


How are Substance Use Disorder Treatment Programs Adjusting to Value-Based Payment? A Statewide Qualitative Study

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ABSTRACT: Healthcare systems are implementing value-based payment (VBP) arrangements in efforts to incentivize cost-effective, high quality of care. These arrangements represent a major shift for substance use disorder (SUD) treatment providers who may need to make changes to their clinical and business operations to meet new demands for quality under value-based contracts. This qualitative study was conducted in the context of New York State's efforts to implement VBP among SUD treatment providers to understand their experiences, challenges, and needs. Five focus groups were conducted across the State with a total of 68 treatment professionals. Content analysis was conducted and five themes emerged. First, competing demands, limited workforce and technology infrastructure, and perceived lack of information were leading to overwhelmed administrators. Second, confusion and financial fear was being driven by the need for new clinical roles, business practices, and external partnerships. Third, providers were undertaking a number of measures to address workforce needs. Fourth, providers were building new business models and clinical practices. Fifth, providers desired more support and information. As VBP models are being adopted, health-care systems should identify ways to mitigate challenges and support SUD treatment providers that may have limited resources to address complex workforce, client, and infrastructure needs.

KEYWORDS: Value-based payment, substance use disorder, qualitative research

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Introduction

Healthcare reforms in the United States have led to calls for improvements to treatment access, quality, efficiency, and population health.^{1,2} In response, some states, healthcare systems, and insurers are implementing value-based payment (VBP) arrangements.^{3,4} Such arrangements incentivize cost-effective, high quality of care rather than quantity or volume, as in fee-for-service arrangements. Payments made to providers under VBP arrangements are often linked to defined quality metrics or a demonstrated value (eg, providing evidence-based practices; EBPs).⁵ There are multiple frameworks and models for VBP, however they generally emphasize bundled-payment models for specific treatments or conditions or pay-for-performance models that reward measurable aspects of care.⁴⁻⁶ In the United States, and worldwide, the interest in value-based health care is increasing rapidly.^{4,5,7,8}

VBP arrangements to date have focused mostly on physical health service delivery; however, interest is slowly growing for mental health and substance use disorder (SUD) treatment services.^{5,8} As part of VBP arrangements, behavioral health providers (ie, mental health and SUD treatment providers) may need to make changes or improvements to their clinical and/or business operations to meet new demands for quality. For example, they must incorporate or improve their EBP offerings, care management services, and integrated services for physical and behavioral health problems.⁵ Providers will also

need to demonstrate value by becoming more data and outcome-driven.⁹⁻¹² Implementing quality improvement (QI) programs and expanding the use of technology will become essential to monitoring quality metrics and improving outcomes.^{9,13,14} Developing partnerships with larger healthcare systems and other support services (eg, housing) may also be necessary to ensure all client needs are addressed.^{9,14}

VBP arrangements, as well as the clinical and business practices that are meant to improve quality, represent a significant shift for behavioral health providers. Research conducted during earlier healthcare reforms brought about by the Affordable Care Act (ACA)¹ suggests that these providers may require significant resources to improve organizational and administrative infrastructure (eg, electronic health records [EHRs], data monitoring, reporting).^{15,16} Unfortunately, behavioral health providers have historically lacked the financial resources, organizational structures, and workforce required for such significant changes.² Research to date has focused on SUD provider challenges related broadly to the ACA; however, challenges specific to VBP reforms have not been widely studied among SUD providers. This study will address this research gap by not only examining challenges providers face as they look to implement VBP, but also how they are addressing these challenges and the ongoing supports they would find helpful as they adapt. Such findings can potentially provide vital information to other states or systems thinking about implementing VBP.



Little research has been conducted to understand behavioral health providers' experiences implementing VBP models. Most VBP implementation and research has been done among primary care practitioners, and they have been given significant resources as part of healthcare reforms to build infrastructure to support VBP models (eg, EHRs).¹³ Therefore, the challenges and resources needed may be quite different for behavioral health providers. Policymakers have noted several key potential challenges in implementing VBP models in behavioral healthcare settings. For example, there is: a lack of valid and reliable behavioral health quality measures, limited provider organizational and financial capacity, the need for state and stakeholder collaboration in determining payment methodologies, and privacy and data-sharing constraints.⁵ Qualitative studies in particular are needed to better understand the context of these challenges and how they specifically apply to SUD treatment providers and VBP; most previous research on healthcare reforms among behavioral health providers has been quantitative.

Both public (Medicaid, Medicare) and private insurance plans in the United States are considering or implementing VBP models. However, there is little research examining how the SUD treatment system is faring under these models given that these are more recent endeavors¹³; therefore, it is critical to assess the potential challenges and experiences of SUD treatment providers in order to better understand the supports needed to facilitate this transition.¹⁷ In this study, we sought to answer three questions: (1) What are the main challenges facing SUD treatment providers when adapting to VBP arrangements? (2) How are SUD treatment providers addressing these challenges within their organizations? (3) What are the needs of SUD treatment providers as they adapt their services to fit the VBP model?

We conducted this study in the context of New York State's (NYS) efforts to implement VBP arrangements. Over the past five years, NYS has been implementing many reforms to its Medicaid-funded mental health and SUD treatment systems to improve quality, efficiency, and better integration with medical services. In 2015, the State carved-in the addictions treatment payments into mainstream Medicaid health insurers to promote better coordination of care. This was followed by a number of ACA-derived initiatives, including a robust Delivery Service Reform Incentive Program (DSRIP) targeting large hospital systems and their partners as well as Medicaid Health Homes for individuals with multiple chronic health conditions that could include SUD.

These initiatives were all part of a larger reform program that had the goal of using new payment models to incentivize better quality of care for New York Medicaid beneficiaries. The State's plan envisions that VBP contracts will be the natural sequelae of these reform programs and will be the mechanism to incentivize better coordinated care that is more responsive to client's needs. As such, the State created a VBP roadmap in

2015, with the goal of 80% of provider payments based on VBPs by 2020.¹⁸ The key objective was to support and achieve integration of care, with a stronger focus on prevention, wellness, and population health management. The State has provided resources to behavioral health providers as part of the VBP roadmap. For example, it funds a technical assistance center (TAC) to provide training and technical assistance (TA) to SUD treatment providers on VBP-related topics. Further, the State created the Behavioral Health Care Collaboratives (BHCC) program in 2018 to assist community-based behavioral health providers in making VBP transitions. Funding from this program will allow providers to identify treatment gaps, improve IT infrastructure and develop QI processes to improve behavioral and physical health outcomes. BHCCs facilitate shared infrastructure and administrative capacity, collective quality management, and increased cost-effectiveness, and encourage VBP payers, (eg, Managed Care Organizations [MCOs], hospitals) to work with behavioral health providers who demonstrate their value.

Method

Procedures

Providers from each of the five main State regions were sent focus group email invitations from the Single State Agency (SSA) that regulates SUD treatment as a follow-up to a recent training on SUD treatment quality, access, and integration in which they had participated. In 2018, five focus groups lasting approximately 90 minutes were facilitated by two moderators, one from the SSA and one from the TAC. Each focus group followed the same structure with three main questions: (1) How are you viewing changes in the healthcare system toward VBP and what are the impacts of these changes on you as a SUD service provider? (2) How are you preparing your staff and organization to meet the challenges? (3) What assistance do you need from the State or the TAC to support your training, workforce and TA needs?

Participation was voluntary and no compensation was provided for attending the focus groups. All sessions were audio recorded and transcribed; a note taker was also present. To ensure quality of the transcriptions, two researchers transcribed each focus group recording independently and then compared transcripts to identify and correct any discrepancies. In addition, the note-taker's documents were compared to the transcripts. No identifying information was collected to maintain the privacy and confidentiality of participants. The first author's IRB determined that this was a QI study and therefore it did not qualify as human subjects' research.

Participants

Participants included 68 SUD treatment professionals representing five regions of NYS and 65 different organizations. Forty percent of the organizations invited to a focus

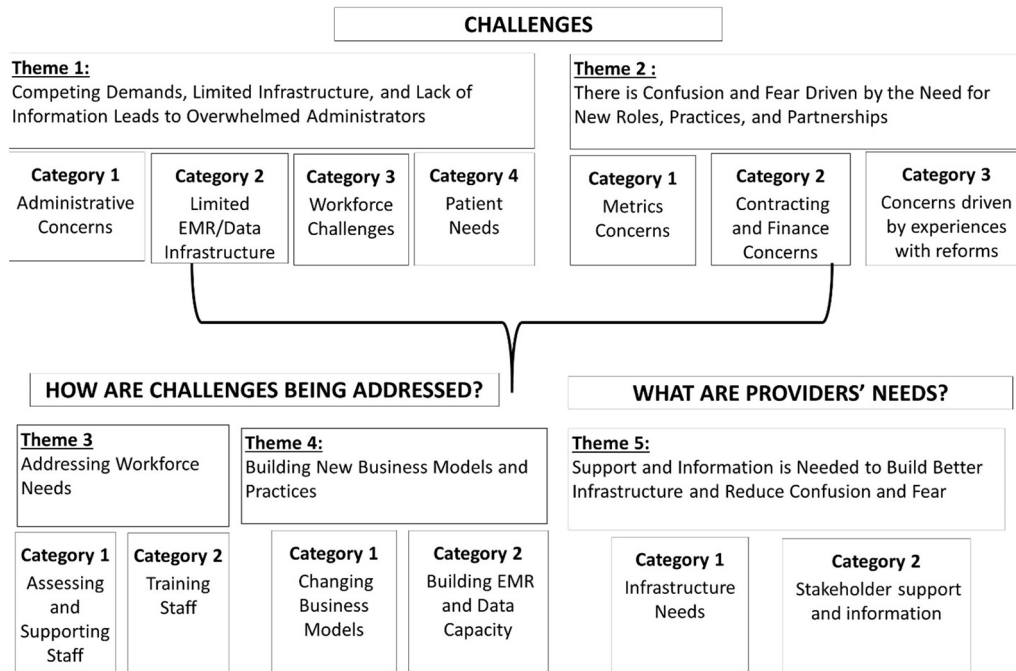


Figure 1. Themes and categories.

group attended one. One third of participants represented Western New York, nearly a quarter represented North Country, followed by Long Island (19%), New York City (15%) and Central New York (12%). Almost half (46%) of participants were CEOs or Program Directors, 15% were direct service providers/counselors, and the remaining had other roles (eg, supervisors, managers). The majority (72%) had 15 or more years' experience in the field. Over half (62%) were New York State Credentialed Alcoholism and Substance Abuse Counselors (CASACs). Many participants also held additional certifications/licenses such as master's level counseling (LCSW, LMHC; 53%), terminal degrees (6%; MD, PhD), and RNs (1.5%). A small number had no license/certification (12%). Just over 60% were 41 years or older, with the remaining being 20-40 years old. Focus groups averaged 14 participants, with the smallest being eight and the largest 21.

Analysis

The five focus group transcripts ranged from 2436 to 8951 words in length, with an average of 5925 words. Three coders (MO, EG, MK), led by the first author, made up the coding team. Atlas.ti was used to organize, manage and examine the data. Conventional qualitative content analysis¹⁹ was used to analyze the data following the process outlined in Erlingsson and Brysiewicz.²⁰ First, the coding team read and re-read each transcript to get a sense of the whole dataset and to document initial impressions. Second, the first author broke text down into meaning units, the smallest text unit that contains insights the researcher is interested in.²¹ Meaning units

ranged from part of one sentence to a paragraph. Third, codes and definitions were developed into a codebook. Codes were developed inductively based on the team's initial read of the transcripts and open-coding of one full transcript. Once the 3-person coding team reached an acceptable level of coding reliability on one transcript (80% agreement) the remaining transcripts were coded by 2 coders, with the first author coding all five. The codebook was continually refined throughout the coding process through team discussion and consensus; the coding team met weekly to discuss coding impressions, compare codes, and refine the codebook. Any coding disagreements were resolved through team discussion. In the fourth and final step, once coding was completed, codes were sorted into categories and then themes.

We took several measures to demonstrate study trustworthiness,²² a qualitative research concept often compared to validity and reliability in quantitative research. For example, at least two people coded each transcript. A detailed codebook was maintained and all decisions and activities throughout the analysis were carefully documented. Participants from several different regions across the State were included to increase transferability. The focus group facilitators, who did not take part in the coding, were consulted on the study analysis and results, including categories and themes.

Results

We identified 345 meaning units in the data. These meaning units were coded using thirty-six different codes that were organized into 13 categories; the 13 categories were further reduced into five themes organized under the three overarching themes related to each research question (see Figure 1).

Table 1. Workforce challenges.

WORKFORCE CHALLENGE	REPRESENTATIVE QUOTE
Buy-in to VBP concepts	“The hardest thing is changing the mindset of where we’re going with our staff and the administration. It’s a whole different mindset now. The mindset is all about outcomes. That transition is hard because we’re asking our line staff to do more. . . and we have to be able to have measurable outcomes. We’re going to have to implement depression scales, so we’re gonna train you on that, tell you when we’re gonna do it, and change our policies and procedures, so we have viable measurable outcomes”
Understanding data	“Because they’re clinicians, so they’re trained as clinicians, and then at some point they’re administrators. And they have no skillset for that like with spreadsheets, how to manage numbers, how to do excel sheets beyond how to manage staff.”
Recruitment and retention	“There has been a very significant transformation moving from a peer-based to a more professional, you know, master level clinician trained model, and it comes back to the salary. It’s impossible for us right now, in terms of how to recruit people. We also lost clinical supervisors to (insurance companies), so yeah, it’s very similar when you are encouraging people to go back and gets certs (certifications) and get more training but not able to give them raises. It’s, to me, unconscionable.”
Training needs	“So I mean that’s a fear among administrative staff – how can we get them ready faster. How can we get them trained faster?”
Limited time/capacity	“(the TAC) is doing an incredible job of providing trainings, substantive trainings. The issue is the implementation because of all this other stuff. Because then they’re (staff) so excited, but there are four people in the waiting room waiting to see one person (counselor). It is what it is. And they’re (administration) looking at you like, ‘well did you follow up on that data collection outcome.’”

What are the main challenges facing SUD treatment providers when adapting to VBP arrangements?

Theme 1: competing demands, limited infrastructure and perceived lack of information leads to overwhelmed administrators. As a first theme under challenges, we found that competing demands, limited infrastructure, and a perceived lack of information was leading to overwhelmed administrators. This theme was divided into four categories: administrative concerns, limited EHR/data infrastructure, workforce challenges and patient needs.

Administrative concerns. The most frequently mentioned administrative concern was feeling overwhelmed in terms of understanding and staying on top of the many clinical and regulatory changes related to VBP. Participants felt like they could easily lose relevance unless they participated in as many meetings and trainings related to VBP as possible. For example, one participant said:

“the TAC is great in having all these webinars that kinda help, but who has time? Sometimes I have it (webinar) going but I’m doing 20 other things. It’s just a crazy role. It’s exciting but it’s tough on staff.”

Participants also felt in some cases that organizational executive teams or top administrators were not fully sure of how to support the organization through VBP-related changes, one participant expressed these challenges by saying:

“From the top level admin I think they’re behind with all the changes. I don’t think the mindset is there. . . you know really changing everything with these organizations and it has to start at the top. And I feel like I can go to these meetings, I can get this information, but I need that other support and I need them to be

on board with it. And that’s probably one of my biggest challenges. I feel like the engine pulling the rest of the train at my level. It’s very difficult.”

Limited EHR/data infrastructure. Providers seemed keenly aware that having a strong EHR and data management structure would be important as VBP moves forward. Providers were also realizing that their EHRs may not be useful in terms of pulling out data, or that they do not have the capacity or expertise to analyze data that they can pull from their EHRs. However, having funding and support to build this infrastructure was another common challenge. One participant stated:

“The greatest challenge is the infrastructure needed to deal with the demands of the Performing Provider Systems and moving towards a VBP model. We’re being asked to look at diabetes screening, med adherence, all of these things and we haven’t gotten a reimbursement increase. . . we’ve worked with IT people to see what we can pull and we’ve realized our EHR is not going to be helpful to us going forward in terms of pulling the data we’ll be needing to pull. So the challenges are really in terms of infrastructure to meet new demands and we haven’t had a rate increase and that’s challenging.”

Workforce challenges. A number of workforce challenges were highlighted, as noted in Table 1. There were concerns that the VBP concept of focusing on outcomes and building in additional services would not be well-received by staff. In addition, there were concerns that focusing on new data points (eg, indicators for diabetes, depression) may be difficult for staff and that staff generally do not have training in how to understand and manage numbers.

Recruiting and retaining staff were seen as significant challenges and were the most cited workforce challenge. While participants acknowledged that the field has long had this

issue, they noted new pressures with VBP such as (1) needing to utilize more qualified staff with higher degrees and more certifications, (2) having higher caseloads and more administrative work but the inability to pay more and (3) non-hospital based programs losing highly qualified staff to higher paying hospitals or MCOs.

Another workforce challenge centered on training. First, participants felt that staff were not knowledgeable about EBPs, requiring a lot of training. Second, participants felt it was challenging to provide training given the cost and need to keep staff engaged in providing billable services. Third, participants felt they needed to train staff very quickly given the number and types of new practices and services they would need to implement under VBP.

Finally, limited staff time and capacity was noted as a challenge. Participants felt that caseloads were getting larger and more complex, while at the same time administrative burden and collection of clinical data from patients has increased. Further, though many staff were being provided with trainings, they were having difficulty implementing newly learned practices because of the many other competing demands in their workdays.

Patient needs. Participants suggested that patient acuity was getting worse. For example:

“For our agency, we’re seeing a lot more clients coming into our agency with severe psychiatric issues and active addiction – not just with one substance, but several different substances.”

Participants cited several potential reasons for the increased acuity including, (a) that the more severe clients used to go to hospitals for treatment but are now being diverted away because it is too costly, (b) that there was an expectation that programs would provide integrated care to address medical and mental health issues, and (c) that they felt pressured to take on more severe clients to show their worth to VBP partners. They also felt that patients were more demanding of a variety of services than in the past, including care coordination and assistance with mental health issues, harm reduction, and navigating insurance issues.

Theme 2: confusion and financial fear is driven by the need for new roles, practices and partnerships. As a second theme under challenges, we found that there was confusion and financial fear driven by the need for new roles, practices, and partnerships. This theme was divided into three categories: metrics concerns, contracting and finance concerns, and concerns driven by experiences with reforms.

Metrics concerns. Participants expressed that they were unclear about the metrics they were going to be measured upon in VBP contracts. Participants were generally looking to MCOs and/or state entities to communicate the target metrics

and outcomes; several indicated that knowing the exact metrics would help them to better prepare their staff and organizations, as indicated by this participant:

“No one has come out and said these are the outcomes, prepare yourself, start looking at that, start training your staff. The sooner the outcomes have specifically been identified, and we can bring this to direct care staff, in addition to always doing the right thing, how are we doing, how are we measured against those outcomes?”

Participants were also concerned that they would not be able to meet the metrics once they were set. Several reasons were cited including difficult populations with many medical, mental health and social service needs, movement toward harm reduction rather than purely abstinence-based models, and providing more flexible, patient-centered care that may not appear to meet traditional definitions of treatment success. A participant reflected this by saying, “I think the thrust here is that at a time where measurement is becoming more prominent, treatment is becoming more complex, I mean that’s what we’re saying here, so that’s frightening.” Another participant echoes this by saying:

“I think one of the major things when we talk about meeting people where they’re at and being more tolerable when people are using less harmful substances, and when one of the metrics we are going to be assessed by is successful completion by insurance companies, yeah, how many people are completing successfully?”

Contracting and finance concerns. A number of participants suggested that they are unsure about how the VBP contracting would work with MCOs and what types of entities would even be contracted with (eg, individual agencies vs. networks of providers). One provider said, “I think there’s a lot of confusion and mixed messages. A lot of messages that were given and allowed agencies to ramp up in a certain way, and now there’s a lot of confusion about what that is.” Some participants expressed fears of VBP arrangements because they do not have money to provide staff training, hire highly credentialed staff, meet staff salary demands as job duties expand, and improve facilities and infrastructure in order to be competitive, for example:

“We’re a small fry, and we’re afraid, our budget is really small, and we’re afraid of value based payment because our facilities aren’t pretty, we don’t have tons of money for training so we have to get creative to get training. We don’t have great technology, our EHR isn’t great, doesn’t do a lot of data. . .”

Other financial fears were related to the perception that community-based behavioral health providers may receive smaller amounts in terms of shared savings as compared to hospital and physical health provider network partners they have contracted with. One participant stated, “That’s where I see the problem, the fact that the money isn’t trickling down.” Other providers mentioned they feared the financial impacts of not meeting quality metrics or expected outcomes.

Concerns driven by experiences with reforms. Many providers had experiences with related Medicaid reforms already underway, such as the DSRIP program that began 5 years ago in NYS. As noted by this participant, community-based behavioral health providers felt left out of the financial benefits of such programs:

“All you have to do is look at DSRIP. What percentage of DSRIP money is going to the community based agencies? 10 percent? Maybe. Maybe in some regions it gets up to 12 or 15 percent. I mean the integrated health systems have sucked that 8 billion dollars up in a New York minute.”

Experiences with related reforms also lead to uncertainty about government and MCO roles as well as participants hoping that the State would take an active role in working with MCOs to set metrics and payment structures. Others noted that MCOs can be difficult to engage in partnerships and can lack transparency in what they expect from providers. Participants were concerned that MCOs may not fully understand their service offerings.

How are SUD treatment providers addressing these challenges within their organizations?

Theme 3: addressing workforce needs. Providers reported undertaking a number of workforce initiatives, including providing training, assessing staff needs, and putting staff supports in place.

Assessing and supporting staff. Some providers reported surveying staff in their agency on VBP readiness in order to better prepare and gain buy-in, as one stated, “we sent a SurveyMonkey through the whole agency, and we’ve got some work to do. . . Lot’s of the staff doesn’t think we’re ready to go there.” Providers also indicated they were working on how to communicate VBP-related topics to staff and tried to do so in multiple venues (eg, team meetings, clinical supervision, trainings).

In terms of supporting staff to increase retention and buy-in, providers reported a variety of techniques such as staff meals, providing staff with individual counseling and group supervision that focuses on health and wellness, counselor support groups, and staff appreciation parties. One provider engaged staff in self-directed QI projects:

“And the other part is getting the buy-in. When we’re developing QI projects it’s what do you wanna do? What do you see as something you can work on? Okay great, create a goal around that. Similar to our clients when they’re eliciting the change and motivation, it’s something they’re invested in as opposed to me saying this is what we need to be doing.”

Training staff. Providers reported that they were using both internal and external trainings to provide staff with training in EBPs (eg, motivational interviewing). They also reported training staff for outcomes that will likely be targeted metrics

under VBP, such as engagement and retention in care, as noted by a participant:

“I think it’s a shift when someone doesn’t show up to actually engage them. I think for a lot of our clinicians we’re trying to train them. In their minds, it’s ‘they need to take accountability for their addiction and they need to do this, we’re enabling them’. So it’s been a big shift, talking about engagement, picking up the phone and saying, ‘hey where are you, you missed your appointment? Let’s get you in here as soon as possible.’”

Theme 4: building new business models and practices. Participants acknowledged the need to build new clinical and procedural practices, as well as EHR and data management capacity in order to prepare for VBP.

Changing business models. Participants reported that they were changing their business models by adding new services, identifying niche populations to serve, expanding their workforce, and seeking external partnerships. A few participants reported that their organizations are working with private consultants or VBP consulting networks to help them with their business plans and strategic planning to address VBP. Examples of added services included mobile/transportation, warm handoffs to next level of care, person-centered care, integrated care, mental health services, telehealth, peer recovery programs, care management, harm reduction, engagement/outreach services, adolescent services, and medication assisted treatment. As noted by a provider:

“We’re doing this to help people, not because we show up and say you have to do it. We have one engagement specialist and she’s on call, we’ve got peer engagements and recovery coaches going and picking up people for treatment.”

Providers also suggested that they could serve niche populations that perhaps other providers were not interested in serving:

“Because the mission of our organization is to identify and fill gaps. To find the population that nobody wants to deal with and to develop individualized approaches to work with them to make them successful. That allows us to cross all kinds of borders. So now we’re into mental health, housing, health homes, and home and community-based services.”

Providers are also expanding their workforces beyond the typical counseling staff including peers, transport drivers, IT staff, and medical and mental health staff. External partnerships have also become more important to help programs attend to the whole health needs of clients. For example, new partnerships mentioned by participants include case management agencies, harm reduction organizations, mental health clinics, hospital systems, emergency departments, housing providers, and community-based health providers.

Building EHR and data capacity. Participants highlighted the importance of becoming more data driven in the way they monitor their clients and program outcomes as well as making sure their EHRs have the functions needed to pull useful information out. For example, a participant said:

“We’re very data driven, this is a constant thing, like you said with the EMR (electronic medical record), putting in the right questions in the EMR and having people who can pull that information out and is used to improve our system, but this becomes more personalized.”

What are the needs of SUD treatment providers as they adapt their services to fit the VBP model?

Theme 5: support and information is needed to build better infrastructure and partnerships in order to reduce confusion and financial fear

Infrastructure needs. Participants indicated that building the SUD treatment workforce as well as better IT infrastructure is needed. As far as IT, there were common struggles with choosing the best EHR products and the cost associated with purchasing new products to better meet the needs of the VBP landscape.

A variety of training and TA needs were also mentioned. First, participants desired an advanced training for organizational leaders on VBP that could give them information that was beyond just a description and conceptual model of VBP. For example, a participant said:

“I get the concept, but to show us some more concrete structures instead of giving us the concept. Doesn’t matter who is doing the training. So when I’m talking to the staff and they ask more specific questions, I always say I’ll get back to you. So I need the answers to the ‘I’ll get back to you’ questions which I don’t know.”

Providers also mentioned that VBP training for line staff would be helpful, as noted by a participant, “I think we need to have a training that is geared towards direct care staff. A lot of what has been done has been at the administrative level or board level saying this is coming and get prepared.” They also mentioned that clinical trainings as well as workbooks and other support materials would be useful on EBPs like Seeking Safety, Motivational Interviewing, Dialectical Behavior Therapy, and Cognitive Behavioral Therapy. Providers also wanted more hands-on TA at their programs, as noted by this participant,

“More individualized consulting opposed to generalized webinars and day-long sessions we’ve all gone through the same things, but I think each agency is at a totally different point, so you can’t compare any of us on where we are. But we could all use individualized consulting from someone who really knows how to do it.”

Stakeholder support and information. Other areas of need that participants discussed were building better partnerships,

having better relationships with MCOs, and needing clarity on the specifics of the VBP rollout. As far as building better partnerships, participants noted difficulties in working with hospitals and other medical providers while also acknowledging these partnerships are important. A participant noted, “I think the place where we fail is trying to coordinate with medical people who just don’t take the call or return the call or talk to us at all.” Better relationships with MCOs were also desired. This was desired because participants did not always feel that MCOs understood the services they were providing, and they also wanted to have input as MCOs were deciding on quality measurement targets. Participants wanted to benefit more from information MCOs have, as noted by a participant, “It would be nice to get data directly from the insurance companies as opposed to having to dig for it.”

Finally, participants wanted clarity and better communication on a number of things. First and most frequently mentioned were the exact quality metrics targets, as discussed by this participant:

“Unless you know what you’re digging for, we’re all inundated with the general knowledge of what we need to do and we’re all trying find our niche and expand and not put all eggs in one basket, but we don’t know what the right things are yet.”

Participants also wanted more streamlined communications about regulatory and clinical guidance changes from the State and MCOs, including regular update meetings and more streamlined emails.

Discussion

SUD treatment delivery system payment reforms are expanding throughout the United States and internationally with the aim of improving treatment quality and efficiency. This study highlights some key challenges and needs of SUD treatment providers as VBP arrangements are implemented. Also highlighted are solutions providers have started implementing that can serve as examples to other providers and systems preparing for VBP arrangements. In the discussion below, we additionally highlight efforts that NYS has embarked upon to support providers during the VBP transition.

Some of the main challenges identified in this study were related to the SUD treatment workforce. There were challenges and needs in terms of training, gaining staff buy-in, and difficulty recruiting and retaining staff into a challenging and changing work environment. Providers were trying to provide staff with training opportunities while managing the cost in terms of time and money. A well-prepared and well-trained workforce that can be held accountable for improving quality and outcomes is critical to the success of SUD system reforms.^{8,9,23} Workforce challenges and resistance to change may require large investments in training and retaining the workforce.^{21,24}

As training needs and demands continue to grow, health-care systems and states may consider examining ways to offer

trainings in flexible formats that reach as many providers as possible as well as initiatives to retain staff in the workforce. As an example, in collaboration with the TAC at Center on Addiction, the NYS Office of Addiction Services and Supports (NYS OASAS) is now developing and offering structured, interactive, web-based trainings to SUD treatment providers that can be incorporated into staff supervision or in-house professional development trainings to allow for greater staff participation in trainings.²⁵ Organizations may also consider ways to better support staff and understand their views of VBP. Participants in this study noted they were increasing their attention on clinical supervision, wellness activities, and team-building for staff as well as assessing staff readiness for VBP using surveys and focus groups.

Participants had a strong awareness of the need to build their IT infrastructures to better support rapid review and reporting of data and measure organizational performance. Participants suggested that they are attempting to become more data driven. Experts have noted this as one of the most critical elements of creating a strong system of care for SUD.⁹ However, systematic use of data may be a culture change for SUD treatment organizations; historically, SUD treatment programs have had limited technical capacity in this area.²¹ Participants reported uncertainty about how to work with data as well as concerns about their EHR systems' capabilities to provide requisite reports to inform management decision making. Further, while the need for data management and infrastructure was widely acknowledged, mostly absent from discussion were the QI processes and practices providers could implement to make good use of data for performance management. Using data along with strong process improvement practices are needed to improve quality^{9,24}; providers may benefit from training and tools to implement strong QI and practice improvement processes. More research is needed on how to support providers in the implementation and sustainment of QI programs to help monitor quality as part of VBP models.

Participants expressed frustration in not knowing the quality measures they would be asked to report on, as well as uncertainty about whether they would meet the measures and remain financially viable. They understood the need to reorient toward outcomes but expressed concern that without a standard set of agreed upon measures, there could be multiple different measurement demands from different payers. This reflects the current national status of quality measures for SUD, in that there are few measures and those that exist do not perform particularly well.² Measures tend to focus on process, rather than outcomes.⁸ The need for a national, meaningful set of SUD measures has never been greater. It has been recommended that more meaningful measures be developed and tested, with careful attention to also reducing measurement burden and reporting on staff,⁸ which was noted as a significant challenge by participants in this study. In response, NYS has been working

on enhancing the set of quality measures for SUD care that can be incorporated into VBP contracts. In consultation with a stakeholder group of providers and health insurers, NYS OASAS identified a pressing need for new quality of care measures for addictions treatment that could be used for the new value-based contracting. Together with the stakeholder group, Center on Addiction, NYS Department of Health, and national partners—notably the National Committee for Quality Assurance—NYS OASAS embarked on a process of developing measure sets based on national standards, scientific evidence, and expert clinical guidance. These measures included use of pharmacotherapy for opioid and alcohol use disorders, coordinated transitions between inpatient and lower levels of care, and treatment retention.²⁶

Additionally, the State has been providing multiple opportunities for providers and health plans to come together in public meetings to discuss viable measures for assessing quality of SUD treatment. For example, NYS OASAS and Center on Addiction presented information about the contractual requirements for VBP as well as the quality measures at annual trade association conferences^{27,28} and at four regional forums held across NYS in 2017.²⁹

Further, results suggested that contracting partners and the SUD provider role in VBP arrangements is not immediately clear to many providers. While they are aware of the need to focus on efficiency and quality measures, they are unsure of the specific expectations of contractors. This has contributed to providers' uncertainty of where to focus attention and resources. Many providers are only in the beginning stages of negotiating for VBP contracts. At the time of the focus groups, no provider had reported to the state that they had successfully developed value based contracts with health plans or hospital systems. Three pilot projects between plans and providers that targeted very specific high-needs populations were being conducted.³⁰ Many questions remain unanswered about how the broader treatment system would develop these contracts with the plans. In addition, related reforms in NYS, such as DSRIP, that were meant to prepare providers for VBP by incentivizing the development of new business models and administrative procedures for contracting with plans were viewed with skepticism by some providers in this study. This skepticism seemed to be mainly driven by the perceived lack of financial benefit for SUD providers in these arrangements and difficulty in engaging with MCOs. In DSRIP, Performing Provider Systems (PPSs) were responsible for creating and implementing DSRIP projects; PPSs were made up of providers that formed partnerships and collaborations. One participant indicated that they did not receive resources from the PPS that would have helped to improve their infrastructure to meet new reporting demands. However, participant experiences with individual DSRIP PPSs seemed to vary; therefore, experiences within particular PPSs may have been driving subsequent attitudes toward VBP rather than the DSRIP program itself.

The challenges reported in this study as a result of VBP are not necessarily new for SUD treatment providers. While there have been large investments in primary care to implement EHR systems to collect, track and report data, there has been little investment for behavioral health providers. For example, under the Health Information Technology for Economic Clinical Health (HITECH) Act in 2009, most physical healthcare providers were financially incentivized to adopt some form of EHR.³¹ However, most behavioral health providers, including SUD treatment providers, were not eligible for incentives payments authorized under this act, therefore they did not have the same resources as physical healthcare providers to help with upfront financial investments as well as sustainability of EHR systems.³² Behavioral health providers have struggled with attempting to modernize their workforce and business practices and have received limited TA in some states to address these struggles since reforms resulting from the passage of the ACA.³³ A study among Massachusetts SUD treatment organizations found that providers faced similar challenges as they were responding to ACA reforms in terms of expansion of services and clinical practices, workforce development, and IT infrastructure.³⁴ This highlights that significant support to providers is needed to improve the SUD treatment system as well as more research to understand barriers and facilitators to making system-level quality improvements.

While this study provides an in-depth description of providers' experiences in terms of implementing VBP arrangements, there are some limitations. First, this study occurred in one state and the state has made significant efforts to support providers as VBP expands. Other states may differ in terms of VBP readiness, status, and state support. In addition, there were variations in the focus groups in terms of size and transcript length that may have affected the results; however, there were overlapping codes found across all of the transcripts, therefore it is unlikely this had a major effect on the results. Finally, some focus groups had only supervisory or executive leadership staff, while others also included clinical front-line staff, which may have caused the dynamics in each focus group to differ.

NYS is among the early adopters of VBP in Medicaid for general healthcare broadly, and for SUD treatment specifically. Despite significant investments from the State in terms of TA, funding to build partnerships and infrastructure through BHCCs, and widespread training efforts, providers noted challenges as they prepared for VBP. Much still needs to be learned and communicated to ease the transition for others. Additional research is needed to monitor SUD treatment providers' outcomes, barriers, and facilitators as VBP efforts continue to expand across the country. In addition, other states considering VBP for SUD treatment should invest considerably in TA and training to help providers improve business and clinical practices. For example, a recent study suggests that a large percentage of SSAs have not provided TA related to adoption of EHR

and technology infrastructures³⁵; SSAs may need to consider increasing their TA efforts in this area. In conclusion, as alternative payment models are being adopted in the United States and internationally, states, MCOs, and healthcare systems should identify ways to mitigate challenges and support SUD treatment providers that may have limited resources to address complex workforce, client, and infrastructure needs.

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Authors' contribution

All authors contributed to the conception of this manuscript and were involved in revisions and drafts of the manuscript. All authors approved the final version for publication.

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REFERENCES

- Rosenbaum S, Schmucker S, Rothenberg S, Gunsalus R, Beckerman JZ. *Medicaid Payment and Delivery System Reform: Early Insights from 10 Medicaid Expansion States*. Washington, DC: The Commonwealth Fund; 2017.
- Pincus HA, Scholle SH, Spaeth-Rublee B, Hepner KA, Brown J. Quality measures for mental health and substance use: gaps, opportunities, and challenges. *Health Aff*. 2016;35(6):1000–1008.
- Wilson H, Gole J, Mishra B, Mishra J. Value based healthcare. *Adv Mgmt*. 2016;9(1):1–8.
- Cattel D, Eijkenaar F. Value-based provider payment initiatives combining global payments with explicit quality incentives: a systematic review [published online June 19, 2019]. *Med Care Res Rev*. doi:1077558719856775
- Soper MH, Matulis R, Menschner C. *Moving Toward Value-Based Payment for Medicaid Behavioral Health Services*. Washington, DC: Center for Health Care Strategies; 2017.
- Health Care Payment Learning & Action Network. Alternative payment model: APM framework. Hcp-lan.org. 2017. <https://hcp-lan.org/apm-refresh-whitepaper/>. Accessed October 1, 2019.
- Berwick DM, Hackbarth AD. Eliminating waste in US health care. *JAMA*. 2012;307(14):1513–1516.
- Center for Health Care Strategies. *Behavioral Health Provider Participation in Medicaid Value-Based Payment Models: An Environmental Scan and Policy Considerations*. Washington, DC: Center for Health Care Strategies; 2019.
- Padwa H, Urada D, Gauthier P, et al. Organizing publicly funded substance use disorder treatment in the United States: moving toward a service system approach. *J Subst Abuse Treat*. 2016;69:9–18.
- Buck JA. The looming expansion and transformation of public substance abuse treatment under the Affordable Care Act. *Health Aff*. 2011;30(8):1402–1410.
- Pating DR, Miller MM, Goplerud E, Martin J, Ziedonis DM. New systems of care for substance use disorders: treatment, finance, and technology under health care reform. *Psychiatr Clin North Am*. 2012;35(2):327–356.
- Roy AK, Miller MM. The medicalization of addiction treatment professionals. *J Psychoactive Drugs*. 2012;44(2):107–118.
- Maxwell J, Bourgoin A, Tobey R, et al. *The Road Ahead: A Model for Advancing High Performance in Primary Care and Behavioral Health under Value-Based Payment*. Berkeley, CA: The Delta Center, 2019.
- Quinn AE, Stewart MT, Brolin M, Horgan CM, Lane NE. Massachusetts substance use disorder treatment organizations' perspectives on the affordable care act: changes in payment, services, and system design. *J Psychoactive Drugs*. 2017; 49(2):151–159.
- Molfenter T, Capoccia VA, Boyle MG, Sherbeck CK. The readiness of addiction treatment agencies for health care reform. *Subst Abuse Treat Prev Policy*. 2012; 7(1):16.

16. Molfenter TD. Addiction treatment centers' progress in preparing for health care reform. *J Subst Abuse Treat.* 2014;46(2):158–164.
17. Stuart EA, Barry CL, Donohue JM, et al. Effects of accountable care and payment reform on substance use disorder treatment: evidence from the initial 3 years of the alternative quality contract. *Addiction.* 2017;112(1):124–133.
18. New York State Department of Health. A path toward value based payment: annual update. Health.ny.gov. 2018. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2018/docs/2018-06_final_vbp_roadmap.pdf. Accessed October 1, 2019.
19. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res.* 2005;15(9):1277–1288.
20. Erlingsson C, Brysiewicz P. A hands-on guide to doing content analysis. *Afr J Emerg Med.* 2017;7(3):93–99.
21. D'Aunno T. The role of organization and management in substance abuse treatment: review and roadmap. *J Subst Abuse Treat.* 2006;31(3):221–233.
22. Bengtsson M. How to plan and perform a qualitative study using content analysis. *NursingPlus Open.* 2016;2:8–14.
23. Pincus HA, Scholle SH, Spaeth-Rublee B, Hepner KA, Brown J. Quality measures for mental health and substance use: gaps, opportunities, and challenges. *Health Aff.* 2016;35(6):1000–1008.
24. McCarty D, Gustafson DH, Wisdom JP, et al. The network for the improvement of addiction treatment (NIATx): enhancing access and retention. *Drug Alcohol Depend.* 2007;88(2–3):138–145.
25. Center on Addiction. Center on addiction learning center. <https://www.centeronaddiction.org/learning-center>. Accessed 2/21/2020.
26. New York State Department of Health. Value based payment quality measure set. Health.ny.gov. 2020. https://health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/quality_measures/2020/harp_qms.htm. Updated February 2020. Accessed March 30, 2020.
27. Neighbors C, Garnick DW, Lincourt P, Hussain S, Lambert-Wacey D. *Value Based Payment.* Syracuse, NY: NYSASAP; 2018.
28. Hussain S, Neighbors CJ, Lincourt P. *Quality Measurement for VBP: Practical Implications for Practice and Quality Improvement.* Niagra Falls, NY: ASAP NYS; 2019.
29. MCTAC/CTAC. Past events. <https://calendar.ctacny.org/list/past/>. March 2020. Accessed March 3, 2020.
30. New York State Department of Health. Value based payment (VBP) resource library. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/. Published 2020. Updated March 2020. Accessed March 30, 2020.
31. The Office of the National Coordinator for Health Information Technology. Behavioral health clinical quality measures. Why focus health IT on behavioral health? <https://www.healthit.gov/topic/behavioral-health-clinical-quality-measures>. Accessed February 21, 2020.
32. The National Council. *HIT Adoption and Readiness for Meaningful Use in Community Behavioral Health.* Washington, DC: National Council for Community Behavioral Healthcare; 2012.
33. Andrews C, Abraham A, Grogan CM, et al. Despite resources from the ACA, most states do little to help addiction treatment programs implement health care reform. *Health Aff.* 2015;34(5):828–835.
34. Quinn AE, Stewart MT, Brolin M, Horgan CM, Lane NE. Massachusetts substance use disorder treatment organizations' perspectives on the affordable care act: changes in payment, services, and system design. *J Psychoactive Drugs.* 2017;49(2):151–159.
35. Abraham AJ, Smith BT, Andrews CM, et al. Changes in state technical assistance priorities and block grant funds for addiction after ACA implementation. *Am J Public Health.* 2019;109(6):885–891.