trac9 Insights

How to Value-Based Care

I. Executive Summary

Value-based care (VBC) has been an ongoing topic of discussion, with minimal progress, in the field of substance use disorder (SUD) treatment for over a decade. This paper analyzes the root causes of this lack of progress and proposes a roadmap to accelerate VBC for SUD treatment. Success with VBC requires standardized treatment and outcomes measures that reliably predict treatment effectiveness and post-discharge outcomes. Clinical staff must be trained how to use the measures. The measures must provide clinical benefits that exceed the extra clinician time required, otherwise clinical staff and patients will lose motivation to use them. The near term financial benefits of implementing the measurement system must be sufficient to justify the implementation and ongoing operational costs to providers. Payers (e.g., Medicaid MCOs) should establish and pay for the use of common outcomes measures and systems to ensure accuracy, consistency, and comparability across providers. This enables VBC bonuses for above average outcomes and the ability to optimize the provider mix to reduced population-level relapse risk and associated claims.

II. Background - How Did We Get Here?

Over the past decade plus, health care payers have increasingly moved toward value-based care models that tie a portion of reimbursement to patient outcomes. This has fueled advances across fields from primary care to management of diabetes and cardiac conditions. Behavioral health care has been slow to make this shift, sticking with fee-for-service schemes that reward utilization: The more sessions a patient has, the more the provider makes, regardless of whether the patient improves. This system creates a disincentive for therapists to pursue the most rapid and effective treatment for their patients.[1]

While there are examples of residential SUD providers who have implemented VBC plans with their payers, it typically takes multiple years to negotiate the VBC plan and is more the exception than the rule. Most providers are stuck in a "vicious cycle" of declining or insufficient payer reimbursements, leading to cost cutting, which degrades treatment quality, leading to increased patient readmissions, and greater claims costs for providers. Each iteration of the cycle negatively reinforces the previous one. For some providers, this becomes a death spiral.

Treatment Industry Vicious Cycle

Payers facing rising total claims / Need to manage payment rates and authorizations

Patients get less effective treatment / Have greater relapse risk

Providers forced to cut costs and quality to stay in business

Consequences for Providers

Treatment quality takes a back seat to cost reduction as treatment quality is not financially rewarded. Providers lower their costs by using lower skilled therapists, higher patient to staff ratios, and less clinical supervision. Budgets are cut for staff development, clinical programming, quality and productivity tools, and facilities. This leads to staff burn-out, turnover and degraded treatment quality. Providers face a perverse incentive to increase revenue by maximizing readmissions.

Consequences for Payers

Payers face tremendous pressure to contain health care spending. Because they don't have treatment outcome measures that predict relapse risk, measurement of relapse risk is based on claims data and lags treatment by 1-2 years. Most SUD treatment providers do not have the wherewithal to invest for years to achieve superior outcomes for uncertain payments. While our data shows a 3:1 difference in outcomes achieved by top vs. bottom treatment providers, payers are not able to reward high performing providers or weed out chronically low performing providers, so aggregate costs continue to increase and the cycle continues.

Consequences for Patients

Patients receive less and less effective treatment, experience reduced treatment success and higher risk of relapse post-discharge. There is a significant difference in treatment outcomes between top and bottom performing therapists - our data shows a 5X difference in treatment outcomes. Patients who are not feeling or seeing the benefit of treatment leave against medical advice (AMA) at higher rates, resulting in higher relapse risk and readmission rates.

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III. What Is Holding Back VBC?

1. Measures

Unlike in medicine, where lab values, such as HbA1c for diabetes, can be used to demonstrate clear improvement, it is more difficult measure SUD outcomes. There is lack of a commonly used outcomes measures that are both useful clinically during treatment and credible for predicting relapse risk. Most treatment programs only measure pathology factors and do not measure resilience factors. Using a combination of both leads to better treatment outcomes and better relapse risk prediction power. Furthermore, there is a dearth of research (beyond our own) that identifies a combination of factors with sufficient relapse risk prediction power. This may be due to the difficulty of getting the 10's of 1,000's of subjects needed to sufficiently power multi-variate analysis (our database includes 100's of 1,000's).

2. Clinician Readiness

While most SUD therapists are trained to interpret individual assessments, most are not trained in the multivariate interpretation skills necessary to assess the combination of pathology and resilience factors that are predictive of relapse risk. Often, half the therapists at a facility are not accustomed to reviewing any assessments. If therapists are not getting clinical value from reviewing assessments, patients will quickly sense their therapist is not reviewing their assessments, and assessments will soon stop being done. Overcoming this issue requires a combination of training to build the clinical interpretation skills and clinical supervision skills to ensure therapists are following quality processes.
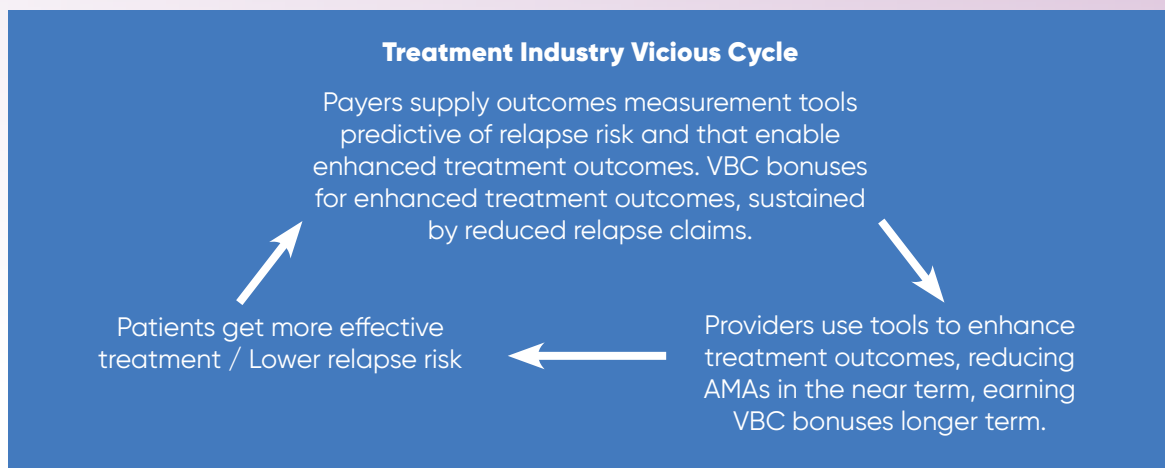
3. Business Case That Works in the Near Term

Because most treatment facilities are experiencing financial stress, it is hard to justify implementing an outcomes measurement system if there is not a rapid payback. Because of the aforementioned lack of measures that are useful for treatment and the lack of clinical interpretation skills, most facilities cannot realize a positive ROI in the short term. And because measures available to them do not have relapse risk predictive power, it can take years for payers to evaluate program effectiveness and establish VBC payment plans.

IV. How to Break the Vicious Cycle - Roadmap to a Virtuous Cycle

From our experience working with over 200 SUD treatment facilities over the past 8 years, we have identified the necessary steps to flip the current negative-reinforcing vicious cycle into a positive-reinforcing virtuous cycle:

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Treatment Industry Vicious Cycle

Payers supply outcomes measurement tools predictive of relapse risk and that enable enhanced treatment outcomes. VBC bonuses for enhanced treatment outcomes, sustained by reduced relapse claims.

Patients get more effective treatment / Lower relapse risk

Providers use tools to enhance treatment outcomes, reducing AMAs in the near term, earning VBC bonuses longer term.

1. Adopt a proven combination of measures that both inform treatment and are predictive of relapse risk. Measures should include both pathology and resilience factors to maximize treatment utility and predictive power. Use technology to automate use of the measures for patient clinical monitoring, clinical supervision, and facility supervision.

2. Train clinical staff in clinical interpretation and train clinical supervision in adherence monitoring.

3. Realize initial benefits within 2-3 months, primarily from reduced AMAs and the associated benefits of patients successfully completing treatment. Treatment outcome improvement metrics can be used in marketing with patients and referral sources.

4. Conduct regular program optimization reviews to identify clinician and facility-level opportunities for improvement.

5. Realize increasing financial benefits from further reducing AMAs and from patients admitting initial relapse on follow-up surveys and requesting contact from their treatment facility. This can return 2-3% of census to treatment before they have a catastrophic relapse and is a win-win-win for patients, providers and payers.

6. If Payers (e.g., Medicaid MCOs) are sponsoring the measurement system, they can use aggregated outcomes data from the system to operationalize the VBC payment plan.

7. If Payers are not sponsoring the measurement system, providers negotiate with their payers armed with credible outcomes data.

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V. About Trac9 Informatics

Trac9 is a proven solution to enable VBC, providing measures that both enhance treatment and are predictive of relapse risk. Trac9 automates weekly assessment administration, scoring, alerts, and clinical suggestions so clinicians can review assessment results in as little as two minutes. Trac9 provides training to develop the necessary clinician and supervision skills. Trac9 analytics and program optimization identify practical steps to reduce AMAs and improve treatment outcomes. SUD treatment facilities using Trac9 have experienced a reduction of up to 36% of patients leaving AMA, up to a 32% improvement in treatment outcomes, and a corresponding 29% reduction of relapse risk.

Benefits for Providers: Trac9 pays for itself within months of implementation. Providers typically reduce AMAs by 30%+, with corresponding benefits of clients successfully completing treatment, within 3 months. Trac9's post-discharges outcomes surveys typically return 2-3% of census to treatment (patients who admit relapse and request contact by their treatment provider) within 12 months of implementation. These two categories typically result in a 4X ROI (return on investment). Additional benefits include marketing differentiation with patients and referral sources, and improved reimbursement rates based on credible treatment outcomes data.

Benefits for Payers (e.g., Medicaid MCOs) can improve population-level outcomes while simultaneously reducing medical and behavioral health claims resulting from reduced relapses and readmissions. The cost of a relapse can be $20,000 across medical and behavioral health readmission. Reducing 1 year risk of relapse by 25% (e.g., from 50% to 37.5%) reduces average cost per member admitted to residential treatment by $2,500.

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[1] An Outcomes-Focused Approach to Mental Health Care, Aparna Atluru and John Bracaglia, *Harvard Business Review*, March 3, 2023

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