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Value-Based Arrangements for Addiction Care & Recovery Including Opioids

June 18, 2019

Agenda

1. Defining the problem
2. The Alliance for Addiction Payment Reform – Incentivizing Recovery, Not Relapse
3. Creating an Addiction Recovery Medical Home – Alternative Payment Model (ARMH – APM)
   - The model – Episode 0, 1, 2
   - Building a payment structure
   - Defining the boundaries of the bundle
4. Development of a Network of High-value Providers
   - Reward right behaviors
   - Remove barriers
   - Levers for intervention and success metrics

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Greg Williams
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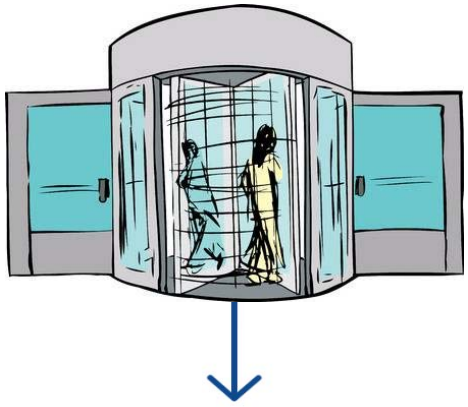
The Current Addiction Treatment System

- Addiction/overdose is now the leading cause of death for those under 50 in America
- An infectious disease model is in place attempting to manage a chronic illness
- Only ~10% of people receive any kind of Substance Use Disorder (SUD) healthcare service – leaving 18.2 million Americans in the current "addiction treatment gap"
- Those receiving any specialty care today largely are doing so in fragmented short-term interventions not well designed to manage a chronic condition – many providers of which are out-of-network
- $442B in economic loss per year – 70% of which is lost productivity in the work place as a result of untreated substance use issues



+$35 Billion/Year

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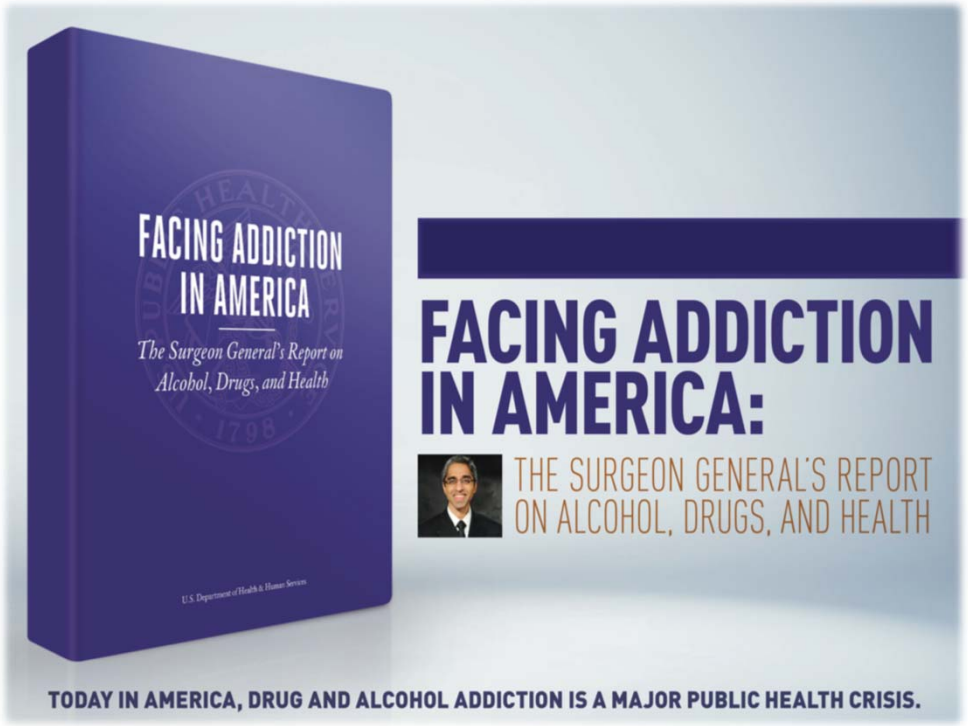

The recently released first-ever Surgeon General's Report dedicated an entire chapter to a call-to-action for health systems to integrate evidenced-based and evidenced-informed addiction prevention, treatment, and recovery services into mainstream healthcare delivery (i.e. not carved out)

Chapter 6 – Healthcare Systems and Substance Use Disorders

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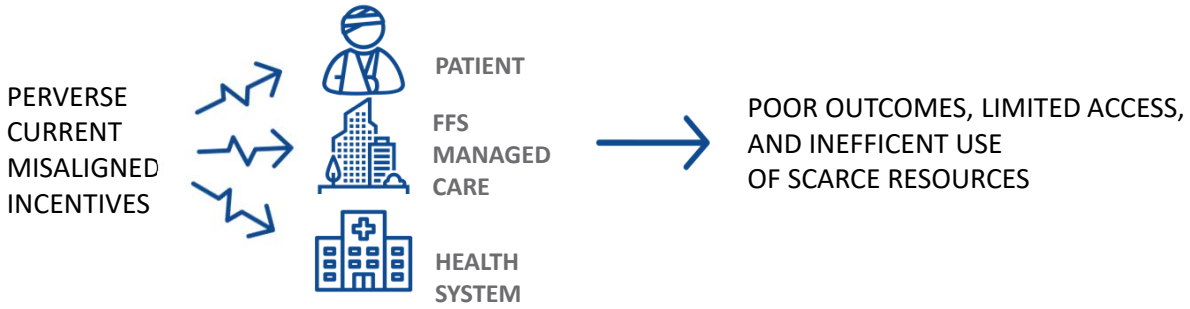
The Integration Problem Requires A Full System Redesign

- Payers, providers, and patients all operate in a considerable amount of pain today in the current fee-for-service volume-driven delivery of addiction care
- While most providers are well-intentioned, the current incentives are perverse
- Delivering care in short-term redundant acute episodes does not effectively or efficiently produce quality outcomes
- There are key roles and functions needed to help manage a patients long-term recovery journey that the current system does not provide reimbursement for
- Patient records are not being shared across providers nor are interoperable (42 CFR Part 2)



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Video Clip

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Addiction Recovery Medical Home Alternative Payment Model (ARMH-APM)

Incentivizing Recovery. Not Relapse.

www.IncentivizeRecovery.org

Addiction Recovery Medical Home – Alternative Payment Model

ARMH-APM

- A consensus learning model published in September of 2018 by The Alliance For Recovery-Centered Addiction Health Services
- The culmination of a year of various workgroups staffed and managed by Leavitt Partners including subject matter experts, industry leaders, and diverse cross-sector stakeholders including a lead investment from national non-profit, Facing Addiction
- Only longitudinal model to-date with comprehensive, wing-to-wing approach to incentivize sustained recovery
- It is a model grounded in overarching consistent principles, but maintains flexibility and adaptability to be deployed in a variety of commercial and network contexts
- Pilot demonstration projects are now in development and will be live and evaluated beginning in 2019 and 2020

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ARMH-APM Guiding Principles

1. Multiple Pathways
Recovery from Substance Use Disorder (SUD) is a process of change whereby individuals achieve SUD remission, work to improve their own health and wellness, and live a meaningful life in a community of their choice while striving to achieve their full potential.

2. Three Critical Components
Care recovery has three critical, interconnected states: pre-recovery/stabilization, recovery initiation and active treatment, and community-based recovery management.

3. Multi-Disciplinary Care Team
Recovery management requires a multi-disciplinary care recovery team who can provide the diverse biopsychosocial elements of treatment needed and is critical in creating optimal conditions for recovery and improving personal, family, and community recovery capital.

4. Broad Continuum Of Care
A well-managed and broad continuum of care ranging from emergent and stabilizing acute-care settings to community-based services and support is essential to managing patient needs across the stages of personal and family recovery.

5. Integrated
Clinical and non-clinical recovery support asset across a continuum of care should be integrated, allowing for a sharing of patient information, high-functioning care transitions, and commensurate clinical and safety standards.

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ARMH-APM Guiding Principles

6. Includes Co-Morbidity/Co-Occurring
Co-morbidities and co-occurring mental health challenges must be managed in concert with the underlying treatment and recovery of a SUD.

7. Patient-Centered
Recovery support strategies must accommodate and support the growing varieties of SUD recovery and the broader spectrum of alcohol and other drug problem solving experiences. There are no static SUD cases, requiring a model sufficiently malleable to accommodate for multiple pathways and styles of alcohol and other substance problem resolutions, including a subclinical focus.

8. Aligned Incentives
Integrating economic benefits and risks between payers and the delivery system will promote greater accountability and care design to facilitate holistic and comprehensive care recovery environment for the patient.

9. Longitudinal Care Model (~5 Years)
Recovery is a life-long process, with five years of sustained substance problem resolution marking a point of recovery stability in which risk of future SUD recurrence equals the SUD risk within the general population.

10. Dynamic Treatment and Recovery Plan
A dynamic treatment and recovery plan with the breadth and flexibility to engender increased recovery capital should be authored in collaboration with the patient, the patient's family, and other key social supports.

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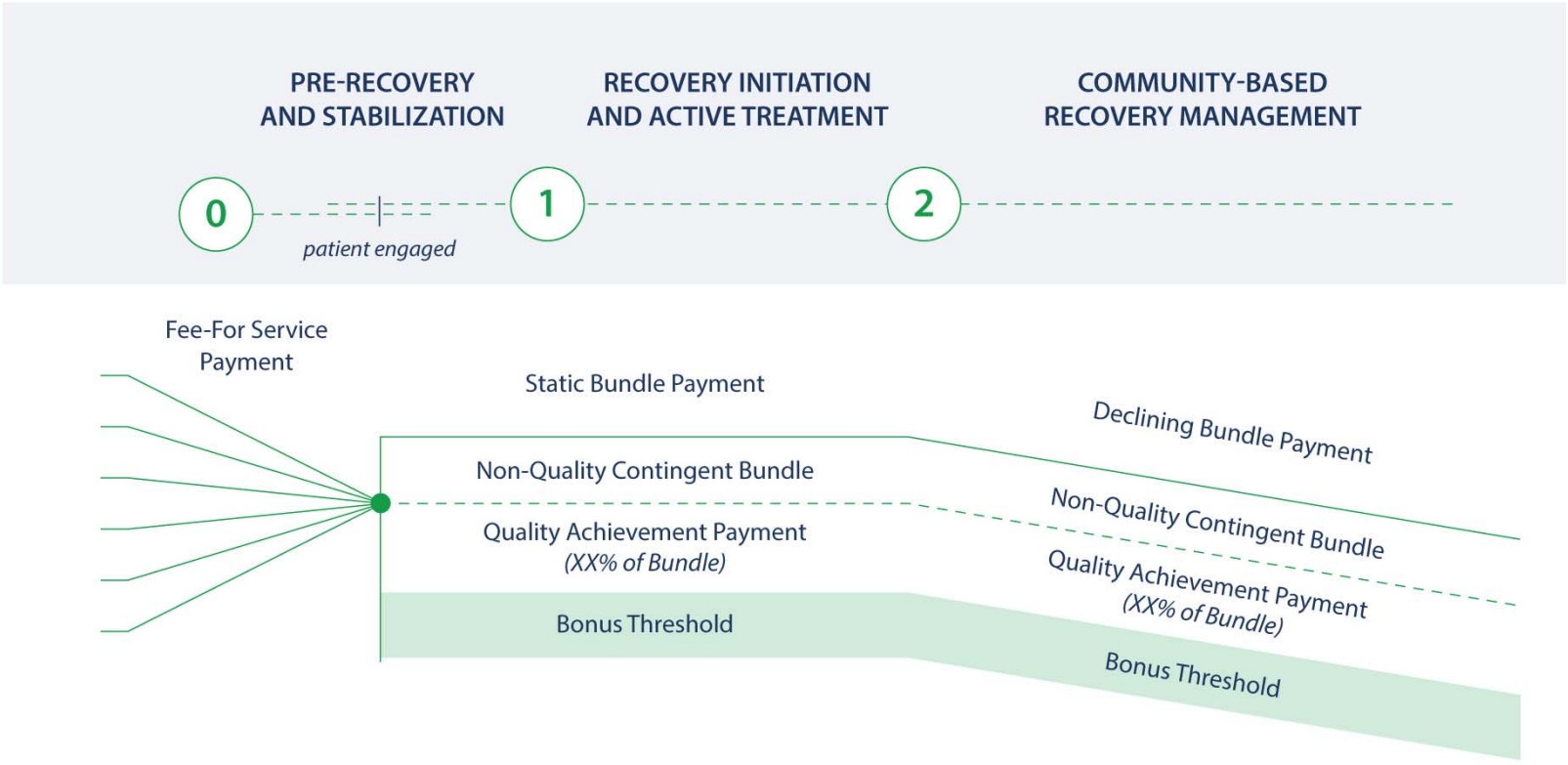
Patient Engagement & Payment Episodes



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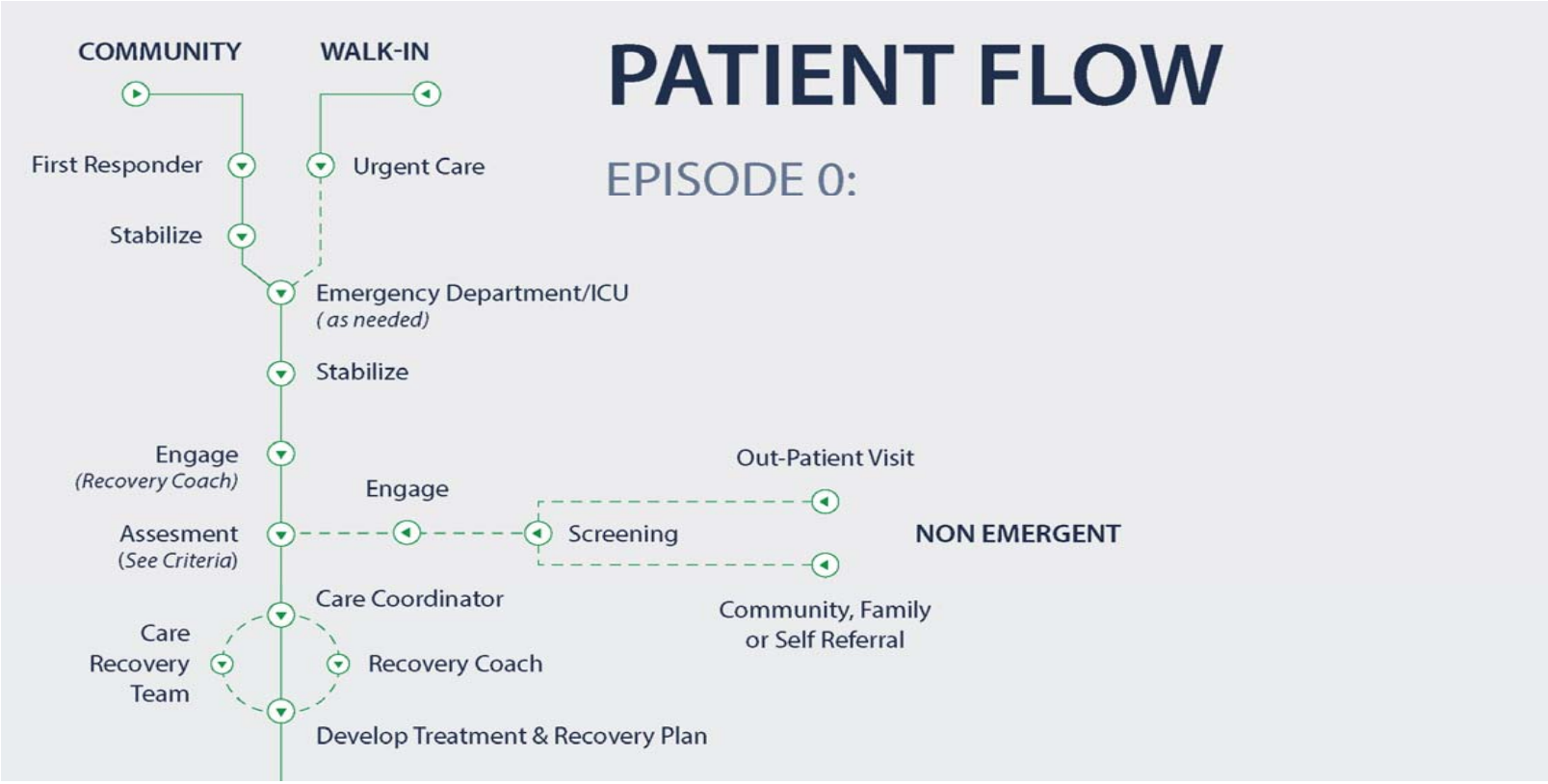
PATIENT FLOW

EPISODE 0:



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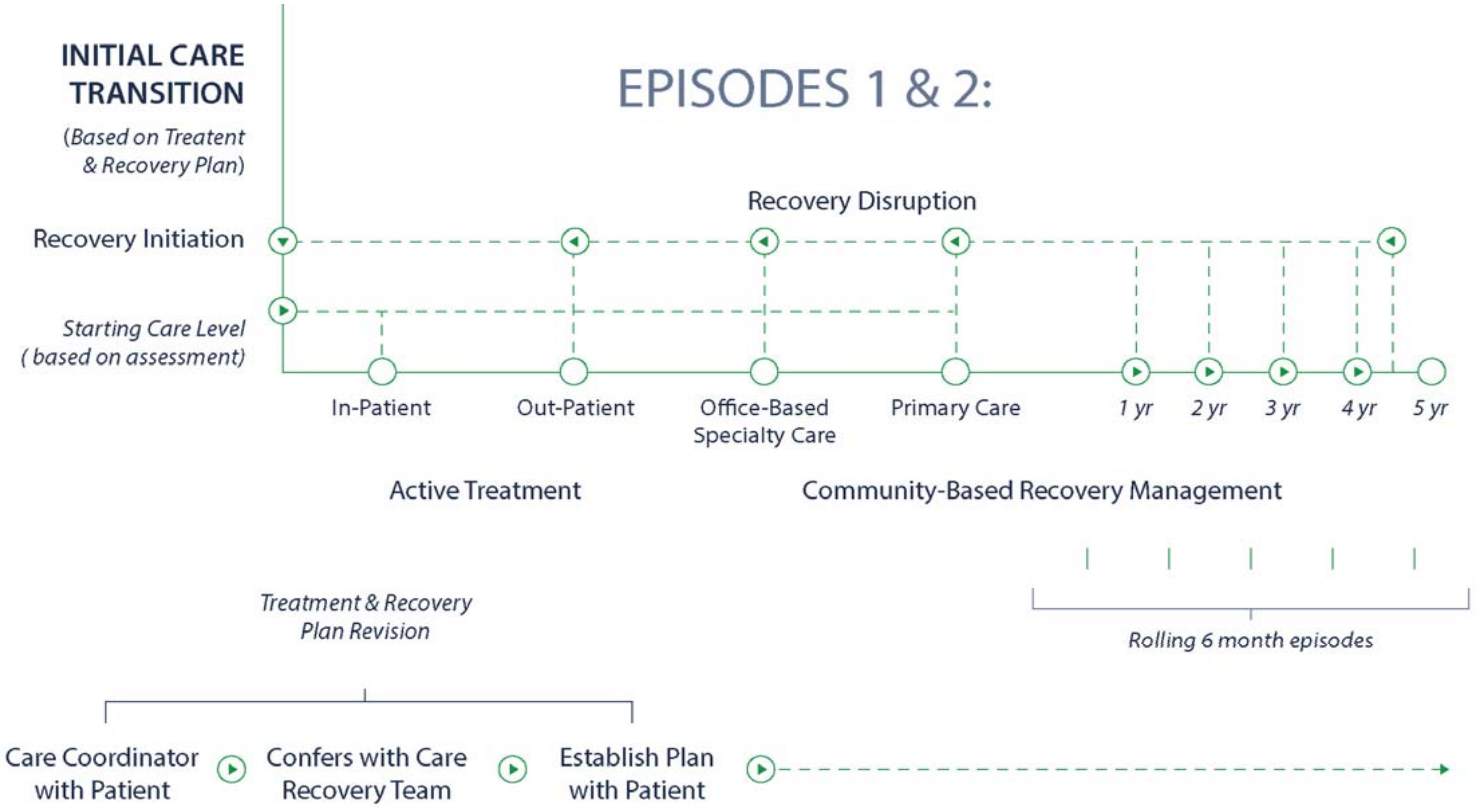

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Episode 0 **Pre-Recovery and Stabilization**	• High clinical intensity and emergent situations • Unpredictable in nature (includes overdoses, MVA's, heart attack's, etc.) • Gateway to engagement in ARMH-APM • Payments remain fixed on FFS; performance bonuses can be paid • Timing can be variable – 1-30 days
Episode 1 **Recovery Initiation and Active Treatment**	• Activation of care recovery team and treatment and recovery plan • Initial inclusion of the patient in the ARMH-APM and assimilation into the integrated treatment and recovery network • Covers specialty clinical resources from inpatient (as needed) to intensive outpatient • Introduction of value based payments • Timing can be for up to one year
Episode 2 **Community-Based Recovery Management**	• Does not exclusively rely on specialty care settings, moving the locus of care closer to community/primary care • Increased emphasis on the treatment and recovery plan and community supports • Risk factors decrease, although recovery disruptions are well-managed with patient closely linked to ongoing care • Timing can be for up to five years, depending on MCO continuity

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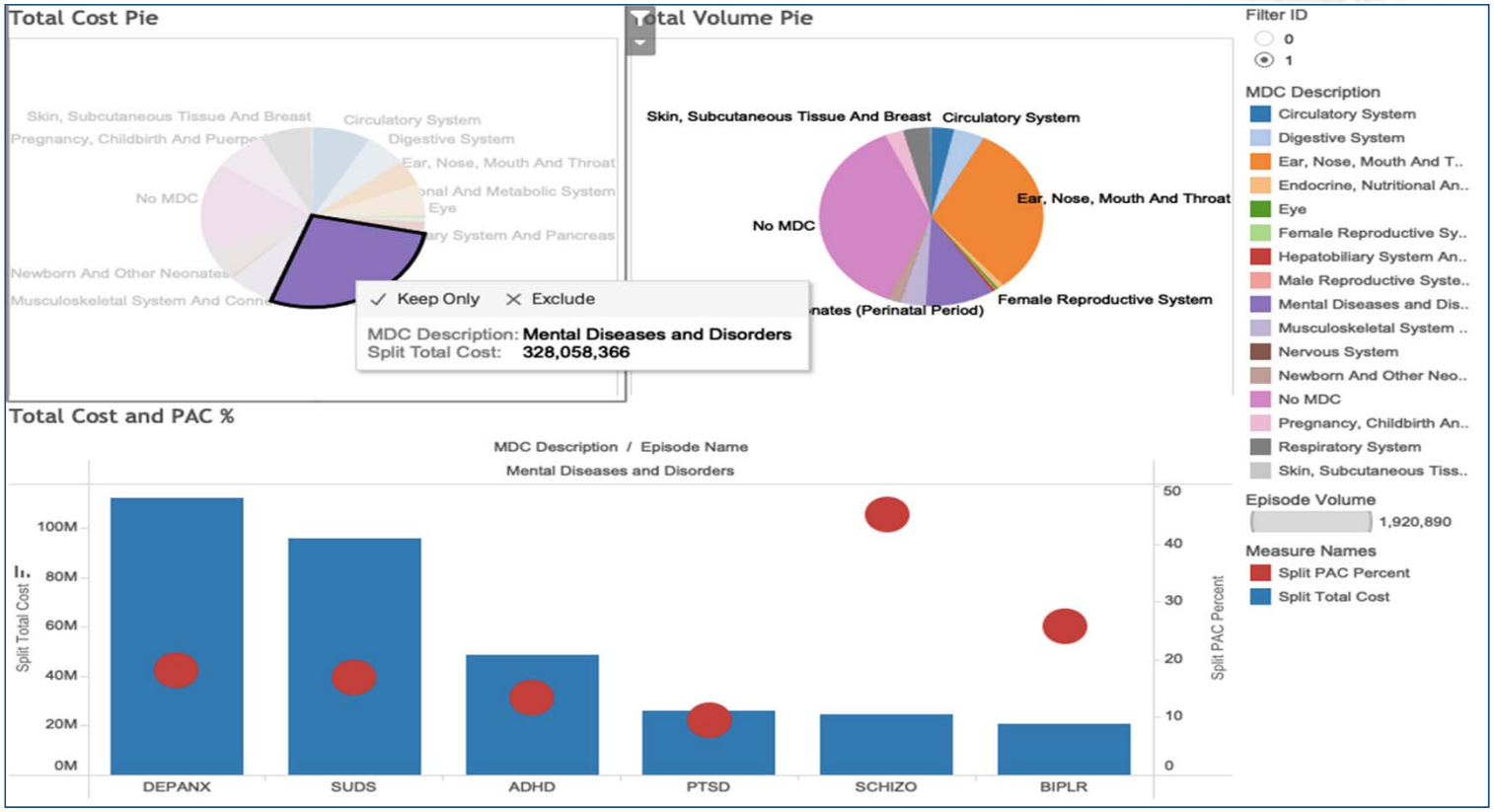
Developing A Bundle Price For SUDS & Addiction Recovery

Amita Rastogi MD, MHA, MS, FACHE
VP, Medical Director, Remedy Partners

Behavioral Health Accounts For > 30% Of Healthcare Spend



Episode of Care as The Unit of Accounting And Accountability

FEE-FOR-SERVICE	BUNDLED PAYMENT
Manage patient one encounter at a time	Comprehensive, patient-centered approach
Underlying depression, social determinants of health not addressed	Depression screening, suicide risk, screening for HIV, HCV included as part of the bundle
Paid for relapses, ED visits, hospitalizations	Savings achieved my minimizing relapses, held accountable for providing consistently excellent outcomes
Fragmented care for comorbidities – patient lost between behavior health specialists, PCPs, and specialists	Integrate care for SUDs with care of underlying depression, schizophrenia etc., as well as manage care for consequences of SUDS such as diabetes, COPD, HCV, HIV, MVA (some services carved out)
Community based services not paid for	Covered services include CBT (cognitive behavioral therapy), peer-recovery coaches, rehabilitation into the community
Care management, feedback not included	Integral part of Bundled Payments: • Shared decision making • Lifestyle changes • Patient reported outcomes

Catalyzing Delivery System Redesign for the SUD Episode

- Payment reform drives delivery reform

- We need to get payers and providers engaged around the SUDs crisis

- Gain sharing arrangements create an atmosphere for shared accountability with shared savings

- A bundled price creates an environment to manage care within the budget and to be accountable for outcomes

- Creating a payment structure that is comprehensive and covers all aspects of care in the treatment and recovery of a SUDs patient is paramount

Create a Budget (Target Price) for Each Provider-Patient-Payer Combination

Informed by guidelines and empirical data analysis	Severity Adjusted Core/Typical price for services based on best-practice or evidence
Adjust bundle price for local patterns	"Normal" variation reflecting practice patterns
Based on current relapse rate and current actionable adverse events	Allowance for Complications (provides a built in incentive to reduce complications)
Allowance for care coordination – could pay for itself from savings from reduced relapses	Allowance for care-coordination, MAT, PCP visits, integrating primary care w behavioral health, weekly counseling
Rehabilitation into community – added allowance	Allowance for community based services, recovery coaches, linkages to employment, sober houses

- The bundle price creates an environment to manage care within the budget and to be accountable for outcomes
- It creates an atmosphere for shared accountability with shared savings
- Episode 2 services are a subset of episode 1 with greater emphasis on care management, rehabilitation and integration into the community

Allowance Varies Based On The Stage Patient Is In

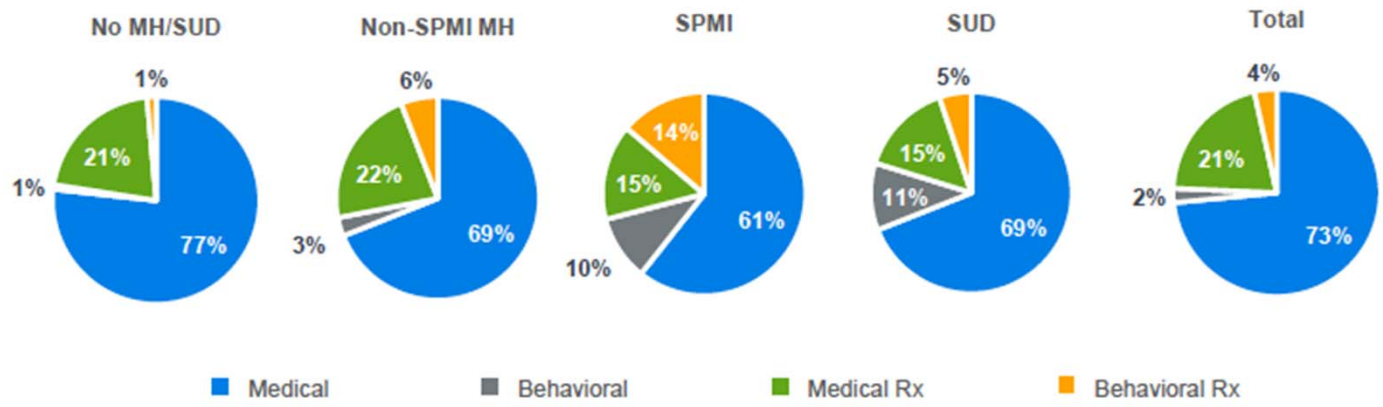
Episode 0 **Pre-Recovery and Stabilization**	• Fee for Service
Episode 1 **Recovery Initiation and Active Treatment**	• Use historical claims data to price the episode (includes services for typical / routine care plus care for AAEs - actionable adverse events) • Severity Adjust based on patients comorbidities • Added allowance for social determinants of health
Episode 2 **Community-Based Recovery Management**	• Historic claims to price base episode 2 • Add care management monthly fee • Add payments for non-billable services such as for recovery support and community based services

- Episode Initiator for episode 1 is also accountable for episode 2
- Accountability is year to year
- Target price (budgets) are created on a yearly basis based on historical trends
  Annual reimbursement is high for Episode 1
  For episode 2, it is declining payments – with front loaded initial high utilization and declining units billed per month

Integrating Physical Health with Behavioral Health (1)

Physical Health conditions constitute a major bulk of costs for SUDs population

FIGURE 4: PMPM COSTS BY SERVICE CATEGORY, COMMERCIAL



SPMI: serious and persistent mental illness
Non-SPMI MH: Mental Health diagnosis but no serious and persistent mental illness

Source: Milliman Research Report: Potential economic impact of integrated medical-behavioral healthcare Jan 2018
http://www.milliman.com/uploadedFiles/insight/2018/Potential-Economic-Impact-Integrated-Healthcare.pdf

Integrating Physical Health with Behavioral Health (2)

Per member Savings Potential – Value Opportunity (Commercial Market)

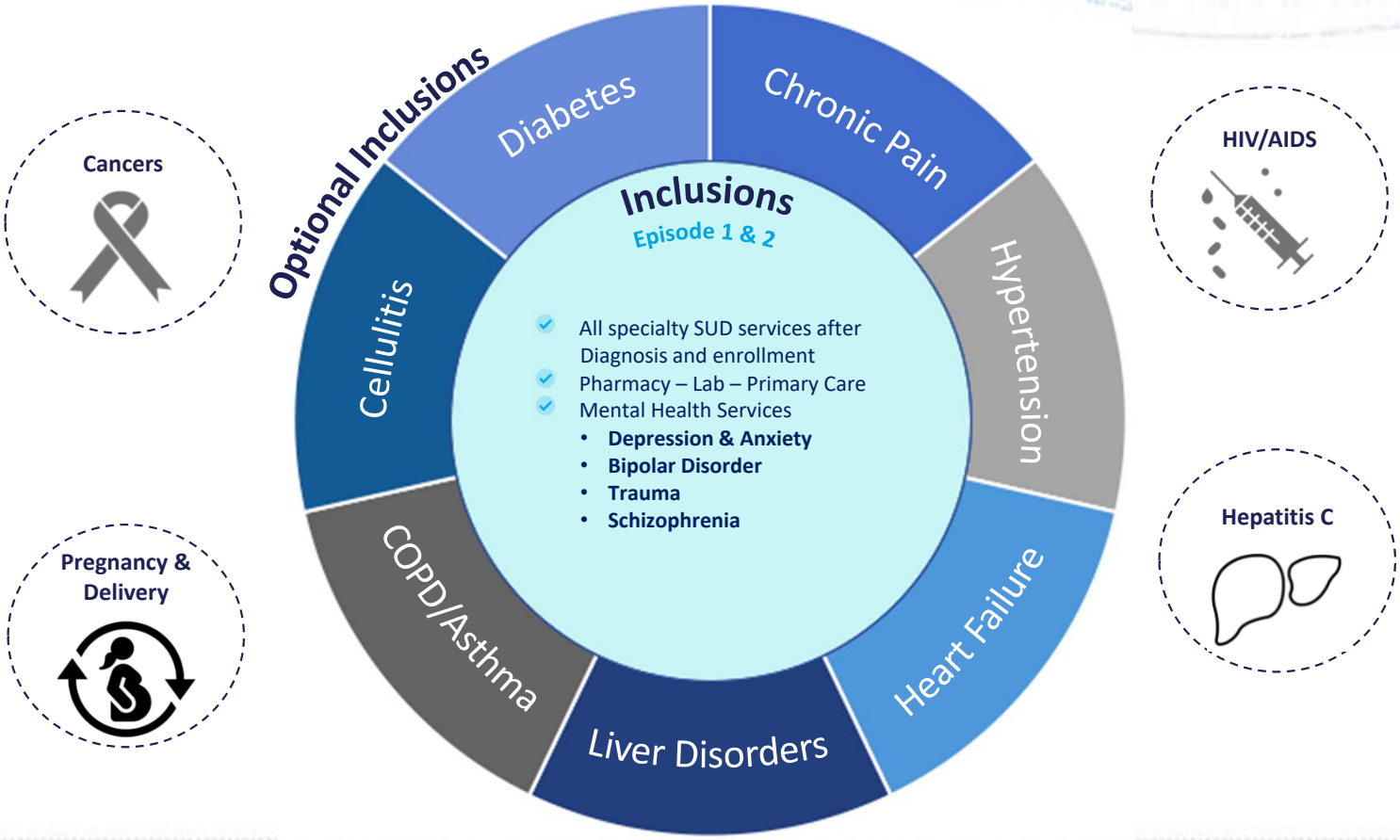
Medical Condition	No MH/SUD	SUD	Potential for savings (Value Opportunity)
Overall pmpm costs	$426	$1,419	$993
Anemia	$2,292	$4,455	$2,163
Liver Disease	$2,411	$4,571	$2,160
Heart Failure	$1,713	$3,660	$1,947
Osteoporosis	$1,232	$3,139	$1,907
Diabetes (no compl)	$1,004	$2,117	$1,113

In addition, high volume comorbid conditions have the highest savings potential:

- Diabetes and other endocrine / metabolic conditions: $77 Billion
- Arthritis: $47 billion
- Hypertension: $31 billion

Source: Milliman Research Report: Potential economic impact of integrated medical-behavioral healthcare Jan 2018
http://www.milliman.com/uploadedFiles/insight/2018/Potential-Economic-Impact-Integrated-Healthcare.pdf

Defining the Boundaries of the SUD Episode of Care



CARE RECOVERY TEAM

Development of a Network of High-Value Providers

Development of support and training across the care continuum

- EMS / First Responders → take patients directly to prep centers, not to ED
- Institute Medication Assisted Treatment (MAT) – gold standard of care for opioid abuse
- ED – create a protocol for management of drug overdose including appropriate referral once discharged
- Train PCPs to accept SUD patients → make them feel supported, provide access to behavior health specialists, share best practices, create learning collaborative around MAT
- Train peer recovery coaches, create a nurturing environment, get PCPs to be comfortable with peer recovery coaches
- Develop local community based resources for recovery and support

Measuring Success Levers

Clinical levers of success identify opportunities and provide ways to help providers 'win' within episodes. We are looking for significant episode volume with high variations in cost and/or outcomes.

Validation of levers includes a clinical validation where we verify operational opportunity with physicians and specialists, and a claims validation where we verify volume and cost opportunity.

Episode 0: Pre Recovery and Stabilization

- EMS /First Responders – move to prep centers directly (no need for ED)
- MAT initiation for OUD
- Follow up within 72 hours of patient identification
- Identify high risk patients + social determinants of health needs (underlying depression, PTSD, Bipolar; co-morbidities, Hep C, homeless)

Episode 1: Recovery Initiation and Treatment

- Use of in-network providers & detox facilities
- Screening for underlying depression, other BH conditions
- Harm Reduction Measures
- Development of care/treatment plan
- Adherence to treatment plan
- MAT, adherence to treatment, and Medication reconciliation
- Use of prescription generics
- Identify patients at high risk of relapse

Episode 2: Community Based Recovery Management

- Relapse rate by risk category
- Follow up with primary care
- Peer support/Recovery coach
- Integration into Community

The ARMH-ARM Model Creates an Environment For Rewarding Good Practices

- The ARMH – ARM model creates a flexible model to reward good practices
- Episode time window is variable based on patient's stage and recovery
- Each market will have its own price based on their own contractual fee schedules
- Funding for episode 2 needs to cater for PCP visits, recovery coaching, weekly counseling, care management fees, MAT services in addition to a subset of episode 1 services – debate is on whether it will be new money or it will be from the shared savings achieved from the program

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