NAATP NATIONAL 2023

NATIONAL ASSOCIATION OF ADDICTION TREATMENT PROVIDERS

Voice. Vision. Leadership.

A Value-Based Opportunity:
New Leverage for Provider-Led Payment Innovation and Parity Enforcement

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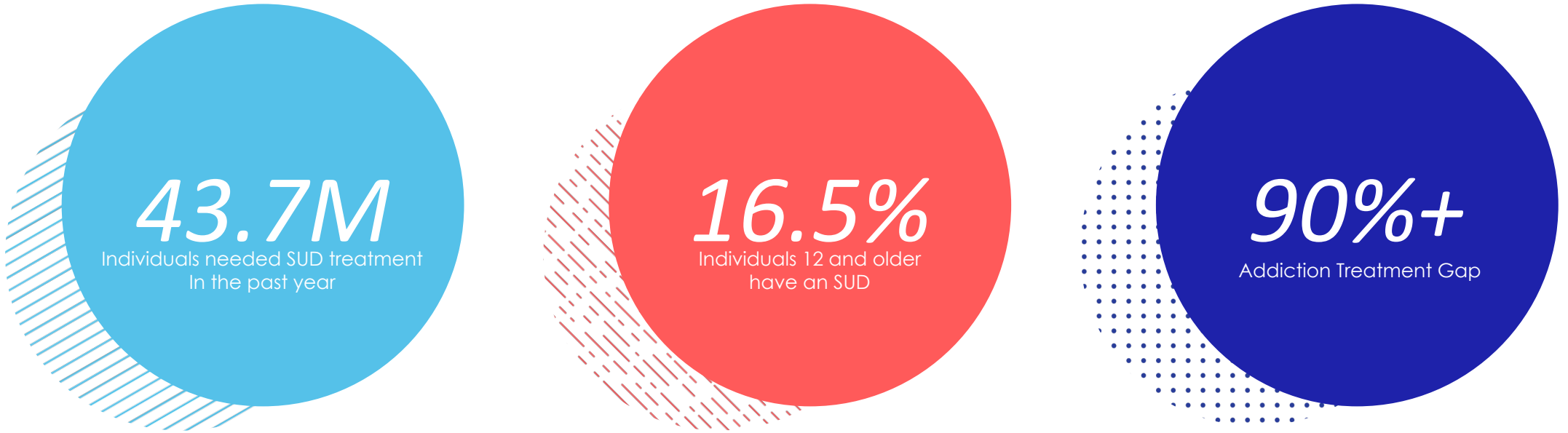
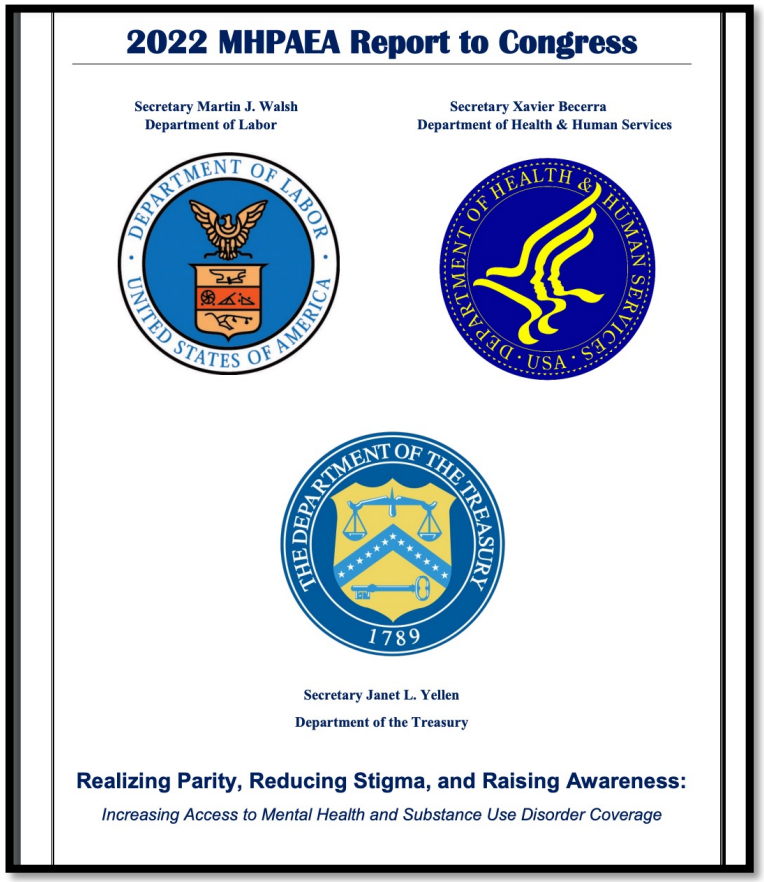
National Household Survey - SUD Prevalence



Among the 40.7 million people aged 12 or older in 2021 with an illicit drug or alcohol use disorder in the past year who did not receive treatment at a specialty facility, ***96.8% (or 39.5 million people) did not feel that they needed treatment****, 2.1% (or 837,000 people) felt that they needed treatment but did not make an effort to get treatment, and 1.1% (or 447,000 people) felt that they needed treatment and made an effort to get treatment.*

Parity Enforcement Emerging … At Last



[2022 DOL Parity Report]

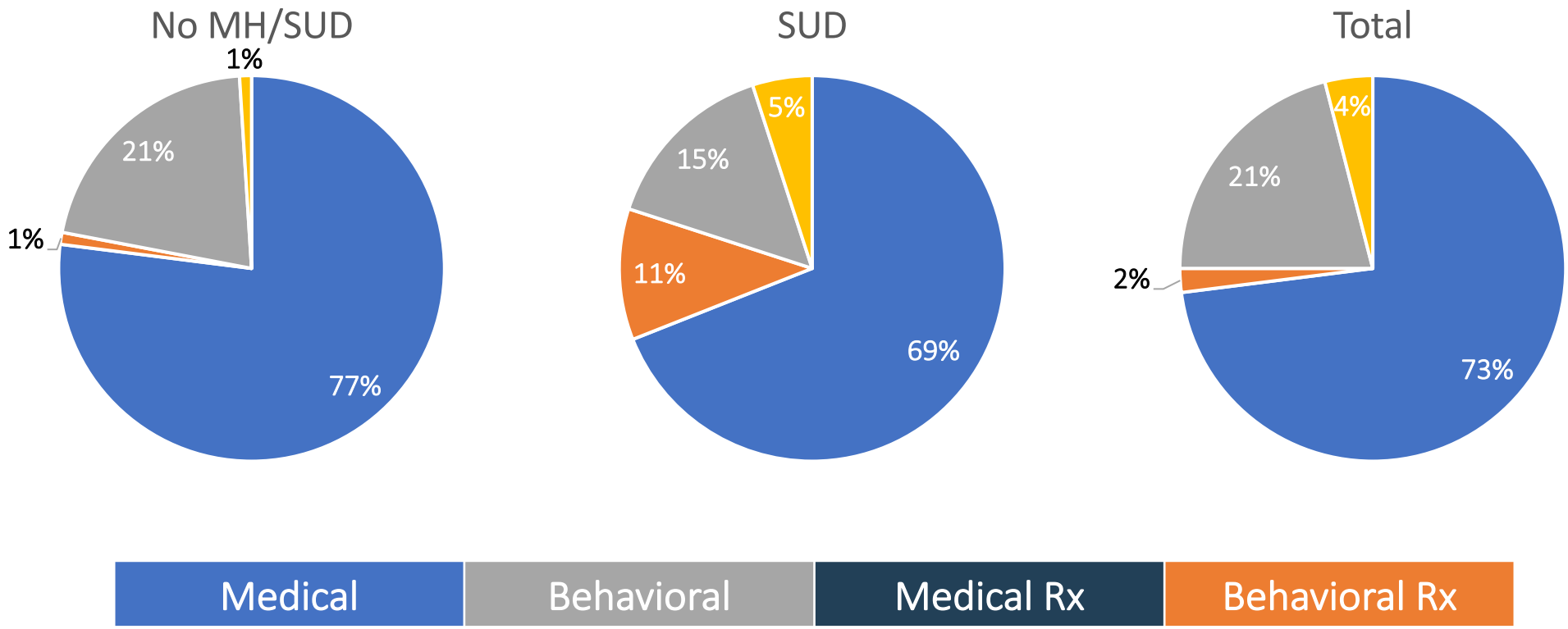
Table 1. Parity Requirements Related to Coverage Limits (Private Health Insurance)

Coverage Limits Subject to Parity Law[a]	Definition of Coverage Limit in Parity Law	Test for Determining Parity Compliance
Aggregate Lifetime Limits	Dollar limitations on the "total amount" the plan will pay for specified benefits for a "coverage unit" (e.g., an enrollee or family).	If a plan *does not* include aggregate lifetime or annual limits on *substantially all* medical/surgical (M/S) benefits, it may not impose *any* such limits on mental health/substance use disorder (MH/SUD) benefits.[b]
Annual Limits	Dollar limitations on the total amount the plan will pay for specified benefits "in a 12-month period" for a coverage unit.	
Financial Requirements	Cost-sharing requirements for coverage units such as co-payments and coinsurance, and "cumulative financial requirements" such as deductibles and out-of-pocket maximums.	A plan may not impose a financial requirement or QTL on MH/SUD benefits that is "more restrictive than the *predominant* financial requirement or treatment limitation of that type applied to *substantially all* [M/S] benefits" in the same classification.[c]
Quantitative Treatment Limitations (QTLs)	Numeric benefit coverage restrictions or plan attributes, such as limits on the number of days or visits covered.	
Nonquantitative Treatment Limitations (NQTLs)	Non-numeric benefit coverage restrictions or plan attributes. Examples of NQTLs include "medical management standards (e.g., limits based on medical necessity or if a treatment is experimental)"; drug formularies; step therapy requirements; and "standards for provider admission to participate in a network, including reimbursement rates."	A plan may not impose an NQTL on MH/SUD benefits unless "any processes, strategies, evidentiary standards, or other factors" used in applying the NQTL to MH/SUD benefits are *"comparable to, and are applied no more stringently than,"* the processes, etc., used in applying the limitation with respect to M/S benefits in the same classification.[d]

Tipping The Pain Scale (Feature Film) – Marty Walsh Clip

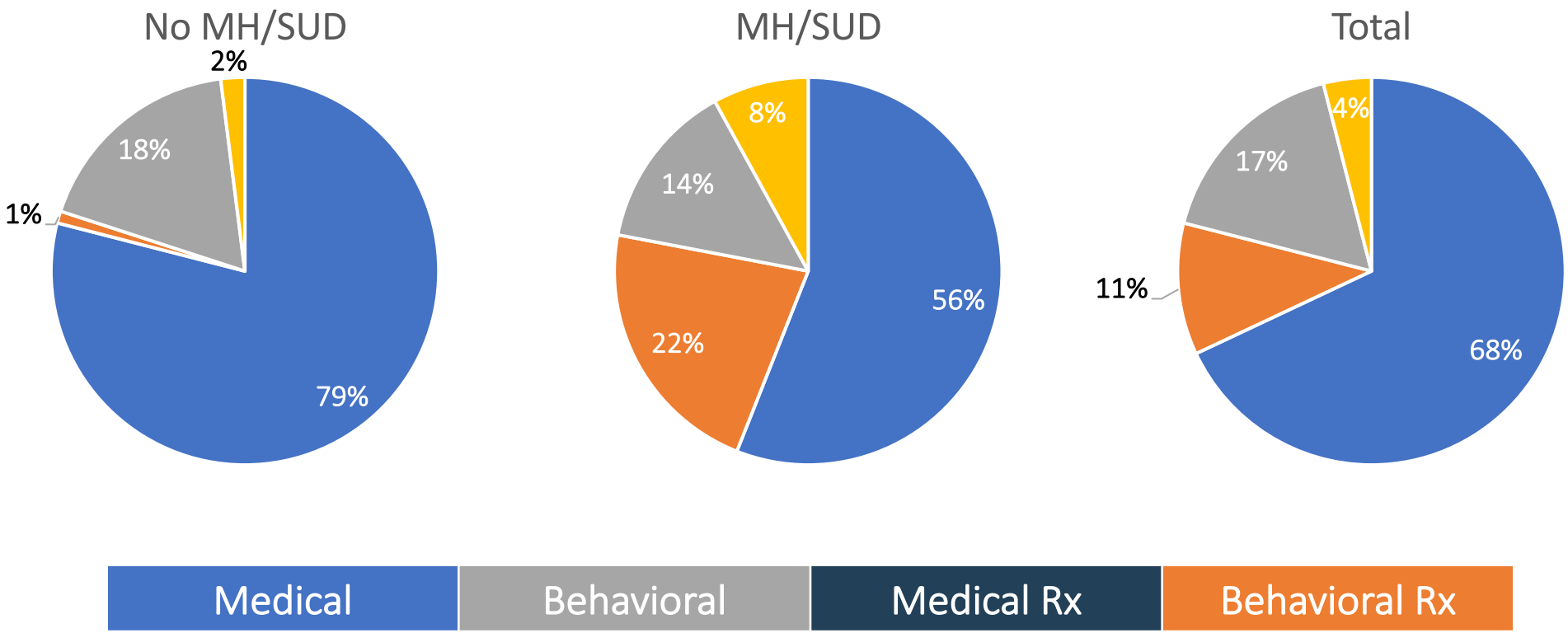
Now Available Through High Watch Media For Licensing:
https://www.highwatchmedia.com/tippingthepainscale

PMPM Costs for BH/SUD Population, Commercial



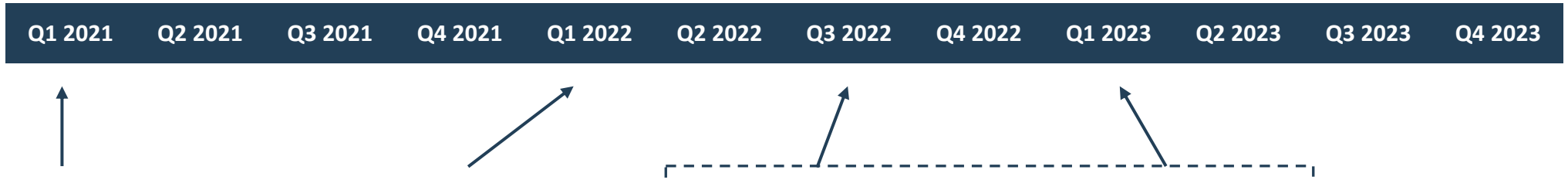
Milliman, 2018

PMPM Costs for BH/SUD Population, Medicaid



Milliman, 2018

Transparency In Coverage – Federal Regulatory Actions Have Prompted a Significant Release of New Market-Level Data



Hospitals Required to Post Charge Master

Compliance appears to be < 50% given light civil monetary penalties

Providers Required to Post Contract Rates with Payers

Limited compliance and significant gaps and inaccuracies in the data

Payers Required to Post Contract Rates with Providers

High compliance due to material civil monetary penalties for non-compliance

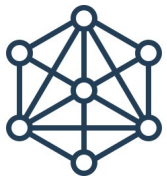
Full Regulatory Effectuation and Enforcement of Good Faith Estimates

Significant Opportunity to Leverage Pricing Data to Navigate Pathways to Full Value Capture

Federal Regulatory Actions Have Prompted a Significant Release of New Market Level Data

Transparency in Coverage	Required Dates			
Machine-Readable File Requirement – Public Disclosure of Pricing Data	**1/1/22**	**7/1/22**	**1/1/23**	**1/1/24**
Three Machine-Readable Files (Publicly Accessible)	✓	✓		
In-network Negotiated, Underlying Fee Schedule and Derived Rates for **All** Services	✓	✓		
Out-of-network Historical Allowed Amounts for All Services	✓	✓		
Prescription Drug Negotiated and Historical Net Prices	✓	delayed until further notice		
Files Updated at least **Monthly**	✓	✓		
HIOS Identifier or EIN to Identify the Plan	✓	✓		
CPT, HCPCS, NDC, DRG, or Other Code for each Item or Service	✓	✓		
NPI, TIN, and Place of Service Code for each Provider	✓	✓		
Last Date of Price Validity	✓	✓		
Notation of Capitated or Bundled Payment Arrangements	✓	✓		

Access to Contract Pricing Data Will Create a New Set of Opportunities

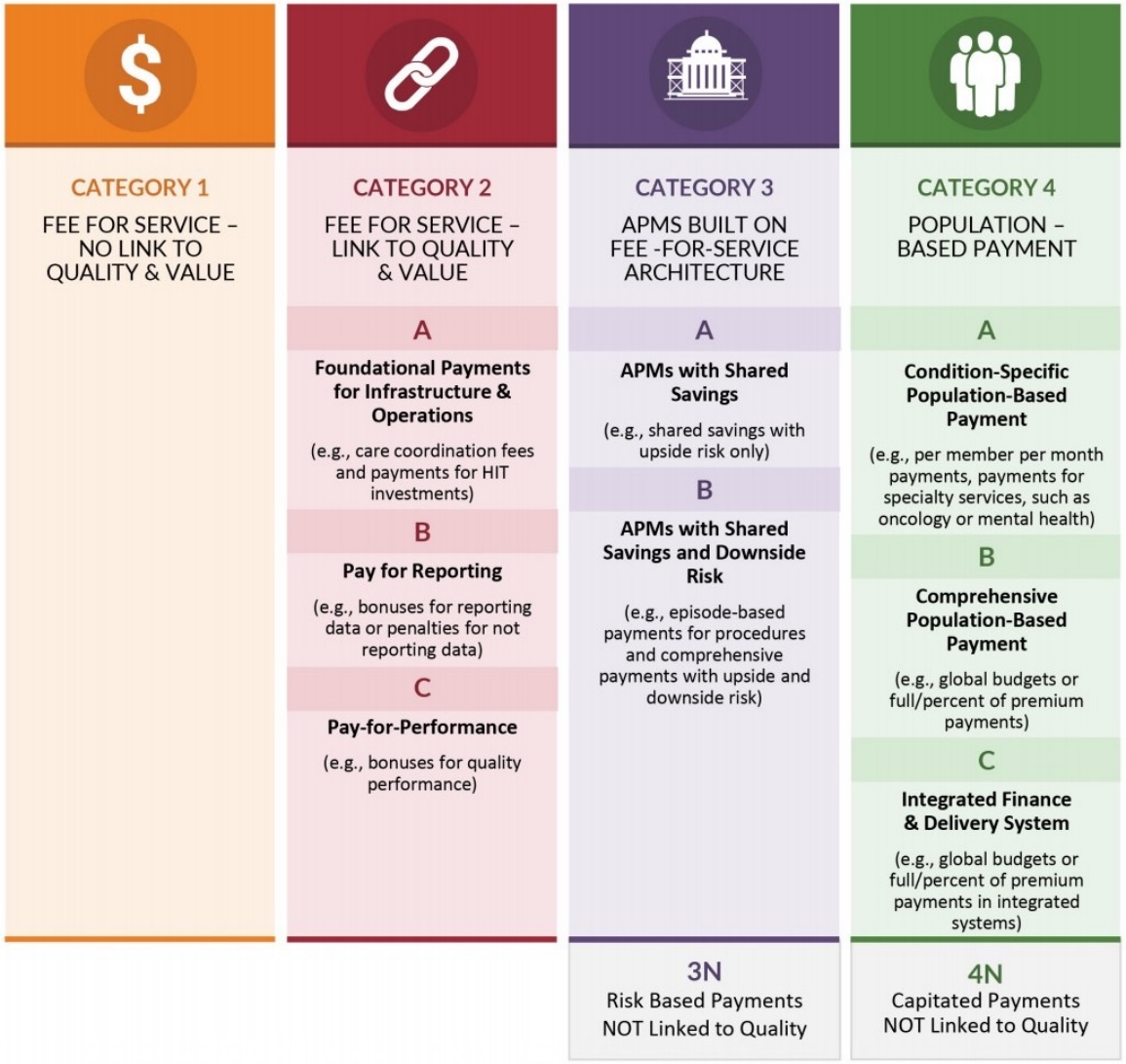
	 Cost Reduction	 Network Optimization	 Provider Steerage
Providers	Reformulate contracts with competitive pricing, value-based and outcome-based contracts	Focus on quality and cost profiles for value-based purchasing and/or care management programs	Rewarded with a steady influx of members by focusing on high-quality, outcome-centric care
 *Employers*	Financial incentives to move employees towards low-cost, high-quality care	Identify networks that best meet the health needs of employee population	Encouraging employees to select high-quality care options at low-cost providers
 *Payers*	Renegotiate contracts, referential pricing and savings from high-value services	Adjust networks to ensure adequate member coverage and reasonable access	Member incentives for effective and optimized utilization

Contract Pricing Data is *the* Keystone to Unlocking Powerful New Insights

Our Industry Has Defined "Value" in Arbitrary Terms

$$Value = \frac{Cost}{Quality}$$

HCP-LAN Alternative Payment Model Framework



SUD Value-Based Payment Model Landscape

	Category 2 FFS +link to quality			Category 3 Built on FFS architecture with risk		Category 4 Population-Based Payment		
	A. Foundational Payments for Infrastructure & Operations	B. Pay for Reporting	C. Pay for Performance	A. APMs with Shared Savings	B. APMs with Shared Savings and Downside Risk	A. Condition Specific Population Based Payment	B. Comprehensive Population Based Payment	C. Integrated Finance & Delivery System
WV SB 419			○					
ARMH-APM				●	○	○		
Value in Treatment Demonstration	●		●					
P-COAT		●	○					
CCBHCs		●	○					
PA COEs	●							

● = Baseline Program

○ = Optional or Being Phased In

State Models Leveraging Payment Models

In 2022, the National Academy for State Health Policy highlighted four states using different approaches to leverage payment to improve SUD delivery

Arizona Targeted Investment Program

- Leverage state directed payments to create 13 integrated clinics to co-located primary care and behavioral health care
- Years 1-3 of the program clinics earned incentivizes by meeting infrastructure milestones
- Years 4-6 of the program clinics earned incentives based on achieving quality metrics

Pennsylvania HealthChoices and Hospital Quality Improvement for Opioid Use Disorder Program

- HealthChoices contract requires BH-MCOs to pay 20 percent of expenditures in VBC arrangements
- The Hospital Improvement program offers hospitals payments for implementing up to four clinical pathways into OUD treatment and then incents the use of the pathways

New York Medicaid Redesign Team

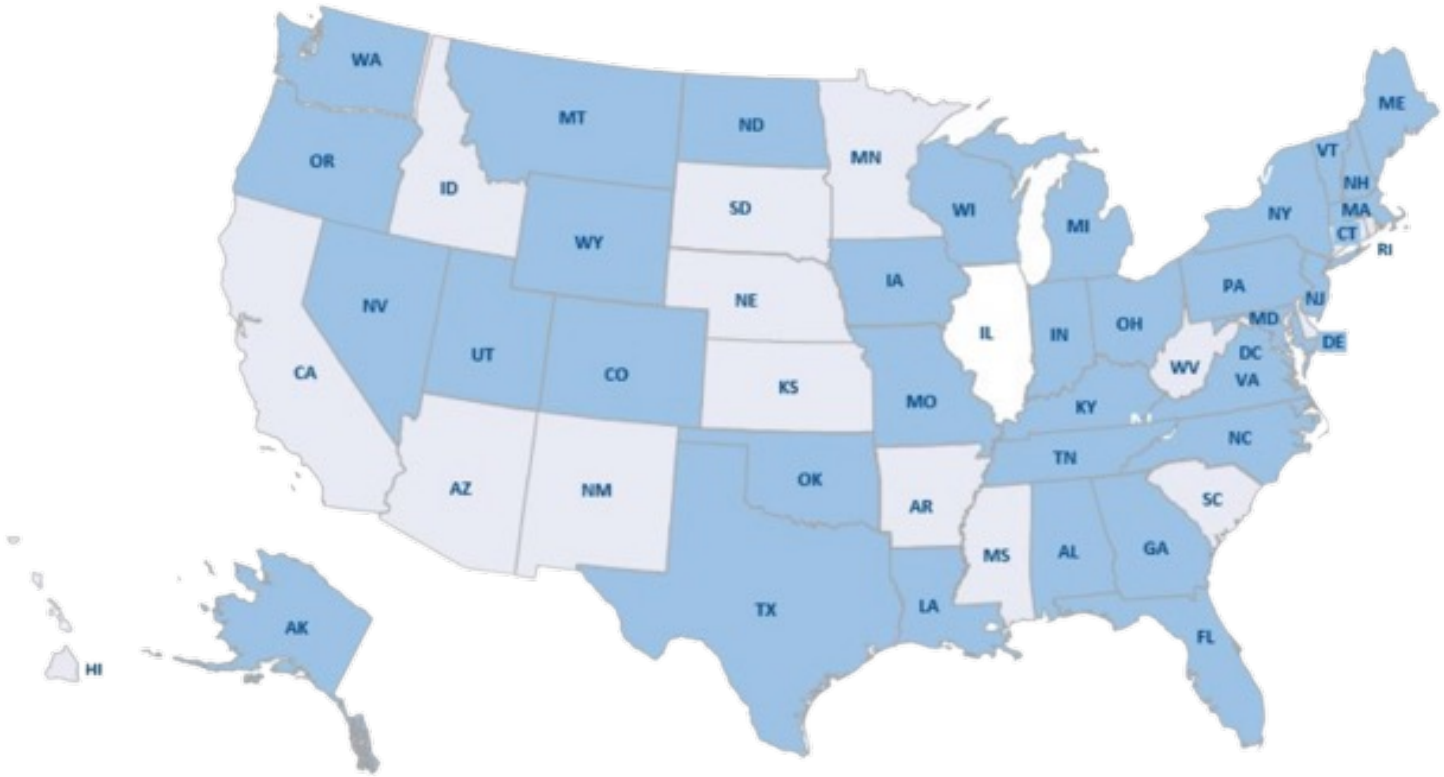
- VBP Roadmap sets VBP expenditure targets and defines VBP models, including some SUD care models
- MCO capitation rate adjustments are based on MCO performance on a set of measures, including SUD measures such as Initiation and Engagement of Treatment and Follow-up after Discharge from the ED for Alcohol or Other Drug Dependence

Oregon Coordinated Care Organizations

- CCOs contracts require VBP for behavioral health providers in 2022
- CCOs can earn incentives based on performance of measures including Alcohol and Drug Misuse Screening and Initiation and Engagement of Alcohol/Drug Abuse or Dependence Treatment.

Medicare Value in Treatment Demo

The four-year Value in Treatment (ViT) Demonstration is for Medicare FFS enrollees creates a new payment model demonstration for participating entities with three primary components:



Medicare Bundle
Opioid Fee
Schedule

+

A new per beneficiary per month care management fee (CMF) of $125

+

A performance-based incentive with respect to quality specified by CMS

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

Incentivizing Recovery. Not Relapse.

What's The Opportunity?

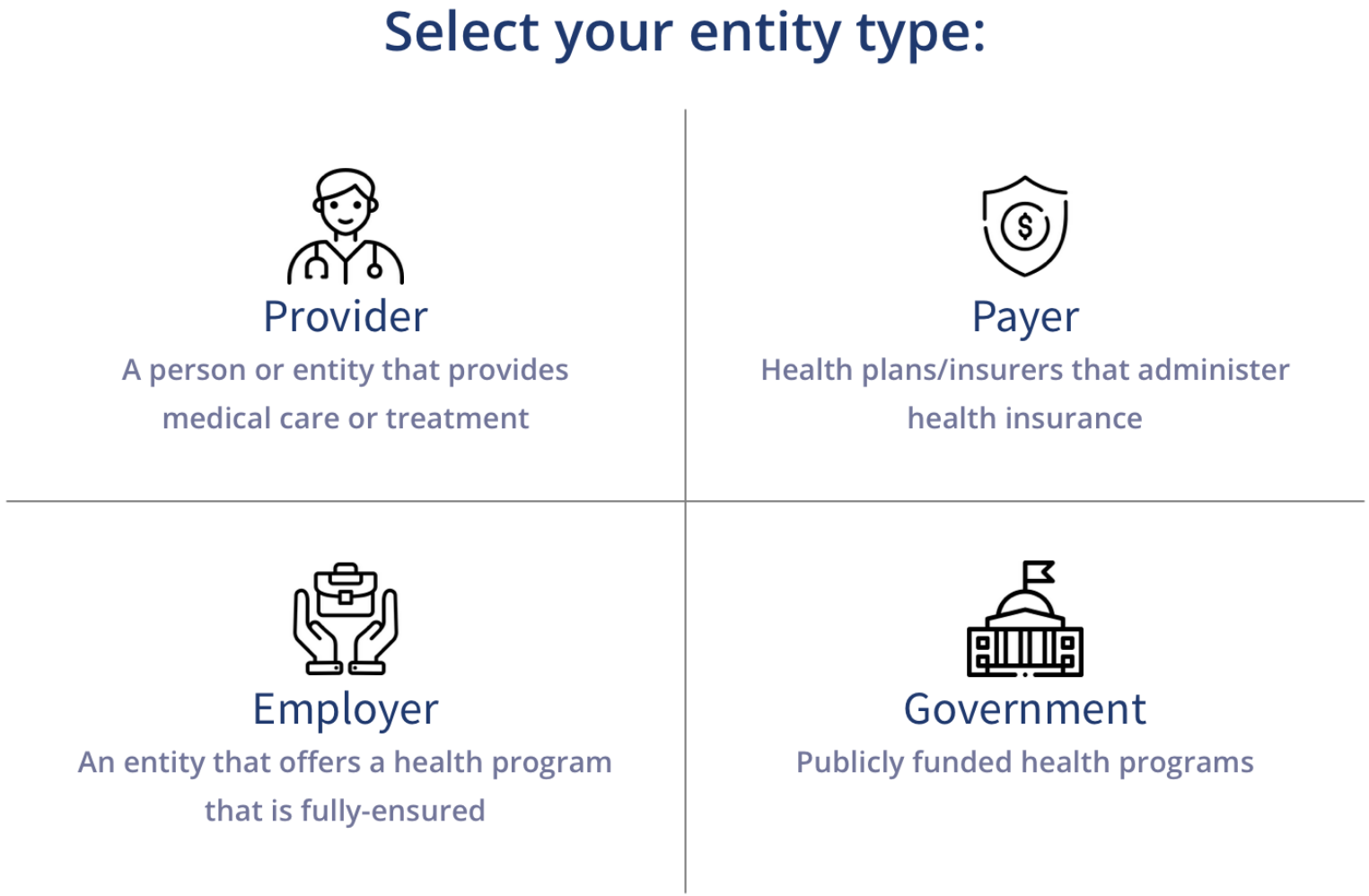
www.IncentivizeRecovery.org

Live Demo – Value Opportunity Calculator

New Interactive Tool:
www.IncentivizeRecovery.org

Core Inputs:

 # Medicaid Lives
 # Commercial Lives
% Prevalence of SUD



Development of The Addiction Recovery Medical Home – Alternative Payment Model (ARMH-APM)

- A consensus learning model first published in September of 2018 and updated in 2023 by The Alliance For Addiction Payment Reform, a national collaborative of over 40 multi-sector health care stakeholders.
- Only longitudinal shared-risk APM model to-date with a comprehensive, wing-to-wing approach to incentivize sustained recovery moving away from often redundant fee-for-service SUD care.
- It is a model grounded in overarching consistent principles but maintains flexibility and adaptability to be deployed in various market contexts, including both commercial and Medicaid.

+$40 Billion / Year

ARMH-APM: Guiding Principles

Recovery from SUD is a process of change whereby individuals achieve SUD remission through **multiple pathways**

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

Recovery management requires a **multi-disciplinary care recovery team** who can provide the diverse biopsychosocial elements of treatment needed

A well-managed and **broad continuum of care** ranging from emergent and stabilizing acute-care settings to community-based services and support

Clinical and non-clinical recovery support asset across a continuum of care should be **integrated**

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

Recovery support strategies must accommodate and support the **patient centered** growing varieties of SUD recovery

Integrating economic benefits and risks, **aligning incentives** between payers and the delivery system will promote greater accountability and care design

Recovery is a life-long process and requires a **longitudinal care model** with five years of sustained substance problem resolution marking a point of recovery stability

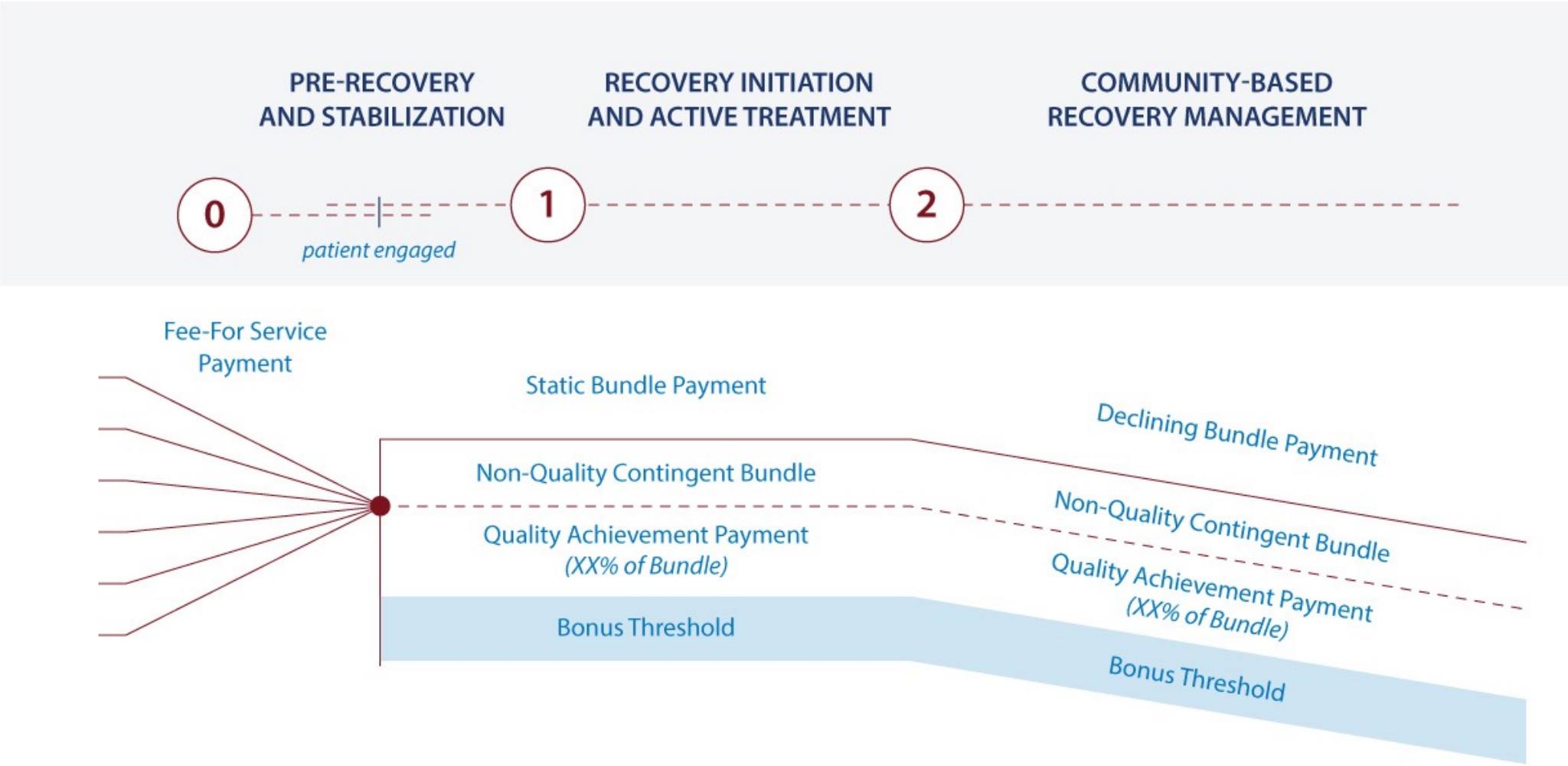
A **dynamic treatment and recovery plan** with the breadth and flexibility to engender increased recovery capital

ARMH-APM: Payment Model Elements

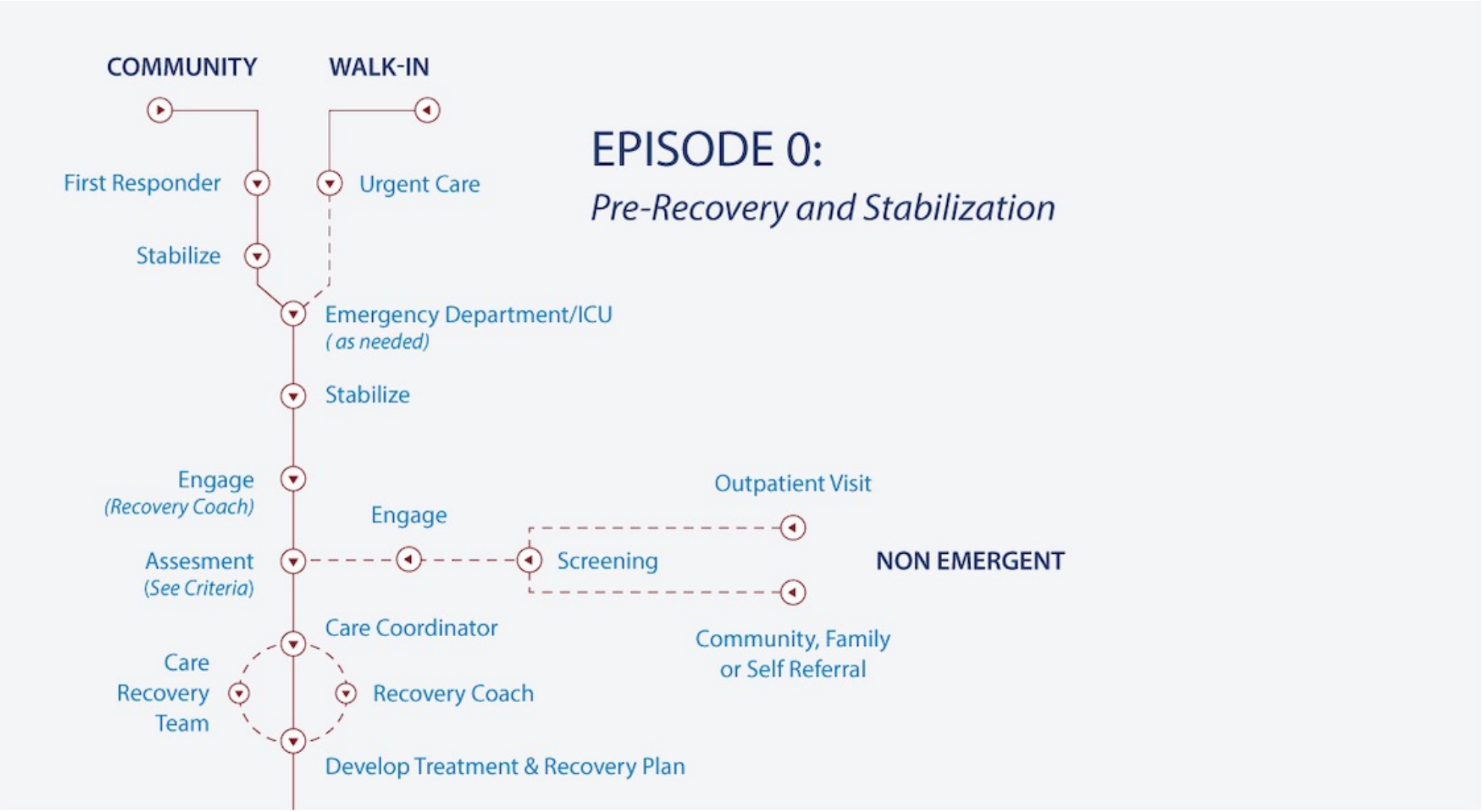
Episodes of Care	Quality Achievement Payment	Shared Savings
Risk/reward is tied to the provision of more integrated and personalized care using the defined ARMH bundle definitions and optional modules	A portion of the bundled payment is tied to achievement of successful patient outcomes	Providers may be eligible to share in additional savings created from better coordinating patient care across all health care services, including addiction, behavioral, and physical health services

Financial incentives to promote improved integration of treatment and recovery

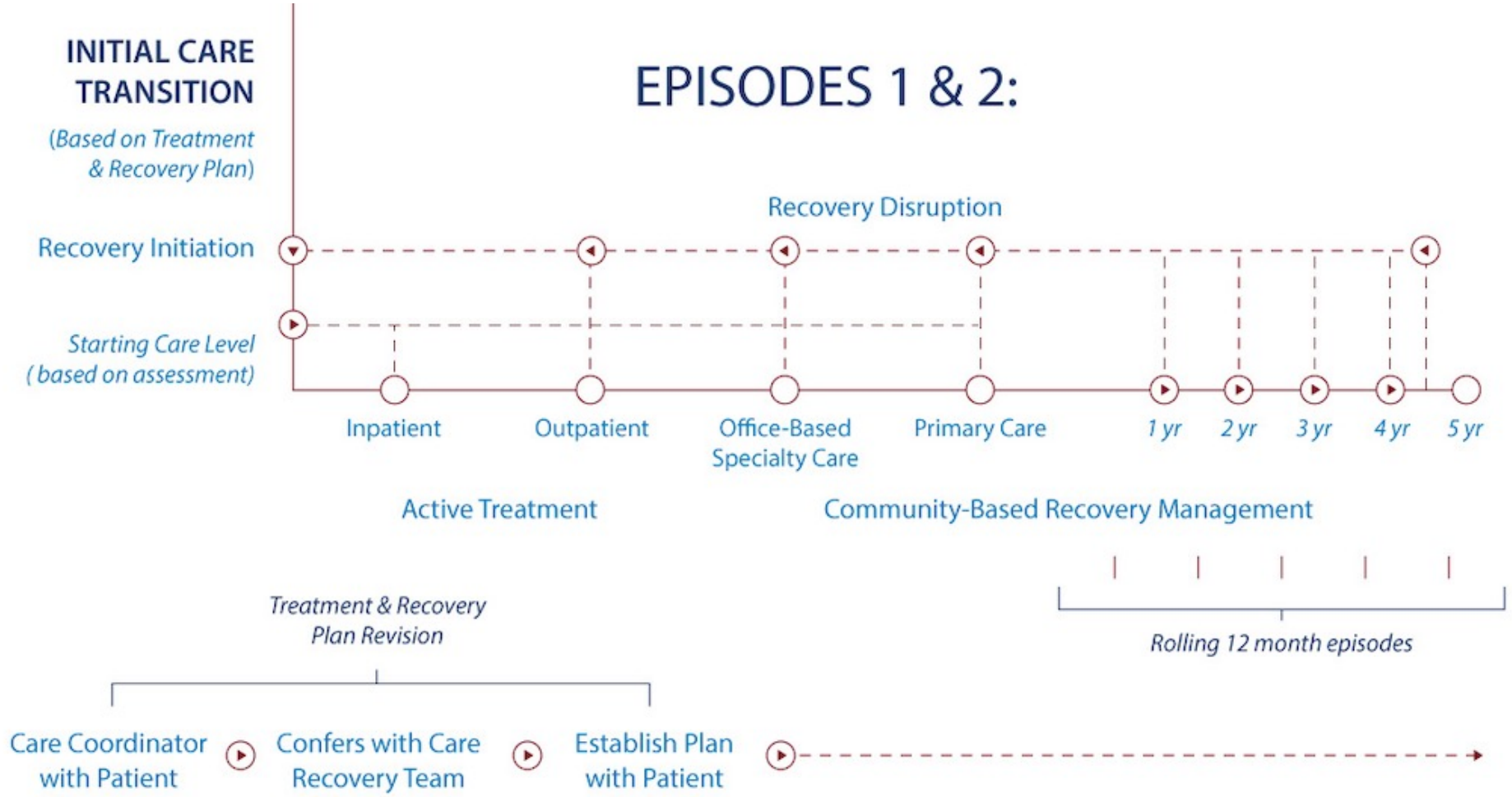
ARMH-APM: Episodes of Care



ARMH-APM: Patient Flow



ARMH-APM: Patient Flow



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www.incentivizerecovery.org

Thank you for attending

Upcoming Events:

12:00 - 1:30 Leadership Luncheon: Addiction is a Bipartisan Healthcare Responsibly
Advanced Registration Required

Sponsored By:

ALINA LODGE

HALEY HOUSE
Women's Transitional Living

HIGH WATCH
RECOVERY CENTER

1:45 - 2:45 Workshops

- Managing Increased Patient Acuity and Complexity from both a Clinical and Organizational Perspective
- Critical Juncture: Where Healthcare and Addiction Treatment Converge
- The Science of Spirituality and Healing: The NIH-HEALS Tool