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Addressing Key Barriers to Value-Based Payment for Substance Use Disorder (SUD) Treatment and Recovery: Current Gaps and Opportunities for Advancing Quality Measurement

October 4, 2021

Meeting Summary

Executive Summary

Despite the potential for improved outcomes and cost savings resulting from the integration of substance use disorder (SUD) treatment and behavioral health services with physical healthcare services, uptake of alternative payment models (APMs) that can incentivize such integration have been relatively limited. In July 2021, the Duke-Margolis Center for Health Policy convened health systems, providers, state and federal policymakers, addiction experts, and other key thought leaders for a virtual roundtable to discuss key barriers and opportunities for advancing payment and delivery reforms that can support expanded access to high-quality SUD treatment and recovery services. Key takeaways from the discussion include:

- Behavioral health needs and drug-related mortality both increased during the pandemic, with widening gaps in access for individuals in need of SUD treatment services.
- Value-based payment (VBP) models have the potential to incentivize high-quality care, encourage longitudinal care coordination, and ensure appropriate linkages to support services as patients move through the continuum of care.
- Despite their potential to improve care, improve access, and reduce costs, APMs for SUD treatment are not widespread. Promising models include the Patient-Centered Opioid Addiction Treatment (P-COAT) APM, Addiction Recovery Medical Home APM (AMRH-APM), and CMMI's Value in Treatment demonstration.
- Payers and providers face significant challenges in designing and implementing new APM models. Key needs for facilitating wider implementation of APMs include upfront funding for treatment infrastructure, technical assistance to support providers in building capacity, incentives for primary care providers to participate in collaborative care models, and improved linkages to community-based and wrap-around services.
- A significant challenge for wider implementation of VBP models for SUD is the relative paucity and lack of consensus around quality measures, with most measures focused on process and structure. Meeting participants highlighted the need for development of patient-reported outcome measures in SUD, and the need to disaggregate outcomes by race and ethnicity to ensure that the model reduces disparities in access and outcomes of treatment.

Based on this expert discussion, critical opportunities and next steps for advancing alternative payment approaches for SUD include identifying opportunities for integrating SUD in primary care; identifying strategies for improving consistent data collection, quality measurement, and analytical approaches; capturing early experiences in APM implementation and recommending opportunities

for improvement and broader use; and identifying actions states can take to support further adoption of SUD-focused APMs.

Introduction

Despite the potential for improved outcomes and cost savings resulting from the integration of substance use disorder (SUD) treatment and behavioral health services with physical healthcare services, uptake of alternative payment models (APMs) that can incentivize such integration have been relatively limited. In July 2021, the Duke-Margolis Center for Health Policy convened health systems; providers; state and federal policymakers; addiction experts; and other key thought leaders for a virtual roundtable to discuss key barriers and opportunities for advancing payment and delivery reforms that can support expanded access to high-quality SUD treatment and recovery services. Key topics included:

- Opportunities and barriers for adoption of APMs that can improve outcomes and reduce costs for individuals with SUDs;
- Challenges to identify and implement meaningful quality measures that can drive broader adoption of APMs; and
- Potential needs and next steps for establishing consensus on quality measures for SUD-focused APMs.

This meeting summary provides an overview of how the COVID-19 pandemic exacerbated the substance use crisis, key perspectives and takeaways from the virtual roundtable, and outlines a potential agenda for future research and coordination efforts to drive further adoption of innovative payment and delivery reforms that can improve early intervention practices and facilitate long-term recovery.

Widening Gaps in Substance Use Services During the COVID-19 Pandemic

The COVID-19 pandemic has exacerbated the challenges of the substance use crisis and revealed longstanding gaps in access to quality care. Drug overdose deaths rose by over 30 percent between 2020 and 2021, rising to an all-time high of more than 95,000 reported deaths.* While recent increases in drug-related overdose deaths have been driven largely by deaths related to synthetic opioids, such as illicitly manufactured fentanyl, there is also substantial evidence that the pandemic has exacerbated stressors and disruption of care for individuals with SUDs. Recent surveys by the Center for Disease Control and Prevention (CDC) have indicated that behavioral health needs have increased during the pandemic. However, a recent analysis of claims by Milliman, Inc., indicates that utilization of services for behavioral health services—while recently bouncing back to pre-pandemic levels–has not risen enough to meet these additional demands.

Despite these recent challenges, persistent gaps in access to high-quality SUD treatment far precede the pandemic. A recent study, using data from 2013-2015 from the National Hospital Care Survey, showed that among individuals who presented at the emergency department (ED) with an opioid-related issue, almost 20 percent made two or more visits and 1.2 percent died within 30 days post-discharge. Nationally, an estimated 10.3 percent of the more than 21.6 million people 12 or older needing substance use services in 2019 received it and more than half of all rural counties lack any Drug Enforcement Administration (DEA)-waivered provider that can provide buprenorphine in an office-based setting. Poorly-managed behavioral health conditions like SUDs are also a major driver of health care

* Based on data available for analysis on September 25, 2021.

spending. A study by Milliman found that six percent of individuals with co-morbid behavioral and physical health conditions drove 44 percent of all health care spending for the study population. With missed opportunities for intervention for high-risk individuals, gaps in access to evidence-based care, and fragmented care delivery approaches that result in poor outcomes for patients and higher health care costs, systemic reforms are needed to advance a "whole-person approach" to substance use recovery that addresses patients' physical, behavioral, and social needs throughout the recovery process.

The Case for Value-Based Payment for Substance Use Disorder Treatment and Recovery Services

Value-based payment, including APMs or pay-for-performance arrangements, can be a critical tool to incentivize high-quality, coordinated care that can support continued disease management. Individuals with SUD often have complex psychosocial needs that may require varying levels of inpatient or residential treatment, outpatient medication management, cognitive behavioral therapy or other counseling, peer supports, or other wrap-around social supports. Comprehensive or "team-based" care delivery models can support coordination across these services; facilitate improved delivery of evidence-based practices, such as Medication for Opioid Use Disorder (MOUD); and connect individuals to the appropriate level of care through the recovery process. Given the impact of unmanaged SUD in driving overall health care costs, VBP approaches and accountability for outcomes may help address critical gaps in current treatment systems, including a limited workforce, lack of support as patients transition between levels of care, gaps in longitudinal care coordination, and appropriate linkage to social supports.

Along with the financial case for new payment approaches for SUD, recent influxes in federal funding may help provide health systems and state policymakers with additional tools to support system transformation. In addition to traditional Medicaid, Medicare, and third-party reimbursement structures, states have received an additional $3.15 billion in Substance Abuse Prevention and Treatment (SAPT) block grant funding through the FY 2021 Omnibus Appropriations Bill and the American Rescue Plan Act of 2021 (ARPA). ARPA also funded treatment priorities, including Certified Community Behavioral Health Clinics (CCBHCs) Expansion Grants and $450 million in additional funding for Substance Abuse and Mental Health Services Administration (SAMHSA); Health Resources and Services Administration (HRSA) programming, including funding for mental health and addiction services, workforce education and training, suicide prevention, and public education campaigns. Additionally, recently announced settlements with Johnson & Johnson and opioid distributors will mean an additional $26 billion to participating states for the purposes of funding opioid-related expenses.

Across the health care system, payers and providers are increasingly moving away from fee-for-service (FFS) and toward VBP arrangements that reward high-value, cost-effective care. In October 2019, the Health Care Payment Learning and Action Network (LAN) set an aggressive target for accelerating the percentage of US health care payments tied to quality and value, setting a goal that at least 25 percent of Medicaid and commercial payments and 50 percent of payments in both traditional Medicare and Medicare Advantage should occur through the adoption of shared-risk APMs by 2022. Despite this momentum toward value-based care, uptake of APMs focusing on behavioral health conditions has been relatively limited. With new federal resources and momentum toward value-based care, increased adoption of APMs can help address critical gaps in treatment systems that have failed to provide quality care for individuals with SUDs. With new and innovative models only beginning to proliferate,

understanding key challenges and leveraging opportunities for coming to consensus can help drive improved adoption of effective models.

Challenge and Opportunities for Advancing Alternative Payment Models for SUD Treatment

Throughout the roundtable discussion, participants detailed their own challenges and lessons learned in exploring and implementing alternative payment approaches, as well as key barriers to VBP that may be meaningfully addressed through policy or collective action by stakeholders across the addiction treatment community. While the discussion reflected a rich diversity of perspectives, priorities, and levels of optimism regarding the health system's capacity and receptivity to behavioral health-focused APMs, there was little disagreement among the group that chronic underinvestment, lack of parity, and fragmented care delivery approaches for SUD treatment have resulted in poor access and outcomes for patients. However, many participants did highlight progress in implementing both smaller-scale models and partnerships, as well as momentum within state Medicaid programs resulting from 1115 waivers, CMS Section 1003 Demonstration Projects to Increase Substance Use Provider Capacity, and APM targets for Medicaid Managed Care Organizations (MCOs).

The following reflect takeaways from the discussion on promising models for expanding APM approaches, system barriers to advancing APM models for SUD, and potential strategies for addressing key issues around quality measurement, as well as potential next steps to support the advancement of quality measurement and APMs moving forward.

Existing Alternative Payment Models for SUD and OUD Treatment

To better understand the challenges and opportunities for advancing alternative payment models for addiction treatment and recovery services, roundtable participants highlighted several promising payment models in various stages of implementation by a number of health systems, in partnership with both public and commercial payers. These models included:

- **Patient-Centered Opioid Addiction Treatment (P-COAT) APM:** Designed by the American Society of Addiction Medicine (ASAM) and the American Medical Association (AMA), the P-COAT model is designed to support team-based Office-Based Opioid Treatment (OBOT). Opioid Addiction Treatment Teams (OATTS) receive risk-adjusted payments for initiation of treatment (evaluation, diagnosis, and treatment planning), as well as an ongoing monthly payment to provide or coordinate medication, psychological treatment, or social services. Performance measures tied to payment include the percentage of patients who filled prescribed medications, demonstrated compliance with treatment plans, demonstrated compliance with drug-testing programs, and the number of opioid-related ED visits.
- **Addiction Recovery Medical Home APM (AMRH-APM):** Designed by the Alliance for Addiction Payment Reform, the AMRH-APM applies a chronic disease management model, over a five-year period, to support patients through long-term recovery management. Although the model is intended to be flexible, key elements include individualized treatment and recovery plans, care recovery teams, payment tied to patient outcomes, and potential shared savings from coordinating patient care across health services. The model is currently in pilot development in local commercial and Medicaid markets, and in a statewide Medicaid exploration effort.

- **The Center for Medicare & Medicaid Innovation (CMMI) "Value In Treatment" Demonstration:** Representatives from CMS provided roundtable participants with an overview of their Maternal Opioid Misuse (MOM) Model and the Value in Opioid Use Disorder Treatment Demonstration Program. The Value in Opioid Use Disorder Treatment Demonstration Program is a 4-year demonstration program, begun in April 2021, intended to increase access to opioid use disorder (OUD) treatment services for the Medicare FFS population, improve physical and mental health outcomes, and reduce health care costs for individuals with OUD. As part of the demonstration, participating providers will receive a per-member, per-month (PMPM) care management fee and will be eligible for performance-based incentives payable based on participant's performance with respect to criteria specified by CMS (e.g., evidence-based medication-assisted treatment (MAT) and patient engagement and retention in treatment).

Addressing Barriers to Further Adoption of SUD Payment Reform

Reflecting perspectives from state policymakers, public and private payers, health systems, treatment providers, and other experts, roundtable participants reflected on some of the many systemic, cultural, and policy challenges that have hindered delivery of patient-centered quality care for SUDs generally, and implementation of value-based models, specifically. Some key priorities for addressing common barriers included:

- **Increase investment in treatment infrastructure and reimbursement for services:** Despite the recent influx of federal funding, participants noted that public investment in SUD treatment systems remains inadequate and reimbursement rates for behavioral health services—which are consistently lower than physical health services—continue to contribute to gaps in provider workforce and access. As such, participants cautioned that models focusing on immediate cost-savings are unlikely to expand access, and that true cost savings—reflecting improved management of both physical and behavioral health conditions—are more likely to accrue over a longer period of time.
- **Need for federal, state, and health system leadership:** Participants pointed to a long history of underinvestment and fragmentation in the behavioral health system and stigma against people with SUD as enduring barriers to payer and provider willingness to explore alternative payment approaches in SUD treatment. Tackling a challenge of this magnitude will require significant leadership and political will from health system leaders and payers, with federal and state policymakers having significant payment and policy levers to help prioritize reform.
- **Don't let the perfect be the enemy of the good:** The chronic, often reoccurring nature of SUD and the need for patients to navigate through levels of care, multiple providers, and social supports on the path to recovery can contribute to significant challenges in adopting shared risk arrangements. Further, many substance use treatment providers may not have capacity or confidence in implementing models with shared downside risk. As a result, "starting small" with bundled payments, pay for reporting, shared upside-only APM's, or incentives toward structural improvements may be realistic, initial steps for some health systems.
- **Provide greater support for integration of SUD treatment in primary care:** With only 20 percent of individuals receiving SUD care in a specialty settings, supporting primary care providers will be critical for expanding access to high-quality services. Participants discussed the need for greater training, resources, and technical support for primary care providers in treating

complicated cases; incentives for Screening, Brief Intervention, and Referral to Treatment (SBIRT); support for primary care practices in adopting case management collaborative care models; and incentives for improving integration with specialty providers and social support services. Participants also highlighted the importance of care coordination or PMPM payments, as included in the Value in Treatment Program, as vital to supporting these care coordination efforts.

- **Encourage evidence-based approaches for treating multiple substance use disorders:** With a number of current reform efforts focusing specifically on treatment of OUD, participants noted the increasing role of stimulants and polysubstance use in rising mortality trends and the need for payment models to incentivize the adoption of evidence-based approaches, such as contingency management and other methods for addressing the full range of patient needs.

Incentivize community-based services and social supports as individuals transition to recovery: A whole-person approach to recovery includes appropriate counseling, peer and community-based supports, and connections to necessary supports to address housing, employment, and other social needs. Care coordination is integral to navigating these services as patients transition through levels of care. As such, payment and delivery reforms should incentivize care coordination and the building of networks and partnerships with community-based services. A number of participants also raised the importance of supporting telehealth, and other innovations to reach patients in a flexible way that meets their needs, particularly during the pandemic.

To overcome some of these barriers, participants emphasized the role of state and federal policymakers in incentivizing and generating momentum for value-based approaches, while acknowledging the heterogeneity of the treatment system and the need for flexible approaches in a variety of settings. As the largest payer of SUD services, state Medicaid programs have significant ability to shift toward VBP approaches and leverage contracts with MCOs. At the state level, SAPT block grant funding, State Opioid Response grants, and other funding streams also can go to support upfront costs associated with care delivery reforms, including provider training and technical assistance, data infrastructure improvement, bundle administration support, risk corridors, and wrap around services. Lastly, a number of participants pointed to the ability of the federal government to support states with improved data collection and to generate momentum for initiatives, such as CCBHCs.

Focusing on Key Barriers: Moving toward Consensus on Quality Measures to Inform APMs

Although participants discussed many different practical challenges related to implementation of APMs, a lack of consensus within the addiction field on adopting uniform quality measures across settings that measure and pay for value remains a significant barrier to APM implementation. Participants discussed the relatively few SUD measures that currently are used as the basis for payment related to quality, including the limited number of Adult Core Health Care Quality Measures in Medicaid and reliance on process-level Healthcare Effectiveness Data and Information Set (HEDIS) measures, such as Initiation and Engagement of Treatment and Follow Up After Emergency Department Visit for Alcohol or Other Drug Dependence. While participants expressed differing levels of confidence in the association between retention in treatment and overall improved patient outcomes, there was wide agreement on the need for research that can better link achievement of quality measures to improved patient outcomes and reduced healthcare spending as well as the need for development of meaningful patient-reported outcome (PRO) measures. A number of providers underscored the wide gulf between what is currently measured in SUD care and outcomes that matter to patients and providers, emphasizing the need to

develop patient-specific treatment plans and sometimes, work outside of traditional health systems to reach patients that have been stigmatized by previous interactions with the health system.

Participants pointed to a number of efforts underway to establish common quality measures that can be applied to create uniform quality comparisons across settings. These efforts include the National Quality Forum's (NQF) 2020 Final Report from its technical expert panel on Opioids and Opioid Use Disorder: Quality Measurement Priorities, providing recommendations on priority gaps in quality measurement science and recommendations for adoption of quality measures across federal programs. The National Committee for Quality Assurance (NCQA) also recently released a Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care, which attempts to align and coordinate quality measurements across the delivery system to help drive and measure behavioral health quality and outcomes. Additionally, Shatterproof's Rating System for Addiction Treatment Programs Measure Set, is intended to provide consumers, payers, states, and referral sources with information on how addiction treatment providers align with Shatterproof's National Principles of Care.

Despite these efforts, significant practical challenges remain to collect and share patient data that can be used for quality measurement, as well as more theoretical challenges in coming to agreement on quality measures that can serve as a proxy for value in APMs. While noting that many providers already track measures of patient progress and well-being (e.g., reduced drug use, employment status, subjective feelings of well-being) as a part of clinical care, participants cautioned that privacy restrictions under 42 CFR Part 2 and limitations in Electronic Health Record (EHR) design often make accessing or sharing relevant patient data for the purposes of payment difficult. Several participants also noted the extent to which behavioral health carveouts in many states can cause data sharing challenges and can complicate sharing of claims information that would allow providers to holistically address a patient's physical and behavioral health needs. Furthermore, participants highlighted onerous federal reporting requirements for treatment providers, cautioning that poorly designed quality measurement requirements can contribute to additional provider burden. While these quality measurement challenges remain difficult, participants offered some potential ideas and paths forward to support more consistent and meaningful measurement approaches:

- **Invest in the continued development of PRO measures:** Several participants highlighted the Recovery Capital Index (RCI) as an emerging framework and construct for measuring a patient's multi-dimensional well-being as they transition into recovery. While the RCI has been implemented in a number of clinical care settings, the measurement of Recovery Capital generally within payment models is limited. Given the substantial costs of developing and validating PROs, participants suggested that the federal government could play a leading role in investing in PRO development that incorporates patient priorities and needs, similar to previous PROs developed for hospice care.
- **Build on successful models:** Noting the importance of care coordination and integration with specialty providers for office-based opioid treatment (OBOT) and other primary care models, a number of participants advocated for payment approaches that further incentivize integrated approaches. Potential examples are the Virginia ARTS program "Gold Card Office Based Opioid Treatment Program" and collaborative care models for depression. Within specialty settings, participants pointed to current experiences with established

requirements and quality measures for Certified Community Health Clinics demonstration projects as a potential model that could be studied and replicated more broadly.

- **Improve population and community-level data**: Prioritizing and funding improved data collection and research to advance both population and disaggregated community-level data on SUD prevalence, treatment access, and outcomes can help better define baseline needs and cost for the SUD population, while helping to identify gaps and disparities in health system access.
- **Build incrementally:** While participants reflected a range of perspectives on strategies for moving toward large-scale system transformation, a number of participants urged moving forward on APMs incrementally, starting with "pay for reporting" approaches that can reduce health system burden as health systems they move toward value-based approaches.
- **Track outcomes related to health equity:** With significant evidence of disparities in treatment access and outcomes for American Indian, Hispanic/LatinX, and Black communities, data collection, payers, and health systems designing APMs should protect against potential adverse selection and monitor outcomes to ensure that APM efforts do not have a disparate impact on communities of color.

Conclusion and Next Steps

While there is no shortage of challenges for advancing VBP reform for substance use and behavioral health services, the roundtable discussion underscored the need to reform a system that has too often failed to provide quality care for patients. Throughout the discussion, participants were able to point to pockets of innovation, best practices, and potential models that can be examined further, highlighted, and scaled. With implementation of APMs for SUD still early in development, there is significant opportunity to extract early lessons learned from these experiences to share with stakeholders interested in implementing payment and care delivery reforms. At the same time, significant research and policy reforms are needed to help reduce established barriers within this space.

To support further adoption of APMs that can drive quality improvement, additional research and policy priorities for healthcare stakeholders include the need to:

- **Promote integration and care coordination within primary care:** Supporting primary care providers by implementing integrated care models is critical to expand access to MOUD and other evidence-based approaches. State and federal policymakers, funders, and academic institutions can prioritize resources, training, and technical assistance for providers while public and private payers can incentivize integrated care coordination approaches and greater linkages with specialty providers and community supports.
- **Drive consensus in the field on measurement, definitions, and analytic practices:** With limited experience and a lack of consensus on quality measures that can be linked to improved outcomes and reduced costs, moving towards consistent definitions and approaches for quality measurement and data analysis that can be applied across settings can reduce the burden of adoption for payers and health systems. In addition to efforts to drive expert consensus around quality measures themselves, additional work to promote alignment around key APM design issues, such as claims-based definitions for SUD patient populations, processes for attribution,

and uniform analytical approaches can help reduce friction in the adoption of new models and support consistency across payers and settings.

- **Share early experiences with APM design and implementation:** With many integrated SUD models still early in implementation, research to better understand the landscape of APM innovation, as well as both quantitative and qualitative evaluations of implementation challenges and lessons learned, can help support other interested stakeholders in advancing APM models. On a state level, researchers also may evaluate payment and care delivery innovations of state Section 1115 waivers for SUD residential treatment based on performance measures and other data reported in Section 1115 demonstration reports.
- **Encourage state-level coordination between flexible SUD funding and Medicaid:** Medicaid remains a major payer of SUD services and driver of payment innovation efforts. However, with flexible federal and opioid litigation resources flowing to states, building partnerships and coordination between state Medicaid leaders and state behavioral health and substance use agencies can promote alignment of efforts, promote infrastructure and provider training, and support upfront or wrap-around costs that can further support healthcare transformation.

Roundtable Participants and Acknowledgements

The following experts participated in the roundtable discussion "Addressing Key Barriers to Value-Based Payment for Substance Use Disorder (SUD) Treatment and Recovery: Current Gaps and Opportunities for Advancing Quality Measurement," hosted by the Duke-Margolis Center for Health Policy on July 29, 2021. The priorities and considerations in this paper reflect ideas generated during the discussion and subsequent feedback from participants, but does not necessarily reflect a formal consensus of the group, nor the endorsement of any specific participant or their organization. Duke-Margolis would like to thank Greg Williams as well as roundtable participants who offered their feedback on this summary.

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