Value in Opioid Use Disorders
Treatment Demonstration - Financial Reporting Guide

Financial Reporting Guide

December xx xxxx

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I. Annual Financial Report: Overview and Guidance

Per the Value in Treatment Participation Agreement (PA), participants are required to complete and submit an Annual Financial Report as part of their attestation on how CMS demonstration funds were used. The information collected under this report helps inform CMS how much was paid out to participants for Value in Treatment through the Care Management Fee (CMF) and how such payments were used to furnish demonstration services to eligible beneficiaries. This information will also support the demonstration's evaluation.

Only CMS and CMS' implementation and evaluation contractors will view your identifiable financial reporting data. CMS may share aggregate data at the county or state/program level publicly to the extent permitted by appropriate regulations.

For Performance Years (PY) 2021, 2022, 2023, and 2024 (reporting period= January 1 to December 31), participants should use this guidance to prepare the Value in Treatment Annual Financial Report. We recommend you review this guidance completely to support your reporting efforts.

Due Date and Submission Process

1. At least one month prior to the Annual Financial Report due date, CMS will email participants a request to complete the financial report. The request will include instructions on how to access and submit the updated financial report template. Participant's financial report template is static and will not change year-over-year. Please note, however, that CMS will calculate and generate the payment fields for each participant, as specified under this guidance, and include the most updated OUD care team roster on CMS records for your review.

2. The three tabs (*OUD Care Team*, *Financial Report, Part 1*, and *Financial Report, Part 2*) are to be completed by each participant. Please follow the instructions listed at the top of the page of each tab.

3. Complete and submit this report to CMS within a month of receipt via the Box.com. Please refer to ["ViT Documentation Submission Guidance_Box.pdf"] for detailed submission directions. For any issues, please email ValueinTreatment@cms.hhs.gov.

II. OUD Care Team

Overview and Definitions tab

Overview: This tab is the roster maintained and updated by CMS on an ongoing basis. The list reflects all OUD care team members submitted by participants as part of their Value in Treatment application and any additions or changes submitted to CMS since. Per the PA, participants are required to identify to CMS all OUD care team members throughout the demonstration program performance period. It is the participant's responsibility to email CMS at ValueinTreatment@cms.hhs.gov when any changes occur.

The information in this tab reflects the most updated information CMS has as of the submission of this request.

Definitions:

> ***Participant Name:*** The entity or individual that applied to Value in Treatment and is listed as such under the PA.

> ***OUD Care Team:*** The OUD multi-disciplinary care team hired or contracted to furnish demonstration services, per the PA.

> ***Status:*** The status of each OUD care team member(s) for Value in Treatment, which include "active", "inactive", or "New Member" as of the submission of this report to CMS. "Active" refers to a team member that is actively furnishing Value in Treatment services. "Inactive" refers to a team member that was furnishing Value in Treatment services but is no longer doing so. "New Member" refers to a newly added team member that will be or is already furnishing Value in Treatment services, and that was not previously listed in the roster.

> **Directions under OUD Care Team tab**

Directions:
1) Please verify the Participant Name and billing information listed in rows 20 to 24.

    a. Any changes to the Participant Name or billing information (TIN, NPI, PTAN, CCN) must be communicated with CMS at ValueinTreatment@cms.hhs.gov, per the PA. Changes approved by CMS will be reflected in the next iteration of this financial report, if not already captured.

2) All columns below, except those with a "*" are required. Columns with a "*" are if applicable only; if not applicable, please fill with "N/A". Please verify that all information is accurate and complete.

    a. If listed OUD care team member is associated with more than one TIN, please list and separate with a comma (,).

3) The first three rows in the table below (green filled color) must identify a Medicare-enrolled primary care provider (PCP) or addiction treatment provider, and a Medicare-enrolled provider authorized to prescribe/dispense narcotic drugs to applicable beneficiary, per participation requirements. The listed providers in these three rows were identified by the participant as meeting these requirements. Specifically:

    a. If one provider is all three (a PCP, an addiction treatment provider, and provider authorized to prescribe narcotics), then this individual can be listed three times in the first three rows with the same information, but in Column B separately select "PCP-Required", "Addiction Provider- Required", and "Prescriber- Required" drop down options.

    b. If one provider is both a PCP and an addiction treatment provider, but not authorized to prescribe narcotics, then this individual can be listed twice in the first two rows with the same information, but in Column B separately select "PCP- Required" and "Addiction Provider- Required" drop down options. The third row must separately list the provider authorized to prescribe narcotics and have "Prescriber- Required" drop down option

selected.

    c. If the OUD Care Team only includes a PCP or an addiction treatment provider, but not both, then the applicable individual must be listed in the first row and select one of the two drop down option ("PCP- Required" or "Addiction Provider- Required") in Column B. The second row must separately list the provider authorized to prescribe narcotics, even if it is the same individual listed in the first row, and have "Prescriber- Required" drop down option selected. The third row may be left blank.

    d. If the PCP, addiction treatment provider, and prescribe of narcotics are three separate providers, then these three individuals can be separately listed in the first three rows. Please select the "PCP- Required", "Addiction Provider- Required", and "Prescriber- Required" drop down options, where applicable.

4) All other care team members, including those that may also be PCPs, addiction treatment providers, and prescribers of narcotics, and non-healthcare providers (social service providers, care coordinators, etc.) may be listed in the rest of the rows, with "Additional OUD Care Team" drop down option selected in Column B. There are no limits to how many care team members are listed.

5) For each OUD care team member, the address refers to the mailing address.

6) For all OUD care team members, please select the appropriate "STATUS" dropdown option.
    a. To add new care team members, add another row with requested information and select the "New Member" status. The next iteration of this roster submitted to participants by CMS will reflect this newly added team member as "Active".
    b. OUD care team members no longer rendering Value in Treatment services should be reflected as "Inactive" status. DO NOT delete from the roster. A team member may go from active to inactive during the duration of the demonstration; the status may be updated to reflect current status.

III. Financial Report

Overview and Definitions tab

Overview: This tab summarizes total Value in Treatment payments and services. Specifically, it lists the number of unique beneficiaries for whom the participant submitted a claim for the Value in Treatment CMF, total claims billed for such services, and total CMF payments made by CMS to participants, as indicated through Medicare claims. Total Payments will be generated by CMS and its contractors, and provided to each participant via this Annual Financial Report Template. Value in Treatment services furnished under the demonstration, and estimated cost, including staffing and services furnished, are to be populated by participants by the requested due date.

Definitions:

    # Beneficiaries: number of unique beneficiaries for whom Value in Treatment claims were submitted by the participant. This number is generated by CMS using claims and is cumulative over time (quarterly). Thus, the Q4 figure reflects the cumulative total number of unique beneficiaries for whom a claim was reflected between January 1 to December 31 of the

performance year.

CMF Rate: the amount paid for the Care Management Fee, minus the quality withhold, per applicable beneficiary per month, as specified in the PA.

 # Paid Claims: number of Value in Treatment claims that were paid to a participant during the performance period. Numbers are broken down by claims paid per quarter and in total. The total # Paid Claims for the entire year is the sum of quarterly figures.

CMF Payments: the total Value in Treatment payments made to a participant based on # Paid Claims and the CMF Rate. Please refer to the PA for calculation formulas.

Incentive Payment: the total amount of any annual performance-based incentive payment made to a participant based on quality performance, per the PA. Incentive payments are calculated in the second quarter following the end of a PY, and paid in the third quarter.

Quality Withhold (%): percentage of the CMF withheld from each quarterly payment (5% in PY1 and 10% in each performance year thereafter).

Staffing: The actual staff involved in furnishing or administering Value in Treatment services, and its associated staffing cost.

> **Number of Staff:** the number of medical and non-medical staff involved in furnishing or administering Value in Treatment services each quarter. The staff furnishing Value in Treatment services should be an OUD Care Team member. Each person should be counted as one regardless of staff time allocations.

> **Staffing Cost:** actual cost associated with the number of staff identified as having furnished or administered Value in Treatment services. Quarterly expenses are summed to reflect the actual staffing cost of providing such services during the PY. You may enter '0' for any category, where applicable.

> **Physicians:** physicians and physician assistants who are licensed under state law to furnish medical care, and are enrolled in Medicare. This may include primary care physicians, addiction treatment physicians, and physicians authorized to prescribe narcotics who are furnishing Value in Treatment OUD treatment services.

> **Nurse Practitioners:** nurse practitioners (NPs) licensed under state law who are furnishing Value in Treatment OUD treatment services.

> **Counseling & Psychology:** practitioner licensed under state law to furnish psychiatric, psychological, and counseling services to applicable beneficiaries. These may include auxiliary personnel who furnish services incident to a physician or non-physician provider, including licensed professional counselors, licensed clinical alcohol and drug counselors, or licensed marriage and family therapists who are permitted to furnish such services by state law within their scope of practice.

> **Social Support Providers:** non-healthcare providers furnishing OUD treatment services under Value in Treatment, such as social support, care management, and care

coordination. This may include social workers, community health workers, care managers, certified peer specialists, and qualified clergy.

Administrative: includes program directors/managers, schedulers, and any other administrative staff supporting the administrative, operations, and management activities of Value in Treatment. These individuals may or may not be listed as part of the OUD Care Team.

Other: any other staff supporting Value in Treatment that was not otherwise captured. This may include volunteers not employed or contracted by the participant that were rewarded with Value in Treatment funds for their dedicated time.

Services Furnished by Service Type: The actual Value in Treatment services furnished directly or through contracts/vendors, and its associated cost. These services are categorized as "Delivery Settings/Modalities", "Recovery Social Support", and "Treatment Initiation & Engagement," each of which is defined below.

Service Type Cost: The cost associated with furnishing Value in Treatment services. Note that associated service type cost is different from staffing cost. For example, if the Value in Treatment service furnished was providing meals, the service would be categorized as "Nutrition", and only capture non-labor expenses like the cost of the actual meal, supplies for packaging the meal, facility expenses (equipment and space used for cooking and preparing meals), and travel expenses (mileage to and from), if applicable. Staff time spent preparing and providing meals would be separately captured under staffing related expenses. Quarterly expenses are summed to reflect the actual cost of providing such services during the PY. You may enter *'0'* for any category, where applicable.

Delivery Settings/Modalities: the setting or modalities in which Value in Treatment services were furnished. "Office Visits/Consults" are those that occurred in-person at office location. "Home Visits/Consults" are those that occurred in-person at the beneficiary, family, or caregiver's home. "Remote Consults" includes any visit/consultation that were not in-person but were offered remotely via telephone or other telecommunication technology during or after office hours. "Care Delivery- Other" are all other that do not fall in the other categories, which may include mobile outreach (e.g., text reminders or encouragement).

Recovery Social Support: recovery-enabling social support services offered on a limited or extended duration in-house (if appropriate) or in coordination with state/local agencies and community-based organization that through existing evidence has shown to have a "reasonable expectation of improving or maintaining the health or overall function of applicable beneficiaries," and that comply with applicable fraud and abuse laws. For monitoring and evaluation purposes, CMS has categorized and defined social support services, as listed below. Categorization is also intended to ensure standard use among participants under this financial report. Please note that the listed social support services under each category definition are examples only and not intended to be CMS endorsement or suggested services. Social support services furnished under the

demonstration should align with the PA.

> ***Assessments/referrals:*** the use of social needs assessment tools to identify social needs for the purpose of referring beneficiaries to appropriate resources and/or confirming eligibility for select social needs interventions being provided by the participant. Assessments and referrals may only be listed as Value in Treatment expenses if not already covered by Medicare or other program for applicable beneficiaries.

> ***Housing:*** housing support, which may include housing navigation services, rent subsidies, utility subsidies, transitional housing, permanent supportive housing, recovery housing, home-based modifications to improve mobility, accessibility, and safety, etc.

> ***Employment:*** employment support services for applicable beneficiaries seeking to enter the workforce, which may include employment navigation services or referrals to employment support programs, vocational assessments, resume writing, interviewing skills, job placement, etc.

> ***Nutrition:*** nutrition support, which may include navigation services to enroll beneficiary in SNAP, referrals to other community programs, food and nutrition case management, medically and/or non-medically tailored meals (delivered or for pick-up), groceries (delivered or for pick-up), etc.

> ***Transportation:*** non-emergency transportation support for medical or non-medical needs, which may include public transportation subsidies or private transportation (shuttles, taxi, ride-sharing services, etc.).

> ***Recovery Social Support- Other:*** other recovery-enabling social support services not otherwise captured in other sub-categories, such needle exchange programs or services addressing interpersonal violence/toxic stress, education, legal, social isolation/loneliness, etc.

Treatment Initiation & Engagement: recovery-enabling treatment initiation and engagement support services offered on a limited or extended duration in-house (if appropriate) or in coordination with state/local agencies and community-based organization that through existing evidence has shown to have a "reasonable expectation of improving or maintaining the health or overall function of applicable beneficiaries," and that comply with applicable fraud and abuse laws. For monitoring and evaluation purposes, CMS has categorized OUD treatment initiation and engagement services, as listed below. Categorization is also intended to ensure standard use among participants under this financial report. Please note that the listed OUD treatment initiation and engagement services are examples only and not intended to be CMS endorsement or suggested services. OUD treatment initiation and engagement services furnished under the demonstration should align with the PA.

> ***Medication-assisted treatment (MAT):*** MAT services not otherwise covered by Medicare or other programs. MAT is the use of medications (buprenorphine,

naltrexone, or methadone) in combination with counseling and behavioral therapies, which is effective in the treatment of opioid use disorders (OUD) and can help some people to sustain recovery.

Non-Opioid Pain Management: patient-centered non-opioid pain management services not otherwise covered by Medicare or other programs, which may include non-opioid medication options (e.g., analgesics, select anticonvulsants, select antidepressants, topical agents, etc.) and nonpharmacological treatment (e.g., exercise therapy, cognitive behavioral therapy, multimodal and multidisciplinary therapies, etc.).

Naloxone: access to naloxone, a medication that rapidly reverses the effects of opioid overdose and is the standard treatment for overdose.

Treatment Planning & Education: individualized, patient-centered treatment plans, and/or treatment education provided to the applicable beneficiary and family/caregiver.

Care Transition & Coordination: partnerships and coordination with inpatient hospitals and emergency departments to transition an applicable beneficiary to receive Value in Treatment services through the participant's OUD care team.

Treatment Follow-Up: regular patient treatment outreach/follow-up.

Social/Peer Support: addiction support groups and/or one-on-one peer support services through certified peer counselors to motivate recovery.

Contingency Management (CM): CM provides incentives to OUD patients contingent upon treatment attendance and/or verified drug abstinence in order to increase likelihood of these behaviors.

Treatment Initiation & Engagement- Other: other OUD treatment initiation and engagement services not otherwise captured in other sub-categories.

Other: broadly, any other service type offered in Value in Treatment that did not fit the definition for "Delivery Settings/Modalities", "Recovery Social Support", and "Treatment Initiation & Engagement."

Directions under Financial Report tab

Directions:
1) Performance Year (PY) dates are from January 1 to December 31. All figures in this Financial Report should be applicable to the previous PY, as noted in row 21.

2) Sections 1 and 2 are calculated and generated by CMS, and are reflected in green-filled color. CMS generated fields are locked and may not be edited by participants.

   a. It is the participant's responsibility to verify that the payment rate, # of Payments, Total Payments, and number of unique beneficiaries indicated in Sections 1 and 2 align with

actual figures.

b. Please refer to the "Overview & Definitions" tab for definitions of each populated field. Some calculation notes are also reflected under each table.

c. If participant has any questions or identifies any discrepancies, please though email CMS at ValueinTreatment@cms.hhs.gov. Because payments are calculated using Medicare billed claims through the demonstration G-code, any errors or discrepancies in CMS generated figures may be due to billing issues or misunderstandings with the MACs.

d. Unique beneficiaries in Section 2 reflect cumulative totals each quarter and by the end of the performance year (Q4). For example, if there were 10 unique beneficiaries in Q1, 15 in Q2, 20 in Q3, and 25 in Q4, the Q1 total figure would be 10, 25 in Q2, 45 in Q3, and 70 by the end of Q4.

3) Section 3 is to be populated and completed by participants. These fields are indicated in grey-filled color.

a. For subsection a, please indicate the number of staff involved, and the associated staffing cost. Please refer to the "Overview & Definitions" tab for staffing definitions. Some calculation notes are also reflected under each table.

   i. Please calculate total figures by summing the cost and number of staff from each quarter.

   ii. All staff listed, except administrative and other, who are furnishing demonstration services should be reflected in the OUD care team roster. Please update the roster, as needed, to ensure the count is accurately aligned.

b. For subsection b, please indicate the number of unique beneficiaries furnished Value in Treatment services, and identify the types of services furnished.

   i. Please calculate total figures. The cost total is the sum from each quarter. The # Beneficiaries is calculated in accordance to the definition (refer to "Overview & Definitions" tab). A given beneficiary may receive more than one type of service, and thus should be counted as a unique beneficiary under each row. You may enter "0" (zero) for any rows, where applicable.

   ii. It is the participants' responsibility to accurately track the number of unique beneficiaries furnished each type of Value in Treatment services.

   iii. It is also the participants' responsibility to estimate associated cost. The estimated cost is collected for evaluation purposes only, and is not intended to be collected for reconciliation or recoupment purposes.

   iv. If rows 84, 91, 101, and 102 have figures greater than "0" (zero) in any given quarter, participants must explain in the text box starting in row 109, as requested. Applicant must specify what the "other" service was. If more than one service falls under "other", please break the numbers down in the explanation. For example, if two "other" recovery social support services were provided to a total of 20 unique beneficiaries, participant will need to specify the number of unique beneficiaries that received each of the two "other"

services by the end of the performance period.