Inside The Payer View: The Future of Addiction Treatment Service Delivery

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Speaker 1 0:00

Welcome to New Orleans, and welcome to the 2026 OPEN MINDS Strategy and Innovation Institute. For everyone who knows me, New Orleans is one of my favorite cities. So, in addition to being here with 500 of my closest friends, I get to listen to jazz every day. We have an exciting day ahead. I just wanted to start with a couple announcements. The first is, of course, just to thank our sponsors. Events like this are not possible without the underwriting of a lot of important folks, and our premier sponsors this year are Lira Health. If you had a chance yesterday to go to the summit, it was fabulous. Cantata Health Solutions, Core Solutions, Netsmart, Otsuka Pharmaceuticals, Qualifax Recademy, and Trillium Health Resources. So, just to call out to those folks for underwriting the meeting and making all of this possible. I wanted to call out a couple other special things today. This is our fourth annual Autism and IDD Executive Summit this year, sponsored by Monarch Health, we are, you know, it has been an interesting four years, as we've really seen, I think, the evolution of the discussion around best practice management, both business and service management in the autism and IDD space, that is a call out for your calendar, we have an interesting payer panel today with Jennifer Black of Carolina and Dr. Stephen Pratt of Magellan. My favorite topic is the behavioral health carve out dead, and no one laughed when I said that, except Paul, but I mean, I think one of the questions it raises is this whole question of what's the future of integrated models, and what are integrated models? What do they look like? We also have our third annual Pitch Day today, sponsored by Vista Care. For those of you who are new to Pitch Day, every year we have a curated competition for eight organizations that are looking for funding, all in our market space, and they will be giving their very best pitches for why they are the best investment for investors. We have an investor panel who's going to be evaluating the pitches, and the most investable solution of the day will win, and they will win a prize package of $40,000 so it's a, it's a big, it's a big opportunity for them to get kind of both endorsements from the panel and a year of advertising and promotion, and then last, be sure you mark your calendar, the end of the day, we have our executive networking reception in the exhibit hall, we've, as I mentioned, we have about 550 folks on site. It's a good chance to be able to, I would say, share experiences and get some perspectives from new places. A couple call outs for tomorrow, things I

won't miss. Our close our opening keynote is with Stephen Pratt, the Chief Medical Officer of Magellan, all of us are very curious. Magellan has been on its own trajectory the past two years to kind of see where Magellan is headed and get an update for everyone in the room. And we are bringing back something that we did 10 years ago. We are having our new Government Health and Human Service Executive Summit, sponsored by Bamboo Health, that will be all day tomorrow. Really, looking at, we thought it was given the many, the teeny tiny small changes coming down from the federal government, it would be a good time to kind of revive the, you know, a discussion among among the government execs about what is their roadmap for the future as we look at these changes now. Without further ado, I want to introduce you to our today's keynote speaker, Dr. Deborah Nussbaum. She is the senior director of Behavioral Health Evidence-Based Services and National Sud Strategy for Optum. She has led their specialty arm and in a clinical leadership role since 2010 she has led behavioral health product design, network development, and specialty substance use disorder initiatives since 2013 The products that she's working with are designed to improve access to evidence-based services, including the adoption of ASAM criteria, of which I have many questions today, and the development of alternative payment models and value-based models of care. She has a clinical background in substance use treatment, family services, and was an addiction treatment counselor prior to getting her PhD.

Speaker 1 4:34

Just one note, Deb and I are going to have a - I would call it fireside chat. I have prepared many difficult questions, which I'm going to make her answer. And then afterwards, for we're going to have a deep dive Q and A in the room next door for Pete. So bring all of your questions for Deb. Once you join me, Dr. Deborah Nesbaum, do. A welcome, welcome, grab a chair. I'm going to take the hot seat. Yes, take the hot seat. It's always, you know, as people know, I like the opportunity to ask lots of questions. I'll start with the softball one, for folks here who don't know Optum, and United, can you just give them the, you know, three minute overview of Optum, what it does, its relationship to United Healthcare.

Speaker 2 5:30

Three minutes,

Speaker 1 5:31

three minutes. Yes.

Speaker 2 5:32

Okay. Optum is a very complicated company. We are the specialty arm of United Healthcare, and we have many different specialty services. Some of you might recognize the term Optum RX. Optum RX is the pharmacy benefit manager. Optum Behavioral is the Behavioral Health Benefit Manager. So we do behavioral health benefits manage care for Medicaid in many states, 24 to be exact, Medicare and commercial health plans. We are a network model managed care organization. What that means is that we hire a network of clinicians, facilities groups to do the care for us. We are not a care delivery system. We are not rendering the care. We hire clinicians to do the oversight, the case management, and the utilization management, there are many other divisions within Optum. Optum has specialty care, Optum

has something called Optum Care, which is a delivery organization. So, when you say Optum, it's a big umbrella, and then you come down to all of the different specialty services. Under Optum, we also deliver cancer support, neonatal support, kidney care, but these are case management solutions that are hired to provide specialty case managements for people with chronic diseases, but that's not my division. My division is the benefits division. So, hopefully I didn't confuse you too much.

Speaker 1 7:21

No, that's a useful road map. And just following up on that, you have a very long title.

Speaker 2 7:27

I do. I do.

Speaker 1 7:28

Can you tell us what you

Speaker 2 7:31

do? My old boss, for those of you that remember the name Dr. Martin Rosenzweig, he was the chief medical officer of Optum for a long time, and I reported to him for a long time, and he calls me a comet. He says everything that I ever done drags behind me. So, I've been with Optum for 17 years. I report to the Chief Medical Officer, and my responsibilities as one of the clinical leaders, and by the way, there's five clinical leaders in the organization, and half of us are in this room right now, not not pointing out any, any of my other colleagues, but, but do stand up now, so we, because I started in the addiction field, I acquired addiction services prior to the first opioid epidemic, where we started to see a lot of people overdosing and dying from oxycodone. They created a role, basically the National Sud strategy lead, which took over what we needed to do to mitigate the overdose deaths at the time that I took over the Sud lead, we weren't even covering methadone in the insurance. The only place that we were covering methadone was for Medicaid, and that was ridiculous. We needed this lifesaving care, so we really started to, I started to focus on network curation, building a network that could provide evidence-based services for trends that we see in our claims and trends that we heard from the human beings that were that we're insuring for years behind me on my on my wall I had names of our members that overdosed and died, and they were all young persons, 2324 21 and we needed to, we needed to do something to stop that, so that really started the Sud strategy lead position, and then I realized, well, our benefits don't really align to cover the services necessary to then kind of morphed into benefit design and different payment models, so that keeps me occupied.

Speaker 1 9:49

I bet. Well, you know, I do want to pivot right to, I think, the big question. I mean, I would have assumed by now Optum has solved all the Sud problems out there. Okay, but I'm assuming probably there is one

or two left. If you had to identify two or three pain points, you know what keeps Optum folks up at night around

Speaker 2 10:12

Sud. I'm sorry to say that in the addiction treatment industry we are not aligned on clinical philosophy. Unfortunately, we have a lot of bifurcation in the field. There should never be a time where someone goes into a treatment program for an opioid use disorder and is not educated on recovery enhancing medications ever. There should not be a time in our field where a facility, a treatment program, says to a member's parent, if your son doesn't stay here for 60 days, he will die, because that's giving, that's misleading information in our industry, we've come a long way from, you know, where we started, where Dr. David Mailey started in the wild, wild west of trying to kind of get their arms around the addiction treatment industry. To we have evidence now on what works and what doesn't work, but I'm not seeing that I have a team, and we vet treatment programs always. They send in their programming, and we look at their programming, and I mean, I still get - I still get applications from treatment programs that are quoting the PPC two criteria from 2002

Speaker 1 11:38

And what is that?

Speaker 2 11:39

That is the ASAM second edition. Okay, we're now on the ASAM edition, so you know we're behind in this industry, and it's a constant struggle for us in the in the payer space because we have in network benefits and we have out of network benefits. I can control my in network providers, I contract them, I pay them. In their contract, it says you have to do evidence base, you have to align to the American Society of Addiction Medicine, you have to have physicians, you have to have board-certified addiction docs, but in the out of network space, and 90% of my customers have out of network benefits. It's the wild west, so that definitely keeps me up at night, and constantly thinking about what I could do in benefit design to mitigate.

Speaker 1 12:32

Well, this is sort of an off the off the script question, but I want to follow up on a piece with two questions. Why do you think that the we were having a small discussion about this at the table when we started. Why do you think the adoption of evidence-based practices in the field is so slow?

Speaker 2 12:52

I think change, I think the change is hard for many organizations, especially organizations that have, that have been around. I think evolving is hard. Also, our industry has a lot of people that have come through their own recovery and achieved sobriety, and they align to what their path took, and not necessarily what different paths might be for different people, so I think that it's, it's part of just legacy and part evidence.

One of my earliest jobs in, in the addiction field was in a therapeutic community, and in therapeutic communities I was one of the first persons to work there that hadn't graduated from the program. All of the people in therapeutic communities came through and were program graduates, and it led to a lot of very interesting insights on my part on what they wanted to do, because what happened to them versus what what the science and what treatment and what's appropriate, very very different, and you know that bifurcation from when I did it in the 80s to now still exists

Speaker 1 14:16

in statistics, we call that the fallacy of anecdotal experience, but it is the very true, so it is the kind of personal experience and lived experience, sort of brought, brought to the network. Well, the other, other interesting part about your answer is this whole out-of-network benefit piece. So I know there is a certain amount of discussion at the federal level about eliminating networks altogether and going with networkless benefit plans. How do you see that if that did happen? How do two questions? How do you see that affecting the quality of care, and what do you see of the effect of that on cost?

Speaker 2 14:55

I think that out of network cost. Are a driver for a lot of customers to be pushing more toward in network only benefits, because out of network, how you define out of network allowables is very, is very different, and it really depends on how medical does it, so out of network costs can explode trend where by in network we negotiate rates normally based upon CMS plus plus some and I think it would be very problematic and I don't think customers would be able to afford

Speaker 1 15:36

it customers meaning on the employer side in particular

Speaker 2 15:40

side in particular, and you know, right now we're promoting at the federal level to add residential benefits to Medicare. Medicare does not have residential benefits, so it's either inpatient or outpatient, and we really.. oh, hey, Debbie, we really need. we really need a Medicare intermediate level of care, but we have to be very careful because it could be ripe with with problematic spend, and that would then that would then end the initiative.

Speaker 1 16:18

Well, one last question on networks before we leave that, so what do you at Optum do to encourage if I'm a member of United Healthcare, and Optum has my benefits. What do you do to encourage me to use in-network providers? What does your.. I know it probably varies by plan, but kind of.. what are the range of plan options to do that?

Speaker 2 16:40

So most of our health plans on the United Healthcare side are PPO and POS plans that have in and out of network benefits. The medical plan defines the behavioral benefit because of mental health parity. So, what we can do on the behavioral side, to compete with out of network, is we could encourage no cost share. We could waive cost share, because that's what happens on out of network programs. They say, and God knows I've called enough of them, you know, I cold called them, and they always say, my poor son has been admitted to like 50,000 programs, because I'm always calling, going, I have a son who needs treatment, and what do I do? And they say, 'Oh, come here, we'll send you a plane ticket, and no cost, no out of pocket expense. We'll take whatever your insurance gives. So we have to compete with that on the on the behavioral side, on our network side, by waiving cost share. We, in 2015 16, we developed a center of excellence model on behavioral, where we can identify top performing treatment programs. We have it for substance use, we have it for eating disorder, and we have it for acute mental health. So, using that methodology, like a center of excellence, we could do a third tier and waive cost share for that third tier, and cover it at 100% We also implemented, about five years ago, a service area limitation where people can only use their out-of-network benefit in state, so those plane tickets to California, which are legal, or the trips down to Florida or Texas or Arizona or Utah are all the all the favorite places they can't go, they can't utilize, they could utilize though anywhere in the country in network, and that's been very successful. We've really seen, we've really seen some good outcomes with that.

Speaker 1 18:40

You think you know one last question on the evidence-based side, so what? What are you doing? You mentioned the importance of at least informing consumers about medication-assisted treatment in substance use disorder, sort of. How do you make that happen at the network level?

Speaker 2 18:58

So when we bring a program into the network, we require them to offer at least buprenorphine and naltrexone. They don't, you know, they can't do methadone. A lot of programs, you know, methadone is limited to wear, but we make sure that they have prescribing physicians. We also look at med adherence in our outcome data, so my center of excellence methodology includes how many, what percent of the people that you discharge with opioid use disorder receive a first fill of buprenorphine or an injection of Sublocade or Naltrexone within 30 days of discharge on alcohol use disorder. We just started doing that. We're actually in our first year for Naltrexone or Vivitrol injection for alcohol use disorder, so we're really pushing that, and it's weighted into. To our methodology for outcomes and providers that achieve the best outcomes, they get, they get bonus incentives. Okay.

Speaker 1 20:08

Related to, so do you see, last year we had one of the execs from Carillon was speaking at our meeting, and he had an from the Carillon data, an interesting observation. He said that adoption of medication-assisted treatment for Sud of any type was much higher in Medicaid than in the commercial population. Is that the same adopt them?

Speaker 2 20:30

Yes, that's because methadone has been around forever under Medicaid.

Speaker 1 20:33

Okay, so

Speaker 2 20:35

it's, you know, it's common, and now methadone programs, they could do buprenorphine and they could do naltrexone, so methadone is a very mature benefit for Medicaid commercial members. We only started covering it in 2017 People don't necessarily like to go to methadone clinics, even though there's more generous take-homes these days. So we do, we have a very generous buprenorphine network, virtual buprenorphine prescribing immediate access to care. I mean, if someone wants to start buprenorphine in an hour, we could get them an appointment to get inducted on buprenorphine. So, access is not a problem in the virtual world now, but uptake is still, is still very low.

Speaker 1 21:22

Well, I want to shift the discussion a little bit to kind of, you know, the whole issue of value-based reimbursement. So many of the provider organizations that we're working with would like to abandon fee for service. It is not, I mean, frankly, from the provider perspective, fee for service rates have not kept pace with inflation. There's a lot of concern on the behavioral health side that you don't really get to participate in good, you know, if you have savings or outcomes. Can you talk a little bit about your, you know, kind of network curation and what you see as both current and future models for VBR and behavioral health overall, and maybe substance use in particular.

Speaker 2 22:04

Sure, commercial plans are not as generous as Medicaid plans, and do not cover services that should be covered. Years ago, we've known that peer services support recovery efforts, yet commercial plans did not cover peer services. Why? Well, we can't credential peers, they're not licensed, a whole host of issues. So, by doing alternative payment models, we can build in services, we could get the providers covered for services that they can't bill fee for service. Another vital component of addiction treatment is case management, social determinants of health. Who is going to coordinate all of the paperwork and all of the necessary communication for a member, so we can bundle in and get away from fee for service, and I agree, fee for service is like the 1990s like we need to be in the, you know, we need to come current with different types of payment models, where we're paying providers to do the necessary stuff outside of the office of treatment, case management, peer services, labs, God, I said the word labs. Labs has been just a problem, a thorn in my side for years. I call it urine farming. Do you know how much labs have been built under the medical plan? Why in the world would you need to do a lab two or three times a day on someone in a residential treatment program, it's billable, so we bundle in labs, we bundle in case management, we bundle in peers, we bundle in nursing, we bundle in the docs, in methadone programs, I've even bundled in the medication, we're covering it all, one payment, guess what it does for the

member, one cost share. So, if I can pay a month, the member has one outpatient cost share per month. Lower cost share leads to higher engagement in care, because you're taking away, if you have to go to a therapist and a lab, and then get see the doc and then pick up your medication, that's a lot of money in cost share. So, in the commercial space, having these alternative payment models really helps the members stay engaged in care, and we see better outcomes in care. So, different models, weekly bundles, monthly bundles really improve on the Medicaid side. They don't have cost share, everything is billable, so it's not an issue. And unfortunately, on the Medicare, Medicare is very rigid in how we could pay for things, so we're working, we're working on it. Was not my intention, for those of you that run OTPs, to have Medicare release the G codes for OTP. That was not the original intent when we were pushing CMS to do this, but at least it's the start of abundant discussion with Medicare. Well, you know, if we can drill down a little further with this, can you talk about when you're talking about the daily or monthly bundled rate? Is this for residential? Is it for outpatient? Can you describe in a little more detail how that works? Sure. Sure. So for residential, it's normally a per diem, and the per diem is a bundled payment per day, and we've looked at doing other types of bundles like case rate bundles, but that's a bit problematic for very logistical reasons. The bundles that I'm having the best success with are outpatient bundles.

Speaker 1 25:51

Okay,

Speaker 2 25:51

so when the person leaves care and needs to go on for treatment, staying engaged in an outpatient program that could do everything, including the medication services, and the counseling, and the support, and the peer, and the community, and the app, everything together. If they could stay in care for a year, I'm happy. If they could stay longer than a year, would be great. That's our, that's our goal. So it's beyond that grief-intensive stay.

Speaker 1 26:21

How does someone.. I mean, this is always a question on the provider side. How does someone.. so I'm released from a residential treatment program. How do you assign that person to a provider, community-based provider who gets the bundled rate? How does that process..

Speaker 2 26:37

so because we do utilization management, we have case managers that work with the discharge planners at the facilities, and we know, okay, they're being discharged on medication, hopefully, and they need this, and this is the community, so we can connect them to care. Now, there's a lot of programs that don't work with us that they have their own referral streams, and we have to honor that. We have to honor that as well, but we try to steer, and I know it's a nasty word in insurance, steer, but we try to encourage people to go to these network programs that have these value-based models,

Speaker 1 27:17

and you said that the outpatient models have the best success so far in your work, can you talk a little bit about how are you measuring that, and what does the success look like?

Speaker 2 27:26

So, my system, I have medical data, I have pharmacy data, I have behavioral data, I even have EAP data, my data has data, and we take all of that data and we look at total cost of care, so I could see what a member costs prior to going into treatment, and then coming out of treatment. As long as I have a year's worth of data, as long as they stay insured with me, I could look at their total cost of care, their trend, and their spend, and keeping a member on buprenorphine or methadone. There is a huge return on investment, over $6,000 for opioid, and it's even more once we get more people on naltrexone for alcohol, it's even higher in the alcohol space because of the other chronic diseases that alcohol use disorder brings, but there's tremendous ROI in that.

Speaker 1 28:32

Well, you brought up an interesting point. I wanted to talk a little bit about kind of co-occurring disorders, and both on the behavioral side, and then co-occurring in terms of physical, physical conditions, but starting, you know, starting on the behavioral health side, there was a new study that came out, 42% of people with opioid, with any substance use disorder, have some mental health disorder, so big co-occurring disorder. How does the network, the intake process, how, what kind of programming do you have for those folks, and how do they get to that place? You know, who are your preferred providers?

Speaker 2 29:07

So, we have it used to be called dual diagnosis, now it's called co-occurring COE, and we have identified programs that have psychiatrists that work within the program that can adequately handle a co-occurring patient, and we also have programs that do not. So, when we're making a referral, we're making a referral to identify programs that has co-occurring capability. Most people self-refer. Unfortunately, Google and Yahoo searches are how people find treatment in substance use disorder. It's very unfortunate because they're not allowing us to kind of direct them to what we feel would be the best type of treatment program, but we're sophisticated enough now with. If we could identify the programs that are in our network that do the best care for particular conditions,

Speaker 1 30:09

and on the on the physical health side, there's a lot of.. I was just reading a study that cancer patients, the incidence of alcoholism has risen dramatically, they were going through all the different co-occurring disorders, how does that in, in because I'm going to come back with a very pointed question, you know, in the United Optum model with a carve out, you know, kind of managing that, how does, how do you bridge that gap, you know, if someone has a heart condition and you know some substance use disorder, how does that work?

Speaker 2 30:42

Painfully, it's a painful, it's a very painful process. Because behavioral with psychiatric and with substance use disorder, it's easy peasy, because it's all under Optum, right? It's all us, and we're the financial, we have financial responsibility for all of that with medical services, it's a little bit more complicated because the medical plan, and we're not always the medical plan, United is not always, we, we have 12 other payer that we do that we do behavioral health for, they're the financial responsibility for the medical services, and there really is some very low hanging fruit that we've been trying to bridge, the lowest hanging fruit is Hep C HIV treatment and substance use disorder. It requires a dual contract, behavioral will take care of the behavioral service, and you need a medical contract to cover the Hep C, the HIV, the infectious disease services. We also see this with programs that deal with pregnant, pregnant women that are in substance use treatment. Medical needs to cover the medical services, so we, we try to create these bridge contracts, but it all falls apart if you have a different medical plan, and not, and not us. We recently, with our neonatal program, we brought in a treatment program called Seven Starling, which all they do is maternal mental health, and we built it into our neonatal support program, and I thought that was a really big win for us, like it might seem small, but for us having this integration where all of the women in this program get a referral to Seven Starling, it was like, yay, we did it, like it's it's a step forward, but we're not there, and it's based upon the bifurcated reimbursement model.

Speaker 1 32:46

Yeah, because I can say, I mean, and maybe I'll ask you for a free piece of consulting advice. So, we're working with the program, it has a well-established mental health and SUD program, they're building out medical services, but they are having a heck of a time with contracting, you know. If you were them, they're trying to offer, you know, this turnkey sort of all in one place. It's inpatient. Where would you go to try, you know, they're really kind of trying to figure out how do they approach getting a health plan to contract with both sides.

Speaker 2 33:19

Okay, and what's the bed type?

Speaker 1 33:21

It's actually acute.

Speaker 2 33:22

Okay, psych or

Speaker 1 33:24

medical licensed as psych, and getting a medical license.

Speaker 2 33:28

Okay, so the medical providers would be contracted separately, like a group, like an outpatient group. Memorial Sloan Kettering, New York City Cancer Treatment, they have an outpatient group of therapists and psychiatrists that see patients for cancer. That group is contracted through Optum Memorial Sloan Kettering is contracted through the health plan. So we cover all of the psych consults and all of the psych services for that. So that's how they have to do it as a specialty group,

Speaker 1 34:03

and then my last really pointed question, Who at Optum would they call? I mean, yeah, How do you approach that? Is it the state people if you're doing something complicated like that, because it's a big question for every provider, is what you know, where do I start?

Speaker 2 34:21

Okay, so here's the, here's the secret sauce. Good, don't call anybody Provider express.com Scroll down on the page to join our network, and all of the applications are there: individual, group, facility, hospital. Okay, and it's all electronic now, so all you need to do is go to Provider express.com scroll down to join our network, and then click on the link and submit it, and it will go through the process. We have a different contracting team for each region that we're in and. And they will, they will pick it up, and you'll get assigned a contractor, and it will, and it will go through, even

Speaker 1 35:06

these complicated programs. My example, I'm doing medical, and I'm doing psychiatric, and I want to do psych consults. All of that is through the one,

Speaker 2 35:16

through the through there, and then when you get the human, and then you talk to the human about, but we can't do, we can't start anything until we get the application, the license, and under and understand, and then the human interaction will occur.

Speaker 1 35:33

I'm always glad when I get to a human. Yes, most of the time I talk to a chat bot, and I just keep repeating human. I think that's a good strategy,

Speaker 2 35:42

very good strategy.

Speaker 1 35:43

Well, I want to, I want to shift and talk a little bit about ASAM, you know, and you know, I have, I have two questions for you. So, when the ASAM four was released a couple years ago, there was a lot of, I think, anticipation that it would fundamentally change how service was delivered for a lot of the pieces that were in it, you know. Have I haven't seen that, but I'm wondering if you've seen that, and sort of, if not, sort of, what's the what's the problem with the rollout?

Speaker 2 36:17

You're hurting me, Monica. So, I've been leading this initiative. I was so excited when the, when the criteria was coming out, Bob here was the, was the publisher, and I was so excited, like Hazelton's the publisher, and I got this advanced copy of the criteria, and I got a project manager, and I lined up all these meetings with everybody in my organization, hundreds of people, and we had this beautiful project plan, and we were ready to go November 2023 What's it now?

Speaker 1 36:48

Later,

Speaker 2 36:49

2026 Okay, so 2024 was Deb's kind gentle year, where we trained everybody, and we started to have provider conversations on the recontracting towards the fourth edition at the end of 2024 I had 45 facilities contracted, you know how many facilities I have in the network, over 4800 So 2025 came and they were telling me, Deb, you got to do something, got to do something. So we did unilateral amendments. It was the shotgun approach. Everybody got a unilateral amendment. Sign, don't sign, we don't care. We're changing you to the fourth edition. Now this is for adult commercial only. We cannot change for Medicaid until the state Medicaid division tells us we can. Right now today, there's only two states that I manage that have gone to the fourth edition, Kentucky and Missouri. That's it. None of the other state entities have gone, so in 2025 we did a massive overhaul, and we got to about 60% recontracted for adult commercial under the fourth edition, but I still have facilities saying they're on the third edition, they don't know, they don't know the criteria, the criteria is built into our platform, so when you request an authorization, you're just answering the questions in accordance with the fourth edition. It's just the ASAM, the ASAM questions built into the Interqual tool. It's been very challenging to get the industry to move to the fourth edition, and for me it's very disappointing, because if it was the American Heart Association or the American Cancer Association, would we still want to use a 13 year old criteria, and David, no offense to the criteria, we have one of the editors sitting here in the room, the third edition, we all loved it, but it's old, and we really need to move on. And why in the addiction treatment industry are we behind, and are we not adopting a new criteria? It's.. I just don't have an explanation for it.

Speaker 1 39:18

Yeah, I was going to ask you, if you knew why.

Speaker 2 39:20

Yeah, I. it's fear of change, fear of doing something new, changing your programming. I, it's just very disappointing to me. In this, you know, being in this industry for so long, I thought we would really want to embrace change, because a lot went into that criteria. I mean, we were open for months for input and a lot of research, a lot of rigor behind the criteria. So I'll just keep pushing. The adolescent is out. I just got my adolescent book, so I'm coming, I'm. Comment for your adolescent program,

Speaker 1 40:01

so two questions related to this. So, for the 45 facilities that have adopted the new addition, have you seen an actual difference in performance

Speaker 2 40:12

there? So my network has tremendous performance. Our I'm always looking at, I have a dashboard in real time. I'm always looking at readmission rates, med adherence rates, AMA rates. The network is performing great. I haven't isolated between third and fourth edition, but

Speaker 1 40:35

that would be an interesting thing. I'd like to publish. I

Speaker 2 40:37

think it would be a very interesting thing

Speaker 1 40:40

if you were to look at it and look at that, those 45 facilities, what do you think the difference in service delivery would be? The

Speaker 2 40:50

medical services in the point sevens are far more flushed out, the 3.7 than the 2.7 services. services are really well defined in the fourth edition. The third edition, and David, no offense, kind of nebulous, and, and, and vague, but I think the fourth edition really defines the services. What I also like in the fourth edition is it spells out the number of hours that treatment should be rendered day to day, seven days a week. Programs can get very concrete when it comes to the services. Well, I don't have to do it. Show me in the criteria, you know, and we would be arguing, like, why am I paying for residential care if someone is just, you know, meditating on the weekends and journaling and not doing clinical services? So, I think that, that it's just better. There's a lot of good definition in there, but the, I like the medical piece. I think that Corey, Cory, and team did a great job with, with the medical.

Speaker 1 42:00

So, one just interesting question. So, if I'm a provider and I adopt the ASAM four criteria, do I have a better shot at getting referrals from your network?

Speaker 2 42:09

I wish I really wish that we had that secret sauce. I would love to put in the benefit design that you have to get a referral from your insurance company before you could go to treatment, but I can't. People, people have the ability to self refer, so now steer steerage and network referrals has always been very challenging for us.

Speaker 1 42:32

Well, I want to, I want to shift from a Sam and talk a little bit about technology, so in two categories, I'd like to talk a little bit about from using virtual telehealth, you know, kind of virtual, they're synchronous, asynchronous, whatever sort of what have you seen as changes over the past few years in the Sud space using telehealth and virtual care,

Speaker 2 42:55

coming out of coming out of COVID, we've seen a real explosion in virtual and virtual services, not only for prescribing, but for support services. I think the virtual support services are are fantastic. We have now digital apps, you, you can have a peer in your pocket when you need them. You could go into virtual rooms and Zoom rooms and get support 24 hours a day, seven days a week. I think that those services are just fabulous. We've contracted with a lot of programs that do both virtual prescribing, virtual support, virtual peer support. We also have some programs that are doing contingency management with peer support and case management and prescribing, so we're seeing a lot of, we're increasing the continuum through these virtual digital solutions,

Speaker 1 43:56

are they, so in terms of using the I would say the virtual live, you know, kind of interaction and kind of the asynchronous app kind of applications are this, are the fees for that then covered in like your bundled rates? Yes, is that how we bundle,

Speaker 2 44:15

we bundle it up and cover and

Speaker 1 44:17

are providers free to use whatever sort of app or platform they prefer, or do you have endorsed sort of tools?

Speaker 2 44:25

So they, we don't endorse anything, but they have to go through a security review with our company, because there could be PHI in there, so we have to protect that. So they go through security review.

Speaker 1 44:37

All right, and you know, are you seeing anything on the kind of horizon, in terms of digital treatment, I mean, you know, there was, was it five, I forget how long ago, the, the, you know, there was a really great digital app in SUD, but they actually went bankrupt, you know, and are you seeing any other kind of emerging. More treatment-oriented apps out there that have sparked your interest.

Speaker 2 45:04

I think I think more peer apps are sparking my interest more, because we have a lot of professional services. I think we need more of the peer and remote monitoring apps that are, that are emerging, and we've been, we've been looking at adding more of those to our to our network.

Speaker 1 45:25

Well, one one question that I think most provider organizations have, you mentioned in your introduction, Optum is a big place there. There is Optum owns a lot of provider capacity, you know, of all sorts, you know how, and I think a lot of independent providers feel they're competing with the Optum owned and operated capacity. Can you talk a little bit about how that works in behavioral health? I mean, what's the overlap of what you own to network? How do referrals get made?

Speaker 2 45:56

So, Optumcare is our delivery system. Optumcare owns primary care groups, they own kidney dialysis centers, and they purchased a large mental health provider organization that has a national footprint. We were looking to purchase substance use disorder services a couple years ago, our previous, previous, previous CEO was very interested in building up Optum Care. We never pulled the trigger on buying it. I was kind of pushing for us to buy an OTP selfishly, you know? I wanted us to get into the OTP business, but we never did. So we have behavioral health services that support our primary care programs.

Speaker 1 46:49

Okay,

Speaker 2 46:50

but we on the behavioral health benefits side, we use our broader network. We have 500 over 500,000 providers in the network. They are, they are one of them, but they're not prioritized in any,

Speaker 1 47:01

okay,

Speaker 2 47:02

in any fashion, but they do work with the PCP groups,

Speaker 1 47:05

so there is, they're sort of like any other provider, they're like any

Speaker 2 47:10

other provider, right, and but they, they, they're supposed to support those PCP groups that are in the communities,

Speaker 1 47:17

and do you think you know, as you look ahead, do you see Optum moving ahead with a plan to acquire Sud providers.

Speaker 2 47:23

No, my new, our new CEO doesn't have that interest to expand into care delivery. I think that they're trying to, you know, continue with the benefits business that we have.

Speaker 1 47:34

Well, you know, kind of next step question to that, and really the kind of place I'd like to sort of end the discussion is, I think, most, most provider organizations right now are trying to, I would say, diversification is large on everyone's, there's a lot of chaos in the field about benefits rates, sort of everything, and you know, I do a lot of strategic planning work with providers. The big question is always, what do we invest in? You know, if you're looking ahead and saying, I'm going to invest in building a new service of some type, and you're trying to look three to five years out, you know, what do you see as we kind of look to the future? If you had your ideal network, and you could ask people here to go develop something that would be something you clearly need and would contract for. What is that?

Speaker 2 48:30

Okay, well, first thing, before, before I get to the, that make sure your programs are getting the outcomes that we need, because we are paying for performance, we have the data on your programs, and we're looking for the outcomes. If you want a rate increase, we need to see that you are performing above other programs that are that are in our network, that's number one.

Speaker 1 49:02

Before you leave one, so what is that measure? Am I investing in measurement-based care? Am I measuring readmissions? Am I what am I measuring?

Speaker 2 49:11

Readmission, med adherence, AMA, keeping people engaged, follow up after discharge, follow up after discharge, follow up after discharge.

Speaker 1 49:23

Okay,

Speaker 2 49:24

and did I say follow up after discharge? Because a residential discharge is not a one and done, that's the start of the program. Now, what you could do for me, what I need is I need programs that will rehabilitate people beyond sobriety. We have a ton of young adults that started using maybe 1617, years old, they lost. Their way, they had, they maybe got a GED, maybe they didn't. They have no idea what they want to be when they grow up, and there's no programs out there that are rehabilitated that are habilitating them, figuring out what, what they should be doing connecting them to vocational services years ago, and I think I mentioned this, that, that I was a reentry, I was, I worked in the therapeutic community. The one great thing about a therapeutic community is that we were able to connect people once they had a period of sobriety to services that could educate them, we made electricians, we made guys that did body work, we made plumbers, we made, we gave a lot of people career and focus, and we got them out of just thinking that their addiction was their full-time job, and we gave them like direction to go in. I don't have that anymore. Those days are gone, and I need programs to do the educational vocational testing, figure out someone's strengths, and get them going. So that's that's a big one, two adolescents. These kids are struggling. I open an adolescent program, and the beds are full, and I have to go on adolescent addiction trauma, and adolescent addiction, gender-specific trauma, and adolescent addiction also, because the kids don't want to be, you got to get them away from the boys and girls. The boys need to be with the boys, the girls need to be with the girls to discuss topics. So, gender-specific programming is becoming a pretty big ask in the space, and that's for adult and adolescent, and trauma and addiction, huge. I can use some more eating disorder and addiction programs. Also, I don't really have many that can handle the dual, the dual, the dual focus, because once you have the eating disorder under control, and then you have the substance, and if you get the substance under control, then the eating, so it needs to be handled simultaneously.

Speaker 1 52:27

Well, two last questions. I know we're almost out of time. One of them is, are you seeing any increase in gambling addiction? Yes.

Speaker 2 52:34

Yes. Oh my god, the online gambling.. I think I have an online gambling addiction, but it's like, yes, definitely, you know, the sports book. I live in Florida, so I'm doomed, but it's absolutely, yeah. And there's moneys set aside to, like, those online sports books, they have to put a percentage of their earnings into this pool of money, and no one really knows where that money is.

Speaker 1 53:00

Where is that? I'm

Speaker 2 53:01

looking forward to I see it on

Speaker 1 53:03

every billboard in Pennsylvania, and I always ask myself, where is that money?

Speaker 2 53:07

That's exactly right. So, no, that it's a big, it's a big issue, and we're trying to understand how that money is spent, because we're getting a lot of requests for gambling addiction, so, and gambling and gaming, and I'm looking forward to another pitch for the ACM criteria. The next book is going to be on other behavioral addictions, so looking, looking forward to that too. Well,

Speaker 1 53:30

one last question, because I want to go back to you, you know, the point about developing programs that have a longer tail and habilitation. Do you see provider organizations being paid to do that out of, like, their outpatient cap rate? I mean, is that yes, is that it'll be,

Speaker 2 53:49

it'll be under outpatient, it'll definitely be under outpatient programming.

Speaker 1 53:53

Okay,

Speaker 2 53:53

there'll be an ROI. I'm positive that there'll be an ROI there, but yes, we want these outpatient programs doing it in a residential setting, like we did under the therapeutic community model, wasn't, is not financially sustainable, but doing it in the outpatient space will, will make it far more sustainable.

Speaker 1 54:14

Well, one last question, and then we will wrap up our session. My question for you is, as you know, last summer they passed the congressional budget bill, the HR one. If you look ahead this year, all of the provisions of HR one are being implemented now. They should be completely implemented by next February. What do you think is going to be the biggest impact on the Sud?

Speaker 2 54:39

I hope that people that have benefits that are using their benefits for treatment don't lose them, and pushing people back out onto the streets would be, would be devastating, and cost cutting. We were barely helping providers make their margin now in doing addiction treatment, any costs, any. Cost cuts to the, to the Medicaid space, we're going to lose providers, and you know we have no, the plan has no control over it, because we're given the rate packages that we're, we're supposed to use. If we, if those rates go any lower, providers are not going to be able to sustain, and that's unfortunate.

Speaker 1 55:20

Well, I hope you'll join me in thanking Deb. We are.. this has been a really.. I've learned a lot, you know, on the Sud space and the Optum approach. I do hope everyone will check out Rick Academy, the online Sud community that is the sponsor of our keynote today. We have a power-packed day ahead, check your programs, Deb, and I will be in the room next door for a kind of deep dive. I like to call it Stump the Expert session. So, thank you all for coming, and look forward to talking to everyone today.

Speaker 2 55:52

Thank you.

Unknown Speaker 55:53

Thank.