Remedy
Powering the Potential™

Substance Use Disorder Episodes of Care - FAQs

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TABLE OF CONTENTS

BACKGROUND AND OVERVIEW

A. What is the impact of Substance Use Disorders on employees?

Substance use disorder (SUD) infiltrates every area of a patient's life. Workers' substance use issues are often directly tied in with their professional lives; a majority of the time, these substance use issues put peoples' careers and financial wellness at risk, which leads to more hardship, trauma, and stress for which they may continue to self-medicate.[1]

B. What is the impact of Substance Use Disorders (SUD) on employers?

Healthcare costs, employee turnover, and lost time and productivity can be directly linked to Substance Use Disorders. 25% of workplace injuries are a result of drugs or alcohol, and employees with and SUD are five times more likely to file for Worker's Compensation.[2]

In 2015 alone, the economic cost of the opioid crisis was $504B or 2.8% of GDP – and these numbers continue to rise.[3]

C. What is the current status quo in addiction treatment?

The current Substance Use Disorder treatment system incentivizes relapse, and is not organized to treat addiction as a chronic disease that requires coordinated, outcome-focused care.[4] This is because in the current short-term, fragmented acute care offering gaps are created and persist in the continuum of care, limiting the impact that providers can have in a patient's recovery. Additionally, this fragmentation means that there is little to no alignment between acute care, intensive clinical settings, primary care, and community-based services.

In terms of costs this is an expensive system, hosting many "recovery centers" that thrive on relapses at the expense of the patient and their family, in addition to incurring exorbitant out-of-network costs to the employer.

Comparable coverage for mental health and other medical treatment is a requirement, yet barriers stand in the way of achieving this parity. Current network inadequacy and high costs of out-of-network utilization create limitations around access to high-value care for Substance Use Disorders.

[1] https://novarecoverycenter.com/substance-abuse/effects-workplace-substance-abuse-2/

[2] https://novarecoverycenter.com/substance-abuse/effects-workplace-substance-abuse-2/

[3] https://www.whitehouse.gov/sites/whitehouse.gov/files/images/The%20Underestimated%20Cost%20of%20the%20Opioid%20Crisis.pdf

[4] https://addiction.surgeongeneral.gov/executive-summary/report/early-intervention-treatment-and-management-substance-use-disorders

EMPLOYER ACTION

A. Why should employers participate in care redesign for SUD?

Employers face the growing challenge of maintaining a healthy workforce in the face of rising rates of Substance Use Disorder. The good news is, care redesign through Episodes of Care can (and is already doing so) change outcomes in SUD and drive long-term recovery. Long-term recovery makes a difference for employers and their employees alike: workers in recovery miss 5 less workdays per year and help employers avoid $1626 in turnover costs. On average, each employee who recovers from a SUD saves a company over $3200 per year. [5]

B. How can employers advocate for and participate in care redesign for SUD?

Employer coalitions are participating in a coordinated effort across the market to pursue an alternative care model for a number of conditions and procedures, including Addiction Recovery. This coordinated effort is intended to build collaboration with carriers in the market, encouraging their participation in a comprehensive, wing-to-wing approach to incentivize sustained recovery – the Addiction Recovery Medical Home Alternative Payment Model (ARMH-APM). Employers can take a number of actions to drive the program to actualization:

- Commit to participating in the SUD alternative payment model in collaboration with the coalitions
- Send letters to/meet with their TPAs to discuss their commitment to the model and urge them to collaborate
- Implement a Carrier Survey to assess current capabilities of their TPAs (as well as any gaps) with respects to Episodes of Care
- Collaborate with Remedy on the establishment of regional Centers of Excellence – designated groups of providers that meet high standards for both the quality and the cost of care for individuals who suffer from SUD.

[5] https://recoverycentersofamerica.com/yourworkplace/

BUNDLED PAYMENTS

A. What are Episodes of Care?

Episodes of Care encompass the set of services provided to treat a clinical condition or procedure, for which a single, bundled payment is offered. In an Episode of Care (EOC), the burden of savings and losses is shared across both providers, payers and administrators of the Episode. As a result, Episodes encourage efficiency and higher quality care delivery by promoting collaboration and communication between practitioners to reduce healthcare inefficiencies, avoid service duplication, and reduce complications and adverse events. An episode of care, as a unit of analysis makes it possible to evaluate the quality of care delivered around a specific condition, at varying points within the episode.

B. How do Episodes of Care correct key issues with SUD treatment?

Creating sustainable change in SUD treatment requires a shift from a volume-based payment model (Fee-For-Service) to a value-based one (Episodes of Care):

FEE-FOR-SERVICE	EPISODES OF CARE
Every service is paid separately, however community support services are not paid (often rely on charitable donations and/or public funding)	Comprehensive payment/bundle that includes all services – medical and non-medical
Alternative treatment programs (e.g. Sober Houses) have to be paid out-of-pocket by patient	Alternative treatment programs can be paid for out of the comprehensive payment/bundle
Every relapse means more FFS payments	Relapses are debited against the comprehensive payment – no additional payment
Out-of-state/out-of-network providers are paid charges, some coming from family members or the patients	Risk sharing and coordination of care provide a big incentive for a “Center of Excellence” to manage the whole patient, versus using providers outside network

ADDICTION RECOVERY MEDICAL HOME ALTERNATIVE PAYMENT MODEL (ARMH-APM)

A. What is an ARMH-APM?

The Addiction Recovery Medical Home Alternative Payment Model is the only longitudinal model to-date with a comprehensive, wing-to-wing approach to incentivize sustained addiction recovery. Key elements and goals of ARMH-APM include a personalized treatment and recovery plan, Adapted Care Recovery Team, flexible network, supportive payment model, and anchoring in quality metrics.

B. What general principles guide the development of an ARMH-APM?

The ARMH-APM model recognizes that recovery is a process of change that takes time and expertise, and incorporates the following principles:

- Pre-recovery/stabilization, recovery initiation and active treatment, and community-based recovery management for at least five years of sustained substance problem resolution
- Multi-disciplinary care recovery team
- Well-managed and broad continuum of care
- Integrating economic benefits and risks between payers and the delivery system
- Clinical and non-clinical team integration to facilitate information sharing and care transitions
- Whole patient care, including co-morbidities and co-occurring mental health conditions
- Flexible model to manage the variety of SUD recovery and the broader spectrum of alcohol and other drug problem solving experiences, in close collaboration with the patient.

KEY CONSIDERATIONS FOR THE DEVELOPMENT OF SUD CENTERS OF EXCELLENCE (COEs)

There are many questions concerning what guidelines and practices are important to establish in the development and implementation of addiction recovery COEs, categories of which are covered in the following sections:

- **Parity and Benefits Design:** The rules and restrictions built into designing benefits for SUD and the utilization of SUD COEs, such that 1) the standards for achieving parity between mental/behavioral health care and medical care are met, 2) employees are driven to COEs versus high cost/poor outcome facilities, and 3) essential benefits requirements are met.

- **Network Development:** How the network of providers for SUD COEs is built such that there is assured quality and adequacy in the supply of services to manage patients.

- **Claims and Patient Flow:** How centers of excellence will work in terms of payment and patient coordination between all care-providing and administrative entities.

- **Integration with Medical Care System:** Approaches to preventing missed connections and fragmentation in SUD care delivery by leveraging and linking the medical care system.

PARITY AND BENEFITS DESIGN

A. How can employers craft SUD benefits design so that it does not violate parity standards?

Every employer's benefit design is different, so there is not one prescriptive answer. However, the rationale behind the parity legislation is to avoid any type of discriminatory behavior against mental and behavioral health patients, in order to ensure that they receive care at the same befit level as they would for medical care – therefore benefits should be designed around this. This means that employers cannot offer a benefit associated with mental and behavioral health (MH/BH) that is less than the benefit that is offered for medical care. It also means that mental and behavioral health care can be offered to be better than medical care.

A sufficient benefit for employees is designed to ensure that patients are having all of their mental and behavioral care needs met in their local area, which means that there must be adequacy of care delivery in the local system so that the need to go out of network is addressed (more on this is covered in the next sections).

B. How can employers craft SUD benefits design in order to keep patients within the COE network?

Employers must take advantage of benefits mechanisms/levers that incentivize staying in the local area:

- "Negative" incentives: Narrow networks for certain types of medical care (again, parity must guide these incentives, therefore such network restriction is possible in MH/BH care if there is similar restriction in medical care)

- Positive incentives: In medical care with normal deductible, co-pay, and out-of-pocket structures, to the extent allowable waivers of the deductible, co-pay and out-of-pockets costs can be offered when the employee goes to specifically designated providers (COE). The use of waivers for MH/BH care is possible even if they do not exist in medical care. In fact, this is an enhancement of the benefit relative to medical care.

Depending on plan design some restrictions and constraints may preclude employers from applying benefit levers. However there are additional ways to drive people to COEs, for example, Google ad placement or

integration with EAP to influence the decision making of employees. The bottom line is, the process of finding providers should lead people in-network.

NETWORK DEVELOPMENT

A. How do we assure quality and adequacy in the supply of services to manage SUD patients?

A network of providers for COEs will be built on **QUALITY** and **ADEQUACY** to ensure that it is truly a high-value network:

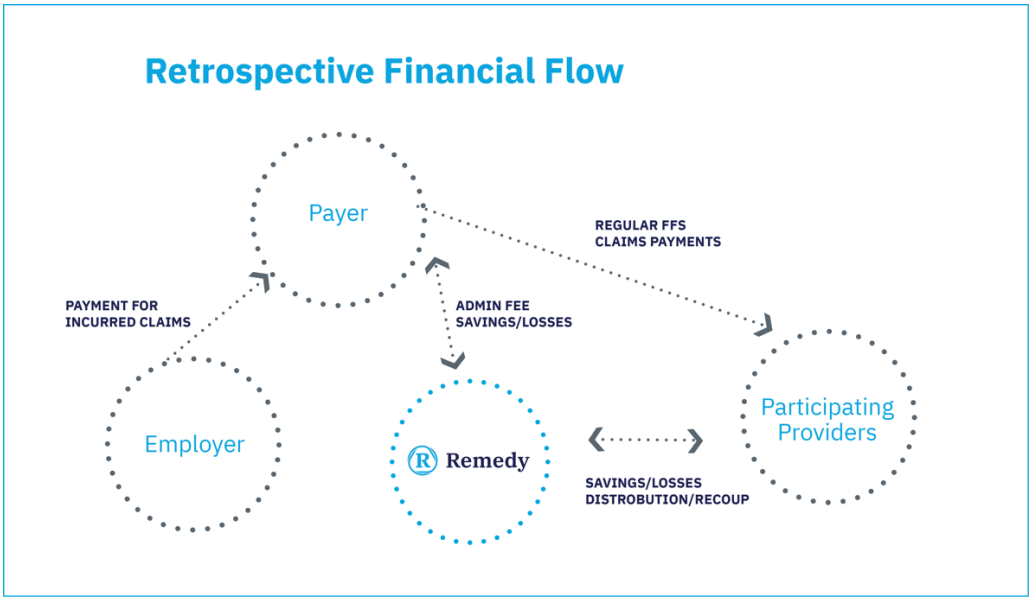
- **Quality:** A growing consensus is emerging around quality measures for assessing SUD programs. These quality measures, jointly developed by Shatterproof (national nonprofit), the National Committee for Quality Assurance (NCQA), and the National Quality Forum (NQF) will be used for pre-screening and assessing provider quality.

- **Adequacy**: To assess the adequacy of the scope of treatment for patients with SUDs, a checklist developed from the work of the Alliance for Addiction Recovery will be used to consider and assess the adequacy of SUD treatments.

CLAIMS FLOW

A. How do funds flow within the SUD Episode of Care Program?

The goal of the administration of SUD COE programs is to fit in with existing TPA structures, so as to overcome the potential difficulties of a completely new implementation and administration structure. In that vein, the claims flow is structured for that purpose. Remedy contracts with providers/medical homes, shares financial risk, and acts as an administrative intermediary (via IPA structure).



The episode price is prospectively set. This price is a target price for the episode that is defined and contracted with the provider organization. This episode price contract has upside and downside financial risk associated with it.

The financial flow is maintained: Employers continue to pay the payer (carrier) as it does today, and the carrier continues to pay providers their FFS rates. However, in this model there is an additional payment loop added between the carrier and provider that goes through Remedy. Through that loop, costs against the episode definition are created and accumulated. Reconciliation occurs upon completion of the SUD episode and after claims run out period. Remedy performs budget to actual reconciliation, comparing the preset episode price to the actual FFS total amassed throughout the episode period. Savings/losses are distributed or recouped between the carrier and participating providers/ facilities depending on program results. Remedy's administration free is integrated into the saving/losses, and not structured as an additional fee.

INTEGRATION WITH THE MEDICAL CARE DELIVERY SYSTEM

A. How will ARMH-APM leverage the medical delivery system for program success?

A growing awareness and understanding of patient needs is motivating the integration of SUD and general medical services, which come be done in a variety of ways with consistently positive outcomes. Incorporated as a core part of ARMH-APM, for example, is the engagement of emergency departments. Emergency Departments are a key service point where a number of SUD-related interventions take place, and evidence has demonstrated that intervention at this point with warm handoff to local provider for continuation and maintenance of treatment is a recipe for success. A bundled payment for all providers in the care continuum – including those integrated medical care providers – provides an incentive to intervene early, at crucial points in the continuum, and with appropriate intensity.