ADMINISTRATIVE MANAGEMENT MODELS

COMPILATION OF APPROACHES BY INITIAL ACCESS TO RECOVERY GRANTEES

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Contents

Introduction

During the summer of 2007, the Center for Substance Abuse Treatment in the Substance Abuse and Mental Health Services Administration, (SAMHSA/CSAT) tasked its Access to Recovery (ATR) technical assistance contract, the Performance Management Technical Assistance Coordinating Center (PM TACC), to develop a set of resource materials for incoming second-round ATR grantees. The PM TACC prime contractor, the American Institutes for Research (AIR), and their subcontractor, JBS International, Inc., brought to this product-development task the experiential knowledge rooted in service to CSAT and the ATR Round 1 grantees throughout all phases of the first-round grants-- from the pre-application roll-out of the Presidential initiative, to early implementation and sustained operation of the grant programs, to their eventual close-out. SAMHSA/CSAT's selected topics for the resource materials target key issues, barriers, challenges, and decision points that faced the first-round grantees during each of these phases. They are written from the PM TACC contract's experiences with the 15 grantees that broke new ground for the substance abuse field by demonstrating the feasibility of using a voucher model for providing publicly-funded treatment and recovery services.

Some of the newly developed resource materials modify, update, and consolidate technical assistance (TA) reports emanating from the Round 1 grantees' TA experiences. Other products provide syntheses of the Round 1 grantees' experiences related to various topics central to effective and efficient planning, implementation and management of an ATR grant. CSAT has requested that these reports be made available to Round 2 ATR grantees so that the new cohort may benefit from the experience and work accomplished by the initial ATR grant recipients. Below are lists of the available reports.

SYNTHESES

- Access to Recovery Report: Lessons Learned from Round 1 Grantees' Implementation Experiences
- Administrative Management Models: Compilation of Approaches by Initial Access to Recovery Grantees
- Planning and Implementing a Voucher System for Substance Abuse Treatment and Recovery Support Services: A Start-Up Guide
- Setting Up a System for Client Follow-Up
- Recovery Support Services
- Case Management
- Summary and Analysis of Grantee Fraud, Waste, and Abuse Activities

TA CONSOLIDATED REPORTS

- Basics of Forecasting and Managing Access to Recovery Program Expenditures
- Compilation of Technical Assistance Reports on Rate Setting Procedures
- Development of a Paper-based Backup Voucher System
- Financial Management Tools and Options for Managing Expenditures in a Voucher-Based System: Round 1 Grantee Experiences
- Motivational Interviewing: A Counseling Approach for Enhancing Client Engagement, Motivation, and Change
- Outreach to Faith-Based Organizations: Strategic Planning and Implementation
- Strategies for Marketing Access to Recovery to Faith-Based Organizations
- Targeted Populations: Technical Assistance Examples

About this TA Report

The purpose of this report, *Administrative Management Models: Compilation of Approaches by Initial Access to Recovery Grantee*, is to provide new ATR grantees or others wishing to implement a voucher program with information on how Cohort One grantees approached setting up their administrative operations, including their data capabilities. Additionally, any issues that led grantees to modify or reassess their approach are also described.

This report addresses: (1) administrative management models and (2) voucher management systems (VMS). The first section provides an outline of thematic similarities among the ATR grantees and covers such topics as responsibility for day-to-day operations, provider credentialing, voucher payment processes and mechanisms, and descriptions of processes for client movement through the system (e.g., referrals, screening, assessment and placement). The second section provides a general overview of the VMS models adopted by the Round 1 grantees, voucher management software, VMS development key features, and an appendix of profiles detailing the administrative set-up and VMS system for each Round 1 grantee.

About the ATR Program

ATR is a competitive discretionary grant program funded by SAMHSA that provides vouchers to clients for purchase of substance abuse clinical treatment and Recovery Support Services (RSS). ATR program goals include expanding capacity, supporting client choice, and increasing the array of faith-based and community-based providers for clinical treatment and recovery support services. Key among ATR's goals is providing clients with a choice among qualified providers of clinical treatment and RSS. Under the ATR program, treatment and RSS can be provided by both nonsectarian and faith-based organizations (FBOs).

Methodology

CSAT requested the American Institutes for Research® to collect information about administrative management models from all initial ATR grantees using information from a variety of sources. Previously developed documents were examined, including but not limited to the following documents:

- Strategic implementation site visit reports
- Key State summaries
- Technical assistance reports (if relevant to topic)
- Recent site visit notes

The remainder of this narrative summarizes the information found regarding administrative and voucher management models used by the initial cohort of ATR grantees. For a compilation of information for each grantee, please see the appendixes.

Administrative Management Systems

The purpose of this section is to describe the common themes across the grantees regarding their different administrative management systems. Administrative management systems coordinate the provision of care for clients including, but not limited to, recruiting clinical and recovery support providers, training providers on the ATR system, managing or contracting out the VMS, developing the intake process and procedures, determining the eligibility requirements, and providing fiscal oversight.

Establishing a System

Implementation was either phased in or implemented all at once. Grantees either implemented the ATR program all at one time or phased it in. California, California Rural Indian Health Board (CRIHB), Illinois, New Jersey, Tennessee, and Wyoming all implemented the program at once. Connecticut, Florida, Louisiana, New Mexico, Texas, Washington, and Wisconsin phased it in by region. Louisiana and Wisconsin had a pilot before full implementation of their program. Regardless of whether it was implemented all at once or phased in, approximately one third of the grantees implemented the program statewide and two thirds of the grantees implemented ATR in specific counties or regions; thus the choice of phasing in or implementing it in its entirety does not appear to be based on the size of the region.

Two States followed a slightly different model of phasing in the program. Idaho and Missouri first implemented treatment services and then later implemented RSS. For Missouri, this meant that the delay in providing RSS to after treatment services caused some participants to go without RSS.

Collaboration levels varied based on target population. Virtually all grantees worked collaboratively with other State or local agencies to collaboratively develop an ATR system. However, some States were far more broad-based in terms of what organizations they collaborated with. Usually, the amount of collaboration related in some part to the population they targeted. For example, grantees that focused mostly on adolescents or adults that are in the court system, such as Illinois, Texas, and Wyoming, mainly collaborated with internal agencies and the court system. In contrast, other grantees, such as Idaho, Louisiana, New Mexico, Tennessee, and Washington to name a few, collaborated with not only internal State agencies, but also clinical provider organizations, FBOs or associations, tribes, substance abuse treatment advocates, academia, and/or CBOs.

In most cases, grantees that collaborated with more organizations tended to work with less focused populations. In some cases, grantees that collaborated more with organizations typically experienced fewer problems with recruiting providers, particularly faith-based and recovery support providers. For example, New Jersey worked with a pre-existing faith-based collaborative known as Bridge to Recovery, and Friends of Addiction Recovery-New Jersey, a peer-to-peer recovery community services program. New Jersey was very successful with recruiting RSS and nontraditional providers such as FBOs; approximately 45 percent of services received by clients were RSS with a relatively even distribution among case management, aftercare, education services, and peer-to-peer services. Additionally, of the 143 total enrolled providers by 12/31/06, 45 (or 31.4 percent) were FBOs. On the other hand, Louisiana collaborated with agencies including nonprofit and faith-based agencies, but the grantee still had challenges with recruiting and approving FBOs, which led to a delay in implementation.

Established or establishing infrastructure critical to timely implementation of the program. Six grantees—California, Florida, New Mexico, Texas, Tennessee, and Washington—encountered delays as a result of needing to take time to develop the appropriate infrastructure to conduct the ATR program. For two of the grantees, contracting out the very important tasks of the administrative services organization (ASO) delayed the implementation. For another, California, the responsibility of the management of substance abuse services is typically at the county level and the grantee had to work to develop a system for the counties to report to the grantee.

Implementation delays as a result of developing a VMS. Four of the grantees had a VMS prior to the advent of the ATR program; however, even these four had to modify or add to their program to make it fully functional for the ATR program. The other 11 grantees needed to develop or contract out the development of the VMS. For a variety of reasons, this caused delays for six of the grantees (California, Connecticut, Illinois, Louisiana, Tennessee, and Washington). For example, Illinois had technical problems including not collecting all necessary information. The State of Washington did not have a problem, but rather potential providers did not always have the necessary technology. Others simply had problems developing the system delaying the implementation.

Internal and External Administrative Services Organization

Grantees' often used either internal resources to serve as the ASO or they contracted out this service. Not all ASOs perform the same activities, but they are at least in charge of operations, the VMS, and fiscal management. Some are also in charge of outreach and education to providers and recovery service providers, monitoring Government Performance Results Act (GPRA) data, outreach and education to potential clients, call center, and the program Web site (if applicable).

Grantees used external ASOs or managed these functions internally. Eight of the grantees—California, Connecticut, CRIHB, Florida, Idaho, Illinois, New Jersey, and New Mexico—all had external ASOs. Seven of the grantees—Louisiana, Missouri, Tennessee, Texas, Washington, Wisconsin, and Wyoming—managed the ASO functions internally. In most cases, difficulties related to ASOs had more to do with general infrastructure development problems or VMS development problems as noted earlier rather than differences between whether administrative services were performed internally or contracted out. The one exception is that New Mexico and Florida had difficulties setting up a contract with their external ASO; for New Mexico, the difficulty led to a last-minute change in the ASO.

Provider Credentialing

Provider credentialing is the process by which a grantee reviews a potential provider's attributes and determines whether they can participate as ATR providers.

Most grantees entered into formal contracts with clinical providers. Once a grantee credentialed a provider, they entered into a formal arrangement, usually known as a memorandum of understanding (MOU). MOUs were used by the Connecticut, CRIHB, Idaho, Louisiana, Missouri, New Mexico, Texas, and Wyoming grantees; other grantees may have used this method but not stated it explicitly. For example, Tennessee used an Authorization to Vendor instead and Wyoming had a "business agreement." California was the one outlier and did not require an MOU.

Credentialing options for RSS providers have more variation. In some cases, grantees requested RSS providers to go through virtually the same process as clinical treatment providers. In other cases, such as for Illinois, Missouri, Tennessee, Washington, and Wyoming, the grantees asked for different information than they did for clinical providers. They sometimes required information on the

population, a description of the staff, and in a few cases (at least for California and Connecticut), RSS providers needed to give the number of years of experience providing recovery support. Typically, they did not ask for licenses, unless it was warranted, such as for day care providers.

Challenges were specific to grantees. A description of challenges relating to provider credentialing by grantee and their solution is provided below.

- Missouri and Wisconsin: Due to a lack of infrastructure among FBOs or RSS providers, many were unable to use the technology originally required to participate in the ATR program. Missouri changed the requirements allowing the FBOs to submit paper copies of their services and other information. Wisconsin softened the information technology requirements regarding billing and provided technical assistance to the RSS providers.

- Illinois: Lack of experience working with providers delayed client enrollment; the grantee assigned individuals to communicate and interact with providers and potential providers and increased the number of providers participating (and in the process being credentialed).

- Washington: Washington lacked formal definitions for FBOs and RSS providers. As a result, the State had to negotiate parameters of what constituted an FBO or RSS on an ongoing basis.

- Tennessee: The grantee initially lacked sufficient numbers of providers to provide client choice to eligible clients. SAMHSA-sponsored technical assistance helped the State to develop an action plan with strategies for outreach to providers; part of this market plan was offering technical assistance to providers, particularly FBOs, interested in enrolling.

Managing Clients

Clients move through the ATR program system in a variety of ways. However, each system incorporates processes for common functions (referral, screening, assessing, and vouchering processes), that ultimately end with the provision of care and services.

1. Referral

Referral to ATR program often related to target population. Typically, referral sources are related to the target populations. For example, Idaho, Illinois, Louisiana, New Mexico, Tennessee, Texas, Wisconsin, and Wyoming focused on people moving through the court system at the very least. As a result, they used the courts or probation system to refer clients to their ATR program.

Referral sources used as an outreach tool. Referral sources are also used as an outreach tool. Idaho has a significant number of rural/frontier areas and used a Web-based portal to reach out to potential clients. Similarly, the California Rural Indian Health Bureau and the State of New Jersey used a hotline that they marketed as a way to reach out to potential clients.

The following table summarizes the various referral sources by grantee:

Table 1. Referral Sources

Referral Sources	Grantees														
	CA	*CRIHB*	*CT*	*FL*	*ID*	*IL*	*LA*	*MO*	*NJ*	*NM*	*TN*	*TX*	*WA*	*WI*	*WY*
Child welfare					X										
Community-based organizations					X		X								
Court system					X	X	X			X	X	X		X	X
Faith-based organizations					X		X								
Hotline		X							X						
Health agencies		X									X				
Portal programs		X			X								X		
Providers	X	X	X												
Substance abuse programs							X								
Schools							X								
Self				X	X				X		X				
Unknown				—				X							

2. Screening

Screening involves evaluating potential clients for eligibility, including financial eligibility and simple evaluation, with typically 4–10 questions to assess whether a potential client has a substance abuse problem. This evaluation of a substance abuse problem is different from the assessment of a client's substance abuse problem, which will be addressed in the Assessment section.

Grantees often used different types of entities to screen potential clients. As noted below in Table 2, grantees had different assessors, including assessment or intake centers, call centers, case managers, CBOs/FBOs, the courts or court system, public health departments (including Indian Health Agencies), portal programs, providers, RSS providers, substance abuse programs, and schools. In only a few cases were there some themes: Once a potential client was referred, the client was assessed at assessment or intake centers for five of the grantees; and for four of the grantees, clients were referred to ATR providers for assessment.

Table 2. Screening Sources

Screening Sources	Grantees														
	CA	*CRIHB*	*CT*	*FL*	*ID*	*IL*	*LA*	*MO*	*NJ*	*NM*	*TN*	*TX*	*WA*	*WI*	*WY*
Assessment center	X			X						X				X	X
Call center		X							X						
Case manager			X												
Community- and faith-based organizations				X		X									
Court system							X				X	X			

Screening Sources	Grantees														
	CA	*CRIHB*	*CT*	*FL*	*ID*	*IL*	*LA*	*MO*	*NJ*	*NM*	*TN*	*TX*	*WA*	*WI*	*WY*
Health agencies		X									X				
Portal programs			X		X										
Providers	X	X	X					X							
Recovery support service programs								X					X		
Substance abouse programs							X				X				
Schools							X								

Grantees often used a variety of screening tools, some of which were grantee defined. There were 11 different previously developed tools used for screening, not including the grantee-defined tools, or the legal screening. Five grantees developed their own (Idaho, Illinois, Tennessee, Washington, and Wisconsin). The most commonly used tool was the Cut, Annoyed, Guilty, Eye-Opener (CAGE or CAGE-AID) tool, used by three grantees, California Rural Health Indian Board, Louisiana, and New Mexico. Table 3 summarizes the screening tools used by the various grantees:

Table 3. Screening Tools

Screening Tools	Grantees														
	CA	*CRIHB*	*CT*	*FL*	*ID*	*IL*	*LA*	*MO*	*NJ*	*NM*	*TN*	*TX*	*WA*	*WI*	*WY*
Adolescent Alcohol and Drug Involvement Scale (AADIS)		X													
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (2 items)										X					
Alcohol Use Disorder Identification Test (AUDIT)										X					
Cut, Annoyed, Guilty, Eye-opener/Adapted to Include Drugs (CAGE/CAGE-AID)		X					X	X							
Car, Relax, Alcohol, Friends, Forget, Trouble (CRAFFT)		X													
Drug Abuse Screening Test-version 10 (DAST 10)			X												
Drug Use Screening Inventory (DUSI)	X														
Grantee-defined					X	X					X		X	X	
Juvenile Automated Substance Abuse Evaluation (JASAE)	X														
Legal Screening												X			
Personal Experience Screening Questionnaire (PESQ)	X														
Substance Abuse Subtle Screening Inventory (SASSI)	X														
Social Service Review (SSR)				X											
Unstated/undefined									X						X

3. Assessment and Placement

Assessment is the process by which eligible clients are assessed using valid and reliable instruments to evaluate the level and type of substance abuse problems a person has. This is typically a lengthy process and is typically conducted by clinical or specially trained staff.

Many grantees used the same screening sources as their assessment sources. Seven grantees, including California, Florida, Illinois, Missouri, New Mexico, Wisconsin, and Wyoming, all used the same assessment sources they used for screening. Five of these seven grantees used assessment or intake centers for both screening and assessment. Illinois used its ASO, a CBO with experience in assessing offenders for many years, thus making it a suitable choice. Missouri initially used ATR providers only, but then trained RSS providers to conduct the assessments. While this cost the grantee some initial money to train the RSS providers, in the end, clients had more access to RSS as a result.

Most grantees used ATR providers to conduct assessments. Nine of the 15 grantees used ATR providers to conduct assessments. In many cases, this judgment call was made because providers are more likely to be versed in the concept of using assessments, if not conducting the specific assessments themselves. For most grantees, this worked fine and clients were able to obtain the services they needed. For one grantee, Missouri, using the provider as their sole assessment source did not work that well, because the providers did not refer clients to any RSS services. As noted earlier, the grantee fixed this by teaching RSS programs to conduct assessments and soon clients had access to all services.

Table 4 summarizes the various assessment sources used by the grantees:

Table 4. Assessment Sources

Assessment Sources	Grantees														
	*CA**	*CRIHB*	*CT*	*FL**	*ID*	*IL**	*LA*	*MO**	*NJ*	*NM**	*TN*	*TX*	*WA*	*WI**	*WY**
Assessment center	X			X						X		X		X	X
Community- and faith-based organizations				X		X	X								
Health agencies							X								
Providers	X	X	X		X		X	X	X		X		X		
RSS programs								X							

*Grantees with asterisks used the same assessment sources as they did referral sources.

Virtually all grantees used the Addiction Severity Index (ASI) tool for assessment. Thirteen grantees used ASI, including California, CRIHB, Florida, Idaho, Louisiana, Missouri, New Jersey, New Mexico, Tennessee, Texas, Washington, Wisconsin, and Wyoming. Unlike the screening tools, there were no grantee-defined tools. Use of the various assessment tools is summarized in the following table:

Table 5. Assessment Tools

Assessment Tools	Grantees														
	CA	*CRIHB*	*CT*	*FL*	*ID*	*IL*	*LA*	*MO*	*NJ*	*NM*	*TN*	*TX*	*WA*	*WI*	*WY*
Addiction Severity Index (ASI)	X	X		X	X		X	X	X	X	X	X	X	X	X
Adolescent Drug Abuse Diagnosis (ADAD)	X														
Alcohol Use Disorder Identification Test (AUDIT; a screening tool typically)			X												
Clinical Institute Withdrawal Assessment (CIWA-R)														X	X
Comprehensive Adolescent Severity Inventory (CASI)	X	X					X								
Global Appraisal of Individual Needs (GAIN)	X	X													X
Minnesota Multiphasic Personality Inventory (MMPI)		X													
Recovery Attitude and Treatment Evaluator (RAATE)		X													
Texas Christian University (TCU)					X	X									

Virtually all grantees used the American Society of Addiction Medicines 2nd edition (ASAM PPC-2R) tool to place clients. There were only four different tools used across all grantees, and twelve grantees used the ASAM, including California, Connecticut Florida, Idaho, Illinois, Louisiana, New Jersey, New Mexico, Tennessee, Washington, Wisconsin, and Wyoming. While the Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM-IV) is a tool used for diagnosis as opposed to helping determine where a client should be placed, five grantees stated that they used it, although in four of those cases, the ASAM was used as well, thus in most cases supplementing the ASAM. The grantees using the various placement tools is summarized in Table 6.

Table 6. Placement Tools

Placement Tools	Grantees														
	CA	*CRIHB*	*CT*	*FL*	*ID*	*IL*	*LA*	*MO*	*NJ*	*NM*	*TN*	*TX*	*WA*	*WI*	*WY*
American Society of Addiction Medicines 2nd ed. (ASAM PPC-2R)	X		X	X	X	X	X		X	X	X		X	X	X
Recovery Attitude and Treatment Evaluator (RAATE—typically used in assessment)		X													
Grantee-defined								X							
Diagnostic and Statistical Manual of Mental Disorders 4th ed. (DSM-IV)						X			X	X		X			X

4. Providing Vouchers

The provision of vouchers usually occurred at two different points; for some grantees, they provide an assessment voucher when the potential client comes in for screening; the voucher is then used for an assessment. Once the potential client is assessed, they are given a voucher or vouchers for services, either clinical or RSS. Other grantees only provided the client with service vouchers, but the assessment was done by a contracted provider and therefore provided without a voucher for this service.

One voucher and one point of providing a voucher. Connecticut, Florida, Illinois, Louisiana, Missouri, Texas, Wisconsin, and Wyoming provided a voucher at only one point and as a result, all of these vouchers were for clinical and/or RSS services only. Connecticut screens clients then immediately provides options to see providers and issues a voucher. Florida, Illinois, Missouri, Wisconsin, and Wyoming all conduct a screening and a clinical assessment at the same time and from there, provides a voucher for services. Florida, Wisconsin, and Wyoming used central assessment or intake centers to conduct the screenings and assessments; Missouri used clinical providers and later used RSS providers; and Illinois used a CBO that had been performing this function for years.

Two vouchers, two points of providing vouchers, *different* sources. Five grantees—CRIHB, Idaho, New Jersey, Tennessee, and Washington—provided vouchers for both assessment and RSS services during the screening and the assessment of a client. In each of these cases, the screening source first provided a voucher for assessment. When the client was assessed, the client was given a voucher for a service. Typically, clients chose the provider who conducts the assessment.

Two vouchers, two points of providing vouchers, *same* location. Two grantees—California and New Mexico—combined screening and assessment activities and provided an assessment voucher and a services voucher separately. These two grantees conducted an initial screening at an assessment center/central intake unit prior to providing a voucher for assessment. California's screening focused on financial eligibility whereas New Mexico's focused on a short substance abuse screening for eligibility. If a potential client met the criteria, the client was given a voucher for a thorough clinical assessment at the same location.

A summary of the voucher characteristics by grantee is presented in the following table:

Table 7. Voucher Characteristics

Voucher Characteristics	Grantees														
	*CA**	*CRIHB*	*CT*	*FL**	*ID*	*IL**	*LA*	*MO**	*NJ*	*NM**	*TN*	*TX*	*WA*	*WI**	*WY**
Types of Vouchers															
Assessment voucher	X	X			X				X	X	X		X		
Services voucher	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Voucher Points															
Screening	X	X	X	X	X	X		X	X	X	X		X	X	X
Assessment		X			X		X		X		X	X	X		

*These grantees used the same entities to screen and assess clients.

Voucher Management Systems

As part of ATR's requirements, all grantees must utilize a system to manage the substance abuse service vouchers provided through the program. The following table provides an overview of each of the past grantees' approaches to developing and implementing an ATR VMS. Each grantee is listed along with the agency responsible for creating and managing the system, whether the system is Web or paper based, and whether or not the system is portable for use by future grantees. For more detailed information on any of the approaches taken by previous ATR grantees, please see the individual summary of the grantee's system in the appendixes.

Grantee	Development of Voucher Management System (VMS)	Responsibility for VMS	Paper or Electronic	Portability
California	The administrative services organization (ASO), MAXIMUS, developed a new system.	The ASO owns and manages the system.	Web-based system with paper (manual) capabilities.	Future grantees would have to contract with MAXIMUS to use the system.
California Rural Indian Health Board	The ASO, MAXIMUS, developed a new system.	The ASO owns and manages the system.	Web-based system with paper (manual) capabilities.	Future grantees would have to contract with MAXIMUS to use the system.
Connecticut	The ASO, Advanced Behavioral Health, modified a VMS prototype created by the United Way of Connecticut.	The ASO owns and manages the system.	The VMS is currently a combined paper and electronic system. It will be expanded by ABH to a Web-based system that can handle all service requests and claims submissions.	Currently very limited. The system is dependent on the ASO, who is willing to share the system's design with future grantees.
Florida	The ASO purchased a license for KIS Express to create ATR KIS Express.	The ASO owns and manages the system.	Electronic, real time but not Web-based.	Limited. Future grantees would have to contract with the ASO.
Idaho	The ASO enhanced an existing State data collection system to create the VMS.	The ASO manages the system, which is owned by the State.	Electronic system	Not portable.
Illinois	The State contracted with FEI Inc. to add voucher management modules to SAMHSA's existing Web Infrastructure for Treatment Services (WITS) software.	FEI, Inc. maintains the system.	Web-based system.	The system is portable. Future grantees may contract with FEI Inc to use a similar system. Tennessee and Wyoming ATR grantees utilized this approach.
Louisiana	The VMS was developed by the Sperry Corporation, but owned by the Office of Addictive Disorders (OAD).	The LA-ATR system is maintained by the University of Louisiana at Lafayette, Center for Business Information and Technology (CBIT).	Web-based system.	The system is portable.
Missouri	The VMS was developed by a contractor with support from Missouri Department of Mental Health (MDMH) staff.	The system is owned and operated by MDMH.	Web-based system.	The system is not portable, but MDMH may consider hosting other ATR grantees.

Grantee	Development of Voucher Management System (VMS)	Responsibility for VMS	Paper or Electronic	Portability
New Jersey	Department of Human Services (DHS) staff created the system by adding a voucher module to an existing system.	The system is operated by the ASO but is owned by the State.	Web-based, real time system.	The system is public domain software and is portable.
New Mexico	The State contracted with the ASO, Value Options New Mexico (VONM), which added a voucher module to its previously existing proprietary system.	The system is owned by the New Mexico Behavioral Health Services Division (BHSD) and is managed by both BHSD and VONM.	Web-based system	Portability is questionable since the system is a modification of an existing system belonging to VONM.
Tennessee	The State contracted with FEI Inc. to add voucher management modules to SAMHSA's existing WITS software.	Responsibility for the system lies with the State Division of Alcohol and Drug Abuse Services (DADAS).	Web-based system.	The system is portable. Future grantees may contract with FEI Inc to use a similar system. Illinois and Wyoming ATR grantees utilized this approach.
Texas	Department of State Health Services (DSHS) staff added voucher modules to the State's existing data collection system.	The system is owned and managed by DSHS.	Web-based system	Severely limited. Although the system is freely available to other grantees, it is highly dependent on its contract management system.
Washington	The Division of Alcohol and Substance Abuse (DASA) added voucher capabilities to an existing State reporting system.	The system is owned and managed by DASA.	Web-based system	The system is not portable.
Wisconsin	The system was developed by an external contractor in coordination with ATR staff, and built upon pre-existing County software.	The system is maintained and operated by Milwaukee County.	Currently electronic and paper system. Will be updated to a Web-based, real time system.	The system is not portable.
Wyoming	The State contracted with FEI Inc. to add voucher management modules to SAMHSA's existing WITS software.	FEI Inc. maintains the system.	Web-based system.	The system is portable. Future grantees may contract with FEI Inc to use a similar system. Illinois and Wyoming ATR grantees utilized this approach.

Creation of a New Voucher Management System

New voucher systems. Two grantees elected to create an entirely new VMS in the absence of any pre-existing models. California and CRIHB grantees pooled a portion of their administrative funds to jointly contract with an external agency that served as the ASO for both grantees. The ASO developed and managed their VMS. Development of the Louisiana VMS was also completed by an external contractor, and maintenance of the system continues to be carried out by a separate external organization.

Modification of an Existing Data Collection System

Existing voucher systems. The majority of grantees elected to modify existing data collection systems to make them applicable to ATR. Some grantees chose to build upon pre-existing VMS used by other voucher programs within their respective States. The Wisconsin grantee hired an external contractor to enhance existing voucher modules for Milwaukee County's existing data collection systems. In Texas, New Jersey, and Washington, the State agency in charge of ATR assumed the responsibility for adding voucher management capabilities to their existing data systems. In Idaho, the ASO in charge of ATR implementation was placed in charge of adding voucher modules to the State's data system. At the onset of ATR implementation, the Missouri grantee was using two separate data collection systems. Since this proved to be a challenge for ATR providers, the State contracted with an external agency to develop a new VMS that incorporated both information from the two older systems along with new data items.

In other cases, grantees modified existing data collection systems from outside agencies. The New Mexico ATR program contracted with an external agency to add voucher modules to the agency's existing system. Connecticut delegated voucher management responsibility to its ASO, which added to an existing voucher management prototype created by The United Way. Florida's ASO elected to purchase a license from a software vendor and add ATR-specific modules to the ASO's system. The Illinois, Tennessee, and Wyoming grantees contracted with FEI Inc., an external information technology vendor, who developed State-specific systems by adding voucher management capabilities to SAMHSA's existing Web Infrastructure for Treatment Services (WITS) software.

Challenges Faced

Challenges in creating VMS. Few of the grantees had any experience with VMS to guide them in development of a system to provide substance abuse services. The next section outlines some of the challenges the initial group of ATR grantees experienced in developing VMS.

- Grantees that contracted with an administrative ASO to either develop or maintain their VMS were generally able to delegate significant levels of responsibility to the ASO. However, multiple grantees encountered difficulties and delays when contracting with these external agencies. In instances where the grantee did not have an existing electronic VMS and an ASO was contracted to create one, delays in VMS development led to subsequent delays in client enrollment or the use of a less convenient paper-based system. Because ATR program structure may be new for certain States, grantees should try to plan for delays throughout the implementation process.

- VMS that were a combination of electronic and paper-based approaches appeared to be more burdensome and less portable than systems that were entirely electronic. Grantees may want to consider utilizing user-friendly Web-based systems.

- Certain grantees faced problems with errors, duplication, and report generation in their VMS. Future grantees may want to take necessary precautions to test for such occurrences prior to system implementation.

- In situations where FBOs did not have prior experience working with Federal programs or electronic databases, technical assistance was necessary to fully inform them of the ATR program's requirements and to help them navigate an electronic system. Grantees may wish to consider allotting time and resources to allow for provider training, especially during the initial period of provider recruitment and enrollment.

Strengths Observed

Strengths of a VMS. Some features of the VMS worked very well. Following are some observations on strengths of these systems:

- Those that were Web-based and that operated in real time allowed assessment providers greater flexibility when enrolling clients into ATR. Assessors were able to travel to the client's location to conduct the initial assessment with real-time systems. This may be especially useful for grantees that wish to broaden their target population and increase client enrollment.

- Real-time VMS allowed clients to be fully informed of their enrollment into the program at the time of the initial assessment, rather than being required to schedule follow-up visits. Real time systems also enabled providers to be immediately informed of changes to a client's service requirements.

- VMS that allowed providers to file electronic invoices and be reimbursed electronically appeared to be easy for providers to use and enabled providers to receive payment quicker than was the case with paper-based payments. Grantees may want to consider electronic payment systems or require providers to file paper invoices soon after service provision in order to ensure prompt payment.

Appendixes

California

Grantee—The State of California Office of the Governor is the official grantee for the California Access to Recovery Effort (CARE) program. Federal grant funds are directed to the California Department of Alcohol and Drug Programs (ADP), which functions as the single State authority (SSA) responsible for CARE's overall success. ADP contracted with an external organization named MAXIMUS to serve as the administrative service organization (ASO) in charge of the CARE's operational side.

The State focused its ATR program on youth due to a significant unmet need among this population for treatment and recovery support services (RSS). Through CARE, the State designed a program targeting substance abusing youth between 12 and 20 years of age who reside in Los Angeles and Sacramento counties.

Administrative Management System—Prior to ATR, California did not have a voucher program to fund substance abuse service provision. The ATR model consists of collaboration between the SSA, ASO, clinical and RSS providers, referring agencies, faith-based organizations (FBOs) and other nontraditional providers, and an oversight committee. ATR's State-centered administrative structure presented a significant challenge for California, where county agencies are responsible for managing service provision and the SSA is responsible for providing financial management and creating statewide policies. CARE does not operate within this county-based model, with ADP and MAXIMUS serving as the major structures responsible for the program.

In assuming responsibility for managing the voucher distribution system and performing accounting procedures, the State encountered significant delays in contracting for development of the electronic VMS. During this time, MAXIMUS provided a paper-based voucher system until the electronic one being developed was completed and approved by the State Controller Office (SCO).

An oversight committee composed of stakeholders was created to provide general direction for CARE. Committee members include administrative representatives from the participating counties as well as members of major provider organizations and FBOs and networks. Roles of the oversight committee include assessing CARE's effectiveness and helping ADP modify and improve the program when necessary. The committee also provides oversight, guidance, and policy recommendations to MAXIMUS and ADP for implementation and program management, and identifies groups and communication channels for outreach.

ADP's responsibilities under ATR include approving eligible providers, monitoring and assessing provider performance, identifying provider training and technical assistance needs, collecting and analyzing program data, and providing general program oversight and support. While ADP provides statewide policies, it does not directly manage ATR voucher distribution. MAXIMUS assumes responsibility for all administrative and operational tasks related to CARE. These duties include conducting outreach and education to potential clients, providers and referral sources, managing the VMS, and operating a call center to answer questions about ATR from clients and providers.

Providers and the court system refer potential clients to assessment centers (ACs) and the hotline, which are the point of entry into CARE. Each county has multiple ADP-designated assessment sites. The screening tools that are used include the Drug Use Screening Inventory (DUSI), Juvenile

Automated Substance Abuse Evaluation, the Personal Experience Screening Questionnaire, and the Substance Abuse Subtle Screening Inventory. Clients may also be directed to an assessment site by any referral source or provider within the community. The AC determines the client's financial eligibility for ATR and requests an assessment voucher from MAXIMUS for eligible clients. MAXIMUS issues the assessment voucher and creates a unique identifier that can be used to track the client throughout the client's involvement with CARE. The AC or a designated provider conducts the assessment, collect intake GPRA data, and develop a treatment plan outlining the client's service needs. The assessment tools used are the Addiction Severity Index, the Adolescent Drug Abuse Diagnosis, the Comprehensive Adolescent Severity Inventory, or the Global Appraisal of Individual Needs. The client is assigned a care coordinator who is responsible for tracking the client's progress between CARE service providers, regularly collecting and reporting GPRA data, and modifying the level of treatment as needed.

The ACs are responsible for identifying providers that offer services the client needs and giving the client a description of the providers as a way of ensuring client choice. Once the client selects a provider, the client is issued a voucher for treatment and RSS. If a client selects multiple providers, a voucher is issued for each of the providers. After the voucher request is approved by MAXIMUS, the care coordinator contacts the client's chosen provider(s) to determine availability and schedules an appointment for the client.

As the ASO, MAXIMUS is responsible for CARE's fiscal management. Through the voucher management system (VMS), MAXIMUS tracks vouchers, monitors expenditures, collects outcome and financial data from providers, and submits reports to ADP that allow ADP to monitor the rate at which ATR funds are spent as well as services that are being utilized.

ADP divides annual voucher funds into quarters. If the maximum for a given quarter is reached, MAXIMUS stops issuing vouchers until the start of the next quarter. In this event, clients are given a choice of a referral or placement on a waiting list. Clients who are placed on a waiting list can receive a voucher and resume services when funds become available at the start of the following quarter.

Electronic vouchers are subject to a maximum dollar value and remain active for 60 days, but they are cancelled by MAXIMUS if services are not obtained within 30 days. Vouchers were initially valid for 90 days, but in an effort to cut the program's burn rate, the program shortened this time to 60 days and reduced the voucher maximum by one third.

Following service provision, vendors must submit invoices within 14 days to MAXIMUS, and they are then paid by the SCO. Provider payment is contingent on receipt of GPRA data, which is verified by MAXIMUS. The SCO receives payment authorizations from MAXIMUS and mails checks directly to providers. The SCO is also responsible for conducting onsite fiscal audits if CARE program fraud is suspected. Once providers are paid, MAXIMUS generates reports for ADP to monitor the funds available for each client and all clients. MAXIMUS also reports monthly to ADP with an unduplicated count of clients served through ATR. ADP uses this information on client count and funding to analyze client and program outcomes.

In order to register as an ATR service provider, an organization must complete a Provider Participation Agreement form but does not have to agree to a formal memorandum of agreement with the California ADP. RSS providers must have at least 1 year of experience providing an ATR RSS before they are eligible to participate in the program. CARE provider responsibilities include

developing individualized service plans for clients, providing services according to these plans, and reporting client data in the voucher management system.

VMS—California did not have an electronic VMS in place prior to ATR. Therefore, CARE and another ATR grantee, the California Rural Indian Health Board (CRIHB) combined portions of their administrative funds to contract with MAXIMUS to develop an ATR-specific VMS. The system took 8 months to develop and is owned by MAXIMUS. Because the California and CRIHB grantees share the system, future grantees would have to use directly contract with MAXIMUS in order to utilize this or a similar system.

The VMS developed by MAXIMUS is a Web-based screening, assessment, voucher-issuing, clinical reporting and billing system, with manual capabilities for providers who cannot or do not wish to use the electronic system. Through this system, MAXIMUS is able to issue vouchers to clients; track vouchers, services, and associated costs; collect outcome and financial data from providers; and review and authorize payment requests from providers. The VMS also contains modules that allow providers to report GPRA data at client intake as well as throughout the service delivery process, a requirement for provider payment.

While MAXIMUS is in charge of collecting financial data from providers and authorizing provider payments, it does not directly pay the providers. Instead, it sends payment requests to the SCO, which is responsible for provider payment.

Connecticut

Grantee—The Connecticut Department of Mental Health and Addiction Services (DMHAS) assumes overall responsibility for the Connecticut Access to Recovery Program (CT ATR) and serves as the single State authority (SSA) for substance abuse and mental health services. DMHAS reports directly to the State Governor's Office, which is the official ATR grantee. Administrative management of CT ATR was contracted to Advanced Behavioral Health (ABH), an external organization that functions as the administrative service organization (ASO) in charge of the voucher management system (VMS), provider enrollment, and the program's daily fiscal management.

CT ATR is a collaboration across multiple State agencies, and faith- and peer-based organizations. It is a statewide effort based on a regional model that divides the State into five geographic regional networks. Program implementation began in four phases from January to April, 2005, with each phase corresponding to specific regions. Each region offers clients a range of clinical, recovery support, and housing services and has a designated lead agency and coordinator. The lead agency and coordinator are responsible for coordinating the region's ATR provider network by distributing program information to providers, communicating information about program changes, and assisting providers with GPRA-related questions.

Administrative Management System—ATR implementation in Connecticut was facilitated by the State's existing infrastructure, including the Basic Needs Program (BNP), a State-sponsored initiative for clients in behavioral health treatment. DMHAS' approach to CT ATR was to design it to build upon the State's BNP, which also uses ABH as its ASO. Additional factors easing ATR implementation were an existing network of substance abuse treatment services, strong relationships with faith-based providers, and a State-funded pastoral counseling program in place prior to ATR.

CT ATR is a statewide effort based on a regional model that divides the State into five geographic regional networks. Program implementation occurred in four phases from January to April, 2005, with each phase corresponding to specific regions. Each region offers a range of clinical, recovery support, and housing services and has a designated lead agency and coordinator. The lead agency and coordinator are responsible for coordinating the region's ATR provider network by distributing program information to providers, communicating information about program changes, and assisting providers with GPRA-related questions.

ASO and/or the network of eligible clinical or recovery support providers deem referred individuals eligible for a comprehensive clinical and/or recovery assessment through the CT ATR program. The tool used for screening is the Simple Screening Form for Alcohol and Other Drugs (AODs). The assessment tool used is a grantee defined tool together with the Alcohol Use Disorder Identification Test (AUDIT). The placement tool that is used is the American Society of Addiction Medicines, 2nd edition. The referring individual is responsible for discussing provider options with the client using region-specific provider grids and lists. The ASO distributes these documents that contain information contributed by providers. The lists promote client choice in selecting a provider because they contain information such as the provider's geographic location, services offered, languages available, and any other pertinent descriptive information. Once the client has been informed about providers, the referring individual completes a Referral for Services form that lists two providers for each service required by the client. The referring individual faxes this referral form to the selected provider(s) and ASO, and contacts the provider(s) to schedule an appointment for the client. The ATR provider is responsible for collecting baseline GPRA data, completing a provider Assessment and Request Form (ARF), and faxing it to the ASO for authorization to initiate services. Use of fax is

emphasized, as opposed to e-mail attachments, to preserve HIPAA confidentiality and security. The client is considered an ATR client once authorization has been received from the ASO.

In order to be considered an ATR provider, an organization must submit the following forms to DMHAS and/or the ASO: Certification Application Form, Provider Information Sheet, Client Population Grid, W-9 form, and Billing Fact Sheet. As part of the provider application, an organization must submit detailed information on each ATR service they intend to provide. This information is used to compile the provider lists that are presented to clients at the referral appointment. Clinical treatment providers specifically must have proof of their State license along with proof of liability insurance. While RSS providers do not need to show proof of licensure or insurance, they must detail their previous experience providing services, their client grievance policy, and any pending litigation or investigations against them. Once a provider is approved by DMHAS, a memorandum of understanding is enacted between the provider and the State of Connecticut. In order to enforce quality management, providers undergo site visits throughout the year. This lets the State review documentation and billing practices and allows the State to verify that invoices correspond with services rendered.

Voucher Management System (VMS)—In implementing the ATR grant, the State used a combined paper-based and electronic VMS called the ATR Advanced Behavioral Health Client Information System (ATR ABHCIS). The VMS is owned by DMHAS but is not integrated into the State client data system. Prior to ATR, the State used the entirely paper-based BNP voucher system. To develop ATR ABHCIS, the ASO added an ATR module to a VMS prototype created by the United Way of Connecticut. The ASO assumes responsibility for the voucher management system, which is not directly accessed by providers. As previously described, providers are responsible for completing ARFs for prospective clients and submitting this information to the ABH. ABH manually enters the information from the ARF into the ATR ABHCIS, reviews the client's ATR eligibility, and ensures the client was provided with a choice of providers. The ASO staff makes eligibility determinations for prospective clients within 5 business days of the request.

ABH is responsible for issuing paper vouchers for physical goods as well as authorizations for clinical services such as treatment and RSS. Examples of physical goods and services provided through CT ATR include clothing, food, gas, and haircuts. ABH prints paper vouchers on a weekly basis and ATR case managers are responsible for picking them up, distributing them to the specified client, and returning unused vouchers each week. The client must sign the paper voucher while purchasing the good or receiving the service, and the vendor must then submit this voucher to the ASO for payment. Vouchers for physical goods and services may be renewed up to three times throughout the client's episode of care.

Although authorizations for clinical services specify the units of service and dates within which the services may be accessed, they do not have associated caps. A separate voucher is issued for each clinical service required by the client. Once a clinical service has been rendered, a provider must submit an invoice or claim by mail to the ASO within 60 days. Clinical treatment providers use the industry standard Health Care Financing Administration 1500 form for billing, and RSS providers use an ATR-specific invoice form. Payment is made within 30 days; however, if the client is receiving housing services, the ASO checks program capacity and verifies that the client is living in a housing program prior to paying the provider. To ensure proper use of the voucher system, ABH carries out yearly visits to assess providers and conducts a chart audit of client data and billing records. ABH also sends out quarterly reports of client, voucher, and GPRA data to DMHAS for general management of the ATR program.

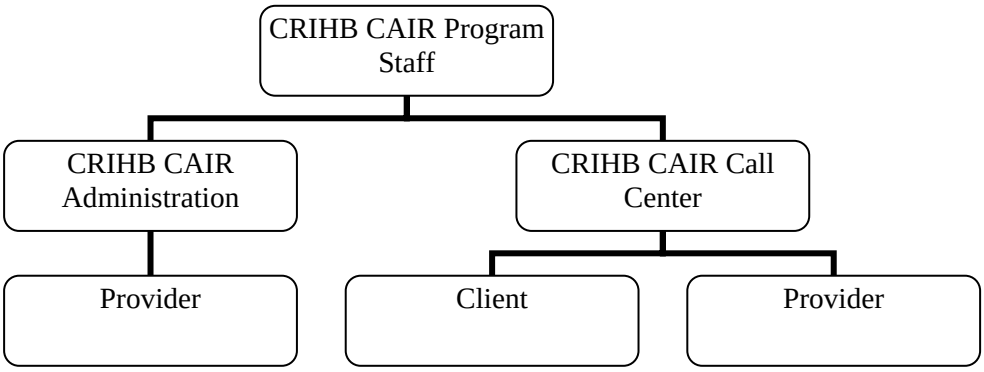
Although other States may be able to adopt the VMS used by CT ATR, the system's high level of dependency on the ASO severely limits its portability. ABH does not have the resources to support another grantee but is willing to share the system's design and concepts with future grantees.

California Rural Indian Health Board

Grantee—The California Rural Indian Health Board (CRIHB), an American Indian organization, was awarded a 3-year grant to serve as the lead agency responsible for the California American Indian Recovery (CAIR) ATR program. CRIHB directly receives Federal funding for CAIR and in turn distributes these funds to existing community structures for service provision. The CAIR program specifically targets rural and urban American Indian/American Natives (AI/AN) along with their spouses, and is implemented in all 58 counties throughout the State.

ATR Management System—CRIHB subcontracts with agencies to provide project coordination, evaluation, and provider training for the CAIR program. The agency's main subcontractor is MAXIMUS, which serves as the administrative service organization (ASO) in charge of the voucher management system. CRIHB and the ATR grantee for the State of California combined a portion of their ATR administrative funds to contract with MAXIMUS, which serves in the same capacity for both grantees. Figure 1 provides a visual display of the CAIR program organizational relationships.

Figure 1. CAIR Program Administration



The management structure of the ATR program is a consortium of nine California American Indian tribes that advocates for the provision of Federal health care services for California's American Indian population. Traditionally, Federal substance abuse funds were awarded to the State and were then allocated to county agencies. Although CRIHB has overall responsibility for the CAIR program, it is not a direct service provider. Rather, it distributes the ATR funds to existing Indian health services clinics that may use the funds to provide services directly or may purchase them from community-based programs and providers.

An ongoing challenge faced by the CAIR program is the recruitment of new clients. By December 31, 2006, the grantee had served 1,000 fewer clients than its target. To confront this issue, the grantee has conducted large-scale outreach initiatives, developed and distributed marketing materials, and had MAXIMUS create a comprehensive Web site for its ATR program.

Initially, CRIHB tapped into its existing network of providers that were either groups working with AI/AN populations or were employed at Indian health agencies. At the program's onset, all providers were faith based. In order to recruit more providers, CAIR provided onsite technical assistance to prospective providers, publicized the program's Web site, and presented on CAIR at tribal and Indian health service meetings. By the end of 2006, there were 44 faith-based providers and 59 secular providers enrolled in CAIR.

In order to become a CAIR provider, organizations must complete a five-part Clinical Provider Enrollment Application and Agreement, which establishes a formal relationship between the provider and CRIHB. The types of services offered by CAIR providers include, but are not limited to, substance abuse services, mental health therapy, drug/alcohol testing, transitional services, and additional services such as traditional medicine, case management, childcare, and so on. The program has at least two providers enrolled for each type of ATR service offered. Additionally, they must complete GPRA reporting in a timely manner, have continuous client record updates, and provide accurate billing.

CAIR providers and Indian health agencies are the major structures responsible for identifying and enrolling CAIR clients, but nontraditional and faith-based organizations may also refer and enroll clients. Potential clients may also contact a CAIR call center and be referred to a CAIR enrollment site. The agency conducting the enrollment must complete a five-part Client Enrollment Application with the potential client and submit it to the CAIR call center operated by MAXIMUS. The application consists of sections for demographic information, client consent, GPRA data collection, and a substance abuse assessment. During the client enrollment process, the provider is responsible for discussing various substance abuse providers with the client and ensuring client choice when selecting a provider. Once the client enrollment application is submitted to the call center, it is reviewed and an approval or denial letter is issued to the provider. CAIR issues a voucher that covers a comprehensive assessment to determine which services are needed by the client.

Once a client is admitted to the program, providers request a Screening, Assessment, and Diagnosis (SAD) voucher through the voucher management system (VMS) and a Treatment Outcome Evaluation form, which contains the GPRA intake data. The SAD voucher is used to determine which clinical treatment and/or recovery support services (RSS) best meet each client's needs. Assessments include one of the approved assessment tools (Addiction Severity Index, Comprehensive Adolescent Severity Inventory, or the Global Appraisal of Individual Needs). The licensed or certified provider uses the assessment tool to produce an American Society of Addiction Medicine number that translates into a level of care determination and includes the clinical treatment type (outpatient, intensive outpatient, or residential); and/or RSS (for example: transportation, housing support, food, etc.) most appropriate to each client's unique needs. Based on the level-of-care determination, the provider then requests a treatment voucher. Informed by the level-of-care determination, clients select their own unique pathway to recovery by choosing among the provider operations or options they receive. Eligibility criteria must be met and assessments completed before providers recommend treatment.

Before serving a client, providers must notify the call center in order for the call center to verify the voucher number, client's name, level of care, approved services, and time period for service provision. Vouchers are valid for 3 months or until the end of the fiscal year. If a client does not utilize ATR services at least every 14 days, the call center notifies the case manager. In this event, the client must resume receiving services within the next 14-day period or the voucher will expire. CAIR issues vouchers to clients on a first come, first served basis until funds for that quarter of the year are depleted. CAIR acts as a payer of last resort; therefore clients must use any available public or private funding for services before receiving program funds.

Maximum values placed on vouchers for initial assessments, clinical treatment, and RSS are based on a fixed fee and fixed number of units of service. After a client is served, providers must submit a detailed invoice to the call center within 14 days. The call center submits information about authorized payments to CRIHB for final approval and the grantee requests funds in this amount from

SAMHSA. The call center is responsible for submitting payments to providers. Payment to a provider is not guaranteed when a voucher is issued. Instead providers are paid based on the availability of ATR funds. MAXIMUS is responsible for CAIR's financial management, monitors the rate at which the program spends funds, and notifies providers if the funding limit is reached. In this event, clients are placed on a waiting list until funds become available, which occurs on a quarterly basis. The call center reviews all submitted GPRA data and will not issue payments to providers until GPRA data has been submitted.

VMS—Prior to ATR, substance abuse treatment programs throughout the State relied on paper-based systems to enroll and treat clients. CRIHB therefore contracted with the ASO to develop an electronic voucher system. The largest hurdle faced by the CAIR program pertained to the development of this electronic system due to delays faced in coordinating with the State of California ATR grantee.

The system is a Web-based client enrollment, data collection, billing, and voucher system that can also function manually for providers who cannot or choose not to use the electronic system. The system is owned by MAXIMUS and is operated by the CAIR call center. Through the VMS, the call center is able to issue vouchers to clients; track voucher clients, services, and associated costs; collect outcome and financial data from providers; and review and authorize payment requests from providers. Provider reimbursement data is uploaded twice monthly. The VMS can also produce financial reports to monitor the CAIR program's operation and effectiveness.

Following client intake, the client enrollment agency is responsible for submitting client applications and treatment outcome evaluations to the call center and sending a hard copy version within 5 days. After verifying the client's eligibility, the call center enters the information into the VMS and sends an approval letter to the enrollment agency. In the event an application is denied, the call center offers technical assistance to the enrollment agency. As described in the preceding section, the call center is responsible for issuing follow-up vouchers, verifying issued vouchers, notifying case managers when vouchers have not been utilized, and paying providers once services have been provided.

Because MAXIMUS owns the electronic voucher management system, future ATR grantees would have to directly contract with the organization in order to utilize this system.

Florida

Grantee—The Florida State Department of Children and Families (DCF) carries overall responsibility for the MyFlorida ATR program and reports directly to the Office of the Governor, the ATR grantee. DCF selected Central Florida Behavioral Health Network (CFBHN) through a competitive bid process to act as the administrative service organization (ASO) in charge of the program's daily operations and the voucher management system. The ASO assumes a wide range of roles including the following: monitoring GPRA data collection, operating the voucher management system, handling provider payments, providing technical assistance, and monitoring treatment capacity and service utilization to identify potential problems and service gaps.

MyFlorida ATR targets clients from the criminal justice system, individuals with co-occurring disorders, prescription drug abusers, uninsured individuals on welfare, adults age 60 and older, and individuals who are homeless or in dependent living situations.

Florida planned to phase in ATR implementation throughout certain regions of middle and southern Florida that represent over 40 percent of the State's unmet substance abuse treatment need. The first area selected for implementation was District 15, which was chosen because of an already operating, small-scale voucher system called Cache, as well as existing formal linkages to faith-based organizations (FBOs) in the region. Implementation began in District 15 in February 2005, with the remaining regions phased in beginning July 2005. Currently the program operates in 21 counties in six geographic regions throughout the State. Implementation was scheduled to begin earlier but was delayed due to difficulties experienced in contracting with the ASO and getting State approval on certain program components. Hurricanes affecting the State led to a temporary shift in State priorities and resulted in further delays. These delays led to a much lower client count than was projected for the program's first year.

Administrative Management System—The first initial administrative challenge faced by the program related to ensuring client choice. Insufficient numbers of FBO and recovery support service (RSS) providers meant clients were not guaranteed a selection of service providers. In order to address this issue, the ASO partnered with organizations experienced in FBO outreach and recruitment, such as Florida Faith-Based Association (FFBA), the NET Training Institute, and the South Coast Addiction Technology Transfer Center (SCATTC). SCATTC was also employed to conduct workshops aimed at promoting collaboration among faith- and community-based organizations, in an effort to strengthen service provision. Treatment and RSS providers may enroll with MyFlorida ATR through a provider agreement process. However, in 2006, the State limited recruit of new providers due to a high grant burn rate based on any existing service gaps identified by the ASO.

Intake and assessment centers serve as the ATR entry point for potential clients. Each district has multiple designated intake and assessment sites to perform comprehensive assessments, collect intake GPRA data, enroll the client, facilitate client choice, and provide limited RSS. When the client presents for intake, the assessment provider is required to spend at least 30 minutes of the initial appointment providing case management by familiarizing the client with ATR and enabling the client to speak directly with ATR service providers. Assessors are also responsible for linking the client with any non-ATR services the client may require, such as public insurance, food stamps, and any other applicable public programs. At this initial appointment, the assessor uses the electronic voucher management system (VMS) to report the following information: GPRA data, Addiction Severity

Index data, American Society of Addiction Medication patient placement criteria, demographics, and eligibility information.

In order to be financially eligible for ATR, a client must be at no more than 250 percent of the Federal poverty level. The assessment provider verifies this through a W-2 form, pay stubs, disability checks, or by having the client sign a form certifying no income. The provider submits this information along with a voucher request to the ASO, which holds the responsibility for reviewing and approving the information. ASO staff is notified about the voucher request in real time, as soon as it is submitted by the provider, and is also able to respond to the request in real time. ASO staff can send voucher authorizations and any additional messages to the provider through the VMS, as required.

Upon receiving the approved voucher request, the assessor assigns the client to appropriate services and helps the client select providers using provider lists available on the VMS. A paper voucher is printed for inclusion in the client's record but the client does not need to carry the paper voucher in order to access services. The assessor uses the VMS to create an electronic voucher containing the approved services, the number of service units required and the total dollar amount of the voucher, and submits this electronic voucher. The ASO is notified of this updated voucher request in real time and is able to approve it in real time. The assessor then contacts the selected service providers to make the client's initial appointment and follows up to determine if the client presented for the appointment.

DCF set a maximum voucher value of $2,000 per client, which can be exceeded with approval from DCF and the ASO. Each service also has an associated time cap specifying the total number of hours a client may receive that service. Vouchers were initially valid for 12 months, however this was shortened to 90–120 days in February 2007 to control the rate at which ATR funds are spent. The State also instituted caps on the numbers of assessments done each month, in an additional effort to curb the program's burn rate. Providers may request an extension on vouchers as long as they provide documentation for why the extension is necessary. In order for a provider to receive payment for services rendered, the provider must sign a Contractual Goods or Services Authorization (Form 1701) with the State and submit a Billing Invoice for Client Related Goods or Services. To ensure provider payment, the ASO submits an invoice to the State, which reimburses providers within approximately 40 days.

VMS—MyFlorida uses ATR KIS Express, an electronic VMS that was implemented in July 2005 and is managed by the ASO. The ASO purchased a license for the KIS Express System, which was similar to the KIS Enterprise system being used by the State for other treatment programs, and developed KIS Express. The ASO then added ATR-specific modules over approximately 2 months to create ATR KIS Express, which is used exclusively by ATR providers and the ASO. The software used for the VMS was developed by the software vendor Knight Information Systems (KIS). Future grantees would be required to contract with the ASO in order to use this system.

Providers use KIS Express to conduct the initial assessment; collect demographic, eligibility, and GPRA information; and submit invoices and voucher requests. This process is outlined in the preceding section. The system stores clients' entire record including demographic information, assessment, initial and follow-up GPRA data, voucher record, and the number and types of services received by the client. Service providers also use the system to track the services they provide each month and in turn receive monthly invoices from the ASO containing this information.

A major strength of the MyFlorida VMS is its ability to work in real time. This enables the client to be fully enrolled and informed of the approved voucher at the time of the initial assessment, rather than being required to come back or follow up on the voucher's status. A second strength of the system is that it allows assessments to be submitted online from any location using a laptop. The software is installed on individual computers and interacts with the server program at the ASO via an Internet connection. This allows assessors to travel to the client and decreases the likelihood that the client will be a no-show for the appointment. It also allows for incarcerated clients to be assessed before release, thus expanding the program's reach.

Idaho

Grantee—The ATR grantee, the Executive Office, State of Idaho, delegated implementation and management responsibilities for the grant to the Department of Health and Welfare (DHW), the single State authority (SSA). By State statute, the SSA has the authority to receive and manage Federal funds and has been responsible for providing substance abuse services to the State's population. The SSA reports directly to the Governor.

The Access to Recovery—Idaho (ATR-I) program is implemented statewide. It was phased in incrementally with treatment services first, followed by recovery support services (RSS). The populations targeted by ATR-I are adults and adolescents who are at or below 175 percent of the designated poverty level, and persons who are Hispanic, court-supervised, or Native American. Referrals come from diverse sources including self, courts, faith-based organizations (FBOs), child welfare, schools, and other community-based organizations (CBOs). Because Idaho is a rural/frontier State with limited service capacity spread over a large geographic area, another goal of the program was to increase service capacity.

Administrative Management System—Idaho's approach to implementing its ATR-I program was to form a statewide, broad-based, stakeholder partnership, chaired by Idaho's First Lady, to provide guidance during the ATR-I grant period and work toward creating a broad coalition to sustain and build upon the ATR program when the grant is complete. The alliance reaches across the State to draw from Idaho's Tribal Nations, the faith community, the three branches of State government, business and industry, local government, and citizens, including the recovering community.

In 1981, the SSA privatized its substance abuse program through a contract with an administrative services organization (ASO). The ASO performed management capabilities to provide substance abuse services funded through all of the SSA's various funding streams. The SSA, through a Request for Proposal process, chose to use the existing ASO contractor, Behavioral Psychology Associates, Inc. (BPA), to provide similar services to the ATR-I program. The SSA retained responsibilities for approval of the adult and adolescent alcohol/drug outpatient and residential treatment programs not affiliated with tribal organizations or FBOs; individual counselors are not required to be licensed.

BPA has been serving as the SSA's ASO since July 1, 2003, managing the substance abuse treatment services system of care by selecting and managing a network of State-approved alcohol/drug treatment service providers, prior authorization and utilization review (i.e., care management), claims payment, quality assurance and client outcomes. ATR-I expanded these responsibilities to include promoting the use of the public system by clients and new providers through marketing and outreach activities, recruiting and assisting clinical and RSS providers to become ATR-I service providers, managing anytime client access to information and referral to ATR-I services, managing the voucher issuance and payment system, and managing data collection and reporting. The ASO processes performance evaluation reports on a monthly basis and distributes them to State staff to support decisionmaking.

Idaho views creation of new and innovative avenues of access as crucial in addressing their underserved populations in its rural/frontier State. Having heavy State investment in "Web-access public services" to improve access to many goods and services including public services, the ATR-I program determined it would use this medium to develop the "Portal to Recovery." The portal is a Web-based and toll-free gateway providing 24-hour access for all Idahoans to information about ATR-I, education about substance abuse, and information about ATR-I providers. Individuals can do

a self-administered initial screening at the portal, with access advocates available to assist potential clients in navigating the portal, if necessary. The site also provides a link to assessment providers. The access advocates assist persons unfamiliar with or untrusting of Web-based services, such as handicapped persons, emotionally challenged persons, or those who are culturally disinclined to use such services. In this regard, the access advocates act as intermediaries to facilitate the client's access to appropriate or desired services. The access advocates are ASO staff. Data entered into the portal initiates the voucher issuance and payment process in the ASO's voucher management software.

If the potential client is determined, through the screening process, to be in need of substance abuse clinical or RSS, an assessment voucher is issued by the ASO to a client-chosen assessment provider and RSS vouchers for immediate needs, such as transportation to the assessment provider. The assessment voucher is valid for 3 months to redeem for a complete assessment to determine level of care. Immediate RSS vouchers will be contingent on completion of an assessment. Depending on the outcomes of the assessment, the client could be issued a treatment voucher for treatment services, and/or a recovery voucher for RSS. Vouchers are issued on time and unit basis, depending on the level of care and/or identified RSS/FBO. The duration of the voucher varies depending on the type of service. For example, a voucher is valid for 3 months for outpatient treatment services, 6 weeks for intensive outpatient treatment, and 7 days for residential treatment.

If a client is assessed to need 30 days of clinical treatment and three RSS, then four vouchers are issued—one for clinical treatment and three for RSS. If a voucher is revised at a later date, the voucher is not counted separately; however, a continued stay at a concurrent review is a separate voucher. Vouchers are canceled by the ASO when the unused voucher is mailed or faxed back to the ASO. The providers have 60 days from the date-of-service to bill and the ASO has up to 30 days to pay on a submitted claim.

In its non-ATR substance abuse program, the SSA screens clients for financial and clinical eligibility, and the ATR-I program will include such requirements. A financial disclosure form is completed that collects information on the potential client's (1) insurance coverage; (2) other financial resources, such as savings, personal or real property, with certain exclusions; (3) the number of dependents in the family unit; (4) current gross income for the family unit for the previous month; (5) parent's income when a youth is requesting treatment; and (6) support payments. A client is financially eligible if the income amount gained from the financial disclosure form does not exceed 175 percent of the Federal poverty rate for the most current calendar year for their family size. Clients with income at 100 percent of the poverty rate have a 5 percent copay of the fee for service. The copay increases in 10 percent increments until at the 175 percent of the poverty level; the client's copay is 70 percent. The copay policy has a few exceptions, such as participants in drug court, who automatically pay 5 percent copay regardless of income, and adolescents who have signed themselves into treatment without parental consent.

Clinical eligibility is addressed through a screening and risk assessment process that uses the Diagnostic and Statistical Manual of Mental Disorders–4th edition to determine if a potential client exhibits a substance abuse or dependence disorder that warrants further assessment and treatment at least at Level I of the American Society of Addiction Medicine Patient Placement Criteria–2nd Revision. When the program was implemented, the ATR Alliance members were asked to help define standards and processes for RSS providers based on the various services they provide and assessment criteria for these services were identified. Idaho's SSA program functions under a fee-for-service payment schedule, and this payment methodology is also used in the ATR-I program.

Despite implementing the program on time and effectively meeting its target numbers the ATR-I program faced two challenges that delayed its success. The program decided to phase-in its services beginning with clinical treatment followed by RSS. The consequence of this phasing process was that very few clients received RSS or faith-based services in the first year. The second challenge pertained to the delivery of culturally appropriate services to its targeted Native American clients. The grantee had established MOUs with four Idaho tribes on three different reservations, but soon discovered that there was a significant need for motivational interviewing techniques to help engage and retain clients. Following SAMHSA sponsored technical assistance training in motivational interviewing, the feedback from the tribes and the grantee was overwhelmingly positive as the trainees were able to quickly apply the new technique in a culturally appropriate fashion to their Native American clients.

The Web-based Portal for Recovery appears to be a good option to addressing outreach and service provision challenges presented by the geography of Idaho, particularly when the grantee has been doing much to encourage use of Web-based services. It is a concept that may be helpful to other rural/frontier grantees.

Voucher Management System—The ASO selected for the ATR-I program is also the current contractor for the existing SSA-operated substance abuse program. Part of the responsibilities of the ASO under the SSA program is to authorize services, track clients, and make payments for services provided. A data system established to perform these functions was enhanced to become the Portal to Recovery system that manages the issuance, redemption, and payments for the ATR vouchers. Basic modifications to the system were made, tested, and implemented into production as the first client entered ATR-I services. Data collected as part of the ATR-I program is being transferred to a data warehouse that will ease data querying and reporting.

Providers are able to bill daily for services provided to ATR-I clients. Claims are submitted utilizing the Health Care Financing Administration (HCFA) Form 1500 or an ASO-approved alternate billing form for providers not accustomed to completing the HCFA Form 1500. The ASO also accepts electronic claims via an 837 electronic format. The claims are processed by applying the standard fee schedule rates on a fee-for-service basis for previously authorized services. Payments are made to ATR-I providers twice weekly.

The ASO reported that FBOs and RSS providers encountered systemic issues in billing for ATR services due to lack of knowledge and experience in this area. Consequently, the ASO had to provide continuing training to providers as they came online with ATR-I in an effort to engage and assist them in navigating the ATR-I system. Training included GPRA reporting requirements, billing protocols, clinical and recovery support documentation, American Society of Addiction Medicine, and policies and procedures for case management/transportation. The ASO also identified key staff to answer questions and provide ongoing support to the providers.

While the VMS was developed to fill the needs of Idaho's SSA and ATR-I programs, it may be possible to engage the ASO as a contractor to perform similar services for additional grantees. Portability remains in question.

Illinois

Grantee—Illinois Office of the Governor is the grantee and administration of the ATR program is delegated to the Illinois Department of Human Services, Division of Alcoholism and Substance Abuse (DASA). DASA is the single State authority (SSA) for substance abuse treatment. The Illinois ATR program, known as Pathways to Re-entry and Recovery, contracts with Treatment Alternatives for Safe Communities (TASC), an independent nonprofit statewide agency, to serve as its administrative services organization (ASO). The program provides clinical treatment and recovery support services (RSS) to adult probationers within the urban Cook County court district and three rural downstate court districts in the central eastern portion of the State for a total of 17 counties. TASC is an appropriate ASO for this ATR project, as it has been responsible for assessing offenders with substance abuse issues for the Illinois courts for many years, and it serves more than 100,000 probation clients annually. The program began with adult probationers supervised by the designated Illinois counties and expanded to individuals in these target areas who are referred by enrolled RSS providers.

Administrative Management System—Illinois' TASC serves as the primary agency for performing screening and level-of-care determination and issuing vouchers for treatment and RSS. TASC is the designated agency to assess offenders with substance abuse issues for the Illinois courts, pursuant to an Illinois statute. The Illinois ATR Program target population of adult probationers will be divided into three cohorts:

- Cohort 1—nondependent users referred from the courts
- Cohort 2—dependent users referred from the courts
- Cohort 3—probationers already in treatment, referred for RSS

After being initially assessed by TASC, Cohort 1 participants received a brief educational intervention, because recovery support does not apply to this group of nondependent users. Cohort 2 participants were issued vouchers for treatment assessment and RSS as warranted by their assessment, and Cohort 3 participants were referred by treatment providers for vouchers for RSS.

Potential ATR providers are required to submit an application to DASA. Clinical treatment providers must complete the relevant sections of the application and meet the State's standard licensing requirements, regardless of whether they are faith-based organizations (FBOs). For recovery support providers, Illinois decided that it was not appropriate or necessary to hold them to the same types of standards, thus licensure or other credentialing requirements were not established. However, regardless of whether they are FBOs, Illinois requires recovery support providers to complete the relevant sections of the enrollment application and provide information about (1) their board of directors, (2) the organization's mission, (3) individuals currently served, (4) services provided, and (5) the backgrounds of persons who will be involved in providing services. They also need to provide evidence that they are in good standing with the Illinois Secretary of State's Office as a sole proprietorship or corporate entity to receive payments from the Illinois Comptroller's Office.

In Cook County, "Evidence Based Pilot Teams" (which are in several court-based locations) can refer probationers with at least 12 months left on their sentence to the ATR program. Also, individuals who are sentenced to probation with the Cook County Offender Accountability Initiative are referred to ATR. These probationers are referred to TASC, which administers the Texas Christian University (TCU) Drug Screen II screening instrument and based on their score, TASC places them

into the appropriate ATR group and provides them with (1) a brief educational intervention if in Group 1 or (2) referral to and vouchers for clinical treatment and/or RSS if in Group 2.

Downstate, probation officers administer the TCU Drug Screen to new probationers and use the same procedures to place clients into Groups 1 and 2. Group 3 clients are probationers who are already in clinical treatment in ATR agencies, and these agencies request supplemental ATR RSS for them. Once it is determined that a probationer meets Illinois' ATR eligibility criteria and a baseline GPRA is completed, they are considered an ATR client.

To choose service providers, clients receive hard-copy profiles of providers who offer the types of services they need. The referring individual uses a "Priority Checklist" to help the client identify the factors most important to them in selecting a program (e.g., location, program hours, non-English language needs, and faith-based preferences). A "Referral Choice Verification" statement is included in the checklist and signed by the client, to ensure that the client was offered adequate choice. All clients receive a voucher at intake because all assessments are vouchered services.

During the early stages of the program, Illinois struggled with enrolling additional RSS providers in the targeted downstate counties. From the State's perspective, Illinois delayed implementation due to complexities related to ATR. Implementation required the sequential development and melding of four major changes in the Illinois publicly-funded substance abuse service system. These changes consisted of (1) recruitment and monitoring relationship with a large group of provider organizations (nontraditional RSS providers) with whom the SSA have had limited previous experience; (2) determination and definition of service types (RSS) that have not previously been eligible for DASA-administered funding support; (3) development and implementation of a large-scale approach to service reimbursement (vouchering); and (4) a new automated client monitoring, data collection, reporting, vouchering, and service billing system (Illinois Service Tracking for Addiction and Recovery Services [ISTARS]). Documentation development and training issues were inherent within each of these major system changes.

From a nongrantee perspective, the main barrier to enrolling these providers pertained to the State's lack of experience with them. It took time to build a trusting, collaborative partnership with a new set of providers who formerly had never been affiliated with the State system. Illinois understood that communication and interaction between the State and the providers were crucial to building these new partnerships, and therefore assigned individuals from the State to regularly maintain contact and communication with the new providers. This proved to be a highly successful strategy as the partnerships quickly solidified and the new RSS providers enhanced the program through their ability to engage and retain clients.

Voucher Management System (VMS)—PRR has worked with its contracted IT vendor (FEI, Inc.) to develop and maintain ISTARS, which is based on its pre-existing WITS system (Web Infrastructure for Treatment Services, which was CSAT-sponsored). Illinois selected the WITS-based ISTARS Web-based application and modified ISTARS by adding VMS modules.

DASA is responsible for maintaining ISTARS, which is used strictly for the ATR program. However, it is not completely paperless and uses both paper and Web entry. Illinois maintains a separate system for clients funded from other funding streams (DHS Automated Reporting and Training System [DARTS]). The State does not use ISTARS for the general treatment Management Information System MIS; it is still using DARTS.

ISTARS is portable in a limited way.

Louisiana

Grantee—The Office for Addictive Disorders (OAD) is the designated administrator and regulator of the ATR program that authorizes eligible entities to provide services to ATR clients. OAD is the State agency that is charged with implementing Louisiana's full continuum of prevention and treatment services for citizens affected by alcohol and other addictions. The Louisiana ATR (LA-ATR) program operates under the auspices of the Governor's office through the leadership of the Department of Health and Hospitals (DHH).

LA-ATR targets adolescents and women, including pregnant women and women with dependent children, throughout the State of Louisiana who present with substance abuse concerns and are at or below 200 percent of the Federal poverty level. These populations were targeted because previous needs assessments indicated that adolescents and women were the most underserved populations with regards to substance abuse treatment services in Louisiana.

Administrative Management System—Implementation of the program occurred through a phasing process in which various regions of the State implemented the program according to a staggered timeline. Phase I of the implementation took much longer than anticipated, consequently delaying implementation of the later phases. The delay was attributed to an unfinished data system which resulted in limitations on the provision of RSS. Additionally, Phase I was delayed because of challenges with recruiting and approving FBOs.

The program was fully operationalized by May 2006. The organizational model of the program is based on a collaborative partnership that includes OAD, other departments within the public system serving women and adolescents, and nonprofit and faith-based community agencies. OAD headquarters staff provides statewide management and oversight for LA-ATR. Eight OAD regional offices and two semiautonomous districts operate 24-hour treatment facilities and contract with private providers of treatment and recovery support services (RSS). Statewide meetings are conducted with administrators of each OAD region/district to discuss continued implementation of ATR. Each region/district submitted their plan for implementation of ATR, including a State of Readiness report. Regions/districts were informed that future ATR implementation will be based on their states of readiness, which includes the number of faith-based and new providers they have recruited as providers with ATR.

OAD worked to ensure that supplantation did not occur by developing four financial strategies for the implementation of ATR in each region/district that would ensure that supplantation did not occur. Each region/district was provided with the ATR funding strategies and instructed to develop an implementation plan utilizing these strategies in order to ensure that funds were supplemented and not supplanted.

OAD headquarters implemented the LA-ATR program utilizing four different operational models. Regions and districts had the option of choosing one or all four models. Track 1 enables regions or districts to identify and contract with new providers. Regions and districts may contract with treatment providers that have never served OAD clients or with current OAD providers that offer new treatment modalities or new levels of care.

Under Track 2, State and/or contracted providers could expand treatment capacity with existing personnel and physical resources. Providers must continue serving an equivalent number of clients with Substance Abuse Prevention and Treatment (SAPT) funds, as measured against a FY 2003–2004

baseline. The regions and districts utilize ATR funds to serve additional clients when capacity increases.

Under Track 3, State-operated facilities predetermined the number of clients to be served, using ATR funds to a percentage based on a FY 2003–2004 baseline. The facilities provide treatment services to the designated number of clients using ATR monies and reinvest any saved SAPT Block Grant funds to create new treatment programs to address treatment gaps, giving priority to adolescents and women with children.

Under Track 4, regions and districts provided RSS to existing SAPT-funded clients. Clients continue to receive treatment services paid for by the SAPT Block Grant and access RSS using ATR funds. LA-ATR provides for a flat-rate payment for RSS.

OAD headquarters staff is responsible for enacting policies and procedures to insure that all ATR grant funds are expended in accordance with applicable regulations. The financial management requirements of the ATR program resemble those that have been established for other Federal awards managed by OAD staff, including the SAPT Block Grant. However, with the introduction of ATR, OAD-operated facilities are being paid for services that they render to clients on a fee- for-service basis for the first time.

A Memorandum of Understanding (MOU) is the mechanism used to establish the relationship between OAD and providers. As part of the LA-ATR provider approval process, various forms of information are requested from the applicant to ensure that they are able to provide the service(s) for which application is made. All clinical treatment providers must supply a copy of their substance abuse treatment license issued by the DHH Bureau of Health Standards that indicates the maximum capacity of each clinical treatment provider. New clinical treatment providers are also required to submit a copy of their treatment curriculum. Clinicians in private practice may be independent assessors if they are licensed and attend the required ATR trainings.

Existing licensing, credentialing, and certification requirements for recovery support providers and faith-based organizations (FBOs) are utilized. Participation requirements for recovery support providers and FBOs are outlined in the MOU. Providers of childcare services are required to submit a copy of their license from the Department of Social Services Licensing Authority that also indicates their maximum capacity. Providers of job readiness must submit a copy of their curriculum for this service. Transportation providers must submit a copy of their vehicle insurance, the driver's license of each driver, and the driving record for each driver. In addition to this information, region/district administrators are asked for their feedback regarding providers in their area. At times, site visits may also be conducted to potential ATR providers. ATR administrative staff has conducted site visits to potential ATR providers to ensure that they have the capacity to serve ATR clients and provide the appropriate services. In the event that a provider does not have an opening for an ATR client upon referral, the client will be placed in an alternative service until the recommended service becomes available.

Screening includes urine tests and a screener. Faith-based, community-based, criminal justice, school, and substance abuse treatment programs are examples of some of the referral entities that may screen clients and refer them for assessments. All organizations use a Web-based tool that uses the same screener and automatically determines financial eligibility for LA-ATR as part of the screening process.

LA-ATR assessment sites include OAD clinics, faith- and community-based entities, and private clinicians. Assessment tools include Addiction Severity Index (ASI) and Children's ASI and the Level of Severity Index. Once an assessment is completed, the assessor then determines the appropriate clinical and recovery support needs of the client to best meet his or her needs. Once the first level of care is determined, the Web-based system automatically generates a listing of all providers for that level of care. The client then chooses a clinical treatment provider from this list. The recovery support providers may be chosen by the client either immediately following the assessment or once the client enters the first level of care for clinical services. Prior to transferring the client in the system, the Web-based system forces the assessor to check a box confirming that the client has signed the Freedom of Choice verification form and Consent to Release Information form. When the first level of care is determined and the client is referred to this provider in the Web-based system, a voucher is generated.

When the first level of care and RSS needed by the client is determined, the system automatically generates a listing of all providers of those services from throughout the State. This listing can be narrowed down to a specific region/district or parish (county) for the client to choose. As stated above, the system forces the referring entity to check a box confirming that the client has signed a Freedom of Choice verification form before allowing the transfer of the client to the service provider.

LA-ATR's voucher management system (VMS) is Web-based. Vouchers are issued for both assessments and services. Assessment vouchers are issued once a client is screened and determined to meet the eligibility criteria for participation in LA-ATR. When the eligibility criteria are met in the screening, an assessment voucher is automatically generated by the system. The lifetime of an ATR voucher is 6 months, and all clinical treatment and RSS are included on one voucher for the duration of the voucher. A client has 30 days to present for initial treatment and 14 days to transition from one level of care to another. Failure to present in the above time periods will result in the voucher being cancelled. If a client is assessed to need 30 days of clinical treatment and three different RSS, one voucher is issued. The client is counted as one enrollment for combined clinical treatment and recovery support. If a voucher is revised at a later date, the revised voucher is not counted separately from the initial voucher.

The development of the Web-based voucher system by the March 1, 2005 implementation date was the most notable challenge. From the onset, the developers of the LA-ATR system informed OAD that March 1 was an extremely aggressive implementation datebecause they were attempting to develop a system that would typically take 8 months to build in 5 months; however, they were able to develop the provider enrollment and client intake portions of the system for the March 1 implementation date. Additionally, a backup data system was developed in order to permit the provision of RSS while the full-scale electronic system was being built. The delay of the VMS also delayed outreach and training efforts to potential LA-ATR providers.

A major challenge faced by the State pertained to the damage inflicted when Hurricanes Katrina and Rita hit the coasts of Louisiana. Seven of OAD's 10 regions were either inoperable or significantly diminished, and a total of 378 beds were lost. The plans to implement the program statewide in a comprehensive manner were curtailed, and the State revised its scope in an effort to better manage the reality of the situation. The State still implemented the program in all of the planned regions; however the implementation was limited to the major cities and population hubs.

VMS—Louisiana Addictive Disorders Data System (LADDS) is a Web-based application that gives users real-time access to all client treatment data, allowing for constant review and updating. LADDS was developed by the University of Louisiana at Lafayette and OAD headquarters staff; regional

LADDS system administrators run and maintain the program. LADDS houses the data in a secure centralized SQL database and is a standalone system.

The system is used to store client screening and assessment data, determine provider and client eligibility, issue clinical treatment and RSS vouchers, and generate a list of eligible providers for ATR clients. LADDS also has the capacity to monitor program funds spent per person and can be used to report both individual- and aggregate-level data for quality improvement activities.

Clients are tracked throughout the LA-ATR Web-based system with an Internal Control Number (ICN) that is assigned to a client once the assessment is completed and the voucher is issued. This ICN will be used to identify this client and the services he/she is provided through the LA-ATR voucher throughout the 6-month lifetime of the voucher. The system sends a notification to the care coordinator and facility administrator of the client's clinical treatment provider each time a GPRA recollection is due. The system will begin to alert the clinical treatment facility's care coordinator and administrator 7 days prior to the actual due date and also alert them when the assessment is past due. When the client is discharged from LA-ATR, the system automatically takes the clinician or care coordinator to the discharge GPRA for completion.

LADDS is a portable system.

Missouri

Grantee—The Office of the Governor for Missouri received a $15 million ATR grant. The Division of Alcohol and Drug Abuse (DADA), Missouri Department of Mental Health (MDMH), was designated as the agency with State government to administer the grant. DADA is also the designated Single State Authority (SSA) for substance abuse services in the State of Missouri and is organizationally within the Executive Branch of State government. The ATR program is administered through State fiscal and client information technology systems, with assistance with a contractor to help with recruitment and technical assistance to faith-based programs participating in the ATR program—Missouri-ATR.

Missouri implemented its ATR program focusing on its statewide adult population. A significant treatment gap was intensified by the methamphetamine epidemic that swept across the State, especially in rural regions, during the last decade as Missouri lead the nation in clandestine methamphetamine lab seizures. Further, as a result of State budget cuts and ATR funding, the SSA revamped its publicly funded substance abuse treatment service system to eliminate funding for residential treatment services and increase day treatment and intensive outpatient treatment services. Coupled with those services was supportive housing and newly funded recovery support services (RSS). The program is known as the Primary Recovery Program, and is implemented throughout the State.

Administrative Management System—Missouri uses a memorandum of understanding (MOU) process to credential treatment, RSS and faith-based organization (FBO) providers. Treatment vendors are licensed by the State through existing licensing processes. Missouri has created a credentialing process for RSS and FBO providers, including certain required training and adherence to certain standards of practice. Challenges experienced by the FBOs appear to be related to their having adequate business infrastructure for program operations. To lessen the challenge to FBOs regarding infrastructure, the State is allowing FBOs to use a paper reporting process for enrollment, reporting, and billing. Missouri-ATR is providing ongoing outreach and training and technical assistance (TA) to FBOs supporting their enrollment.

The ATR program was initially implemented with the clinical treatment providers serving exclusively as screening and assessment agents. The Cut, Annoyed, Guilt and Eye-Opener four-question screening tool is used to screen clients. Clients are then administered the Addiction Severity Index and the Global Level of Functioning tool and, depending on the results, eligibility information is gathered and the client is given a list of treatment providers within a 100-mile radius. Clients are asked to acknowledgement that they have been provided with a list of treatment providers from which to choose and that they have made the choice of provider of their own free will before being issued a voucher. The State keeps a file of all signed vouchers.

Because clinical treatment agencies do not usually provide RSS, often the clients were not accessing the RSS portion of the ATR program. To address this issue, Missouri piloted a project in May 2006 allowing 10 specially trained recovery support programs the ability to screen, enroll, and assess clients. Additionally, the programs were allowed to issue recovery support vouchers. Prior to this initiative, RSS could not be accessed directly or independently from clinical treatment if needed. Immediately after implementing the pilot project, the State began to notice that the use of RSS was helping to increase treatment retention and completion. The State quickly shifted to incorporate even more RSS providers.

Vouchers are issued for both assessments and services. Assessment vouchers are automatically issued once a client is screened, determined eligible for Missouri-ATR, and enrolled in the data system. The fee paid for an assessment is $120. Following assessment, a treatment voucher is created for the appropriate level of care and the client is informed of treatment providers. The lifetime of ATR treatment and RSS vouchers is governed by the Customary Service Authorization (CSA). The CSA for treatment level 1 is $1,678 (approximately 1 month), $1,503 for treatment level 2 (approximately 2 months), and $926 for treatment level 3 (approximately 3 months). The CSA for a RSS voucher issued through the clinical assessment process is $400. The CSA for both treatment and RSS may be exceeded through the clinical utilization review process. Following completion of treatment (or administrative discharge, dropped out of treatment, etc.), the client is discharged through the data system. Treatment and assessment vouchers are cancelled after 60 days of inactivity. If a client is assessed to need 30 days of clinical treatment and three different RSS, one voucher for treatment and one voucher for each RSS are issued if multiple providers are chosen.

The invoicing process begins when the provider enters the service online into the Consumer Information Management Outcomes Reporting (CIMOR) system, which automatically generates an invoice. The provider signs and submits the invoice to MDMH's Controller. The Controller keys the payment into the Statewide Accounting and Management System. Most providers receive payment through direct deposit.

Missouri finances traditional substance abuse treatment services through a blended funding mechanism. (Note: grantees wishing to implement a blended funding program are cautioned to be vigilant to address potential supplantation issues and develop appropriate documentation.) In its initial approach to implementing ATR services through its clinical provider agencies, the ATR program provided each participating program with an ATR allocation included in its annual blended funding amount. Providers were then charged with providing clinical and RSS services with these funds. Providing an allocation to each agency controlled the amount of ATR funds that were being expended in specific timeframes and locations, and because the funds were "blended" with other funding streams, any balance left unspent from one allocation period to another was not identifiable to one stream over another.

In addition to controlling by provider allocation, the SSA limited the amount of funds that could be billed in a particular quarter to ensure that services are available throughout the complete fiscal year. An allocation letter is issued at the beginning of the year that includes the first quarter amount and the annual amount to the provider. The amount for the first quarter is one fourth of the total amount plus 5 percent of the whole, the second quarter is one fourth of the total plus 5 percent of the total allocation, and the third quarter is awarded on a similar basis. The provider then uses the fourth quarter to bill for the remaining balance. If an allocation is not expended in one quarter, the funds are rolled over to the subsequent quarter. Missouri's reasons for using this financing methodology are to provide an adequate cash flow to providers and to ensure that services are available through the State.

With the RSS pilot sites, the funding basis is different. Vouchers issued through the pilot agencies have a $1,000 cap, and these agencies also have limiting allocation caps. When an agency is getting close to spending its full allocation amount, the ATR program will review the service levels and raise the cap if it appears appropriate. The shelf-life for a voucher is up to 1 year or as long as the recipient is in treatment. If there are 90 days of client inactivity in the system, the voucher is considered closed. With the implementation of its new data system, these constraints will be easier to monitor than they have been in the past. In situations where additional clinical providers are recruited into the

ATR program and the basic clinical provider allocation process of blended rates is closed, these new providers can only participate through the RSS pilot sites.

Voucher Management System (VMS)—Missouri began implementation of its ATR grant using two different systems to collect client substance abuse data—the Client Tracking, Registration, Admission, Commitment (CTRAC) system and the Outcomes Web. The Outcomes Web supports the Addictions Severity Index and gathers other client information at enrollment, including medical information, employment history, and so on. A temporary bridge system was developed to incorporate the ATR GPRA and VMS into the Outcomes Web. Use of two systems presented challenges for the clinical and RSS providers. Ongoing TA was made available through the Missouri Department of Mental Health Help Desk, which is accessible through a toll-free number to all providers. The SSA anticipated that the CTRAC system serving the substance abuse, mental health, and developmental disabilities programs would be replaced by a new purchase of service computer system within 6 months of the ATR grant award, thereby helping with many of the voucher and financial management requirements in ATR. As is often the case in development of new systems, it took much longer than anticipated to get the CIMOR system online. Population of existing data into the new system began in early September 2006 with the system going live by early October.

The initial conversion focused on entering program services, organizational information, and human resources information and then allowed the programs to fill in missing data. The second conversion effort involved client data. Some information could not be converted through an automated process, particularly the provider information at the program level and the standard means test (sliding fee scale) used to assess client eligibility to participate in the public service systems.

The CIMOR system operates on a .net platform (Web-based). It is built around business rules established to keep inappropriate billings from being entered into the system and keeping them from inadvertently being paid. If a voucher is not entered into the system by the provider, the clinical or RSS provider will not be able to invoice. Providers will know immediately if the system is rejecting the voucher request or claim. The system will also track services against the voucher so that providers cannot exceed the voucher authorization amounts. It is able to pay provider invoices on a biweekly basis, enabling service providers to have a more consistent and positive cash flow.

The CIMOR system can be used to collect client demographic information, record client screenings and assessments, and collect and submit GPRA data to CSAT. The system allows users to track vouchers, providers, and clients throughout the intake, treatment, recovery, and postdischarge process.

The system was developed by a contractor with internal staff assistance and is owned and operated by MDMH. The system is not portable, but the Department may consider hosting for other ATR grantees, depending upon the nature of the request.

New Jersey

Grantee—State of New Jersey, Governor's Office, designated the Department of Human Services (DHS), Division of Addiction Services (DAS) as the organizational unit to implement the New Jersey Access Initiative (NJAI). The DAS is also the State's single State authority (SSA) for substance abuse services to citizens of the State. The DHS reports directly to the Governor of the State.

The NJAI initiative is implemented statewide with emphasis on RSS availability in the densely populated areas of Newark, Camden, and Trenton during the 1st year of the grant. The initial target population was recovery support services (RSS) for aging out adolescents and adults who are opiate addicted; however, because the opiate focus was not producing sufficient numbers of ATR clients, the target population was broadened in June 2006 to include cocaine- and crack-addicted clients. The revision also implemented funding methadone maintenance for 6 months, including a physical and one follow-up visit with the physician. A means test was developed as a mechanism to avoid supplantation.

NJAI is heavily focused on the use of recovery mentors in its recovery model; the ATR program experienced difficulties reaching the projected goal for number of clients accessing this service, as well as finding providers interested in helping to implement NJAI's housing initiative. New Jersey based its NJAI network of service providers on a proven and successful faith-based cooperative in Northern New Jersey known as Bridge to Recovery. Bridge to Recovery is an eclectic group utilizing a holistic approach to addiction recovery. While the above mentioned efforts increased demands for NJAI services, NJAI expanded its service base further in early 2007 to include alcohol-addicted clients so that client counts and expenditures would increase.

NJAI partnered with the New Jersey Office of Faith Based Initiatives (OFBI) on its Project ATLAS which provides grants to FBOs for customized training and onsite consultation and capacity building support. In order to be eligible for these grants, providers are required to become participants in NJAI.

Administrative Management System—As the State's lead agency for ATR, DAS oversees the contract with the ALA, and provides direct programmatic oversight, including program monitoring and handling of any inquiries regarding the initiative. DAS also oversees bed management for all residential service providers and utilization of funded outpatient services to ensure that NJAI funding is truly the payer of last resort. It also conducts training for organizations interested in joining the NJAI network of service providers, as well as providing technical assistance in the licensing process for FBOs and CBOs. DAS approves all providers prior to their admittance into the NJAI network and provides an Ombudsman to investigate provider and client grievances regarding the NJAI.

The NJAI ATR program operates with a slightly modified administrative services organization (ASO) structure. New Jersey refers to its subcontractor, Addictions Hotline of New Jersey, as an administrative lead agency (ALA). New Jersey owns and operates its staff-developed voucher management system (VMS), but the ALA is charged with many of the remaining ASO-type responsibilities, such as handling fiscal oversight to the program, including payment of vouchers (making payment for services quicker and more efficient from the State's central payment system), developing and maintaining a user-friendly Web site offering detailed information regarding the NJAI and its providers, maintaining the Addictions Hotline of New Jersey for individuals to be screened into the initiative, providing technical assistance to potential providers regarding the

program, assisting DAS with workshops regarding vouchers, attending regularly scheduled regional coordination meetings for member of the provider network, creating and distributing vouchers to approved providers, tracking the billing and payment of vouchers, maintaining an accurate fiscal records system and complying with all reporting requirements of DAS, collaborating with DAS to maintain the list of members of the provider network, projecting and controlling spending through their fiscal management information system, expanding the NJAI provider network statewide, integrating their fiscal system with the report of NJSAMS data, maintaining and staffing an 800 number during regular business hours for providers to call for authorizations, and training staff of the Addictions Hotline of New Jersey to perform those duties outside the business hours.

Any resident in New Jersey can contact the addiction hotline and be screened into the program. All callers included in the NJAI target populations are immediately transferred to the NJAI counselor on duty, who screens the caller for opiate dependence, then issues an electronic voucher for an assessment. A client may be deemed medically indigent for a variety of reasons: unemployed but not eligible for Medicaid, unemployed but not well enough to be employed, family income too low to afford treatment yet too high to be eligible for Medicaid, no insurance coverage, and so on. The criteria attempts to ensure that State funding for treatment is based on the principle of need that will include both financial and medical necessity.

Those presenting for screening who meet the above eligibility requirements and have a pressing need for RSS, including shelter, food, and detoxification, are also eligible to receive a voucher for urgent RSS, which is valid only until assessment (no more than 72 hours after screening). The assessment is completed using the Addiction Severity Index or another DAS-approved assessment tool, and persons who present with a Diagnostic and Statistical Manual of Mental Disorders–4th edition diagnosis indicating an abuse and/or dependence are eligible to receive vouchers for substance abuse treatment based on the American Society of Addiction Medicine Patient Placement Criteria–2nd Revision level of care. NJAI approved treatment providers may also require a client to contribute a co-pay of up to 80 percent of the NJAI service rate based on a DAS statewide sliding scale.

The bulk of the services will be after detoxification when a recovery support mentor begins working with the client. The recovery support mentor service is designated to support the client's treatment and transition the client from treatment to long-term recovery in the community.

The client has free choice to select a provider(s) and also has the right to leave the current provider. The voucher is valid for 30 days from the date of authorization, and the activation expiration date is on the voucher. If the voucher is not validated prior to the activation expiration date, the client will have to be reassessed. The provider encourages the client to access an authorized service as soon as possible to begin the treatment and recovery process, as well as to guarantee the availability of NJAI funding. The voucher has a 6-month life.

Providers are required to submit a monthly invoice to the ALA within 20 days for services rendered to clients. Failure to submit invoices in the defined timeframe may result in significant reimbursement delays and possible nonpayment. The quality division of the SSA performs onsite visits annually or if prompted by a concern, and during these visits a percentage of clinical records are reviewed to ensure that services are rendered for the services billed.

VMS—The New Jersey Substance Abuse Monitoring System (NJSAMS) is a Web-based, real-time VMS developed in-house by staff of the DHS in existence when the application for ATR funding was submitted. When New Jersey received an ATR grant award, the same staff member who created NJSAMS created a module to accommodate the needs of the NJAI management. NJSAMS supports

data collection and reporting of screening, assessment instruments, and admission of client information. QuickBooks, a desktop accounting system, is used to handle provider payments.

Assessment vouchers are created by NJSAMS using unique client identifiers and are issued verbally, over the phone, upon completion of the screening process. Specifically, a phone call is received at the NJAI fiscal office or the Addictions Hotline of New Jersey from a provider or a client. The client is screened for eligibility using the NJAI module of NJSAMS. The NJSAMS creates a client profile that includes information on drug use, insurance, employment, and family/social life. If the client is determined to be eligible, the NJSAMS will create and record the voucher transaction and the client profile.

The module is reported to be very user friendly. It was created and in place early in the implementation of the NJAI program. New Jersey staff report that the system is portable, and because the VMS was created through public funds, it is public domain software available for use by the general public.

New Mexico

Grantee—New Mexico Office of the Governor designated the Department of Health, Behavioral Health Services Division (BHSD) to administer the ATR grant. The Department of Health is in the Executive Branch of State government and reports directly to the Governor. The BHSD is also the single State authority (SSA) charged with managing public substance abuse services for the State. The ATR grant provides New Mexico with the opportunity to build and expand upon an existing City of Albuquerque's Albuquerque Metro Central Intake (AMCI) program experience with operating a voucher system. The grantee also called upon the Stone Soup Collaborative to lead the State's capacity to offer increased choices in recovery support services (RSS) through faith-based and community-based organizations.

Policy oversight of the ATR project is through an existing committee made up of representatives from all State agencies that fund behavioral health programs, community representatives, and advocates. The group is the Governor's appointed State Incentive Grant Policy Steering Committee and Advisory Council, chaired by the Governor's Health Policy Advisor. The BHSD initially attempted to use a contracted team of professionals to manage the project but, through subsequent observations and negotiations with CSAT, the management team was replaced with employees within the BHSD.

In addition to expansion of the City of Albuquerque's AMCI program throughout all of Bernalillo County and to Native American tribes through Five Sandoval Indian Pueblos, Inc., New Mexico has replicated the Albuquerque model in the next two largest population centers of the State—Santa Fe County and Dona Ana County (Las Cruses). The Native American services ultimately become an independent site.

Administrative Management System—Initially, New Mexico planned to execute a Joint Powers Agreement (JPA) or official contract between the State and AMCI, but obstacles arose with finalizing the document. The program scope was renegotiated to substitute AMCI with ValueOptions, Inc., a managed care organization that serves as New Mexico's administrative services organization (ASO) for implementing the ATR program.

The ATR program in New Mexico is regionally based. The voucher program focuses on the general population of people in need to recovery services which are accessed through central intake units (CIUs) established in the various county locations. In Santa Fe and Las Cruces, a screening tool is also used to establish eligibility for ATR services. The Santa Fe and Las Cruces sites target clients in protective custody, detention centers, and other Native Americans needing services. The Albuquerque site (which includes the Five Sandoval Indian Pueblos) targets clients that are nontraditional DUI and other criminal justice referrals.

Through the atrnm.org Web site, CIU assessors walk the voucher recipient through the ATRNM systems. The information collected is client demographic and locator information. This is used by both CIU and providers to contact the client for engagement into and follow-up for services, which are the responsibility of both provider and CIU staff. The assessor then determines the client's eligibility based on the criteria established by each CIU and indicates eligibility on the Web site. The Client may be interviewed in Spanish, English, or Native American Traditional Language. The Alcohol Use Disorders Identification Test (AUDIT) instrument is administered for screening eligible clients, and the clinical assessment includes administration of the Addiction Severity Index-Multimedia Version (ASI-MV), GPRA, and Treatment Outcome Package (tool varies from site to

site). The clinical assessor reviews the ASI-MV, which is completed by the client at intake, and determines the American Society of Addiction Medicine (ASAM) Level of Care (LOC). The LOC corresponds directly to the clinical voucher type that is selected. An electronic voucher is generated by selecting a voucher type. Once the assessor has created the voucher, he or she is able to view with the client those providers that offer the needed LOC. The provider list can be filtered to meet the needs of the client (location, language, culture, etc.). The assessor selects the provider chosen by the client, and subsequently creates an electronic referral to the provider. The assessor then discusses options for RSS, and encourages the client to visit the Recovery Support Service Coordinator (RSSC) who conducts a needs assessment for RSS. Based on this assessment, RSS are prioritized and selected in the Web site. Once selected, providers that offer the services are displayed and the RSSC assists the client in choosing which provider they would like for each service. When the client has chosen the provider for each service, an electronic referral is automatically generated to each of the selected providers.

The ATR Treatment Provider Credentialing Committee oversees provider network maintenance for customary treatment providers. A treatment credential is already recognized by the State, as well as the State's Medicaid Authority. A memorandum of understanding is developed between the State's Department of Health (administering the ATR program) and Medicaid to accept Medicaid provider credentialing as valid for New Mexico's ATR program. Primary source documentation is verified by a third party through a contractual arrangement with the State. Every provider must acknowledge that they meet credentialing criteria, provide a copy of their practice license, and agree to permit health and safety checks by the State.

The State uses the application process, provider agreements, and quality assurance site visits to ensure that providers have capacity to serve the referred voucher client. New Mexico established two credentialing committees to establish standards for eligible providers offering faith-based or community-based RSS. The ATR Recovery Support Credentialing Committee will establish training protocols and ethical standards, knowledge of substance abuse issues, confidentiality, service data reporting, ability to bill and report client progress, and so on. The Committee provided its framework to BHSD for inclusion in the Web-based system. A similar committee, the Five Sandoval Indian Pueblos Native American Recovery Credentialing Committee, performs similar functions for Native American providers from the pueblos who offer traditional pueblo practices that can support recovery.

New Mexico uses a fee-for-service reimbursement system for all clinical treatment services at an ASAM LOC lower than inpatient treatment. However, higher-end services such as inpatient treatment or medical detoxification programs receive a bundled rate with services clearly identified. Patterned after the experience of the City of Albuquerque model, New Mexico established voucher values in accordance with the type of service indicated by the assessment. Reimbursement rates follow the established fees for the treatment of substance use set by ValueOptions New Mexico (VONM) for behavioral health services in New Mexico, within the guidelines established by SAMHSA. If a service is added to the system that has not been previously funded or is not funded by any other means in the State, the fee will be determined by conducting research of current rates for provision of the service elsewhere in the country and relative cost compared to other services offered inside ATRNM.

In June 2006, New Mexico increased the rates on certain treatment and RSS services, raised the value of its RSS voucher from $1,500 to $1,800, permitted clients who are not currently participating

in a treatment program but working a program of recovery to participate in ATR, and reduced the life of a voucher from 1 year to 6 months in duration.

In order to avoid funding shortfalls, ATRNM implemented a series of policies and rules to insure successful allocation of resources, principally quarterly distribution of funds and allowing a two-week window for submission of services from providers. When the voucher funding pool is exhausted during any given quarterly period, providers are notified that they may not bill for further services during the quarter. To participate in the project as approved providers, they are required to make a commitment to continue to provide all services to voucher clients at a reduced or no cost, and to begin billing again at the beginning of the following quarter, but only for new services during that quarter. Burn rates for each level of care and number of clients assessed are reviewed by the operations team each week. Necessary adjustments are made immediately through notification of Client Information System (CIS) and providers. Central intakes are contracted to provide a number of assessment each year, including some at no cost to allow for the management of funds.

To reimburse the providers for services to ATR clients, the State's Web system automatically generates invoices based on services entered by a provider that have not been previously invoiced on the first of every month. Providers approve services based on electronic signature. The New Mexico Department of Health or the City of Albuquerque, as appropriate, issues payment for invoices around the 3rd week of each month and mails the payment to the provider.

Voucher Management System (VMS)—Initially, New Mexico planned to supplement its existing Comprehensive Data System New Mexico with a voucher system similar to that created and used for 9 years by the City of Albuquerque. When it was not possible to execute the JPA with AMCI in a timely manner, the State contracted with ValueOptions, Inc. to provide administrative services, including an automated VMS. The contract became effective July 1, 2006. The system is managed by ValueOptions in coordination with the New Mexico BHSD. ValueOptions, added a module to its previously existing proprietary system to provide management capabilities for New Mexico's ATR voucher program.

The ATR operational components are managed via a centralized Web-based system that includes relational database technology for advanced data mining. Centralized methodology within the ATR Web-based system has proven to be instrumental in developing a streamlined approach to managing all operational facets of ATR including, but not limited to, accounts receivable (billing), fraud waste and abuse monitoring, generating management reports, and managing the service provider network.

VONM operates two Web sites for the New Mexico ATR program. The first Web site, atrnm.org, is responsible for the majority of voucher management. The Web site allows providers real-time access to clinician and client information. It is used to collect client demographic information, determine client eligibility, collect GPRA data, conduct assessments, and generate vouchers. Client information is entered at the CIU sites. Once entered, it is managed electronically for the duration of the client treatment/recovery episode enrollment period. Provider data is also collected electronically. Each provider, when chosen by a client, receives an electronic voucher that approves a range of services and establishes the required service mix for the client, along with the voucher amount and pricing of each element of service. Within 14 days of delivery of a service unit, treatment or RSS are entered into the project Web site by the provider. All services are entered throughout and assigned a pre-established reimbursement rate for the service. At the end of each month, the services are summarized and transferred into a billing module that creates a provider invoice for billing to the State or to the City of Albuquerque for its network. The system has the capacity to monitor funds spent per client served.

The second Web site, atrnm.com, disseminates information about ATR to consumers and providers. It contains a list of eligible providers and their contact information, along with service definitions. The Web site also has a resource manual that outlines all available resources statewide as well as the phone number of a 24-hour hotline operated by VONM and staffed by a clinical nurse.

Although the grantee reports that the New Mexico BHSD owns the system and software, it is an addition to an existing system, and may not be portable for that reason.

Tennessee

Grantee—The Tennessee Department of Health, Bureau of Alcohol and Drug Abuse Services is the grantee, and the Bureau (now called the *Division*) of Alcohol and Drug Abuse Services (DADAS) administers the Tennessee's Access to Recovery for Methamphetamine Users program (TN-ATR). The Division of Alcohol and Drug Abuse Services resides within the Tennessee Department of Mental Health and Developmental Disabilities (DMHDD). The DADAS is the single State authority (SSA) for administering Federal Substance Abuse Prevention and Treatment Block and ATR grant funds.

The target area for the TN-ATR program spans the entire state; the target population is those with substance abuse or dependence issues or who have experienced these in the past. However, there is a focus on persons with a methamphetamine or cocaine abuse and dependence issues. Originally, the grantee had planned to focus treatment services on rural areas of the State because statistics indicate a growing need for services to combat methamphetamine use in these regions; however, need for client enrollment expanded their population.

Administrative Management System—The State's DADAS coordinates the program through partnering with a broad array of State and local agencies, community-based treatment and recovery providers, professional organizations, the faith community, and academic institutions.

DADAS works directly with providers for care. The formal mechanism that establishes a relationship between providers and the grantee, and allows providers to be reimbursed, is the Authorization to Vendor. To obtain the Authorization to Vendor, providers apply and meet DADAS eligibility criteria. Providers, regardless of whether they are clinical or recovery support services (RSS), send facility and staff information that may factor into providers' capacity to serve referred voucher clients. Once the State has certified their information, providers sign an Authorization to Vendor to do business with the State. Clinical or treatment providers must be licensed by the State. DADAS does not require licenses for RSS providers. FBOs offering only RSS must submit to DADAS documentation that all direct staff has been trained in SAMHSA's Core Competencies for Clergy and other Pastoral Ministries in Addressing Alcohol and Drug Dependence.

Potential clients are referred and screened into the program through drug courts, which naturally encounter those who have methamphetamine and other substance abuse problems and have entered the criminal justice arena; public health departments, which are located in each county of the State; and authorized substance abuse treatment centers around the State. Clients are screened for substance abuse using a two item scale and a conjoint screening questionnaire for alcohol and other drug abuse. Additionally, they must meet financial eligibility requirements. If the screen is positive, the client is provided a list of potential assessment providers and issued a voucher for treatment and services.

Once a client is screened and determined to meet the eligibility criteria for TN-ATR, the service provider completes the consumer application form, consumer profile, and assessment voucher application form and enters the data into the grantee's voucher management system (VMS), the TN-Web Infrastructure for Treatment Services (WITS) system. DADAS approves the voucher and the provider notifies the client to set up or conduct an assessment. The assessment includes (at a minimum) the Addiction Severity Index to determine severity of the problems.

Once the client is assessed, the level and types of care are determined by using the American Society of Addiction Medicine's Patient Placement Criteria for the Treatment of Substance Abuse Related

Disorders, Second Edition, Revised if treatment services are required. The provider faxes the treatment and/or recovery services voucher application to DADAS. Once DADAS approves the vouchers, the provider notifies the consumer and schedules or provides ATR services. Vouchers are provided for each type of service, for example, four vouchers would be provided if a client needed clinical treatment and three different RSS.

DADAS withholds 10 percent of a provider's monthly invoice to ensure compliance with GPRA and other data collection needs. A provider is paid based on the proportion of clients he or she entered data for. All rates are present and claims are automated.

Tennessee has exceeded its target number of clients served, expanded treatment capacity with a special emphasis on the inclusion of FBOs, and enhanced the array of available services. To recruit FBO, the Division set up a faith-based advisory committee to represent the faith-based community for ATR and served in an advisory capacity to the Division in other areas relating to treatment and/or recovery services.

The grantee delayed implementation due to the need to develop program infrastructure, particularly a voucher management system (VMS). Without an electronic voucher system, the grantee decided to first pilot the program in the city of Nashville using paper vouchers. The grantee learned lessons during this time, while developing an electronic VMS. The State remained on the paper voucher system for approximately 8 months before transitioning statewide to what is now called the TN-WITS system.

Client choice was also a challenge, mainly due to small numbers of providers. The grantee managed this problem by conducting more marketing and offering technical assistance to providers interested in enrollment.

A third challenge Tennessee faced was controlling finances. Originally, funds were held until a voucher was closed or a consumer was discharged. This often slowed the process of obtaining care, and would in some cases close enrollment. At the same time, the grantee determined that only 25 percent of allocated service dollars were being spent. Thus, the State decided to change the process to give each provider a set dollar amount per month that may be billed in TN-WITS. This requires that providers and consumers work together so that services are not requested beyond what they will be able to deliver. As a result, the TN-WITS system has not shut down due to the overallocation of dollars. This has allowed for a smooth enrollment process for providers since the system does not "close its doors" to new consumers. In addition, consumers have benefited by the increased communication required with providers to ensure that services are chosen more strategically.

VMS—Tennessee's ATR program uses TN-WITS, a Web-based real time VMS that is capable of issuing and tracking vouchers, collecting GPRA data, and monitoring program expenditures. The State based the system generated through SAMHSA's WITS system software and added its own unique modules. DADAS is responsible for the system which is used exclusively for the ATR voucher program. However, the system resides on the FEI server in Maryland.

Tennessee did not have an electronic voucher system prior to ATR. Without a statewide electronic voucher system, the State decided to first pilot the program in the city of Nashville using paper vouchers. The State remained on the paper voucher system for approximately 8 months before transitioning statewide to what is now called the TN-WITS system.

The system was developed by FEI and is also used by the States of Wyoming and Illinois.

Texas

Grantee—Administrative responsibility for the Creating Access to Recovery Through Drug Courts program lies with the Texas Commission on Alcohol and Drug Abuse (TCADA), which was later reorganized into the Department of State Health Services (DSHS), Division of Mental Health and Substance Abuse services. DSHS reports to the State Governor's Office, the official ATR grantee.

Prevalence of substance abuse is higher among individuals within Texas' criminal and juvenile justice system compared to the overall State, but existing funds and treatment providers were insufficient to serve these individuals. To address this unmet need, DSHS created an ATR program specifically targeting individuals with substance abuse disorders from drug courts, but later expanded the program to include individuals from juvenile and adult probation, child protective services, and former Louisiana residents displaced by Hurricane Katrina. The program was implemented in 13 counties.

Administrative Management System—Texas did not have an existing voucher program in place prior to ATR, and struggled with creating the infrastructure necessary for ATR. DSHS spent a significant amount of time on program design and infrastructure development. The first 6 months of the grant were dedicated to this purpose, causing a delay in program implementation and client enrollment. This delay resulted in a low client count and required DSHS to recruit outreach specialists and receive SAMHSA-sponsored technical assistance to overcome this challenge. Since the program's inception, DSHS has created a client information brochure, a client satisfaction survey, training materials, and application packets for providers. It has also been responsible for voucher design, creating service utilization and budget reports, and establishing relationships with drug courts and service providers.

Formal relationships between DSHS and participating drug courts were established through signed memorandums of understanding. DSHS initially trained drug court personnel and assessment providers on ATR programmatic requirements and use of the electronic voucher management system (VMS). Once trained, these individuals then conducted similar trainings for treatment and recovery support service (RSS) providers. The trainings were followed up by DSHS with phone and in-person technical assistance on ATR program implementation for the drug courts and providers.

The main points of entry to ATR for prospective clients are through drug courts. Drug court personnel carry out a legal screening to verify that the client meets the legal criteria for participating in the drug court, as well as a clinical screening to verify presence of a substance abuse problem. Once deemed eligible, the drug court judge refers the individual to an ATR intake center/assessment provider for a comprehensive intake. Each of the 14 participating counties has one central assessment provider. This structure is an independent entity separate from the drug courts and treatment and RSS providers.

The assessment provider is responsible for determining a client's financial and clinical eligibility for ATR, completing a comprehensive assessment, and developing an individualized service plan tailored to the client's needs. The assessment instrument that is used is the Addiction Severity Index Lite and a modified Brief Psychiatric Rating Scale. Texas uses "Client Placement Guidelines" to determine the level of care. The assessment provider functions as a care coordinator, collecting GPRA data at intake and updating this information periodically for as long as the client remains in care. The care coordinator helps the client select appropriate service provider(s). Once a client has agreed to a service plan and chosen provider(s), the care coordinator uses the electronic VMS to

create a voucher that specifies the services to be obtained from a specific provider. The care coordinator then contacts the provider(s) to determine availability and finalize linkages between the client and provider(s). The care coordinator continues to monitor clients' progress and can modify vouchers as clients' needs change.

In order to participate as an ATR treatment or RSS provider, an organization must complete an online application at the Texas ATR Web site. The online application contains a description of ATR services, the qualifications required to provide those services, and the rates for each type of service. Providers must also submit a description of their program, the hours of operation, languages spoken, location, and any other pertinent information of use to prospective clients. This information is compiled into a brochure and presented to clients in order to facilitate informed choice. Throughout the year, DSHS quality management staff conducts onsite reviews with providers to review client records, provider billing practices, and use of the VMS.

Texas ATR initially faced a challenge in recruiting FBO to serve as RSS providers. Although providers were offering faith-based services, they did not self-identify as faith based. DSHS addressed this issue by offering personalized technical assistance to inform each provider about the process for declaring themselves faith based. By the end of 2006, 63 percent of all providers were FBOs.

VMS—Texas currently uses the Behavioral Health Integrated Provider System (BHIPS), a Web-based screening, assessment, voucher-issuing, clinical record, and billing system. BHIPS is used in conjunction with its contract management system SOURCE, and is highly dependent on this system. Although BHIPS was in place prior to ATR and was used by general treatment providers, ATR-specific modules, such as voucher and GPRA modules, were added to the system in order to meet the program's needs. Both BHIPS and SOURCE are owned by DSHS and were developed by the agency along with ATR staff. It took approximately 3 months to integrate the add-on modules with the existing BHIPS and the system became operational with the first client in June 2005.

BHIPS is a very comprehensive system that is used at all levels of service delivery by assessment providers, RSS providers, and treatment providers; however, each type of service provider has access to different screens within the system and uses it for different purposes. RSS and treatment providers use BHIPS primarily to develop treatment plans, track recover support notes, and file claims. Assessment providers use the system to conduct the initial assessment, collect GRPA data, complete consent forms, and generate electronic vouchers. BHIPS also contains a list of providers for each county and each type of service, along with a description of each service.

Vouchers created in BHIPS are entirely electronic and are linkable to all information about the client. Each voucher created in BHIPS lists the maximum units of service a client may access and has a cap of either $20,000 or 1 year of service, depending on which is reached first. Vouchers may be modified throughout the year or reissued at the end of the year with accompanying documentation in BHIPS. Vouchers are terminated automatically after 60 days of inactivity. A provider may notify DSHS immediately after serving a client in order to receive payment for the voucher.

Although BHIPS is freely available for use by other grantees, its dependency on its contract management system, SOURCE, impedes its portability. DSHS plans to replace the BHIPS system in December 2007 with Clinical Management Behavioral Health Services, a new VMS that will be used for both substance abuse and mental health programs. This new arrangement will lessen the dependency between BHIPS and its contract management system, thus increasing the systems portability and usefulness to other grantees.

Washington

Grantee—The ATR Grantee is the State of Washington. The Division of Alcohol and Substance Abuse (DASA) manages the implementation of the program. DASA resides in the Department of Social and Health Services (DSHS).

The State's ATR program was designed to target families with early involvement with child protective services, residents of supportive housing or shelters, clients in detoxification programs, and patients of low-income community and migrant health clinics residing in the most populated county in each of the State's six administrative regions. In other words, it focused on low-income individuals diagnosed as alcohol or other drug dependent who do not qualify for other publicly funded programs and who require recovery support services (RSS). These specific populations were targeted because they represent the subsets of people who were falling through the State's treatment gap.

Administrative Management System—The State of Washington has an established history working with the faith-based community in the provision of social services to needy individuals, including providing services to persons involved with drugs and alcohol. Prior to the ATR grant, the DASA certified and funded addiction treatment in 27 faith-based organizations (FBOs). The ATR grant allowed DASA to work with faith-based systems already serving persons using or abusing drugs or alcohol in the six counties designated for ATR funding, emphasizing that the ATR program as a community resource development effort.

The State phased in the ATR program over a period of several months in a total of six counties (Clark, King, Pierce, Snohomish, Spokane, and Yakima) representing the largest counties within each of the State's six regions. Shortly before the end of the 1st year of the ATR program, DASA received a significant amount of money, and DASA modified its approach to concentrate on providing RSS to ATR clients.

Washington State's approach to implementing the ATR program is to set up agreements with the counties in the State. Agreements were established with each county that articulate the roles and responsibilities of the county in implementing the program and includes meeting standard service, data, reporting, and fiscal requirements in accordance with the State's ATR grant submission to SAMHSA. Each county developed a service network that includes DASA-certified chemical dependency service providers and/or other appropriate providers using rates that are consistent with usual and customary rates for the service. The target population for the ATR funding is clients receiving other DSHS- or DASA-funded services. The county models are distinct but report outcomes to a statewide data system. They also meet regularly to share information. The strength of this system is local control focused on local priorities.

The State is involved with oversight and monitoring each of the counties. Each county submits a schedule of planned expenditures for the State fiscal year. Additionally, ATR program staff conducted regular site visits to monitor progress in the field. The ATR program director and program manager work extensively with counties to provide technical assistance as necessary.

The program emphasizes wraparound services. In terms of the array of services offered to clients, Washington State's emphasis on RSS has been strikingly apparent. The State is only one of two ATR grantees that offer 40 different options of RSS to its clients—these figures are the highest among all

grantees. Ninety eight percent of the enrolled providers in Washington's ATR network are RSS providers. The RSS that are most frequently used are housing, transportation, and case management.

Potential clients are identified at established portals in each county. The clients are screened for drug or alcohol abuse or dependence and motivation for recovery. They are then referred to a recovery support specialist. The recovery support specialist verifies that they meet the income guidelines and are motivated for recovery. They assign the client a voucher number and the client is referred to their choice of assessment provider. Once the client has an assessment and is determined eligible for ATR services, a recovery plan is developed by the client and the recovery support specialist.

Memorandums of understanding are used to establish a relationship with a provider that the county currently has a contract with for programs other than ATR. Provider or vendor agreements are used for all other service providers. A voucher is used in all counties for fee-for-service payment.

All treatment providers, including faith-based, are required by State law to be certified by DASA. Recovery support providers are required to meet any State certification or licensure requirements for their business scope or profession. This includes but is not limited to child care, physicians, and counselors.

Beyond the common difficulty of implementing the project on time, the State had difficulties that implementing the concepts of FBOs and RSS in the field were difficult because they lacked formal definitions. As a result, the State had to negotiate parameters of what constituted an FBO or RSS on an ongoing basis. Recruiting FBOs was a challenge as well.

The program emphasizes quality improvement based on results from ongoing client satisfaction surveys, treatment completion rates, employment outcomes, and stabilized housing outcomes. These data are compiled on a monthly basis and are distributed to each county as a performance management and evaluation tool.

Voucher Management System (VMS)—Washington State's VMS is the Treatment and Assessment Reports Generation Tool (TARGET) data system and is maintained by DASA. Washington appended additional modules to the State's pre-existing reporting system and added voucher management capabilities at the local level and administrative management capabilities at the State level. The current TARGET2000 system (revamped in 2000) is Web based and includes an expanded dataset that contains more than 450 separate data items on the demographics and service of each individual receiving publicly funded chemical dependency treatment in the State. The TARGET system is integrated into the DASA Substance Abuse Management Information System (SAMIS), which is an enterprise-wide relational database covering contracts management and provider certification.

The participating counties are charged with voucher management using the electronic reporting tools provided by DASA. Clients identified as needing services available through the ATR program are given either a virtual or a paper voucher for an assessment. If the client is determined to be in need of further treatment and/or RSS, a paper voucher will be issued at the county level for these continuing services.

The voucher numbering system is controlled at the State level through DASA's TARGET system. Each client is issued a voucher number, and all service vouchers issued to the client will use that centralized voucher number. Client-specific voucher data are accessible to the county issuing the voucher and DASA only; other counties cannot access information about clients not under their service management.

The recovery support specialist enters the recovery plan into the TARGET system. Funding is set aside to provide the client with the identified services. If services are added to or deleted from the recovery plan, the plan is updated as appropriate. TARGET will document every revision to the plan. Each county sets time limits on client participation in the program so that the program is not abused. A paper voucher using the master voucher number established through TARGET is issued to the client.

The State of Washington doesn't feel the current ATR VMS would be particularly useful to other recipient States without extensive redesign and support from DASA staff. DASA also feels that potential recipient States would have too many State-specific business rules to make a transfer feasible or cost effective.

Wisconsin

Grantee—The State of Wisconsin, Office of the Governor implements its Wisconsin Supports Everyone's Recovery Choice program (WIser Choice) in collaboration with the Department of Health and Family Services (DHFS), Wisconsin's Department of Corrections (DOC), the Milwaukee County Executive, Milwaukee County Behavioral Health Division (BHD), the Milwaukee Innercity Congregations Allied for Hope (MICAH), the Milwaukee Behavioral Health Providers Group (BHPG), the Wraparound Milwaukee Provider Network (WMPN), and the Southeastern Chapter of Sharing Treatment and Recovery (STAR). The DHFS, within the executive branch of State government and reporting to the Governor, holds primary responsibilities for the overall grant with the operational and managerial focus of the program in the BHD. The grantee initiated a Faith Advisory Council to advise on the ATR project and to assist with information dissemination, identification, and faith-based organization (FBO) enrollment. The ATR program also incorporates a liaison position to work with the faith community in implementing recovery support service (RSS) provision in the program.

The WIser Choice program provides funding to expand access to and enhance the quality of the continuum of care supporting recovery for Milwaukee County residents with substance use disorders. WIser Choice significantly enhanced an already existing voucher management system (VMS) in Milwaukee County and serves the general population 18 years and older with special emphasis on families with children and the criminal justice population. The criminal justice effort targets inmates who are reentering the Milwaukee community from prison and offenders on probation or parole supervision who are facing revocation proceedings and imprisonment and can be safely supervised in the community.

The program is based on a model that incorporates multiple central intake units (CIU) strategically located throughout the county. These CIUs perform client assessments and financial eligibility determinations. In addition to the geographically dispersed CIUs, the program also incorporates mobile assessors to provide intake to inmates prior to their re-entry into the community. Formal mechanisms are in place with DOC that facilitates the identification of Milwaukee residents leaving prison with substance abuse disorders.

Administrative Management System—The State of Wisconsin selected Milwaukee County BHD to serve as the contracted project management agency for WIser Choice. BHD develops and maintains all provider agreements with RSS, and has integrated the ATR resources and requirements within its entire substance abuse services delivery system.

BHD collaborates with the following organizations: DOC for recruiting clients; WIser Choice Faith Community Advisory Council, a 12-member council to recruit and support faith-based providers; Milwaukee Behavioral Health Providers Group, which educates providers and community regarding WIser Choice; Alliance for Recovery Advocates, a consumer recovery advocate association; Word of Hope Ministries, a prisoner re-entry initiative; Network for the Improvement of Addiction Treatment; and WIser Choice Executive Operations Committee, consisting of representatives from all sectors including non-traditional and RSS providers.

The WIser Choice program was implemented in two phases—the first a pilot before the second phase, full implementation, occurred. The ATR program released a request for applications (RFA) to potential providers of clinical treatment and RSS. The county uses the application process to ensure that participating providers have capacity to serve the referred voucher client in the pilot phase and,

during the second or full implementation phase, added a wait list management tool, ongoing capacity management activities, and utilization review. The program also uses existing licensing and certification requirements for recovery support providers and FBOs, and these are outlined in the RFA. The initial RFA contained stringent information technology requirements regarding billing, but when these requirements became a barrier to some potential RSS providers, they were soften and technical assistance was provided to help new providers meet the revised billing criteria.

Wisconsin uses a comprehensive screening and assessment tool combining Addictions Severity Index and other items (readiness to change items, placement decision items, mental health items, spiritual religious needs, culture-specific items) for both clinical and RSS. The level-of-care determination and tool used is the American Society of Addiction Medicine's (ASAM) Patient Placement Criteria, 2nd Edition.

Eligibility information is collected at the CIU and transmitted electronically to Milwaukee County Benefits Coordination Unit and to BHD where the information is verified and the necessary data and funding records are created.

The application form for providers wishing to participate in the WIser Choice program includes listings of both clinical and RSS services and rates the program is willing to pay for each service unit. If enrolled in recovery support coordination services, providers may charge BHD for each day that a client is enrolled, regardless of how much actual service is provided on a given day. Agencies are, however, expected to document the amount of direct service time (at quarter-hour intervals) provided to each client and report this data to BHD, but there is no connection to the amount billed. The unit of service for RSC provision is 1 day, with a reimbursement rate of $9.50 per client per day, with a maximum caseload of 20 clients. Individual, group and family counseling services are purchased as a package. A certain number of units are preauthorized and agencies are responsible for provision of a mix of these services at a level that is in agreement with the client's needs, as documented in the treatment plan.

The Recovery Team and the BHD Administrative Coordinator (AC) create a Single Coordinated Care Plan (SCCP) for each client. The BHD AC reviews the clinical assessment, ASAM results, and the SCCP for each client and provides authorization for services accordingly. The initial authorizations for treatment and RSS are automatically set to a standard number of units and durations, specific to each service, to allow the recovery team and the BHD AC to become familiar with the client's functioning. The SCCP is updated every 30 days or as needed and the number of units and duration of each authorized treatment or RSS is adjusted in response by the BHD AC.

The current information system now permits automated voucher authorizations and redemptions; has given BHD the ability to manage "burn rates" and other data in real time; has significantly enhanced reporting capabilities; and will soon create online billing, service capture, automated billing, and reimbursement processes. These changes have enabled WIser Choice to effectively and efficiently manage all of its service and financial resources. Project staff is able to access and provide timely, complete, and accurate data as required by SAMHSA and by WIser Choice, including the ability to accommodate SAMHSA's ATR reporting requirements.

Providers are required to report detailed service information to BHD at least once a week. The providers receive a billing report from BHD listing all services authorized for the previous week. These worksheets contain a list of each provider's clients and the authorized units for that client. Providers are required to record detailed service information on the worksheets and return them to BHD in order to receive payment. Providers may only provide and bill for those services that have

received prior authorization. Checks are cut each week to reimburse providers for services reported for the previous week. Failure to report all services within the prescribed timelines may result in nonpayment. Providers are paid on a fee-for-service basis.

VMS—In its earlier voucher program, Milwaukee had developed the Community Mental Health Center (CMHC) software that served the voucher system; this system became the basis for further development of the ATR VMS. The electronic voucher system has the ability to assign unique client identifiers, distinguish between new and existing clients, and provide a history of episodes of care. The VMS has both electronic and paper components. BHD staff enters the data on the manual Service Reporting Documents into the CMHC; this information is submitted by each provider at least weekly.

CIU workers use the VMS to collect and submit eligibility, screening, and level-of-care information to BHD in real time. They are also responsible for entering service authorization requests (electronic voucher) into the CMHC and printing (1) the client appointment record that is given to the client and (2) the provider feedback form that is faxed to the primary treatment provider and the Recovery Services Coordinator (RSC). The voucher is activated when (1) the primary treatment provider or RSC faxes the provider feedback form to the CIU and (2) CIU sets the status of the request to ready to process in the CMHC. Vouchers are updated when the RSCs receive and approve a service authorization request for continued stay or change in level of care.

Clients are discharged after the RSC conducts a fact-to-face interview with the client and completes and forwards the discharge form to staff to close the RSC episode and discharge the client (e.g., cancels voucher). Once a service is rendered, treatment providers fax the CIU to confirm that the client presented for and was admitted to services. The CIU then submits a payment authorization request for the CMHC VMS to process and pay the provider. The CMHC conducts scheduled nightly process updates of used and remaining units on authorized service records.

The VMS was developed by an external contractor for the Milwaukee County BHD in coordination with Milwaukee County staff. County staff maintains and operates the nonportable system.

Wyoming

Grantee—A 3-year ATR grant was awarded to the State of Wyoming in FY 2004. The State delegated the implementation and management responsibilities to the Wyoming Department of Health's Substance Abuse Division.

Wyoming calls the State's ATR program the Wyoming ATR program (WATR). The program targets 12- to 25-year-olds who have been adjudicated through the Wyoming Circuit Court System and their families as well as truant adolescents with substance abuse issues from the Natrona County School System. The program was exclusively implemented in Natrona County, which has the second highest need for clinical treatment services in the State and the second highest methamphetamine incidence in the State.

ATR Management System—The State of Wyoming's Mental Health and Substance Abuse Services Division (MHSASD) operates and manages WATR, which is implemented through the Wyoming Circuit Court system. It was originally known as the Substance Abuse Division, but toward the end of the grant, the division was merged with another division to create MHSASD. The program was originally intended to serve a statewide adolescent population, but following a reduction of the budget, the program was revised to serve juveniles in the juvenile justice system, residing in Natrona County (total population 88,000). However, it later expanded to include young adults because of a significant methamphetamine problem affecting this age group and their children, ages 8–12. Start-up was delayed to improve a fragmented juvenile service delivery system. Service delivery for the target WATR population would have been hampered without taking the necessary time to enhance the existing juvenile service system before beginning service delivery for the WATR.

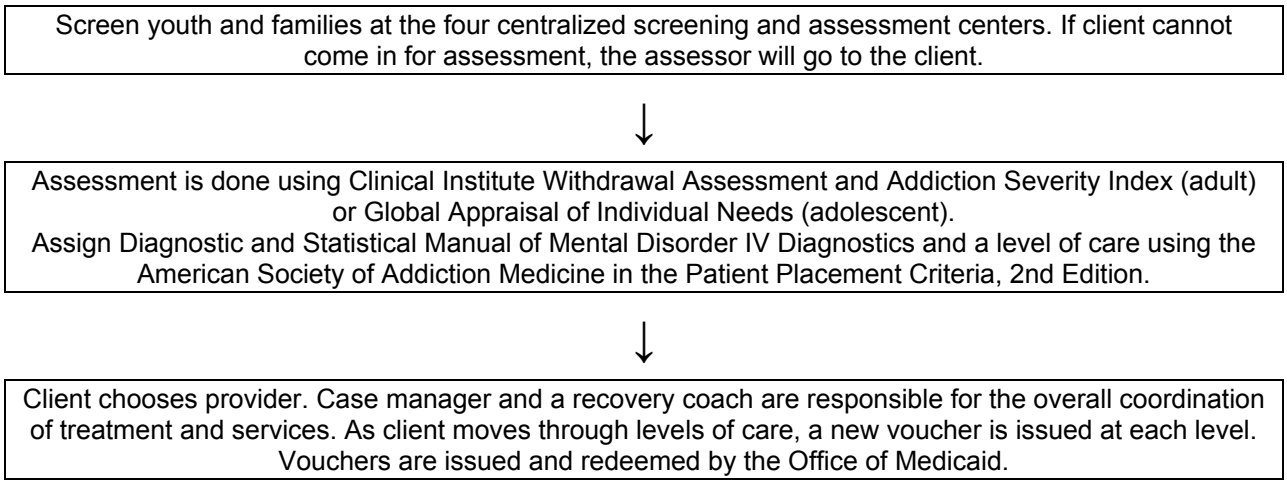
The Wyoming MHSASD has a credentialing process for clinical treatment and recovery support providers. Upon completion of a provider application, the application is processed within the State system for a period of up to 90 days. Following the successful completion of the application, the provider enters into a "business agreement" with the State. Standards for licensing treatment facilities were already in existence, and standards for credentialing recovery support providers have been developed. There are no specific standards for faith-based organizations (FBOs). An FBO would be required to apply as either a treatment or recovery support provider.

Service needs are funded through a voucher system where the youth and their families choose, from the WATR provider referral list, who they want to receive treatment and/or recovery support services (RSS) from. The WATR program generates treatment vouchers that are made available to the treatment providers and recovery support providers that have been chosen by the youth and their families. Once services are rendered the providers submit these service vouchers through the electronic voucher system where they will be redeemed from the ATR grant funds.

The WATR utilizes the Web Infrastructure for Treatment Services (WITS) Web-based system to manage its voucher management system (VMS). Clients presenting at the assessment center are screened. If the screener determines that an assessment is required, a full assessment is completed and the level of care is determined. The client is offered a choice of at least two clinical treatment providers. Once the client chooses the clinical treatment provider, the client signs an affidavit evidencing that the choice of clinical treatment providers was made without coercion. Needed recovery support services (RSS) that are identified during the assessment process are provided by the clinical treatment service provider chosen by the client. The assessment center also enters the voucher amount and the units of service authorized for clinical treatment services and RSS. When the

client presents for treatment, the provider checks WITS to determine the voucher amount and units of service authorized. Clinical treatment providers enter clinical service and RSS data into the WITS billing screen as services are provided. Wyoming uses a care coordinator model as a client advocate and to track the client's progress through his or her treatment care. The care coordinator will manage the client's progress and is involved throughout the client's episode of care. The process is outlined in the exhibit below.

Exhibit 1: Screening and Voucher Process



The lifetime of a WATR treatment voucher is 90 days. Providers can request an extension from the State. Vouchers are not issued for assessment. Vouchers can be cancelled if not used within 30 days of issue, if not used within 45 days after initial service, and when a client changes providers. If a client is assessed to need 30 days of clinical treatment and three different RSS, four vouchers would be issued to the client. The client would be counted as one admission. If a voucher is revised at a later date, the revised voucher is not counted separately from the initial voucher. State approval is required before central intake staff is able to update or cancel a treatment voucher.

WATR made a substantial impact on decreasing the wait time for obtaining services. Previously, it had been up to 5 weeks, but WATR modified the process and the average is approximately 3 days, with some juveniles receiving an assessment in approximately 4 hours.

The program has also had challenges. Unanticipated award reductions at the start of the program meant that Wyoming had to revise its scope. Initially, the program was to be implemented in five cities throughout the State but with the reductions, the State decided to target just Natrona County. Additionally, the program was designed to exclusively target adolescents but methamphetamine users tend to be slightly older so the program expanded the age eligibility criterion to include 12- to 25-year-olds.

In May 2006, the State changed its central intake unit in an effort to continue strengthening its collaborations and achieve its ATR goals and objectives. Overall, the program made unprecedented inroads with the following collaborative partners who quickly integrated into the ATR system:

- Municipal Court;
- County Circuit Court;

- Juvenile District Court (through the office of the District Attorney);
- the Natrona County School District;
- the Natrona County Correction Facility; and
- Corrections Corporations of America's Casper Facility.

Today the program focuses on a continuous quality improvement process with a particular emphasis on marketing and outreach to local communities. Although a full scale program evaluation has not been conducted, the WATR program does collect client outcomes data and conducts a client satisfaction survey to help assess the impact that ATR has had on its clients. The data show that the program is effective in increasing abstinence among its clients.

VMS—Using SAMHSA-sponsored technical assistance, the State built a unique electronic voucher system based on CSAT's WITS. For the first time, this voucher system effectively linked together all referral agencies and providers into one centralized structure. Implementation of the ATR program has permitted Wyoming to greatly expand the number of clients served, the number of enrolled providers, and the range of services supported by the voucher system. This system is hosted, maintained, and corrected by FEI.

Under WITS, providers enter service data into the system for services approved by the assessment center. Provider invoices are produced every 2 weeks. The fiscal and contract manager from the State reviews the invoices and manually enters them into the State accounting system. The State accounting system produces warrants twice a week.

Some problems occurred with WITS, particularly with errors and duplication. Federally required reporting information for month-end, quarterly, and grant renewal documentation was not available through WITS reports as of early 2006. Case management tools, such as client progress through the system, are unavailable. It has thus become necessary to develop parallel processing software to track these management statistics, while continuing to enter the same data into WITS for GPRA and screening data.

The VMS system is portable.