

When Coverage, Quality & Cost Collide In SUD Care – What Leading Organizations Do Differently: A Caron Case Study

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Dr. Stuart Buttlair 0:03

Hello everyone and welcome. I'm Dr. Stuart Buttlair, Vice President of Clinical Excellence and Leadership at *OPEN MINDS*. Thank you for joining us. One of the biggest challenges facing behavioral health organizations today isn't simply delivering excellent clinical care, it's demonstrating value to patients, payers, purchasers, and the broader health care system. As organizations continue to move beyond fee-for-service reimbursement, provider organizations are increasingly being asked to improve outcomes, expand access, manage costs, and demonstrate measurable value. That requires a different kind of relationship between providers and payers, one built less around transactions and more around shared accountability of quality, outcomes, and sustainability. Today's webinar explores those issues through the experience of care and treatment centers, rather than talking about these concepts in the abstract. We'll look at how one organization approached the challenge of strengthening payer partnerships while remaining committed to the Clinical Excellence and their mission. Joining us today is Lee Peterson, Executive Director of Revenue Strategy at Caron Treatment Centers. Lee leads Caron's revenue strategy and payer partnerships, working at the intersection of clinical operations, reimbursement strategy, and organizational sustainability. His work is focused on helping Caron strengthen relationships with health plans while demonstrating value through outcomes, collaboration, and performance. Lee, thank you for joining us today. I'm looking forward to hearing about Caron's journey and the lessons you've learned that may help other provider organizations navigate this evolving landscape. I'll turn it over to you now.

Lee Peterson 2:23

Well, thank you for having me. When we talk about substance use disorder treatment, we often focus on the clinical innovation, the patient engagement, and the outcomes from that recovery.

And they're obviously the most critical factors. But in today's business landscape, we have to focus on delivering high quality care that also depends on how effectively we can partner with the payers to control and make sure we have access to that care. Historically, those relationships have been viewed as adversarial. Providers were advocating for their patients while payers were managing utilization costs. But today's healthcare environment, we have to change that approach. We need a better approach, a different approach. The most successful organizations are discovering that when providers and payers align around access, quality, and outcomes, and a little bit of accountability. Everyone benefits, especially patients and families navigating recovery. I look forward to coming together on this and I think we'll have a great conversation. Like I said before, this matters a lot now, and it matters a lot more now because of the increased focus people have on the bottom line and the tightening of the bottom line. We're seeing a great shift right now in the world, in the industry, where people are not willing to just throw money out to go to a top of the line care. They actually want to use the health insurance they pay for to get the benefits they pay for and they expect the same high quality care and they expect to use the insurance the same way they would for their health, their acute care health care needs. In our world today, we see so many challenges in provider-payer collaborations, and it's because of the relative infancy of our industry working with insurance companies. And even working with insurance companies is not a strong enough word for what we need now. We actually need collaboration. When we think of where we are for those of us who worked in acute care and also in behavioral health, we see a much more mature relationship that's created on the acute care side. And that's because largely, most large behavioral health companies have been working with insurance companies for 10 to 15 years, whereas there have been decades of partnership on the acute care side. We're still feeling each other out. We don't have generations of people who have come up always working with insurance companies. And that shows, especially in leadership and behavioral health, where a lot of times the people leading the negotiations are leading the partnerships, have come up as clinicians and are not necessarily seeing the world through the lens of a payer. So there's a lack of shared definitions held on here. Well, when we talk about quality and value, we're sometimes talking about different things. We also understand too that while we travel with the patient on their care journey. That care journey often extends beyond the reach we have with the patient at the time. We have an episode of care with them. They have a more longitudinal view as a payer where they're seeing us, how the care they get with us impacts their ED utilization, how they might have fewer inpatient stays outside of this. They're seeing a much bigger picture and we're seeing just the piece that we're controlling in front of us. We also understand too that in today's world, the payers world is changing. Frequently, employers are changing insurance companies on a yearly, if not, you know, bi-yearly basis. So that means that a patient who they're investing in care right now, they may not be around to reap the benefits of down the road. I think the other thing too, and the biggest thing is we have to understand too, that when we talk about what value is SUD outcomes are oftentimes very subjective, whereas a payer's definition value is definitely very objective. And so we need to find a ways to bridge that gap, to measure more specifically, more clearly what outcomes are

and how we achieve them or if we do not. You know, and we think about that different perspectives, the different perspectives of a payer and a provider, they're very different. I'm biased, I'm on the provider side, but I think that, you know, we focus tremendously on the care we deliver. That's the hallmark of who we are as providers. We see the patient and we're here to deliver quality and clinical aspect. We're here to bring families together. Our heart is truly with the patients and their families. I'm not going to come across and say that payers are heartless because they're not. They're good people that actually enable more care than we would have otherwise. But at their core, payers are insurance companies. They're about making profits and there's profit in getting patients to get the care they need. But they also need to make sure that they have access to quality and that the cost is good and that the member experience is good so that the member actually benefits from that care and it's not just treated like a commodity. It's a very delicate balance between how we deliver quality and how it's affordable and how that care is actually has a lasting impact. It's something that we don't spend enough time talking about the different perspectives. Oftentimes, I'll be at a conference or I'll have a webinar like this, and I'll be joined by a member of an insurance company, you know, your head of Optum or Cigna, and I'll ask them point blank, you know, "How do you define quality? What's your goals?" And it's truly, it's a balanced approach for them. They want the best access to care. You get that delivers quality. So it reduces that patient's trend of overall cost expense. Everything comes down to cost for them. And that's not saying that they're bad people, they're not, but they have to be good stewards of resources. And because of our infancy in this industry, we haven't always been the world's greatest at being good providers. We've had, we have some bad players in industry. We have to do a better job as good providers of policing. I give full credit to NATAP and the work they've been doing to make sure that ethical providers are spotlighted and unethical providers are, I don't say sanctioned, but you know, highlighted as well in a negative light. So it's something we can do to help make the care that we deliver as a quality provider stand out to everyone in the industry. And that helps reduce the bad players and it makes actually makes more resources available to the good players from the assurance side of things. Really a big point that we don't talk a lot about enough, I think we don't take enough accountability as an industry, is how we've allowed bad players to ruin the playing field for so long. And now we need to overcome that by being that much better. And a big part of that is building relationships and understanding the other side's perspective. You know, we see these things and they come through and a lot of times we see these things and we as providers see them at a very minute, very micro level. So I think about coverage decisions. You know, we're always saying, oh, this is super complex. There's individual placement. You know, we have to get level of care alignment. All these things where there's sources of failure. And the payers are saying, hey, we need to have policies that meet our employers' needs and wants. We have to have medical necessity rules and utilization criteria because they're bad players that will take advantage of the situation otherwise. You know, the more we understand both these perspectives, the more we kind of start seeing what the path forward is. We talk about quality expectations. We talk, you know, we talk about psychologists. We're talking about very much a subjective measure. We're talking

about engagement. How do you measure engagement? How do you measure a patient's sense of efficacy or a sense of hope? How do you measure their provider alignment and how they feel a sense that that provider's got their best interest in heart? You know, how do you measure how someone's doing in their support? How they're feeling supported? Those are things that we can say, this is a seven and now it's a nine, or is a three and now it's a five. These are things that are very much subjective, but from a payer perspective, they need to be measurable. They need to be things they can measure payer to pay or provider to provider and help us help them indicate who are the good ones, who are the bad ones. You know, we talk about outcomes, recovery, addiction itself is a chronic disease, not that different than high blood pressure, cholesterol, heart disease, diabetes. It takes a long time to measure the impact of this and the impact of keeping sustained recovery in place. From a payer perspective, they need a quicker turnaround. The outcomes must be timely. They have to be able to show return to that employer who's paying out for a residential stay or a partial hospitalization stay. That's significant cost, and they need to see how that payout is coming back to them. And for the fully insured plans an insurance company has where it's the insurance company's money going out, they need to see the longitudinal returns on that longer than an employer would. Reimbursement structures are amazing. I can talk all day about that. I'm a big old nerd when it comes to this stuff. I love how we've evolved our reimbursement methods. I've loved how they evolved, why they evolved, and I have a whole slide coming up later on that. But we have to remember too that the core behind reimbursement structures and how we get reimbursed is trust and we're going to touch on that a whole lot about how we can build trust and how we can kind of evolve how we're paid to reward trust, and I think that's a huge thing we're going to touch on in a few slides down the road. Care transitions is such a key piece to this, that where misalignment occurs. Because a provider says, hey, I offer these services and these services and network and the patient's mind during that time, but they don't always make sure that they're also accountable for the results that happen after the patient leaves their care and that can be done by another provider. One of the great measures and a great example of this is the focus that insurance companies use on readmission, right? Well, you can do a great job in residential care and you send that patient back to their home community, to someone else for IOP and that person doesn't continue on the programming, they don't engage the patient, you're going to see a relapse and that relapse may be tied back to a readmission from your initial state, not from necessarily the IOP state. So we as providers need to do a better job working with insurance companies to say who are the good players and partners that we partner with when we're not staying within our system for, you know, the less acute levels of care. If there are providers that we partner with for IOP and they're having, and we're seeing high readmission rates tied to them, we have to either work with those providers to increase their quality, increase their outcomes, or we need to switch where the providers we work with and partner with are, because the more we raise the quality industry, the better off we all will be, and the better off our industry will be, and will thrive. So a lot of times we talk about value-based care and value-based care is the absolute where all of these things come together. Everyone wants to define value. I love value. Value is so subjective in the eyes of

the purchaser. And in our industry, who's the purchaser? It's the patient. Patient, the patient's family. But who controls access to that purchase is oftentimes the insurance company. So we have to make sure that our value meets the criteria for everyone. It has to be clinically. It has to help promise and deliver on that promise to deliver sustainment of recovery to that patient and their family, but also it has to be now appeal to the payer's definition of value, which is, does it cost according to what the benefit is going to be? Is it reasonable in cost? Does it produce measurable outcomes that we can be held accountable to? That's now of a sudden, it's not just an AB conversation, it's an ABC conversation with three parties that all have to be involved. We have to have decisions that are made that are not just one-on-one conversations, but also our patient, provider, and insurance company, all three in a giant triangle where we can't team up against each other. We can't put the patient in the crosshairs. What we absolutely have to do is say, this is the way that we deliver clinical effectiveness in a cost-effective way. A great example of this and the reframe it takes is if you think about the traditional approach to a patient going from residential to partial. Historically, places aside, hey, it's a 28 day model and if you, and they set that expectation of the patient that you need 28 days. Well, not every patient needs 28 days and that kind of is a cookie cutter approach and I'm biased, but I think that having personalized care is the better approach. Well, personalized care means that you have to check in frequently and say, hey, where is the patient compared to the clinical standards that define each level of care? That can't be 28 days. It may average 28 days. That's fine. But what it needs to say is, hey, as you're progressing in your recovery and you're getting more stabilized, we can actually move you from a place of less clinically managed care to more self-managed care. And that's what this looks like. That is the, it's really not a step down. We always call it a step down rate or a waterfall. But really, it's a graduation. The patient is graduating from a level of needing more clinical care to more self-managed care. And that's the goal for all of us. You know, we think about, you know, heart disease or diabetes. Diabetes is probably the best example I can think of. You know, a person goes into like a diabetic shock. They might be in the hospital for a while, but as they get better at managing their diet, better at managing their insulin and their blood sugar goals. All of a sudden, they're able to be more self-managing of the disease and are able to go back and transition. Now, because it's diabetes and there's blood tests and things, usually the transition is faster than with behavioral health, but the same tenants of moving from a clinically managed position to a self-managed position are entirely the same. We also need to make sure, too, that our payments evolve to match these. So on the next slide, I have probably my favorite slide, which is the value-based spectrum. And I'm going to jump to that slide real quick. I could talk about this slide for about an hour. I'm going to try to keep it to 5 minutes so we all don't get totally bored. But I absolutely love this slide in this deck because it shows that where we want to go is we want to be paid for outcomes. Anyone who produces outcomes wants to be paid for them. Where we are right now is still largely fee for service. We're paid to do more. And if you think of the evolution of health care, the evolution of behavioral health specifically here, let's walk through where we are and where we've been and how we're going to get to the future. Where we started with insurance companies and we started partnering with them, even before

we started partnering with them in contracts, was seeing their patients in an out of network place where we would send them our claims that listed everything we did, every lab, every charge, everything we put in there. And we tried to make those charges as high as possible because we get paid as much as possible, right? We wanted to make sure they knew everything that was happening, and everything we charged for was everything we got paid for, so we made sure we charged for everything and we got paid a percentage of charge. It could be 100% charge, it could be 50% charge, whatever it was. But if you think of it as a game, the way we earn more revenue is by charging for more and doing more. There's nowhere in that equation where we're saying necessarily getting paid for doing better quality. So, if we think of it as in a kind of a parallel example. If I'm making birdhouses, I'm paid per birdhouse I make. It doesn't matter how high quality the birdhouses are. It doesn't even matter if the birdhouse is standing a day after I'm done making it. I made a birdhouse, I get paid for it. If I'm the, if I'm the payer in that situation, I don't like that because I want to pay for quality. I want a, I want a birdhouse that's going to stand up. And so I started saying, all right, well, I'm not paying for everything. I'm only paying for things that provide value. So we start saying, all right, there's a fee schedule now. This fee schedule is because these are the services that provide some value. And so now I'm going to pay you for each step of that pathway, every step of building the birdhouse. I'm going to pay you for the nails you put into the birdhouse. I'm going to pay you for the different pieces of wood you use to build the birdhouse. And the theory being the more of these you do, the better the quality of the birdhouse is going to be. And so I'm not going to get a birdhouse that's, you know, taped together. I'm going to get nailed together walls and it's going to hold up better. And that's great. But now I'm just saying, well, my best bet is to, you know, put more nails than ever in each birdhouse and not necessarily make more birdhouses, but just do more in each one. Again, not about quality, but doing more. So then the industry evolved. In this case, it's to a per diem where you were saying, we're gonna pay you per day that the patient is with us. This is where a lot of behavioral health providers still are. It's still, it's a step towards fee for value, but it's largely still fee for service because you're paid to keep the patient longer. It doesn't matter what you do in that day. It doesn't matter how intense they are. It doesn't matter how easy. The goal is we want as many days as possible. And that's why you see a lot of times in this industry we see a large focus on what's the length of stay. Not the length of engagement, but the length of stay. We need more days at these levels. If, if you think about, if we kind of take a step back and detach from that, a conflict, this is where a lot of conflict between payers and providers come from is because the payer is saying you need to be more effective and efficient in your days, and let's move the patient to the next level of care. The provider's saying I get paid at this, I need more days, and they might, but there's a battle and the patient stuck in the middle. And that's not the triangle we want where we have three decision makers. It's a fight over where the patient is placed and that's not a great one. It starts becoming, well, this provider is not delivering enough value, not moving your patient through, or this insurance company doesn't think you're sick enough and needs to move on. It becomes a two versus one approach, or really one versus one with the patient caught in the crossfire, and that's not a good place to be. Kind of skipping over

APCs and EAPGs, which are ways that a lot more acute care systems kind of group care together to help bundle services. We jump to case rates and case rates, I think, are where a really a sweet spot for a quality SUD provider because in a case rate, you're being paid for delivering an outcome. Love that. The patient comes in for a residential stay. Here's your payment from the insurance company. You manage it yourself. I worked for an organization before Karen, where we moved our largest payer from a per diem to a case rate, and it was amazing. We always heard beforehand about how selfish the insurance companies were and how greedy they were. We moved that largest payer to a place where we're managing the days and our average length of stay actually was reduced. We got so much focused on how we could move the patient to the next level of care and it became less of a financial decision for us and we saw more patients moving from residential to partial, where it was not included in that case rate. But we also saw higher people saying it was sustained recovery following because they were able to better have the care match where they were on that self-management, Clinical management kind of exchange, we were able to see better clinical results because we had the care now instead of focused on number of days and being on 28 days, we were focused on what the clinical symptoms were and that was amazing to see. I can't stress enough that when you have a trusted relationship with an insurance company, you can move to case rates. Another thing that gets in the way of case rates and makes people stay in per diems, kind of going back a chapter, is that per diems are needed by the insurance company to match the authorized days with the days they're going to pay for. Because providers are have been historically bad about just trying to maximize days. A lot of CFOs will tell you, hey, you have to look at all the days you're not using the days you're leaving on the table. I just I agree that you need to look at them. I disagree that you need to maximize that or maximize the number of authorized days you're using. I think what you can do is say, if we're not using them and we're moving patients to the next level of care and we're leaving authorized days, we should state that to the insurance company. Hey, this patient's progressing faster, better. We're going to move into this next level of care and use that as justification to go to a case rate. The beautiful thing about a case rate is this. When you have to do an authorization on the front end and not authorizations every three to seven days, that means for you, it's three to four less calls you're making to get days authorized. It's more certainty of the patient in a time when they're in turmoil and their family's in turmoil. It's more knowledge that they're going to be okay and they don't need to be worried about being kicked to the next level of care. We're going to transition you as we see best with that focus being on the next level of care and not on where we are right now, and from an insurance company perspective, every time, you know, we pick up the phone and we call that insurance company and get those days authorized, there's someone on the insurance side who's answering the call and picking that up. That's extra cost, extra administrative burden. That's on both sides. It's not delivered, not closely tied to care being delivered, just being an extra burden that's on there because there's a level of distrust between the two organizations. And it doesn't mean those two organizations specifically, but in the industry. So as we can evolve that and we can say, all right, let's move more to a case rate where we're not fighting over the days, but we're saying this

patient's with us. There is value in bringing that patient from point A in their life to point B. We can't always define where point A is, but we can say, hey, this patient is this sick in order to qualify for this level of care. We agree on that. And we can agree on what the clinical criteria is for point B. Moving them from point A to point B shouldn't get paid differently because it takes longer or shorter periods of time. It should be paid based on the quality of the care that patient receives. A way to kind of supplement that and help build that argument is even further than the right. We see pay for performance. I love pay for performance because it builds clinical alignment. I have yet to see a good P for P programs, as I call them, because it's a lot easier to see the say in the real long word performance, which I'm just tripping over nonstop. And I say the beautiful thing about this is that you have clinicians in the room. Clinicians often agree a lot more than the business people do. Clinicians want to see the same thing. We talked about before about that alignment. Clinicians have the alignment. They know what quality care looks like. They may disagree on some of the minute details, but they know firsthand oftentimes what it looks like when a patient comes to a care provider with their life in disarray and they know the hope that exists and the better life and the better relationships and the better health that comes when the patient then has is in recovery, sustained recovery. So they both want to get there. So at a high level, there's agreement. That's awesome because when you get to focus on that and you get to focus on talking about how the organizations are going to move towards that common goal. All of a sudden, the patience is not in the middle of a tug of war. It's now the strong triangle with all three sides working in the same direction. Even if that patient side of the triangle is changing over, you know, every month, every three weeks, however long, but that all three little parts of that triangle are in alignment and that is awesome. So we see a lot of organizations, they'll go from a contract rate, usually for per diems, and sometimes they skip ahead to pay for Performance, and they use that as justification to go to a case rate. I love it. The next step that really is the evolution that we're seeing some companies do, not a ton, is what I call TCOC, or affordability, total cost of care perspective. This requires the insurance company to share information with the provider and requires the provider to put on an insurance hat, which I absolutely think is amazing. I love at conferences when I always hear about how evil the insurance companies are and you hear people talk about how much the insurance companies don't care and they just don't get it. But truthfully, and I hope this webinar is being seen by a lot of providers, think right now how many clinicians the insurance company has. I have yet to meet an insurance company that doesn't have at least one or two or a couple providers, you know, clinicians on their side that have been in our shoes. Now, think about the provider side of things. How many of us have actuaries, have people with insurance experience that can understand their perspective? Not many, and so when we need to truly be a good partner, we have to be able to walk in other shoes. Total cost of care forces us to do that. It forces us to look at all the expenses tied to our patients, both before they come to us and afterwards. This helps us identify the best care paths. That doesn't necessarily mean levels of care. It could mean the partners, the external partners that we work with that can drive results. I was amazed at some locations where at a previous organization, I haven't seen it yet with Caron, where we would have a patient

who had a bad IOP, we had a bad IOP partner we sent someone to, and then the next thing we know, they're relapsing and they're going to a spotlight place where it's out of network and a quarter \$1,000,000 of cost. Now, from an insurance perspective, that episode of care started with our residential stay, which is nowhere near a quarter \$1,000,000 of cost. But because of that stay, the IOP, and then that readmission for a lot more, when they did their analysis, that patient entered in SUD care with us, is super expensive. That's not fair to us, but of course, we didn't have quality checks all the way through with all of our affiliates, everyone that we referred out to, and that process quickly changed because we had to be a good partner to our insurance company. And what's funny was when we actually did better checks and did better quality controls of who we referred out to. We had better quality scores with the insurance company and we actually looked like we were doing a better job of keeping things affordable and we were able to justify higher increases in our rates. And it cost us nothing because it was all about controlling where we send to externally, who we partnered with. It saved the insurance company money and thus led to us getting paid more, but it didn't cost us anything, which is oftentimes people think, well, I have to give up something in order to get something. It's why you see these bad providers that go and say, well, we have to bank on having a 20% readmission rate so we have continued volume. That's an unhealthy mindset. A much healthier mindset is to understand that we live in an ecosystem, and everything we do impacts everyone around us. And once we start having that viewpoint. We start seeing that the partnerships with the insurance companies are much, much further driven. I do want a specific story about Caron's journey. And if we go to the next slide, I can walk through that. You know, for those of you who are unfamiliar with Caron, we've been around for seven years, nearly seven years. And largely, we're self-pay, largely self-pay to, I'd say, a, we call it signature crowd, a patient base that would go out and pay significant money for a very intensive, neurocognitive approach, and very high quality care. But what we found is that we're not helping everyone. As a nonprofit, our job is to help as many people as possible. And by keeping our doors only open to self-pay, we're limiting access, which means we're failing our mission. So we said we need to, we need to change. We need to be a much better partner. And so long before I got there, they started working with some insurance companies. So we're going to do this and, the goal was right, the execution left something to be desired, but we started with case rates. We're gonna get paid a case rate, so we don't have to spend the time fighting over all the all the different per days, we don't have to be patient in the middle, best of intentions, but what happened was they never took the time to build that build that foundation with the insurance company to say, what does quality look like? You know, we'd use going from point A to point B example. That's so critical in a case rate. We never once talked about what are clear definitions of point A or what of the entry specifics for a level of care and what are the clear measures and factors that lead to the next to them transferring to the next level of care? That kind of, like how it was dating. Like if you think of a case rate as being married to an insurance company, because you're not, there's a trial of trust. Both sides, you have to date and build that build that relationship. Not only that, literally, my wife would kill me if I if I was saying telling everyone I needed, I'm dating a bunch of insurance companies, but I truly believe

you have to experience trust. You have to have those kind of ups and downs where you work through problems before you can jump into that case rates scenario. So what we said is, you know what, we need to have better access and we need to be willing to kind of go through the process to build that trust. So we did that. We started building with insurance companies. We started saying, all right, we're going to be very open. We're going to listen to the good and the bad you have to say about us, and when we're going to go from that, and we're going to do better. So we started this. We went from basically having contracts with Blue Crosses and Aetnas to as of now, every residential location is in network with many regional plans, but also the National Blue Cross networks, Aetna, Cigna, and Optum, United Healthcare. And that comes from having communication with the payers, understanding what's expected, and making sure that we deliver. We had them on site. We also let them teach us what they're seeing so that we're able to better to be a good partner. And we always say we don't want to be just a network provider. That's a name on a list. We want to be the partner. And when you're the partner, that's the one people want to work with. It was absolutely, absolutely critical. And on the next slide. An example of how we kind of came together with Optum and really had a huge, huge impact. So Optum came to us actually almost two years ago now and said, one of the things that we really need are SUD services. We don't have a great place in the northeast quadrant of the United States for that. Now, Caron had previously had a team program we shut down years before, and, but they came to us and said, we really need you to reopen that. Now, as a, you know, I'm on the business side of things, but I can't imagine a customer coming to me saying, hey, we want to pay you for this. You have history doing this. Can you do more of this? I mean, that's a dream scenario. And so we had a strong relationship with the individuals at Optum so that they knew they could trust us when they shared with us their weakness, their struggle. And it came from knowing that we would do everything we could to make it work. So what we did was we opened, we reopened our program for our youth, their teens. And it's amazing. Today, we have 20 patients in there right now. 20 patients. That program was shut down and we'd had zero of those. But right now we have 20 and they're not all optimum. They're paying for it. Other insurance companies love it too. In fact, some told us how upset they were with us. When we shut it down, we didn't listen to them when they told us that. And so now we have this additional revenue stream of 20 patients, which is a pretty strong census. Because we are willing to listen, and what the lesson that we learned that we took away from this that we've been preaching internally is, you get to that point not because, oh, we're special. We get to that point because you build a relationship where you're open to feedback with the insurance companies, you build the level of trust and you can say, what can we do for you? Think about that sentence for a second. What can we do for you? How can we be of service to you as the insurance company? Not just the patient. We say it to the patient all the time. How can we help you? But how often do we as providers say that to the insurance company? And when we do that. Not only do we avoid problems of tomorrow, we also identify the opportunities tomorrow because now we're a trusted partner. That's a huge thing. I mean, I can't think of any business that would say, I really wish my customers would come to me and stop telling me ways they can give me my money and give

give me their money. That just doesn't exist. So I really can't stress enough that really, really, really building that relationship, it's not for just today. It's great when you have those connections and you can say, oh, I know who to call to get this claim paid. That's fine. That's still a transactional relationship. When you're talking about transformational relationships, you're saying, I want to go to them when I'm having a struggle with this. I'm having. We're seeing some potential growth opportunities. We want to know the best way possible to build something. When you make the focus on how you can help the insurance company as much as you can help the patient, that's when things start really taking off. And that's a fun place to be. So I'm really proud of this relationship we built with Optum. I'm really proud of how it's already manifesting and a lot of people getting help, and a lot of families receiving care that they truly, truly benefit from. Because that really kind of kind of speaks to my going from what we can do for you. You know, we talk about, I'm gonna start in the middle with organizations that struggle. You know, there's a winner and a loser is the best way of saying it. Who won this negotiation? You know, who is trying to get the every dollar out of this thing? You know, we don't, and you don't have ways to measure success other than what the payment rate is. It's wholly transactional. I think what successful organizations understand is that how the payer is thinking about things, what means to them, and how you help support that. Another thing that a lot of providers are slow in recognizing is that your payment rate, the part that you're arguing most famously with insurance companies, is just one-third of how you actually drive revenue. The other two-thirds are the number of patients you're able to see and how long you're able to engage those patients in your care. Those 3 factors are what drives your revenue. So only to make things all about the one-third, you might lose the other two because you're being so combative and adversarial. So the key take away I have with this, what drives success is collaboration. Collaboration. Seeing the overall big picture, not just focusing on the one little number on a paper where there's one person gets what they want, the other one doesn't. But find that balance where you can have access to care, engagement from multiple levels of care through the insurance companies and a reasonable rate. That's what drives success. It's not about maximizing one number on a sheet on a contract. It's not that at all. It's about how can you build that overall relationship so you can be as you can help as much as possible and as you can help each individual as much as possible. That's what is absolutely driving things. Jumping to this in a little a different view on the next slide, we have a diagram that kind of shows these these relationships and how the triangle of the relationship. So if you could jump to the next slide, please. Here you see it, we have patients, providers, and payers, and they're all sharing the accountability. You know, the patient wants quality. They get that from the payer. The payer can provide affordability to the patient because they're not, they're offering a discount because they're using their insurance and they're responsible for their out of pocket, not their full cost of, you know, everything, including what is discounted to the insurance company. The provider is giving access to that care to the patient and also providing outcomes. That's critical. And so when we start doing this, you start seeing all three parties sharing in the accountability, sharing and moving things forward and taking responsibility when things go sideways. And when you do

that, the one who benefits the most is the patient. That's very clear. Because when this goes wrong, generally it's the patient, again, in between the provider and the payer being tugged and not knowing who to trust, and a time when their life is in crisis, that's the last thing they need. So if the provider focuses on making sure the patient's taken care of and making sure that the payer is respected and the payer is, you know, you're a good steward of the payer's resources as well. All of a sudden, all three are thriving. And I say that, you know, I'm saying this and people are probably shaking their heads saying, yeah, Lee, but you're putting everything in the provider's corner. I am, because I'm in that provider's corner, and I can only control what I do. The patient, the patient has to have insurance. You know, the patient has to know which provider to go to. The patient has to work with both and they have to know how to interact with both. That's something that not everyone has. I can't tell the patient, you need to do this. I can, however, as provider, say, what can we do to educate the patient so they know how to interact with the payers? They know how to ask for and advocate with us, you know, we can educate them, we can only control what we do. I can't go, I can't, I can put on a payer hat and say, this is what I would do as a payer. I would, you know, educate my patients on what to expect with all different kinds of care. I would tell providers exactly how they need to deliver value to us and what it has to look like for us to optimize that. But the truth is, as a provider, I can tell you how I as a provider see this relationship and what I expect them to want, but I can only can take control for what we can do as providers. So a lot of the stuff I'm saying here is definitely driven from a provider point of view, but it's because that's the part where we can take ownership. I love this because this is at the core of everything and this kind of speaks to the the clinical nature that we that we as providers just absolutely. We're strong in is understanding relationships. We help our patients with this almost every day. What kind of partnership we want and it should be really called instead of strategic, it could be called transformational because I think that's a better word for it. Because when you think about transactional relationship, there's a winner and a loser. It and it's done in a micro level. You know, you have. We got this authorization or this payer is giving us 23 days instead of 22 days on average. And it only and things only rise up when denials get out of control or when authorizations drop down and there's problems and every time you meet, you're fighting about something and you're always afraid of, you know, we can't let them know what we're doing or they're gonna they're gonna shut it down or they're gonna take away. You're hiding something. It's about a winner and a loser. In the strategic or transformational relationship, we understand that we're entering this partnership with an insurance company and the contract mainly stays for a one year term or three-year term. But truly, we're planning on being in this relationship forever. And that means that we can't have a winner and a loser because it's going to lead to an eye for an eye approach and someone's always going to come back for the other one. We have to focus on how we can all drive things forward. There's a pacing. There is a way that we can. We can all win. I know a win-win scenario is traditional business speak, but it's true. You know, we talk about what each side needs from a value perspective. That's how we can drive and transform these relationships. We can talk about what success looks like and how they how there's overlap in those categories. And then we honestly have good discussions about

what's going right, what's going wrong, and what are situations where we're confused. It's real easy, you know, when we have a situation where we're not seeing eye to eye to say, well, they're wrong, they're not doing what they're saying. Maybe we're just not using the right words. We found that out with a payer where we're noticing that we were not getting authorizations up front, and it was shocking. Like, we were like, what's going on here? Like, we were getting, you know, 10 admissions and authorizations a month, and all of a sudden, we were almost seeing like one or two, and we're like... What happened, you know? So we had a conversation with him and we said, what are we not doing? Not why did you change your criteria? What are we not doing? And they said they didn't know. And so what we actually, what they ended up doing to help us was actually they gave us the criteria they had for admissions. Now that was an amazing gift, and it came from a place of trust. And, but what we were able to do is say, hey, we're going to, we're able to go forward and say this is the criteria that we need to have for each level of care. And that's going to make sure that we bring the patient forward that meets that criteria. It also meant that we could use the key phrases at key times to help drive the success. And that came by learning the insurance company's perspective. This is how we build that alignment that works. Define shared goals, define the measures that kind of support those shared goals, and then producing the outcomes that are there. It's all, you see, we're building on this right now. When we define the goal that's shared, all of a sudden we're moving in the same direction. The quality measures, I wouldn't say have all of them, and that's sometimes the problem with the clinicians I work with is that they want to measure everything. That's great, but let's have three. Let's have three that we think are actually gonna move the needle. And then we focus on those outcomes and we measure on them. We measure on them and we meet frequently. That doesn't mean we're meeting every other day. It could mean we're meeting quarterly even to see how things are going and having discussions to see what the trends are going on. And there should be incentives for both sides. And I know it sounds like what you want payers to pay the insurance company or you want providers to pay the insurance company. No, not at all. But I do think that if there is progress that delivers better outcomes, that's a benefit to the insurance company. They see that. In turn, there should be some reward back to the provider. It needs to go both ways. And finally, there needs to be accountability. If things go sideways, actions need to be taken. Things need to, it can't just progress into a fight. It's easy to get along when everything is going swimmingly, but you really test a partnership when things go sideways. So I'm big on that. On the next slide, some steps that really initial steps that help build those pay relationships. You know, you have to understand the value of data. You have to be able to understand what builds access, what builds engagement, what builds those clinical outcomes. Be able to see utilization, how it impacts not just when they're with you, but when they're outside of you. What that continuous nature of the care is, how they're going, how you're following up, and what that experience is. You know, are you engaged in the family? All, that's so critical. And data is the key thing because it's how you communicate back and forth. When you start thinking about transparency and data sharing on the next slide, we talk about transparency being the foundation of trust. You know, we have data sharing. It creates a common language. If we're

saying the right things and we're both understanding things the same way, all of a sudden there's no misunderstandings of what's going on. Also, if we can both see things the same way, oftentimes we can understand where the patient journey is breaking down. I go back to that referral partner example where we would never have seen that. We would have just said, what do you mean we're expensive? We're not super expensive to the payer, but the payer said, hey, this case skewed the data because you didn't have the patient journey completely mapped out and completely effective. Understanding your data and sharing your data and learning how the other side sees it is such a valuable tool to building a strong relationship. It's how you communicate. It's how you move forward. So let's jump to the next slide. I know I'm getting long-winded here, but I really want to talk about partnership structures that work. These are things that you can focus on, making sure you have them and making sure that if you have them, you're doing them the right way. Value-based contracts, defining the definitions. Sounds so simple, but it's so key. Understanding how patients are attributed to your model, if there's a cost model at all in there. Understanding is it done when a patient, if you have a residential or detox, is it done when anytime a patient hits your care, it's easy in acute care because you can say, hey, we're going to go where your primary care, your primary care professional puts you. But in our care, we're specialty care. Do we need to be better at understanding how we define an attribution model? We're talking about bundled payments. Let's make sure we're clearly defining what's included and what's excluded and when they're included and when they're excluded. I think of the pitfalls of labs and pharmaceuticals not being included in a per diem or being included in a per diem and how that can drive things from both sides, with a cost perspective and a payment perspective being absolutely critical. You know how we're going to handle care transitions. There are great organizations out there right now like Navigator that are really helping make sure that these are taken care of. Engage in them, engage with them. Make sure if the insurance company is using those and has care management services that you're partnering with them. You're not sidestepping or ignoring those emails. Making sure that when the quality initiatives are there, that P for P is set up, that both sides see the value in them. They're not just doing it because they're saying it makes sense and make sure that both sides benefit before taking on financial risk. Again, Coordinator Care Management speaks with the care transition partnerships. Both are so important in this complex specialty care arena we live in. We absolutely have to, have to, have to be building this to make sure that we're taking care of patients, not just when they're with us, but afterwards as well. On the next step, we have some initial steps you can take to really help drive that. There you go. Let's look at where we're currently at with payers. Talk internally. You know, see, do a quick inventory of what are the contracts, where are the points we talk to them, where are the friction points, what are denial patterns, and how do we talk to them? Oftentimes, we don't do this stuff, and it's very important before we even go out and talk to the payer with the insurance company, we actually understand how we fully interact with them. If when you have that mapped out, identify a problem, start small. You know, let's figure out one way we can improve that relationship and build on that success. Have that value story that you then measure on, you tell the story of so you can further that experience and you can build it better. Let's agree

on a scorecard. And it can be one that you create, but also ask them to make one for you as a provider. It only shows you how you're doing. Again, regular meetings, communication is so key. Have those regular meetings. Don't just meet when something's going wrong. Don't just meet when there's a contract up. Meet to check base, meet to make sure that, you know, everything's going well and know that going well is a great thing. Things going sideways, that's an opportunity. If we can do these things, we're really going to drive better pay relationships that matter. Let's end up taking out a step. Let's jump out to on the next slide, we're talking about what a five-year outlook looks like. If we do these things, what's going to happen? We're going to have more emphasis on outcomes, accountability, total cost of care. You're going to see payment systems that actually show more trust. You're going to have more fee for outcomes, less fee for service. You're going to have more understanding of what longitudinal engagement looks like, how those care transitions are so important. And if you look at the post-acute outcomes, how patients avoid hospital stays that are very costly through using residential partial ILP. I think if we understand that and we start building that framework of infrastructure of data and analytics, We're going to move the industry in a much, much better, much better way. Let's understand now our our capabilities to build now. What, what we what we need to do? We need to understand how we can build that data capture and reporting skills so we can build on our outcomes, how we can define our payer strategy and say, what are the opportunities we have to build that? Who's in charge of it? Who interacts with them? Oftentimes that includes not just payer relations person, but also the UM team, the admissions team, the business office team, then find ways to partner together. Looking at care coordination, understanding where the insurance company would like to see patients go. That's huge. Understanding how we model things and how it governance. And the final thing that I can't really stress enough is being able to tell a story. You know, when we transition and we take Caron's clinical model and we push it into a pair relevant model, we're able to now align things totally and we're able to get more patients and more engagement of those patients through engaging clinical personnel on both sides. If I can leave you with one, one overarching statement, one overarching thought and mantra, maybe what's on the next slide here, and it's that we shouldn't strive to be a network provider. We should strive to be a network partner. And if we jump down one more slide, you'll see what that's built on. It's built on trust, transparency, accountability for both sides, and working together to solve problems. If we do those things, we will absolutely drive the industry forward.

Dr. Stuart Buttlair 59:11

I think that was a pretty complete discussion, Lee. So the questions for you, more practical, I think, in terms of what Karen's done. One point I thought was particularly important was that providers and payers often share the same goals, but define, you know, success differently. Was there a specific point during Caron's journey that you were involved in that where you saw that that began to shift? You know, and along with that, really what helped move the conversation from negotiating contracts to aligning around outcomes and value. You know, what specifically happened?

Lee Peterson 1:01:16

That's a great point. You know, we were very fortunate. We had John Driscoll take over as CEO. And John came to us from, you know, a long experience at another organization. And he made it very clear that in order to succeed, we could not keep fighting insurance companies. We could not keep, you know, calling favors from that board level to get things done. We had to be sustainable in our own right through our actions. And that meant not bowing down clinically, but it meant working to really help drive excellence through working with the insurance company. And it's true. I mean, if you think about historical 28-day programs, and Caron was one of them, it's a really big jump for that patient after that 28 days, and they go back to their home community or they go back to ILP and there's a big step between residential and ILP or another level of care. We were able to really say, you know, one of the good things that came from our partnership with insurance companies is how it's forcing us to treat care more as a transition and understand that those handoffs have to be so some would have to be so well orchestrated and we have to make sure that the patient is taken care of while they're with us and that we keep them engaged because this disease is is horrible. It, you know, it does not take much for a patient to relapse and then kind of and slip backwards. And we want to make sure if they do relapse, it's a relapse and not a collapse. And that comes from having an engagement that where there's never a big gap between what the patient needs and the love of clinical management we're able to provide.

Dr. Stuart Buttlair 1:03:01

So, Lee, what did you all need to show the insurance companies to get their agreement to move to a different type of relationship? You know, I'm sure that a lot of what you all did, you know, in terms of thinking about your processes, made a difference, but what did you actually need to show them to move them into a different type of relationship with you?

Lee Peterson 1:03:28

You know, that's a great question, a phenomenal question, because you have to give away the tricks of my trade, but one of the things we really did was we owned. We owned what we did wrong. It's funny. We, you know, we think of the 12 steps is only a recovery tool. It's not. It's a relationship tool. First thing we did is we had to make a listing of our, we had to make a listing that we were powerless and we had to change. And when we embraced that and we took ownership and we showed them, here's what we're doing now. We invited them. We again, transparency is key. We invited them to our campus to walk through and interact with our clinicians. I think one of the great things we did was we let people like me talk less and we let the doctors talk more. And it goes to show, and I truly believe Caron is one of the very best organizations in the world at treating this. One of the worst things we could do is have people like me lead treatment. It should be the doctors and the clinicians who are smart doing it and to help me help us best partner with insurance companies by understanding their positions. We just basically did more of that. I got out of the way and we just let them talk and it was amazing

how much better things got when that happened.

Dr. Stuart Buttlair 1:04:59

So thank you for that and for sharing the specifics. And and so, you know, I'm wondering, you know, as you look ahead, things are changing, you know, in terms of reimbursement and federal government, state governments, and our situations with payers right now. So, you know, how do you see the payer-provider relationships evolving over the next three to five years? You've talked about a number of different models of ways in which you can work with the health plans. So I'm curious, what capabilities do, you know, you believe provider organizations should be building now to be successful in that future as things begin to change and that they continue to need to be sustainable.

Lee Peterson 1:05:53

Again, huge. You're asking the best questions. I appreciate that. I'm a big believer in data analytics. I mean, you're just an absolute big believer in it. I think we have to be able to critically show ourselves what success looks like and what are the common factors in that. We need to be able to and to do that effectively, we need to increase our ability to have longitudinal research done on a outcomes basis for us as a provider, which means engaging in alumni services, engaging organizations like Chess Health that really help patients engaged in outcomes reporting to us. So we can say, hey, what's going right? What's not going right? Making sure that we can measure the various steps and pathways and pipelines that patients go through so we can optimize care and learn from where we're at right now, keep studying ourselves and not assuming that we know the answer. It's funny, for this industry for years and years and years have fought this battle. We're healthcare, we're healthcare. Well, we won that. We won that in a big way. And now that behavioral health and SUD care is truly part of healthcare, with that status comes a really great responsibility to help keep furthering how we deliver care. You think about cancer treatment. 40 years ago, it was a death sentence, maybe 50 years ago. Then all of a sudden, okay, we can cut it out or we can treat it with chemicals. And now we get drugs that come in and just precisely eradicate the cancer cells. We as SUD treatment need also evolve. And we've done some steps in that. You know, treatment doesn't look the exact same way as it did 40 years ago. We've got M18 now. But we need to evolve that even further and say, hey, what's going on with the brain? The brain, you know, we're always told, hey, you're going to burn those brain cells up and they're gone. I'm learning that, you know, and thankfully for me, that it's not that way. There's neuroplasticity. Your brain recovers. Let's focus on that organ and see if we can open up the next, you know, the next frontier of this treatment and help evolve because that's our responsibility now that we've won that battle of being part of health care.

Dr. Stuart Buttlair 1:08:11

You know, I really liked one of the things you talked about in your presentation about really

understanding your own organization, understanding where you're coming from, taking a look at your side of things in terms of responsibility and accountability. As part of that, a lot of organizations, particularly nonprofits, to go into these type of negotiations with providers, with health plans, they may not need to know, they may not know their cost structure. How did you move that forward in terms of understanding your cost structure to make those types of agreements with the health plans. Can you say one or two things about that?

Lee Peterson 1:08:59

Yeah, first off is, I'm not, I'm not some magician. I'm anyone that works with me to tell you I'm not some accounting superstar, that's for sure, but I think you can just be practical about this. I mean, you understand you've got, from a business standpoint, you've got some overhead, but walk through the steps of a patient, walk through the process of being a patient, see what costs they actually incur, and you'll find out that from a lot of behavioral health, a lot of SUD health especially, it's not variable cost, overhead, and the way to then to actually benefit as an organization increase your margin is to see more patients, to get more access. Even if you're not getting paid as much per patient, you get more patients because that overhead doesn't increase. And again, I'm not an elite business mind despite what people may say about me, that I pay them to say about me, or they pay me to say about me, but, it's about understanding your overhead versus your variable cost. And I think it's as simple as that. And even if you can't get the exact number on it, walk through the process of a patient. Think about this. You know, are you hiring a new counselor every time you get a patient? No, you're not. Are you? Sometimes you're not even making more food in the cafeteria. You're just actually just feeding one more in there. The cost of taking a chance on helping someone, it's small. You have to have faith in that and that's not a small thing either. But, and understand that a patient that you help. The payoff may not just come in the payment from the insurance company, the payment from them. The payment may come when they become a counselor or they become a referrant themselves or they become a donor. And sometimes, especially, and I, Karen is a large nonprofit, so I feel very comfortable in saying this. Sometimes we don't make money on patients. We don't get paid at all. But you know what? We're serving our mission, and that's what a not-for-profit stands for, is serving that mission. Again, I'm on the business side of things, so sometimes we see things more transactional, but I couldn't, I don't think I'd sleep well at night. If I were for a company that focused on this is what we get, this is what the return on each patient is, it was dollars and cents. It has to be more of a mission and it has to be, and that's one of the great things about us is that if we take a chance on a patient, we may not get paid in 90 days. I mean, I don't want to say oops, no big deal, because it is a big deal, but that payoff could come back tenfold a year down the road, two years down the road. And that's what makes these organizations so great is that we're not so short-sighted to find success at the end of 1 transaction, but let it, let it, let the tree grow, you know, and let's see what fruit comes from it. And I'm really proud to be working for an organization that believes that.

Dr. Stuart Buttlair 1:11:18

Lee, thank you for sharing your experience today. One of the important takeaways from today's discussion is that successful provider-payer relationships are no longer defined simply by reimbursement rates or contract terms. Increasingly, they're built around shared accountability and relationship for access, quality, outcomes, and long-term sustainability. The care and experience demonstrates that organizations willing to invest in collaboration, transparency, and measurable outcomes are better positioned for the future of behavioral health care. Thank you to everyone who joined us today. We appreciate your participation and encourage you to explore Recademy's growing library of webinars, executive briefings, and practical resources. We hope you'll join us again for a future Recademy webinar. Thank you all.