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RESEARCH BRIEF: THE DELAWARE EXPERIMENT

Improving Public Addiction Treatment Through Performance Contracting

Paying substance abuse treatment providers for results, not services, may lead to improved quality of care, according to the first published study of a novel performance-based contracting system implemented by the State of Delaware. Increases in capacity utilization and proportion of patients actively engaged in treatment after 30 days suggest that providers who stood to gain or lose financially may have taken steps to make their services more appealing to patients and do more to integrate evidence-based practices.

Importantly, the state followed the "practice based evidence model" by specifically *not* mandating the use of one or more evidence-based practices, but choosing instead to set achievable, measurable performance targets and encouraging providers to implement proven strategies and clinical practices to achieve the targets.

Of Interest To: Addiction treatment policy makers, providers.

Study Title: Improving Public Addiction Treatment through Performance Contracting: the Delaware Experiment

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Authors: A. Thomas McLellan, Ph.D.; Jack Kemp, M.S.; Adam Brooks, Ph.D.; Deni Carise, Ph.D.

Major Findings: Under a 2002 "performance based" contracting experiment by the State of Delaware, average rates of capacity utilization increased from 54% to 95%; average proportion of patients engaged in treatment more than 30 days increased 53% to 70%.

Background: improving AOD treatment quality by reforming government practices, in this case purchasing practices, is a long-sought goal of many in the alcohol and drug (AOD) field - provided the reform can be clinically accommodated. In fiscal 2002, the Delaware Single State Agency (SSA) replaced traditional cost-reimbursement contracts with performance-based contracts for all outpatient addiction treatment programs. Incentive targets included 80% and later 90% capacity utilization and active patient participation in treatment. Incentives were designed to foster program collaboration and sharing of "best practices."

Procedures: Three measures were selected as the key performance criteria: (1) capacity utilization, (2) active participation, and 3) program completion.

Capacity Utilization was defined as maintaining an active program census at contract-established levels. All programs were required to accept all patients who sought admission and met eligibility criteria. In fiscal 2002, programs were required to maintain an 80% utilization rate to earn their base payment for the month. After 2002, the utilization rate was increased to 90%. The SSA agreed to pay one twelfth of the total annual operating costs for a program at the end of each month, contingent upon that program successfully maintaining the utilization rate in effect that month. Utilization rates below that threshold received gradually decreasing payments based on a percentage of the base rate. Because utilization was considered key to the general effort to improve the accountability and performance of the treatment system, the remaining criteria (and corresponding incentives) were *only* applicable if the utilization rate was at or above the target level.

"*Active participation in treatment*" was operationally defined based on a tiered system of participation intensity. The expected participation rate for a patient in the first month of care was a minimum of two group or individual sessions per week, as opposed to two sessions per month for patients nearing the end of their treatment regiment. Again using the individually negotiated costs of care for each program - and first contingent upon meeting the capacity utilization target - programs could earn an additional 1% for each of four participation targets met, along with a 1% bonus for meeting all the targets.

"*Program completion*" was operationally defined as active participation in the Treatment Phase for a minimum of 60 days beyond the 30-day Orientation Phase; achievement of the major goals of a client treatment plan; and submitting a minimum of four consecutive weekly "clean" urine samples. Providers could earn $100 for each client who completed the program in accordance with the criteria. In fact, due to a combination of funding limits and the fact that most programs rapidly improved their performance on this criterion, funding for this criterion was set to a yearly maximum for each program.

Because the experiment introduced a major systemic change, the SSA offered three types of assistance: a one time, six-month hold-harmless period to allow both the state and providers time to gain experience with the model; regular meetings among the state and all treatment providers to collaboratively discuss successes and failures, and to share practice innovations that worked; and training on evidence based practices requested by the programs. The SSA also established data collection procedures for the key criteria, developed auditing procedures and created payment reimbursement procedures to pay incentives on a monthly basis. *(See related TRI Research Brief: Relieving Provider Paperwork Burden in Addiction Treatment.)*

Findings: Admission reports from 2001 - 2006 show increases in average capacity utilization (54% to 95%); and increase in average proportion of patients meeting participation requirements (53% to 70%) with no notable changes in the patient population during this time. One program lost its contract after failing to meet requirements, but two other agencies agreed to provide services in that coverage area. Strategies adopted by the programs included longer hours of operation, facility enhancements, passing incentives directly to counselors, and adoption of two evidence-based therapies (Motivational Interviewing and Cognitive Behavioral Therapy).

Limitations: Lack of a control group means it is possible that some other emphasis on quality improvement was fully or partly responsible for the observed improvements. Even if it is accepted that the performance contracting was responsible for the observed gains in utilization and patient participation, these criteria are related to, but not an adequate proxy for, traditional rehabilitation outcomes capturing the broader goals of recovery embraced by most providers. Thus, it remains to be seen whether and to what extent these measures relate to traditional outcomes. There is also a need to determine whether performance contracting might be an appropriate way to foster and sustain these more traditional client outcomes.

Contact: Jack Kemp, M.S.
Center for Policy Research & Analysis
Treatment Research Institute
600 Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106
(215) 399-0980
jkemp@tresearch.org

The Treatment Research Institute (TRI) is an independent, non-profit research and development organization specializing in science-driven reform of policy and practice in addiction and substance use. TRI was founded in 1991 by A. Thomas McLellan, Ph.D. and colleagues from the University of Pennsylvania's Center for the Studies of Addiction. To learn more, visit the TRI website at www.tresearch.org or contact Bonnie Catone, Director of Communications, at bcatone@tresearch.org.