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**Alliance for Addiction Payment Reform:** *Value-Based Reimbursement Methodologies for SUD Treatment, Including Peer Recovery Support Services (PRSS)*
**NHBHS -** December 2024

**Presenters:**

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**Objectives**

1. Create a general understanding of the use and application of value-based reimbursement for mental health and substance use services and supports
2. Develop a clear understanding of the Alliance for Addiction Payment Reform's Addiction Recovery Medical Home Alternative Payment Model (ARMH-APM)
3. Refine how these value-based payment models can be used in the context of Peer Recovery Support Service delivery

# Substance Use Disorder Alternative Payment Model Overview

## Value-Based Payment (VBP) Opportunity for Behavioral Health

**VBP is a significant opportunity within APM frameworks for providers of behavioral health services, given that:**

- Total spending per person for individuals with a behavioral health diagnosis is nearly four times higher than for those without
- 20% of Medicaid enrollees who have a behavioral health diagnosis account for almost half of total Medicaid expenditures
- 29% of adults with chronic physical health conditions have comorbid mental health conditions
- 68% of adults with serious mental illness have comorbid chronic medical conditions

**However, there are challenges and barriers to implementing these strategies, including:**

- Inadequate baseline funding
- Patient attribution definition and methodology
- Access to total cost of care data
- Limited opportunity to benefit from shared savings
- Upfront transformation costs
- Implementing sophisticated data analytics
- Navigating complex confidentiality laws
- Lack of standardized outcome measures and multi-payer alignment

## HCP-LAN APM Framework


https://hcp-lan.org/apm-framework/

## State Example: New Hampshire



The State of New Hampshire Department of Health and Human Services contracts with Medicaid managed care organizations (MCOs) with language directing the organizations to include implementing substance use disorder alternative payment models. Two models are contractually required:

1. At least one APM that promotes coordinated and cost-effective delivery of high-quality care to birthing parents and infants born affected by exposure to substance use.
2. At least on APM that promotes greater use of Medication Assisted Treatment through a bundled payment as outlined in the Department's Medicaid APM Strategy.

*2024 MCO Contract, P. 300*

## State Example: West Virginia



A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new section, designated **§9-5-29**, relating to the establishment of a pilot project in Cabell, Ohio, and Wood County, WV by the Department of Health and Human Resources; **evaluating the impact that post-discharge planning and the provision of wraparound services has on the outcomes of substance use disorder** in three years post-substance use disorder residential treatment; setting forth service area for pilot project; **setting terms of the performance-based contract**; and requiring reporting.

*Full Bill*

## State Example: Pennsylvania



Medicaid-managed care organizations in Pennsylvania are directed to pay Centers of Excellence (COEs) through a bundled Per Member Per Month (PMPM) rate for OUD and care management services for enrollees in the community. In 2021, the PMPM rate was $277.22 for community-based care management services. The covered services include screening and assessment, care planning, referrals, monitoring, and making and receiving warm hand-offs. The MCO contracts outline 20 measures the state will evaluate via claims analysis but do not specify whether there are quality bonuses for achieving targets.

*Centers of Excellence*

## National Example: Medicare Opioid Bundle & Value in Treatment Demo

| Bundle Overview |
|---|
| Payments are based on weekly episodes of care for the following services:<br>• FDA-approved treatment medications for the treatment of OUD<br>• The dispensing and administration of such medications (if applicable)<br>• Substance use counseling<br>• Individual and group therapy<br>• Toxicology testing<br><br>Medicare beneficiaries can receive services covered under the OTP bundled with a $0 copay. |

| Sample of 2024 MAT Final Unadjusted Rates | |
|---|---|
| Methadone | $259.80 |
| Buprenorphine (oral) | $290.85 |
| Buprenorphine (injectable) | $2,006.50 |
| Naltrexone | $1,646.39 |
| Bundle with no drug | $207.29 |
| Intensive Outpatient Services | $777.39 |

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 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

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## National Example: CMMI Innovation in Behavioral Health

Announced in 2023, the Innovation in Behavioral Health (IBH) is an eight-year demonstration for eight states to "improve the quality of care and health outcomes for people with moderate to severe behavioral health conditions."

| | FUNDING TYPE | | |
|---|---|---|---|
| | Cooperative Agreement Funding | Infrastructure Fundings | VBP for IBH Care Delivery Network |
| **Recipient** | States | Practice Participants | Practice Participants |
| **Purpose** | Enhance state capacity to develop and implement the IBH Model to support practice participants | Develop the essential infrastructure and practice capacity to implement the model | Provide BH practices with a glidepath to VBP |
| **Distribution** | Section 3021 funding issued via Cooperative Agreements with CMS | • CMS distributes to Medicare practice participants<br>• States use Cooperative Agreements Funding to administer infrastructure fundings to Medicaid-only practice | • Medicaid APM<br>• Medicare risk adjusted integration support payment (ISP- estimated $200-$220 PBPM)<br>• Medicaid and Medicare Performance-based payments (PBP) |
| **Timing** | MY1 – MY8 | MY2 - MY5 | MY4–MY8 |

Presented at IBH Webinar March 1, 2024

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## 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 |
| New Hampshire: Medicaid NAS/MAT | | ● | ● | | | | | |
| Pennsylvania: Centers of Excellence | ● | | | | | | | |
| West Virginia: Senate Bill 419 | | | ◐ | | | | | |
| ARMH-APM | | | | ● | ◐ | ◐ | | |
| Value in Treatment | ● | | ● | | | | | |
| Innovation in Behavioral Health | ● | ● | ● | | | | | |

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● = Baseline Program
◐ = Optional or Being Phased In

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

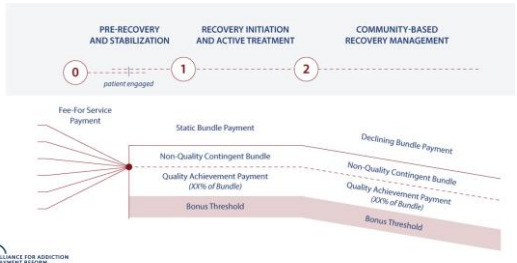
- A consensus learning model first published in September of 2018 and updated in 2023 by The Alliance For Addiction Payment Reform, a national collaborative of over 40 multi-sector health care stakeholders.
- Only longitudinal shared-risk APM model to-date with comprehensive, wing-to-wing approach to 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 a variety of market contexts including both commercial and Medicaid.


## 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

## Interdisciplinary Care Recovery Teams

## ARMH-APM: Episodes of Care Framework




## Value Opportunity Calculator


## New Hampshire Total Cost of Care Opportunity

***Inputs*:***

*176,616 Medicaid Lives*
*Ages 12+*
*12.8% Prevalence of SUD*

**Data from TMSIS 2021 SUD Data Book*

Based on national cost data, you may be spending approximately **$575,517,365.28** on your total cost of care – inclusive of total cost of physical health, behavioral health, pharmacy, and laboratory – for your population with SUD annually. While only **13%** of those your serve have an SUD, this subgroup makes up **39.7%** of your total health care spending today.

## New Hampshire – SUD APM Opportunity

By implementing an Alternative Payment Model (APM) that increases recovery rates for those with an SUD, you could be saving **$59,586,818.83** ($216 PMPM) to **$89,380,228.25** ($324 PMPM), or 4% to 6% of the total cost of care annually for these individuals.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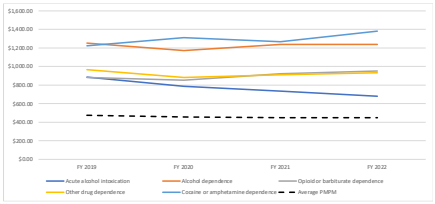
## Medicaid Per Member Per Month Cost for SUDs

The Institute for Health Policy and Practice publishes a visual analytics tool of New Hampshire Medicaid claims supporting analysis of the costs associated with SUD in the Medicaid population. The SFY 2022 average per member per month (PMPM) Medicaid expenditure is $450 in New Hampshire, a slight decrease over the past four years from $476 in 2019.

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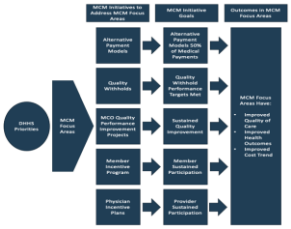
## DHHS APM Strategy

In 2019, NH DHHS set forth an APM Strategy providing key guidance for MCOs to meet requirements for developing, implementing, and reporting on APMs.

There are three goals of expanding the use of APMs to improve the following while simultaneously enhancing transparency:

- Quality of care,
- Health outcomes, and
- Cost trends

While this effort will establish base guidelines for MCO APM plan execution, MCOs currently have the latitude and flexibility to leverage provider partnerships and build APMs of their own design, including Recovery Care Organizations (RCOs).

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# Development of a Sustainable Peer Recovery Support APM for New Hampshire

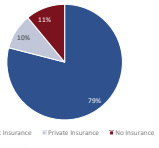
## Recovery Care Center (RCC) and RCO Stakeholder Interview Themes

1. Peer recovery support is not a clinical intervention and, therefore, must have a unique payment model that better encapsulates the breadth of community-based, SDOH-focused services that peers provide.
2. RCCs/RCOs are faced with an immense administrative burden, which is compounded by their lack of technical structure for billing.
3. RCCs/RCOs leverage multiple funding sources and thus emphasize the importance of building an APM with enough flexibility to support "braided and blended" funding.
4. RCCs/RCOs have access to robust data through RecoveryLink that can be better leveraged to drive higher-value care.

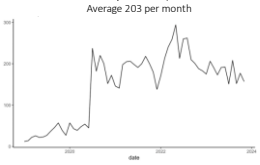
## Active Engagement in RCOs

Since the start of 2019, data show 9,293 total individuals served by the RCOs. As of the last report date of December 6, 2023, approximately 20 percent of those individuals are still considered active in the system, while 894 (~10 percent) are currently categorized as "Active Engaged."

**Engagement by Insurance Status**
N= 894 Active Engaged Members



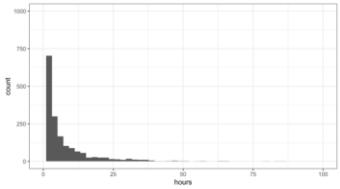

**Total statewide intakes per month (Jan 2019 – Nov 2023)**
Average 203 per month



## Active Engagement in RCOs

Over the last two years, the average number of total session hours per month for all participants is 1515 hours. Utilization per participant varies widely, ranging in 2023 from a minimum of zero hours to a maximum of 155 hours.

**Total # of participants by hours spend in sessions: 2023 (Jan 1 – Nov 30)**




## RCO Outcomes

| Outcome Measure | Baseline | Current | Change |
|---|---|---|---|
| Physical Health | 3.31 | 3.42 | 0.11 |
| Mental Health | 3.09 | 3.24 | 0.15 |
| Services Satisfaction | 4.38 | 4.46 | 0.07 |
| Self Satisfaction | 3.83 | 3.96 | 0.13 |
| Quality of Life | 3.77 | 3.86 | 0.10 |

## RCO APM Key Findings: Strengths & Weaknesses

**Strengths**

- The regulatory environment is conducive to the utilization of APM methodologies in the financing of PRSS.
- The current braided funding approach has the potential to provide ongoing and critical flexibility to RCC/RCOs to provide services and activities that could fall outside of any developed APM model.

**Weaknesses**

- There is limited understanding of APM models within New Hampshire's recovery ecosystem.
- MCO requirements to engage with RCCs and RCOs in the existing MCO contract appear to be unmet, and RCOs have been mixed in their interest and willingness to bill Medicaid, regardless of state requirements.

## RCO APM Key Findings: Opportunities & Threats

**Opportunities**

- New Hampshire's RCC/RCO system can likely benefit from a specific APM designed for PRSS that can provide more predictable cash flows.
- While each RCO is different relative to its internal capacities and business acumen, all RCC/RCOs are currently structured to allow for APMs.
- Two RCOs also operate as Family Resource Centers (FRCs), which potentially can provide lessons that can inform APM development efforts.

**Threats**

- The Alliance's assessment of the landscape did not find significant threats to the state of New Hampshire's ability to develop an APM for the recovery system.
- Relying strictly upon a FFS reimbursement methodology is not sustainable

## RCO APM Recommended Next Steps

- Expanded socialization of APM models with key stakeholders
- Development of the financial and structural underpinnings of the APM
- Development of infrastructure, regulatory, and administrative structures needed to implement an APM
- Development of a taxonomy of included billing codes
- Selection of quality measures
- Rate Setting

## Public Data Assumptions

**2024 Medicaid FFS Peer Recovery Rates**

| Service Type | Code | Unit | Rate / 15 Min | Rate / 60 Min |
|---|---|---|---|---|
| Individual Peer Recovery Support | H0038 | 15 minutes | $25.69 | $102.76 |
| Group Peer Recovery Support | H0038-HQ | 15 minutes | $10.05 | $40.20 |
| Screening, by behavioral health practitioners | H0049 | Each | $71.18 | |
| Assessment | H0001 | Each | $211.80 | |

**2021 Prevalence of SUD in New Hampshire Medicaid Population, Transformed Medicaid Statistical Information System (TMSIS)**

| Total Number of Medicaid Beneficiaries | Total Population Number Any SUD | Total Population Percentage Any SUD |
|---|---|---|
| 176,615 | 22,871 | 12.9% |

## Recovery Link Data Assumptions

**Average Length of Engagement in First 90 Days: 200 minutes (3h 20m)**

- On average, 20% of engagement is attributed to group sessions
- Average Individual sessions: 180 Minutes
- Average Group Sessions: 20 Min

**Average number of all individuals served per month: 800**

- Average number of new intakes per month: 200


*To be released on 3/26/24

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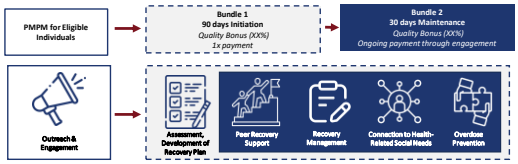
## *Payment Model - Illustrative*

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Thank you!
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