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IN BRIEF

From 2000 to 2014, the rate of deaths in the United States from drug overdoses increased by 137 percent and the rate of overdose deaths involving opioid pain relievers and heroin by 200 percent.[1] Tobacco use and excessive alcohol use also continue to be leading causes of preventable death.[2] Nevertheless, access to treatment services for individuals with substance use disorders (SUDs) is lacking.[3] Expanding the capacity and ability of primary care providers (PCPs) to assess and treat SUDs is critical to filling this gap in service delivery, particularly given the stigma associated with seeking treatment in specialty settings. Furthermore, PCPs are well positioned to address comorbidities like HIV, hepatitis C, and cardiovascular disease, which are more prevalent among adults with SUDs than in the general population.[4] Value-based payment (VBP) is among the tools that policymakers and payers can use to encourage greater access to SUD treatment in primary care. With support from the Melville Charitable Trust, the Technical Assistance Collaborative and the Center for Health Care Strategies conducted interviews with stakeholders to understand how VBP levers can be used to encourage this type of integration. Drawing from the interviews, this brief examines how states and health plans are exploring VBP to promote SUD treatment in primary care, and offers considerations for implementing these models.

Introduction

Drug overdose is currently the leading cause of accidental death in the United States, driven in large part by the opioid epidemic.[5] In addition, tobacco use and excessive alcohol use rank first and third as preventable causes of death.[6] Despite this, a clear gap in treatment remains for individuals with substance use disorders (SUDs), with only one in ten people with SUDs receiving specialty treatment.[7] This gap in care, along with the emotional, familial, societal, and economic implications associated with SUDs,[8][9] highlights the need for expanded access to treatment for those dependent on drugs, alcohol, or other substances.

A comprehensive approach that includes prevention, early intervention, treatment, and recovery support is needed to fully address the broad spectrum of substance use problems and disorders. Primary care should be included in that continuum as it offers a unique opportunity to intervene early and provide access to treatment through enhanced services like medication-assisted treatment (MAT) and early and periodic screening for SUDs with referral to treatment. In addition, primary care providers (PCPs) are uniquely positioned to address comorbidities common in people with SUDs such as lung disease, hepatitis, and cardiovascular disease,[10] as well as tobacco use which is more prevalent among people with SUDs than in the general population.[11] Furthermore, SUDs often complicate the treatment of other chronic conditions, highlighting the importance of connections to primary care for ongoing treatment and management.

> **In recent years, the ability to integrate SUD services into primary care has gained momentum.**

The Affordable Care Act (ACA) required most health plans to offer preventive services, screening, brief interventions, and other types of treatment for SUDs.[12] The ACA also gave states the authority to establish Medicaid health homes to coordinate and manage physical, behavioral, and long-term services for individuals with multiple chronic conditions. Many states have used health homes to create programs specifically tailored to the needs of people with SUDs.[13]

Payers can use a variety of levers to encourage better identification and treatment of individuals with SUDs in primary care settings. One potentially effective lever is payment reform. The health care system has been evolving to reward quality over the volume of services provided, with a focus on achieving the "Triple Aim": improving patient experience of care, improving population health, and reducing per capita cost of care.[14] In 2016, for example, the US Department of Health and Human Services (HHS)

announced that 50 percent of traditional Medicare fee-for-service (FFS) payments should be moved to alternative payment models (APMs) by 2018.[15] Similarly, state Medicaid programs are rapidly adopting value-based payment (VBP) arrangements, for example through the establishment of accountable care organizations (ACOs) and with new requirements that managed care organizations (MCOs) adopt alternative provider payment approaches.[16] A recent survey of Medicaid directors showed that 13 states had VBP requirements in managed care contracts as of fiscal year 2017, and 9 more were pursuing such requirements for fiscal year 2018.[17] The health care system's move toward VBP and the growing need for comprehensive SUD treatment are creating an opportunity for alignment: using VBP to accelerate the integration of SUD treatment into primary care.

With support from the Melville Charitable Trust, the Technical Assistance Collaborative and the Center for Health Care Strategies conducted interviews with states, MCOs, and providers to better understand how VBP approaches can be used to encourage SUD services in primary care settings. This brief outlines how states and payers are exploring VBP arrangements to encourage SUD treatment in primary care, as well as considerations for implementing these models.

Defining Value-Based Payment and the Importance of Quality Measures

Understanding the HCP-LAN Framework for Alternative Payment Models

While there are many frameworks for the continuum of VBP arrangements, we selected the Health Care Payment Learning and Action Network (HCP-LAN) APM Framework (see Exhibit 1) to guide this paper.[18] States currently using HCP-LAN's APM Framework to structure their transition to VBP include Arizona, South Carolina, Virginia, and Washington. This framework allows states to align more closely with Medicare and gives states a standardized continuum of VBP arrangements, with higher categories representing greater levels of clinical and financial risk. HCP-LAN aims for the majority of national health care spending to move from FFS to APMs in Categories 3 and 4 (see Exhibit 1). However, it also notes that Category 2 APMs may be an endpoint for certain providers working within specific health care markets, and that the strength of incentives should be weighed against the risk that providers are able to take and the potential for the delivery system to be transformed.[19]

Exhibit 1: HCP-LAN Alternative Payment Model Framework[20]

- **Category 1** encompasses traditional fee-for-service payments that are not tied to performance on cost or quality measures. These payments are not designated as infrastructure investments and do not require provider reporting of quality data.
- **Category 2** links fee-for-service payments to quality and value. Payments are based on provider investments in infrastructure, reporting, or the achievement of specific quality benchmarks. Subcategories include:
    - Category 2A includes payments tied to investments in infrastructure that have the potential to improve the quality of care provided, such as investing in new staff or electronic health records (EHRs). These payments are not adjusted based on performance, but are key to improving the way services are provided and the patient experience. While often a preliminary step toward payment reform, HCP-LAN considered Category 2A payments an important building block toward alternative payment models.
    - Category 2B, often referred to as pay-for-reporting, includes payments that provide positive or negative incentives to report specific quality information to a health plan or the public. Pay-for-reporting helps plans grow their capacity to collect data, and helps familiarize providers with the reporting process and the performance metrics to which they may eventually be held accountable.
    - Category 2C, commonly referred to as pay-for-performance, rewards or penalizes providers based on their performance related to specific quality measures. Therefore, pay-for-performance directly ties payment to quality. Payments within this subcategory are not influenced by provider performance against aggregate cost targets.
- **Category 3** payments build on fee-for-service infrastructure toward alternative payment models that are based on cost performance against a target, regardless of financial or utilization benchmarks. These payments are designed to encourage providers to deliver high-quality, effective, and efficient care that may need to be coordinated across a multitude of providers. Subcategories include:
    - Category 3A, upside shared savings, allows providers to share in a portion of the savings generated from meeting specific cost or utilization targets. Providers must meet specific quality measures to participate in the shared savings arrangement, and do not need to compensate payers for any losses should cost or utilization targets not be met.
    - Category 3B, upside shared savings with downside risk, is similar to Category 3A in that providers can share in a portion of savings by meeting specific cost or utilization costs and quality measures, however, this category allows payers to recoup losses should a provider not meet those designated targets.
- **Category 4** includes prospective, population-based payment arrangements. These payments are intended to encourage high-quality, person-centered care that is well coordinated and held accountable through quality measurement. Subcategories include:
    - Category 4A includes bundled payments that cover the treatment of specific conditions. Prospective payments that are population-based and cover all care provided by a specific type of clinician are also included in this category.
    - Category 4B includes prospective, population-based payments that cover all of an individual's health care needs.
    - Category 4C is similar to Category 4B in that prospective, population-based payments cover comprehensive care, however, these payments are often derived from an integrated financing and delivery system. For example, an insurance company may also own a provider network, or a health system may also offer an insurance product. For payments within Category 4C to be effective, both the delivery and financial aspects of an organization that is providing those payments must be aligned.

Within Categories 3 and 4, there are additional subcategories outside of those mentioned above. These groups, often referred to as Category 3N and Category 4N, represent payment models that move away from traditional fee-for-service, but are not tied to quality. ("N" refers to "no quality.") Category 3N includes risk-based payments that are not tied to quality measures, while Category 4N includes prospective and population-based payments that are not contingent upon achieving specific quality metrics.

The State of Quality Measures for Addressing SUDs in Primary Care

Quality measures are an integral part of VBP. In fact, APMs must take quality into account to be considered as progress toward payment reform, according to the eight principles of the updated HCP-LAN APM Framework.[21]

Recently, there has been a push to develop and implement quality measures specific to SUDs, in recognition of significant gaps in current quality measurement approaches to these disorders. For example, the National Committee for Quality Assurance (NCQA) developed performance measures for the Healthcare Effectiveness Data and Information Set (HEDIS) aimed at improving the health and well-being of people with SUD treatment needs. The additions include process measures to improve follow-up (within seven days and within thirty days) after an SUD-related emergency department (ED) visit, in response to data showing that "patients who failed to receive aftercare following an emergency psychiatric visit (including substance use) were more likely to return to the ED."[22] While these measures address follow-up care in any outpatient setting, primary care settings are uniquely positioned to reduce the likelihood of unnecessary ED use through management of not only the SUD, but also any comorbidities that may have been suboptimally managed.

Another SUD-specific HEDIS measure is Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET). Per the measure, initiation of treatment should occur within 14 days of diagnosis while engagement with two or more additional services should occur within 30 days of the initial visit.[23] In a recent reevaluation of the IET measures, NCQA added MAT as a qualifying treatment for both initiation and engagement, enhancing the measure's relevance to primary care settings.[24] In 2018, NCQA added a number of opioid-specific measures to HEDIS, including "Use of Opioids at High Dosage" and "Use of Opioids from Multiple Providers," both of which address the issue of inappropriate prescribing of pain medication, a leading cause of opioid addiction.[25][26]

Also of note, the National Quality Forum (NQF) recently convened a multi-stakeholder committee to identify quality measures for consideration by state Medicaid programs in four priority areas, including SUDs. In 2017, the committee recommended 24 measures and 5 concept measures for SUDs, all of which have some relevance for primary care settings (see Exhibit 2).[27] Pennsylvania's Centers of Excellence (COE) for Opioid Use Disorder (OUD) — state-designated facilities (including primary care practices) that receive funding to coordinate behavioral and physical health services — are required to report on quality measures at both the individual and aggregate levels, including: the number of individuals initiated in treatment and engaged for 30, 60, 90, 180, and 365 days; the percentages of individuals evaluated within one business day of referral, diagnosed and referred for mental health conditions, receiving drug and alcohol counseling, referred for comprehensive pain management treatment, and concomitantly taking benzodiazepines or prescription opiates; and a time series survey for quality of life and movement towards recovery for each individual.[28] Collectively, these measures hold the COEs accountable for coordinating care across treatment settings for individuals with opioid addiction.

Types of Quality Measures for Substance Use Disorders

Organizations such as the National Quality Forum, the National Committee for Quality Assurance, The Joint Commission, the Agency for Healthcare Research and Quality, and the Physician Consortium for Performance Improvement have been actively involved in the creation of SUD-specific quality measures, including process, structural, and outcome metrics.[29] In the context of SUD treatment:

- **Process measures** demonstrate a provider's efforts, per standard best practices, to shepherd patients through the necessary processes to determine and provide treatment for SUDs. Process measures can help identify systemic barriers to receiving SUD treatment.
  - o Example: Screenings for SUDs and following up with a patient who presents with SUD-related issues at the ED.
- **Structural measures** indicate the capacity of a provider group or hospital system to respond to the needs of those with SUDs.
  - o Example: The number of primary care physicians certified to prescribe buprenorphine or the capacity for providers to report SUD screening results through an electronic health system.
- **Outcome measures** signify the impact of an SUD intervention on improving health care outcomes of patients.
  - o Example: The percentage of patients who completed an SUD treatment program who have sustained reductions in alcohol or other drug use.[30]

While the majority of quality measures for SUDs are considered process measures, efforts are ongoing to create outcome-based measures.

Exhibit 2: SUD Quality Measures Recommended by the National Quality Forum by Source[31]

Measure	Source
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA
Tobacco Use Treatment Provided or Offered and the subset measure Tobacco Use Treatment	The Joint Commission
Tobacco Use Treatment Provided or Offered at Discharge and the subset measure Tobacco Use Treatment at Discharge	The Joint Commission
Alcohol Use Screening	The Joint Commission
Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention	The Joint Commission
Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge	The Joint Commission
Substance Use Screening and Intervention Composite	American Society of Addiction Medicine (ASAM)
Alcohol Screening and Follow-Up for People with Serious Mental Illness	NCQA
Tobacco Use Screening and Follow-Up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NCQA
Use of Opioids at High Dosage in Persons Without Cancer	Pharmacy Quality Alliance (PQA)
Use of Opioids from Multiple Providers in Persons Without Cancer	PQA
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Physician Consortium for Performance Improvement (PCPI)
Adult Access to Preventive/Ambulatory Care 20-44, 45-64, 65+	NCQA
Documentation of Signed Opioid Treatment Agreement	American Academy of Neurology
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	NCQA
Mental Health/Substance Abuse: Mean of Patients' Overall Change on the BASIS 24-Survey	Susan V. Eisen, PhD, McLean Hospital
Percentage of Patients Prescribed a Medication for Alcohol Use Disorder	ASAM
Percentage of Patients Prescribed a Medication for Opioid Use Disorders	ASAM
Percentage of Adolescents 12 to 20 Years of Age with a Primary Care Visit During the Measurement Year for Whom Tobacco Use Status Was Documented and Received Help with Quitting If Identified as a Tobacco User	NCQA
Measure Concepts	
Annual Hepatitis C Virus Screening for Patients Who Are Active Injection Drug Users	PCPI
Presence of Screening for Psychiatric Disorder	ASAM
Primary Care Visit Follow-Up	ASAM
SUDs: Percentage of Patients Aged 18 Years and Older with a Diagnosis of Current Alcohol Dependence Who Were Counseled Regarding Psychosocial AND Pharmacologic Treatment Options for Alcohol Dependence Within the 12-Month Reporting Period	American Psychiatric Association, NCQA, PCPI
SUDs: Percentage of Patients Aged 18 Years and Older with a Diagnosis of Current Substance Abuse or Dependence Who Were Screened for Depression Within the 12-Month Reporting Period	APA, NCQA, PCPI
SUD Treatment Penetration	Washington State Department of Social and Health Services

Models for Incorporating SUD Treatment into Primary Care Settings

Many providers acknowledge the challenges associated with treating SUDs in primary care, related to PCPs' lack of formal training and general knowledge about treating and managing SUDs. Primary care, however, is a natural setting to address SUDs as these disorders share many of the same characteristics as typical chronic conditions like hypertension and diabetes that are often managed by PCPs (e.g., late onset of symptoms, unpredictable course of disease manifestation, behaviorally oriented treatment).[32] In addition, behavioral health (which encompasses both mental health and SUDs) and physical health conditions rarely occur in silos. Many people with serious behavioral health disorders also have physical health comorbidities,[33] and the stigma associated with SUDs is a recognized barrier to seeking treatment in specialty settings. If individuals are already engaged in primary care, there is an opportunity to provide integrated behavioral health treatment in that setting, while also attending to the array of medical comorbidities or associated risk factors that may be present.

While the severity of any condition should dictate the setting in which a patient receives care, primary care can be an appropriate venue for screening for SUDs, providing brief interventions, and assessing and prescribing SUD medications. More specifically, SBIRT (see inset) can be administered in a primary care setting and maintenance medications like buprenorphine can be prescribed by PCPs who have completed the necessary training and received a waiver from the Drug Enforcement Administration. For more information on SBIRT and the different medications that can be used in combination with behavioral health therapies to treat SUDs, see Exhibits 3 and 4.

Integrating SUD and primary care services can be accomplished in many ways, and the type of integration should be based on the delivery setting, provider capacity, the extent to which integration of services is possible, and other considerations. Some ways to incorporate SUD services into primary care settings are[34] :
- Training PCPs to identify and address SUDs
- Providing SUD consultation within care settings
- Co-locating SUD treatment services and primary care
- Integrating team-based SUD treatment and primary care
- Utilizing health homes to support people with SUDs

Exhibit 3: Screening, Brief Intervention and Referral to Treatment

Screening, brief intervention, and referral to treatment, commonly referred to as SBIRT, is a public health approach to identifying and providing treatment for people with or at risk for developing SUDs.[56]

- **Screening refers** to the use of a validated tool to identify patients who are misusing or abusing drugs. The screen may not necessarily determine the substance a person is using, but whether or not a problem exists. Screening typically takes between five and ten minutes, and can be done in a variety of practice settings, including primary care. Patients who screen positive for moderate or risky behaviors may be referred for brief intervention.
- **Brief intervention** techniques are implemented at the site of screening and are used to generate patient awareness of health risk behaviors. Brief interventions typically involve one to five sessions that last between five minutes and one hour. The goal is to motivate the patient to reduce risky behaviors and increase their knowledge of the impact of such behaviors.
- **Referral to treatment** is typically made to SUD treatment providers for patients with identified needs. Providers referring patients to treatment may use motivational interviewing techniques, provide transportation, or follow up with patients after an appointment to encourage completion of the referral.[57]

Exhibit 4: Medication-Assisted Treatment for Substance Use Disorders in Primary Care

Medication-assisted treatment (MAT) or pharmacotherapy uses medication and behavioral therapy to treat SUDs.[58] It is primarily used in the treatment of opioid addiction, however it is also used to reduce the withdrawal symptoms associated with alcohol abuse.[59] Aside from methadone, which must be administered at an opioid treatment program (OTP), many medications used to treat SUDs can be administered in primary care settings:

- **Acamprosate** is taken three times per day by people living in recovery who want to avoid drinking alcohol. It helps people avoid drinking by re-stabilizing the chemical structure of the brain which can be disrupted by chronic alcoholism.
- **Buprenorphine** is an opioid partial agonist. Often combined with naloxone (e.g., Suboxone, Zubsolv) to prevent the likelihood of intravenous misuse of the medication, buprenorphine is a safe and effective drug to help treat opioid addiction.[60] Physicians who wish to prescribe buprenorphine must receive a waiver from SAMHSA and the Drug Enforcement Administration and complete training requirements.[61] There are three phases to buprenorphine treatment:
    1. *Induction* is often performed in an OTP or physician's office after an individual has abstained from using opioids for 12 to 24 hours and is in the early stages of withdrawal.
    2. *Stabilization* occurs after a patient has greatly reduced or discontinued their use of opioids. During this phase, patients may be able to switch from daily dosing to alternate-day dosing.
    3. *Maintenance* often occurs once a patient is doing well on a steady dose of buprenorphine. The length of maintenance is dependent on the individual and may continue throughout a person's life.
- **Disulfiram** is taken daily and used to treat chronic alcoholism. It is most effective in people who have gone through the initial stage of abstinence or in people who have gone through detoxification. If an individual consumes alcohol while taking disulfiram, the drug induces a severe physical reaction. This knowledge may act as a deterrent to drinking alcohol.[62]
- **Naltrexone** is available in pill form and as a long-acting injectable (Vivitrol). It works by binding and blocking opioid receptors, thus inhibiting the euphoric and sedative effects of opioids. Similarly, naltrexone inhibits the pleasurable effects of alcohol and feelings of intoxication. It can be prescribed by any health care provider for patients with opioid or alcohol use disorder.[63]

Laying the Groundwork for Value-Based Payment

Although states and health plans are at an early stage in their efforts to target payment reform efforts for SUDs, a number of interviewees pointed to promising approaches. The following examples were gleaned from conversations with state and health plan representatives from California, New York, Oregon, Pennsylvania, and Virginia.

Building the Infrastructure for Treating SUDs in Primary Care

As a stepping stone toward more advanced payment arrangements, states and health plans are building the capacity of their primary care workforces to address SUDs. This is consistent with the continuum outlined in the HCP-LAN APM Framework, where the move toward VBP begins with infrastructure payments that have the potential to improve the quality of care provided, as outlined under Category 2A. For example, Partnership HealthPlan of California (PHC), a non-profit community-based Medi-Cal (Medicaid) plan located in the northern part of the state, has been encouraging PCPs to

prescribe SUD maintenance medications like buprenorphine to patients in need. Through its Primary Care Provider Quality Improvement Program, which offers financial incentives, data resources, and technical assistance to PCPs to help improve clinical practices, patient experience, and resource and operational management, PHC has encouraged PCPs to become waivered to prescribe buprenorphine, sometimes referred to as receiving an X-license. Upon proof of becoming X-licensed, PCPs are awarded a one-time $500 incentive payment.[35] Central California Alliance for Health (CCAH), another nonprofit community-based Medi-Cal plan, is implementing a similar program aimed at increasing the number of X-licensed providers in its network. In 2018, CCAH started providing a $1,000 bonus payment to PCPs and mid-level providers who complete the required hours of training and receive a waiver.[36]

To address the increased management and services often required by patients being treated with SUD medications, CCAH recently launched the Enhanced Primary Care Pain Management program to support PCPs offering MAT to patients with OUD or those on high doses of opiate medications for chronic, non-cancer pain management.

The program allows waivered PCPs, as well as physician assistants and nurse practitioners working under them, to bill for initial and follow-up consultative evaluation and management services related to SUDs on an FFS basis. These payments are in addition to the capitated rates that CCAH's contracted PCPs receive for primary care services and are viewed as an incentive for waivered physicians to use their X-licenses while building the capacity of a provider network to offer SUD services within primary care. To be eligible for enhanced payments, initial visits must include a history and physical exam; an assessment of a patient's cause of pain, current treatment regimen, and any co-occurring SUDs; and the development of a plan of care regarding MAT. Follow-up visits must include MAT management along with meeting other requirements, and providers must receive prior authorization from CCAH before billing.[37]

Similar to CCAH, New York State's Staten Island Performing Provider System (PPS) has been working to build capacity to provide services for individuals with SUDs. Staten Island PPS is an alliance of clinical and social service providers with over 70 partners, including skilled nursing facilities, behavioral health providers, home health care agencies, community organizations, PCPs, and other medical practices. Among its selected areas of focus for earning Delivery System Reform Incentive Payments (DSRIP),[38] Staten Island PPS has prioritized the integration of primary care and behavioral health services.

> **Over the past three years, Staten Island Performing Provider System reports that the number of providers in its service area waivered to prescribe buprenorphine has doubled.**

Specifically, Staten Island PPS is focused on improving the community's capacity to deliver high-quality SUD treatment services in primary care. One of the ways Staten Island PPS has done this is through enhanced payments for PCPs to become waivered to prescribe buprenorphine and treat patients with SUDs. More specifically, provider practices (the majority of which are primary care) that are actively engaged in the PPS' withdrawal management services project are eligible to receive incentive payments for each Medicaid patient enrolled in treatment. Over the past three years, Staten Island PPS reports that the number of providers in its service area waivered to prescribe buprenorphine has doubled. In addition, Staten Island PPS encourages PCPs to pursue patient-centered medical home (PCMH) certification with enhanced payments and technical assistance. Larger provider practices that achieve PCMH Level 3 certification and participate in at least three Staten Island PPS DSRIP projects receive a one-time $250,000 bonus payment. Smaller provider practices that achieve at least PCMH Level 2 certification and participate in the state's population health

improvement program are eligible for a $15,000 bonus payment. Furthermore, Staten Island PPS assists practices looking to hire additional staff to support the integration of behavioral health services into primary care. For example, larger primary care practices are often awarded project implementation dollars to hire social workers, care coordinators, or other support staff to establish the infrastructure needed to provide SUD services in primary care settings. Smaller provider practices are connected with free social workers through the Mental Health Service Corps.[39]

While MCOs in New York reimburse practitioners for care provided, Staten Island PPS has helped transform the infrastructure and platform of delivery for SUD services within its network of primary care, specialty health, and SUD providers. This is preparing them for an eventual shift to VBP and potentially a more global approach to integrating and paying for care through a future Medicaid ACO.[40]

There are also state-level examples of this approach. Pennsylvania's COEs receive $500,000 annually for two years from state funds to meet specific requirements related to coordinating physical and behavioral health services, such as having defined referral standards, tracking and reporting quality outcomes, and participating in a learning network. Similar to HCP-LAN's Category 2B, providers only receive their annual allocation if they meet specific performance measures including quality measure reporting. Out of the 45 COEs, 19 are in physical health settings involving PCPs, obstetrician-gynecologists, and other physical health specialists.

Virginia has actively redesigned its system of care for individuals with SUDs through its Medicaid Addiction and Recovery Treatment Services (ARTS) program that launched in 2017.[41] Through ARTS, the state expanded access to the full continuum of evidence-based addiction treatment for Medicaid beneficiaries, including SUD treatment in primary care settings. Similar to Category 2A, Virginia is providing enhanced payments to select providers working with individuals with OUD receiving MAT. This includes those who meet the certification requirements for the state's Preferred Office-based Opioid Treatment (OBOT) Provider program with co-located buprenorphine-waivered practitioners and behavioral health clinicians. Through the program, providers receive a 400-percent rate increase when billing for opioid individual and group counseling, as well as a new per-member-per-month (PMPM) payment for care coordination and new reimbursement for peer recovery support services.[42] The state is also building a data warehouse and formalizing specific measures that will monitor Preferred OBOT providers' performance on quality and outcomes and inform future value-based payments.[43]

Paying for Performance

States and MCOs are using pay-for-performance arrangements to encourage providers to incorporate SUD screenings and services into primary care. UPMC for You, a Medicaid MCO affiliated with UPMC Health System, enrolls more than 400,000 Medicaid beneficiaries across 40 counties in Pennsylvania.[44] In response to the opioid epidemic, UPMC is giving incentives to PCPs to prescribe SUD medications to patients in need, using a pay-for-performance model that evaluates providers on a variety of structural and process measures for SUD screening, screening for hepatitis C, care coordination, and length of member engagement in treatment. UPMC's screening process measures to evaluate provider performance include screening and documenting co-occurring medical conditions and secondary symptoms in new evaluations and ensuring that a high percentage of new members who are new to treatment (i.e., no buprenorphine within the past 90 days) receive a behavioral health assessment by a licensed drug and alcohol counselor. The health plan also uses a care coordination measure to capture providers' successful coordination of care with patients' behavioral health providers. Furthermore, UPMC assesses provider groups' ability to train at-risk members and available family members on the use of intranasal naloxone and provide a naloxone overdose rescue kit or a prescription.[45] Providers receive an additional payment from UPMC if their treatment meets these and other quality standards. UPMC notes that its ultimate goal is to move its pay-for-performance model into its shared savings arrangements.[46]

> **To receive an incentive payment, Partnership HealthPlan requires primary care providers to average at least one urine toxicology screening annually for each patient on chronic pain medications for 90 days or more.**

In Northern California, Partnership HealthPlan has implemented pay-for-performance arrangements under its quality improvement program to facilitate PCP practice change. The plan uses a process measure to encourage PCPs to conduct urine toxicology screens for patients prescribed opioid medications for 90 days or more. The urine toxicology measure captures the percentage of members on chronic pain medications who have had a urine toxicology screen during the measurement year. To receive an incentive payment, providers must have an average rate of at least one screening annually for each patient on chronic pain medications for 90 days or more. The payment is based on a PMPM allocation multiplied by the number of capitated members attributed to a practice and the proportion of its patients taking chronic opioids who are screened. The health plan notes that the urine

toxicology screen allows providers to track whether or not patients are taking pain medications as prescribed and to see if they are using any illegal substances like heroin, amphetamines, or cocaine. Depending on the result of the screen, PCPs are encouraged to use their clinical judgement to take the appropriate next steps with their patients.[47]

Lastly, the Oregon Health Authority has also used pay-for-performance arrangements through incentive pools that encourage its coordinated care organizations (CCOs) to meet benchmarks and improvement targets for select measures. Through its quality pool, Oregon allows CCOs to earn back dollars that the state previously withheld. Some of the money withheld is also included in a challenge pool from which a CCO can earn back more than the original amount.[48] From 2013 to 2016, alcohol or other substance misuse screening, which is a part of SBIRT, was included as an incentive measure for the quality pool and the challenge pool. Currently, alcohol and drug misuse screening is not included as a measure for CCOs as the state is switching from claims-based data to electronic health record data to measure SBIRT. The state plans to reintroduce SBIRT into the measure set for 2019.[49]

Exploring More Sophisticated Value-Based Payment Models

States and health plans are in the early stages of developing more advanced payment arrangements for SUD treatment in primary care. Although these payment models represent a departure from the traditional FFS payment methodology, true progress toward value can only occur when payments are tied to quality. As a result, some of the models in this section do not yet count as APMs under the HCP-LAN Framework. For example, Geisinger, a Medicaid MCO in Pennsylvania, recently implemented a retrospective bundled payment as a PMPM for providers (including PCPs) treating patients with buprenorphine or Vivitrol (the bundled payment does not include SUD medications). Currently, Geisinger does not require providers receiving the bundled payment to achieve specific quality benchmarks. Thus, in its current form, this payment model does not count as an APM but rather, aligns with HCP-LAN Category 3N. Geisinger is exploring the use of quality measures, such as reduction in ED visits, adherence to prenatal visits, and mortality rate, for potential incorporation in the future, which would move its payment model towards a more value-based approach that would count as an APM under the HCP-LAN Framework.[50]

In HCP-LAN's APM Framework, Category 4C includes integrated systems that make prospective, population-based payments to provide comprehensive care. Integrated systems offer the potential to expedite investments in crucial care delivery infrastructure, such as population health management

support, programs to improve care coordination and care transitions, health information technology, and community health initiatives. As an integrated health care delivery system in Northern California, Kaiser Permanente takes an approach to delivering and paying for health care services that aligns with this category. Specifically, the health system has incorporated SBIRT into all primary care practices. Every year, the electronic health record system automatically prompts medical assistants to ask patients about their alcohol consumption. If a patient's screen suggests a hazardous consumption level, the PCP conducts a brief intervention. Those who receive a brief intervention are screened to determine risk for alcohol use disorder, and if necessary are then referred to an in-network addiction treatment specialist. Kaiser currently measures the rates of screening, brief intervention, and those who screen positive for risky drinking to assess risk for developing an alcohol use disorder. While Kaiser does not tie provider performance on these measures to payment, its approach to paying for and providing services at the systems level aligns with Category 4C in the

APM Framework and is a clear movement away from more traditional ways of paying for care. Kaiser used its own research to help justify the move toward SBIRT, such as studies showing that hypertensive patients may benefit from receiving brief intervention in primary care for unhealthy alcohol use, as well as the potential population-level benefits of brief intervention for alcohol use if widely applied.[51]

At the state level, New York has been actively pursuing more advanced VBP arrangements. In coordination with its DSRIP program, the state is committed to tying 80 percent of payments to value by the end of the five-year DSRIP demonstration period. To guide providers' transition to various VBP arrangements, the New York State Department of Health issued a comprehensive report, The New York State Roadmap for Medicaid Payment Reform, in July 2015. Each year, the report is updated and in 2016, the state included two VBP options relevant to primary care practices providing SUD services: the Integrated Primary Care (IPC) Bundle and Total Care for Special Needs Populations.

Exhibit 5: Rebundling Medication-Assisted Treatment in Maryland[64]

While the following example is not specific to primary care, it offers a valuable lesson for states and health plans looking to implement bundled payments for medication-assisted treatment (MAT). In March 2017, the Maryland Department of Health announced a new payment policy for community-based service providers who dispense methadone and buprenorphine. Under the new arrangement, opioid treatment programs providing methadone maintenance receive a bundled payment for the following services:
- Managing medical plan of care
- A minimum of one face-to-face meeting per month
- Methadone dosing
- Nursing services related to dispensing methadone
- Ordering and administering drugs
- Presumptive drug screens and definitive drug tests
- Coordination with other clinically indicated services

In addition, providers can now receive separate reimbursement for:
- Alcohol and drug assessment
- MAT induction
- Six medication management visits annually, or up to twelve if clinically indicated
- Individual and group counseling

The state specifically rebundled the payment to exclude counseling services in order to encourage providers to provide that component of evidence-based MAT. Excluding counseling services from the MAT bundle also allows the state to collect and monitor claims data for these services.[65] The buprenorphine rate structure was similarly rebundled. In addition to weekly buprenorphine maintenance, providers may seek reimbursement for:
- Alcohol and drug assessment
- MAT induction
- Up to 12 medication management visits annually
- Individual and group counseling
- Buprenorphine

The IPC Bundle holds providers accountable for the cost and quality of care for 14 physical and behavioral health conditions, including SUDs. Under these arrangements, MCOs contract directly with participating primary care practices or patient-centered medical homes responsible for preventive and routine sick care of patients, as well as the coordination of services. Savings in an IPC contract are based primarily on reductions in routine sick and chronic care management that can occur when integrated care is functioning optimally. Currently, the Community Health Independent Practice Association is participating in the IPC pilot.[52] The state hopes that the IPC Bundle will encourage better population health management, the integration of physical and behavioral health care, and improved care coordination and referral management.[53]

Under Total Care for Special Needs Populations, providers assume responsibility for the total cost of care of the attributed population, which can be defined to focus on individuals with serious behavioral health needs. Both Maimonides Medical Center and Mount Sinai Health Partners are participating in a two-year pilot of this payment model, focused on individuals

with serious mental illness and/or SUDs. This pilot will play a critical role in helping the state assess and validate the quality measures associated with the model.[54]

To encourage additional states across the country to pursue more sophisticated payment methodologies for SUD services, the CMS-sponsored Medicaid Innovation Accelerator Program (IAP) has created clinical pathways and rate design tools for MAT (see Exhibit 6). Similarly, the American Society of Addiction Medicine (ASAM) and the American Medical Association recently released a concept paper that details a new alternative payment model, Patient-Centered Opioid Addiction Treatment (P-COAT), which is geared toward supporting office-based opioid treatment using buprenorphine or naltrexone. The payment model includes a one-time payment for the initiation of MAT for OUD, as well as an ongoing monthly payment to support providers in the coordination of outpatient, psychological, and social services for patients that have successfully initiated treatment.[55]

Exhibit 6: Medicaid Innovation Accelerator Program Tools for States: MAT Clinical Pathway and Rate Design Tools

In July 2014, the Centers for Medicare and Medicaid Services (CMS) launched the Medicaid Innovation Accelerator Program (IAP), a collaboration between the Center for Medicaid and CHIP Services and the Center for Medicare and Medicaid Innovation focused on helping states improve care, reduce costs, and improve the health of their Medicaid populations.[66]

One target area of the IAP is reducing the number of Medicaid recipients living with SUDs by helping states improve how care is paid for and delivered. These clinical models were designed by the IAP team to help states create MAT service delivery and payment models[67] :

- **Model #1,** adapted from the Baltimore Buprenorphine Initiative in Maryland, includes five different levels of bundled payments as a patient moves through a course of treatment with buprenorphine or extended-release naltrexone.
- **Model #2**, adapted from the Massachusetts Collaborative Care model, includes rates for both episodic and monthly components. The model, designed for clients moving through treatment at a primary care practice or clinic, includes four levels of bundled payments for clinical assessment and induction, stabilization, maintenance, and discontinuation and medical withdrawal.
- **Model #3** is based on Vermont's hub-and-spoke model for buprenorphine only. The model is for patients served by "spokes" or primary care practices with physicians waivered to prescribe buprenorphine. Four levels of bundled payments are outlined for patients moving from clinical assessment and induction to discontinuation and medical withdrawal.

States that are interested in using these tools to move toward APMs should be sure to include appropriate quality measures which are an integral component of any VBP arrangement. Corresponding rate tools are available for each of these clinical pathways.[68]

Considerations for Effective Implementation

There are a number of challenges to implementing VBP arrangements for SUD services within primary care. These challenges are multifaceted, arising from cultural and societal norms around SUDs, the ways care is delivered, and how behavioral health services are measured and reimbursed. The notion of integrating SUD treatment and primary care is relatively new — and to date, much of the focus on integrated primary/behavioral health models has been on mental health as opposed to SUD care. While there is a clear opportunity to learn from these efforts, we are in the early days of integrated primary care/SUD development — with the potential to use well-designed payment levers to achieve our goals as effectively and quickly as possible. The following section highlights considerations for effective implementation of VBP arrangements focused on SUD treatment in primary care, as noted by states, plans, and provider representatives, and addressing: (1) system, regulatory, and reimbursement barriers; (2) the stigma of SUDs and provider and practice capacity to integrate care; and (3) lack of quality measures specific to SUDs and the integration of SUDs into primary care.

Delivery System, Regulatory, and Reimbursement Barriers

Traditional mechanisms that guide how behavioral health services are delivered, regulated, and reimbursed can often deter the development of VBP arrangements for these services in primary care settings. States, plans, and providers should take the following steps on the way to establishing payment models for SUDs in primary care:

- **Consider how physical health and behavioral health services are financed and managed.** Physical and behavioral health care services are often fragmented across three distinct systems: physical health, mental health, and SUD services. Adding to the complexity, the pharmacy benefit is most commonly managed entirely by physical health payers, even when prescribed for "carved out" behavioral health conditions. Such fragmentation can limit the incentives for providers to address SUD issues in primary care settings and for payers to incorporate SUDs into APMs. Many states — such as Arizona and New York — are addressing this by integrating physical and behavioral health services under single managed care contracts. Other states, including Maine, have included behavioral health services in total cost-of-care calculations for ACO arrangements. In addition, some carve-out states have allowed physical health providers to bill for select behavioral health services. In 2014, for example, California started including SBIRT as part of the physical health managed care benefit.[69]

- **Explore whether licensing or other regulatory requirements inhibit providers from pursuing integration.** States often have separate and potentially duplicative or conflicting licensing requirements for primary care and SUD treatment facilities, which can impose substantial administrative or financial barriers to providers looking to integrate service models.[70] For states seeking to use VBP to encourage the integration of SUDs into primary care, it is important to address such barriers in advance of or alongside payment reform efforts.

- **Identify billing reimbursement policies that may impede physical and behavioral health integration efforts.** Twenty-four states restrict billing for Medicaid beneficiaries seeking mental health services on the same day as other health care services at the same provider site. Of those, 12 states (including Washington, D.C.) exclude same-day billing for federally qualified health centers (FQHCs).[71] These limitations have the potential to impact a significant portion of Medicaid beneficiaries, especially those who receive primary care services in safety net facilities like FQHCs. Additionally, some states limit the types of practitioners that can be reimbursed for providing these services, and others have imposed onerous prior authorization requirements that dissuade practitioners from attempting to provide and bill for certain services. States should consider examining their respective policies to maximize reimbursement opportunities for integrated services.

- **Provide clear guidance on how to operate in compliance with federal and state privacy laws** as regulations protecting the confidentiality of patient drug and alcohol use information may impact the extent to which services can be seamlessly integrated. Title 42 of the Code of Federal Regulations (CFR) Part 2, which regulates the disclosure of patient drug and alcohol use information,[72] was noted by interviewees as a barrier to delivering integrated care. Of interest, interviewees noted that it is not the regulation that is problematic, but rather its interpretation by clinical providers. As one interviewee mentioned, so long as patient consent is obtained, a PCP who administers an SBIRT assessment can legally share that information with other providers.

- **Limit the potential for unintended consequences when selecting a payment model.** Risk-based VBP models (e.g., bundled payments, population-based payments) are designed to substantially reduce the incentive to increase volume, but many states, plans, and providers are looking for ways to increase access and utilization of SUD services. Whereas some argue that risk-based VBP arrangements inherently incentivize preventive activities because investing in them will lead to improved outcomes and lower costs of care, HCP-LAN recognizes that in certain cases, such as with

vaccinations and colonoscopies, FFS appropriately incentivizes increased utilization.[73] In these cases, linking FFS payments to quality indicators (i.e., measures that reinforce the right care at the right time) can be an ideal arrangement. For instance, Maryland recently rebundled MAT payments to OTPs to exclude counseling services, in order to encourage practitioners in OTPs to provide (and separately bill FFS for) the counseling component of MAT (see Exhibit 5). Overall, it is important that risk-based VBP models be linked to appropriate quality measures to ensure that the intended outcomes of the model are achieved.

Stigma and Provider and Practice Capacity

Primary care providers have a unique opportunity to engage patients in SUD treatment through already established relationships. Nevertheless, many interviewees noted that PCPs are often reluctant to treat patients with SUDs due to stigma and lack of confidence resulting from limited formal training. Many PCPs are uncertain about how to navigate the levels of SUD treatment services, and have limited networks for patient referrals. Finally, some providers may feel ill-equipped to address the array of complex social needs like housing instability, homelessness, or barriers to transportation that people with SUDs often face.[74] [75] The following considerations focus on addressing stigma, as well as the capacity of providers and primary care practices to care for patients with SUDs:

- **Support training to address stigma and meet SUD-related needs in primary care.** Many states and health plans working to increase the number of PCPs addressing SUDs have offered trainings to build the capacity of their workforce. When rolling out its SBIRT measure, the Oregon Health Authority offered free trainings throughout the state for the continuum of providers — receptionists, billing staff, and direct service professionals — so that entire clinic teams understood the rationale behind SBIRT and how to bill for the service. Other programs, like Project ECHO and the Collaborative Opioid Prescribing (CoOP) model, have addressed provider hesitation to treat SUDs by providing linkages to addiction specialists for ongoing peer consultation and support.[76] Given the challenges associated with spending time and resources to participate in trainings, states and payers should consider how VBP and other incentives could help providers to justify spending time on these activities. Another interviewee noted that training alone is typically not sufficient to get providers to provide SUD-related services, and that real-time, on-the-job coaching was a more effective technique to change provider behavior.
- **Consider incentives to support care coordination activities.** Caring for patients with SUDs is often

time- and resource-intensive and may require significant coordination with other providers (e.g., addiction specialists, therapists). With few financial incentives or administrative advantages to delivering this enhanced level of care, coordinating care for patients with SUDs within primary care can be difficult to sustain without enhanced or flexible funding. CCAH incentivized providers to offer MAT by allowing them to seek reimbursement for initial and follow-up patient visits on an FFS basis in addition to the capitated rates that PCPs were already receiving.[77] Staten Island PPS provided infrastructure dollars to primary care practices for support staff to help coordinate care for patients with SUDs.[78]

- **Identify clinical and administrative champions to lead integration efforts.** When implementing any sort of practice change, it is widely recognized that the involvement of champions is critical to success. Chapmions act as advocates for change, help build support, guide practice transformation, and serve as point persons for others within the field or organization who may have questions or concerns. For SUD integration in primary care to gain traction in the field, more champions will need to take on this issue in a visible and large-scale way.
- **Invest in necessary infrastructure to integrate SUD services into primary care settings.** This includes ensuring that staff are trained in making referrals and coding claims for SUD services; that IT systems are upgraded to house patient information pertaining to SUD treatment separately from physical health information to address 42 CFR Part 2 concerns referenced above; and that there is adequate supervision to oversee the transition and ongoing work. In a statewide study of physical health/SUD integration efforts in California, several participants highlighted the importance of incremental integration efforts such as co-locating SUD specialists in primary care settings, using front-office staff to complete initial SUD screenings, or adding a few SUD screening questions to pre-existing health and mental health screening protocols.[79]

Quality Measurement Considerations

Effective quality measures for SUD treatment in primary care are key for developing VBP models and evaluating provider performance, yet the field is still evolving. When selecting quality measures to assess provider performance on treating SUDs in primary care, these steps should be considered:

- **Address gaps in quality measurement.** Few nationally endorsed quality measures exist for substance use compared to physical health, and only some of these are relevant to primary care settings. The majority of the SUD measures that are currently recognized are process and structural measures, rather than outcome measures

— and among these outcome measures, few address the high-risk acute and chronic conditions specific to people living with SUDs. The development of concrete outcome measures is hindered by the still-evolving evidence on the appropriate treatment of those with SUDs and by the inconsistent collection of relevant data. Furthermore, misunderstandings around 42 CFR Part 2 regulations make providers and hospitals reluctant to share necessary information on patient outcomes. Consequently, outcome measures are difficult for providers, hospitals, and community-based organizations to implement and assess. Interviewees also noted that because MAT can continue for many years, and even a lifetime for some patients, it is difficult to determine how best to measure value and quality of care. In turn, this can make structuring payment arrangements for MAT challenging. To support states' efforts in this area, CMS' Medicaid IAP created clinical pathway models and rate-setting tools for MAT for states (see Exhibit 6).

- **Support health information technology and EHR implementation to capture the data needed for SUD process and structural measures.** The Oregon Health Authority, for example, is transitioning from using claims-based data to using EHR-based data for evaluating its SBIRT measure. The state hopes that with EHR data it will be able to track whether the "referral to treatment" component of SBIRT is actually completed. Using EHR data would ideally allow the state to collect more nuanced and outcome-based information on SBIRT, which will support Oregon in the transition to using more outcome measures for evaluating its CCOs' performance.

Looking Ahead

Among providers, states, and health plans, interest is growing in integrating SUD services into primary care settings in order to improve treatment access for individuals with unmet needs. Many payers are using financial incentives to increase the capacity of the primary care network to provide screening and treatment services for those with SUDs, as well as appropriate referrals to more advanced care when needed. States and health plans are still in the early stages of developing more sophisticated VBP arrangements for SUDs in primary care, but there is great opportunity for these models and valuable lessons to be learned from those that have already taken preliminary steps. CMS' active interest in exploring payment models for SUDs, and for opioid use disorders in particular,[80] is promising — and a likely signal that alternative payment arrangements for SUDs in primary care as well as specialty settings will continue to be explored.

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