

# The State of Addiction Treatment

An overview of the key trends currently affecting  
commercial addiction treatment centers



## Letter from the Editor

This is an extremely challenging time for many substance use disorder treatment programs as a wide variety of stricter regulatory, payer and marketing requirements are taking effect at once. As most of these changes were in response to the unscrupulous behavior of a small number of bad actors, the requirement of more ethical and transparent business practices is in many respects long overdue. Nonetheless, it is concerning that many excellent treatment programs are being hurt in the fall-out.

At the same time treatment providers are dealing with these pressures, they're also being asked to change the way they provide treatment. Abstinence-based treatment centers are being strongly encouraged to incorporate medication-assisted treatment whenever appropriate. And all treatment providers are being asked to invest for the first time in quantitative tools to measure and improve the effectiveness of their treatment.

To thrive in the years ahead, addiction treatment leaders need to understand and comply with more stringent regulatory requirements, negotiate fair reimbursement agreements with payers who are under tremendous financial pressures themselves, and learn how to take advantage of the latest research tools to prove and improve treatment effectiveness. The industry as a whole needs to develop hard data on which types of treatment are most effective for patients with different drug usage profiles and demographic characteristics. Finally, treatment center owners who want to either grow through acquisition or eventually sell their centers need to understand the latest addiction treatment merger and acquisition trends.

In the hope that we can help the many excellent commercially-paid addiction treatment providers weather this perfect storm, Harry Nelson, Ben Dittman, Dexter Braff and I have summarized the major trends currently underway and made recommendations where appropriate. We hope you find this report useful!

**Joanna L. Conti, Founder & CEO**

Vista Research Group, Inc.

*March 4, 2019*



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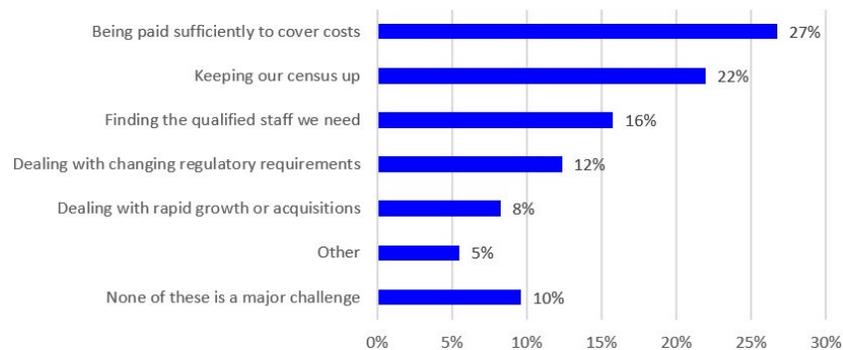
# Addiction Treatment Overview

By Joanna Conti

The substance use disorder treatment field is in a period of tremendous upheaval as new regulatory, payer, accreditation and marketing requirements create havoc. And quite a few addiction treatment centers, some of whom have been in business for many years, are struggling to survive.

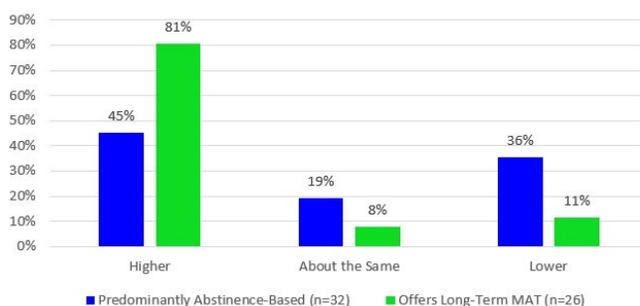
In a small, informal study of 73 addiction treatment center leaders, 23% reported being concerned about their ability to remain in business. When the leaders were asked about the biggest challenge facing their treatment center, respondents reported a variety of issues:

**Biggest Challenge Facing Treatment Centers In Early 2019**  
(among 73 leaders of addiction treatment centers)

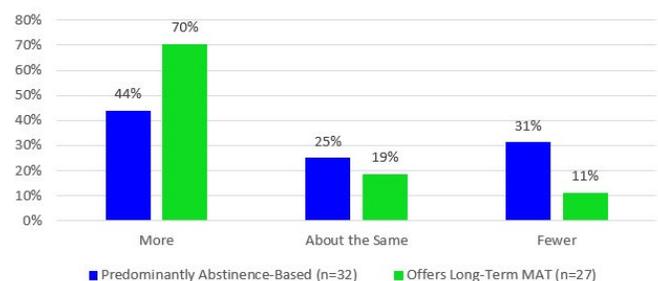


Revenue and census challenges seem particularly acute among primarily abstinence-based programs. While the majority of treatment programs offering long-term medication assisted treatment (MAT) reported having both higher revenues and more patients than in the previous year, about one-third of the predominantly abstinence-based programs in this informal study reported that their revenues and/or number of patients had declined:

**2018 Treatment Center Revenues Compared to 2017**

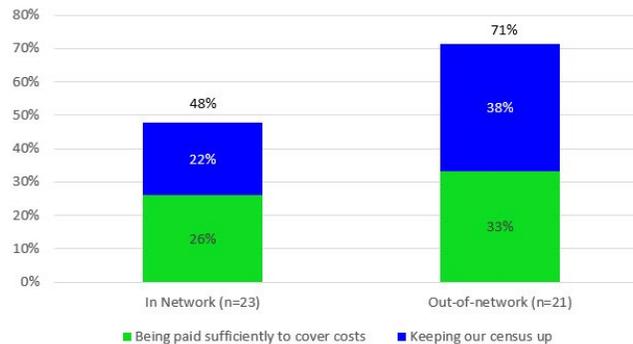


**Number of Patients in Treatment in Jan. 2019 Compared to One Year Ago**



Treatment centers who are predominantly in network with their biggest payers report struggling less with payment or census issues than the out-of-network providers:

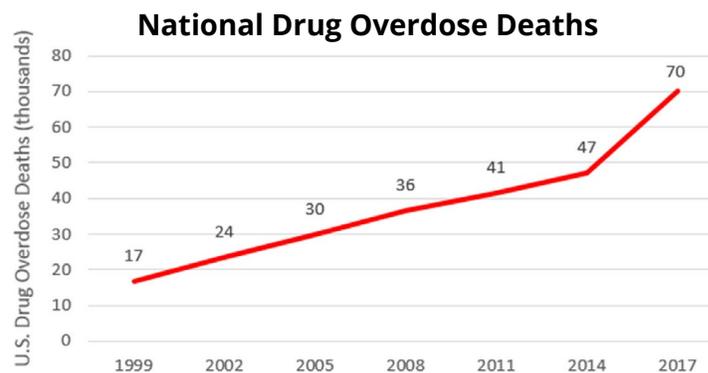
### The Biggest Challenge Facing Treatment Center as a Function of Network Status



What is driving these revenue and census challenges? It certainly isn't a reduction in the need for effective addiction treatment.

### The Need for Effective Addiction Treatment Remains Sky High

In recent years, there's been a dramatic increase in the number of drug overdose deaths. Not only has the number of Americans addicted to dangerous drugs like heroin, cocaine and methamphetamine increased, but dealers have started diluting street drugs with extremely-potent substances such as fentanyl and carfentanyl:



Source: Centers for Disease Control & Prevention

According to SAMHSA's 2017 National Survey on Drug Use and Health, 20.7 million Americans needed treatment for substance use disorder in 2017. Of these, only 2.5 million received treatment at a facility specializing in addiction treatment that year.

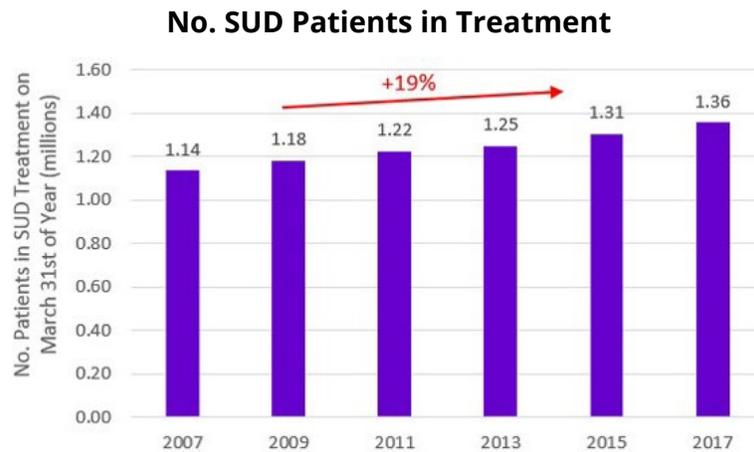
Why did so few people who met the criteria for having an illicit drug or alcohol use disorder receive the treatment they needed? The primary reason is that of the 18.2 million people who didn't receive treatment, only 1.0 million felt they needed treatment. And the people who recognized that they needed treatment but didn't receive it reported a variety of different issues that kept them from entering treatment:

Reason for Not Receiving SUD Treatment	Percent Claiming *
Cost:	
No health care coverage & could not afford cost	30.3%
Had health care coverage, but did not cover treatment or did not cover full cost	10.4%
Cost Total	<b>40.7%</b>
Not Ready to Stop Using	39.7%
Stigma or Job Concerns:	
Might have negative effect on job	20.5%
Might cause neighbors/community to have negative opinion	17.1%
Did not want others to find out	7.2%
Stigma or Job Concerns Total	<b>44.8%**</b>
Did Not Feel The Need for Treatment:	
Could handle the problem without treatment	12.6%
Did not feel need for treatment at the time	12.3%
Treatment would not help	3.9%
Did Not Feel the Need for Treatment Total	<b>28.8%**</b>
Couldn't Find Treatment:	
Did not know where to go for treatment	10.9%
Did not find program that offered type of treatment that was wanted	9.0%
No transportation; programs too far away or hours inconvenient	6.7%
No openings in a program	4.9%
Couldn't Find Treatment Total	<b>31.5%**</b>
Did not have time	7.9%
Some other reason	3.0%
* Totals more than 100% because many respondents gave more than one answer to the question	
** Sub-totals may double-count some respondents	

Source: SAMHSA, National Survey on Drug Use and Health, 2017, Table 5.53A

In fact, among these one million people, only half made any effort to get treatment.

So despite the almost doubling in drug overdose deaths between 2007 and 2017, the number of patients in substance use disorder treatment increased only 19% during this time:



Source: Nat'l Survey of Substance Abuse Treatment Services (N-SSATS) 2017

It is unclear what can be done to change the minds of those who do not feel the need for treatment or who are not ready to stop using. However, it should be possible to make progress on some of the other factors hindering treatment. There are a number of organizations (such as [Faces & Voices of Recovery](#) and [Shatterproof](#)) working hard to reduce the stigma associated with addiction.

One area where the country needs to move quickly is to improve the access of prospective patients to affordable addiction treatment.

### **Paying for SUD Treatment Remains Problematic For Many Patients**

The Affordable Care Act (often called ObamaCare) required insurance companies to provide mental health and addiction treatment coverage equivalent to that provided for the treatment of physical health issues by 2014. As coverage expanded, insurer costs for addiction treatment started escalating quickly. To make matters worse, some unscrupulous providers took advantage of the situation by overbilling for laboratory tests such as urinalyses.

Insurers responded in various ways. Some denied care or limited patients to short treatment stays. Others started requiring frequent chart audits and/or intensive utilization reviews. Recent court cases against [United Behavioral Health](#) and [Anthem](#) reveal how egregious some of these insurer practices have been.

Surprisingly, despite all the emphasis on fighting the opioid epidemic in recent years, the percentage of patients who were able to use private health insurance, publicly-funded health insurance or employer coverage to cover at least a portion of the cost of their substance use disorder treatment declined in 2017 compared to 2016:

### Source of Payment for Last or Current SUD Treatment at a Specialty Facility

	Percent of Patients For Whom This Was a Payment Source		
	2016	2017	Dif.
Total Patients Reporting (thousands)	1,566	1,626	+3.8%
Private health insurance	53.0%	47.7%	-5.3%
Publicly-funded insurance:			
Medicare	38.0%	35.5%	-2.5%
Medicaid	44.2%	40.3%	-3.9%
Public assistance other than Medicaid	28.6%	28.5%	-0.1%
Own Savings or Earnings	41.3%	39.8%	-1.5%
Family Members	24.4%	22.4%	-2.0%
Other:			
Courts	10.1%	11.0%	+0.9%
Military Health Care, inc. the VA	5.4%	5.2%	-0.2%
Employer	4.7%	4.2%	-0.5%
Note: Respondents could indicate multiple sources of payment for their last or current treatment			

Source: SAMHSA's National Survey on Drug Use and Health, 2017, Table 5.34A

More recently, commercial insurers have started exploring other ways to keep addiction treatment costs under control. First, in an effort to reward treatment centers providing the highest-quality, lowest-cost treatment (and, of course, to eventually punish those that don't), insurers are starting to replace the fee-for-service agreements they have with treatment centers with value-based reimbursement agreements. And some insurers are fairly dramatically reducing the amounts they pay to providers who don't accept their lower in-network rates.

The second thing commercial insurers are doing is encouraging patients to enroll in medication-assisted outpatient treatment in their communities rather than the traditional (and more expensive) residential abstinence-based treatment.

## The Use of Medication-Assisted Treatment is Growing Rapidly

Methadone has been used to control the cravings of heroin users for decades. In the last 10 years, buprenorphine, often mixed with naloxone to reduce the potential for abuse, has also become widely prescribed as an opioid replacement drug. Patients who have been opioid-free for at least 7 to 14 days can also use injectable naltrexone (Vivitrol) to help reduce their cravings.

Research shows that death rates decline while patients are taking one of these medications, and the federal government came out firmly in support of medication-assisted treatment (MAT) in 2018:

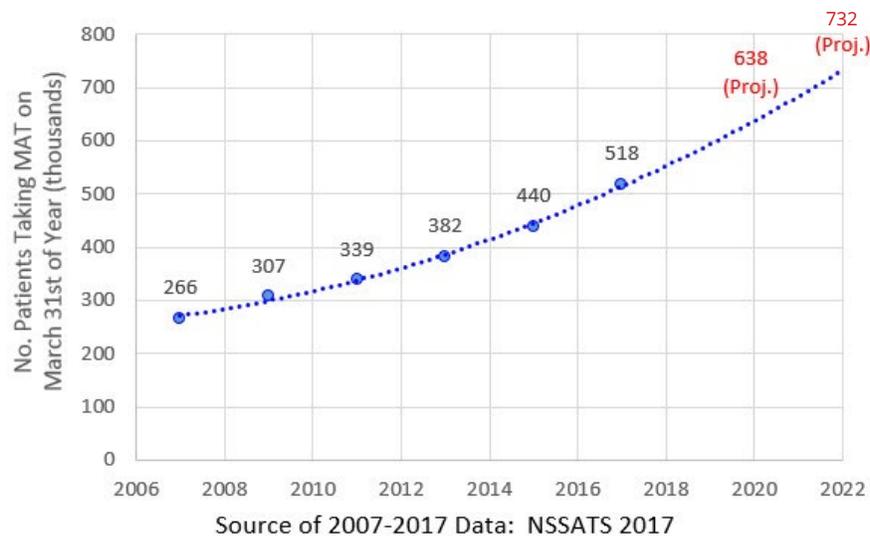
***“Medication-assisted treatment combined with psychosocial therapies and community-based recovery supports is the gold standard for treating opioid addiction.”***

**Dr. Elinore F. McCance-Katz,**

Asst. Secretary for Mental Health & Substance Use, Dept. of Health & Human Services

This crucial statement of support, combined with insurer preference for less expensive community-based MAT coverage over residential addiction treatment, has contributed to the exponential growth of medication-assisted treatment. If current trends continue, almost 750,000 patients could be using buprenorphine, methadone or injectable naltrexone within the next few years:

**Patients on MAT Treatment**

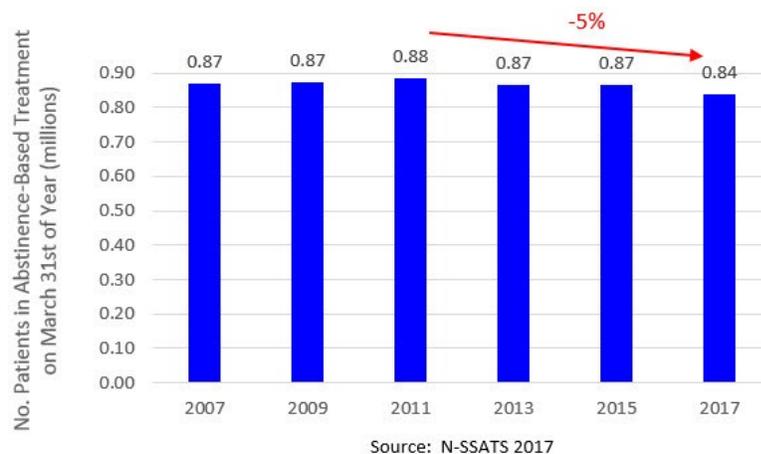


Unfortunately, research has also shown that between 31% and 70% of patients stop taking their medication during the first month it is prescribed to them<sup>1</sup>.

***Since patients who stop taking their medication are at risk for overdosing, there's a strong need for research that follows up with patients post-treatment to learn the overall impact of MAT treatment for patients with different drug usage and demographic characteristics.***

In the meantime, the combination of the slow growth in the number of patients utilizing any kind of addiction treatment and the rapid growth in MAT usage has caused the number of patients in abstinence-based substance use disorder treatment to actually decline in recent years:

### Decline in Abstinence-Based Treatment

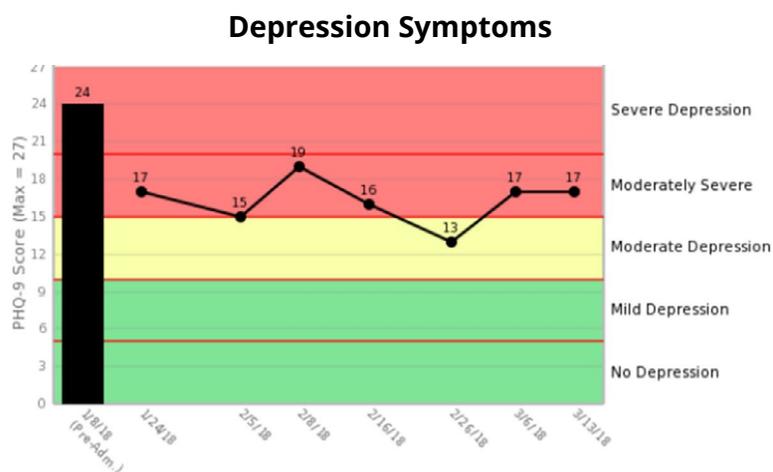


<sup>1</sup>Morgan, Jake R. et al., "Injectable Naltrexone, Oral Naltrexone And Buprenorphine Utilization And Discontinuation Among Individuals Treated For Opioid Use Disorder In A United States Commercially Insured Population." *Journal of Substance Abuse Treatment*, no. 85 (2018): 90-96.

## New Research Tools Allow Centers to Prove & Improve Treatment Effectiveness

Fortunately, new research tools have made it easy to monitor how patients are progressing during treatment and to follow up with patients post-treatment to measure the impact treatment had on their quality of life.

By providing clinicians with real-time information about how their patients are feeling, progress monitoring software makes it easy to identify patients who aren't responding as well as expected to treatment:



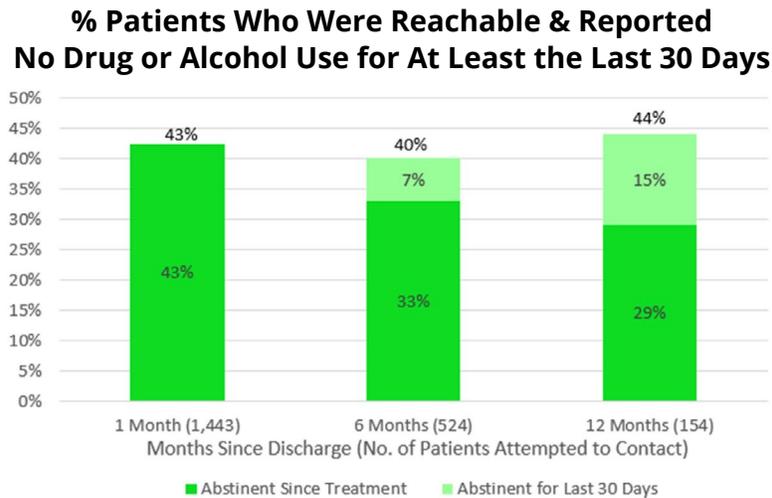
***Since clinicians then use this information to modify their treatment plans, research<sup>2</sup> shows that patients get better faster when progress monitoring is used.***

A second useful research tool is outcomes research. By following up with patients after they've completed treatment, outcomes research quantifies the impact of treatment on the drug/alcohol use and emotional health of patients post-treatment.

<sup>2</sup>Goodman, Jessica D., McKay, James R., DePhilippis, Dominick, "Progress Monitoring in Mental Health & Addiction Treatment: A Means of Improving Care", *Professional Psychology: Research and Practice* 44 no. 4 (2013): 231-246.

***Outcomes research identifies the most effective treatment programs and the most effective types of treatment for patients with different drug usage and demographic characteristics.***

Vista Research Group, Inc. has been conducting progress monitoring and outcomes research for addiction treatment clients for the last three years. One very positive finding from Vista's outcomes research is how effective good abstinence-based treatment can be. When Vista attempted to contact patients at different points during their first year after leaving treatment, between 40% and 44% of the patients were reachable and claimed to have not used any drugs or alcohol in the last 30 days:



These results were significantly better than those reported in the last federally-funded addiction treatment research, the DATOS study of 1992-94.

### **Regulatory & Marketing Challenges**

At the same time that addiction treatment programs have been dealing with the desire of many payers to expand medication-assisted treatment and with accreditation agency demands that they use new research tools, regulatory and marketing changes have created additional challenges.

In the last several years, a variety of federal, state and local governments along with payers and private businesses have become increasingly concerned about the unethical actions of a number of disreputable addiction treatment operators and marketers. This has resulted in a plethora of new regulations and stricter licensing requirements that have either recently gone into effect or are expected shortly in the following areas:

- Patient Brokering & Problematic Marketing Practices
- Inducements to Patients
- Stricter Licensing Requirements
- Expanded Access to and Pressure for Medication-Assisted Treatment
- Expanded Regulation of Recovery Residences (Sober Living)
- ASAM Criteria, Coverage Criteria and Telehealth
- Expanded Coverage for Medicaid Beneficiaries
- Expanding Focus on Social Determinants Relevant to Opioid Use Disorders
- Patient Privacy & Communication Among Physicians and with Families

These regulatory trends are described in detail in Chapter 4.



In addition to various governments, private companies have also taken actions that dramatically affected the ability of addiction treatment organizations to advertise for patients. Google became so concerned with the activities of unscrupulous marketers that it preemptively stopped all Adwords addiction treatment advertising in September 2017, and Facebook followed suit the following year. After requiring all addiction treatment advertisers to undergo stringent marketing and background checks prior to being certified by LegitScript, a very limited number of centers were allowed to restart Adwords advertising in the summer of 2018.

### **Merger & Acquisition Trends Reflect The Changing Environment**

Not surprisingly, the types of centers preferentially being acquired has changed over recent years to reflect the changing payment and regulatory environment. As Chapter 5 describes, interest in high-end, luxury treatment programs has declined as payers shift their focus to value-oriented, in-network providers and MAT programs.



As her daughter cycled in and out of multiple alcoholism treatment programs, Joanna Conti became very frustrated by the lack of success rate data available to help families identify the best facilities. A serial entrepreneur who had previously started software and consulting companies as well as an international nonprofit, Conti started [Conquer Addiction, Inc.](#) in August 2014 to help families find the treatment centers with the best success rates. When only five treatment centers in the entire country were able to provide post-treatment outcomes results collected using valid research methodologies, Conti launched [Vista Research Group Inc.](#) in September 2015 to help treatment programs cost-effectively measure and improve their treatment success rates.

# Commercial Payer Trends in Addiction Treatment

By Ben Dittman

## Insurance Reimbursement Rates

There continues to be compression in insurance company reimbursement rates. The abusive billing practices in recent history has precipitated a climate in which insurance companies scrutinize treatment center reimbursement requests.

***Between 2017 and 2018, insurance payments on amounts billed decreased by approximately 6% across the industry, with the sharpest dip occurring at the end of last year.***



There is ongoing blowback to patient brokering, and an increase in medical record requests and implementations of maximum allowables. There are also changes in state regulations, payer requirements, and claim requirements. These elements contribute to the reimbursement rate decline that I expect to continue downward through the first half of 2019, though I do not anticipate the drop to be as dramatic as 2018.

The number of new treatment centers has continued to increase over the past 18 months. With that increase, we have seen a decline in the average census by region. An inordinate number of these facilities will shutter their doors during the first half of 2019 due to months of decreased reimbursement rates and lower census numbers, a factor that may work to stabilize the industry through the rest of the year. It is more important than ever to stay on top of patient collections, and to keep a close eye on reimbursements.

Treatment centers are increasingly pursuing in-network contracts. Though in-network reimbursement rates are generally lower, many of the revenue cycle challenges posed by out-of-network billing are mitigated.

Revenue is easier to predict, censuses increase due to referrals, and payments that were previously sent to patients are disbursed directly to the treatment center. However, certain payers are no longer accepting new submissions due to the credentialing/contracting backlog created by the influx of applications and saturation in specific markets.

### Outcomes Measurements

In January 2018, the Joint Commission started requiring accredited behavioral healthcare treatment centers to “use a standardized tool or instrument to monitor the individual’s progress in achieving his or her care, treatment, or service goals.” This new mandate is designed to encourage addiction treatment providers to embrace measurement-based care in their programs.

Other accrediting bodies are encouraging providers to take this even further and follow up with their patients post-treatment. For example, in a recent [Behavioral Healthcare Executive](#) article, Jessica Swan, Outcomes Manager for the National Association of Addiction Treatment Providers (NAATP), discussed the vast gulf that currently exists between “some providers who are doing excellent [outcomes] research and data collection, some centers that aren’t doing it at all and other ‘opportunistic’ centers that are relying on misinformation or marketing research rather than actual scientific research.”

The strongest push for post-treatment outcomes research is likely to come from payers, who are expected to start demanding this information as part of their move to value-based reimbursement strategies.

### Over Delivery of Care

Most treatment centers continue to do whatever they can to provide their patients with the highest level of recovery treatment, whether or not the payer is willing to cover it. Billing a lower level of care feeds the actuaries at the insurance companies with false data that suggests clients are doing better with fewer authorized days. Though done with the best intentions, the practice fosters inauspicious results as payers get inaccurate data and treatment centers typically are not reimbursed for the higher level of care. Instead, treatment centers should focus on providing medical necessity because it answers the patient’s needs and can be proved to the insurance companies, which in turn provides an appeal basis for reimbursement denials and accurate data for outcomes tracking. Undertaking this process as many times as necessary is the only way to implement real, lasting change in 2019 and beyond.

## Medication-Assisted Treatment (MAT)

Use of medication-assisted treatment (MAT) has become more prevalent over the last few years, and I suspect we will see it break through to the mainstream in 2019. The focus on substance use disorders as a public health concern is prompting policy change that supports MAT as an acceptable and viable option to the epidemic. In October 2018, seven major payers in Pennsylvania alone (Aetna, Capital Blue Cross, Geisinger, Highmark, Independence Blue Cross, UPMC and United Healthcare) removed prior authorization requirements for prescribing MAT for substance use disorder. Institutional treatment centers differ philosophically on MAT, but insurance companies tend to support this treatment method.

***As the opioid crisis continues to disrupt communities and gain nationwide attention, many treatment centers are incorporating MAT within their framework or are considering piloting a MAT program.***

## Telemedicine

Telemedicine is becoming more common, but insurance payers are not necessarily keeping up. As with MAT, the opioid crisis is a primary factor in the push for telemedicine because, along with the financial burden, the main obstacle for those working to overcome addiction is access to treatment. My company, Avea Solutions, is based in the state of Oregon, which reportedly has the fourth-highest need for access to care but is ranked dead-last in this regard.

***Last year, the Bipartisan Budget Act of 2018 expanded Medicaid coverage for telehealth, citing it as a powerful tool for combating the epidemic. However, many payers are still not offering reimbursements for telemedicine, which means it remains an unviable option for many.***

## Payer Desire for Value-Based Reimbursements

There have been rumblings of insurance payers' desire to move to value-based reimbursement models for some time now. Simply put, insurance payers would reimburse treatment center providers based on outcomes. At the December 2018 Treatment Center and Valuation Retreat, the Chief Medical Officers of many of the major payers (Humana, Optum and Cigna) reiterated the desire to move to that model for treatment care. At this point, there are a handful of pilot programs in place, but there has yet to be a standard allowing this model to work effectively. This will continue to be a topic within our industry for many years.



Ben Dittman is the founder and CEO of [Avea Solutions](#), a company focused on bringing leading-edge revenue cycle management technology to addiction treatment, eating disorder treatment, and behavioral health facilities. Before founding Avea, Dittman spent 15+ years in banking, system design, and business process consulting and is currently a member of Forbes Technology Council.

# Measuring & Improving Treatment Outcomes

By Joanna Conti

Unlike in almost every other area of health care, there is very little historical data measuring either the progress patients make during addiction treatment or the long-term impact of treatment on patients' quality of life. As a result, addiction treatment has been very slow to recognize how patient data can be used to inform treatment or measure its effectiveness. And shockingly, the last major federally-funded research that followed up with a large base of patients to study their ability to stay abstinent after addiction treatment was the Drug Abuse Treatment Outcome Study (DATOS) in 1992-95!

Fortunately, change is coming. A meta-analysis<sup>3</sup> conclusively showed that the process of monitoring and reporting to clinicians how patients are feeling during treatment helps patients get better faster. Armed with this proof, the Institute of Medicine and the American Psychological Association called for the widespread use of patient monitoring during substance use disorder treatment. The Kennedy Forum issued this call to action:

***“All primary care and behavioral health providers treating mental health and substance use disorders should implement a system of measurement-based care whereby validated symptom rating scales are completed by patients and reviewed by clinicians during encounters. Measurement-based care will help providers determine whether the treatment is working and facilitate treatment adjustments, consultations, or referrals for higher intensity services when patients are not improving as expected.”***

Results from addiction treatment facilities using progress monitoring research enable us to quantify the tremendous progress patients often make during treatment.

<sup>3</sup>Carlier, Meuldijk, Van Vliet, Van Fenema, Van der Wee, Zitman (2012). Routine Outcome Monitoring and Feedback on Physical or Mental Health Status: Evidence and Theory. *Journal of Evaluation in Clinical Practice*, 18 (1), 104-110.



## SUD Treatment Helps Patients Address Underlying Mental Issues

Patients entering addiction treatment are typically dealing with one or more mental disorders as well as a life that's careened out of control. Among the more than 13,000 patients who were treated at one of 84 addiction treatment centers using Vista Research Group's INSIGHT Addiction™ progress monitoring research during the last 3 years, the vast majority (82.9%) reported moderate to severe symptoms of at least one of the primary co-occurring disorders at intake:

Reported Moderate to Severe Symptoms	% of Patients
Depression	66.1%
Anxiety	61.6%
Post-Traumatic Stress Disorder	64.6%
Eating Disorder	28.4%
Moderate to Severe Symptoms of At Least One Disorder	82.9%

Additionally, 38% reported wishing they could go to sleep and not wake up, 16% reported having thought about how they might kill themselves, and 6% had actually prepared to, started to, or attempted to kill themselves in the 30 days before entering treatment.

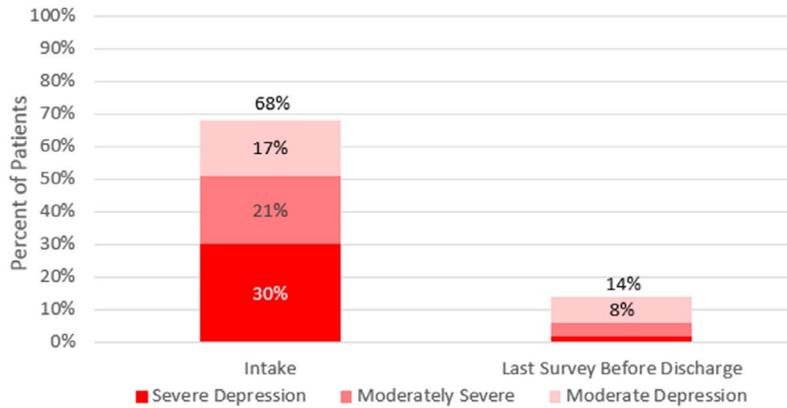
Fortunately, by the time patients left treatment, most were feeling far better.

***Among patients who remained in treatment long enough to submit at least one update survey, most reported a dramatic decline in the severity of their mental disorder symptoms between intake and discharge.***

For example, among those patients who submitted at least one update survey, the percentage reporting moderate to severe symptoms of depression declined from 68% at intake to 14% prior to discharge:

### Reduction in Depression Symptoms

(among 9,344 INSIGHT Addiction patients submitting at least one update survey between 3/1/16 and 2/28/19)

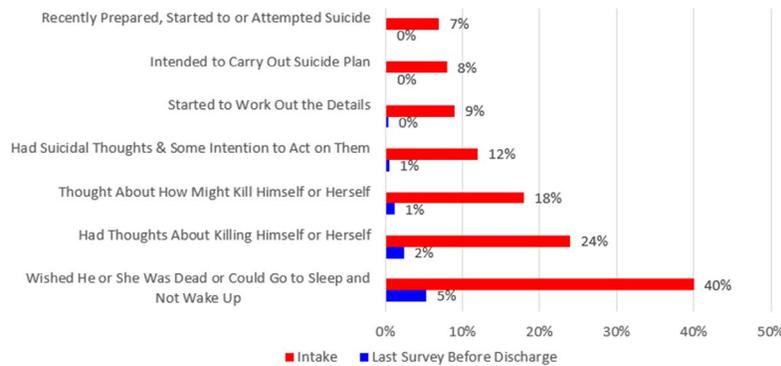


Source: Vista Research Group, Inc.

The reduction in suicidal thoughts and intentions during treatment was similarly dramatic:

### Reduction in Suicidal Thoughts & Intentions During Treatment

(among 9,344 INSIGHT Addiction patients submitting at least one update survey between 3/1/16 and 2/28/19)



Source: Vista Research Group, Inc.

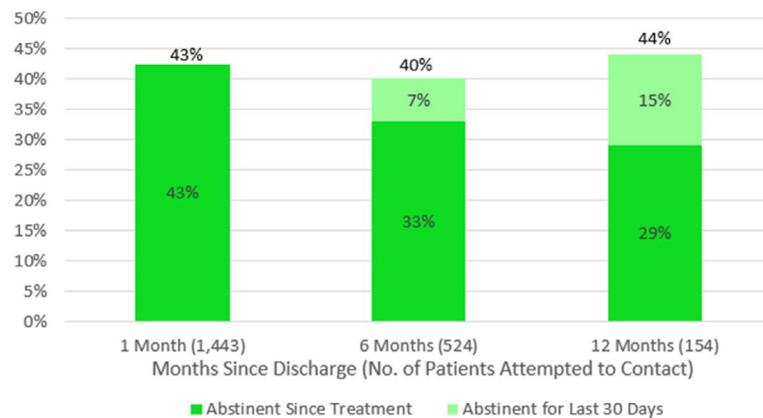
While it is gratifying to see how much better patients are feeling by the end of treatment, the most important measurement of the impact treatment has on patient’s quality of life is what happens after treatment ends. Fortunately, these results are also very positive.

## Abstinence-Based Addiction Treatment Can Be Very Effective

Vista Research Group has followed up with the patients of 28 primarily abstinence-based addiction treatment programs after they left treatment. To date, Vista has followed up with 1,443 patients at one-month post-treatment, 524 patients at six months post-treatment, and 154 at one year post-treatment. And we've learned a lot.

Most importantly, the research shows that abstinence-based treatment can be quite effective. At all three post-treatment time periods, between 40% and 44% of the patients were reachable and claimed to have not used any drugs or alcohol in the last 30 days:

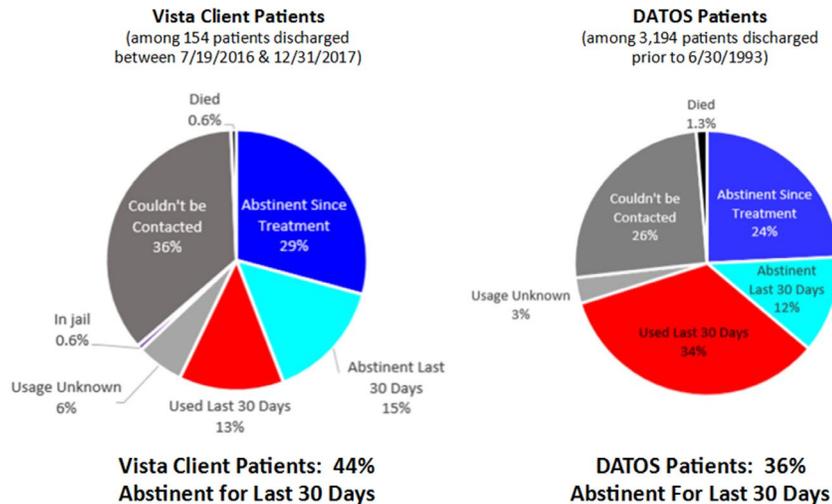
### % Patients Who Were Reachable & Reported No Drug or Alcohol Use for At Least the Last 30 Days



Source: Vista Research Group, Inc.

*The one year post-treatment results of Vista's client's patients are significantly better ( $p < .05$ ) than the findings from the last major federally-funded addiction treatment research, the Drug Abuse Treatment Outcome Study (DATOS) conducted in the early 1990s.*

## Current vs. Historical One Year Post-Treatment Results



Source: Vista Research Group, Inc.

Of course, this does not mean that all addiction treatment programs today are this effective. It is reasonable to assume that only treatment programs that believe their post-treatment results are better than average will invest in outcomes research. Nonetheless, it is also plausible that recent advances in treatment effectiveness (such as the progress monitoring research that all Vista clients use) are helping to improve addiction treatment outcomes.

### Using Outcomes Results to Negotiate with Payers

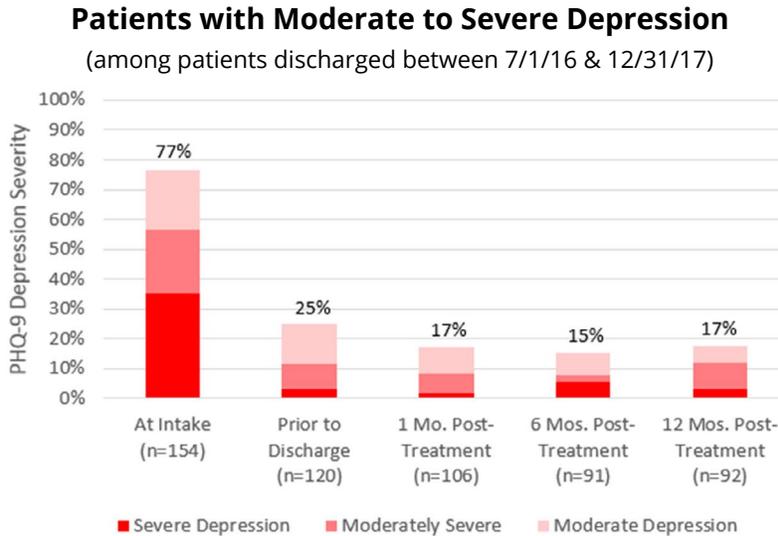
Addiction treatment is far behind the rest of health care in moving from a fee-for-service payment structure to being reimbursed based on the quality of the treatment. The challenge for addiction treatment (and, frankly, for all of behavioral healthcare) in moving to a value-based-reimbursement model has been the lack of a standardized way to measure treatment effectiveness. Now that this is available, payers are extremely interested in using outcomes data to identify the best providers. As the Senior Vice President of AmeriHealth Caritas remarked at last year's Open Minds Technology Institute:

***"Outcomes are more valuable to your business than revenues."***

**Dr. Michael Golinkoff, Oct. 24, 2018**

The ability to use hard outcomes data to negotiate higher reimbursement rates or pay-for-performance bonuses with payers will become increasingly important as the transition from fee-for-service to value-based reimbursement strategies gains momentum.

In addition to showing an overall reduction in drug or alcohol use, post-treatment outcomes data typically identifies specific areas where treatment has reduced post-treatment health care costs. For example, Vista’s research indicates that most of the SUD patients who respond to a one-year post-treatment survey report remaining emotionally healthy throughout at least the first post-treatment year:

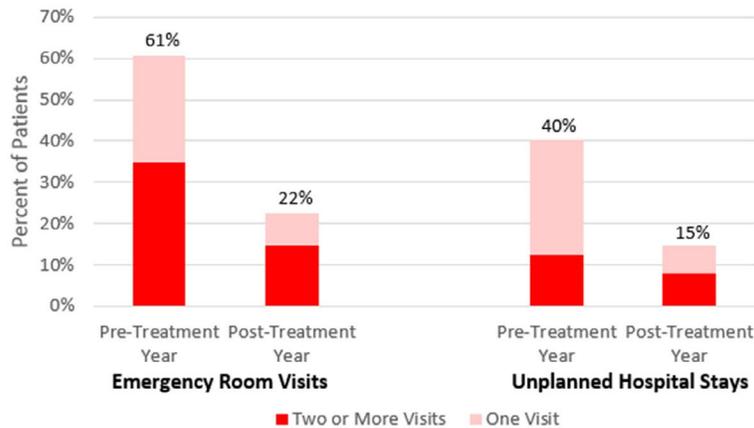


Source: Vista Research Group, Inc.

Additionally, Vista typically finds that patients report having far fewer emergency room visits or unplanned hospital stays in the post-treatment year as compared to the year before treatment:

### Reduction in Expensive Hospital Visits Between The Pre- and Post-Treatment Years

(among 89 patients completing the entire 12 Mo. Survey)



Source: Vista Research Group, Inc.

## Future Benefits from Outcomes Research

Once treatment center leaders are able to compare their results to those of similar treatment programs, we expect to see the overall effectiveness of addiction treatment rapidly improve. Outcomes research provides a wealth of data on the impact of different factors, and as Peter Drucker famously said, "What gets measured gets managed."

***Within the next few years, we expect that outcomes research will allow researchers to predict the type of treatment, the treatment center(s), and the post-treatment choices that are most likely to help specific patients improve their quality of life.***

Already, even with the relatively small number of patients Vista has contacted post-treatment, it is clear that successfully completing treatment, residing in a sober living community after treatment, and patients' primary drug of choice all have a tremendous impact on long-term outcomes.

Additionally, outcomes research identifies those treatment centers providing the most effective treatment. While most Vista clients are achieving 1 month post-treatment abstinence rates close to the 43% average reported above, there are some outliers. One month abstinence rates range between 28% and 72% for different centers for whom Vista has followed up with at least 25 patients.

Vista Research Group's mission is to help the entire addiction treatment community improve by analyzing and regularly publishing our findings. A detailed summary of what we've learned in the first three years of addiction treatment research will be available shortly at [www.2019outcomes.com](http://www.2019outcomes.com).

Treatment center success rate data is of great interest to patients and their families looking for excellent treatment. Now that the number of treatment centers doing post-treatment outcomes research has reached a critical mass, [Conquer Addiction, Inc.](http://ConquerAddiction.com) (Vista Research Group's sister company) is in the process of being relaunched as a non-profit. All addiction treatment centers that can show they are following a statistically-valid outcomes research protocol will be eligible to publish their one year post-treatment success rates on the site for free. This will allow families to find the addiction treatment programs with the best success rates that meet their needs.



With a B.S. in chemical engineering and an M.S. in international business, Joanna Conti has had a very diverse career. In addition to starting software and consulting companies as well as an international non-profit, Joanna was the Democratic nominee for Colorado's 6th Congressional District in 2004. As the founder and CEO of [Vista Research Group, Inc.](#), Joanna has recruited a talented team of experts in behavioral health care, research, and software development to help addiction treatment programs develop the data they need to measure and improve the effectiveness of their treatment.

# Regulatory Trends Shaping the Addiction Treatment Industry

By Harry Nelson

2019 promises to be another period of hyperactive regulatory activity for addiction treatment. At both the federal level and in many states, the pace of legal changes, new regulations, and government enforcement continues to accelerate. What trends should addiction treatment providers be paying attention to in 2019?

## Patient Brokering and Problematic Marketing Practices

*The single biggest regulatory trend in addiction treatment is the continued increase in pressure on patient brokering and kickbacks.*



Perhaps the single most groundbreaking regulatory shift for addiction treatment of 2018 was the October 24, 2018 enactment of H.R. 6, an omnibus bundle of opioid crisis-related legislation formally known as the “Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment [SUPPORT] for Patients and Communities Act.” H.R. 6 represented a follow-up to the 2016 omnibus law, the Comprehensive Addiction and Recovery Act (CARA). Like CARA, H.R. 6 took sweeping aim at the opioid crisis, with 58 distinct pieces of legislation focused on overdose prevention, treatment, and recovery.

Of those 58 bills, the most immediately significant regulatory development is likely to be the roll-out of the “Eliminating Kickbacks in Recovery Act of 2018,” (EKRA). Prior to EKRA, federal investigative and prosecutorial efforts in addiction treatment for over a decade have focused on urine drug screening (UDS) labs. EKRA (Section 8122 of H.R. 6) provides a new federal anti-kickback law making it illegal to pay or receive kickbacks in return for referring a patient to recovery residences, laboratories, and clinical treatment facilities. EKRA represents a significant expansion of federal oversight of marketing relationships around substance use disorder (SUD) treatment and urine drug screening (UDS).

In contrast to the federal Anti-Kickback Statute, the new law is agnostic as to payor source and applies with equal force to services funded by commercial or employer-sponsored health plans. 2019 is likely to bring some federal guidance clarifying questions concerning the limits of EKRA's prohibitions on productivity bonuses and call center practices, as well as FBI investigations and the first Department of Justice prosecutions under the new law.

In addition to EKRA, the stakes for problematic marketing practices are also rising as a result of a series of new state laws. Both Illinois and California, for example, passed new anti-patient brokering laws in 2018. In January 2010, California's Department of Healthcare Services has issued guidance warning that it will focus enforcement efforts under California's new law, SB 1228, on payment of referral fees and payments to call centers. Meanwhile, investigations and litigation relating to UDS-based kickbacks continues apace. Addiction treatment providers should expect additional state anti-brokering laws, regulatory clarification, and rising enforcement in 2019.

### **Inducements to Patients**

In addition to the crackdown on patient brokering, the issue of inducements to patients themselves is receiving growing attention. In January 2010, California's Department of Healthcare Services issued guidance warning that it will focus enforcement efforts under California's new law, SB 1228, on payments and intangible compensation to clients to attend addiction treatment programs or recruitment of potential clients at 12-step recovery meetings.

The practice of paying people to attend addiction treatment programs may be the most flagrant, but is only one of a series of practices that are continuing to lead to increasing regulatory scrutiny, as well as health plan special investigations.

***Among the treatment center practices receiving the most attention are funding of patient travel to the program, covering the costs of insurance premiums, and waiving patient deductibles and co-insurance.***

Insurers continue to investigate these practices for potential fraud charges through special investigative units (SIUs). Many health plans have initiated legislation against providers to pursue practices they believe to be objectionable, in some cases with local, state, and federal law enforcement support. 2019 is expected to bring greater regulatory clarification on the limits of allowances for treatment programs to recognize financial hardship and to finance patient obligations lawfully.

### Stricter Licensing Requirements

Another discernable trend reflects growing strictness in state laws and regulations across the country relating to addiction treatment program licensing. In 2018, for example, California passed laws expanding DHCS power to revoke or discipline facility licenses. The State adopted significant new operational limitations in AB 3162, limiting off-site provision of services and requiring programs to submit written relapse plans to the state. The new law establishes a shorter provisional licensure period for new facilities, during which licenses may be revoked by DHCS for a wide variety of reasons, including repeat deficiencies, mishandling of medication, and failure to adhere to facility policies and procedures.

Similarly, Florida made significant changes, including issuing separate licenses for each service component offered by a provider, requiring providers to admit at least one patient for services during a probationary license period in order to have a regular license issued, and limiting licenses to expiration after twelve months. Florida also adopted a stringent limitation on changes of ownership, providing that transfer of even 1% of ownership will now trigger “change in ownership” approval requirements and the need for a facility license from DCF.

***States have been ratcheting up their oversight authority to discipline and revoke addiction treatment program licenses as well as impose new operational constraints across the country.***

Addiction treatment programs should pay close attention to changing laws in their states, and prepare for this trend to continue as states further identify operational risks and tighten addiction treatment facility standards.

### Buprenorphine: Expanded Access to and Pressure for Medication Assisted Treatment

Regulatory efforts to expand access to Medication Assisted Treatment (MAT) and particularly buprenorphine (distributed under brands including Suboxone, Subutex, and Sublocade) is a discernible trend. Section 2005 of H.R. 6 significantly expanded prescriber capacity by raising the patient limit for physicians prescribing MATs to 275 patients, from a prior limit of 100. H.R.6 also makes permanent the temporary provision in CARA permitting physician assistants and nurse practitioners to provide buprenorphine. H.R. 6 also mandates state Medicaid programs to cover MAT (along with counseling services) and authorizes Medicare coverage for MAT at outpatient

Opioid Treatment Programs (OTPs), also expanding reimbursement of OTPs via bundled payments, rather than as fee-for-service, as a pilot program.

The expanding focus on MAT continues to reflect a tension in addiction treatment. The 2017 Presidential Opioid Commission Report called attention to the small fraction of SUD treatment providers that provide MAT. Federal policy enabling broader coverage and a broader range of providers reflect a public health-focused, harm reduction approach in which buprenorphine reduces opioid overdoses and stabilizes people following opioid addiction, despite misgivings of many SUD treatment providers about a model that leaves many people with a continuing physical dependency on a different substance and fails to address the underlying issues in addiction and the need for a recovery-focused framework to sustain people and prevent relapse.

New state laws and regulations also reflect the same pressure for expanding access to MAT. California, for example, enacted SB 992, which prohibits treatment programs from denying a client admission based on having a valid prescription for narcotic replacement treatment or medication-assisted treatment for substance use disorders. In addition to new statutes and regulations, litigation in multiple states has resulted in rulings establishing the rights of prisoners to access to MAT. 2019 is likely to see further pressure on the trend towards a “right” to access to MAT.

### **Expanding Regulation of Recovery Residences (Sober Living)**

The trend of greater oversight of recovery residences is discernible across the country.

***After decades in which unlicensed recovery residences were largely left unregulated based on Fair Housing Act and Americans with Disabilities Act protections, a growing number of states continue to move towards voluntary certification of recovery residences and articulating standards for recovery residence operations.***

The trend has been driven by safety concerns as recovery residences have expanded in number, as well as concerns about the financial interrelationships of outpatient treatment programs and sober living.

While Florida enacted a recovery residence voluntary certification law in 2015, California had resisted any statewide regulatory oversight of recovery residences until 2018. The result was a trend of increasingly aggressive local ordinances seeking to limit the density of recovery residences, as well as growing local pursuit of nuisance litigation in coastal Orange County, California. While California has not yet established a voluntary certification framework, it enacted a new disclosure requirement (SB 992) in 2018, mandating that licensed and certified addiction treatment facilities disclose ownership, control of, or a financial interest in recovery residences. The new requirement signals DHCS' increased interest in the relationships between sober living homes and addiction treatment facilities and is anticipated to be the first step in increased oversight of sober living homes in the coming year and beyond. West Virginia and New Jersey are two of the most recent states to consider oversight, and a trend of more oversight of recovery residences should be expected nationwide.

### **ASAM Criteria, Coverage Criteria, and Telehealth**

Another trend is the growing number of states (now in excess of 30) requiring use of the American Society of Addiction Medicine (ASAM) criteria to assess a patient's condition across six dimensions of needs and to match those needs to the appropriate type and intensity of care. In September 2018, California became the latest state to join this list, reflecting a trend towards clearer national standards and pressure for evidence-based treatment.

In addition to state-mandated adoption of ASAM criteria, the trend of evolving health plan coverage criteria for various addiction treatment services continues. These criteria include new health professional oversight requirements for some plans, as well as heightened documentation requirements. At the same time, the trend towards greater use of telemedicine to provide oversight through providers at a distance continues. H.R. 6 reflected the expanded use of telehealth in eliminating geographic restrictions placed on services "to an eligible telehealth individual with a substance use disorder diagnosis for purposes of treatment of such disorder or co-occurring mental health disorder," and requiring a report from the Health and Human Services Department within five years on the effectiveness of telehealth and telemedicine programs in treating people with substance abuse issues.



### Expanded Coverage for Medicaid Beneficiaries

Another pronounced trend has been the expansion of coverage of a growing range of addiction treatment services for Medicaid beneficiaries. Perhaps most striking was H.R. 6's temporary repeal of the Institutes for Mental Diseases (IMD) exclusion, a 50-year old prohibition on states receiving Medicaid funds for "hospital[s], nursing facility[ies], or other institution[s] of more than 16 beds" that treat mental health and substance use disorders. The effect of the IMD exclusion had been to block Medicaid funding for badly needed residential and inpatient care – without any alternative available.

H.R. 6 includes a partial repeal of the IMD exclusion. Until H.R. 6, CMS utilized state-by-state Section 1115 demonstration waivers to circumvent the exclusion and provide funding for Medicaid expanding. However, CMS negotiation of waivers to bypass the funding prohibition did not stimulate broad increases in bed capacity. (Many waivers and grants, for example, focused on outpatient services, such as expanding MAT capacity.) Section 5052 of H.R. 6 issues a temporary repeal (until a 2023 sunset) enabling states to reimburse for SUD treatment of patients ages 21-64 in facilities with up to 40 beds, for up to 30 total days of care during any 12-month period. Implementation guidance will be forthcoming from the Department of Health Care Services. Section 11002 also allows for IMDs to receive Medicaid funding for other medically necessary services to treat OUDs or cocaine-use disorders.

H.R. 6 includes several other provisions to expand IMD-related access to care. Section 5012 requires more reporting on IMD service offerings from state to state from Medicaid and the Children's Health Insurance Program (CHIP) Payment and Access Commission. Section 1012 modifies the Social Security Act to ensure that pregnant and postpartum women receiving SUD care at an IMD can continue to receive other Medicaid-covered services (such as prenatal care) outside the IMD.

With demand for access to care rising from the population of Medicaid beneficiaries, providers are likely to see continuing opportunities to drive expanded coverage to fill the void in a broader continuum of SUD/OD services.

### Expanding Focus on Social Determinants Relevant to OUDs

Another discernable trend in addiction treatment regulation is increasing focus on social determinants relevant to addiction. H.R. 6, for example, calls attention to peer recovery as a critical piece of the puzzle. Sections 7151 and 7152 of H.R. 6 establish grants to recovery community organizations to provide regional training and technical assistance in order to expand peer recovery support services nationwide. These provisions reflect a growing awareness of how much healthcare organizations need to learn from recovery community organizations. Section 8082 provides \$15 million to HHS to replicate a “recovery coach” program for parents with children in foster care due to parental substance use.

The Peer Support Communities of Recovery Act, including Section 7182 of H.R. 6, authorizes the Substance Abuse and Mental Health Services Administration (SAMHSA) to award grants to nonprofits that focus on SUDs to establish regional technical-assistance centers that implement peer-delivered addiction-recovery support services and establish recovery community organizations and centers. Section 7183, the CAREER Act, is intended to improve resources and wrap-around support services for individuals in recovery from a SUD in the transition from the treatment programs to independent living and reintegration into the workforce.

The Transitional Housing for Recovery in Viable Environments (“THRIVE”) Act establishes a demonstration program (Section 10002) for nonprofit organizations and tribally designated housing entities to provide low-income rental-assistance vouchers to individuals recovering from an opioid- or other substance-use disorder. Section 7032 of H.R. 6, the Ensuring Access to Quality Sober Living Act, requires the Department of Health and Human Services (HHS) to develop best practices for operating recovery housing, defined as shared living environments free from alcohol and illegal drug use and centered on peer support and connection to services that promote recovery from substance-use disorders.

***The ability to focus on social determinants appears to be an essential piece of supporting the initial decision to seek treatment and preventing relapse. At the same time, traditional reimbursement mechanisms do not provide funds to meet these needs.***

## Patient Privacy and Communication Among Physicians and With Families

A final observable trend has been a growing attention to the question of whether patient privacy has gone too far. H.R. 6 included a law known as Jessie's Law, named for a young woman who died as a result of an OxyContin overdose. Her surgeon had prescribed the opioid for acute, post-surgical pain, without any idea that she was in recovery from heroin addiction. After being reintroduced to opioids, Jessie ground up the pills to avoid the time-release and overdosed.

The young woman's family argued that if her doctor had known of her heroin addiction, he would not have prescribed OxyContin, but that the law prevented Grubb's doctors from accessing records relating to Jessie's substance abuse treatment history and made it difficult to talk to her family about it. The specific criticism was that the Health Insurance Portability and Accountability Act (HIPAA) and the substance abuse treatment-specific Title 42, Code of Federal Regulations (CFR), Part 2, discourage doctors from inquiring with family or previous doctors about patients' history of substance abuse or SUD treatment.

***In response to this criticism, the Department of Health and Human Services Office of Civil Rights is evaluating and requesting comment on new regulations allowing for more family-physician communication and provider-provider communication concerning past substance abuse treatment.***

While the new "Jessie's Law" provisions of H.R. 6 do not directly address the foregoing constraints (requiring HHS to develop best practices for healthcare providers and state agencies regarding the display of a patient's history of opioid addiction in the patient's medical records), these questions are likely to draw growing attention.

While the new provisions do not change the details of regulatory compliance around patient privacy, they reflect an evolving view of the balance of harms. The longstanding view has been that we need to keep substance abuse treatment secret so that stigma does not deter people from seeking treatment. Jessie's Law signals that we may have hit a "high watermark" on privacy considerations, with growing concern for the countervailing need to prevent more opioid-related tragedies by ensuring that doctors can see records of past treatment of SUDs and talk to families and other doctors who treated the SUD.

*At the same time that regulatory compliance must continue to focus on the particulars of healthcare privacy and data security, Jessie's Law signals that organizations should consider steps that can be taken to encourage permissible communication with families and among providers.*

For example, nothing in HIPAA or Title 42 should prevent providers from directly seeking patient permission for communication with families or previous providers related to substance use.



Harry Nelson, the founder of Los Angeles-based [Nelson Hardiman, LLP](#), is a leading legal expert on behavioral health and addiction treatment. He is the author of the new book *The United States of Opioids: A Prescription for Liberating a Nation in Pain* (ForbesBooks) and chairs the Behavioral Health Association of Providers (BHAP).

# The Evolving Landscape of Substance Use Disorder Mergers and Acquisitions

By Dexter Braff

As we have long expected, the mergers and acquisitions market for substance use disorder treatment providers is beginning to reflect certain market realities that, in turn, are changing buyers' perspectives on the type of providers they are targeting.

The initial wave of M&A activity was narrowly focused on high-end, luxury treatment programs.

And why not? The margins were strong and, for those relying on their treatment being covered under their out-of-network benefits, the expense had not yet risen to the point that insurers were balking.

But then several things happened.

The Affordable Care Act expanded the mandate for insurance companies to cover behavioral health "on par" with medical benefits. Suddenly, insurers were forced to better understand their current and future exposure to behavioral health spending. They began to scrutinize the extraordinary bifurcation of out-of-network (OON) vs. in-network rate schedules. They also began to examine the efficacy of costly residential care.

At the same time, the opioid crisis demanded that local, state, and federal agencies get involved (a.k.a. fund) prevention and treatment programs. No surprise that in doing so, the watchwords would be cost and efficacy.

Flash forward 24-36 months.

Insurers began to push back on reflexively paying out-of-network rates, either by seeking in-network relationships with providers or, perhaps, by withholding reimbursement as a cudgel to leverage reduced payments on a claim-by-claim basis.



Quite naturally, then, buyers began to look closer at providers that had strong in-network relationships with payors in their catchment area, and, not so coincidentally, would also be well positioned to meet the increase in demand from often cash-strapped state and federal payors (including Medicaid).

With inevitably lower reimbursement rates, the interest in high-end, luxury residential programs began to give way to more affordable residential, and non-residential alternatives. This second part began to stoke interest in community-based PHP, IOP, and other non-residential counseling programs and services. Moreover, it shined a bright light on medication-assisted treatment programs (methadone and suboxone) which check off the boxes for cost and efficacy.

Based upon proprietary transaction data collected and analyzed by The Braff Group, buyers are indeed pivoting in these directions, albeit at a slower pace than we originally expected.

To wit:

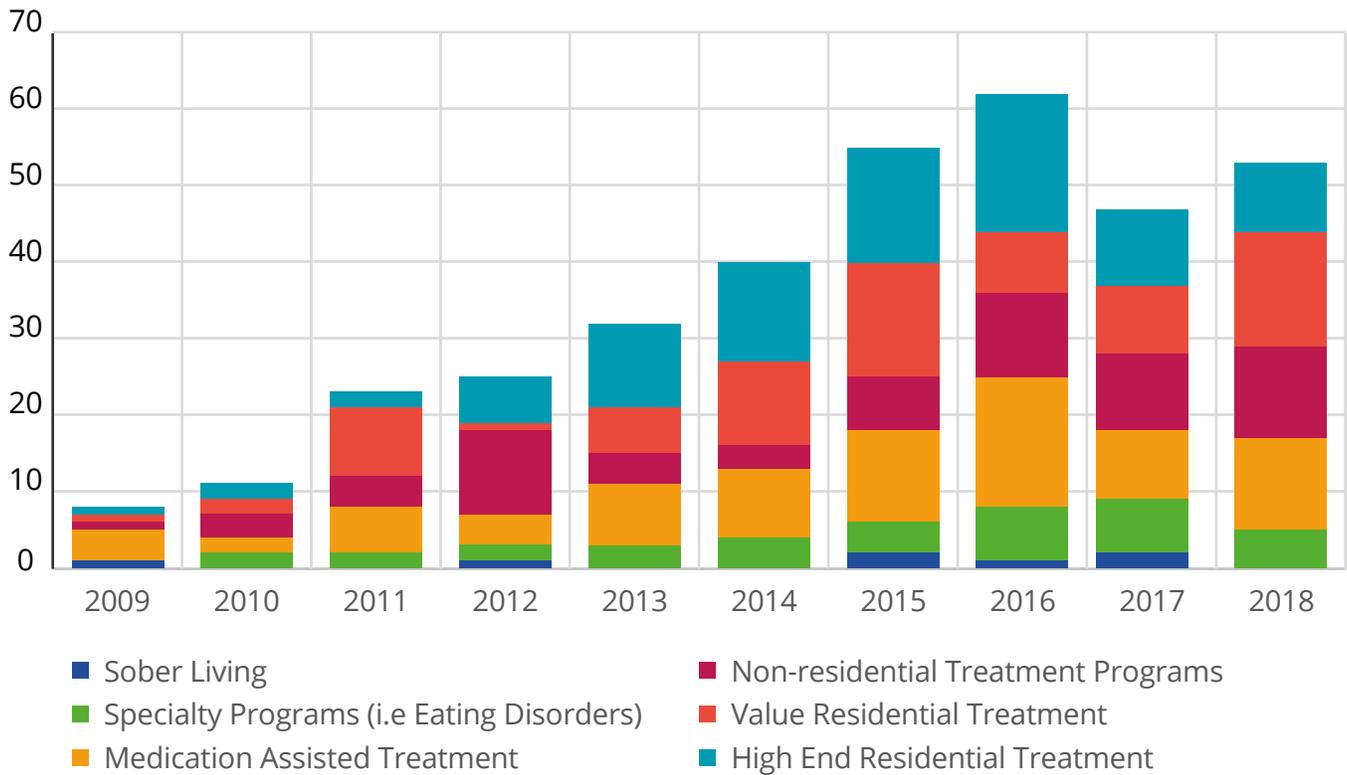
- Deal counts in high-end residential SUD programs have fallen sharply over the past 24 months.
- Transaction volume in more “value” oriented programs is taking up the slack, but the movement is not nearly as dramatic or consistent as what we’ve seen in the luxury programs.
- Although the raw number of deals are on the small side (less than 15), there has no doubt been a more or less steady increase of non-residential transactions over the past four years.
- The biggest shift was in medication assisted treatment which posted substantial gains in deal volume between 2012 and 2016, largely funded by private equity sponsors<sup>4</sup>.

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<sup>4</sup>We note that the numbers are down in MAT over the past two years, however we speculate that this is because the first wave rush of activity drained the initial pool of attractive candidates. This pool will be replenished as younger companies mature and consider exit opportunities.



### Number of Substance Use Disorder Deals



So, what do we expect over the next three to five years?

Essentially more of the same, but with increasing volume and momentum. Additionally, from a cost and efficacy standpoint, we suspect that so-called destination programs (where clients seek treatment outside of their community, either for warmer climes or greater anonymity) will see some fall-off in utilization. In their place, we expect more campus-like programs that offer everything from residential to non-residential and medication assisted treatment services. As a result, we anticipate buyers will become increasingly more interested in acquiring a diversity of providers over a tight geographic footprint versus the more traditional model of consolidating single service companies on a regional or national basis.

Overall, though, it is a near lock that with increased funding amidst a populace that is far more accepting of those suffering from SUD, that an extremely long runway of increased utilization will support a thriving M&A market for the foreseeable future.



Dexter W. Braff, MBA, MS, BA, is the President of [The Braff Group](#), one of the nation's leading health care mergers and acquisitions advisors according to Thomson Reuters. Since its founding in 1998, the firm has completed more than 325 health care deals and has established itself as the leading M&A advisor in health care services.