Use of CONTINUUM™ to Meet Federal Health Care Reforms

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The ASAM State of the Art Course
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Disclosure Information

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Abt Associates, ASAM (Royalty), Alkermes Inc. (Shareholder),
DynamiCare Health™ (Chief Medical Officer),
(Scientific Advisor:) BioCorRx Inc., Indivior Inc., Intent Solutions, Kaleo Inc., Purdue Pharma,
Rand Corp., Treatment Research Institute, Truven Health Analytics/IBM Watson
ACA, Parity & Health IT Acts: Huge Implications

The Affordable Care Act (2010)

- Phasing out fee-for-service
- Penalties for preventable readmissions
- By 2018, 50% of CMS $s via alternative payments
- Value-based contracts, Case-based rates, Pay-for-performance
- Tens of millions with high SUD prevalence become insured

SUD gets a seat at the table
...but will it be THE HOT SEAT???
ACA, Parity & Health IT Acts: Huge Implications

The Mental Health Parity and Addiction Equity Act (2008):

- Rules, lawsuits & change...slow, but ON THEIR WAY
- Published medical necessity criteria, e.g., ASAM Criteria
- Equal coverage for SUD as for medical/surgical care
- Kennedy Forum & TRI launching Online Appeals Guide for reimbursement denials under parity

...SUD finally gets its day in Court!

www.thekennedyforum.org
ACA, Parity & Health IT Acts: Huge Implications

There's a price to be paid

- In 2007, NY Medicaid spent >$800 million on potentially preventable readmissions
- In 2012, ~2 million beneficiaries readmitted within 30 days of release: cost to Medicare = $17.5 billion
- Starting in October 2012, hospitals forfeited ~$280 million
- 2,211 Hospitals Fined for Medicare Readmissions

Given the readmission burden from SUD, & the opioid epidemic

...we need a solution!
Improving outcomes with CONTINUUM™

- Structured Clinician Interview
- Quantitative Decision Algorithm
- Cloud-based
- Only available through integration with an EHR, practice management or billing software
- NEW quick CONTINUUM Triage – 20 question provisional Level of Care recommendation
Under-Matching Worsens No Show to Next Treatment

- All patients: Under-matched patients' no-show rate: ~25% worse
- Cocaine users: Under-matched patients' no-show rate: ~100% worse
- Heroin users: Under-matched patients' no-show rate: ~300% worse
3-mo Drop-Out, Improvement & Stepdown Need

Naturalistic Match Status – According to ASAM Software
Bed-Day Utilization over 1-Yr in the VA
Bedford MA VA, N = 97 (Sharon et al., JAD 2003)

Bed-day Use Pre- vs. Post-Naturalistic L-III Placements

- ~24-mos Before
- ~13 mos After

Patients given residential but who needed hospital care at the mid-point used significantly more inpatient bed-days the following year (whereas matched or adequately matched patients used fewer days).
Addiction Assessment & Treatment Planning:

- Harvard B. School: MCO telephone tag averages 90 min – 3 days
- >30 States required or endorsed ASAM Criteria – but created their own versions: CASAM, MASAM, NYSAM...
- “ASAM” use in a major US MCO: ~50% of cases were denials
  - on appeal: ~50% reversed; on review ~50% reversed again!
- By 2000s, SAMHSA & CSAT called on ASAM: create a standard!
Learning from Counselor/Patient Evaluations

- **Alpha Test (Norway):** Patients like to read the screens
- **Beta Test (Milwaukee):** Overall, not a longer process than before
- **National Demonstration (20 sites):**
  - Systems were able to implement across all adult LOCs
  - Detoxes started with just Med & Alc/Drug questions
  - Systems achieved mandated use across all clinicians
- Good ease of use & learning curve (~5-10 cases)
- Improved clinical assessment & patient engagement (MI effect)
- Faster & more successful MCO approval – public & commercial
OPTIONS for States/Counties implementing the 1115 Waiver:
1. Managed care organization vendor contract
   – at a cost of millions
2. OR, ASAM’s CONTINUUM™ - at a fraction of the cost
States, Counties, MCOs, & Health Systems

• **Los Angeles**: 1st in nation to bid & award CONTINUUM™

• **California**: CMS 1115 Waiver received; Counties now planning

• **Massachusetts**: Seeking 1115 Waiver, CONTINUUM planned

• **Other States**: In discussion/planning phase

• **MCOs**: National MCO planning ASAM LOC Certification pilot

• **Health Systems**: Several large, statewide, regional or county-wide
"Where's Waldo in five years?"
In the past year, think about your use of alcohol.

"Do you need to use more alcohol to get the same feelings you used to by using less? Or do you get less of a high by using the same amount? (Tolerance indicates either need for increased dose for same effect or reduced effect with same dose.)"

"Do you ever get physically sick when you stop using alcohol? (Indicates characteristic physical or psychological withdrawal symptoms.)"

"When you are using alcohol, do you ever feel that you don’t stop when you want to or feel that you should? Indicates substance often taken in larger amounts or over longer period than was intended."
1809808
Religion: Protestant  Ethnicity: Caucasian

"How strong is your desire to use any drug right now?"  

Options: Not at all, Slightly, Moderately, Considerably, Extremely

"Have your addiction symptoms increased recently? How...? (Ask about any items below not mentioned by the patient) Have you had more craving, risk behaviors, more frequent use, increased amount of substance or have you used a more rapid route of administration?"

Options: No, Increased thoughts or craving, More risk taking behaviors but not use, Relapsed, but to less use than when using before, Increased use or more acute route of administration than before

"Do you feel you are likely to continue using or, if not using, that you are in danger of relapsing? How soon...? Do you feel at risk, even if you have had some treatment previously?"

Options:

"Do you have any concerns about pursuing treatment...? Would anything possibly hold you back, such as money, insurance, schedule, life events, or something else?"

Options:
ASAM-CS

1809808
Religion: Protestant  Ethnicity: Caucasian

How strong is your desire to use any drug right now?*

Not at all  Slightly  Moderately  Considerably  Extremely

Have your addiction symptoms increased recently? How...? (Ask about any items below not mentioned by the patient) Have you had more craving, risk behaviors, more frequent use, increased amount of substance or have you used a more rapid route of administration?

Do you feel you are likely to continue using or, if not using, that you are in danger of relapsing? How soon...? Do you feel at risk, even if you have had some treatment previously?

No: has been fully participating in all recommended treatments
No: open to fully participating in any recommended treatments
Passive or some hesitations
Resists important components
Rejecting or obstructs plan with many contingencies

Do you have any concerns about pursuing treatment...? Would anything possibly hold you back, such as money, insurance, schedule, attending groups, having to take medicines, drug

Legal Information
Family and Social History
1809808
Religion: Protestant  Ethnicity: Caucasian

Trouble with your attitude or holding onto relationships with others?

In your lifetime?
Not at all  Slightly  Moderately  Considerably  Extremely

Serious thoughts of suicide, i.e. that you would be better off dead, or wanting to hurt yourself?

In your lifetime?
Not at all  Slightly  Moderately  Considerably  Extremely

Thoughts of how you might hurt yourself?

In your lifetime?
Not at all  Slightly  Moderately  Considerably  Extremely

Attempted suicide?

In your lifetime?
0 1 2 3 4
Clinical Decision Support: Output

- DSM-5 Substance Use Disorders: Diagnoses & Criteria
- CIWA-Ar & CINA withdrawal scores (alcohol/BZs, opioids)
- Addiction Severity Index (ASI) Composite Scores
- Imminent Risk Considerations
- Access & Support Needs/Capabilities
- ASAM Level of Care recommendations
  - Including Withdrawal Management
  - Including Biomedically Enhanced Sub-level
  - Including Co-occurring Disorder Sub-levels (Capable, Enhanced)
- Also: If actual placement disagrees with Software, the clinician gets to justify the discrepancy
Alex Smith

Birth Date: 03/01/2016  Gender: Female  Religion: Catholic  Ethnicity: Caucasian

Created By: ykldane@asam.org

through with referral in 30 days?

- Following this patient interview, what is the motivation for recovery at this time?
  - 

- For this patient, what is the likelihood of maintaining total abstinence in 90 days?
  - Not applicable (patient agrees)/or No Answer
  - Final disposition is, or is expected to be, same as recommended by ASAM Criteria
  - Different treatment selected due to patient choice
  - Recommended program is unavailable in geographic region
  - Lack of physical access (e.g. transportation, mobility)
  - Patient lacks insurance
  - Patient has insurance but insurance will not approve recommended treatment
  - Program available but lacks opening or wait list too long
  - Program available but rejects patient due to patient characteristic(s), e.g. attitude, behavior, clinical status
  - Court or other mandated treatment is different or blocks ASAM Criteria recommendation
  - Patient rejects any treatment at this time
  - Patient eloped
  - Clinician disagrees with ASAM Criteria recommendation
  - Not known

- Category of final disposition (i.e., where the patient is actually being sent to treatment)
  - 

- Sub-category of final disposition (i.e., where the patient is actually being sent to treatment)
  - 

- Reason for final disposition (i.e., where the patient is actually being sent to treatment), if different from recommended
  - 

- Was patient referred to a biomedically enhanced program?
  - Yes
  - No
The Continuum™ database stores PII (Personal Identifying Info.) and PHI (Personal Health Info.) in a protected sector of a central server for use only by the treatment program and its direct business associates (per HIPAA and 42cfr).

The ASAM National Registry strips these data of PII, and then copies the de-identified record into the National Registry.
Making Budgets Go Further & Outcomes Better

**ASAM’s CONTINUUM™:**
(compared to usual assessment/placement)

- 25% - 300% reductions in no shows to next stage of treatment
- 30% reduction in dropout from treatment
- 3X improvement in addiction severity outcomes at 3 months
- 25% increase in numbers of patients ready for stepdown

**Leading to...**

- Increased patient flow & revenues
- Decreased staffing demands for incomplete intakes & UR delays
Making Budgets Go Further & Outcomes Better

**CONTINUUM™** moves intake effort up front, less intake & “churn”

- More admissions/less staff time/lower costs AND better morale
- Better performance on the HEDIS *Engagement* indicator
- Consistently greater improvements in substance use & severity
- Decreases in overall hospital bed-days

Payer/MCO gets: faster, better telephone prior auth & UR data;

- Potentially eliminating phone prior auth AND most UR
- With precise, quantitative, real-time data
- Opportunity for: Determination of Need analyses
- Opportunity for: QI “hotspots” alerts & targeting
Addiction assessment: A new, state-of-the-art standard

<table>
<thead>
<tr>
<th>THE PAST...</th>
<th>NOW...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-standard, intuitive</td>
<td>• Standardized, quantitative – <em>EHR Ready</em></td>
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<tr>
<td>Telephone tag</td>
<td>• Rapid Prior Authorization</td>
</tr>
<tr>
<td>Proprietary criteria</td>
<td>• Public domain criteria – <em>Parity Ready</em></td>
</tr>
<tr>
<td>Emphasis on cost, not quality</td>
<td>• Emphasis: cost AND quality – <em>ACA Ready</em></td>
</tr>
<tr>
<td>1991: ASAM...a teaching tool</td>
<td>• 2015: Decision tool – <em>HITECH Ready</em></td>
</tr>
<tr>
<td>Each state has its own Criteria</td>
<td>• A single national standard for Criteria</td>
</tr>
<tr>
<td>Managed Care Study: ~50% of cases reversed</td>
<td>• MCOs: Willing to pilot AUTOMATIC prior authorization – <em>CMS 1115 Waiver Ready</em></td>
</tr>
<tr>
<td>2000: SAMHSA calls for a standard</td>
<td>• 2015, SAMHSA has a standard</td>
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</tbody>
</table>
“Nobody ever asks ‘How’s Waldo?’”
Questions and Answers

- Gastfriend@gmail.com
- www.ASAMcontinuum.org
  - Knowledge base
  - Webinars
  - Frequently asked questions
  - Training videos
  - Current list of Authorized CONTINUUM™ Distributors
Issues in Electronic Health Records and 42 CFR

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October 6, 2016
Disclosure Information

Eric Goplerud, Ph.D.
No disclosures
42 U.S. Code § 290dd–2 : Confidentiality of records

• The Federal Statute behind 42 CFR part 2
• Short and Simple – only 730 words!
• ADAMHA Reorganization Act of 1992
  – Consolidates 1970 drug and 1972 alcohol laws
• Only 2 Requirements stricter than HIPAA
  – Patient Consent – “The content of any record...may be disclosed in accordance with the prior written consent of the patient
    • Medical emergency
    • Research
    • Court order
  – Prohibits use of patient information for criminal charges or investigation unless there is a substantial risk of death or bodily harm
42 C.F.R. Part 2 – Confidentiality of Alcohol and Drug Abuse Patient Records

• Meant to encourage people to seek out and remain in SA treatment without fear of prosecution by law enforcement and the government


• Creates a virtual shield against disclosure of PHI related to SA-related conditions and treatment

• Strictly prohibits disclosure and use of SA records of any federally assisted alcohol and drug use program (*federally assisted very broadly defined*)
42 CFR Part 2 Is Much More Restrictive Than Federal Statute Requires

• Consent for a specific purpose
• Consent to a specific organization
• Consent must be time limited
• Consent is limited to minimum necessary for the specific purpose
• Highly formalized content
• Prohibits Re-disclosure

• *Civil penalties* for violations – fines (more on this later)
Part 2’s “specific consent” requirements

- Name permitted to make disclosure
- Name to which disclosure is made
- Name of patient
- Purpose of disclosure
- How much and what kind of information
- Signature of patient
- Date of consent
- Statement that consent subject to revocation
- Date, event or condition consent will expire
- Information disclosed can not be redisclosed
Revising Part 2 – Federal Rule Making

- Public had 60 days to comment—until April 11, 2016
- Agency considers comments received and then issues a Final Rule
- 385 comments received by SAMHSA
- Final Rule must be followed as part of the law
Proposed Revisions - Consent

- New option for general designation in “to whom” section of consent form
  - Limited to those who have “treating provider relationship” with patient
  - Can include past, present, and/or future treating providers
- “From whom” section of consent form would now need to name specific individual/entity
- New patient right: Can request & receive list of individuals/entities to whom their info has been disclosed pursuant to a general designation consent
Proposed Revision - Research

• Changes make it more consistent with HIPAA research requirements (e.g., Institutional Review Board)

• Maintains core protections of 42 CFR Part 2 (including prohibition on re-disclosure)

• Permit qualified researchers to access Federal secured Medicaid and Medicare database
Proposed Revision – Qualified Service Organization

- Proposed Rule adds “population health management” to list of services QSOs can provide to SUD programs

- Cannot use Qualified Service Organization Agreement (QSOA) for “care coordination” (patient treatment component – should use consent)

- Can use QSOA for “medical staffing services” but not “medical services” (should get consent to make disclosures for treatment purposes)
Proposed Revision – Medical Emergency

• Patient info can be disclosed w/o consent to medical personnel to meet a “bona fide medical emergency in which the patient’s prior consent cannot be obtained.”

• Previously could be disclosed w/o consent “for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.”
Concerns from the Field with 42 CFR Part 2

- Low penalties
- “To whom” issues with consents
- No express discrimination provisions
- Setting sets the rules
- Redislosure issues
- MH and SUD information are both categories of sensitive health information, yet not treated equally under the law
- No duty to warn provision
- Regulations contemplate written consent – we live in an increasingly electronic world
Disadvantages Persons with Substance Abuse Disorder

- Have to anticipate what care they will need from who in the future
- Must constantly update expiring consents
- Do not get extra attention and supports
  - That providers give to any patient with a known chronic disorder
  - That Health Care systems arrange for high risk and high utilized patient groups
Disadvantages Substance Use Treatment Providers

- Expense of constantly updating and re-doing consents
- Expense of EMR that can track and manage the complicated 42 CFR Part 2 consent requirements
- Public relations cost of being seen as non-responsive and obstructive by other Healthcare Providers
Keeps SUD Treatment System Small & Isolated

- General Health Care Providers
  - Less likely to add SUD treatment
  - Less likely to partner or do projects with SUD treatment providers
- Health Information Exchanges all say they will work out later how to manage 42 CFR part 2 and just exclude SUD treatment
- Excludes SUD providers and conditions from care coordination and care management initiatives
Increases Overdose Deaths

• Methadone is reported by the Centers for Disease Control and Prevention to be involved in 30 percent of prescription overdose deaths

• CDC also reports that the death rate from methadone overdoses was 6 times higher in 2009 than in 1999.

• While buprenorphine abuse and overdose deaths are much rarer, they are rapidly increasing in number.
Prescription Drug Abuse

- Prescription drug abuse in general has become a national epidemic.
- While individuals who have received specialized substance abuse treatment are less likely to abuse prescription medications than substance abusers who have not received treatment, they remain more likely to abuse prescription medications.
- Some persons who have received specialty substance abuse treatment relapse to prescription drug abuse and
- Some subsequently die of prescription drug overdoses.
False Promise of Magical IT Solutions and “Segmented Consent”

• IT vendors wanting new contracts say it’s “do-able”
• Nobody has done yet
• IT Experts who are not vendors looking for contracts say “Sure, We can do anything... given enough time and money”
  – Who loves SUD treatment enough to give that money?
  – Who has put their initiatives on hold to give the SUD field time to catch up?
  – We will be Billions of dollars short and decades late
• Even if it gets built where are the staff to help patients continuously update their consents? Will Treatment providers re-contact all previous patients for every new regional project and annually to get new consents?
42 CFR Part 2 Makes SUD Patients & Providers Miss Out On

• The better Electronic Medical Records
• Health Information Exchanges
• Prescription Drug Monitoring and Improvement Systems
• Care Coordination
• Population Management
Substance Use Cannot Be Treated In Isolation From Health

- People with SUDs die 20+ years younger than their peers
- 100,000+ die annually,
  - 4th leading cause of preventable death in US.
  - Alcohol and drugs cause 1 in 10 deaths of working adults.
- Common BH and medical co-morbidities.
- Medically ill inpatients with SUDS at greatly increased risk of rapid rehospitalization, greater health care use, costs.
- SUD medical treatments, early intervention more effective
- Integrated care delivered in primary care, BH now standard of practice
Move From Paper In 1970s To Electrons In 21\textsuperscript{st} Century

- Part 2 protects paper records in separate SUD tx programs from disclosure w/o patients’ explicit consent.
- Paper stored onsite, physical secure in locked cabinets, shared by photocopy and mail.

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- EHRs, HIEs, storage and exchange is much different.
- HIPAA, HIPAA regs, HITECH $$$ billions to incentivize EHRs and penalties if not meaningfully use EHRs.
- HIPAA, HITECH regulations create privacy and security standards EXCEPT for SUD records
- “big data” analytics EXCEPT SUD records
Concerns about the new regulations: Any program

- 42 U.S.C. 290 dd-2 applies to “any program or activity”, not to some uniquely defined and segregated set of substance use treatment programs that “hold themselves out to be”

- “Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research, shall be confidential”
What Applying “Any” Means

• Protects all SUD information from disclosure and use for criminal investigations or proceedings without patient consent extended to all, not just freestanding SUD tx

• Remove the barriers that prevent communication and coordination of care between treating health professionals.

• Remove peculiar QSOs, harmonizing with HIPAA and HITECH business associates.

• Entire health system required to protect patients’ substance use information
Ambiguous And Sweeping Definition Of Covered Entity

- A psychiatric hospital or unit that provides substance use treatment to some of its patients
- Including “referral to treatment” sweeps every SBIRT program into the Part 2 restrictions.
- EAPs explicitly included
- OBOT providers
- Community BH providers licensed to tx substance use
- Treating cirrhosis, pancreatitis
- Parts of physicians’ records, such as their OBOT prescribing that is covered by Part 2, but not other parts
- Whole record of SUD tx programs including depression tx26
Qualified Service Organizations Are Regulatory Fictions

- By segregating certain providers as falling under Part 2, regulators must place special requirements on entities providing services to the Part 2 programs.
- Qualified Service Organizations, a unique creation that has no corresponding reference in 290 dd-2.
- Business Associate Agreements defined and regulated by HIPAA and HITECH are entirely serviceable, familiar
- Harmonize Part 2 with HIPAA adding requirements on BAAs to resist unauthorized disclosure of substance use information to criminal investigations and proceedings
Extension Of Protections Beyond Legislative Authority:

- 290 dd-2 restricts disclosure IN CRIMINAL PROCEEDINGS (the bold letters are in the law)
  - “Except as authorized by a court order granted under subsection (b)(2)(C), no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.”

- The proposed regulations expand this authority dramatically:
  - 2.13(a) Part 2 data “may not otherwise be disclosed or used in any civil, criminal, administrative or legislative proceedings conducted by any Federal, state or local authority...”
No Legislative Authority For Part 2 Penalties:

• The regulators propose to continue a set of penalties for infractions of Part 2 questionable enforcement authority.
  – “Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined in accordance with Title 18.”
• BUT -- No mention of privacy law violation fines, penalties, or offenses exist in Title 18.

• By contrast, violators of HIPAA privacy regulations are subject to hefty fines, revocation of professional and facility license or certification, and patients may sue violators for unauthorized disclosure under state laws.
The Attorney General may not provide legal representation solely to vindicate private rights or to redress private grievances in which the public has no vital interests. *Allen v. County School Board of Prince Edward County*, 28 F.R.D. 358 (E.D. Va. 1961). The Attorney General may, however, authorize a United States Attorney to represent a non-government party in a civil case where the interests of the United States are meaningfully involved. See *Brawer v. Horowitz*, 535 F.2d 830 (3d Cir. 1976); 28 U.S.C. § 517. See also *In re Debs*, 158 U.S. 564, 586 (1895). However, it is doubtful that cases involving attempts by law enforcement officers to obtain drug patient records could be said to involve Federal interests to such an extent as to warrant legal representation of alcohol or drug abuse program personnel by United States Attorneys or members of their legal staff. In short, United States Attorneys appear to have no obligation to act as legal representatives for program personnel when requests are made of such personnel by law enforcement officers for patient records or other patient information.
Unnecessary & Ambiguous Restrictions On Use Of Substance Use Administrative Data For Research

• In response to criticism for redacting all SUD information in Medicaid, Medicare claims research data base from “big data” analysis

• Explicit permission to use Federal Medicaid, Medicare data in the research repository with appropriate IRB.

  But

• All other administrative data sets, HIEs, ACOs, state Medicaid agencies, commercial insurance companies, Medicare Advantage plans, etc. not be able to make their data accessible to researchers
Recommendations for improvement

- **Any Program or Activity**: all substance use information protected from use in criminal justice investigations and proceedings.
- **QSOs**: Utilize the “any program or activity” language of the law and harmonize with BAA in HIPAA and HITECH.
- **Fines and penalties**: Move under HIPAA & HITECH; much stronger penalties.
- **Who information is disclosed to**: Harmonize with HIPAA and HITECH consents.
- **Research**: Allow research of additional administrative data sets with appropriate IRB.
- **EAPs**: Do not include Employee Assistance Programs as covered programs.
Integrate – Separate Is Not Equal

• Why should a person who has received SUD treatment not have the same right to make independent decisions regarding the nature, extent, and duration of disclosure as someone receiving any other health care service?

• Not allowing persons who have received SUD treatment to decide that they want their SUD treatment information shared in the same manner as all their other healthcare information is paternalistic, condescending, and discriminatory.
Time for Change

• Best Option
  – Repeal Federal Statute 42 U.S. Code § 290dd–2 - Confidentiality of records except for prohibition on use for investigation or criminal charges

• Easier Option Revise 42 CFR Part 2
  – As consistent with HIPAA as Statute allows
  – Applied as narrowly as Statute allows except for prohibition on use for investigation or criminal charges
  – Extend protections against use to all substance use records, regardless of the health care organization – ANY record
Integrated Care: How important do you think care coordination/integration of substance use, medical and mental health care is to improved outcomes for patients?

- Very Important: 78.30%
- Important: 16.80%
- Somewhat Important: 3.70%
- Unimportant: 1.20%

August 13, 2013 Popovits/Vendome Webinar Poll Results
Revising Part 2 Regulations: What is your position on revising the regulations at 42 CFR Part 2?

- 33.10% I am in favor of revising 42 CFR Part 2 to ease consent requirements in order to facilitate the sharing of SUD information among providers
- 40.90% I am in favor of revising 42 CFR Part 2 to make it more consistent with HIPAA
- 20.10% I am in favor of revising 42 CFR Part 2 to expand the protections to cover SUD information collected by all medical providers

August 13, 2013
Webinar Poll Results
The Law Of Unintended Consequences
Roles And Accountabilities Of Professionals And Systems Under The Affordable Care Act (ACA)

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The ASAM State of the Art Course in Addiction Medicine
October 6, 2016
Disclosure Information

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Alkermes-Honorarium-Speaker’s Bureau Membership/Presentations
Braebum-Stipend-Physician Advisory Board
BioDelivery Sciences International (BDSI)- Stipend-Physician Advisory Board, Speaker’s Bureau Membership/Presentations
Curry Rockefeller Group-Consulting Fee-Consultant
Concepts Underpinning the ACA

- Make care more affordable (can it be done for a lower cost?)
- Make care more available (more primary care locations; more addiction care locations?)
- Make more persons eligible for insurance coverage so they can receive care without paying for it 100% (but with high deductibles and other self-pay portions of the bill, care is still out of reach for many)
If the ACA could do ONE THING:
- *It would expand coverage to more persons so that fewer people would be “outside the system”*
- The **ONE THING** was not to lower the overall cost of care or to reduce unit costs for episodes of care.
- *It is called the **AFFORDABLE** Care Act, but the major thrust is to expand the number of insureds.*
  - This is “music to the ears” of entities offering health insurance products, as long as the fee structure isn’t unfeasibly low
Expanding covered lives:

1. Blocking coverage exclusions for pre-existing conditions
2. Offering dependent care to adult children through age 25 years 364 days
3. Creating health plans individuals can afford to buy through a “community rated” risk pool, i.e., the Health Insurance Exchanges
4. Medicaid expansion
New Rules of the Game for Insurers

- Less “underwriting” – community rating vs. experience rating
- No pre-existing condition exclusions
- Ramping up managed Medicaid in many markets
- Developing expanded provider networks to “absorb” all the newly covered individuals
- Parity provisions affirmed and expanded
- Develop expanded MH/SUD care networks
What Addiction Clinicians Care Most About in the ACA

- Parity affirmed and extended
  - No quantitative limits different than those in med/surg
  - No qualitative limits different from those in med/surg
  - UR processes transparent and no different
  - PBM processes no different
  - Fewer exceptions (“small employer exclusion”)
- Parity now impacts group health plans and ERISA-exempt plans (self insured entities) but also individual policies purchased over the Exchanges, plus Medicaid plans as part of the Medicaid expansion (except IMDs)
The Pressure on the ADM Care System

- The flood of newly covered individuals
- Expanding Medicaid increases the # of persons with coverage for outpatient care, but at payment rates most providers won’t accept, for individual visits, IOP, PHP; and residential care is still excluded under the IMD (Institution for Mental Diseases) Exclusion.
- But placing those ages 18-26 under their parents’ coverage changes cases to patients!
Due to Medicaid expansion, public payers will continue to drive funding for addiction treatment (but less FSATBGS and more Medicaid)

- The growth rate of addiction treatment spending is nearly as high as for overall health care spending from 2009 to 2020
  - However, by 2020 addiction treatment spending will only represent 1 percent of total health care spending
- Medicaid spending as a percentage of total addiction treatment spending will double from 2009 to 2020 as the Medicaid expansion population is enrolled

So How To Make It More Affordable?

- Lower prices for units of service?
- Lower costs for care: if care more efficiently designed/executed (i.e., engineered, e.g., NIATx), lower costs of production can allow providers to offer care at a lower price
- Lower costs for professional services – more mid-level providers cf. physicians
- Different systems of care delivery: FQHC’s
Fundamental Assumption of ACA: ADM Care

- When so more persons become eligible for services, it won’t be affordable to offer them all care in the specialty (separate) delivery system
- Shift addiction care from specialty care system to the primary care system
- Offer care within FQHC’s
- Offer health professionals education within FQHCs
The Affordable Care Act: The Essential Role of Community Health Centers

- Health centers are poised to play an essential role in the implementation of the Affordable Care Act.

- In particular, health centers emphasize coordinated primary and preventive services or a “medical home” that promotes reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities and other underserved populations.

http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf
The Affordable Care Act: The Essential Role of Community Health Centers cont’d

- Health centers place emphasis on the coordination and comprehensiveness of care, the ability to manage patients with multiple health care needs, and the use of key quality improvement practices, including health information technology.

- The health center model [utilizes] a team-based approach to care that includes physicians, nurse practitioners, physician assistants, nurses, dental providers, midwives, behavioral health care providers, social workers, health educators, and many others.

http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf
Physician-Led Team Based Care

- New health care delivery system reforms hinge on a team-based approach to care. In the physician-led team approach, each member of the team plays a critical role in delivering efficient, accurate, and cost-effective care to patients. With seven years or more of postgraduate education and thousands of hours of clinical experience, physicians are uniquely qualified to lead the health care team. Physicians, physician assistants, nurses, and other health care professionals have long worked together to meet patient needs for a reason: the physician-led team approach to care works.
A driving force behind health care practitioners’ transition from being soloists to members of an orchestra is the complexity of modern health care, which is evolving at a breakneck pace. Given the complexity of information and interpersonal connections, it is not only difficult for one clinician to provide care in isolation but also potentially harmful. As multiple clinicians provide care to the same patient or family, clinicians become a team—a group working with at least one common aim: the best possible care—whether or not they acknowledge this fact (emphasis added).

Each clinician relies upon information and action from other members of the team.
What is an ACO?

- **Accountable Care Organizations (ACOs)** are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.
- The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
- When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.
- www.CMS.gov
Hospital Value-Based Purchasing (VBP)

- VBP- A term for Medicare, but generalization to commercial health insurance world is expected; it’s “med/surg”-only, for now

- The VBP Program is a Centers for Medicare & Medicaid Services (CMS) initiative that rewards acute-care hospitals with incentive payments for the quality of care they provide to Medicare beneficiaries
How Does Hospital VBP Work?

CMS rewards hospitals based on:

- The **quality** of care provided to Medicare patients;
- How closely best clinical practices are followed; and
- How well hospitals enhance patients’ experiences of care during hospital stays.

_Hospitals are no longer paid solely on the quantity of services they provide._
Bundled Payments

- Traditionally, Medicare makes separate payments to providers for each of the individual services they furnish to beneficiaries for a single illness or course of treatment. This approach can result in fragmented care with minimal coordination across providers and health care settings. Payment rewards the quantity of services offered by providers rather than the quality of care furnished. Research has shown that bundled payments can align incentives for providers – hospitals, post-acute care providers, physicians, and other practitioners – allowing them to work closely together across all specialties and settings.

- The Bundled Payments for Care Improvement (BPCI) initiative was developed by the Center for Medicare and Medicaid Innovation (Innovation Center). The Innovation Center was created by the Affordable Care Act to test innovative payment and service delivery models.

Bundled Payments

Under the Hospital VBP Program, Medicare makes incentive payments to hospitals based on either:

- How well they perform on each measure; or
- How much they improve their performance on each measure compared to their performance during a baseline period.

New Accountabilities, Expectations, & Demands

CHIP
MACRA

The MACRA makes three important changes to how Medicare pays those who give care to Medicare beneficiaries.

These changes create a Quality Payment Program (QPP):

- Ending the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers’ services.
- Making a new framework for rewarding health care providers for giving better care not more just more care.
- Combining our existing quality reporting programs into one new system.

These proposed changes, which we’ve named the Quality Payment Program, replace a patchwork system of Medicare reporting programs with a flexible system that allows you to choose from two paths that link quality to payments: the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs).
The MACRA QPP

“...will help us to move more quickly toward our goal of paying for value and better care.

The Quality Payment Program has two paths:
- Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)

MIPS and APMs will go into effect over a timeline from 2015 through 2021 and beyond.”
The MIPS

“...is a new program that combines parts of the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) incentive program into one single program in which Eligible Professionals (EPs) will be measured on:

- Quality
- Resource use
- Clinical practice improvement
- Meaningful Use of certified EHR technology
APMs under MACRA

What are Alternative Payment Models (APMs)?

- APMs give us new ways to pay health care providers for the care they give Medicare beneficiaries.

- **Accountable Care Organizations** (ACOs), Patient Centered Medical Homes (PCMHs), and **bundled payment models** are some examples of APMs.

www.CMS.gov
New Accountabilities, Expectations, & Demands

Performance Measures
www.CMS.gov
Performance Measures

- Quantitative instruments that replace the qualitative statements:
  - “Treatment Works”
  - “I am a high quality provider”

- Include:
  - Process Measures: rate of adherence to a health care process.
  - Outcome Measures: extent to which various outcomes of health care processes are attained
  - System Measures (how does the delivery system perform?)
  - Physician Measures (how do individuals on the team perform?)
Great Examples Of System Measures

- Wait times for initial appointments
- Wait times for initial phone inquiries
- Patient satisfaction with the global experience of care offered by the clinic/hospital/etc.
- Rate of readmissions after an index episode of care (e.g., ER readmits, detox readmits, rehab readmits, med/surg readmits)
Great Examples Of System Measures cont’d

Continuity of care measures (including hand-offs)
- Rate of capture by the subsequent level of care
  (what % of detox patients make it to OP follow-up?)
  (what % of IOP patients make it to Level I care?)
- Rate of revisits after initial visit (outpatient addiction assessment visit, buprenorphine induction visit, any medication management revisit)
  - Do they return once? Do they return 6 times? Are they still in care at 90 days? At 360 days?
  - Do they get a refill of Rx after the initial Rx?
PIPMAG

- ASAM’s Practice Improvement and Performance Measurement Action Group
- Developed ASAM’s “Standards of Care” document
- Developed ASAM’s “Performance Measurement” document
Why PIPMAG?

- In all of medicine, there is a push for measurement of results, payment for results/outcomes vs payment for volume, process improvement, minimization of unexplained variation and medical errors
- A push for quality means a push for measurement
- Maintenance of Certification includes measurement of “performance in practice”
- In all of health care, there is a push for public reporting: transparency regarding quality and costs
Why PIPMAG? cont’d

- Physicians in other medical specialties have standards of care & performance measures – addiction medicine is behind the trend
- Insurance companies or others (governments) will develop practice guidelines if professional societies (ASAM) do not take the lead
- Focus is on the Addiction Specialist Physician but Standards apply to ALL physicians caring for addiction and related disorders
PIPMAG Structure

Steering Committee
(Michael Miller, MD, Chair)

Standards Panel
(Margaret Jarvis, MD, Chair)

Performance Panel
(Corey Waller, MD, Chair)

Field Review Panel
(David Pating, MD, Chair)
STANDARDS OF CARE
The Standards will “raise the bar” of expectations and accountabilities, applying to any physician assuming the responsibility for caring for addiction and related disorders.

» Learn More

STANDARDS OF CARE:
For the Addiction Specialist Physician
What Are We Measuring: High Priority Domains

- Assessment and Diagnosis
- Withdrawal Management
- Treatment Planning

- Continuing Care Management
- Care Transitions & Care Coordination
- Treatment Management
ASAM
THE PERFORMANCE MEASURES
For the Addiction Specialist Physician
Performance Measures

Performance Measures Expert Panel is charged with:

- Defining the domains of addiction specialist physician performance that should be measured based on the Standards document
- Reviewing current measures, including “meaningful use” measures proposed by SAMSHA, DHHS & NQF, and defining the process for closing gaps in measures
- Identifying and recommending process and outcome measures
- Recommending opportunities for research
Process Measures vs. Outcome Measures

- **Process Measures** are used to assess how well a health care service provided to a patient, or on a patient’s behalf, adheres to evidence- or consensus-based recommendations for clinical practice (Garnick et al, 2006).
  - In other words, process measures show whether steps proven to improve outcomes are followed correctly.

- **Outcome Measures** take stock of the actual results of care by evaluating the state of a patient’s health resulting from the health care services and interventions received. They are generally the most relevant measures for patients and the measures that providers most want to change (NQF, 2012).
Standard: Standard III.2
Providing Therapeutic Alternatives:
The addiction specialist physician discusses and offers all available clinically indicated psychosocial and pharmacological therapies to all patients, assisting the patient to collaborate in clinical decision-making, assuring that the patient is aware of therapeutic alternatives.

- % of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12 month reporting period.

- % of patients aged 18 years and older with a diagnosis of current alcohol addiction who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12 month reporting period.
Nine Selected Performance Measures

- MEASURE #1: Percent of patients prescribed a medication for alcohol use disorder (AUD)
- MEASURE #2: Percent of patients prescribed a medication for opioid use disorder (OUD)
- MEASURE #3: 7-day follow-up after withdrawal management
- MEASURE #4: Presence of screening for psychiatric disorder
- MEASURE #5: Presence of screening for tobacco use disorder
- MEASURE #6: Primary care visit follow-up
- MEASURE #7: All cause inpatient, residential re-admission
- MEASURE #8: SUD diagnosis documentation in addiction treatment
- MEASURE #9: Psychiatric disorder diagnosis presence
Implications

- Define the way addiction specialist physicians practice medicine
- Partner organizations will be asked to endorse Performance Measures
- Develop a research agenda based on gaps and needed data determined during the process
- Incorporate standards & measures into maintenance of certification, credentialing, and performance in practice exercises
- Align Performance Measures with the ability of Health IT to be used in meaningful ways (EHRs, MU criteria)
Summary: Roles of Systems

- Quality providers (ABMS: ABPM as well as ABPN)
- Hire/train ADM specialists to lead teams (more likely easier to build than to buy, due to dearth)
- Build service continuums – actually offer care!
  - Don’t just delegate to the “public sector safety net”
- Address addiction as a health problem and as a chronic disease (‘Multiple Chronic Conditions’)
- That means engagement, retention, continuity
Summary: Roles of Systems

- Measure Quality
  - Structural aspects of quality: certifications, services are in place
  - **Structure** includes all the factors that affect the context in which care is delivered. This includes the physical facility, equipment, and human resources, as well as organizational characteristics such as staff training and payment methods. These factors control how providers and patients in a healthcare system act and are measures of the average quality of care within a facility or system.

*(Wikipedia on 2003 review by Donabedian of his 1966 model of quality)*
Summary: Roles of Systems cont’d

- Measure Quality
  - Process aspects of quality: clinical practices
  - Process is the sum of all actions that make up healthcare. These commonly include diagnosis, treatment, preventive care, and patient education. Processes can be further classified as technical processes, how care is delivered, or interpersonal processes, which all encompass the manner in which care is delivered. According to Donabedian, the measurement of process is nearly equivalent to the measurement of quality of care because process contains all acts of healthcare delivery.
  - Information about process can be obtained from medical records, interviews with patients and practitioners, or direct observations of healthcare visits.

*Wikipedia on “Donabedian Model”*
Summary: Roles of Systems cont’d

- Measure Quality
  - Process aspects of quality: clinical practices
  - Integration of addiction care into primary care
  - Counseling at “point of care”
  - Inpatient Consultation-Liaison services in ADM
  - Including addiction clinicians in Health Care Teams in Patient Centered Health Care Homes
Summary: Roles of Systems cont’d

- Measure Quality
  - Outcome aspects of quality: outputs and results.
  - Outcome contains all the effects of healthcare on patients or populations, including changes to health status, behavior, or knowledge as well as patient satisfaction and health-related quality of life. Outcomes are sometimes seen as the most important indicators of quality because improving patient health status is the primary goal of healthcare. However, accurately measuring outcomes that can be attributed exclusively to healthcare is very difficult.
  - Wikipedia on “Donabedian Model”
Summary: Roles of Professionals

- Get trained/certified
- Primary care: get your waivers!
- Specialty care: embrace primary care colleagues
- Be willing to work in PCHCHs, FQHCs, medical teams that are not just behavioral healthcare medical teams
- Be willing to offer consultation services in general medical settings
- Be willing to teach medical students and residents in general medical settings, not just “where you usually work” in specialty treatment settings
Summary: Roles of Professionals cont’d

Adhere to the ASAM Standards of Care

I. Assessment and Diagnosis
II. Withdrawal Management
III. Treatment Planning
IV. Treatment Management
V. Care Transitions and Care Coordination
VI. Continuing Care Management

♦ Engagement, Retention, Collaboration, Hand-offs
Accountabilities of Systems

- Be measured on performance and outcomes
- Share in financial risk
- Bring structural quality to ADM care
  - Facilities, Information Technology, Amenities
Accountabilities of Professionals

- Be measured on performance and outcomes
- Performance Measures in Inpatient and Ambulatory Care settings
- MIPS and APMs
- Figure out your role in ACOs and in assumption of financial risk
- Be engaged in community solutions, prevention, and public policy advocacy ("we’re never gonna treat our way out of this, we have to prevent it")
Thank you!

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