CENTERSTONE

May 15, 2018

The Honorable Michael C. Burgess, Chairman
House Committee on Energy and Commerce
Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Jr., Ranking Member
House Committee on Energy and Commerce
2322A Rayburn House Office Building
Washington, DC 20515

Cc: Zack Dareshori

E-mailed and mailed

Re: Additional Questions for the Record

Dear Chairman Burgess and Ranking Member Pallone,

Once again, thank you for inviting Centerstone to participate in the "Combating the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care for Patients" hearing on April 11th/12th. Below, please find our responses to your additional questions for the record.

1. Individuals who are opioid dependent often have complex social, physical, or behavioral health comorbidities. For example, six out of 10 people with a substance use disorder also suffer from another form of mental illness and could benefit from increased care management. What kinds of benefits does a SUD Health Home offer to a Medicaid beneficiary that would not be available outside of the model? Can you provide details on how states have taken the concept of team-based care, which includes: wrap-around services such as comprehensive care management, care coordination, and support services and put that into practice using the health home waiver?

The Patient Protection and Affordable Care Act (ACA) established authority for states to develop and receive federal reimbursement for health home services for their state´s Medicaid populations with chronic illness(es).[1] Health Home services support the provision of coordinated, comprehensive medical and behavioral health care to patients with chronic conditions through care coordination and integration that assures access to appropriate services, improves health outcomes, reduces preventable hospitalizations and emergency room visits, promotes use of health information technology (HIT), and avoids unnecessary care.[2] An eligible chronic condition includes, but is not limited to: a mental health condition, a *substance use disorder*, asthma, diabetes, heart disease, and being overweight.[3]

At Centerstone, through our Medicaid Health Home[4], we are able to not only provide patients with a host of direct medical and behavioral health services, but also to connect them with needed wrap-around services, which increase their chances of staying healthy. Through Tennessee Health Link[5], we provide the

[1] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/
[2] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/
[3] https://www.ssa.gov/OP_Home/ssact/title19/1945.htm#ftn490
[4] https://centerstone.org/our-services/services-directory/healthlink
[5] https://www.tn.gov/tenncare/health-care-innovation/primary-care-transformation/tennessee-health-link.html

following six types of services: (1) comprehensive care management – including a patient-centered health assessment and active management of your customized care plan; (2) care coordination – making sure all of a patient's healthcare providers actively work together to deliver the highest quality care; (3) health promotion – helping patients take charge over their own health through education, annual screenings and disease prevention; (4) transitional care – helping patients after any hospital or emergency room visit by answering their questions and ensuring they receive appropriate follow-up care; (5) patient and family support – identifying ways to aid patients in treatment, providing a mix of check-ins and wellness coaching as needed to help maximize recovery; and (6) referral to social supports – linking patients to any other resources or services they may need such as housing, employment, legal, peer support, etc.

The benefits of an SUD health home are that people receive not only one-time interventions as is typical in the status-quo fee-for-service healthcare environment, but also, just as importantly, receive a range of services that help them stay in treatment, get relevant check-ups, deal with other, co-occurring health challenges, participate in and with their communities, and feel able to stay in control of their medical and behavioral health needs. Through better coordinated behavioral and physical health services, health homes produce improved member outcomes, greater provider accountability and flexibility when it comes to the delivery of appropriate care for each individual, and improved cost control for the state.

A Centerstone client success story, generated 08/14/17, follows:

When T.M. enrolled into "Health Home," he was in bad shape. He had lost his job and his insurance. His housing situation was uncertain. His diabetes was out of control. At his enrollment interview, his blood glucose level was 512. The pain in his legs and feet were a constant reminder of his ill health. In the prior year, he had lived in five different places. His health was on a general downward trajectory. All of this weighed heavily on his mind, and his anxiety was starting to get the better of him.

A year later, a blood test revealed that T.M.'s glucose level was 70 - a decrease of 442 points. When asked what changes he had made to achieve this change, T.M. said that it was "Health Home" that brought everything together for him. It wasn't just eating habits that were contributing to his diabetes. It was stress, lack of medication, and unstable housing that made eating right seem far from a priority. T.M. now says that the biggest change for him was in his thinking. After attending the Mindfulness class offered through our "Health Home" program, he realized he couldn't keep doing what he was doing. "It's about keeping your mind in the moment. It's all a new normal". When faced with a craving, he says he has to "be mindful of whether I want to be sick today or if I want to live."

Health has been a long term issue for T.M., and he has tried other programs in the past. In describing other programs, T.M. said that no one know what everyone else was doing. His care had gaps in services and staff members gave him conflicting information, all of which lead to frustration. T.M. explained that Health Home was different because of the team approach. He continues to say that the Health Home program helped him to find his weaknesses and his strengths, but more importantly, that the program helped him to hone his strengths. Whenever he finds himself slipping back into old habits, he knows that he can contact people that care. "The support system is really spectacular."

This type of integrated, whole-person care is the type of care that health homes are designed to provide. With such dramatic positive results, Centerstone fully supports further health home initiatives not only for patients with SUD, but for patients with any chronic disease(s).

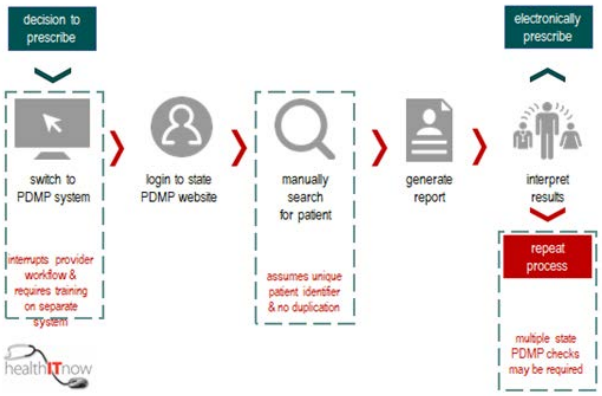
2. One goal of Health Homes is to provide care in primary care settings and help participants effectively manage their conditions by increasing preventive care. For example, South Dakota's Health Home has increased access to primary care: is this something you are seeing across your Health Homes?

A health home is not necessarily a physical place, although it can be one.[6] Rather, a list of eligible providers, a team of health professionals, or a health team may become designated health home providers as long as they work together to make sure patients get the care and services they need to stay healthy.[7] Preventive care is only one of the multiple aims health homes are designed to address. In short, Centerstone is seeing increased access to primary care through these initiatives.

Centerstone operates health homes in Illinois, Indiana, Kentucky, and Tennessee. Outcomes from our health home in Clarion, Illinois, for example, indicate that within 6 months of enrolling in a health home, our patients exhibited improved blood pressure, improved body mass indexes, normalized carbon monoxide levels, smaller waist circumferences, and a decreased frequency of feeling depressed.[8] Within one year, our patients exhibited significantly improved plasma glucose, triglyceride, and cholesterol levels.[9] Outcomes from our health home in Tennessee show similar results.[10] With enrollments continuing to grow in our health home models, we agree that health homes increase access to primary care, but even more than that, they increase access to high-quality, whole-person care.

It is important to note, however, that although health homes are permitted by law, we are nevertheless constrained by allowable billing codes. This means that Centerstone has only been able to set these up via grant funding, which is inevitably unstable and temporary. Thus, seeing as health homes improving patient outcomes and reducing costs, we recommend a more permanent space for health homes in the behavioral health space.

3. The National Association of Boards of Pharmacy reports that 39 states already mandate use of PDMPs. What has your experience been in using PDMPs to combat the opioid crisis? What is your sense on how providers and dispensers view the usefulness of PDMPs?



The usefulness of PDMPs is highly dependent upon the level of sophistication of the health IT system providers utilize. Currently, in order to check a state's PDMP, most clinicians are required to log in to a system separate from their normal medical record software (EHR, prescription dispensing system, etc.), query the site, analyze the report results, and then return to their original workflow. (An image indicating this process is shown to the right.[11]) A 2016 study on the usefulness of PDMPs in emergency departments, for example, found that the PDMP task took a longer time to complete (mean = 4.22 minutes) and greater number of mouse clicks to complete (mean = 50.3 clicks) than other tasks (CT-pulmonary embolism = 1.42 minutes, 24.8 clicks; prescription = 1.30 minutes, 19.5 clicks; SureScripts = 1.45 minutes, 9.5 clicks).[12] This makes clear that accessing PDMP data is not currently user-friendly. The core challenges we see in utilizing PDMPs for the most clinically effective purposes are: (1) lack of interoperability among

[6] https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/
[7] https://www.medicaid.gov/medicaid/ltss/health-homes/index.html
[8] For more detailed results, please see Exhibit 1, attached.
[9] For more detailed results, please see Exhibit 1, attached.
[10] For more detailed results, please see Exhibit 2, attached.
[11] Image provided by HealthITNow.
[12] *Academic Emergency Medicine* 2016;23:406–414 © 2016 by the Society for Academic Emergency Medicine. Accessed: https://doi.org/10.1111/acem.12905

states or with other health IT, (2) data latency, (3) data is not within workflow for providers and dispensers, and (4) the fact that it is unable to trigger a Screening, Brief Intervention and Referral to Treatment (SBIRT) function.

As long as providers communicate with others along the care continuum by phone and fax, our industry will be unable to fully utilize the tools to treat and prevent SUD effectively that PDMPs can offer. To harness the full potential of PDMPs, all providers must have access to some minimum specified standard of technology. A national PDMP would help providers identify patients who may be at risk for opiate abuse. A national standard for an interoperable, real time PDMP would address the challenges of limited data tracking, weak responses to overprescribing, and under informed prescribers. PDMPs are crucial sources of data for providers. Improving interoperability of PDMPs will allow providers the ability to check patient prescription histories, alert providers to individuals with patterns indicative of misuse, and prevent patient doctor shopping. PDMPs currently run on batched information, only being utilized retroactively to track dispensing data for patients. If PDMPs ran real-time, many prescriptions would not be dispensed; others would never be written. Checking a real-time PDMP would allow a clinician to not only stop the medication from potentially falling into the hands of an individual exhibiting addictive behaviors, but to address those potential harmful behaviors and help refer to treatment or alternate therapies, something we term a "warm hand-off." To facilitate real-time access to data and reduce prescriber burden, patient data must be accessible within workflow.

Finally, PDMP technologies should be more than simply a data-gathering tool; any national PDMP standard should link patients to treatment by automating, or incenting, a Screening, Brief Intervention and Referral to Treatment (SBIRT) function to help providers catch patients who may otherwise fall through the cracks. SBIRT is an evidence-based preventative measure designed to move patients, who may need help, into treatment. By linking SBIRT functions to a PDMP system, we would not only be able to "flag" at risk patients, but also screen and refer them to appropriate treatments, thereby increasing their chances of recovery.

It is our sense that providers would use information offered by PDMPs more regularly and consistently in making decisions with their patients were it more easily accessible. The usefulness of PDMPs is currently far from being realized. However, this presents us with a great opportunity for improvement.

4. Numerous studies have found that Medicaid enrollees have excessive burdens of chronic pain and are at a much higher risk of substance use disorders compared to populations with other types of insurance. Similar studies have found that Medicaid enrollees are thus at heightened risk for prescription opioid misuse and were five to six times as likely to die from opioid related overdose compared to populations with other types of insurance. Because of this, according to the authors of one such study, which I quote: "reducing the number of unsafe prescriptions of opioids in the Medicaid population should be a priority for any drug control policies." I believe that we have several bills before us today that will help achieve that goal. Our Pharmacy Home Bill, our PDMP Bill, and our DUR bill for example. Do you believe that these policies will help to advance the important goal of reducing the number of opioids in the Medicaid population?

The goal of reducing the number of opioids in the Medicaid population is a laudable goal, and should be a goal for all subsets of the American population.

Regarding H.R __ Medicaid Pharmacy Home Act: This bill mandates states to operate a qualified drug management program for at-risk beneficiaries identified by the states. The program functions to: (1) identify at-risk individuals, (2) mandate that those individuals be assigned/choose two health care providers and two pharmacies that would always be in charge of prescribing and dispensing any controlled substances to them. An at-risk individual would be enrolled for a year and then re-evaluated. It is unclear to us whether

states should be the ones identifying at-risk individuals. Without further information detailing how these persons would be identified, and what the added benefit of having two go-to prescribers and pharmacies would be (in excess of the benefit derived from having providers and pharmacists check PDMPs), we feel that commenting on this bill is outside our scope of expertise.

Regarding the Medicaid DRUG Improvement Act: This bill mandates that states have claims review automated processes, put in place automatic denials of excess refills, and put in place protocols to protect children from inappropriate prescriptions of antipsychotic medications. Without further information detailing what practices these protocols would be based upon, we feel unable to properly comment on this proposal.

In short, however, we recommend that legislation improve and incent PDMP use so that providers utilize this technology more systematically to identify at-risk patients and make more fully informed decisions when prescribing medications. Regarding the PDMP bill(s) in the House: The Prescription Drug Monitoring Act of 2017 (H.R.1854), the bill to enhance and improve state-run prescription drug monitoring programs (H.R.___) introduced by Reps Griffith and Pallone, and the Medicaid PARTNERSHIP Act (H.R.___) each have strengths and weaknesses, but none address all of the core challenges we describe above. Thus, we recommend that the final PDMP proposal address each of the above-defined challenges.

5. The Medicaid HUMAN CAPITAL Act would provide enhanced funding for states to recruit highly-experienced Medicaid directors, Chief Information Officers, and Chief Financial Officers. In Mr. Douglas's testimony, he discusses the importance of strengthening Medicaid's role as a payer in combatting opioid misuse. He notes "Congress should implement policies that support state recruitment and retention of strong Medicaid executive leadership," because as he explains, a stable and strong state leadership will be best equipped to respond to the opioid crisis and further public health crises." In your opinion, is it helpful to improving Medicaid's role in addressing the opioid epidemic and other public health challenges by helping states secure the most talented, innovative, and experienced leadership possible?

At Centerstone, we believe that when employees feel valued, they do better work. Without having directly observed state Medicaid leaders in their roles, we assume that this general maxim would apply in their context, as well.

6. I am interested in the draft that proposes a demonstration project to increase provider capacity in Medicaid for treating substance use disorder. States could apply to use the funds to recruit or train current or new providers. However, I do have several concerns with the idea. Given all the funds that Congress has authorized to support provider capacity such as GME as well as grants from HRSA, SAMSHA, and CDC. Is this idea duplicative? I am also unclear why we would start a new program when those are well established and have staff that understand workforce capacity. Can you comment on that?

Centerstone has not specifically looked into whether these grants are duplicative, but it is nevertheless our experience that many GME grants are more oriented towards medical facing practitioners and not on supporting work to close the 20 year science to practice gap in behavioral health. Today, adherence to evidence based practices in behavioral health settings can be quite low. For example, according to researchers at the University of Southern California, "a minority of patients with schizophrenia (in some instances less than 10%) are receiving evidence-based psychosocial interventions[13]." Moreover, the National Institute on Drug Abuse notes, "ninety percent of privately funded substance abuse treatment programs in the United States offer cognitive-behavioral therapy (CBT), but one-third of these do not provide their counselors with any formal training in the intervention[14]."

[13] http://www.chhs.ca.gov/Child%20Welfare/Translational%20Social%20Work.pdf
[14] https://www.drugabuse.gov/news-events/nida-notes/2012/07/training-gaps-evidence-based-practices

For providers serving safety net populations, Medicaid rates are typically lower than the actuarial cost of delivering the service the patient receives. Thus, providing additional training on fidelity to evidence based models may not be attainable for many providers. At Centerstone, through our Research Institute and funding from a mixture of grants and philanthropic donations, we have started some initial investments into assessing clinical model fidelity, as well as providing support in clinical translations. With approximately 5,000 staff, however, we have to be extremely careful and precise in evaluating specific pilots and interventions. In brief, we recommend urging SAMSHA/CMS to ensure some of the GME funds and associated grants for recruitment and training be directed toward behavioral health providers and inclusive of a range provider types (psychiatric, social work, and peer supports).

1. How does Centerstone use telehealth as part of its comprehensive addiction care model? How can telehealth be used to deliver the supportive services that are crucial to long-term recovery?

In Indiana, Centerstone utilizes telehealth in the context of an integrated health home model that serves persons with co-occurring physical and mental health concerns. Through this model, we have been able to provide contiguous care to consumers who had previously only experienced fragmented, expensive care. We have observed the following results within our population: 84% of our patients with high blood pressure saw lower readings after 12 months, recipients reported a 56% improvement in anxiety levels, and patients showed a 53% improvement in general health. Participants awarded this model a 98% approval rating. We've also seen a significant reduction in ER utilization within this population.

Given the positive outcomes and cost saving associated with our health home model, Centerstone is actively exploring implementing telehealth in the context of an integrated addictions care model. To pilot this, our first area of focus is the utilization of telehealth to help with psychiatric capacity needs to better address the shortage of available psychiatrists in some of our rural locations in Southern Indiana and Illinois. Ultimately, we would like to have Centerstone Kentucky provide medication assisted treatment services via telemedicine to rural areas in Illinois and Indiana because it has been much easier to recruit and retain certified addictionologists in urban areas (in this case Louisville, KY) than in some of our more rural counties. To be able to do this, however, we need to have our physicians licensed and credentialed in all the states they may end up providing services within. The process of licensing and credentialing in each state, as you may suspect, is very costly. Onboarding new physicians who encounter longer-than-anticipated delays in licensing and credentialing across state lines, coupled with low Medicaid rates, has resulted in our medical services running at a deficit. Thus, even for providers who can recruit addiction specialists, the current licensing and reimbursement realities pose significant threats to the long-term viability of the most dedicated providers in the space. Another barrier is caused by the Ryan Haight Act, which prohibits the prescribing of MAT via telemedicine without an initial in-person encounter. We eagerly await DEA guidance regarding a special registration process that may extent telemedicine capabilities.

Thus, lawmakers should fully optimize the value of our behavioral health workforce by affording them a wider latitude to treat SUD patients via telemedicine. The Access to Telehealth Services for Opioid Use Disorders Act (H.R. 5603) would allow HHS to waive certain telehealth requirements for eligible practitioners providing SUD services to Medicare patients diagnosed with an SUD. Licensed community mental health and addiction providers, who follow nationally recognized models of treatment, should gain access to a special registration process so that they may register with the DEA to prescribe substances now commonly embraced in MAT practice, without a prior in-person patient/provider encounter. To bring about this end, we support the Special Registration for Telemedicine Clarification Act of 2018 (H.R. 5483), and the Improving Access to Remote Behavioral Health Treatment Act of 2018 (H.R.5594).

3. Provider shortages in the field of behavioral health services field create continuing challenges for those seeking treatment. How can telehealth help to fill this gap?

According to the National Rural Health Association, 30 million Americans currently live in rural counties where access to addiction treatment services and medications is unavailable[15]. At Centerstone, with much of our population living in rural areas, we are quite attune to this reality. For example, Scott County, IN is a rural county in Southern Indiana and is a 45 minute drive from Louisville, KY, where the Centerstone Addiction & Recovery Center and several of our addiction specialists are located. In striving to build out our continuum of care in the Scott County area, we sought to utilize some of our psychiatric capacity in Louisville to complement therapy, peer, and other supportive services that we offered. However, despite their close proximity, it took over 6 months to finalize the licensing and credentialing process to get just 1 prescriber licensed and credentialed to provide psychiatric services, across state lines, to one of our own facilities. This is extremely costly for providers who need to hire new staff to meet telehealth capacity. Moreover, this process causes an unacceptable delay for some of the regions hit hardest by the opioid crisis.

More broadly, as direct to home/direct to consumer services become more widely available, we will become more skilled at triaging clients and treating them in the most appropriate settings. Therefore, site restrictions generally prevent providers from delivering care to patients where and when they need it, and are an antithesis to the purpose of telehealth. Telehealth services will alleviate problems of access to care.

We are seeing telehealth advances in other healthcare arenas, but some of the slowest dissemination has occurred in mental/behavioral health – arguably one of the fields most suited for telehealth and technology-enabled care. Earlier this year, for instance, the *Bipartisan Budget Act*[16] took steps to facilitate telehealth in Medicare Advantage plans, provide nationwide access to telestroke, and improve access to telehealth-enabled home dialysis therapy.[17] The Veteran Affairs Administration finalized rules to deliver telehealth wherever a veteran may need services[18]. These are significant steps toward removing barriers to the use of telehealth, and the same can be done for the mental/behavioral health space.

To address workforce shortage gaps, Centerstone recommends that lawmakers advance the Mental Health Access Improvement Act of 2017 (H.R.3032) that would allow LMFT and LMHC services to be reimbursed by Medicare. This bill would enable faster access to care for Medicare and some commercial patients, as well as optimize our current workforce to operate at the top of its licensure. Peer support services are currently accepted as evidence-based practices by both CMS and SAMHSA. Peer supports serve as a vital "connective tissue" in the continuum of care. The bill to support the peer support specialist workforce may help peers become more integral in the behavioral health workforce. Additionally, a top priority for behavioral health not-for-profit providers is recruiting and retaining top talent, with the primary challenges being (a) an inability to offer competitive pay and benefits, and (b) a lack of qualified applicants. The Substance Use Disorder Workforce Loan Repayment Act of 2018 (H.R.5102) would function to directly alleviate the supply problem.

Lastly, we urge committee members to continue to evaluate options to break down regulatory barriers for the delivery of telehealth, such as originating site definitions and cross state licensing requirements. These collective actions would greatly ameliorate the behavioral health workforce shortage.

[15] https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/Treating-the-Rural-Opioid-Epidemic_Feb-2017_NRHA-Policy-Paper.pdf
[16] Bipartisan Budget Act of 2018. Accessed: https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf
[17] http://thehill.com/opinion/healthcare/373589-congress-just-took-action-on-technology-enabled-medicare-reforms
[18] https://www.healthdatamanagement.com/news/va-telehealth-rule-allows-providers-to-treat-patients-across-state-lines

4. How can better coverage of psychotherapy and behavioral health services delivered via telehealth expand access to psychosocial treatment that is necessary to promote long term recovery from opioid use disorders?

Coverage of psychosocial support services via telehealth – such as peer support specialists and all licensed therapists – can increase the continuum of outpatient services geared toward sustained recovery. Congress and the Administration can break down barriers for use of peer support services, delivered via telehealth, in both Medicaid and Medicare. Peer support services are currently accepted as evidence-based practices by both CMS and SAMHSA. Research indicates that use of peer supports leads to significant decreases in substance use, symptom improvement, and better management of patients' own conditions[19]. These outcomes are largely achieved by a sense of trust and by the non-judgmental attitude peers exhibit towards patients.

Licensed marriage and family therapists (LMFTs) and licensed mental health counselors (LMHCs) hold licensures on par with licensed clinical social workers (LCSWs), yet their exclusion under Medicare is somewhat arbitrary. As a result of this workforce gap, providers face significant barriers when recruiting within the limited allowable provider types, particularly in rural areas. This shortage in eligible workers also results in wait times that can be 4 times higher amongst Medicare patients, as opposed to under Medicaid, which permits for reimbursement of LMHC and LMFT services in some of our sites. The Mental Health Access Improvement Act of 2017 (H.R.3032) would allow LMFT and LMHC services to be reimbursed by Medicare. This bill would enable faster access to care for Medicare and some commercial patients, as well as optimize our current workforce to operate at the top of its licensure. We ask that this language be added to the final opioid proposal.

5. At present, providers utilize a variety of interventions for opioid use disorders and lack a standardized approach for treatment. In some instances, patients may receive only medication treatment or behavioral treatment, while other providers offer comprehensive care for opioid use disorder.

a. Why is this problematic in our efforts to fight the opioid epidemic?

This is problematic because there is no gold standard for comprehensive SUD treatment. If a patient walks into 5 separate facilities, they may receive 5 different treatment protocols. Furthermore, adherence to best practices and evidence based protocols is quite varied, so a patient may not even receive an intervention that is considered an evidence-based practice. Without a clear standard of care for SUD treatment, we are unable to determine quality, compare outcomes, and ultimately provide the best quality of care for patients. This results in costly and fragmented care that can potentially obstruct the aim of reversing the opioid crisis. This is particularly true in the case of MAT "pill mills," which may be exacerbating the problem. There is no question that the industry is in desperate need of well-vetted standard for comprehensive, evidence-based SUD care.

To this end, Centerstone recommends developing a "gold standard" certification that would establish "clinical excellence hubs" as preferred providers for courts, corrections, emergency departments, etc. for trusted patient referrals. These clinical excellence hubs would need to demonstrate use of evidence-based interventions, linkages to a full continuum of care, including services geared towards increasing patients' recovery capital, and report on patient outcomes. The Comprehensive Opioid Recovery Centers Act (H.R.5327) is an appropriate legislative vehicle to bring about this shift.

b. While we know the best treatment for opioid use disorders combines medication assisted treatment and behavioral health therapy, no value-based models exist to incentivize this standard of treatment. Is there

[19] https://www.ncbi.nlm.nih.gov/pubmed/26882891

a need for value-based payment models for the treatment of opioid use disorder, and how might such payment models improve the quality of care for patients?

Centerstone supports linking value based payment models to meaningful outcomes designed to incentivize integrated, whole-person care models for addictions treatment, particularly for patients with co-occurring and complex conditions. To ensure quality in patient care and outcomes, we recommend that providers serving Medicaid/Medicare eligible beneficiaries for SUD demonstrate the ability to offer a comprehensive continuum of evidence based services. At Centerstone, we are in the process of developing a value based model for outpatient SUD treatment. This model includes treating the patient holistically, building their recovery capital, and for the majority of our patients, where appropriate, working toward a discontinuation protocol from medication assisted treatment. In all models we include *treat to target* metrics to assess a patient's progress along the treatment continuum.

To better address the move toward value based care for SUD treatment, health homes are particularly effective in treating patients with behavioral health disorders because they provide whole-person care. The federal government can help spur innovation in whole-person, integrated care via the Medicaid Incentives for Health Homes to Treat Substance Use Disorder (H.R.___). Moreover, the federal government can incentivize value-based, integrated addiction treatment models. The Alternative Payment Model for Treating Substance Use Disorder (H.R. ___) would allow providers the requisite flexibility in designing and implementing whole-person treatment models without the reimbursement barriers of our predominantly fee-for-service system. Lastly, reimbursement protocols should reward trusted providers who work systematically to improve patient outcomes. The Reinforcing Evidence-Based Standards Under Law in Treating Substance Abuse Act of 2018 (RESULTS Act) (H.R.5272) is a straightforward mandate to tie federal dollars to evidence-based services. To ensure optimal implementation of this potential law, it is critical that meaningful *recovery-oriented* outcomes measures are linked to the appropriate EBP's, thus better ensuring valid and reliable results.

c. What measures of quality should be considered in the development of a value-based payment model for opioid use disorder?

Centerstone's Integrated Addictions Care services meet clients where they are, and focus on goals that are important to each client. All clients enrolled in this model have a treatment team consistent with their level of care; treatment teams *may* include a prescriber (MD, NP), therapist, care coordinator, team leader, or recovery coach that have expertise in integrated addictions care. Services provided within the Centerstone Addictions Care model are adapted to client needs and are provided by one treatment team that offers specialized care within our integrated care clinical pathway. This pathway is designed to provide services for clients with substance use and/or co-occurring disorders that cause preventable ER visits, hospitalizations, are interfering with the client's ability to seek employment, and impacting the client's quality of life. To accomplish this, here are some of the outcome measures Centerstone has begun implementing in our integrated, SUD treatment pilots:

- *Superb Customer Service is measured by the Health Home customer service survey. This survey asks:*
  - "How likely is it that you would recommend (provider's name) health home to a friend or colleague?"
  - "How confident do you feel managing your condition(s)?"
  - "How connected do you feel to your care team?"

- *Excellent Access to Care is measured by:*
  - % clients receiving appropriate level of care engagement intensity
  - % clients who access routine care < 10 days
  - % clients who access urgent care < 3 days

- *Treat to Target Care process goals*:
  - % of clients whose improvement is tracked
  - % of clients not improving that:
    - Receive a significant treatment plan change
    - Are staffed in a treatment team meeting
  - % of clients that experience symptom improvement to ASAM Level I.
    - % of urine analyses free drugs of abuse (Note: this outcome measure can assist in drawing a line between MAT pill mills and providers who are appropriately administering MAT)

We hope our comments address your questions pointedly and completely. Please let us know if we can provide any further information, and feel free to reach out to us should you wish to discuss any of these items in more detail. Thank you all, again, so much for your concerted efforts. We look forward to continuing to work with you.

Sincerely,

/s/
Lauren McGrath
Vice President of Public Policy
Centerstone

/s/
Monica Nemec
Director of National Policy
Centerstone