SAAS Provider Readiness and Capabilities Assessment Results: What Does the Data Tell Us?

Identifying Critical Training and Technical Assistance Needs of Behavioral Health Providers in the Era of Healthcare Reform

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Acknowledgments

The successful dissemination and response to the SAAS Readiness and Capabilities Assessment Tool (RCA) would not have been possible without the generous support and committed partnership of several organizations. The State Associations of Addictions Services (SAAS) gratefully acknowledges the contributions and efforts of its members, the state provider associations and their directors, direct service providers who took time from their busy schedules to participate, and partners such as National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Addiction Technology Transfer Center (ATTC) both of whom continue to promote the RCA and dissemination of its results. The support of Neal Shifman, CEO of Advocates for Human Potential, Inc. (AHP), and the contributions and analysis provided by Nick Huntington of the Research Division of AHP, Inc. were essential to this effort. The results of this collaboration are an impressive response rate and collection of data critical to the continuation and expansion of the essential services provided by SAAS and its members.

I. Executive Summary

As a leading national advocate in collaboration with other organizations, SAAS has assumed the lead in collaboration with its members and their direct service providers in preparation for the massive systems transformations taking place as a direct result of Health Care Reform (HCR). In order to determine substance use disorder (SUD) and mental health (MH) provider readiness for HCR and their capacity to operate in an integrated, managed care system, the SAAS Readiness and Capabilities Assessment Tool was developed and distributed to more than 1,800 providers in addition to having been posted to the SAAS website to gather the widest possible data set. In order to gain high levels of support and participation, it was made explicit that the assessment tool was not designed to measure performance or quality of care: the purpose was to measure provider readiness and capability to adapt to and thrive in a new HCR environment where care management, disease management, population management, and reimbursement reforms will prevail. The RCA was developed to determine the areas in which providers would require technical assistance (TA) in order to succeed where many have not yet ventured.

Total participation was impressive with 873 provider organizations responding. All but 11 states participated to some degree. In recognition that both SUD and MH providers participated, for the purposes of this paper they will be referred to as behavioral health (BH) providers. Four-hundred and ninety five (495) respondents completed the entire assessment. The assessment asked 73 questions to determine capacity in the following domains: General Management; Marketing; Information Technology and Data Management; Clinical and Human Resources; Financial Operations and Revenue Management; and Provider Network Organization Participation. Participants were assured of anonymity in their responses if they so desired, were provided with an immediate score across the six domains when they provided an email address, and offered a summary report of their state-specific results.
where at least 10 providers completed the assessment. This paper expounds upon four (4) of the most significant findings in the RCA data:

1. Medication Assisted Treatment (MAT) – providers report low rates of MAT in their organizations and cite considerable challenges with adoption.
2. Marketing – providers illustrate a dire need for help with marketing planning, market research, competitive intelligence, branding and other marketing fundamentals that will prove critical to success in a competitive business environment.
3. Information Technology – not surprisingly, providers’ responses tell the story of inadequate understanding, planning, financial resources and access to expertise – all of which will be vital to operations and business relationships in the near future.

Regardless of venue, state, or service provider, one thing is consistently and abundantly clear: in order to be adequately prepared for reform and to have in place the systems, processes and partnerships that will allow them to survive and thrive, providers urgently require additional training and TA to guide them through this critical shift in the delivery of healthcare in America. It is expected that deeper analysis of the complete RCA data set will be included in a future whitepaper.

II. Overview of Process and Results

The RCA supports the notion that most publically funded providers are in a potentially strong position to affiliate with providers in the private sector, with primary care and community health centers and/or to expand their mission and market-share via joint venture, merger or acquisition. The changing landscape involves great risk for those who remain unprepared, but also great opportunities for those organizations that learn rapidly, and demonstrate the facility to quickly adapt and deploy plans to participate in integrated systems. This cannot take place, however, without developing the readiness, capabilities and infrastructure required in the new business environment where private, for-profit, and managed care fundamentals dominate business models. In an effort to define the TA and resources needed to ensure a strong place at the table in the new environment, the RCA was developed to reflect competencies dictated by Medicaid managed care plans and Health Insurance Exchanges. As demonstrated in the graph below, the majority of providers are well aware of the need for TA to assist in this transition.
Method
Participants in the RCA were treatment service providers generally associated with SAAS state member associations, although non-member behavioral health service providers responded as well. A 73 question self-assessment tool was developed by AHP Healthcare Solutions to determine provider readiness and capabilities. The tool was developed in a web-based survey format and disseminated by SAAS members with state-specific links. A link was also posted on the SAAS website and made available via open link. In order to garner widespread participation, participants were assured of the anonymity of their responses on a personal and organizational basis, were offered a limited number of incentives (free SAAS/NIATx conference registration) for timely participation; SAAS members were offered the same incentive for promoting the largest number of responses in their respective states. The tool assessed participating organizations across the following domains: General Management; Marketing; Information Technology and Data Management; Clinical and Human Resources; Financial Operations and Revenue Management; and Provider Network Organization Participation. A 5-point Likert scale was employed to score each respondent’s readiness across domains, and participants who provided email contact information upon completion of the tool were immediately sent a table providing a score for each domain, ranging from a low of 0 to a high of 4. Responses of “unsure” were assigned a value of -1. Additional narrative and follow-up questions were included to provide context for a broader and deeper analysis, but were not included in the Likert scoring mechanism. Results of the RCA were analyzed on a
nationwide level and a report provided to SAAS. State-specific data reports were also produced for each state with more than 10 participating organizations.

Discussion of High Level Results
In total, 873 respondents participated in the assessment. Many respondents (1,151) started but did not complete the assessment, with 15% exiting at the welcome page (declining participation), 22% departing the program when asked to provide general confidential information, another 9% departing following completion of the General Management phase of the assessment and the balance trailing off in roughly equal increments through each phase of the tool. In all, the number of providers completing the assessment represented the equivalent of approximately one-third of SAAS affiliated providers, offering a significant basis from which to draw conclusions about the readiness and capabilities of similar behavioral health providers across the country.

Of the six domains the RCA examined, MAT responses in the Clinical and Human Resources domain, Marketing, IT and Revenue Cycle Management produced the most salient results, which will be examined in later sections. General patterns of participation as well as the domains of General Management and Provider Network Organization also produced noteworthy findings.

- The 15% of participants who entered the assessment tool but did not complete it was relatively low. A similar but less comprehensive assessment was conducted in 2010 to which the overall response rate was dismal. This indicates a positive development: The ongoing efforts of government agencies and behavioral health stakeholder organizations such as SAAS to mobilize the provider community to be proactive in the face of reforms have had a noticeable, albeit delayed effect.
- The fact that 22% of providers chose to depart the assessment tool when questioned about Information Technology and Data Management is likely indicative of a severe deficit in need of correction: in order to participate in the integrated system of care promulgated by HCR and in order to submit billing to commercial payers, BH providers must have the IT resources and infrastructure to communicate in real time, and bill in a manner compatible with the auto-adjudication goals and HIPAA compliant systems used in the private sector.

“Our program has always been able to adapt to changes in standards and laws. The only issues that we could foresee having problems with is if we are required to purchase software, etc. that would be a great expense to the agency.”
Of note in the General Management section is that although 514 providers reported they operate on a regularly updated strategic plan and the Likert scale indicated an average score of 2.4 (moderate), only 376 providers had updated their strategic plans in 2011 or later, indicating that 55% of those plans are unlikely to take the full measure of HCR into account, drawing their relevancy into question. Similarly, only 53.9% of providers reported using the Strategic Plan as a living document that informs their daily operations and planning. Well known problems revealed in this section also included workforce issues such as lack of adequate compensation, and poor to midrange responses regarding the existence of a robust succession plan for key leaders. While the Likert score of 3.1 regarding participation in formal networks with other providers was high, only 35% felt that the collaborations did not need improvement.

Conclusions that can be drawn from the Provider Network Organization domain of the assessment are limited but very clear. Of the 516 respondents who completed this section, only 13.8% belong to a provider network business model. Over 80% of providers are not benefitting from any centralized or cooperative administrative, clinical, managed care, financial and/or technology functions. Anecdotal evidence indicates that interest in developing Administrative Service Organizations (ASOs), Technology Service Organizations (TSOs) and the like in order to combine resources is high. The training and consulting necessary to develop such cooperatives must catch up to the demand recognized by providers.

Figure 2-Percentage of Organizations Belonging to a Network –Based Shared Business Model

“Our limited staffing resources and shared duties make it very difficult to compete with large providers.”
III. Key Findings

In the expectation of undertaking a more comprehensive analysis of the results of all assessed domains in the future, this paper will focus on segments of the survey that will impact providers most urgently. The following sections highlight the four most striking and important opportunities for growth, investment, and enhancement throughout the field. We have selected these dimensions for the simple fact that each will have an increasingly immutable and determinant impact on the viability of the field as a whole.

Medication Assisted Treatment (MAT)

In a broader section of the RCA dedicated to clinical readiness, collaboration and integration, we asked respondents two pointed questions concerning MAT. Of 541 respondents, 53% indicated they offer no MAT whatsoever. Of 277 respondents, 34.7% indicated this was due to the agency’s treatment philosophy and another 54.9% indicated lack of staff training or cost as the primary cause. The results illustrate a critical need to revisit fundamental treatment philosophies and principles. Two decades of breakthrough brain imaging, neuroscience, genetic research, clinical trials and Food and Drug Administration (FDA) approval of a small handful of medications will only accelerate the demand for MAT.

Figure 3-Use of MAT

In the context of collaboration with primary care, Health Homes, Patient Centered Medical Homes (PCMH) and Accountable Care Organizations (ACOs), aligning culture, principles and values concerning the use of medications is rapidly becoming pivotal to participating as significant partners in these new treatment and business models. That primary care physicians, consumers and health insurance companies expect the use of prescription medications is immutable. The SUD field can utilize the experience already garnered by the MH field. There is ample evidence to suggest that while

...”I don’t know-we never thought of it”

“We are an abstinence based program”
psychotherapy is effective in the treatment of depression, for instance, many more people (9:1) and their physicians seek relief through prescription medications (anti-depressants) alone. The reasons are both legion and indisputable:

- Direct-to-Consumer advertising
- Low pharmacy co-payments
- Convenience and discretion (avoiding stigma)
- Obviating utilization review and medical management

It is safe to suggest the very same reasons will apply where MAT is concerned. It is also true that most health insurers and issuers are more comfortable - from the point of view of liability - with the evidence, clinical trials, and FDA approval of drugs than they are with some of the traditional SUD treatment modalities.

**Figure 4-Reasons for Non-utilization of MAT**

Our challenge has been and remains to ensure the safe and appropriate use of MAT, particularly in an era characterized by an epidemic of prescription drug abuse. The irony is lost on no one. Given this dynamic, it is even more apparent that BH professionals are key members of the integrated treatment team and milieu of the near-future, working closely to inform medical professionals and monitor the safe and appropriate use of powerful medications.

**MAT Recommendations**

Stakeholders should consider:

1. Studying reimbursement for MAT in commercial health plans and Medicaid in their respective states
2. Developing and lobbying on behalf of what they want to see in insurance and Medicaid regulations
3. Providing Technical Assistance and training
4. Working with colleges and universities to promote MAT
5. Promoting greater interaction with joint venture and recruiting of approved prescribers

**Marketing**

With the implementation of HCR and the concomitant increase in consumer choice, leaders in the SUD field recognize that providers must position their organizations in the marketplace to be competitive with primary care, Federally-Qualified Health Centers (FQHC) and mental health providers that may also deliver SUD services.

Marketing – often confused with advertising or attributed with negative connotations such as used car salesmen – is in fact an essential aspect of business planning in this new era. As their traditional client base migrates to and in between Medicaid and Health Insurance Exchanges, BH providers accustomed to being the provider of last resort must now position themselves to be the providers of first choice. To successfully compete in the open market, providers must:

- Identify and analyze their competition and potential partners
- Identify potential new markets and market segments
- Understand general marketing concepts
- Be able to develop a marketing plan that is nested in their larger (and timely) strategic plan
- Develop a brand for their organization that sets them apart from their competition and that “sells” their strengths to a new market, and
- Understand and capitalize on vertical and horizontal integration that will ensure penetration into new markets.

The chart below illustrates a significant deficit in marketing savvy in at least half of respondents. The results are not surprising given that the majority of providers have historically received the largest share of their funding and revenue from state or Federal agencies as contract, fee-for-service, or grant and aid providers.

**Figure 5-Number of Organizations with a Marketing Plan**
HCR is dramatically altering not only who will pay for behavioral health services, but will also provide choice to the majority of those seeking services. This will require a shift in how providers will market to and attract new patients. While there is still much uncertainty about what will happen to the Federal block grant and state funds typically dedicated to substance use and mental health disorder services, field leaders recognize the states will become the payer of last resort as Medicaid Expansion and HEALTH INSURANCE EXCHANGES take root.

**Figure 6-Contents of Existing Marketing Plans**

The RCA data suggests that most providers in the current system have under-developed marketing plans, out-of-date and out-of-context branding, and nearly half need to develop more robust relationships with commercial payers to attract patients. The trend toward reimbursement reform and ACOs aggravates the product development difficulty depicted in the chart below.

**Figure 7-Provider Marketing and Adaptive Capacities**

The organization can identify emerging markets and rapidly develop new services for them.
As primary care, FQHCs and hospitals enter and re-enter the market to capture expanded coverage and markets and to make the most of coordinated treatment teams in health home and medical home models, the number and type of competitors for finite SUD treatment dollars will increase. Unfortunately, more than half of RCA respondents answered “Not at all” and only “To a small extent” when asked about this basic marketing function.

**Figure 8-Competitive Intelligence Gathering**

The organization conducts periodic competitive intelligence (gathering information about products, customers and competitors for use in making strategic decisions).

<table>
<thead>
<tr>
<th>Perception</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>21.8%</td>
</tr>
<tr>
<td>To a small extent</td>
<td>35.0%</td>
</tr>
<tr>
<td>To a moderate extent</td>
<td>23.3%</td>
</tr>
<tr>
<td>To a great extent</td>
<td>10.4%</td>
</tr>
<tr>
<td>To a very great extent</td>
<td>3.2%</td>
</tr>
<tr>
<td>Unsure</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

**Marketing Recommendations**

Provide Technical Assistance and training in marketing fundamentals including:

1. The essentials of market data and research
2. Segmenting markets and finding a profitable niche
3. Identifying markets trends, competitors, and potential partners
4. Effective research and product development
5. Adequately staffing the marketing team with experienced and properly resourced professionals
6. Developing approaches and value propositions specific to the audience
   - Health plans and managed care organizations
   - Employers
   - Health homes, patient-centered medical homes and ACOs
   - Hospitals and clinics
Information Technology (IT)
Data management, information technology infrastructure, and the implementation of certified electronic health records (EHR) are likely the areas where providers will experience the greatest impetus for change under HCR and where, if not adequately implemented, they will experience the most significant negative impact. Unfortunately these are the areas of greatest complexity, cost and volatility. Clearly, more must be done to ensure IT is a higher priority and that it is thought of in the most strategic terms.

Figure 9-Percentage of Organizations with Plans and Budget for IT

Success in a reformed and transformed business environment will depend considerably on an organization’s ability to participate in electronic data interchange (EDI) with third-party payers, insurers, and managed care organizations and the degree to which they can integrate with primary care, health and medical home models and ACOs. To do so, providers must have, and be able to effectively integrate, systems and information. This is rapidly becoming one of the most strenuous areas of change and implementation for hospitals and medical centers of all sizes so the BH field can expect a formidable challenge. What makes the challenge of 2014 so very different is the requirement to participate in health information exchanges; to conduct the majority of business operations (eligibility determinations, service authorizations, and billing) in compliance with HIPAA Standard Transaction Code Sets; to operate on a certified EHR information system platform; and to engage in the certified Meaningful Use of health information. All of this will no doubt be complicated by the implementation of ICD-10 by October 1, 2013 and HIPAA Version 5010 standards in the near future.

Preparing for Version 5010 and ICD-10 will require expertise, time and funds. Preparation will include updated software installation, staff training, changes to business operations and workflows, internal and external testing, as well as updating and reprinting of manuals and other training and instructional materials. Version 5010 and ICD-10 require system and business changes throughout the entire health care industry. ICD-10 will affect coding for every provider.
What the RCA data reveals is a critical level of uncertainty among BH providers. Much of the data illustrates confusion concerning the nature of EHR systems in contrast to portals provided by state agencies for grant and general funding purposes.

**Figure 10-Type of EHR System Agencies Plan to Adopt**

![Pie chart showing types of EHR systems](image)

Additionally, providers will be expected to implement new and more robust forms of:

- Screening and assessment tools
- Clinical documentation and clinical decision support systems
- Computerized physician order entry (CPOE) and e-Prescribing
- Coding, billing processes, and revenue management
- Data analysis and reporting

The data in the chart below depicts the vital importance of tackling IT in cooperation and consortia.

**Figure 11-EHR Collaboration Plans**

![Pie chart showing level of collaboration](image)
Cross analysis of answers given in this domain reveals that many SUD providers do not have the capacity, technology or infrastructure to meet the expectations of emerging markets, though many self-report they do have the capacity. When asked about billing functions, however, most reveal that they are in fact reporting encounters to state payers. Of course, this in no way prepares providers to meet the rigors of commercial payers. Failing to prepare adequately for the IT infrastructure of the near-future will have a devastating impact on cash flow, credit and financial reserves. Many providers need immediate help in this area. The data below illustrate how uncertain providers are today about the Meaningful Use incentive program. More than 50% are simply “Unsure” about the incentives and whether or not they qualify.

**Figure 12-Provider Understanding of Meaningful Use Incentives**

- Do you have eligible Professionals for the Meaningful use incentives?
  - Yes 26.4%
  - Unsure 54.1%
  - No 19.5%

- How has the Meaningful Use Program changed your plans for implementing an EHR?
  - It is the reason we started looking for an EHR 11.9%
  - The incentives have encouraged us to speed up
  - Unsure 52.9%
  - No change 25.1%

**Information Technology Recommendations**

1. Provide Technical Assistance and training regarding IT strategic planning and budgeting
2. Provide training concerning Meaningful Use and Health Information Technology for Economic and Clinical Health (HITECH) incentives for eligible professionals
3. Instigate BH collaboratives and network-based models to share services, IT procurement, software implementation, training, and maintenance/support costs.

**Revenue Cycle Management (Billing and Reimbursement)**

Organizations with fully developed financial tracking and management systems in place will be better positioned in the HCR business environments of health insurance exchanges and Medicaid managed care plans. Organizations with a greater financial management capacity will also be better positioned to negotiate contracts with managed care and ACOs based on their ability to identify and drive down costs through efficiency gains while pricing their services competitively. Nowhere will this be more important than in business models that include pay-for-performance incentives, shared savings (risk), capitation and sub-capitation and Global Payment.

The data below illustrates a significant gap in the level of understanding and preparedness for contracting with new payers.

**Figure 13-Provider Experience with Managed Care Organizations**

The organization has experience in contract/network development negotiation with commercial managed care organizations (MCOs) and health plans.

The table below depicts a nationwide treatment system wherein 78% of providers have at least half of their revenues coming from state and federally funded programs. In fully half of providers nationwide, 75% or more of their revenue is of the sort most likely to be upended by health insurance exchanges and Medicaid expansion, and repurposed for critical (but not considered “medically necessary”) wrap-around services.
Table 1-Current Provider Revenue Sources

<table>
<thead>
<tr>
<th>Per Cent (%) Revenues from Commercial and Private Sector Payers, Issuers and Insurers</th>
<th>Per Cent Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% - 25%</td>
<td>51%</td>
</tr>
<tr>
<td>26% - 50%</td>
<td>27%</td>
</tr>
<tr>
<td>51% - 75%</td>
<td>11%</td>
</tr>
<tr>
<td>76% - 100%</td>
<td>11%</td>
</tr>
</tbody>
</table>

The most concerning data reflects a general lack of familiarity and grasp of common billing codes, formats and rate-setting methods. Failing to address these gaps will very likely disrupt accounts receivable, cash flow, credit and reserves, in some cases threaten the viability of providers. A number of excellent options exist including network-based shared services models.

Figure 14-Familiarity with Private Sector Billing Formats and Reimbursement Methods
The network-based business models discussed above can be modeled after those pioneered by primary care including management service organizations (MSOs) and independent provider associations (IPAs). Providers in some states have already begun developing consortium approaches to shared services and procurement. This trend needs to continue to address the needs of 86% of providers and must evolve to include a wide range of important services including:

- IT implementations and networks
- Billing
- Credentialing
- Quality Assurance
- Accounting
- Legal
- Facilities management and maintenance
- Payroll and benefits administration

Of the 13.8% of respondents who do participate in shared services network-based models, fewer than a third take advantage of shared billing services. This is a service-line that most providers should be exploring now.

**Figure 15-Services Offered to Participants in Shared Services Network-based Models**

![Services Offered to Participants in Shared Services Network-based Models](image)

**Revenue Cycle Recommendations**

1. Provide training and Technical Assistance where billing and revenue management are concerned, developing and disseminating tools and technical resources
2. Develop a national billing, revenue management and financial performance “institute” that can provide training and tools on an ongoing basis
3. Provide Technical Assistance and training regarding compliance with waste, fraud and abuse, the Deficit Reduction Act, state laws and regulations, and health plan policies.
IV. Conclusion

The results of the RCA demonstrate a critical and urgent need for training and technical assistance in order to preserve and expand essential community mental health and substance use disorders treatment services. In the new landscape of behavioral health care delivery, however, providers who remain unprepared to meet competency and infrastructure requirements place their long-term viability and sustainability at considerable risk. Concomitantly, those providers that mobilize and deploy quickly will be able to capitalize on an environment rife with opportunities: payers are now keenly aware of the impact of substance use and mental health disorders on population health and the cost of treating individuals with multiple chronic conditions. The providers reflected in the RCA data are experts in providing highly effective treatment, and with the necessary investment, resources, training, partnerships and cultural shifts may position themselves as important players in the evolving landscape of healthcare delivery and population health. There is a potent opportunity to braid public sector funding for wraparound services with treatment reimbursed via new channels. Providers willing to engage rapidly in this paradigm shift may have the opportunity to expand and improve the services they provide, offer treatment to individuals formerly denied the choice to seek care, and thereby fulfill their respective missions in a more comprehensive manner than ever before. There are choices to be made, however: Will government agencies supply adequate and appropriate TA and training necessary for providers to thrive in the new environment? When TA and training are offered by organizations such as SAAS, will providers shed old paradigms and habits and pursue opportunities for partnership, training and incentives to participate in an integrated system? Those that do will become providers of first choice, serving an expanded population and spreading their knowledge and expertise to the overall benefit of those they serve. The time is now.