How-to Guide

April 2019

Tackling Substance Use Disorders

Catalyst for Payment Reform designed this How-to Guide to help inform employers and other health care purchasers about opportunities to address substance use disorders (SUDs) in their populations.

catalyst FOR PAYMENT REFORM

With support from

PETERSON CENTER ON HEALTHCARE

Table of Contents

Introduction: Substance Use Disorders 3

About the How-to-Guide on Substance Use Disorders 4

The Scope of Substance Use Disorders 5

Assessing Data on an Initial and Ongoing Basis 7

Designing Benefits to Encourage Treatment 12

Enhancing Value and Access Through Network Design 19

Understanding Provider Payment Strategies 23

Conclusion 27

Appendix: Definitions and Terminology 28

Introduction: Substance Use Disorders

Across the United States, the consequences of substance use disorders (SUDs) are widespread and increasing in magnitude. For the first time in history, Americans are more likely to die from an accidental opioid overdose than to die in a motor vehicle crash.[1] To state the severity another way, drug overdoses are now the number one cause of accidental death in the United States, killing more Americans than car crashes and guns.[2]

But what, exactly, is a SUD? A SUD is a chemical addiction that can result from an individual's dependence on alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, anxiolytics, stimulants, tobacco and other substances. This dependence is considered a SUD if it meets two or more of the following DSM-5 criteria: hazardous use of the substance; social/interpersonal problems related to use; neglected life roles related to use; clinical symptoms of withdrawal; increasing physical tolerance to the substance; use in larger amounts than expected; repeated attempts to quit use; time spent using is larger than expected; physical and/or psychological problems related to use; and activities given up in order to use.[3] The primary regions of the brain that are impacted by SUDs support coordination, regulate the brain's reaction to stress and negative emotions, support organization, planning, prioritization, time management, and decision-making, and regulate actions, emotions, and impulses.[4]

Only over the last decade has there been a cultural shift from viewing SUDs as a character flaw to recognizing SUDs as a chronic medical condition and disease – a recognition which spurred the incorporation of SUD treatments into mainstream health care. In 2017, the Department of Health and Human Services declared the opioid epidemic a state of public health emergency, reflecting this cultural shift in perspective. Despite this newfound public recognition and recent health care reforms aimed at addressing SUDs, there continues to be increasing prevalence and growing treatment disparities.[5]

[1] https://injuryfacts.nsc.org/all-injuries/preventable-death-overview/odds-of-dying/
[2] https://www.nydailynews.com/news/national/opioid-overdoses-kill-people-u-s-car-accidents-article-1.3713354
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3767415/
[4] https://addiction.surgeongeneral.gov/sites/default/files/chapter-2-neurobiology.pdf
[5] https://www.samhsa.gov/data/sites/default/files/nsduh-ppt-09-2018.pdf

SUDs have always presented a challenge to employers and other health care purchasers, but more recently purchasers have more significantly felt their impact. SUDs are one of the most common, and costly, conditions affecting Americans, estimated to cost more than $400 billion annually. Individual employers experience the impacts of addiction through lost productivity and absenteeism, increased turnover, inflated health care expenses, and heightened rates of disability and workers' compensation.[6] Workers across a range of industries, geographies, and company sizes are affected by SUDs, though they are especially prevalent in the food industry, the construction industry, mining and drilling, and in excavation. Industries with high stress environments and workplace cultures that normalize recreational substance use can unintentionally lead to improper substance use and addiction.[7]

Employers are uniquely positioned to address addiction among their populations. While many are aware of the prevalence and severity of SUDs across the U.S. and in the workplace, they may be uncertain about the efficacy of available treatments and best practices for navigating their health plan contracts. Prioritizing employees' treatment and recovery from SUDs can reduce the employer's health care expenses and other associated costs, including the costs of decreased productivity and increased absenteeism. Employers are also in the position to reduce the likelihood of SUD among employees by establishing and promoting workplace programs, such as those focused on improving health and wellbeing and reducing stress, and to prevent new cases of addiction, to opioids for example, by using the formulary to reduce inappropriate prescribing of acute prescriptions by providers. It is a critical time for employers to tackle SUDs, bridge the existing gaps in treatment, and make a difference in the lives of their employees. The benefit can come in many forms including greater economic returns, a better company culture, and more opportunities to optimize future success.

About the How-to Guide on Tackling Substance Use Disorders

Catalyst for Payment Reform (CPR) designed this How-to Guide on SUDs to help educate employers and other health care purchasers on the intricacies of SUDs and the implications for health care purchasing strategies. This Guide includes:

- An overview of the scope of SUDs
- A discussion of employer-purchaser opportunities as they relate to:
  - Data analytics
  - Benefit design
  - Network design
  - Provider payment

The Guide stems from extensive research on the topic and from experience gained during CPR's employer collaborative on SUDs, which was formed to educate employers on their pervasiveness and challenges in the workforce. CPR collaboratives are small groups of employers and other health care purchasers that work together to tackle a specific health care

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5671784/
[7] https://www.facingaddiction.org/resources/alcohol-drugs-in-the-workplace

purchasing challenge or learn about a specific topic over the course of several months. Purchasers can learn more about this collaborative and others at catalyze.org.

The Scope of Substance Use Disorders

In the past year, almost twenty-one (20.7) million Americans aged 12 or older needed substance use treatment, yet only 1 in 8 who needed it received treatment at a specialty facility.[8] While millions of Americans struggle with SUDs, the devastating consequences are rarely limited to individuals' lives at home. In addition to negatively impacting family members and one's personal life, SUDs can detrimentally affect performance in the workplace. From an employer's perspective, SUDs can have a significant impact on the success of a business and its prospects for success. Whether it's due to lost productivity, absenteeism, injury, fatalities, theft, or negative attitudes, employees with SUDs are more likely to have increased health care costs, human resource conflicts, legal risks, and workers' compensation costs.[9] Family members battling addiction may impact an employer's health care costs (if covered in the plan) and the employee's productivity and absenteeism.

Employees with SUDs miss nearly 50% more workdays than their peers due to injury and illness, tallying up to six weeks of missed work annually. What's more, health care costs for individuals struggling with a SUD average three times the cost of an employee without one. Getting an employee into treatment and recovery can lower the employer's cost for that employee by $2,607 per year.[10] Considering the prevalence of SUDs, the cost to employers can really add up, especially in industries and occupations where they are particularly prevalent.

The most common forms of SUDs are **alcohol use disorders**, opioid use disorders, and tobacco use disorders. The National Institute on Alcohol Abuse and Alcoholism defines alcohol use disorder as "a chronic relapsing brain disease characterized by compulsive alcohol use, loss of control over alcohol intake, and a negative emotional state when not using.[11] In 2017, 14.5 million people aged 12 or over, about 1 in 19 aged 12 or over, suffered from an alcohol use disorder.[12] In the United States, 88,000 deaths are attributed to excessive alcohol use each year, making alcohol addiction the 3rd leading lifestyle-related cause of death.[13]

[8] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.pdf
[9] https://www.facingaddiction.org/resources/alcohol-drugs-in-the-workplace
[10] https://www.forbes.com/sites/lauragarnett/2017/04/07/substance-use-disorders-could-be-costing-your-business-more-than-you-think/#415bda6a22d5
[11] https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/alcohol-use-disorders
[12] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.pdf
[13] https://www.facingaddiction.org/resources/facts-about-alcohol

Alcohol use disorders affect all aspects of an individual's life, impacting relationships in the home, in the workplace, and in the community. In 2010 alone, alcohol use disorders cost $249 billion, 75% of which is attributable to lost productivity and 11% to health care costs. By industry, alcohol use disorders are especially prevalent in food service, construction, mining and drilling, excavation, installation, maintenance and repair. In the long run, alcohol dependence can lead to health problems, including chronic diseases and neurological impairments.[14]

While employers and their employees must address alcohol use disorders, the reach of substance use disorders extends beyond addiction to alcohol. The rapid rise of **opioid addiction** in the United States has resulted in an epidemic. In 2017, an estimated 2.1 million Americans had an opioid use disorder.[15] Perhaps most shocking, more than 130 Americans die from opioid overdose *every day*. In 2012, the CDC reported that health care providers in the U.S. wrote 259 million prescriptions for opioid painkillers, enough for every single American to have their own bottle of pills. Opioid and other drug dependencies cost $130 billion per year in lost productivity. Opioid use disorders are most prevalent among individuals with musculoskeletal conditions, which are especially common in industries requiring physical work such as laborers, nursing and transportation. Some research estimates that one in every four opioid users will become addicted.

According to the CDC, "tobacco remains the single largest preventable cause of death and disease in the United States," killing an estimated 480,000 Americans each year from direct **tobacco dependence** and second-hand consumption, or about 1 in every 5 deaths. Up to 80% of current smokers meet the criteria for tobacco dependence, including using more than intended, unsuccessful efforts to cut down or quit, time spent using, and failure to fulfill life obligations. Smoking-related health consequences cost the United States over $300 billion annually. Research from 2014 estimates that employees who smoke accrue nearly $6,000 per year in excess costs in the form of absenteeism, presenteeism, smoking breaks, health care costs, and pension benefits.[16]

With more than 15% of the U.S. adult population smoking cigarettes as of 2016, tobacco dependence is likely impacting most organizations, though the prevalence of tobacco dependence among working adults varies by industry and job type. Among workers in mining, accommodation and food services and construction, about 30% smoke. In addition, tobacco

[14] https://www.facingaddiction.org/resources/facts-about-alcohol
[15] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.pdf
[16] https://tobaccocontrol.bmj.com/content/23/5/428

dependence is significantly more prevalent among individuals with other substance use and psychiatric disorders. The development of new varieties of tobacco and nicotine products and their corresponding marketing campaigns has also increased tobacco use and nicotine dependency, including hookahs, electronic nicotine delivery systems (ENDS) and e-cigarettes.[17]

Beyond SUDs involving alcohol, opioids, and tobacco, individuals can also suffer from **addictions to caffeine, cannabis, hallucinogens, inhalants, sedatives, hypnotics, stimulants and other unknown substances**, as categorized by the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). While these other substance use disorders are less commonly mentioned than alcohol, opioid, and tobacco dependencies, the same diagnostic DSM-5 criteria and severity scales apply.

Building on this background, this Guide will now explore the opportunities for employers and other health care purchasers to reduce the negative impacts of SUDs on their populations. During CPR's collaborative, participants discussed four areas that present opportunities for employer-purchasers: data, benefit design, network design, and provider payment. Upon discussing each area and the opportunity as a group, CPR met individually with each participant to discuss in which area the participant wanted to dive deeper. The following sections summarize each area of opportunity, including a view into the work with each collaborative participant, and other relevant findings.

Assessing Data on an Initial and Ongoing Basis

Today, employers and other health care purchasers have access to more data than ever before. On a regular basis, purchasers review standard reports with their health plan, pharmacy benefit manager (PBM), benefits consultant, and data warehouse and analytics vendor, or other vendors. And sometimes they dive deeper, requesting custom reporting from these partners. Their goal is to understand their population and its needs and inform the strategic direction of their programs. One challenge purchasers face with the abundance of data is the risk of having too many inputs to draw a clear conclusion. In this circumstance, rather than guiding the strategic decision-making process, data can paralyze it.

[17] https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm

However, as it relates specifically to SUDs, most purchasers are not over-analyzing their data; rather, they are not getting the data they need to begin with. During CPR's collaborative, participants indicated they weren't receiving actionable standard reporting from their health plan or behavioral health administrator. A few possible reasons include: summary reporting is based on high-level benefit design provisions for inpatient and outpatient SUD treatment; the fact that SUDs are not a primary cost driver for purchasers, and the relative infancy of standardized SUD provider quality measurement and reporting compared to measurement and reporting for physical health.

Now, because of the opioid epidemic and rising SUD costs, purchasers are paying more attention to the prevalence of SUDs and their costs - SUD-related costs have increased faster than health care costs generally and consumers are often seeking care from out-of-network providers that charge exorbitant amounts for treatment with limited effectiveness.

An initial data analysis and the development of a dashboard to monitor SUDs among their populations on an ongoing basis can help purchasers understand the size of the challenge and identify and assess the impact of strategies to address it.

Initial SUD Risk and Prevalence Analysis

As an early exercise in CPR's collaborative, the participants reviewed data that estimate the prevalence and costs of SUDs. The National Safety Council, Shatterproof, and NORC at the University of Chicago together developed an easy-to-use calculator that purchasers can use to estimate the cost of SUDs to the workplace. By indicating the industry, the states in which their workforce is located, and the number of employees, purchasers can gauge the likely costs from productivity, job turnover and training, and health care, as well as the prevalence of alcohol and opioid use disorders. The calculator can help purchasers answer a question likely to come from the chief financial officer – "How much money annually do you estimate SUDs cost our business?"

After reviewing estimated cost and prevalence data, CPR and collaborative participants analyzed each participant's individual data using the following metrics:

1. ***Data metrics to measure SUD/addiction risk***

Data Metric	Timeframe	Significance of Analyzing Metric
Number of patients with: • > 10 emergency room (ER) visits per year, • > 20 ER visits per year, and • > 30 ER visits per year	Most recent 12 months	Patients that frequently visit the ER are much more likely to have a SUD. In addition, patients with more than 30 ER visits in a given year are much more likely to have both a SUD and a MH condition.
Number of patients on controlled substances, including opioids,	Most recent 12 months	Patients that are on these substances for more than 6 months are at increased risk

benzodiazepines, and stimulants		for addiction, particularly for patients on all three controlled substances.
Average morphine milligram equivalents (MME) for prescribed opioids	Most recent 12 months	According to the CDC, there is a significantly increased risk of an accidental overdose when a patient is prescribed a Total Daily Dose of greater than 90 MMEs.
Internal or Workers' Comp request: Number of filed injuries on Monday vs Tuesday	Analyze weekly for the most recent 3 months	This metric is a proxy for addiction potential. If an employee is a recreational weekend user, the employee may have an accident on Monday because of an impairment from using over the weekend.
Internal HR request: Number of sexual harassment complaints per year	Most recent 12 months	This metric serves as a secondary proxy for potential addiction. SUD can be a contributing factor to sexual harassment.
Internal or absence management administrator request: Number of absentees on an average Monday compared to absenteeism on Monday after Super Bowl	Analyze each year	This metric is a proxy for addiction potential. An employee that is absent from work on the Monday following the Super Bowl could be targeted for prevention.

2. ***Data metrics to measure SUD/addiction prevalence***

Data Metric	Timeframe	Significance of Analyzing Metric
Number of patients with any diagnosis for SUD in medical record	N/A	This metric will be much smaller than reality. Most patients with a SUD do not have the indication in the medical record.
Number of prescriptions written for any of the following medications for treatment of SUDs. • *Alcohol use disorder:* Naltrexone, Acamprosate, Disulfiram; • *Tobacco use disorder:* Nicotine Replacement Therapy, Bupropion, Varenicline; • *Opioid use disorder:* Methadone, Buprenorphine, Naltrexone	Most recent 12 months	This metric identifies members that are treated for SUDs, however, they are usually not identified as having a SUD. Providers often don't code the diagnosis even though they are treating someone for a SUD.

Monitoring SUDs on an Ongoing Basis

As mentioned, prior to the collaborative, participants felt they weren't receiving actionable standard reporting. Other purchasers would likely concur. One collaborative participant, having previously developed a broader health care cost and utilization dashboard, was interested in creating a custom dashboard to monitor SUD prevalence, cost, and related utilization in the population. CPR worked with the participant to develop a dashboard to use with a data warehouse vendor. This section offers details on the contents of the dashboard.

Ongoing SUD data dashboard metrics

Section	Contents	Data Warehouse Ability to Report
Demographics and Prevalence		
Section 1: Demographics	• Employee breakout • Member breakout	Participant and its vendor worked directly to define the participant's preferred demographic breakouts.

Section 2: Patients on Controlled Substances	• Opioids, benzodiazepines, and stimulants, including:
	  ○ Fentanyl
	  ○ Morphine
	  ○ Hydromorphone
	  ○ Oxycodone
	  ○ Tramadol
	  ○ Oxymorphone
	  ○ Buprenorphine
	  ○ Dextroamphetamine
	  ○ Amphetamine
	  ○ Alprazolam
	  ○ Diazepam
	  ○ Lorazepam
	  ○ Clonazepam
	  ○ Zolpidem
	  ○ Oxazepam
	  ○ Carisoprodol
	• Patients with a SUD on a controlled substance
		Data warehouse is able to provide reporting.

Section 3: Patients Diagnosed as Having a SUD in the Medical Record	• Opioid use disorder • Alcohol use disorder • Tobacco use disorder • Other	Data warehouse is able to provide reporting.
Section 4: Patient ER Visits in the Past 12 Months	• Number with 10 or more • Number with 20 or more • Number with 30 or more	Data warehouse is able to provide reporting.
Cost and Utilization		

Section 5: SUD Screening Payments	• Number of screenings • Payment per patient • Total cost	Data warehouse is able to provide reporting.

Section 6: Controlled Substances	• Scripts per 1,000 for:
	  ○ Buprenorphine
	  ○ Opioids other than buprenorphine
	  ○ Benzodiazepines
	  ○ Stimulants
	• Payment per patient
	• Total cost
		Data warehouse is able to provide reporting.

Section 7: Medication Assisted Treatment	• Scripts per 1,000 for:
	  ○ Naltrexone
	  ○ Acamprosate
	  ○ Disulfiram
	  ○ Bupropion
	  ○ Varenicline
	  ○ Buprenorphine
	  ○ Methadone
	  ○ Naloxone
	• Payment per patient
	• Total cost
		Data warehouse is able to provide reporting.

Section 8: In-Network Vs. Out-of-Network	• Residential treatment facility in-network average length of stay and cost per day • Residential treatment facility out-of-network average length of stay and cost per day • Inpatient in-network vs. out-of-network cost • Inpatient in-network average length of stay and cost per day • Inpatient out-of-network average length of stay and cost per day	Data warehouse is able to provide reporting.
Section 9: Morphine Milligram Equivalent (MME) Rate	• Average MME for prescribed opioids other than buprenorphine	Data warehouse vendor can calculate metric.
Section 10: Quality Measurement, per American Society of Addiction Medicine Performance Measures	• Percent of patients prescribed a medication for alcohol use disorder • Percent of patient prescribed a medication for opioid use disorder • 7-day follow-up after withdrawal management	Data warehouse is **unable** to provide reporting.

	• Presence of screening for psychiatric disorder • Presence of screening for tobacco use disorder • Primary care visit within 6 months of initiation of SUD treatment • All-cause inpatient, residential readmission • SUD diagnosis documentation in addiction treatment • Psychiatric disorder diagnosis documentation	
Section 11: Workers' Compensation	• Number of injuries filed on Monday vs. Tuesday	Data warehouse is able to provide reporting.
Section 12: Absence Management	• Number of absentees on an average Monday compared to absenteeism on Monday after Super Bowl	Data warehouse does not capture this data.

Designing Benefits to Encourage Treatment

Each purchaser has a unique reason for evaluating its SUD coverage. Many employers have likely lost employees or a covered dependent due to alcohol misuse, an opioid overdose, or cigarette dependence. Some have probably seen their health care costs for SUD treatment increase over the past several years. Others likely have concern about SUD's impact on the business more holistically - not only on health care costs, but also on workplace safety, absenteeism, presenteeism and disability. Finally, others may be laser-focused on an aspect of SUD treatment, for example: "Why has SUD out-of-network inpatient spend increased so much?" or "Why does a small proportion of my covered population visit the emergency room several times a year?" Regardless of the reason, this How-To Guide can help a purchaser get informed and identify opportunities to address one or more of these challenges.

At a basic level, a typical purchaser's mental health/substance use disorder (MH/SUD) benefit design probably looks something like the description below:

	In-Network	Out-of-Network
Deductible (Individual)	$500, $1,500 (HSA)	$1,500, $4,500 (HSA)
Out-of-Pocket Maximum	$2,000, $3,000 (HSA)	$6,000, $9,000 (HSA)
Preventive Care	100% covered, deductible doesn't apply	60% covered after deductible

PCP Visit	$25/visit OR 80% covered after deductible	60% covered after deductible
Specialist Visit	$35/visit OR 80% covered after deductible	60% covered after deductible
Inpatient Hospital	$250/visit OR 80% covered after deductible	60% covered after deductible
MH/SUD Outpatient Visit	**Same as PCP visit, no visit limit**	**Same as PCP visit, no visit limit**
MH/SUD Inpatient Stay	**Same as Inpatient Hospital, no day limit**	**Same as Inpatient Hospital, no day limit**
Pharmacy (Tier 1/Tier 2/Tier 3), per Script	Retail: $10/$35/$70, Mail Order: 2x Retail	50% covered after deductible

The reason the standard MH/SUD outpatient visit and inpatient stay benefits replicate the PCP visit and inpatient hospital benefits is due to the Mental Health Parity & Addiction Equity Act of 2008 (MHPAEA). MHPAEA requires that MH/SUD benefits must not be less favorable than medical/surgical benefits. There are six benefits categories for evaluation, including:

- In-network and out-of-network outpatient
- In-network and out-of-network inpatient
- Emergency care
- Prescription drugs

The regulation applies not only to financial benefits and limitations, but also to non-quantitative treatment limits (NQTLs), e.g., medical management, pre-authorization, and step therapy. Benefits parity testing is quite complicated and, as a result, the Department of Labor (DOL) released a summary in 2016: *Warning Signs – Plan or Policy NQTLs that Require Additional Analysis to Determine MH Parity Compliance*. A few noteworthy NQTLs of interest from the DOL summary include:

- **Medical necessity review authority:** Plan conducts its own review for MH/SUD services but delegates authority to physicians for medical/surgical services;
- **Prescription drug preauthorization:** Requires pre-authorization every 3 months for pain medications prescribed for MH/SUD conditions;
- **Residential treatment limits:** Excludes residential treatment for chemical dependency;
- **Geographical limitations:** Plan imposes a geographical limitation related to treatment for MH/SUD conditions but does not impose any geographical limits on medical/surgical benefits;
- **Licensure requirements:** Requires MH/SUD facilities to be licensed by the state but does not impose the same requirements on medical/surgical facilities.

In addition to MHPAEA, the Affordable Care Act (ACA) considers MH/SUD services to be essential health benefits (EHBs). This means that for these services, there must be no denial,

higher cost, or waiting period due to a pre-existing condition, as well as no annual or lifetime dollar limits. EHBs are defined according to a benchmark plan set by each state. Fully-insured purchasers contract with a health plan to offer a plan that includes the EHBs, while multi-state self-insured purchasers can select the state by which to benchmark its EHBs.

There is a bit of complexity as it relates to parity and EHBs. While purchasers are generally aware of these benefits' compliance requirements (and that's why it's important to start here!), it's likely that most work with the health plan, behavioral health administrator, or another external partner, e.g., a consultant, to ensure the benefits the purchaser offers meets compliance guidelines.

An additional requirement under the ACA is 100% coverage for preventive care services prior to the deductible or any out-of-pocket cost. Preventive care is defined by the U.S. Preventive Services Task Force (USPSTF), as any service that USPSTF has designated as an 'A' or 'B' rating is required for full coverage. As of January 2019, the following SUD services must be covered at 100%*:

Rating	Description	More Information
A	**Tobacco Smoking Cessation**: Behavioral and Pharmacotherapy Interventions -- Adults who are not pregnant	Link
A	**Tobacco Smoking Cessation**: Behavioral Interventions -- Pregnant Women	Link
B	**Tobacco Use: Primary Care Interventions to Prevent Tobacco Use in Children and Adolescents**	Link
B	**Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions --**Adults 18 years or older, including pregnant women	Link

As of January 2019, the following SUD services are rated an 'I' or 'Uncertain'. With an 'I' rating, USPSTF reports the current evidence is insufficient, either lacking, of poor quality, or conflicting:

Rating	Description	More Information
I	**Drug (Illicit) and Nonmedical Pharmaceutical Use:** Primary Care Behavioral Interventions -- Children and Adolescents	Link
I	**Drug Use - Illicit**: Screening -- Adults and Pregnant Women	Link
I	**Tobacco Smoking Cessation**: Electronic Nicotine Delivery systems (ENDS) -- All adults, including pregnant women	Link
I	**Tobacco Smoking Cessation**: Pharmacotherapy Interventions -- Pregnant Women	Link
I	**Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions --**Adolescents aged 12 to 17 years	Link

USPSTF recommendations are routinely updated, so CPR recommends checking for the latest ratings at the Agency for Healthcare Research & Quality's (AHRQ) website.

With all these guideposts for benefit design, purchasers may hesitate to make changes for fear of falling out of compliance. However, there are some opportunities to impact benefit design.

Prevention and Early Intervention

Get informed regarding the plan's opioid prescribing controls

For certain procedures, non-opioid medications such as acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), local anesthetics, and other psychoactive drugs can be effective at providing pain management as part of the recovery process. For example, a 2018 study found that ibuprofen and other NSAIDs with acetaminophen ease pain for dental procedures better than opioids. Regarding opioids, when prescribed and taken appropriately, they also support an individual's recovery from an acute medical condition or procedure and provide pain management for a chronic condition, as part of palliative care, or at the end of life. The Center for Disease Control has published opioid prescribing guidelines and many states have implemented them.

Purchasers should understand the day limits their PBMs have in place for an initial prescription, when there are exceptions to the rule, and the standard for managing chronic pain. Too many controls, e.g., a lower day limit or lower morphine milligram equivalent, can pose challenges for patients that need a greater days' supply or stronger dosage. Few controls can increase the risk for addiction. Finally, cutting off medication for a patient with addiction presents other clinical challenges. As a result, it's helpful to understand the PBM's standard, monitor the data, and ensure members are receiving extensive communications and support about the risks associated with opioid use.

Other resources purchasers can leverage regarding opioid prescribing include the National Alliance for Health Care Purchaser Coalition's Opioid Initiative and the Midwest Business Group on Health's Pain Management & Opioid Toolkit.

Detoxification and Ongoing Treatment

Enhance benefit design to direct members to a preferred facility or center of excellence (COE)

Not all facilities are created equal when it comes to detoxification. Some cost an exorbitant amount without producing good outcomes and bear a greater risk of relapse. Others produce better results. Purchasers should:

- Evaluate with the health plan or behavioral health administrator providers within proximity to key employee populations to identify those that stand out from others on cost, quality, and patient outcomes.
- Evaluate providers based on total cost of care, leveraging cost data combined with risk of relapse.
- Require that the facility work with the health plan case manager to plan for transition to a lower level of care back into the community.
- Steer members to a select provider or providers with benefit design incentives, offering enhanced coverage for seeking care from a preferred provider. For example, GE steers to a COE by covering initial treatment and relapse within one year (after the deductible for GE's high-deductible health plan).
- Implement a communications strategy to ensure members are aware of the preferred providers.

Explore value-based insurance design for MAT

For alcohol, opioid, and tobacco use disorder, there are multiple FDA-approved medications that support treatment and reduce the risk of addiction and overdose. In this section, we summarize the available treatment options, what each medication does, the evidence behind it, and considerations as it relates to benefit coverage.

MAT for ALCOHOL use disorder:

Drug	What Does it Do?[18]	Benefit Design Considerations
Acamprosate *Brand Name: Campral®*	Reduces symptoms of protracted withdrawal, e.g., insomnia, anxiety, restlessness, and dysphoria	• Consider mandatory generic fill • Consider no/low co-pay to eliminate or reduce cost barrier to effective treatment for members Evidence
Disulfiram *Brand Name: Antabuse®*	Produces unpleasant reaction to alcohol if ingested, including flushing, nausea, and palpitations	
Naltrexone *Brand Name: Revia® and Vivitrol®*	Blocks receptors involved in the rewarding effects of drinking and craving alcohol	

MAT for OPIOID use disorder:

Drug	What Does it Do?[19]	Benefit Design Considerations
Buprenorphine	Acts as a partial agonist at opioid receptors by reducing or	

[18] Source: https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/pharmacotherapi-1
[19] https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/pharmacotherapi-1

Brand Name: Suboxone®	eliminating withdrawal symptoms associated with opioid dependence	
Methadone *Brand Name: Dolophine*	Long-acting medication that can prevent withdrawal symptoms and reduce craving in opioid-addicted individuals by blocking the effects of illicit opioids	• Consider mandatory generic fill • Consider no/low co-pay to eliminate or reduce cost barrier to effective treatment for members Evidence
Naloxone *Brand Name: Narcan®, Evzio®*	Treats opioid overdose if someone has taken too much	
Naltrexone *Brand Name: Revia® and Vivitrol®*	Blocks opioids from binding to their receptors and thereby prevents euphoric and other effects and has been used to reverse opioid overdoses	

MAT for TOBACCO use disorder:

Drug	What Does it Do?[20]	Benefit Design Considerations
Bupropion *Brand Name: Zyban®*	Produces mild stimulant effects by blocking reuptake of certain neurotransmitters, particularly norepinephrine and dopamine	Generally, 100% covered under preventive care benefit.
Nicotine Replacement Therapy *Brand Name: Various*	Includes transdermal nicotine patch, nicotine spray, nicotine gum, and nicotine lozenges with the rationale that low, stable levels of nicotine will prevent withdrawal symptoms	
Varenicline *Brand Name: Chantix®*	Acts on a subset of nicotinic receptors in the brain thought to be involved in the rewarding effects of nicotine by mildly stimulating the nicotine receptor but not sufficiently to trigger the release of dopamine	

Finally, when exploring MAT benefit design options, CPR recommends working with the PBM to conduct an opportunity and impact analysis.

[20] https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/pharmacotherapi-1

Peer support for SUD

Peer support is help for an individual recovering from a SUD from someone who has already gone through the recovery process. Historically, peer support has been a cornerstone in treatment approaches and recovery programs. There are a variety of peer support approaches utilizing mixed services that have emerged as promising for managing substance use disorders and health conditions in social contexts.[21] Perhaps the most widely known peer support counselor is an individual's sponsor in a 12-step program. Peer support programs have grown in popularity as the clinical approach to treating substance use disorders has transitioned toward more holistic and sustained recovery - evidence to date on the efficacy of peer support programs is generally promising.[22]

Peer support is frequently covered by state Medicaid programs. However, despite the evidence demonstrating its minimal cost and notable effectiveness, is not yet covered in a standard fashion by commercial health plans, as there is not a licensing or accreditation process. Payers should explore expanding commercial coverage to include access to peer support counseling benefits for SUD treatment. Purchasers should ask payers what they are doing to cover this service. Peer counselors can be covered as part of a bundled payment or Center of Excellence approach as employees of a contracted provider. In addition, there are recovery coaching vendors in the marketplace that can help individuals access peer counseling, as well as through 12-step programs.

Group therapy for SUD

Group therapy provides a community for the individual with others who are sharing in the recovery experience. A group setting can provide peer support and reduce the sense of isolation often affiliated with recovery while creating communal pressure to abstain from substances. Similarly, group therapy allows individuals to see the recovery experiences of others that may help motivate their own recovery process.[23] There is also a strong argument supporting family therapy for individuals dealing with addiction. Family therapy can be an important component to maintaining recovery practices and changing lifestyle behaviors associated with addiction and to work on relationships that may have been strained by addiction.[24]

[21] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5047716/
[22] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5047716/
[23] https://www.ncbi.nlm.nih.gov/books/NBK64223/
[24] https://www.ncbi.nlm.nih.gov/books/NBK64269/

Like peer support, group therapy is not typically covered by commercial health plans, despite the evidence for its effectiveness. CPR recommends employer-purchasers send a consistent signal to commercial health plans by asking about expanding coverage to include group therapy for members with SUD.

Cognitive behavioral therapy (CBT) for SUD

Cognitive behavioral therapy (CBT) is a type of psychotherapy or talk therapy that falls under the broader umbrella of behavioral therapy and can be used for treating SUDs. CBT helps individuals with substance use disorders become more aware of their thoughts, feelings, and behaviors to develop skills to help with sustainable, long term recovery.[25] For SUD treatment, CBT is highly effective because it is focused on developing adaptive behaviors and life skills.[26]

Generally, CBT is covered by most insurance. In addition, new vendor entrants are developing creative ways to deliver CBT digitally to catch at-risk individuals upstream before a condition worsens.

Acupuncture [27]

In the SUD treatment and recovery process, integrative medicine is often used in combination with pharmacotherapies and traditional treatment approaches. Acupuncture treatment for SUDs usually involves inserting and stimulating needles at points associated with dopamine regulation and decreasing cortisol. The procedure aims to balance dopamine levels associated with substance use and with decreasing cravings and withdrawal symptoms.

Because the utilization of integrative medical practices for SUD treatment is recent, there is not a substantial body of evidence supporting acupuncture treatment for SUD. The evidence for acupuncture to date emphasizes the treatment as a method for relieving pain and tension which can be used by individuals in SUD treatment.

In summary, the body of evidence continues to evolve among these treatment options for substance use disorders, and even others. As data becomes more transparent, quality measurement improves, and payment models innovate, there will be continued opportunity for purchasers to align benefit design accordingly.

Enhancing Value and Access Through Network Design

Like other areas in health care, purchasers want to ensure they're offering access to an adequate network of high-quality SUD providers for their members. For the most part, this means selecting a health plan or behavioral health administrator with a provider network that offers the best access to care, in addition to the other qualities a purchaser looks for in a plan or an administrator. In SUD treatment, adequate access means more than just offering a network of specialists and inpatient facilities. The National Society of Addiction Medicine (ASAM) illustrates SUD levels of care as a continuum. Therefore, a purchaser should ensure its vendor partner offers adequate access to SUD providers across the full continuum. In addition, there are some tangible actions that purchasers can take to evaluate and potentially customize its network.

[25] https://www.mentalhealth.va.gov/substanceuse/cbt-sud.asp
[26] https://americanaddictioncenters.org/cognitive-behavioral-therapy
[27] https://www.sciencedirect.com/science/article/pii/S0376871616001095

Identifying High-Value Providers

During CPR's collaborative, one participant was focused on identifying and directing its members to high-value providers. The challenge for this participant is that its health plan administrator did not identify high-value SUD providers, distinguishing them from the rest. Health plans commonly evaluate cost and quality and designate top performing medical providers, but do not do the same with behavioral health providers. So, CPR partnered with the participant to dig deeper into its network.

The participant was interested in a specific geography where a large proportion of its members reside and/or work. We started by narrowing the provider list based on those that have either of the following certifications/designations:

- American Board of Addiction Medicine
- American Society of Addiction Medicine

In addition, we worked with the participant to develop a template data request that would allow it to identify the specific SUD providers that its members were utilizing (identified by looking at visit count and paid claims dollars) and cross-check that with the providers' certification(s) and quality performance (leveraging ASAM performance measure results).

High-Value
Provider Data Reque

The participant discovered only a handful in-network providers in the geographic region with the recommended certifications – far too few for its sizable population. As a result, the participant was interested in expanding the pool of accessible providers. CPR developed a list of questions that the participant could leverage to interview providers to understand their infrastructure, practice patterns, and other characteristics:

SUD Provider Interview Questions
1. Is the provider currently accepting new patients?
2. What is the provider's capacity (current number of patients and maximum number of patients)? *Note: Purchasers will want to understand how many openings the provider has on a weekly or regular basis if offering a treatment program. In addition, purchasers will want to understand the provider's capacity to prescribe/administer MAT.*
3. What is the provider's accessibility (days of week and hours accessible to patients)? *Note: Intensive outpatient treatment is usually not offered 7 days per week, as the treatment emphasizes the importance of making long-term lifestyle and behavior changes as part of recovery. Purchasers can seek a provider available for emergencies and offering expanded hours and/or on demand support (e.g., peer support, 12-step, text-based support) for those in recovery.*
4. What levels of care does the provider deliver per ASAM's delineation? For example: • Level 0.5: Early Intervention Services

- Level I: Outpatient Treatment
- Level II: Intensive Outpatient / Partial Hospitalization Services
- Level III: Residential / Inpatient Treatment Services
- Level IV: Medically Managed Intensive Inpatient

Note: Purchaser should customize interview questions based on the provider's response to this question. All providers should deliver Level 0.5.

5. What SUD treatment services does the provider deliver (e.g., medication, individual counseling, group counseling, vocational services, health care navigation)?

Note: Purchaser should either seek a provider that offers a well-rounded solution with the services summarized above or seek a provider offering access to some of the services with a connection or referral process in place to other services. This could be through a partner or by connecting to the purchaser's programs (e.g., EAP coaching, vocational/ return-to-work program, navigation solution, etc.).

6. What program or assessment tool(s) does the provider use to evaluate patients?

Note: Some standard screening tools include:

- *AUDIT (Alcohol Use Disorders Identification Test)*
- *AUDIT-C*
- *CAGE Questionnaire*
- *CRAFFT Screening Tool (Adolescents)*
- *NIDA Modified ASSIST Drug Use Screening Tool*
- *SBIRT Clinical Tools – these tools also include an intervention component*

Screening and Assessment Tools (ASAM)

It's most important for the provider to use a screening tool consistently, record results of a screening, and track improvement over time for those who score high in the initial assessment. If a provider responds indicating use of "the best tool for the situation", dig deeper to understand the follow-up and tracking over time. There are various screening tool options available to providers that can be utilized, the most important thing to note is a provider's demonstrated commitment to the screening process.

7. Does the provider evaluate and treat co-occurring disorders/co-morbidities?

For example:

- *Screening for depression & anxiety disorders*
- *Testing for HIV, AIDS, viral hepatitis*

Common Co-Morbidities (SAMHSA)

Note: Diagnosing and treating co-occurring disorders/co-morbidities is an important step in SUD treatment and recovery. If the provider does not treat the patient for co-occurring disorders/co-morbidities, the purchaser should dig deeper to understand and ensure that the provider has a referral process in place to steer patients to appropriate providers.

8. What are the provider's indicators for outcomes and how does the provider measure them?

For example:

- All cause inpatient, residential re-admission
- Sustained reduction in patient substance use
- Patient functioning (return to work, return to school)
- ER utilization
- Medication adherence

Note: Providers may have limited/no access to specific data (e.g., ER utilization) outside of own practice, unless in an ACO.

9. In what frequency and situations does the provider direct patients to other specialists and/or treatment facilities? Are these on-site or through referrals? *Note: Listen for whether the provider is doing this. And if so, is the provider consistently referring to a group of other specialists. This suggests that the providers are communicating and in more frequent contact with each other.*
10. How frequently does the provider re-assess patients to monitor progress? *Note: Listen for daily if it's a more intensive program. A person that is prescribed MAT should be assessed multiple times per week for the first month, then less frequently after that.*
11. How do recovery support services fit into the addiction treatment? *Note: These programs are support, not treatment. They can be available online and via phone too. Listen for a provider not offering access to a level of support.*

Implementing a SUD COE

For purchasers that are looking to limit the usage of exorbitant cost facilities that may not be providing high-quality care, implementing a SUD COE presents another network design opportunity. Working with either a contracted health plan or other third-party administrator, the first step is to identify high-performing facilities based on treatment outcomes. One consideration in identifying a facility is the "step-down" in level of care after the initial treatment – that is, the facilitation of getting a patient out of inpatient or residential treatment and integrated back into the home environment and the community. For example, an individual that travels to a COE to receive a knee replacement may easily integrate back into a daily routine, having check-ups or physical therapy on an outpatient basis. With SUD, an individual that travels to an inpatient or residential treatment facility for detoxification may be challenged by potential triggers to use the substance again upon returning to the home environment and community. As a result, purchasers considering a SUD COE strategy should understand how it can be part of a continuum of care from when a patient is admitted for detox through treatment discontinuation.

Read about GE's COE program through Optum here.

Expanding Access with Alternative Solutions

Niche solutions present an opportunity to expand the "network" of providers by offering members access to a lower severity level of care and potentially earlier intervention. These solutions aim to engage and impact individuals that want to change but are not ready to seek care from a provider or are concerned about the stigma associated with seeking professional help.

One participant in CPR's collaborative expressed interest in an up-and-coming vendor solution that aims to reduce alcohol use disorder in the population and wanted CPR to vet the solution. CPR asked the following questions of the vendor to understand their offering; purchasers can use these to guide introductory discussions with other vendors:

SUD Vendor Exploratory Questions
1. When was the company founded and who are its leaders?
2. What solution(s) does the company offer? Which SUDs does the solution(s) aim to treat?

3. On what evidence is the solution based, including its methods of patient engagement?
4. What modalities does the solution use to engage the individual (e.g., website, mobile application, telephonic, coaching, clinician, etc.)?
5. Describe the experience of an individual using the solution from being introduced to it, to enrollment, engagement, and completion of the program.
6. What are the results (e.g., enrollment, engagement, completion, patient outcomes, cost savings/avoidance, productivity, etc.)?
7. Are there any peer-reviewed publications or white papers that feature the solution? Please provide.
8. How is the solution integrated with other purchaser offerings? Is it a direct-to-purchaser solution, offered through the health plan/behavioral health administrator, or delivered in another manner?
9. What is the cost structure, i.e., how does the company get paid for the offering?
10. For how long has the organization offered a purchaser solution? If not currently offered to purchasers, what is the anticipated rollout date?
11. What makes the solution unique compared to others on the market?
12. How is the company funded, and what is its strategic roadmap?
13. Who does the company consider to be its biggest competitors?
14. Can the company provide current client references?

Coming Soon: Shatterproof's Rating System for Addiction Treatment Programs

With a grant from the John and Laura Arnold Foundation, Robert Wood Johnson Foundation, and support from major health care companies, Shatterproof is leading the effort to standardize quality information across the different levels of care for SUD. This initiative, which will create a public facing directory of treatment programs, has the potential to result in a giant leap forward when it comes to the ability of individuals, family members and purchasers to identify high-quality providers.

Understanding Provider Payment Strategies

The health care system continues to shift from traditional fee-for-service (FFS) to new methods of provider payment that emphasize value; today, over 50% of health care payments have some kind of link to quality. While there has been significant progress over the last several years in the shift from FFS to payments tied to quality for physical health care, payment to providers for SUD treatment is still largely traditional FFS. This is, in part, because standard measures to assess the quality of SUD providers are still in development. However, the recent opioid epidemic has spurred purchasers (primarily state Medicaid agencies), payers, and other stakeholders to experiment with payment

innovation. This section tracks value-oriented payment opportunities for purchasers across the various alternative payment methods that exist in the market today.

Shared Savings and Shared Risk

Today, the most common type of value-oriented payments in health care are shared savings arrangements. In these arrangements, payers contract with providers to offer an upside-only financial incentive for providers to reduce unnecessary spending while meeting quality goals. Typically, these involve a budget that has been set and if the provider comes in below budget, they share savings with the payer. In a shared risk model, the payer's contract with the provider contains both upside and downside incentives. If providers overspend, they must absorb some of the losses. Most of these arrangements are with accountable care organizations (ACOs), a network of providers that shares financial and medical responsibility for providing coordinated care to a patient population and eliminating waste in the system. A consumer may actively select into an ACO or be passively attributed to it by the payer as a result of seeking care from an ACO provider.

Purchasers should seek information from their health plans or other third-party administrators about their efforts to integrate behavioral health care with physical health care. For example, does the health plan:

- Require contracted ACOs to offer SUD services or access to them?
- Provide educational opportunities and/or training to PCPs on SUD screening and treatment? Also, does the health plan offer any such opportunities to its broader network?
- Require primary care providers to use a standard SUD screening tool(s)?
- Require the provider to record SUD diagnosis in the medical record in order to be paid?
- Offer access to an adequate number of MAT providers who also offer SUD counseling resources to their patients on MAT?
- Tie specific measures of the quality of SUD treatment to the contract? If so, which ones?

Another consideration for purchasers is to arm primary care providers and care coordinators for key ACOs with EAP assessment and referral resources. ACOs may be challenged to find an adequate number of quality treatment options. Leveraging the EAP gives them another resource to support the individual with care, while managing the cost trend and health care utilization.

FFS Base Payments Plus Pay-for-Performance (P4P)

FFS base payments plus P4P bonuses are fixed dollar payments to providers for the care that patients receive in a given time period, with payment adjustments based on measured performance (quality, safety, and efficiency) and patient risk. P4P allows payers to reward providers for strong performance on specific services; not all providers are ready to enter into shared risk arrangements, nor are they always appropriate. Purchasers should ask their health plans whether they implement P4P and if they include measures of performance related to SUD treatment, such as:

- SUD screening and medical record reporting;

- MAT waiver and prescribing;
- Referral to appropriate level of care, e.g., intensive outpatient or partial hospitalization vs. residential or inpatient treatment.

Organizations leveraging a P4P model for SUD treatment include[28]:

- UPMC *For You*, a Pennsylvania Medicaid managed care organization in which providers prescribing SUD medications and performing well on quality measures can earn bonuses;
- Partnership HealthPlan, a northern California community-based health care organization that contracts with the State of California and rewards providers when they perform an annual urine toxicology screening for patients prescribed long-term opioids.
- Oregon Health Authority rewards for achievement of target quality measures, for example, cigarette smoking prevalence and drug and alcohol screening;

Capitation

Capitation is a fixed dollar payment to providers for the care that patients may receive in a given time period, such as a month or year. CPR tracks multiple methods of capitation, including condition-specific capitation (i.e., for a specific condition or set of conditions), full capitation with- or without quality (i.e., payment based on measured performance or not), and partial capitation (i.e., payment for high-cost services, such as drugs or medical devices).

As summarized below, there tends to be more momentum on capitation payments in Medicaid for SUD services as opposed to the commercial market. CPR will continue to monitor capitation and other alternative payment methods as part of its health plan user groups to understand the extent that it takes off as an APM for SUD services.

- Over the past few years, CMS has approved several Section 1115 waivers that allow states to use federal Medicaid funds for treating non-elderly patients with substance use disorder in an institution for mental disease (IMD). Per the 2019-2020 CMS Medicaid Managed Care Rate Development Guide:

"When IMDs are used to provide in-lieu-of services, states may make a monthly capitation payment to an MCO or PIHP (in a "risk contract" as defined in 42 CFR §438.2) for an enrollee age 21 to 64 receiving inpatient treatment in an Institution for Mental Diseases (IMD) (as defined in 42 CFR §435.1010) for a short-term stay of no more than 15 days during the period of the monthly capitation payment in accordance with 42 CFR §438.6(e)."

- On the commercial side, the Addiction Recovery Medical Home model, described in more detail in the Bundled payment section below, uses capitated payments tied to population-based patient severity criteria (e.g., higher-risk onset of SUD and/or co-morbidities or co-occurring disorders) to adjust the bundled payments during each of the three episodes of care.

[28] https://www.chcs.org/encouraging-substance-use-disorder-treatment-in-primary-care-through-value-based-payment-strategies/

Bundled Payment

Also known as "episode-based payment," bundled payment means a single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or to provide a given treatment. Providers assume financial risk for the cost of services for a treatment or condition as well as costs associated with preventable complications. There are numerous SUD experiments going on using bundled payment:

- Geisinger Health Plan leverages a retrospective payment model for providers treating patients for opioid use disorder.
- Mount Sinai Health Partners is participating in a pilot to assume total cost of care responsibility for SUD patients. [29]
- Beacon Health Options is partnering with Column Health on a bundled payment structure designed to treat patients in phases across a continuum of care.[30]
- OptumHealth and CleanSlate Centers uses a monthly bundled payment to deliver MAT.[31]
- A multi-stakeholder group, including Facing Addiction with NCADD (The National Council on Alcoholism and Drug Dependence), Leavitt Partners, Remedy Partners, and others recently launched an Addiction Recovery Medical Home model intended to support SUD treatment and recovery longitudinally. The new payment model incorporates multiple payment methods across the continuum of care, including fee-for-service, episode-based payment, quality adjustments, and shared savings. The group is piloting the alternative payment method in at least two markets in 2019.[32]
- Vermont Medicaid's Innovation Accelerator Hub and Spoke program offers support for people with complex opioid use addictions at regional Hubs and ongoing treatment integrated with health and wellness at Spoke locations. For buprenorphine treatment, the model includes four levels of bundled payment – clinical assessment and induction, stabilization, maintenance, and discontinuation and medical withdrawal. Similarly, Massachusetts' Collaborative Care Model includes four levels of bundled payments as a patient moves through treatment at a primary care practice or clinic. [33]

[29] https://www.chcs.org/encouraging-substance-use-disorder-treatment-in-primary-care-through-value-based-payment-strategies/
[30] https://www.beaconhealthoptions.com/beacon-health-options-inks-innovative-value-based-contract-with-column-health-to-expand-access-to-medication-assisted-treatment-for-opioid-use-disorder-in-massachusetts/
[31] https://www.openminds.com/market-intelligence/executive-briefings/optum-cleanslate-value-based-partnership-case-study/
[32] https://www.incentivizerecovery.org/
[33] https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/reducing-substance-use-disorders/tools-and-resources/index.html

Payments for Non-Visit Functions

Payments for non-visit functions include payments for services such as outreach and care coordination/management; after-hour availability; patient communication enhancements, health IT infrastructure and use. They may come in the form of care or case management fees, medical home payments, infrastructure payments, meaningful use payments, and/or per-episode fees for specialists.

This type of payment arrangement may include payments to an ACO to establish the infrastructure or care coordination between primary care and SUD providers or access to alternative services that are not part of a visit with a credentialed provider and reimbursable by the health plan, for example, offering peer support or a family program. For example:

- Partnership HealthPlan in California offers a $500 payment to providers that obtain the MAT waiver;
- Central California Alliance for Health offers a $1,000 payment to certain providers for increasing network capacity to manage SUD patients through MAT.[34]

Conclusion

The prevalence and impact of SUDs has everyone's attention – from representatives in our nation's capital, to purchasers offering solutions to their populations, to individuals who know someone with a SUD or who have lost a loved one to SUD. CPR is hopeful that this How-To Guide helps purchasers plot a path forward by being more informed about their populations, enabling them to implement thoughtful benefit and network design strategies, as well as approaches to provider payment.

[34] https://www.chcs.org/encouraging-substance-use-disorder-treatment-in-primary-care-through-value-based-payment-strategies/

Appendix: Definitions and Terminology

Addiction: According to the National Institute on Drug Abuse (NIDA), addiction is defined as a chronic, relapsing disorder characterized by compulsive drug seeking, continued use despite harmful consequences, and long-lasting changes in the brain. It is considered both a complex brain disorder and a mental illness. Addiction is the most severe form of a full spectrum of SUDs, and is a medical illness caused by repeated misuse of a substance or substances.

Behavioral therapies: Behavioral therapies help individuals engage with substance use treatment, incentivizes their adherence to treatment, and emphasizes positive attitudes and behaviors related to reducing drug abuse. Behavioral therapy also focuses on developing life skills to cope with stressful environments and cues that previously may have triggered substance use. Examples of behavioral therapies include: cognitive behavioral therapy (CBT), contingency management, and 12-Step Facilitation therapy.[35]

Co-occurring disorders: An individual with co-occurring disorders implies they have been diagnosed with both a SUD and mental illness. While one disorder may pre-date the other, the existence of both typically aggravates the other, making the symptoms of both more severe.[36]

Detoxification: Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. However, medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use. Although detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.[37]

DSM-5: DSM-5 is the fifth and most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the standardized manual for defining and classifying mental disorders. Definitions for SUD, and more specific types of SUD, likely originate from meeting the DSM-5 manual's criteria. The DSM covers clinical disorders, personality disorders, general medical conditions, psychosocial and environmental problems and more.

Medication Assisted Treatment (MAT): MAT is the use of FDA-approved medications in combination with behavioral therapies to provide a holistic approach to SUD treatment. MAT can be used for opioids, alcohol and tobacco.[38]

What medications are FDA-approved as MAT options?	
Alcohol use disorder	Acamprosate, Disulfiram, and Naltrexone
Opioid use disorder	Buprenorphine, Methadone, Naloxone, and Naltrexone

[35] https://www.drugabuse.gov/publications/principles-drug-addiction-treatment/evidence-based-approaches-to-drug-addiction-treatment/behavioral-therapies
[36] https://americanaddictioncenters.org/co-occurring-disorders
[37] https://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iii/7-medical-detoxification
[38] https://www.samhsa.gov/medication-assisted-treatment

Tobacco use disorder	Bupropion, Nicotine Replacement Therapy (NRT), and Varenicline

Morphine Milligram Equivalent (MME): The commonly used metric for measuring appropriate doses of opioids. Higher doses of MME are associated with higher risk of overdose and death. Calculating the daily MME dose helps patients more closely monitor or reduce their opioid usage. It's important to note that each opioid has a different recommended dose, based on each drug's conversion factor.[39]

Opioid: Opioids are a class of drugs used to reduce pain. Opioids are usually broken down into three categories: prescription opioids, fentanyl, and heroin. Prescription opioids are prescribed by doctors to treat pain but can have serious risks and lead to addiction if not properly managed. Common forms include oxycodone (OxyContin), hydrocodone (Vicodin), morphine, and methadone.[40]

Pharmacotherapy: Pharmacotherapy is substance use disorder treatment using pharmaceutical drugs. Research shows that some SUDs are best managed using medications over a longer period of time in addition to medications that may be prescribed during the initial detoxification and withdrawal process, behavioral therapies, and counseling.[41]

[39] https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf
[40] https://www.cdc.gov/drugoverdose/opioids/heroin.html
[41] https://www.samhsa.gov/medication-assisted-treatment/treatment

Catalyst for Payment Reform (CPR) is an independent, nonprofit corporation on a mission to catalyze employers, public purchasers and others to implement strategies that produce higher-value health care and improve the functioning of the health care marketplace. CPR's membership, a group of 30+ progressive employers and other health care purchasers, collaborate to advance health care payment and delivery reforms, innovative benefit and provider network designs and transparency on costs and quality in the health care system. CPR develops tools, conducts research, and offers education to help purchasers work collectively to push for higher-value health care.

With support from