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RECOVERY

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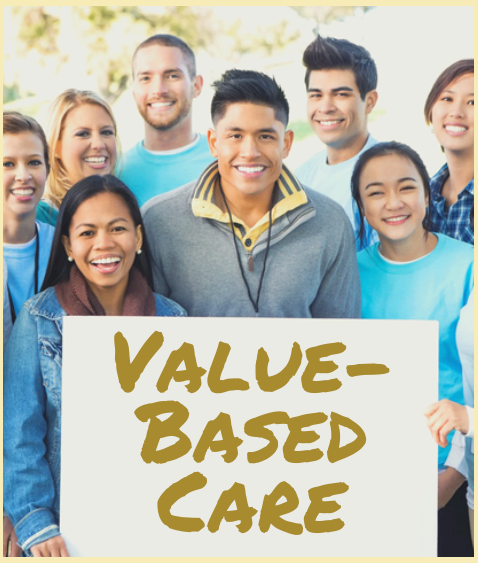

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FROM VOLUME TO VALUE

by Founder and Chief Medical Officer Dr. Ernie Fletcher

Change comes in many forms from many directions. I think of the medical model of recovery and the fee-for-service payment model as top-down systems with patients, clients, and practitioners scampering around to fit in as best they can.

The social model of recovery, in contrast, grew from the ground up, planted and nurtured by common folk who knew only one thing: there had to be a better way. Too many people were dying, not just from gaps in service but from gaps in human contact, connection, and understanding. They sensed correctly what the medical model overlooked: that to accomplish the greatest and most difficult things we need each other.

Value-Based Care is similarly driven by a grass-roots recognition that, despite all the money, buy-in, and advancements, too many of us are left behind.

Once again, that elusive "better way" begins not with system hacks but with a laser-like focus on the real needs of real people.

WHAT IS VALUE-BASED CARE?

The United States spends much more on healthcare than other countries, but doesn't always get the best results. Among high-income countries, for example, we have the highest infant and preventable death rates. A history of inequality in access to healthcare also means that poor people and people of color are more likely to experience adverse health outcomes than others.

Experts agree these long-standing, widespread problems stem in part from the misaligned incentives built into the nation's traditional fee-for-service payment model that pays providers more for delivering more services even if the desired results are not achieved.

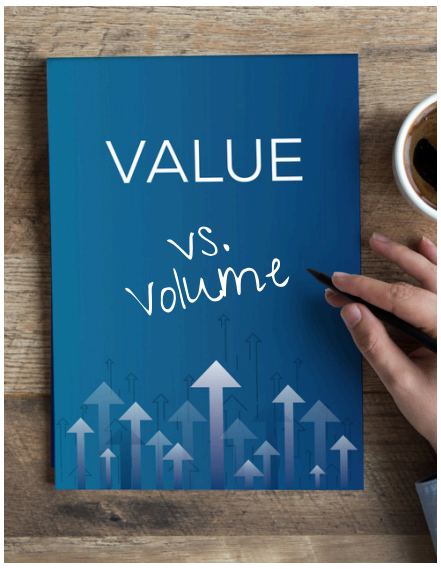
A relatively new approach called "Value-Based Care" aims to change that dynamic by rewarding providers who help patients get better while keeping costs down.

How It Works
VBC ties payment to results such as the quality and cost of care. Through financial incentives and other methods, VBC holds providers accountable for improving patient outcomes while giving them greater flexibility to deliver the right care at the right time.

Outcomes Matter
Healthcare providers are thus incentivized and rewarded for meeting a variety of interrelated goals. If those goals are not met, the provider may forfeit bonuses or lose a portion of their payment from payers like Medicare, Medicaid, or commercial health insurers.

Financial Incentives
Financial incentives can link compensation to specific cost and quality metrics. Quality, for example, can encompass a wide range of factors such as effectiveness, efficiency, patient-centeredness, safety, timeliness, and equity across race, gender, and income.

Non-Financial Incentives
There are additional ways to encourage clinicians, health systems, and payers to improve outcomes. With greater flexibility to deliver the right care at the right time, providers can take pride in producing better outcomes, enjoy a greater sense of purpose, and enhance their professional standing.



What's Next?
Participation in VBC is growing steadily. A particularly strong signal was recently sent by the Centers for Medicare and Medicaid Services. Its new goal is to have all Medicare beneficiaries and most Medicaid beneficiaries enrolled in accountable care programs by 2030.

That being said, many healthcare providers are still not involved. To encourage participation, future models in both the public and private sector will benefit from being more accessible and financially rewarding, particularly in regard to providers serving disadvantaged or rural populations.

Moreover, further research is needed to document how these programs impact patients, providers, and the overall healthcare system, as well as which factors are most strongly associated with success.

WHAT'S IN IT FOR YOU?

Just as the fee-for-service payment model perfectly complements the medical model of recovery (by rewarding the work of multiple, siloed specialists), the new Value-Based Care payment model perfectly fits recovery homes. That's because a comprehensive, person-centered approach is a necessity in recovery homes where the service and support gaps tolerated by the medical model have life and death consequences. A whole-health approach pervades recovery homes for the simple reason that lives hang in the balance.

Recovery homes that consciously see themselves as the centerpiece of locally resourced recovery ecosystems fulfill the main objective of Value-Based Care by integrating and coordinating previously fragmented resources so that residents receive the full continuum of care needed to succeed.

Inherently Efficient
For similar existential reasons, recovery homes must be efficient to survive. Many operate on miniscule budgets that cannot afford waste, redundancy, or ineffective treatments. There's another reason recovery home operators become masters at what the healthcare industry calls utilization management: lower costs means longer care. And longer care, as numerous studies have shown, is a leading factor in recovery. (The savings are real, too, with 210 days in a recovery home costing less than 60 days in a residential treatment center.)

It's Personal
Fee-for-service payments reward transactional interactions. VBC's recognition that no one size fits all syncs perfectly with what the recovery world has long known—that there are many pathways to recovery and each must be fully supported.

The Right Care at the Right Time
Recovery homes provide residents with a community of peers who know each others' needs, habits, and failings and can, through shared experience, help one another overcome the debilitating effects of stigma and shame. Support is available at a moment's notice and can be adapted to meet an impressive range of health-related social needs—from safe housing and transportation to lifeskills and employment training—all without running back and forth between siloed service providers or waiting for appointments with physicians and case managers.

CHECK IT OUT!

In our most recent webinar, Fletcher Group CEO Dave Johnson and Outreach and Engagement Specialist Milena Stott explained how VBC can help recovery homes deliver the best possible outcomes while optimizing financial resources. To watch, simply...

CLICK HERE

Coming Soon!
Despite the obvious social and economic benefits of Value-Based Care, VBC and other alternative payment models are still rarely practiced in recovery home settings.

Until they become more common, a major challenge we can all work on together is helping those in the medical model and those in the social model better understand each others' language, needs, and visions of the future. Neither model is going away and both will be needed to provide all that's needed for people in recovery to succeed.

REAL-WORLD EXAMPLES

Each state decides whether or not to use Medicaid dollars to cover housing and housing-related services. State plans, waivers, and managed care arrangements make it happen. States also differ in how they define their eligibility requirements and target populations, though the latter almost always includes people with a Substance Use Disorder and those at risk of being homeless.

Services
Eighteen states currently use Medicaid dollars to provide housing- and health-related services. While some states (Hawaii, Louisiana, Minnesota, Rhode Island, and DC) focus on pre-tenancy and tenancy-sustaining services, other states (Arkansas, California, Michigan, North Carolina, North Dakota, and Texas) address a combination of health-related social needs.

Reimbursement
Medicaid programs use a variety of approaches to finance housing-support services. All states currently use *Case Rates* for pre-tenancy and tenancy-sustaining services while reimbursements for home modifications, one-time transitional housing costs, and housing deposits are typically processed as *Payments Per Item* with a set annual or lifetime limit. Two states (Arkansas and Connecticut) include incentives or performance payments to reward providers who meet certain goals and outcomes.

Examples

- California's *Recovery Bridge Housing* provides a subsidy for recovery residences that offer concurrent treatment in outpatient services, intensive outpatient treatment, opioid treatment, or outpatient withdrawal management
- Michigan and Washington use Medicaid funds to pay for peer services and *Substance Abuse Block Grants* to finance recovery housing vouchers
- West Virginia, Oregon, and Arizona recently obtained *Section 1115 Waivers** to pay for housing and other health-related services
- North Dakota's *Substance Use Disorder Voucher* provides recovery housing funds for Medicaid-eligible individuals

LET'S GET STARTED!

The Fletcher Group is eager to help recovery homes explore alternative-payment opportunities. We'll even help you conduct an environmental scan of whatever housing-related funding is currently available in your area through Medicaid or other funding streams. To get started, simply...

CLICK HERE

Help Is On Its Way!
Perhaps most importantly, the Centers for Medicare and Medicaid Services this year launched a new initiative called the *Community Health Access and Rural Health Transformation Model*.

CHART will modernize rural health delivery systems by offering technical support, greater operational flexibility, and an alternative payment model designed specifically for rural communities. The goal is to ensure the financial sustainability of rural providers. To learn more about this exciting new program and how it may benefit you, click the link above.

* Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program.

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