ATTACHMENT I: STATEMENT OF WORK

Section C : Description/Specifications/Work Statement

Independently and not as an agent of the Government, the Contractor shall furnish all the necessary services, qualified personnel, material, equipment, and facilities, not otherwise provided by the Government as needed to perform the Statement of Work below:

Background Information

A critical aspect of accountability in the Accountability, Capacity and Effectiveness (ACE**)** agenda of the Substance Abuse and Mental Health Services Administration (SAMHSA) is to provide leadership in evaluating the organization and financing of service systems for persons with mental illness and/or substance abuse problems. As States move toward the implementation of various performance based strategies that seek to optimize the value of provided services by monitoring their cost, utilization and outcomes, they have found that the knowledge base for estimating expenditures for various types of programs and services is essential. More generally, policymakers require good information on changes in the mental health and substance abuse treatment service system such as trends in the settings in which care is delivered, the types of services delivered by providers and the sources of financial support for that care. These types of information are important in assisting policymakers to assess the financial impact and other possible consequences of various policy options.

In support of these goals, Center for Substance Abuse Treatment (CSAT) and Center for Mental Health Services (CMHS) have developed and published estimates of national mental health and substance abuse (MH/SA) treatment expenditures, and provided other analyses of the costs and use of MH/SA services. These reports have received much attention and praise from the field and in the published literature, the National Institutes of Health (NIH), National Association of State Mental Health Program Directors (NASMHPD), National Association of State Alcohol Drug Abuse Directors (NASADAD), state MH/SA directors, financing experts and researchers. The primary purpose of this procurement is to continue this work. This will include, to the extent possible, the analysis of national databases on service use and cost for individuals with serious mental and substance use disorders.

The major report, SAMHSA's *National Expenditures for Mental Health Services and Substance Abuse Treatment* (also referred to as the Spending Estimates Project (SEP)), presents a broad overview of spending on mental health services and substance abuse (MH/SA) treatment. The SEP used data from 15 national sources to produce estimates; the report describes how MH/SA spending was distributed by payer, provider, and service type and how this spending has changed over time. The expenditure estimates are vital to informing national MH/SA health policy decision making and can help to determine policy direction for programs at SAMHSA

SAMHSA, and its component Centers, the Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT), were created by the ADAMHA Reorganization Act of 1992 and reauthorized by the Children's Health Act of 2000.

Among the authorities assigned to SAMHSA (42 V.S.C. 290aa) were the following:

- "...conduct and coordinate demonstration projects, evaluations, and service system assessments and activities necessary to improve the availability and quality of treatment, prevention and related services”

- "support activities that will improve the provision of treatment, prevention and related services, including the development of national mental health and substance abuse goals and model programs."

- In addition to these general authorities, CMHS must "conduct services-related assessments, including evaluations of the organization and financing of care [290bb, 31]".

- The Children's Mental Health Act of2000 "reauthorize(:d) programs within the jurisdiction of the Substance Abuse and Mental Health Services Administration to improve mental health and substance abuse services for children and adolescents".

This contract will produce expenditure estimates that parallel the information available in the National Health Accounts produced by the Centers for Medicare and Medicaid Services (CMS) and that will separate mental health and substance abuse spending by public and private payer categories, such as Medicare and State Government, and provider categories such as hospitals and nursing homes. Estimates will be made over at least ten-year periods, so that trends can be discerned. In addition, separate estimates for vulnerable segments of the population served, such as children and adolescents or other groups may be of interest, will be completed when possible. This procurement also will identify areas in which to focus future data collection efforts in order to improve future use and the estimates.

These statistics provide important information about characteristics and trends in a major component of the nation's economy. They are critical in informing discussions of federal and State policies affecting health care. Prior to the inception of the SAMHSA spending estimates project, most national estimates for MH/SA services either comes from one-time studies or *ad hoc* efforts, or are limited to only one segment of the industry (e.g., Medicaid-financed care). While there are projects that provide useful information for deriving such estimates, none provide a comprehensive picture of national MH/SA spending on an annual basis. For instance, the National Medical Expenditures Survey provides information about service utilization and spending by individuals, but does not provide a current, annualized, comprehensive picture of all national health care spending.

To address this problem, this contract continues the SAMHSA support to develop periodic estimates of past spending and projections of future expenditures of national MH/SA expenditures, which are consistent with those previously developed and disseminated by SAMHSA and with the National Health Accounts prepared by CMS. These estimates will be developed using the same methods as those used previously (with small improvements as these can be identified and approved), and disaggregated using

the same categories of payment source and service type as the estimates that are already developed for overall national health expenditures and the previous sets of MH/SA expenditure estimates disseminated by SAMHSA. It will also provide for separate estimates for mental health and substance abuse treatment services, and for estimates by payers and provider types. The estimates developed will be made comparable to the estimates.

The approach taken to estimate national MH/SA spending was designed to be consistent with the National Health Accounts (NHA). The NHA constitutes the framework for which the estimates of spending for all health care are constructed by CMS. The framework can be considered as a two-dimensional matrix; along one dimension are health care providers or products that constitute the U.S. health care industry; along the other dimension are sources of funds used to purchase this health care.

The Centers for Medicare and Medicaid Services has a long history, as well as substantial expertise, in estimating national spending. The estimates of MH/SA spending for non-MH/SA specialty facilities were carved out of estimates of total national health services and supplies expenditures developed by CMS. Separate estimates were developed from SAMHSA data for specialty MH/SA facilities. Duplicate expenditures between the two sectors were removed. Then, sector estimates were summed to obtain total national spending for mental health (MH), alcohol abuse (AA), illicit drug abuse (DA) and for total MH/SA in the U.S. from 1991 through 2001. Finally, MH/SA dollars were compared to all personal health care and government public health expenditures, which are referred to as national health care expenditures or all health expenditures. Table 1.1 summarizes the methods for estimating MH/SA expenditures for the MH/SA specialty facilities and other providers.

The public sector payer categories are: Medicare, Medicaid, State and local government sources other than Medicaid, and Federal sources other than Medicare and Medicaid (e.g., Veterans Affairs, Department of Defense, and Federal Block Grants). Medicaid expenditures represent combined Federal and State and local funds under the program. The private sources are: private insurance, out-of-pocket expenditures, and other private sources (e.g., philanthropy).

The provider categories are: specialty hospitals, general hospital specialty units, non-specialty care in general hospitals, psychiatrists, non-psychiatrist physicians, other non-physician professionals, multi-service mental health organizations, free-standing nursing homes, specialty substance abuse centers, home health, and retail prescription drugs. Although the definition has differed across SAMHSA surveys and across time, multi-service mental health organizations generally include any facility that provides a variety of MH services and that is not hospital-based. Similarly, specialty substance abuse centers are generally clinics and residential treatment centers that specialize in chemical dependency.

Expenditures by provider and payer were further divided into inpatient, outpatient, and residential care. In some cases, providers offered all three types of care. For example, hospital expenditures could comprise inpatient, outpatient, or residential services. Pharmaceutical (which includes retail pharmacy only) and home health expenditures

were classified as outpatient expenditures. Nursing home expenditures were classified as residential expenditures.

For estimating specialty institutional providers, SEP generally relies on SAMHSA studies of specialty MH/SA facilities. SAMHSA conducts censuses of facilities that treat mental or substance use disorders, through the Survey of Mental Health Organizations (SMHO, formally called the Inventory of Mental Health Organizations (IMHO)) and the National Survey of Substance Abuse Treatment Services (NSSATS, formally called the Uniform Facilities Data Set (UFDS)), respectively. Facility administrators answer these surveys and report data at the aggregate facility level (for example, total number of Medicaid clients or total revenues for clients treated for alcohol abuse).

Expenditures by provider and payer were further divided into inpatient, outpatient, and residential care. Increasingly, providers offer all three types of care. For example, hospital expenditures could comprise inpatient, outpatient, or residential services. Pharmaceutical (which includes retail pharmacy only) and home health expenditures were classified as outpatient expenditures. Nursing home expenditures were classified as residential expenditures.

For other providers, various data sources were used. These included administrative claims data and surveys that collect encounter-level or patient-level data. In some cases, these surveys often sample a first stage of providers and then a second stage of encounters between providers and patients. With characteristics on each encounter or patient, expenditures for specific diagnoses such as mental health, substance abuse, or all health care can be calculated. The following data sets were used in the most recent *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1991 – 2001:*

Table 1.2: Data Sources for the MH/SA Spending Estimates

Data Source	Use in Spending Estimates	Years Used
National Health Accounts (NHA)	• National health care expenditures by provider and payer.	1986–1997, 1998, 1999, 2000, 2001
National Hospital Discharge Survey (NHDS)	• Proportion of general hospital inpatient days devoted to MH/SA diagnoses.	1986–1997 , 1998, 1999, 2000, 2001
National Hospital Ambulatory Medical Care Survey (NHAMCS)	• Proportion of general hospital outpatient visits devoted to MH/SA diagnoses. • Proportion of emergency room visits devoted to MH/SA diagnoses. • Proportion of MH/SA drug mentions during visits to general hospital outpatient departments and emergency rooms for MH/SA.	1992–1997, 1998, 1999, 2000, 2001

National Ambulatory Medical Care Survey (NAMCS)	• Proportion of physician office visits devoted to MH/SA. • Proportion of MH/SA drug mentions during physician office visits.	1985, 1990–1997, 1998, 1999, 2000, 2001—office visits; 1985, 1992–1997, 1998, 1999, 2000. 2001—drugs
National Nursing Home Survey (NNHS)	• Proportion of nursing home residents with MH/SA diagnoses.	1985, 1995, 1997, 1999
National Home and Hospice Care Survey (NHHCS)	• Proportion of home health users with MH/SA diagnoses.	1994, 1996, 1998, 2000
MarketScan®	• Payment ratios for MH/SA and other disorders. • Proportion of physician bills for MH/SA by inpatient, outpatient, and emergency room care. • Proportion of other provider bills (e.g., psychia-trists and home health agencies) for MH/SA. • Average copayment amounts.	1995, 1996, 1997, 1998, 1999
IMS Health Inc. data	• To verify NAMCS, NHAMCS, and MEPS prescription drug estimates.	1994–1997
Medicaid drug rebate data	• To corroborate estimates from MEPS and MarketScan® for the ratio of MH/SA prescriptions to non-MH/SA drugs.	1994 and later
Healthcare Cost and Utilization Project, Nationwide Inpatient Sample (HCUP-NIS)	• Charge differential between MH/SA services and other health care services.	1988–2001
National Medical Expenditure Survey (NMES)	• Distribution of payments among multiple payers for services.	1987
Medical Expenditure Panel Survey (MEPS)	• Distribution of payments among multiple payers for services. • Basic data on spending for psychologists and counselors. • Size, frequency, and cost of refills of prescription drugs by class of drug.	1996–2000
Economic Census, Health Care and Social Assistance Sector	• Data on number of establishments and receipts for establishments based on the North American Industrial Classification System (NAICS) that now identifies several specialty MH/SA providers:	1997

	offices of physicians, mental health specialists, offices of mental health practitioners (except physicians), outpatient mental health and substance abuse centers, psychiatric and substance abuse hospitals, and residential mental health and substance abuse facilities.	
CMS Medicare and Medicaid Statistics (in published reports and special tabulations)	• Inpatient services provided by physicians by diagnosis group for Medicare patients. • Relative Medicare payments for physician services in offices, hospital outpatient departments, and emergency rooms. • Distribution of hospital-based nursing home, home health, and personal care agency payments out of total community hospital payments.	
Alcohol and Drug Services Study (ADSS)	• Expenditures in substance abuse specialty organizations.	1996
Inventory/Survey of Mental Healthcare Organizations (IMHO/SMHO)	• Expenditures in mental health specialty organizations.	1986, 1988, 1990, 1992, 1994, 1998
National Survey of Substance Abuse Treatment Services (NSSATS) / Uniform Facility Data Set (UFDS)	• Expenditures in substance abuse specialty organizations.	1987, 1990, 1991, 1993, 1995, 1996, 1998, 2000

Several complex methodological adjustments were made in developing national spending estimates from multiple and disparate data sets. Methods were devised for allocating spending by diagnosis for facility-level data where disease classifications differed across surveys. Missing total revenues from MH and SA facility surveys were imputed, data sources with small samples and high variance year-to-year were smoothed and incomplete survey response rates were adjusted. Missing years of survey data were extrapolated and projected to 2001 when necessary. The costs of health insurance administration for MH/SA coverage were estimated based on percentages from the NHA. Finally, an NHA-equivalent estimate was computed by eliminating a small proportion of expenditures for social services in order to compare MH/SA estimates to total national spending.

In summary, the work performed under this contract will require extensive experience and sophistication in the areas of actuarial analysis and economic estimation, specific detailed knowledge and understanding of the methods used by CMS to produce the National Health Accounts and technical issues related to these methods and the other source data, as well as familiarity with the provision and financing of mental health and substance abuse treatment. The contractor will be expected to produce estimates using the

methods previously developed, incorporate all relevant sources of statistics and information on health care and MH/SA spending, and that reflects state-of-the-art methodologies in economic estimation and modeling. The estimate shall be viewed as the best possible, and respected within the policy, actuarial, and economics communities.

In addition, the contractor must be familiar with the mental health and substance abuse treatment service system and sources of financial support for that system, as well as current trends and policy issues, so that the data can be developed and interpreted that is highly relevant to the mental health and substance abuse treatment fields and policymakers at the Federal, State and local level. This expertise is essential in proposing and developing special studies. The following summarized both expenditure and special studies published to date under the last five year SEP contract:

Coffey RM, Brady TM, Levit K. Framework for Identifying Gaps in Mental Health Data Needed to Understand Spending Trends. Deliverable under Contract 270-01-7088. Washington DC: Thomson Medstat, December 12, 2005.

Mark TL, Buck JA. Components of Spending for Medicaid Mental Health Services, 2001. *Psychiatric Services*. June 2005, 56(6): 648.

Mark TL, Coffey RM, Vandivort-Warren R, Harwood HJ, King EC, MH/SA Spending Estimates Team. U.S. Spending For Mental Health and Substance Abuse Treatment, 1991-2001. *Health Affairs*. 2005 Mar 29; [E-publication ahead of print].

Mark TL, Coffey RM, McKusick DR, Harwood H, King EC, Bouchery E, Genuardi JS, Vandivort R, Buck J, Dilonardo J. *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1991–2001*. DHHS Pub. No. SMA 05-3999, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

Mark TL, Coffey RM. Decline in Receipt of Substance Abuse Treatment by the Privately Insured, 1992-2001. *Health Affairs*, 2004 Nov-Dec;23(6):157-62.

King EC, Genuardi JS, McKusick DR, Bouchery E, Harwood HJ, Mark TL, Coffey RM. *National Estimates of Expenditures on Mental Health and Substance Abuse Treatment, 1991–2001*. Technical Report, Volume 1, Methods; Volume 2, Key Findings; submitted under SAMHSA Contract No. 270-01-7088, January 14, 2004.

Harwood HJ, King Ec, McKuscik Dr, Mark TL, Coffey RM, Dilonardo J, Chalk M, Buck JA, Genuardi J. National Spending on Mental Health and Substance Abuse Treatment by Age of Client. *Journal of Behavioral Health Services and Research* 30(4): 433-443, December 2003.

Mark TL, Buck JA, Coffey RM, Dilonardo JD. Medicaid Expenditures on Behavioral Health Care. *Psychiatric Services*, 54(2):188-94, February 2003.

Mark TL, Coffey RM. What Drove Trends in Private Insurance Spending on Mental Health and Substance Abuse Care, 1992-1999. *Health Affairs*. 22(10): 165-172, 2003.

Mark TL, Coffey RM, Dilonardo JD, Chalk M. Factors associated with the receipt of treatment following detoxification. *Journal of Substance Abuse Treatment*. 24(4):299-304, 2003.

Mark TL, Dilonardo JD, Chalk M, Coffey RM. *Substance Abuse Detoxification: Improvements Needed in Linkage to Treatment*. SAMHSA Publication No. SMA-02-3728. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, September 2002.

Mark TL, Dilonardo JD, Chalk M, Coffey RM. Trends in Detoxification Services: 1992-1997. *Journal of Substance Abuse Treatment*, 23(4):253-60, 2002.

McKusick DR, King EC, Mark TL, Coffey RM, Genuardi J. Trends in Mental Health Insurance Benefits and Out-of-Pocket Spending. *Journal of Mental Health Economics and Policy*. 5(2):1-8, 2002.

Mark TL, Coffey RM, Dilonardo JD, Chalk M. The Effect of Benefit Design on Receipt of Treatment Following Detoxification. Submitted to the *Journal of Substance Abuse Treatment*, December 2001.

The Spending Estimates Project requires specific technical capabilities and knowledge. The technical capabilities include: actuarial research and estimation, econometric techniques, projections and forecasting methods, ability to impute missing information, understanding of surveys and sampling methodologies, experience with a wide array of health data sources, detailed knowledge with the national health accounts, techniques for quality assurance, understanding of trend analysis, and sound judgment about data quality and usefulness. Technical capabilities also include a wide array of research techniques for special studies to improve the spending estimates and the ability to present technical materials in written and graphical form to non-technical audiences. In addition to these technical capabilities, policy expertise is necessary. Such knowledge must encompass a detailed understanding of mental health and substance abuse treatment services, spending, and financing; knowledge of federal and state policies related to MH/SA; as well as a broad understanding of the U.S. health care system and its trends in practice patterns, spending, and financing.

Objectives

CSAT /CMHS will award a one base year contract with 4 option years to produce estimates of past expenditures, projections on future spending and special reports of national expenditures on public and private mental health and substance abuse treatment services. The methodology used to develop the estimates and projections will be parallel to those used previously for SAMHSA under the Spending Estimates Project and to the extent possible to the overall national expenditures that are produced by the CMS, using the same categories of payment sources and service type. These require a diverse set of statistical and actuarial skills as well as understanding and skill in specialty and health national databases. The spending estimates will also capture and segregate any additional expenditure for mental health and substance abuse treatment that may not be included in the National Health Accounts. Mental health services and substance abuse treatment estimates include spending in both the specialty sector as well as in the general health sector. It would also provide for separate estimates for mental health and substance abuse services, and for desegregation of major service type spending estimates.

If all option years are exercised, this project will provide:

1. Three sets of estimates of national expenditures for mental health and substance abuse (MH/SA) services over at least a 10 year period, the first set to begin in the first contract year;
2. In the intervening years, two sets of projections will estimate mental health and substance abuse spending for a 10 year period beyond the year of the most recent national expenditures report.
3. In each year special reports will explore underlying factors, additional data sources and other special analyses related to the spending estimates and projections.
4. Each year, quarterly literature summaries of recent articles pertinent to the spending, utilization and other systems affecting costs (i.e. managed care) will be provided.

To carry out this project the contractor shall accomplish the following:

A) Update an existing literature review of relevant studies and sources of data;

B) Propose and implement a methodology for making such estimates and projections that provides for continuity and consistency with previous sets of MH/SA estimates disseminated by SAMHSA. Evaluate reports and make recommendations prior to the next round of estimates or projections for improvements in the methodology that has been previously developed, mindful of the central importance of continuity of methods for comparability. In addition to what has been included in the previous studies, at a minimum, the contractor will be expected to propose revisions to the methods so that they can be disaggregated into inpatient, outpatient and residential care, that the availability of new data sources and possible refinements to the out-of-pocket estimates are addressed, in addition to other methods improvements. The contractor shall also propose other additions to the estimates which will enhance their utility relative to public health policy.

C) Develop estimates for at least a ten-year period of national MH/SA spending that parallel the previous sets of MH/SA estimates undertaken by SAMHSA and are consistent with estimates of general health care spending produced by the CMS. This includes utilization of the same categories of payment and service type that are employed in the general CMS Health Accounts estimates. In addition, estimates for these categories should be further disaggregated by the type of MH/SA service and diagnosis (i.e., MH/SA, MH, SA, Alcohol and Drug Treatment).

D) Develop projections of future MH/SA spending across a 10 year period. Like the national expenditure reports, each set of project reports will be evaluated and recommendations made prior to the next round for improvements in the methodology that has been previously developed to produce such estimates mindful of the central importance of continuity of the project estimates. Forecasting methods available should be assessed for usefulness and blended, if this would provide the best projections. As the total time period of past estimates lengthens, increasingly sophisticated methods should be possible.

E) Prepare a variety of special reports integrating financing concerns of the current mental health and substance abuse treatment literature and trends, highlighting policy relevant findings. These special reports will explore cost, service utilization, special populations or other trends to further refine the spending estimates and to explore the factors that affect the trends in spending.

Deliverables

Unless otherwise noted, deliverables will be submitted in both hard copy and electronically as a Word or PDF document, as requested. Electronic copies of deliverables which are prepared for wide dissemination, such as the national expenditures report, will also be required to be delivered in language which allows them to be uploaded to the SAMHSA Web Site and must be compliant with handicap accommodations.

General Requirements:

OWNERS OF MATERIALS: All information and materials including data developed under this contract are the property of the government and shall be delivered as part of the appropriate deliverables listed below. No information developed under this contract shall be released by the contractor without the written permission of the government.

SAMHSA/DMS-IT GUIDELINES: The Contractor shall use software that meets SAMHSA Guidelines. Specifically, the system(s) must be PC compatible, operate in a Windows environment, and use Microsoft Office Suit (Word; Excel; PowerPoint; and Access), PowerBuilder or other software consistent with SAMHSA/DMS-IT standards. The Contractor shall at all times maintain compliance with current DMS-IT standards, which may change over the duration of this contract. Any deviance from the SAMHSA standards should be negotiated with DMS-IT prior to contract award.

IT PROPOSED RESOURCES: The Offeror must submit, in addition to the IT Total Estimate Worksheet, a budget and a narrative for each of the IT resources proposed and an IT Technical Approach for accomplishing the tasks described in the SOW.

ADHERENCE TO SAMHSA INTERNET/WEB POLICY: The Contractor shall follow all SAMHSA Internet/Web Site Policy. Any development and production of Internet/Web applications, including Intranets and Extranets shall comply with SAMHSA policy and procedures. These policies and procedures cover web sites, web page linkages, and web development; and agency programmatic, concept, and technical clearances. All new contracts/task orders or modifications to existing contracts/task orders involving Internet/Web sites will require Programmatic and Concept Clearance from the Office of Communications and ADP/IT Clearance from the Division of Management Systems-Information Technology Team (DMS-IT). The SAMHSA Web Site is the only authorized web site. No new web sites will be created without prior written approval of the project officer, in collaboration with appropriate Agency website officials. Any new web sites created by the Contractor will become part of the SAMHSA Web Site. Applications development may be accomplished on the Contractor's server. Productions versions must reside on the SAMHSA/DMS-IT server.

SECTION 508 COMPLIANCE: Section 508 of the Rehabilitation Act, requires agencies and their contractors to buy Electronic and Information Technology (EIT) that is accessible to people with disabilities.

On June 25, 2001, accessibility requirements for Federal Electronic and Information Technology took effect under Section 508 of the Rehabilitation Act. This law requires that such technology be accessible according to standards developed by the Access Board, which are now part of the Federal government's procurement regulations (Ref. to the Section 508 Federal Acquisition Regulations (FAR) Final Rule published on April, 2001 in the Federal Register).

These standards, as issued by the Board, cover a variety of products, including computer hardware and software, websites, phone systems, fax machines, copiers, and similar technologies. Provisions in the standards spell out what makes these products accessible to people with disabilities, including those with vision, hearing, and mobility impairments. The Board included both technical criteria specific to various types of technologies and performance-based requirements, which focus on a product's functional capabilities.

The law relies strongly on the procurement process to ensure compliance with the new standards. Compliance with the standards is required except where it would pose an "undue burden" (as defined in the standards) or where no complying product is commercially available.

To be considered eligible for award, offerors must proposed goods and/or services that meet the applicable provisions of the Access Board's standards as identified by the agency. Alternatively, offerors may propose goods or services that provide equivalent facilitation. Such offers will be considered to have met the provisions of the Access Board's standards for the feature or component providing equivalent facilitation.

SAMHSA'S WEBSITE PRIVACY POLICY: Each page of the Website, including the front or home page, must include a link to SAMHSA's Website Privacy Policy (found at http://www.SAMHSA.gov/about/content/privacy.htm). DHHS and SAMHSA policy does not allow for persistent cookies on any SAMHSA or SAMHSA funded websites. In addition, any forms on the site which will ask users to enter personal information must first be approved through SAMHSA channels.

Specific Tasks

Task 1: Developing Plan of Performance with Team Integration Plan

a) Not later than 2 weeks after the effective date of the contract (EDOC), the contractor shall meet to discuss the proposed contract work plan addressing the contract projects, clarify any procedural issues related to the Statement of Work, and provide any clarification deemed necessary.

b) Based on the discussion at this meeting, the contractor shall prepare a revised plan of performance reflecting any revisions deemed necessary by the GPO. At a minimum, the work plan will describe approach, lead staff and deadlines for each task. The revised work plan should be submitted not later than 2 weeks after the meeting with the GPO.

c) The plan of performance may be revised by consent of the GPO as the contract proceeds. A draft and final plan of performance shall be prepared by the contractor at the initiation of the option period.

d) Team Integration Plan: Because the spending estimates and projections require a diverse set of statistical and actuarial skills as well as understanding and skill in specialty and health national databases, it is expected that a number of technical experts from widely divergent fields may be required to accomplish this work. The contractor shall propose the methods by which the participating members will be able to work and make contributions to the overall project as team members. It is recognized that each team member may have a highly specialized role to play in the accomplishment of this work. However, it is essential that all team members understand each others role the methodology of these estimates, so that each can answer basic or overall questions about the estimates and their development without regard to each individual's area of responsibility. Such a team approach which includes team members each assuming responsibility for the end product will produce the best product.

i) The contractor shall be required to propose, in writing as part of the work plan, how the project will be managed to maximize teamwork.

ii) This report should be delivered no later than 10 weeks following EDOC and will be finalized after receipt of comments by the GPO.

iii) Implement the team integration plan: Upon approval of the team integration plan by the GPO, the contractor shall implement the plan and include

activities under this heading in each monthly progress report.

Task 2: Establish Expert Panel and Convene at Least Annual Panel Meetings

a) Not later than 8 weeks following the EDOC, the contractor shall provide the GPO with proposed representatives for the expert panel and a proposed agenda and meeting date for the first meeting. Upon review of panel members and review and approval by the GPO, the contractor shall prepare letters of invitation to the prospective panel members, soliciting their involvement and providing information about the proposed schedule of work and subsequent meetings.

b) The proposed panel will include representatives from NIDA, NIAAA, NIMH and CMS, ONDCP, State mental health and substance abuse program and financial offices, NASADAD and NASMHPD, actuarial firms, national experts in mental health and substance abuse treatment economics, as well as mental health and substance abuse treatment providers and policymakers. The group shall not exceed 12 non-federal participants in number

c) Throughout the life of the contract, the panel shall serve in an advisory capacity to the contractor and review and provide comment on all major reports which will be derived from the work accomplished under the contract. For each technical expert panel meeting, the contractor shall schedule, arrange and facilitate all aspects of the meetings of the technical expert panel.

   i) The contractor shall plan at least one meetings of the group per contract year, in the Washington, D.C. area. The first meeting shall be held no later than 24 weeks of EDOC.

   ii) The contractor shall arrange and pay for travel, per diem, and honoraria (up to $400 per day) for each of the non-Federal panel members. Panel members may be proposed at a rate higher than $400 per day, but information justifying the rate must be included and permission for the higher rate received from the contracting officer prior to negotiations with prospective panel members. Requests for such exceptions should be submitted to the contracting officer at least 30 days in advance of the need for the consultant.

   iii) The technical expert meetings shall be held in the Washington, D.C. metropolitan area and shall be one to no more than two days in duration.

   iv) The contractor shall assume primary responsibility for confirming that all participants are paid in a timely manner, but no later than 30 days after submission of necessary materials. The contractor shall follow-up with panel members and provides whatever assistance necessary for submission of their materials for payment. The contractor shall notify the GPO of any participant who has not been paid within 60 days after the event, regardless of the reason.

   v) A proposed agenda for each meeting shall be submitted to the GPO no later than 6 weeks prior to the meeting. The contractor will prepare written and

visual materials for the meeting. These shall be identified with the SAMHSA logos rather than any corporate identifiers.

vi) All meeting materials shall be submitted to the GPO for review at least two weeks prior to the meeting and all materials must be approved by the GPO prior to sending out or sharing at the meeting with the technical experts.

Task 3: Recruitment of and Utilization of Individual Consultants

a) During the course of the expenditures and projections work, expert advice is needed on highly specialized topics relating to these estimates. Although it is not possible to specify all of the types of specialized consultation that may be necessary during the course of the contract, it is likely that specialized consultation and assistance will be required. These consultants will be engaged for a specific review of proposed description of the methods and/or other specialized technical consultation related to contract deliverables. The exact amount of days of consultation that will be required each year cannot be determined in advance, but the contractor should budget for 8 technical consultants at 3 days per consultation in each contract year.

b) Specific Technical Review Consultants: Persons with specialized expertise relevant to the work of the contract shall be utilized as consultants to provide methodological and other technical consultation required specific to methods used in estimates and projects: examples include the use of certain methods to maintain the consistency of the new estimates or projections with previous estimates or projections, the use of appropriate price indices for various components of expenditures, sources of proxy estimates for out of pocket expenditures for persons who have exhausted their insurance benefits, selection of most appropriate trim points, the use of regression models in the estimation process and review of different methods in forecasting methods for the projecting of MH/SA spending.

c) The contractor shall advise the GPO of the need for such consultation and provide suggested experts for GPO approval of persons who can serve to meet such needs.

i) Some consultants will work independently and provide written comments to the contractor.

ii) Other issues (especially highly complex methodological concerns) may require a group of consultants to work together or to review the suggestions proposed. Such a review will usually take place by conference call, after preparation of documentation by the contractor of particular methods issues and alternatives for resolution and review by the technical experts.

d) Generally, telephone will be used for consultation with one or more of these individual experts over the course of each round of estimation. Occasionally, the consultants may need to have face to face meetings, and should annually involve travel costs of to a meeting of no more than 1 day for no more than a total of 3

consultants (excluding the attendance of contractor staff and federal employees).

e) For these members proposed and approved by the GPO, the contractor shall solicit their involvement and providing information about the proposed schedule of work and intermittent or product specific review of issues as they arise.

f) Upon approval by the GPO, the contractor shall make contractual arrangements for the services of such consultants and provide financial support for such services. In general the rate for such consultants will be $400 per day, except in unusual circumstances, subject to the approval of the contracting officer. Requests for such exceptions should be submitted to the contracting officer at least 30 days in advance of the need for the consultant

Task 4: IT MIS Plan and IT Security Plan

a) **IT MIS Plan:** The Contractor shall prepare an IT Plan that will include the Design, Development, Implementation, and Maintenance for all IT Applications. The IT Plan should include functional requirements (e.g., data, workloads, user interface, reliability, security, and maintenance), technical requirements (e.g., hardware, software, and telecommunications) and operational and other requirements. It should also include major IT milestones and implementation dates of the project. The draft and final IT Plan will be submitted as a deliverable to the Government Project Officer (GPO) and the Division of Management Systems-Information Technology Team (DMS-IT) for review and approval.

b) **IT Security Plan:** In compliance with SAMHSA POLICY DIRM 02-01—Establishment of the SAMHSA Automated Information Security Program (AISP), the Contractor shall prepare an IT Security Plan that will include a control process to ensure that appropriate administrative, physical and technical safeguards are incorporated to all new IT Applications and significant modifications. The Contractor shall comply with the IT Application (s) security requirements needed for the Project as set forth in the SOW and applicable portions of the DHHS Automated Information Systems Security Program (AISSP) Handbook. The Contractor further agrees to include this provision in any subcontract awarded pursuant to the prime contract. The draft and final IT Security Plan will be submitted as a deliverable to the Government Project Officer (GPO) and the Division of Management Systems-Information Technology Team (DMS-IT) for review and approval.

c) The draft IT MIS Plan and the draft IT Security Plan will be submitted as a deliverable at 8 weeks EDOC to the Government Project Officer (GPO) and the Division of Management Systems-Information Technology Team (DMS-IT) for review and approval.

d) The contractor shall implement the IT MIS Plan and the IT Security Plan as specified no later than 4 weeks after approval of the plans by Government Project Officer (GPO) and the Division of Management Systems-Information Technology Team (DMS-IT).

Task 5: Monthly Contract Progress Reports and Other Regular Communications

a) Four weeks after the effective date of award and no later than 15 working days following the end of each month during the project period, the contractor shall submit to the GPO one copy of the monthly report.

b) The monthly report shall summarize the progress to date on project tasks and describe any problems encountered and recommendations or actions taken by the contractor to resolve such problems. It shall report on the actual and planned budget for that year, addressing significant deviations and justifying any adjustments needed. The report shall not exceed 8 pages in length. One copy of the monthly progress report shall be submitted concurrently to the Contracting Officer.

c) The contractor will regularly have conference calls with the GPO to discuss the status of work in progress and solicit guidance on products under development. These will usually be convened at least every two weeks unless specifically delayed with the approval of the GPO.

Task 6: Ongoing Literature Review

a) The contractor shall also be required to establish and maintain an ongoing review of the literature about utilization of and financing for mental health and substance abuse treatment services that is pertinent to the work under this contract.

b) This listing of pertinent literature will be reported quarterly and will be organized by keyword or by sections related to key relevance to the mental health and substance abuse economic and policy issues. Examples of organizing sections would be articles on costs (cost benefits, cost effectiveness, per episode, etc), service utilization, managed care or payer studies, benefits design. A plan for the organization will be submitted to the GPO within 8 weeks EDOC for approval by the GPO.

c) Every three months from the effective date of the contract (EDOC), the contractor will provide an annotated bibliography of new sources identified to the GPO and to all members of the study team; and shall make the full text of the materials available to the GPO upon request.

d) The contractor shall submit for approval of the GPO a plan to conduct ongoing literature review and a format for summarizing the information quarterly and over the life of the contract.

Task 7: Special Reports and Products

a) The contractor shall prepare additional reports and products related to the exploring underlying factor in cost or utilization affecting the national expenditure or projection finding in the work performed under the contract. The special reports will aid the project in identifying factors that may be driving expenditures; examples include cost factors contributing to spending escalations for prescription

drug spending, changing provider service patterns affecting utilization and access, analysis of factors increasing MH/SA care in non-specialty settings, analysis of private insurance benefits or managed care practice to identify factors in declining spending for substance abuse treatment services, analysis of specialty provider data bases to identify MH/SA the range of treatment services and types of clients.

b) The special reports are anticipated to account for about 25% to 30% of the total effort under each contract year.

c) Although it is not possible to specify these topics in advance, it is expected that such reports shall include preparation of articles for academic and health policy journals, monographs on various technical topics related to improvement of the methods used to develop such estimates, reports of findings for non-technical audiences and reports of a nature that will be internal to SAMHSA only.

d) The reports may be either simple or complex.
   i) Simple reports will not involve the analyses of additional data but may require synthesis and comparison of data from the spending estimates project with other published data or literature. Examples of topics that would represent simple reports include papers with the following foci: synthesis of national expenditure reports to break out the estimated age distribution of the MH/SA spending; analysis of provider types by a particular payer, such as Medicaid expenditures for mental health and substance abuse treatment; alternative methods to estimate non-traditional community based utilization of mental health and substance abuse treatment services; identification of national data bases available to estimate cost and utilization of a special population.
   ii) Complex reports will usually involve additional data analyses of project or other data, to explore factors underlying findings or verifying the trends seen in the estimates project and other sources. An example of a complex report would be analyses of type of MH/SA service utilization in general hospitals in the Health care Utilization Project (HCUP), analysis of MH/SA benefits in employer sponsored health care as reported in the Kaiser Family Foundation annual employer survey; analysis of data from the NSATTS data base of specialty substance abuse providers to determine differences in facilities with reported care to adolescents as versus specialty providers not reporting care of adolescents.

e) The contractor will propose topics after discussion with the GPO, with estimated cost by topic, but the final determination will be made by the GPO. It is expected to represent a mix of complex and simple reports as determined by discussions with the GPO.

f) Individual schedules of the work for each report shall be developed and include the development and submission of a short proposal, work plan, draft and final outlines and draft and final reports. As required, these special studies may be performed by those outside the SEP team under a subcontract agreement. Especially in subcontracted work, interim deliverables will be specified to increase accountability and assure the timely delivery of the final product.

g) At the beginning of each contract year, a review of special studies and a mapping of the plans for each special study will be made.

h) A report of progress on special studies will be included in each monthly report, as well as the resources used.

Tasks 8 through 14

The contractor will be expected to produce estimates of either a set of 10 year past national expenditures or forecasted projections each year, with the first year producing the national expenditures report. If all option years are exercised, the contractor will be expected in the total contract time to produce three full sets of past estimates and two sets of projections under this contract.

Whether for the spending estimates or the spending projections, each round of either national expenditures or of projections will include the following major tasks:

i) literature review pertinent to methods
ii) proposing an improved methodology
iii) preparation of the 10 year estimates or projections
iv) technical report with detailed tables which decompose spending for each payer and provider.
v) preparation of the general report with specialized chapters breaking out spending and trends into mental health and substance abuse, treating them separately
vi) preparation of a journal article
vii) preparation of materials for briefings, presentations and press conferences, as well as participating in briefings and other presentations of the materials at the GPO's request.

The following outlines these tasks in more detail.

<u>Task 8:</u> Proposed Methodology Report for Next Round

a) At the beginning of each contract year, the contractor shall submit a proposed methodology report on either the national expenditures or the projections that includes:
   i) a review of the literature,
   ii) a review of new or changed data bases used in estimations
   iii) a proposed methodology for the next round of either national expenditures or projections.

b) The methods report will summarize the applicable literature of identified program statistics, published and unpublished studies, and estimation methodologies which may bear on the estimation and projection of spending of mental health and substance abuse expenditures.

c) The report will also include an inventory of existing data sets and applications and recommendations for data and statistical sources to be used in this project with justifications for their selection. Each update shall address new or changed data sources, deficiencies and limitations in the data sources, methods, or studies used

as the basis for previous sets of estimates produced by the project. In the event that the anticipated available and necessary data are not available to support the production of a revised set of estimates in either the base or option periods, the contractor shall propose to the GPO modified, alternative, or partial sets of estimates and related products, which could be produced in lieu of a full round of MH/SA treatment expenditure estimation.

d) The contractor shall submit a proposed methodology for either the national expenditures report or the forecasting projections report. This methodology report for the national expenditures report should include a discussion about:
   i) how the use of such methods will insure consistency with previous rounds of estimation,
   ii) the availability of relevant new or alternative data sources or
   iii) the availability of new methodological approaches including the effect of any changes in the methods of CMS Health accounts
   iv) the feasibility of disaggregating general categories of estimates by type of MH/SA service, including at a minimum, inpatient, residential and outpatient care;
   v) imputations and trim points for data sets included in the estimation process,
   vi) price indices to be applied and methods for estimating data for missing years.
   vii) other types of desegregation may be desirable so that important trends in the mental health and substance abuse field can be addressed. For example, it might be feasible and desirable to examine partial hospitalization or outpatient detoxification in more detail.
   viii) The contractor will propose additional disaggregations or improvements to the methods that are feasible and relevant to policy issues in the field of mental health and substance abuse treatment. Disaggregation by major type of diagnosis/problem will also be included and at a minimum, substance abuse will be disaggregated into treatment for alcohol problems and drug treatment. These sub-categories will be determined in advance in consultation with the GPO.
   ix) Other issues to be addressed will be determined by collaboration with the GPO, after consultation with the advisory panel and technical experts.

e) The methodology report for the projections of future MH/SA spending should include a discussion about:
   i) how the use of such methods will insure consistency with previous rounds of estimation, including the effect of any methodological changes in the CMS Health accounts
   ii) the availability of relevant new data sources or new methodological approaches; or when the cumulative data is sufficient to permit more sophisticated methods
   iii) review of possible methods for projections, noting strengths and drawbacks
   iv) The contractor will propose additional disaggregations or improvements to the methods that are feasible and relevant to policy issues in the field of mental health and substance abuse treatment. Disaggregation by major type of diagnosis/problem will also be included and at a minimum, substance abuse will be disaggregated into treatment for alcohol problems and drug treatment.
   v) The contractor will propose additional refinements or improvements to the methods that are feasible and relevant to policy issues in the field of mental

health and substance abuse treatment

vi) Other issues to be addressed will be determined by collaboration with the GPO, after consultation with the advisory panel and technical experts.

f) It is expected that refinements or improvements can be made each round. The methodology proposed shall contain sufficient detail, that they could be replicated. With significant methodological changes, it is likely that changes to proposed methods be reviewed by the special consultants (Task 4) and/or the technical advisory panel (Task 3) prior to significant work beginning.

g) To ensure continuity and consistency of the SAMHSA spending estimates of MH/SA, if new vendor(s) win the contract award, the contractor shall coordinate an orderly transition for the work. In the first review of methods report, the contractor shall be sure and address the following:

i) Conduct a detailed review of the methods used and products delivered under the first contract for both the 10 year spending estimates and for projections of future spending.

ii) Prepare a transition plan which identifies the major challenges to continuity and consistency of the estimates and strategies and activities the contractor proposes to overcome the identified challenges.

iii) The activities proposed by the contractor in the transition plan shall include the identification of some specific mechanism to gain information and review of the methods and results by those who were previously involved in performing the work. It is expected that such activities will be required over the early period of the contract as the first set of estimates is produced.

<u>Task 9:</u> Preparation of Technical Findings Report for Round Estimates or Round Projections:

a) No later than 24 weeks after EDOC, (or after exercise of option) the contractor shall develop the first set of draft estimates or projections using the methodology approved by the GPO and submit a draft technical findings report The estimates and projections will include a detailed set of tables that will provide:
   i) Spending estimates or projections on major public and private payers of mental health and substance abuse expenditures,
   ii) Estimates or projections over at least a 10 year period with comparisons to expenditures for all health
   iii) With combined as well as separate expenditures or projections for mental health and substance abuse,
   iv) With substance abuse estimates or projections separated into spending for alcohol treatment and for drug treatment
   v) Estimates or projections of MH/SA treatment spending in both specialty providers and general health providers
   vi) In addition, these estimates or projections shall include detailed information on each provider type, including estimates of each provider type by payer and trends in these expenditures over the ten-year period.

b) Estimates shall be for the most recent federal fiscal year for which data or statistics are reasonably complete and accurate, and for which national health expenditures estimates are available. Estimates must be internally consistent and consistent with national health expenditures for the year estimated.

c) The technical report will be organized to include the following:
   i) An executive summary of important or unusual findings
   ii) A complete set of tables by payer and by provider over time period for MH/SA, MH and SA.
   iii) Detailed comparison of the newest spending estimates to previous estimates, with any significant discrepancies explained.
   iv) Detailed methods shall be included in an Appendices to Volume 1
   v) If requested by the GPO, the contractor will provide all tables, algorithms or calculations used in the development of the estimates included.

d) After review and comment by the GPO and the advisory panel, the contractor will revise the technical report based on those comments received and prepare a second and final technical report no later than 28 weeks after EDOC (or after exercise of option). The report may require additional revisions after review and comment by the GPO. The contractor shall also summarize how major themes in the comments were addressed.

Task 10: Preparation of the Draft General Report and Draft Journal Article, each Expenditure or Projection Round

a) After the technical report is approved, the contractor will develop a general SAMHSA report and a journal article covering MH/SA, MH and SA whether it is the national expenditures study or the projections study.

b) The general report of either estimated national expenditures or projections for general distribution will present MH/SA spending which is:

   i) An expenditures study of about 60 pages or a projections study of about 40 pages, not including references and tables,
   ii) It shall be written in everyday language so that persons without technical expertise can understand the methods, findings and implications.
   iii) Graphics and illustrations shall be used to facilitate comprehension and numeric tables shall for the most part only be utilized in the Appendices. Media consultation may be required for a high level of graphic display.
   iv) This report will also contain a two-page executive summary which communicates the most salient and policy relevant findings to the audience.
   v) Prepared both for publication by SAMHSA as well as for posting on the SAMHSA web site

c) The contractor will also use this round of findings to prepare a journal article prepared for submission to a peer review professional journal.

   i) It will address both mental health and substance abuse treatment expenditures

but the specific focus of the paper may change in different rounds.

ii) Prior to the development of the article, the contractor will discuss the approach and focus for an article with the GPO and receive approval prior to writing it.

iii) This report shall be in language and format appropriate to publication in a selected journal.

iv) The contractor may make recommendations about which journal this paper shall be submitted to, but the selection will be made by the GPO.

Task 11: Preparation of the Final General Report of Either National Expenditures or Projections and Related Final Journal Article

a) After review and comment by the GPO and the advisory panel, the contractor will revise each report based on comments received and prepare a final version of each report.

b) Each report may require additional revisions as it goes through the clearance process.

c) The contractor will deliver the final report both in hard copy and on disc and will also complete all of the information or meet other requirements for preparation and printing of the report by the GPO.

d) The contractor shall also prepare the report in the web format specified by DMS-IT, so that reports report can be loaded onto the SAMHSA web site.

Task 12: Preparation of Supporting Materials for Briefings and Giving Presentations

a) For each round of estimation and for each report, the contractor will submit in separate electronic files (in PowerPoint) the graphics prepared for the reports, as well as any additional graphics needed for presentations on the findings of the study, as determined by the GPO.

b) In addition, the contractor will prepare and provide whatever artwork, posters, audiovisuals, handouts, or other supporting materials necessary for briefings and press conferences such as posters, as requested.

c) At the request of the GPO, the contractor shall also make staff available to assist with briefings. The number of briefings to be held will not exceed 10 over the period of the contract, and are most likely to occur, following the completion of each round of estimates.

d) All audiovisual materials used throughout the project shall be identified with SAMHSA logos and shall not be identified with firm logo. The affiliation of various authors will be addressed once only, in a way approved by the GPO.

e) At the request of the GPO, the contractor shall brief SAMHSA staff and advisory councils/constituencies, on the key findings from the project. Most frequently,

this will require a number of separate briefings, numbering up to four per year.

f) These briefings routinely will take place in the Washington, DC area and typically are held within government space. The briefings will last no more than 2 hours and the contractor will be expected to provide for all requirements, as well as appropriate handouts for each briefing.

g) The contractor, at the request of the GPO will schedule, facilitate, and arrange such briefings. In general, each briefing would be conducted by one person. These briefings are in additions to project presentations, which are addressed in a later task.

h) All audiovisual materials used throughout the project will be identified appropriately with the SAMHSA logo and contractor firm id's will not be used. The affiliation of various authors will be addressed once only, in a way approved by the GPO.

i) The Contractor shall make up to three presentations of the results of the project at meetings during each year. These presentations shall meet professional standards for such presentations.

j) The contractor shall assume all costs of preparing and delivering these presentations, including preparation of summary materials, slides, etc. The presentations shall be generally made by one person (i.e., the contractor may budget for only one person to make each presentation), but the GPO may authorize the participation of more than one person in presentations for special circumstances.

k) These presentations may take place at any time and anywhere within the Continental United States.

l) The time, place, and content of all presentations will be determined by the GPO, in consultation with the Contractor.

m) All audiovisual materials used throughout the project shall be identified with SAMHSA logos and shall not be identified with firm id' s. The affiliation of various authors will be addressed once only, in a way approved by the GPO.

Task 13: Draft and Final Contract Report

a) No later than 6 weeks prior to the end of the final period of performance the contractor shall submit 10 copies of a draft report for the contract summarizing the work accomplished during the contract.

b) This report shall be brief, but summarize all of the deliverables accomplished. A copy of each deliverable shall be included in separate Appendices.

c) If requested, the contractor will provide the data sheets from past estimates and will provide detailed methodological description. If new vendors are selected at

the end of this contract, the contractor must work with them to fully explain past methods used.

d) No later than four weeks following receipt of GPO comments, the contractor shall submit 10 copies of a final contract report addressing any comments provided by the GPO on the draft report. One copy of the final contract report shall be provided to the Contracting Officer.

Task 14: Turnover at the end of Contract:

a) If necessary, the contractor shall initiate transition activities. The contractor shall provide, no later than 60 days prior to the end of the final performance period, copies of plans for the transfer of the project.

b) The contractor shall deliver complete documentation and all materials and data acquired with contract funds. This will include full disclosure of methods under the contractor's control. All Government furnished property and materials shall be turned over to SAMHSA or the new contractor at the direction of the GPO. The contractor shall participate in meetings and assist with the development of a project transition plan.