FROM THE CEO
THE CHALLENGE OF TRANSFORMATIONAL CLINICAL AND PAYMENT MODELS

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As treatment providers and as a professional treatment association, our objective is to deliver the best quality care to as many people as we can. We have a strong history of doing so. The roots of our model of care precede NAATP's founding in the 1970s, from early 20th century traditions of recovery, followed by the implementation of a combined clinical and payment design in the form of the Minnesota Model. The model provided multidimensional biological, psychological, and social treatment, typically in the form of a 28-day residential program. The advent of managed care impacted the model considerably, yet it survived and evolved with a greater understanding of medical and psychology tools.

Now the landscape has changed again, and treatment understanding and practice are evolving. Co-occurring disorder treatment is more recognized. Levels of care criteria analysis is drawing greater rigor with each level occupying a valuable place. Medication assisted treatment (MAT) has taken root and is regarded as best practice in certain cases, specifically within opioid use disorder treatment. Addiction treatment, having existed for so long in a social context outside the scope of medicine, is shifting into alignment with behavioral health, which exists in turn within the larger health care industry.

Our field and insurers are, therefore, evaluating and implementing a values-based health care model premised on individualized assessment that focuses on total days engaged in care throughout the entire continuum of care. This is coupled with patient outcomes data demonstrating efficacy. This can, essentially, be seen as the implementation of a Recovery Oriented Systems of Care (ROSC) model.

Simultaneously, as the treatment field is shifting, the addiction crisis grows worse with the addition of the opioid crisis component. Over 20 million Americans suffer from substance use disorder and most go untreated.

Meanwhile, many NAATP members consistently report fewer and fewer insurance authorized days. While a portion of this trend may be attributable to changing clinical care models, many payment denials are simply unwarranted, if not unlawful. A recent study conducted by Milliman, Inc. covering 37 million employees and dependents and based on actual claims data in all 50 states for hundreds of health insurance plans, showed massive disparity, contrary to the provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA), in the payment of claims for substance use disorder compared to medical/surgical claims. And the disparity has been growing. The report shows that health plans limit providers, fail to credential new providers in a timely manner, pay significantly lower rates for care, and apply extreme utilization-review tactics that are not based on medically necessary care. This is unacceptable and NAATP and our colleagues have called for a congressional hearing to address it.

Read the NAATP Coverage of the Milliman Report and the Efforts of our Parity Implementation Coalition

With the shifting landscape as it exists, it is essential that leadership possess a strong and accurate understanding of these trends and pursue a course of action that will steer the field at large with the best interests of the patient as our north star. What the next era of addiction treatment will look like depends largely on what we, as industry leaders do now, and do together.

There are numerous voices representing various interest groups contributing to the conversation. Some of the voices are wise and well-intended. Some are neither. Without doubt, no group is better situated, based on a wealth of experience and knowledge, to guide the field forward than NAATP. Recall that our overarching objective is to provide the best care possible to the most people possible.

NAATP is committed to filling this leadership role on behalf of and together with our members. Developing an accurate and authentic position requires that we hold on to what we know is right while remaining open to what is new. The NAATP roadmap for the way forward, therefore, is comprised of the following five essential principles and programs:

1. Values

We must stay true to our values and demonstrate the same principles of integrity and authenticity that we teach our patients. There are no shortcuts or exceptions. The implementation of the NAATP Ethics Program gave us our foundation of credibility, without which our voice is ineffective. The ethics program makes NAATP unique and essential. As a corollary, the NAATP Addiction Industry Directory (AID) that contains all of its membership is distinguished and trusted, in large part because our members uphold those values and ethics.

2. Quality Assurance

We must demonstrate quality to the consumer, the payer, the policymaker, and the public. This is the essence of the NAATP Quality Assurance Initiative. The efficacy and viability of a professional discipline are dependent on the establishment and implementation of core competencies that ensure quality. Such competencies guide the practitioner, validate the service, and protect the consumer. These competencies are set forth in the new NAATP Quality Assurance Guidebook, to which all NAATP members agree to adhere.

3. Outcomes and Measures

We must demonstrate our value with data. The NAATP Outcomes and Measures Program (OMP) now underway follows on the heels of the recently published NAATP Outcomes Measurement Toolkit that establishes a model for reliable outcomes tracking and reporting. The OMP promises to fill the unmet need of our field to demonstrate effective treatment through the collection and analysis of large data sets for both distal and proximal patient outcomes.

4. Public Policy Advocacy

We must not only do the work of treating patients effectively each day, we must collectively advocate for national and local legislation that provides comprehensive access to care. In particular, NAATP will be a voice within Public Policy for parity implementation and enforcement.

5. Collaboration

Treatment providers, health care providers, insurers, and advocates must find common cause as industry stakeholders and work together. We should neither be siloed provider to provider nor staff member to staff member within treatment programs. We should collaborate with our partners in health care and other advocacy organizations. We should establish payer partnerships with insurers that are fair and mutually accountable.

Thank you for your membership with the National Association and your commitment to industry-wide excellence. NAATP is its members, a society of treatment providers dedicated to something bigger than its individual parts. As a community, we can provide the leadership our field requires. ■