcoholism and other Drug Abuse and Dependency Act. Additionally, in a significant victory for advocates, the law specifically identifies residential treatment services under the definition of inpatient treatment, now requiring parity in coverage of residential treatment. The new law also sets forth a definition for substance use disorders and requires medical necessity determinations to be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine (ASAM). While the Federal law leaves the determination of who is a covered provider up to the states, the Illinois law specifically identifies the state-contracted and licensed providers in Illinois as covered providers. This innovative law thus recognizes the quality of care and life-saving services that have been historically provided by this network of community-based agencies.

## Affordable Care Act

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Further catalyzing change is the Affordable Care Act (ACA), which became public law in March of 2010. The Affordable Care act encompasses the Patient Protection and Affordable Care Act, Public Law 111-148 (enacted March 23, 2010) and the Health Care and Education Reconciliation Act, Public Law 111-152 (enacted on March 30, 2010). This law is dedicated to reforming health care and achieving broad goals of improving access, increasing quality, and constraining growth in health costs.

### Health Insurance Exchanges

The ACA creates several new organizational entities that will assist in achieving legislative aims. A critical role will be played by health insurance exchanges (HIEs), which will begin operations in all States in 2014. HIEs are organizations designed to create insurance marketplaces that will make it easier for customers to comparison shop among plans and for low and moderate-income individuals to obtain public subsidies or to purchase private health insurance. HIEs cover both individual and small group markets for insurance. Exchanges must provide evidence by 2013 that they will be ready to operate fully by 2014; if this does not occur, the Department of Health and Human Services (HHS) will step in to provide a federal Exchange for the State (ACA Rules, 2011).

HIEs will be responsible for ensuring that health plans offering policies sold through Exchanges contain *Essential Health Benefits*. These are the services that will be included in insurance plans available through the HIE. Essential Health Benefits are covered in Section 1302 of the ACA, but the law contains relatively little guidance about what “*essential*” really means, other than outlining the following broad categories of services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- MH/SUD services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive/wellness services and chronic disease management
- Pediatric services, including oral and vision care

The law further clarifies that the essential benefits package must be “equal to the scope of benefits under a typical employer plan.”

In December of 2010, IADDA made the following recommendations to the Governor's Health Care Reform Implementation Council:

1. Explicitly recognize and enforce the essential health benefits requirements of the Exchange. This includes the requirement that comprehensive substance use disorder (SUD) benefits be covered by all plans participating in the Exchange at parity with medical/surgical benefits.
2. Enforce strong consumer protections for qualified health plan enrollees to ensure that individuals can easily obtain access to the type, level, and duration of care they need. Determinations about who needs what services, levels of care, and lengths of stay must be made by professionals treating the patient. Medical management tools cannot be used inappropriately to deny needed care. The Exchange should also enforce strong transparency requirements to ensure that criteria and reasons for denial of care are disclosed.
3. Ensure that coverage is easily accessible for those eligible to receive coverage through the Exchange, and that the Navigator program is sufficiently funded and staffed to facilitate the enrollment process for those individuals for whom the process may be more burdensome as well as those transferring between Medicaid eligibility and the Exchange. Ensure a strong outreach and education component, targeted to the public, eligible employers, and service providers to ensure sufficient access to coverage and benefits.
4. Ensure that the governing board and other advisory bodies tasked with developing and administering the Exchange include individuals with expertise regarding the unique needs of Individuals with substance use disorders. In particular, administrators of substance use disorder programs should be included in the development and management of the Exchange.
5. Develop the Exchange in a way that easily facilitates and encourages the participation of large employer plans, if the State elects to include issuers of health insurance coverage in the large group market beginning in 2017.

Federal regulations, as yet unpublished, are expected to be released this fall. Given that “mental health and substance abuse services” are specifically mentioned, we anticipate they will be defined more fully within the regulations. Because HIEs are anticipated to make coverage available to 30+ million new individuals and small employer groups, the demand for substance use services will grow significantly.

## Essential Health Benefits

Both the Institute of Medicine and the Coalition for Whole Health have addressed the issue of what should be included as Essential Benefits. The Coalition notes that “ACA requires the plans in the *Exchanges*, as well as Medicaid expansion plans, to cover a set of ‘essential health benefits’ that include MH/SUD services, including behavioral health treatment” (Coalition, nd). By including MH and SUD as essential services, Congress recognizes that SUDs and mental illnesses are treatable health conditions, as accepted by the American Medical Association, other public health and medical standards, and decades of scientific research.

For an SUD and mental health system to be accessible, accountable, efficient, equitable, and of high quality, the Coalition for Whole Health believes the Essential Health Benefits package covered by qualified health plans operating in State Exchanges and by Medicaid expansion plans must include the benefits described below. More detail on recommendations in each area may be found in the full report. The Work Group concurs with these recommendations and commends them to State decision-makers.

**Assessment.** Individualized assessment tools must drive the quality of care. Targeted MH/SUD services must be included in a distinct treatment plan, and the beneficiary must be involved in the treatment planning process. The Coalition for Whole Health supports provisions that require the use of standardized assessment tools under the ACA.

**Patient Placement Criteria.** Evidence-based patient placement criteria can help effectively place individuals into the optimal level of MH/SUD care for the amount of time deemed medically necessary. For example, the *Patient Placement Criteria for the Treatment of Substance-Related Disorders—Second Edition, Revised* (PPC-2R) of the American Society of Addiction Medicine (ASAM) is a widely used tool for decision-making that takes into account both clinical and practical considerations in care.

**Outpatient Treatment.** Parity provisions of the ACA require that outpatient treatment services be provided as long as medically necessary with no limits on duration or frequency. Patients must be allowed to access treatment to manage relapses. Services should include evidence-based individual, group, and family therapies.

**Intensive Outpatient Services.** These time-limited treatment programs offer therapeutically intensive, coordinated, and structured clinical services as either a step down or alternative to inpatient acute services for both MH and SUD populations. These services stabilize acute crises and clinical conditions by utilizing recovery principles that help return individuals to less intensive outpatient, case management, peer support, and/or other recovery-based services. Coverage of these services is an integral part of most private MH/SUD benefit packages and should include substance use intensive outpatient treatment, partial hospitalization, dual-diagnosis partial hospitalization, intensive outpatient services for persons with co-occurring MH/SUD conditions, and intensive case management.

**Residential Services.** Residential MH/SUD services are a key component of an optimally functioning service delivery continuum and help offset the costs associated with emergency department visits, hospital admissions, and readmissions. Placement in a residential or inpatient setting should be based on the individual needs of the patient. Patients should be regularly assessed to ensure they are at all times placed within the appropriate treatment setting for the appropriate duration and receive the appropriate level of care, given their needs and severity of their illness. To the greatest extent possible, the use of uniform patient placement criteria should drive placement decisions.

**Laboratory Services.** These should include coverage for laboratory tests regardless of whether they are offered by MH/SUD specialists, general medical professionals (e.g., primary care providers), or persons in non-behavioral, non-primary care medical/surgical specialties (e.g., laboratory services, including drug testing).

**Emergency Services.** These should include:

1. Crisis services in MH/SUD and medical settings (e.g., 24-hour crisis stabilization, mobile crisis services) as well as those provided by peers;
2. 24/7 crisis services, including “warmlines” and “hotlines”; and
3. Hospital-based detoxification services.

**Prescription Drugs.** Medications that are approved for mental illness, alcohol, drug, and tobacco treatment have been shown to be effective and must be a covered *Essential Health Benefit*. All Food and Drug Administration (FDA)-approved medications should be covered for SUDs and matched to the assessed individual’s clinical need and personal preference. The full continuum of FDA-approved medications for MH/SUD must be covered, and parity in access to medications prescribed for the treatment of MH/SUDs must be enforced. Coverage should be continued as long as medically necessary with no limits.

**Rehabilitative and Habilitative Services and Devices.** Rehabilitative services that should be covered include:

1. Psychiatric rehabilitation services;
2. Behavioral management;
3. Comprehensive case management in physical health or MH/SUD settings (e.g., individualized service planning with periodic review to address changing needs, treatment matching, and navigation between all needed services);
1. Assertive community treatment (ACT) teams;
2. Peer provided telephonic and internet-based recovery support services, including those delivered by recovery community centers;
3. Recovery supports, including those delivered by peer run mental health organizations; and
4. Skills development, including supported employment services.

Habilitative services that should be covered include:

1. Personal care services;
2. Respite care services for caregivers;
3. Transportation to health services; and
4. Education and counseling on the use of interactive communication technology devices.

**Case Management.** Both medical and behavioral health authorities have identified case management as an effective service for improving health outcomes among people with chronic medical, mental health, and SUD conditions. Comprehensive case management secures access to and retention in services, promoting compliance with recommended treatment protocols throughout an episode of care. It should be considered an essential benefit.

**Recovery Supports.** Twenty-three States provide Medicaid reimbursement for peer-delivered mental health and/or SUD recovery support services. Ongoing recovery supports for at least one year following an active phase of treatment have been shown to improve and sustain treatment and health outcomes for individuals with SUDs. Recovery support services should include:

1. Peer-provided recovery support services for SUD and mental health conditions,
2. Recovery and wellness coaching,
3. Recovery community support center services,
4. Support services for self-directed care, and
5. Community support programs as well as other continuing care for MH/SUDS.

**Preventive/Wellness Services and Chronic Disease Management.** The ACA requires all group health plans and health insurance issuers that offer group or individual health insurance to include, without cost-sharing, a minimum level of preventive health services, including services that have a rating of A or B by the U. S. Preventive Services Task Force (USPSTF). Requirements include depression screening for adults and youth age 12 to 18, alcohol screening and counseling, tobacco screening, and cessation interventions for adults. These and other preventive services (e.g., drug screening, counseling) are a critical component of prevention and should be included in the preventive and wellness services and chronic disease management *Essential Health Benefit*. Health promotion is also a significant part of comprehensive prevention and wellness plans and should be included in preventive and wellness services and chronic disease management.

**Screening, Brief Intervention, and Referral to Treatment (SBIRT).** This preventive intervention has been shown to be very effective in hospitals, health clinics, and primary care settings in reducing MH/SUD prevalence and future emergency room visits. SBIRT targets people who are just beginning to be symptomatic with MH/SUDs (including tobacco). Medical benefits must support and encourage SBIRT through full reimbursement in emergency rooms and primary care settings.

**Coverage for Youth.** While most services previously mentioned apply to youth, there are additional MH/SUD services that are only appropriate for youth and families. Specific attention should be paid to ensure the needs of transition age youth are met.

### Care Coordination

Two important organizations (among several new entities being created under the ACA) will be catalysts for change. These organizations are responding to one of the key assumptions of the ACA, which is that care must be integrated and coordinated with primary care. One of the new organizational models designed to facilitate that level of collaboration and integration is the Accountable Care Organizations (ACO) model. ACOs are also referred to as Integrated Care or Coordinated Care Organizations, as is the case in Illinois. Other models that represent a new frontier for SUD providers include Patient-Centered Medical Homes (PCMHs) and Health Care Homes, which are similarly intended to facilitate coordination of care. In PCMHs, Primary Care Physicians (PCPs) are the center of a wheel in which behavioral health providers are among the spokes. In Health Care Homes, on the other hand, behavioral health providers may themselves be at the center, providing a wider range of services. These organizations are expected to become part of a new, more person-centered, integrated health care system where care teams

coordinate treatment and ensure access to appropriate and necessary services, including treatment for SUDs.

Proposed federal regulations were recently published defining how ACOs will operate under Medicare, and these regulations are likely to shape the final form of how Accountable and Coordinated Care Organizations will operate. This in turn will determine, at least in part, how primary care organizations can reassume a central role and leadership position within the healthcare system, as well as how primary care will integrate with specialty care.

Both PCMH programs and Health Care Homes are currently being piloted by the Center for Medicaid and Medicare Services (CMS) to help operationalize how care coordination works, and thereby shaping future practices. Community Health Centers (CHCs) and Federally-Qualified Health Centers (FQHCs) are important potential partners for SUD treatment organizations, and many already are engaged in such partnerships.

## Organization Catalysts

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At the federal level it is Medicare and Medicaid that are driving implementation of the ACA through their influence in health care finance. However, two other federal organizations are highly influential organizations for SUDs providers. They include the Office of National Drug Control Policy (ONDCP) and the Substance Abuse and Mental Health Services Administration (SAMSHA). ONDCP plays a key role due to its influence constructing policies on reimbursable services in SUD treatment. SAMSHA is important as a provider of funds and resources for many SUD programs and organizations. To gain a clearer picture of the magnitude of changes that are on the horizon, it is important to understand each organization's influence.

### Office of National Drug Control Policy (ONDCP)

President Obama released the Administration's inaugural *National Drug Control Strategy* in May of 2010 based on the premise that drug use and its consequences pose a threat not just to public safety, but also to public health. The *2010 Strategy* represented the first comprehensive effort to rebalance federal drug control policy in nearly 40 years. The *2011 Strategy* states, "The Obama Administration's approach to the drug problem is born out of the recognition that drug use is a major public health threat, and that drug addiction is a preventable and treatable disease. Overall, the economic impact of illicit drug use on American society totaled more than \$193 billion in 2007, the most recent year for which data are available" (Executive Office of the President, 2011). The *2011 Strategy* continues efforts to coordinate an unprecedented

government-wide public health approach to reduce drug use and its negative consequences in the United States. This plan identifies the following priorities:

- Reduce prescription drug abuse,
- Address drugged driving,
- Prevent drug use before it begins, and
- Focus on special populations (i.e., college/university students, women/families, military/veterans and their families, Native Americans and Alaskan Natives).

### The Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA recognizes the powerful evolution that is taking place due to the ACA's and MHPAEA's implementation and is enhancing access to prevention, treatment, and recovery support services for persons with or at risk of MH/SUDs as well as enhancing access to behavioral health services for millions of Americans. In light of changing health care systems, laws, knowledge, and conditions in States, SAMSHA's Block Grants have made changes to help States prepare for 2014, when more people will be insured through Medicaid or third party insurance. Under this new approach, States and territories will have the opportunity to use block grant dollars for prevention, treatment, recovery supports, and other services that supplement services covered by Medicaid, Medicare, and private insurance (SAMHSA, 2011). SAMHSA Block Grant funds will be directed toward four purposes that include:

1. Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
2. Fund priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and for treatment or services that demonstrate success in improving outcomes and/or supporting recovery;
3. Fund primary prevention (i.e., universal, selective, and indicated prevention activities) and services for persons not identified as needing treatment; and
4. Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services together with plan the implementation of new services on a nationwide basis.

To achieve these purposes, SAMHSA plans to make adjustments in SAMHSA staff functions as well as technical assistance to support States through the many transitions of health reform.

## Conclusion: Catalysts of Change

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The laws, regulations, and agencies discussed are the most important catalysts of change impacting SUDs providers. In a recent article (Buck, 2011), Jeffrey Buck comments on the profound effects these changes will have on SUD treatment services:

Overall, requirements for expanded SUD coverage, along with the expansion of Medicaid eligibility, will greatly increase public support of SUD treatment services. However, these and other changes also will have profound effects on the character of SUD treatment in America, affecting the relative importance of funding sources, the numbers and types of SUD treatment providers, their workforce, and the kinds of services they offer. Also affected will be the size and nature of SUD treatment services in the Medicaid program and the role and orientation of State SUD agencies.

Buck goes on to describe that – nationally - providers have built their organizations atop business plans and funding other than Medicaid, Medicare, and private insurance. Across the country, SUD providers have yet to fully integrate their services with other health care providers and programs. Compared to hospitals and medical groups, behavioral health providers have been slower to purchase and implement information technology. While Buck's observations are not necessarily the case across all of Illinois' SUD system, he underscores the importance and urgency of profound changes coming to every state system soon.

The rapid pace of change will require much from the provider community if it is to realize the opportunities made available by virtue of the new legislation. We will need consensus about how key reform provisions will impact the current SUD treatment system, the system Illinois should create to meet these changes, and how to meet such key challenges as the changes in compensation, transparency and accountability, use of evidence-based practices, incorporation of technology, and the formation of dynamic partnerships to achieve coordinated care.

## Design Recommendations: A Plan of Action

IADDA Parity & Reform Task Force members recently participated in a priority-setting process with consultants from Advocates for Human Potential (AHP). Through a survey, key informant interviews, and a strategic planning process, IADDA received a total of ninety (90) recommendations for specific elements of system design. Through an inclusive voting process, the IADDA Task Force narrowed this list of recommended improvements down to fifteen (15) priorities. By merging some similar priorities, the Task Force was able to refine the list to nine recommendations, three falling in each of three categories:

- Policy Development
- Demonstration and Pilot Project Actions
- Research and Technical Assistance

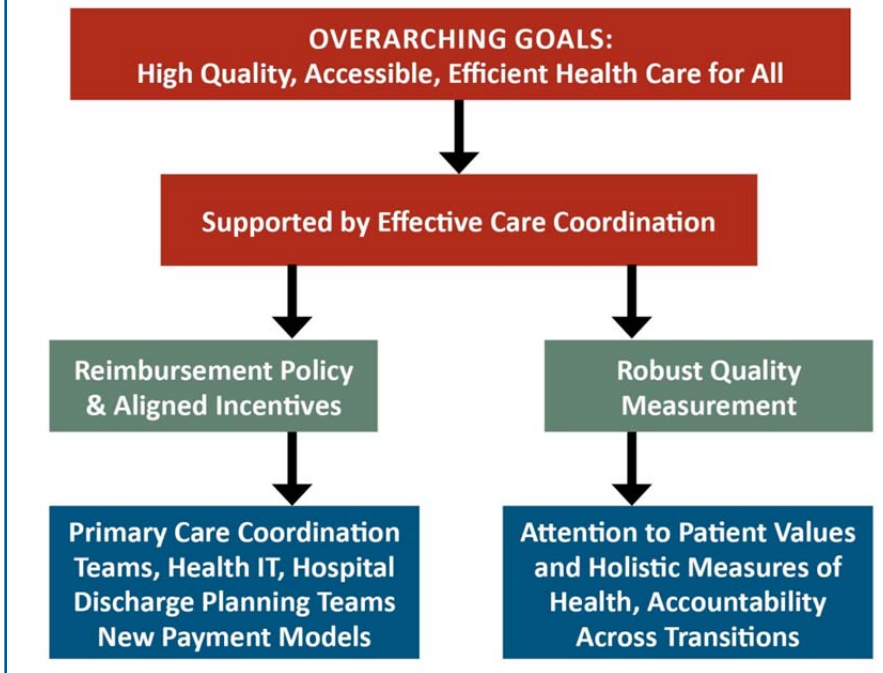
Note that to the extent that the recommendations we are making require analysis of health information and related data, the Task Force assumes that the State will abide strictly by CFR 42 and Health Insurance Portability and Accountability Act (HIPAA) where the privacy, security, and confidentiality of personal health information are concerned.

### Recommendations for Policy Development

The discussion of substance use disorders in the broader medical and healthcare context yielded an overarching recognition that prevention, treatment, and recovery must be viewed as central to the health and wellness of the population. In order to convey this message successfully, participants believe that the historical marginalization and criminalization of substance use disorders must be overcome. A strong policy position has emerged in the form of the State's new parity legislation, especially its important definition of "Essential Community Providers," but more must be done. The group believes that any framework for significant change must be catalyzed around bold inclusion of the field in the mainstream of healthcare.

Change requires effective use of the policy "levers" that can improve the system of care. As shown in the figure below, effective care coordination relies on a combination of appropriate incentives and reimbursement policies that encourage a coordinated approach to client care, combined with ongoing quality measurement to ensure accountability, to give feedback to the system so that it can improve care, and to incorporate patient values in measures of excellence. Robust quality measurements help to monitor the all-important transitions between providers and across levels and locus of care.

## POLICY LEVERS FOR BETTER CARE COORDINATION



Policy makers can support agreed-on goals through well-thought out reimbursement policies with aligned incentives and by identifying appropriate measures to gauge the success of systemic changes.

The following three strategies emerged as most critical for the successful design of a substance use disorders system capable of keeping pace with health care reforms.

### Policy Strategy 1: Recognition and Equity

Policy “levers” play a critical role in accomplishing the overarching aim of placing SUD treatment clearly within the mainstream of health care services. The public, State leaders, and all treatment professionals must recognize that people need equitable access to SUD services exactly as they need access to other primary care services. IADDA urges the State to develop a State-level policy and position that recognizes substance use disorders (SUD) on a continuum of chronic medical conditions and diseases while promoting the fact that they are *preventable* and *highly responsive* to effective treatment and maintenance of recovery efforts. This position encompasses co-occurring disorders as well. Specifically:

- Promote the policy across organizational boundaries, within the contexts of Public Health, Disease Control, Law Enforcement, Judiciary, Correctional system, Education, and Mental Health, such that all State agencies are dedicated to same ideal and objectives.

- Promote the comprehensive implementation of the State’s new Parity and Equity Law and the need for timely issuance of final regulations and guidance for consumers and providers, as well as enforcement of Medicaid and commercial health insurance regulations.

## Policy Strategy 2: Financing and Reimbursement

Develop a reimbursement policy for SUD services and providers who, to succeed, must receive equitable reimbursement for services consistent with American Society of Addiction Medicine (ASAM) Patient Placement Criteria. Specifically:

- Develop reimbursement models that transcend commercial health insurers and Medicaid-managed care plans and that apply regardless of whether the organizations use fee-for-service, pay-for-performance, shared savings, and global reimbursement strategies.
- Support the establishment of standard clinical outcomes measures that transcend State and Federal Block Grant requirements for the Treatment Episode Data Set (TEDS) and National Outcomes Measures (NOMs) and align with commercial managed care and Medicaid managed care plans measures like the Healthcare Effectiveness Data and Information Set (HEDIS) and new measures such as those being promulgated by the National Quality Forum (NQF).

## Policy Strategy 3: Scope of Practice

In order to address a looming workforce shortage, we support addressing the issue of *Scope of Practice* and provider credentials across funding sources in a manner that takes the State’s new Parity Law into consideration. The new law transcends State- funded programs through the Division of Alcoholism and Substance Abuse (DASA), Illinois commercial health plans, and Medicaid managed care plans, enabling the State’s current workforce to operate in each arena. Specifically:

- Support the standardization of professional credentials across funding streams and markets.
- Define licensure and certification requirements and scopes of practice per the new Parity Law.
- Develop a shared understanding of the workforce requirements in a system financed by Medicaid, Medicare, and private insurance.

## Recommendations for Demonstration and Pilot Projects

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There was considerable discussion concerning the transitions Illinois substance use disorders service providers will need to traverse throughout the implementation of health care reform. Many of IADDA's members are much smaller in terms of revenues, capital, and staffing than their primary care counterparts; yet, they will be facing the same standards and requirements. This includes participating in new programs like the State's Coordinated Care Organizations and making required infrastructure enhancements, such as the use of certified, interoperable electronic health records systems. Because the field has been fragmented and marginalized from the remainder of the medical and healthcare context, many primary care providers have little to no clinical and operational experience with our members. Operating in silos makes effective integration and care coordination difficult, hampering efforts to effectively treat serious, persistent and chronic conditions, especially those that are co-morbid with cancers, heart disease and conditions like AIDS, obesity, and diabetes.

Pilot and demonstration policies can help Illinois providers implement changes successfully. IADDA recommends the following three high-priority pilot projects as a way of testing the effectiveness and value of specific strategies.

### Pilot Project 1: Measuring the Impact of Medicaid Reforms

The first pilot project is designed to assess the effects of Medicaid reforms on the Illinois system of care for persons with SUDs, providing feedback on where difficulties are encountered and corrective planning is needed for successful implementation. Specifically, it will:

- Develop statewide implementation plans for the expansion of Medicaid eligibility among childless adults (including those eligible for the State's Coordinated Care Organizations) on a regional and/or incremental basis.
- Measure the impact of expanded eligibility on the SUD system of care, noting where and when access and quality are adversely affected and developing corrective action plans. IADDA recommends developing access and quality measures that span market segments and funding streams, capable of measuring performance in relation to a baseline and benchmarks.

## CARE COORDINATION ACTIVITIES

- Determine and Update Care Coordination Needs
- Create and Update a Proactive Plan of Care
- Communicate:
  - Between Health Care Professionals & Patients/Family
  - Within Teams of Health Care Professionals
  - Across Health Care Teams or Settings
- Facilitate Transitions
- Connect with Community Resources
- Align Resources with Population Needs

PCMH

ACO

Successful coordination of care in the context of health reform will require a systemic approach in which strategies are inclusively planned, communicated clearly, and facilitated at all levels.

### Pilot Project 2: Modeling Specialty Integration

IADDA recommends specific actions be taken immediately to establish SUD as a *sub-specialty* discipline that can and will be integrated into the broader healthcare and medical sectors while preserving its distinctiveness. The following steps encapsulate our recommendations for a statewide integration initiative to accelerate this process, rooting change in communities across the State:

1. Clearly define *Addiction Equity* where the new State Parity Law is concerned.
2. Define the manner in which the American Society of Addiction Medicine (ASAM) patient placement criteria will be implemented and enforced in Illinois' commercial health plans and Coordinated Care Organizations.
3. Clearly defines *scope of practice* in accordance with the new Parity Law and requirements to recognize SUD-specific education, training, experience, certifications, and State licensure.
4. Clearly define SUD prevention, treatment and recovery in the context of *Essential Community Providers* and *Essential Benefits*.
5. Develop reimbursement policies that allow SUD providers to participate fully in the treatment of co-occurring disorders (MH and SUD) in any of the State's major health insurance markets, including Medicaid.

6. Leverage existing Screening, Brief Intervention, and Referral to Treatment (SBIRT) funding, methodology, and assets in primary care, emergency rooms, and other community-based organizations.
7. In the spirit of Health Homes, Medical Homes, and in anticipation of Coordinated Care Organizations, develop and launch a statewide primary care outreach strategy that supports the effective identification of SUD needs in primary care settings. At the same time, familiarize the medical community with statewide networks of qualified SUD providers and mechanisms that facilitate the proper coordination of care between disciplines.
8. Establish 10-15 bi-directional, co-located pilot projects involving mental health, primary care, and SUD providers. Measure and analyze the impact of deep collaboration and integration on utilization patterns, cost trends, access to and quality of care, and clinical/medical outcomes.

### Pilot Project 3: Conducting an IT Assessment and Gap Analysis

Assess and establish a baseline of the current state of the adoption of health Information Technology (IT) among SUD providers and conduct a gap analysis between the baseline and the expected future-states of HIPAA 5010 standards, conversion to ICD-10 diagnosis codes, interoperability, capacity for Meaningful Use of health information, and Health Information Exchange (HIE). IADDA also recommends establishing a timeline, resource requirements, and budget for improving upon the rate of adoption of certified health information systems among our members in accordance with privacy laws specific to SUD (42 CFR).

### Recommendations for Research and Technical Assistance

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The SUD field in Illinois developed for decades in a paradigm that financed the vast majority of treatment and all of the prevention with public monies including Federal Block Grant dollars and State General Funds. In what the Federal government calls the “new business paradigm,” the system of care – our members – are being called upon to transition into a largely third-party payer environment and the advent of Coordinating Care Organizations (CCOs).

For many of the providers affected by this systemic transformation, their revenue base will shift from one in which 80% of revenues are derived from the DASA and similar grant funding to one in which 80% of their revenue comes from a variety of third-party and managed care payers. Navigating this transformation and capitalizing on this wide range of key healthcare assets will require continued investment in the form of research, training, education and widespread communications. Research and technical assistance can ensure that Illinois residents achieve the greatest possible benefit from these changes over the long term.

## Priority 1 (Research): Conduct an SUD Cost/Benefit Analysis

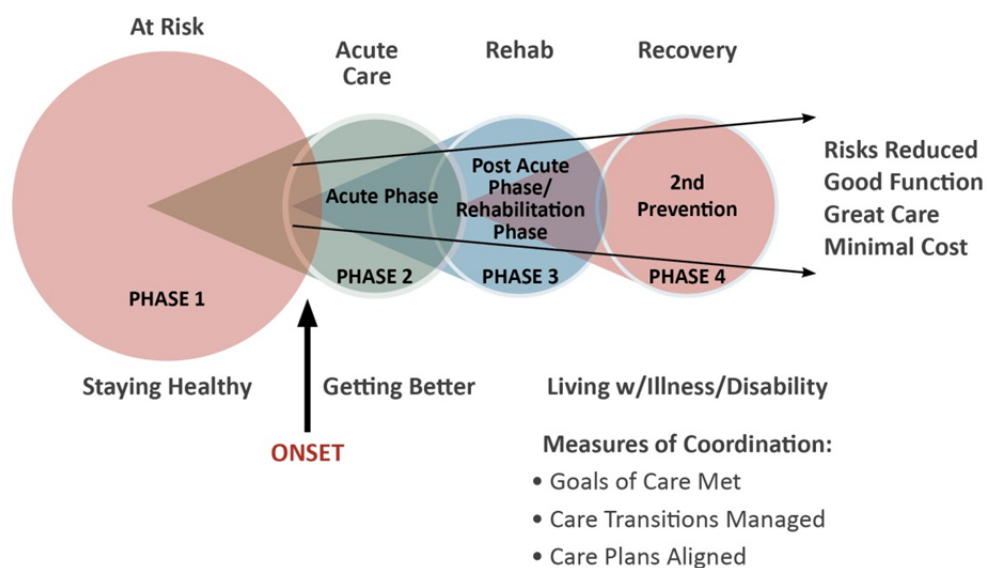
Demonstrating convincingly that SUD prevention and treatment work well and result in savings for the State will have profound benefits for the State, program providers, persons with SUDs, and their families. Changed public perception can also help change the way policies and programs respond to SUDs issues.

IADDA proposes to measure the cost and effectiveness of prevention and treatment across the lifetimes of people with SUD and co-occurring disorders in contrast to untreated and unmitigated SUD. In order to establish the total economic burden of SUD, the approach should focus particular attention on all non-SUD service claims data, including all medical, surgical and pharmacy claims. Specifically, IADDA recommends the following research activities:

- Identify test and control groups with sufficient data and conduct analysis in Illinois with the participation of large commercial payer such as Blue Cross. Using primary and secondary diagnosis codes and service codes (including prescription drug data), payers can play an important role in conducting a comprehensive evaluation of costs and benefits specific to Illinois populations.
- Conduct a Medicaid cost-impact study analyzing the benefits and value of SUD prevention and treatment with an emphasis on medical cost-offset, prescription drug costs, and hospital Emergency Room utilization and admissions.

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### PERFORMANCE MEASUREMENT NQF Episode Measurement Framework



The National Quality Forum (NQF) uses the model of performance measurement shown in this diagram, which facilitates the evolution of on-target, well-coordinated systems of care.

## Priority 2 (Technical Assistance): Develop Information Packages and Assess Resources

In order to design an effective evolved system of care in the context of health reform, it is imperative to define systems for the State of Illinois' purposes from the standpoint of prevention, treatment, and recovery and develop a promotional/informational packet for legislators, stakeholders, health care providers, and the general public. Specifically, IADDA recommends:

- Develop training material and webinars/seminars for providers.
- Conduct Capacity Assessment and Gap Analysis, mapping our assets in the context of expected demand by 2014.

## Priority 3 (Technical Assistance): Develop Readiness and Capacity for Third-Party Reimbursement and Managed Care

Develop a 3-5 year Technical Assistance plan that efficiently and effectively informs SUD providers. Formulate training and education around the following core domains:

1. Health Care Reform – statute and regulations
2. Medicaid expansion and Health Insurance Exchanges
3. Essential Benefits and Essential Community Providers
4. Medicaid CCO and similar models such as Accountable Care Organizations
5. Healthcare financing
6. Coordinated care models including patient-centered medical home and health home models
7. Treating multiple chronic conditions in an integrated delivery system
8. Utilization management, care management, disease management, and population management
9. Market research, marketing and contracting
10. Quality, access, and Pay-for-Performance
11. Reimbursement Reforms and Global Payments
12. Scopes of practice and credentialing
13. Information technology and “meaningful use” of health information
14. Revenue cycle management and billing
15. Compliance

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## Implementation Plan

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The purpose of this portion of the IADDA report to the Governor's Health Care Reform Implementation Council is to articulate and elucidate an implementation plan for the nine initiatives and actions we have suggested throughout this report. This plan will clarify timeline, dependencies, roles, tasks, milestones, resource requirements and other critical factors. Notably, IADDA is also suggesting that it take a lead role in managing the implementation and execution of its system design recommendations. We believe that we understand the nature and extent of the issues, constraints, and critical success factors that pertain to these initiatives, and we are prepared to solicit the assistance of national and local subject matter experts in each specialized domain to ensure our success.

## System Overview

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The system consists of Illinois substance use disorders prevention, treatment and recovery assets including providers, professionals and facilities at all levels of service. The system is relational and has a scope and span that encompasses and affects statewide stakeholders including consumers and their families, mental health providers and managers, medical and general healthcare providers, hospitals, health insurers and managed care organizations, publicly-financed healthcare, family and children's services, homelessness and housing agencies, employers and labor, public health, education, corrections, law enforcement, and the judicial system. The proposed system:

- Is structured to implement change,
- Defines the necessary infrastructure requirements,
- Is financed by a variety of sources and payers,
- Is expected to meet access, quality and cost standards, and
- Is interconnected clinically, as well as from a number of technology perspectives.

## Assumptions and Constraints

IADDA is presupposing that the State and stakeholders will want to make a reasonable effort to implement system design recommendations. We are making the following assumptions:

- **Schedule.** The deadlines and milestones for many of the federal and State health care reforms are approaching rapidly. We propose that agreement on an implementation approach and budget is critically important and must be reached by January 1, 2012.

- **Budget.** Many of the State’s stakeholders do not have the financial resources to fully deploy all of the system design recommendations expected of them. IADDA is asking that a frank discussion of budget be chaired by the State and that grants and other funding be made available to manage the implementation.
- **Resource availability and skill sets.** IADDA recognizes that additional resources and subject matter experts will be required to effectively deploy our recommendations. We have identified the resources we would need on a temporary contract basis and are ready to execute agreements with them, assuming the funding is available
- **Software and other technology.** IADDA submits that much of the technology required to conduct activities suggested in this plan exists and is available. However, we are assuming that stakeholders and partners will be willing to share information openly when it is called for and within the bounds of privacy and security laws. In regard to the adoption of electronic health records, we would support the establishment of funding specifically for that purpose.

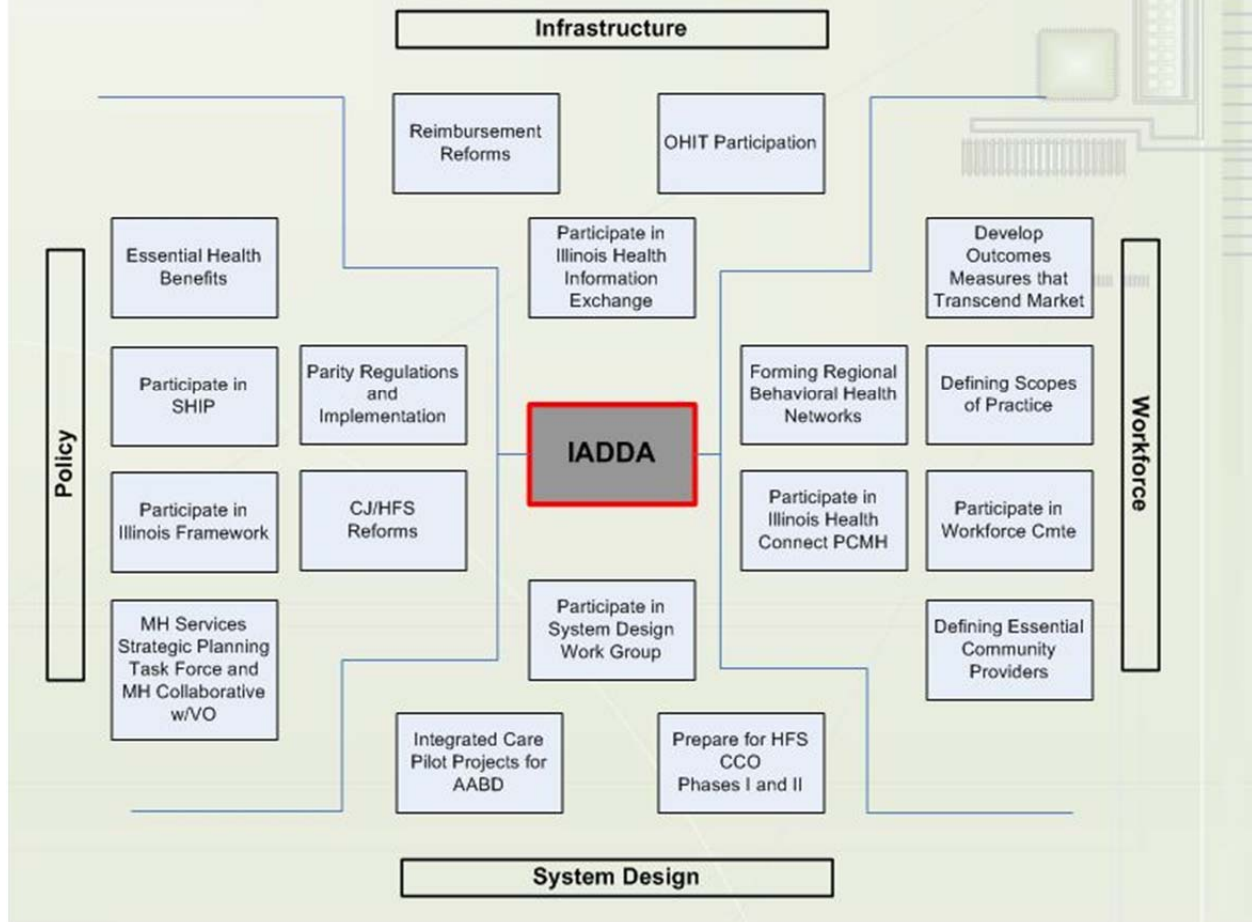
## System Organization

In order for the recommendations we are making to be considered feasible, we would require the approval and participation of many other stakeholders. Primarily, IADDA believes that many State agencies would need to be organized in such a way as to support our progress and success. The participation of Illinois health plans, other health care providers such as primary care providers, and others is also indispensable. IADDA believes system design changes will be most successful if the organization is engaged in dynamic communication with stakeholders, including other agencies. Specifically, IADDA proposes that we do the following:

1. Continue to participate fully in statewide conferences and summits of State leadership, State agencies, community organizations, SUD prevention, SUD treatment providers, mental health providers, public health, schools, and primary care providers. Address funding, communication, cooperation, rules and regulations and other factors that are impeding our progress. Relevant examples include:
  - <http://www.illinoismentalhealthcollaborative.com/index.htm>
  - <http://www.illinoiscebicp.com/>
  - <http://www.ilga.gov/legislation/BillStatus.asp?DocNum=2084&GAID=11&DocTypeID=HB&SessionID=84&GA=97>
  - <http://www.dhs.State.il.us/page.aspx?item=46673>
  - <http://www.idph.State.il.us/ship/>
  - <http://www.hie.illinois.gov/ohit/>
  - <http://www.illinoishealthconnect.com/>
  - <http://www.ilga.gov/legislation/fulltext.asp?GAID=11&SessionID=84&GA=97&DocTypeID=HB&DocNum=2982&LegID=60319&SpecSess=&Session=>
  - <http://healthreformgps.org/resources/essential-community-providers/>

# IADDA PATH: Context & Communication Plan

Monday, August 29, 2011



IADDA's plan for guiding systemic change considers the necessary adjustments in policy, infrastructure, system design, and workforce capacity that provide the context for statewide change. To achieve success in each area, ongoing communications are essential.

2. IADDA must attend any open meetings of System Design Work Group addressing Health Care Reform Implementation to define our role, our recommendations and positions, implementation of system design changes, and pilot or demonstration projects that prove viability and reliability of our field.

3. Participate in any Outcomes and Quality committees – potentially involving representatives from Medicaid, Public Health, MH, DASA, commercial insurers, mental health and primary care – in order to promote the development of core outcomes measures that transcend programs and funding sources. For example, if managed care is using HEDIS measures and the Medicaid Coordinated Care Organizations (CCO) are likely to follow suit, our system must begin to make the transition from TEDS and NOMS to HEDIS. We believe that DASA should support that transition. Otherwise, the risk is that requirements for multiple systems, data and measures will become untenable for providers with inadequate/immature information systems (IS) and limited resources for development.
4. Examine adjacent health care sectors to explore viable solutions to management and administrative operations challenges. Review potential for the development of Administrative Services Only funders (ASOs), Medical Services Organizations (MSOs), Preferred Provider Organizations (PPOs), and other management/technical services cooperative or consortia models.

## Management Overview

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This section of the Project Implementation Plan provides a description of how the implementation will be managed and identifies the major tasks involved.

### Description of Implementation

IADDA is recommending that the implementation be conducted over a period of 18 months. The actions and strategies we are proposing are reasonable in scope and duration and require the skills of different individuals which will enable deploying and managing more than one team at a time. The implementation will be carefully managed and monitored with bi-weekly progress reporting to the State.

## Points of Contact

IADDA suggests that the system design implementation feature comprehensive participation across a wide range of agencies and stakeholders. We recommend the development of contact list as follows:

ROLE	NAME(S)	CONTACT NUMBER(S) AND EMAIL ADDRESSES
Executive Sponsors		
Project/Program Managers		
Government Project Officer		
Consultants		
Health & Family Services and Medicaid Liaisons		
Corrections Liaisons		
Mental Health and Public Health Liaisons		
Security and Privacy Experts		
Data and Information Management Liaisons		
Training and Technical Assistance Liaisons and Subject matter Experts/Trainers		
Epidemiology and Health Informatics Expertise		
Insurance Commissioner Liaison		
MCO and other Payer Liaisons		
Other		

*Others will be added as identified and necessary.*

## Major Tasks

In most cases, the priorities we identified in the preceding sections can be construed as a task with subtasks. We have identified tasks required to implement IADDA's recommendations below.

## Policy Development

### Task 1

Develop a State-level policy and position that recognizes substance use disorders (SUD) on a continuum of chronic medical conditions and diseases.

## Task 2

Promote the policy across organizational boundaries, within the contexts of Public Health, Disease Control, Law Enforcement, Judiciary, Correctional system, Education, and Mental Health such that all State agencies are dedicated to same ideal and objectives.

## Task 3

Promote the comprehensive implementation of the State's new *Parity and Equity* Law and the need for timely issuance of final regulations, guidance for consumers and providers, as well as enforcement of health insurance regulations.

## Task 4

Develop a reimbursement policy that supports equitable reimbursement for SUD services and providers in the Medicaid and commercial health insurance markets. Develop reimbursement models that transcend commercial health insurers, Medicaid managed care plans and other plans, including: fee-for-service, pay-for-performance, shared savings and global reimbursement or payment.

## Task 5

Establish standard clinical outcomes measures that transcend State and Federal Block Grant requirements for the Treatment Episode Data Set (TEDS) and National Outcomes Measures (NOMs) and align with commercial managed care and Medicaid managed care plans measures like HEDIS and new measures such as those being promulgated by the National Quality Forum (NQF).

## Task 6

Standardize SUD professional credentials across all Illinois funding streams and health insurance markets, defining licensure and certification requirements and scopes of practice per the new Parity Law.

## Task 7

Define SUD workforce requirements across Medicaid, Medicare, private insurance and State programs including those for the uninsured.

## Demonstration and Pilot Projects

### Task 8

Develop statewide implementation plans for the expansion of Medicaid eligibility among childless adults (including those eligible for the State's Coordinated Care Organizations) on a regional and/or incremental basis.

### Task 9

Develop access and quality measures that span market segments and funding streams, capable of measuring a baseline and establishing benchmarks.

### Task 10

Measure the impact of expanded eligibility on the SUD system of care, noting where and when access and quality are adversely affected and identifying opportunities for corrective action plans.

## Task 11

Establish SUD as a *sub-specialty* discipline, taking the following actions:

11.1 Clearly define *Addiction Equity* where the new State Parity Law is concerned.

11.2 Define the manner in which the American Society of Addiction Medicine (ASAM) patient placement criteria will be implemented and enforced in Illinois' commercial health plans and Coordinated Care Organizations.

11.3 Clearly define *scope of practice* in accordance with the new Parity Law and requirements to recognize SUD-specific education, training, experience, certifications, and State licensure.

11.4 Clearly define SUD prevention, treatment and recovery in the context of *Essential Community Providers* and *Essential Benefits*.

11.5 Align efforts with existing SBIRT funding, methodology, and assets in primary care, emergency rooms, and other community-based organizations.

11.6 Develop and launch a statewide primary care outreach strategy that supports the effective identification of SUD needs in primary care settings while familiarizing the medical community with statewide networks of qualified SUD providers and mechanisms that facilitate the proper coordination of care between disciplines.

11.7 Establish 10-15 bi-directional, co-located pilot projects involving mental health, primary care, and SUD providers.

11.8 Measure and analyze the impact of deep collaboration and integration on utilization patterns, cost trends, access to and quality of care, and clinical/medical outcomes.

## Task 12

Assess and establish a baseline of the current state of health IT adoption among SUD providers.

## Task 13

Conduct a gap analysis between the baseline and the expected future-states of HIPAA 5010 standards, ICD-10 conversion, interoperability, "meaningful use" of health information, and Health Information Exchanges (HIE).

## Task 14

Establish a timeline, resource requirements and budget for improving upon the rate of adoption of certified health information systems among our members.

## Research, Education, Communication

### Task 15

Measure the cost and effectiveness of prevention and treatment across the lifetimes of people with SUD and co-occurring disorders in contrast to untreated and unmitigated SUD.

15.1 Identify test and control groups with sufficient data and conduct analysis in Illinois with the participation of large commercial payer such as Blue Cross. Use primary and secondary diagnosis codes and service codes including prescription drug data.

15.2 Conduct a Medicaid cost-impact study with a similar emphasis on medical cost-offset, prescription drug costs, and hospital Emergency Room utilization and admissions.

### Task 16

Define the “SUD System” and develop a promotional/informational packet for legislators, stakeholders, health care providers, and the general public. Develop training material and webinars/seminars.

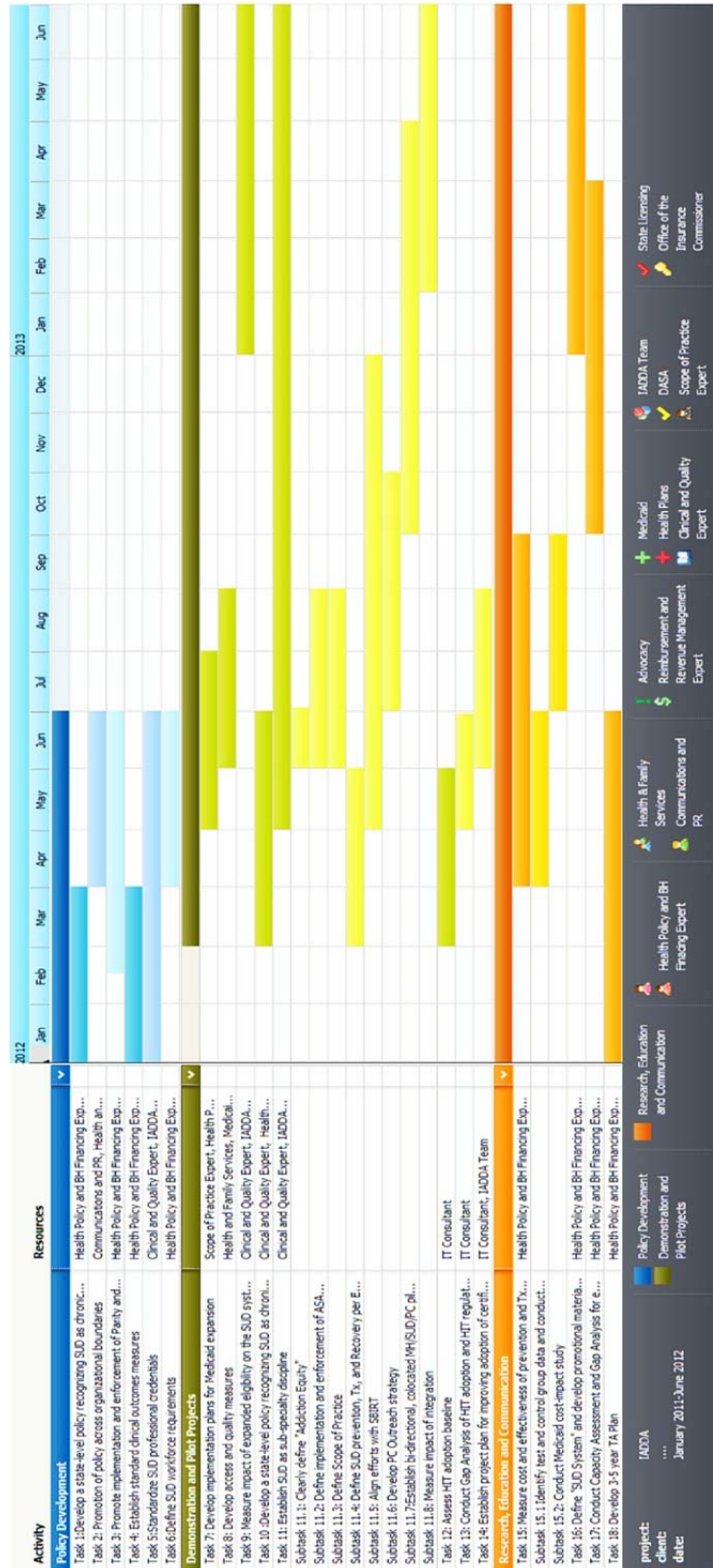
### Task 17

Conduct Capacity Assessment and Gap Analysis mapping assets in the context of expected demand by 2014.

### Task 18

Develop a 3-5 year Technical Assistance Plan.

# Implementation Timeline



## Implementation Plan Management and Performance Monitoring

IADDA proposes that it serve as Project Manager throughout the Implementation Plan and that it be tasked with monitoring the progress of its staff, consultants and the participation of State personnel. IADDA will coordinate schedules and maintain overall quality of deliverables throughout the implementation.

IADDA Project Management consists of the following activities:

- Develop final implementation plan for State and stakeholder review.
- Request pertinent documentation and data.
- Coordinate and conduct Kick-off Meeting key State personnel and stakeholders.
- Introduce and familiarize personnel and consultants to team roles and responsibilities, as well as provide organizational chart.
- Review goals and objectives.
- Review plan (critical path, milestones, tasks, schedule, and resource requirements).
- Discuss perceived issues and risks.
- Review assumptions concerning responsibilities.
- Discuss the Executive Sponsor's directives and expectations.
- Review communications, liaisons, problem escalation, progress monitoring, and status reporting.
- Review planned deliverables.
- Provide ongoing project management, oversight, communication, monitoring, and status reporting.

IADDA will also use a tracking system to identify risks and issues that arise throughout the implementation of our recommendations.

## Conclusions: A System in Transition

IADDA's recommendations to the State of Illinois reflect a deliberate and substantive process of analysis and consideration by a broad constituency serving the needs of individuals with SUD, including our colleagues at AHP Healthcare Solutions. Our recommendations take into consideration the fact that the State's vision for Health Care Reform is broad, complex, innovative, and transformative.

To be successful, the Illinois reforms will require the buy-in and participation of virtually all parts of the health care system. IADDA aspires to be an ideal partner for the State in this transformation, including bringing the necessary leadership that is reflected by this report. IADDA's members address some of the more difficult and yet potentially most promising and rewarding aspects of reform. Breaking the vicious cycle of substance use disorders prevents the accumulated public burden of broken lives, broken families, and the devastating costs of poor health, lost productivity, and the potential for incarceration.

IADDA's recommendations are not simple and they are also not without cost. They take into account the fact that many institutions outside the immediate health care system, as well as those within, influence how health reform is implemented and how successful its outcomes will be. However they are pragmatic and entirely consonant with the broad reform goals of universal access to high quality, coordinated and affordable care. IADDA looks forward to the State's review of our recommendations and to a collaborative, informed and accountable effort.

## Acronyms

ACA	Affordable Care Act
ACT	Assertive Community Treatment
AHP	Advocates for Human Potential, Inc.
ASAM	American Society of Addiction Medicine
ASO	Administrative Services Only
CCO	Coordinated Care Organization
CMS	Centers for Medicare and Medicaid Services
COD	Co-Occurring Disorder (Mental Health and Substance Abuse)
DASA	Division of Alcoholism and Substance Abuse
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
IADDA	Illinois Alcohol and Drug Dependence Association
IS	Information Systems
IT	Information Technology
MHPAEA	Mental Health Parity and Addiction Equity Act
MSO	Medical Services Organizations
NOMs	National Outcome Measures
NQF	National Quality Forum
ONDCP	Office of National Drug Control Policy
PATH	Prevention and Treatment Horizon
PCMH	Primary Care Medical Homes
ACA	Patient Protection and Affordable Care Act
PPO	Preferred Provider Organization
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SMHA	State Mental Health Agency
SSA	Single State Agency for Substance Abuse Services
SUD	Substance Use Disorder
TA	Technical Assistance
TEDS	Treatment Episode Data Set
USPSTF	U. S. Preventive Services Task Force

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