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

Incentivizing Recovery. Not Relapse.
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
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
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 note 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 interoperable (42 CFR Part 2)
• 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.
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.
ARMH-APM Key Elements

Payment Model

Quality Metrics

Network

Care Recovery Team

Treatment and Recovery Plan
Patient Engagement & Payment Episodes

PRE-RECOVERY AND STABILIZATION  RECOVERY INITIATION AND ACTIVE TREATMENT  COMMUNITY-BASED RECOVERY MANAGEMENT

0  1  2

patient engaged

Fee-For Service Payment
Static Bundle Payment
Non-Quality Contingent Bundle
Quality Achievement Payment (XX% of Bundle)
Bonus Threshold

Declining Bundle Payment
Non-Quality Contingent Bundle
Quality Achievement Payment (XX% of Bundle)
Bonus Threshold
PATIENT FLOW

EPISODE 0:

COMMUNITY

WALK-IN

First Responder

Stabilize

Engage (Recovery Coach)

Assessment (See Criteria)

Care Recovery Team

WALK-IN

Urgent Care

Emergency Department/ICU (as needed)

Stabilize

Engage

Screening

Out-Patient Visit

NON EMERGENT

Care Coordinator

Recovery Coach

Develop Treatment & Recovery Plan

Community, Family or Self Referral
INITIAL CARE TRANSITION

(Based on Treatent & Recovery Plan)

Recovery Initiation

Starting Care Level (based on assessment)

In-Patient
Out-Patient
Office-Based Specialty Care
Primary Care

1 yr  2 yr  3 yr  4 yr  5 yr

Recovery Disruption

Active Treatment

Community-Based Recovery Management

Treatment & Recovery Plan Revision

Care Coordinator with Patient
Confers with Care Recovery Team
Establish Plan with Patient

Rolling 6 month episodes
**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 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
CARE COORDINATOR
(clinical level of training)
- Convenes Care Recovery Team
- Facilitates Treatment and Recovery Plan
- Manages care transitions

PEER RECOVERY COACH
(paraprofessional)
- Patient engagement
- Sustained point of contact for patients throughout

Care based on patient need, common clinical information stored in electronic medical record

BEHAVIORAL HEALTH SPECIALISTS
(addiction medicine doctor or psychiatrist)
- Manages the psychological demands of the patient, including medication, therapy and counseling
- Recommends treatment levels of care needed in recovery initiation phase

PRIMARY CARE
(primary care physician, physician assistant, advanced practice registered nurse)
- Manages the physical demands of the patient
- Can manage patient as appropriate and trained at any phase of continuum
- Lead medical provider involved at phase 2 and beyond

PHYSICAL & DENTAL SPECIALISTS

SOCIAL SERVICES & COMMUNITY SUPPORT

LICENSED COUNSELOR
(Alcohol & drug counselor, licenced clinical social worker, mental health counselor)
Treatment & Recovery Plan

Inclusive of Social Determinants

Managing for Stress and Coping

Behavioral Economics and Choice

1. Living (e.g., evaluate your living situation)
2. Recovery (e.g., build a support network)
3. Relationships (e.g., find sober friends)
4. Healthy Body (e.g., pay attention to your body; co-morbid physical conditions)
5. Healthy Mind (e.g., focus on mental well-being; underlying behavioral health concerns)
6. Counseling (e.g., continue to see a therapist)
7. Medication (e.g., transition to a new doctor)
8. School (e.g., do your homework)
9. Work (e.g., return to work)
10. Compliance (e.g., stick with your treatment plan)
11. Spirituality (e.g., heal your spirit)
12. Interests (e.g., discover new ways to have fun)
13. Coping Skills (e.g., practice healthy coping skills)
Quality & Measurement

- No current long-term quality measures for SUD

- Initial pilots to rely heavily on process measures (e.g. patient consent to share medical record, frequency of patient contact, care transitions, etc.)

- Collaborating with The National Committee for Quality Assurance (NCQA) to explore development of longitudinal metrics as part of evaluation of pilots

- Lessons to be learned from the Collaborative Care Model being used in primary care

- Emerging tools to measure a patient’s “Recovery Capital” will be explored

- Following principles in ASAM consensus document for appropriate use of drug testing
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