Alcohol And Drug Use Disorder Treatment Delivery and Payment Reform: A Mixed Methods Study in Massachusetts

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Federal and state health care reforms present opportunities and challenges for the substance use disorder (SUD) treatment system. Such reforms foster the implementation of new payment and care delivery models emphasizing coordination and provider accountability for clinical and financial management. Medicare, Medicaid, and private payers are involved in bundled payment demonstrations nationally. Bundled payments—predetermined payments that cover a group of related services that would typically treat an episode of care in a defined time period—have not yet been developed for SUD treatment despite the burden of SUDs and the need for quality improvement. This study aims to (1) obtain organizational perspectives on health care reform and bundled payment, (2) test the feasibility of designing clinically relevant detoxification and outpatient SUD treatment bundled payments, and (3) predict the impact of bundled payment on organizational revenues, considering potential behavioral responses.

Bundled payment is an example of supply-side cost sharing, shifting risk for health care costs from payers to providers. Economic theory suggests supply-side cost sharing will lead to reduction of services supplied. Behavioral responses to SUD bundled payment could include increasing prevention efforts, reducing detoxification length of stay, and shifting patients from detoxification to outpatient. Providers' organizational networks impact behavioral responses. Provider organizations that own various services (e.g., detoxification and outpatient) have greater potential for coordinated responses to reforms than those in contractual relationships with organizations that offer different services.

Interviews about health reform and bundled payment design and impact were conducted with SUD treatment organizations across Massachusetts (N=12) representing three types of organizations: those that own (1) detoxification, (2) detoxification and outpatient, and (3) outpatient services. Using input from interviews, Massachusetts Medicaid enrollees' behavioral health, medical, and pharmacy claims from July 2010-April 2013 were used to build and test bundled payment models beginning in detoxification and outpatient settings for continuously enrolled adults. There were 5,521 members with detoxification stays and 2,001 members who initiated outpatient treatment episodes.

Results from interviews on health care reform indicated organizations perceive many challenges to the SUD treatment system but also see health care reform's potential to increase its value to the general medical system. Organizations participated in a range of behavioral health and medical care coordination and integration efforts, predominately grant-funded and in collaboration with local community health centers. Those affiliated with medical systems and offering a range of SUD services had greater awareness of health care reform initiatives and the need to make changes.

The design work addressed variants of the following key bundled payment parameters: diagnostic specificity, trigger services, bundle length, service-level exclusions within the bundle,

and risk mitigation strategies. Both detoxification and outpatient bundles included alcohol, drug, and mental health diagnoses. There were 6,901 180-day detoxification bundles with a mean total cost of $4,991 during the study period. Comparatively, there were 3446 180-day outpatient bundles with a mean total cost of $3,635. The majority of detoxification costs are the index detoxification stay and psychiatric inpatient and short-term SUD residential services. The largest service setting costs in outpatient bundles are outpatient care, psychiatric inpatient, and detoxification services. Bundle costs varied by length and member and provider characteristics.

Bundled payment could impact organizations' relationships with payers and other organizations, staffing needs and payment, and care delivery. Under bundled payment, organizations would have higher revenues if they reduced detoxification and short-term residential services.

While there are clinical and statistical challenges, it does appear possible to build SUD bundled payments. Bundle costs are driven by utilization of higher cost services, but they could incentivize prevention and use of lower cost, evidence-based services like group therapy and SUD treatment medications. Implementing SUD bundled payment may require regulatory, financial, operational, and cultural changes. Organizations that own a range of SUD treatment services and are part of medical care systems are better positioned than independent or affiliated organizations to have coordinated responses to the changing health care environment.

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