

Moving Toward Value-Based Payment for Medicaid Behavioral Health Services

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IN BRIEF

States, health plans and providers are beginning to develop value-based payment (VBP) arrangements to pay for Medicaid behavioral health care services. VBP approaches shift the focus from traditional fee-for-service (FFS) systems that pay for volume of services to alternative payment models that reward high-quality, cost-effective care. Many state Medicaid programs have developed VBP approaches to improve quality and slow cost growth for physical health services, but these advances have been slower to emerge in Medicaid behavioral health programs. This brief, produced with support from the California Health Care Foundation, describes how innovative states and Medicaid managed care organizations (MCOs) are building upon models developed for physical health services and incorporating VBP arrangements into behavioral health programs. It explores key challenges in implementing VBP models in behavioral health settings related to quality measurement, provider capacity, oversight considerations, and privacy and data-sharing constraints. Lastly, it highlights considerations to help states advance these models, and suggestions to support MCOs and providers with more effective program implementation.

Public health care payers are increasingly changing the way they pay for health care services through value-based payment (VBP) arrangements. VBP generally refers to activities that move away from the traditional fee-for-service (FFS) payment system, which rewards volume, to alternative payment models that reward high-quality, cost-effective care.¹ The Department of Health and Human Services (HHS) announced in 2016 that it aims to move 50 percent of traditional Medicare FFS payments into alternative payment models that reward efficiency and high-quality care by 2018.² State Medicaid programs have embraced VBP efforts as well: In a year-end 2016 annual survey of state Medicaid directors, nearly 40 percent reported plans to expand VBP arrangements in the following year.³

Most VBP arrangements in Medicaid currently support the delivery of physical health services. However, states, health plans and providers are gradually becoming more interested in transitioning to similar payment models for Medicaid behavioral health services. At 26 percent of total national spending, Medicaid is the largest payer in the nation for behavioral health services.⁴ Spending for individuals with a behavioral health diagnosis is nearly four times higher than for those without. Furthermore, the nearly 20 percent of Medicaid beneficiaries who have a behavioral health diagnosis account for almost half of total Medicaid expenditures.⁵ There is increased recognition that the use of VBP in Medicaid holds promise to improve quality and slow cost growth. However, VBP strategies have been slow to emerge in Medicaid behavioral health programs.

This brief, produced with support from the California Health Care Foundation, describes innovative programs implemented by state Medicaid programs and Medicaid managed care organizations (MCOs) that use VBP arrangements in behavioral health care settings serving individuals with

significant behavioral health needs. Most of the examples describe payment levers that states and MCOs use to improve provider practices, but the brief also includes a state approach to using payment to improve MCOs' delivery and coordination of behavioral health services. The examples also describe current Medicaid behavioral health delivery system models that are a foundation and, in some cases a catalyst for, states and MCOs to accelerate new payment models. Lastly, it provides insights gleaned from expert interviews with state Medicaid officials, MCOs, behavioral health agency administrators, and policy researchers about challenges associated with implementing VBP for Medicaid behavioral health services as well as suggestions to help states advance these models.

Behavioral Health Payment and Delivery Reform Landscape

Defining Value-Based Payment Arrangements

There are several frameworks for VBP, but one commonly used model — created by the Department of Health and Human Services (HHS) in collaboration with partners in the public, private, and non-profit sectors — is the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model (APM) framework.⁶ The LAN framework is increasingly used as a tool by the Centers for Medicare & Medicaid Services (CMS), states, and to some extent by private payers, to establish consistent terminology and to define the levels of risk in, or sophistication required for, types of VBP models. Exhibit 1 provides descriptions of provider payment models from the APM framework.

Exhibit 1: LAN Alternative Payment Model (APM) Framework⁷

Category 1: FFS payments not linked to quality. FFS payments are based on the number and units of service provided, without linkages to, or adjustments for, provider reporting of quality data, or performance on cost or quality data.

Category 2: FFS payments linked to quality and value. FFS payments are adjusted based on other factors, such as infrastructure investments, whether providers report quality data (pay-for-reporting), and/or performance on cost and quality metrics (pay-for-performance). This may also include a penalty disincentive, i.e., a lower or withheld payment if providers do not produce quality indicators, or report events or procedures that are harmful and were avoidable.

Category 3: Alternative payment models based on FFS. Payments are based on FFS, but provide mechanisms to more effectively manage services. Providers must meet quality metrics to share in cost savings, and payments are based on cost performance against a target. Models may include:

- **Shared savings/shared risk.** Also referred to as “upside” or “downside” risk respectively, providers must meet a total-cost-of-care target for some/all services for an attributed set of patients. If actual costs are below projections, providers may keep some savings or may also be at risk for higher-than expected costs.
- **Bundled or episode-based payments.**⁸ A single payment to providers for all services needed to treat a given condition (e.g., maternity care) or to provide a given treatment (e.g., hip replacement). Providers receive an inclusive payment for a specific scope of services to treat an “episode of care” with a defined start and endpoint.

Category 4: Population-based payments. Payments are structured to encourage providers to deliver coordinated, high-quality care within a defined budget. Payments may cover a wide range of preventive, medical, and health improvement services. Examples include global or capitated per-member-per-month payment, which may include both physical and behavioral health. Plans or providers bear the financial risk for the cost of treatment.



LAN recommends that, over time, the U.S. health care system move toward payment models in Categories 3 and 4, while recognizing that this will not be readily achievable in every market (such as in rural areas), or for every patient population.⁹ Payments made to providers under VBP approaches need to be linked to quality or demonstrate value in some way, such as achieving improved health outcomes, choosing evidence-based processes, managing the costs of care, and implementing effective care coordination strategies.¹⁰

With the majority of Medicaid beneficiaries receiving services via managed care, states are also increasingly using MCO contracts as a vehicle to increase the number of providers paid under VBP arrangements. General approaches to promote VBP within managed care include: (1) requiring MCOs to adopt a standardized VBP model to reimburse providers; (2) requiring MCOs to make a specific percentage of provider payments through approved VBP arrangements; (3) requiring MCOs to participate in a multi-payer VBP alignment initiative; and/or (4) requiring MCOs to launch VBP pilot projects subject to state approval.¹¹

In addition, states may also adjust payments to MCOs based on quality metrics and efficiencies to drive behavioral health outcomes and advance integrated models. For example, states have developed MCO-level pay-for-performance incentives or withhold arrangements, in which states retain or “withhold” a portion of capitation payments that are returned to MCOs for meeting specific contract requirements. These differential payments to MCOs can help to align incentives across plans and providers and offer another mechanism for states to help ensure that Medicaid dollars are being spent on high-quality, efficient care.

Medicaid Behavioral Health Delivery System Models

Delivery system models are often the vehicles *through which* VBP arrangements, such as pay-for-performance, shared savings, and bundled payments, are implemented. The number of states implementing behavioral health delivery system initiatives — including a focus on integrating behavioral health with other medical and social supports — has rapidly expanded. In a recent annual survey conducted by the National Association of Medicaid Directors, 15 state Medicaid directors in 2016 cited behavioral health reform as a top priority for the upcoming year.¹²

Integrated care can better align system incentives and increase health plan or provider accountability for managing a more complete range of services, which is important for this population with high comorbidity rates. In addition, the high service use and spending for individuals with behavioral health conditions often does not just reflect behavioral health service utilization. Nearly 70 percent of those with behavioral health issues have a co-occurring physical health condition, including conditions associated with tobacco and alcohol use, such as chronic obstructive pulmonary disease, asthma, and chronic liver disease and cirrhosis.¹³ In many cases a small percentage of overall costs for this population are attributed to mental health services.¹⁴

States are using a number of different Medicaid managed care arrangements to drive integration and quality improvement delivery reform efforts across behavioral and physical health services, including:

- **Carve-in.** A number of states (e.g., Tennessee) have “carved-in” Medicaid behavioral health services. Under a carve-in system, MCOs receive a payment to manage both behavioral and physical health services, among other services as relevant. As of 2016, 16 states currently provide or are planning to offer behavioral health services through an integrated managed care benefit — up from just a handful a few years prior.¹⁵
- **Carve-out.** Some or all behavioral health benefits are separately managed by a specialized behavioral health organization or by the Medicaid state agency on a FFS basis. Some states with specialized behavioral health organizations (e.g., Pennsylvania) have established requirements to increase collaboration and accountability between contracted entities that manage physical and behavioral health services. Meeting these requirements often entails greater coordination of providers on the ground.
- **Specialty managed care model.** A few states (e.g., Arizona) use these programs for individuals with serious behavioral health conditions. Specialty behavioral health organizations manage all benefits, including physical health benefits, which are carved into the program.

States have also launched provider-based delivery system reforms to improve Medicaid behavioral health services, which include a platform for VBP initiatives. Although these models are typically provider-led, Medicaid managed care plans may be involved to varying degrees, ranging from contracting directly with these providers, to sharing partial or full responsibility for service delivery.¹⁶

- **Health Homes.** Medicaid health homes were created through Section 2703 of the Affordable Care Act, which contains provisions that allow Medicaid to reimburse eligible providers for comprehensive care management services for a set time. Fourteen of the 21 states and the District of Columbia that have implemented Medicaid “health homes” have created models for individuals with serious mental illness.¹⁷ These programs, often centralized in a behavioral health provider’s office, must offer several services including comprehensive care management, transitional care and follow-up, and referrals to community and social support services.
- **Accountable Care Organizations (ACOs).** These models seek to improve care coordination and delivery by holding providers financially accountable for health outcomes and costs of their patient population. A few states are requiring ACOs to report behavioral health quality metrics, to involve behavioral health providers in care coordination and related activities, and to link some of these metrics to payment. ACOs are most often reimbursed under shared savings or shared savings/shared risk payment models.
- **Certified Community Behavioral Health Centers (CCBHCs).** CCBHCs were created through Section 223 of the Protecting Access to Medicare Act, which established a demonstration program to expand access to behavioral health services in community-based settings. Eight states were selected at the end of 2016, under which participating clinics will receive enhanced Medicaid funding. To become certified as CCBHCs, clinics must provide a comprehensive range of behavioral health services and meet several requirements related to staffing, access, care coordination, data collection and quality, among others. CCBHCs will be reimbursed under a prospective payment system (PPS), under which states can either make quality bonus payments or incorporate a payment structure that is linked to quality outcomes.

Lastly, the federal government and states are advancing efforts to fight opioid abuse, which has become one of the deadliest epidemics in U.S. history and one that disproportionately affects Medicaid beneficiaries.¹⁸ In February 2015, for example, CMS began working with six states through the Medicaid Innovation Accelerator Program (IAP) to help them pursue strategies to improve states' substance use disorder delivery systems, including developing payment mechanisms for substance use services that incentivize better outcomes.¹⁹ CMS plans to publicly share “starting point” resources on designing episodes of care and payment bundles for medication-assisted treatment (MAT) services delivered to individuals with opioid dependence.²⁰ Pennsylvania has implemented 45 Centers of Excellence designed to integrate behavioral health and primary care for Medicaid enrollees with an opioid use disorder.²¹

Exhibit 2: Behavioral Health VBP Models in Primary Care

Although not a focus of this paper, there are also a growing number of examples of state, MCO, and provider efforts to use VBP models in primary care settings into which behavioral health providers and treatment are incorporated. Approximately 40 percent of mild-to-moderate behavioral health conditions are treated in primary care settings.²² For example, the Collaborative Care Model (CCM) (developed at the University of Washington) is a team-based approach for treating depression and other common behavioral health conditions in primary care. Teams include a primary care physician, care manager, and a consulting psychiatrist. The five core principles of the model include:²³



Patient-centered team care: Primary care and behavioral health providers collaborate using shared care plans that incorporate patient goals and targeted outcomes.



Population-based care: Care teams track and follow-up with individuals who are not improving. Mental health specialists provide caseload-focused consultation, not just ad hoc advice.



Measurement-based treatment: Treatment plans use symptom-rating scales to track clinical improvement. “Stepped care” systematically adjusts or intensifies treatment for patients that are not improving.



Evidence-based care: Patients are offered psychotherapies and medications that are proven to work in treating the target condition.



Accountable care: Providers are reimbursed for quality of care and clinical outcomes — not just the volume of care provided.

Recent research found that incorporating incentive payments that linked 25 percent of total provider payments into CCM models resulted in improved provider fidelity to key elements of CCM as well as improved patient depression outcomes.²⁴

Implementing VBP in Medicaid Behavioral Health Programs: Innovative State Examples

This section provides examples of innovative VBP models in behavioral health settings in five states: Arizona, Maine, New York, Pennsylvania, and Tennessee. Exhibit 3 provides a brief overview of each state’s model.

Exhibit 3: Overview of State Models

State	Program Scope	Medicaid Population Covered	Behavioral Health Delivery Model	VBP Strategy Based on LAN APM Framework*	Authority
Arizona	Statewide	Individuals with a serious behavioral health diagnosis	Specialty managed care carve-in	RBHAs choose strategies from Categories 2, 3 or 4	MCO contract requirements via 1915(b) waiver
Maine	Defined communities	Individuals receiving services in “Accountable Communities”	Medicaid ACO	Category 3	State Plan
New York	Statewide	Individuals with specific chronic conditions, including behavioral health	Managed care carve-in/ specialty managed care carve-in	Both Categories 3 and 4	Delivery System Reform Incentive Payment (DSRIP) Program, 1115 waiver
Tennessee	Statewide	Individuals with a behavioral health diagnosis and/or meets related utilization criteria	Managed care carve-in	Category 2	State Plan
Pennsylvania	Statewide	Individuals with a co-occurring serious behavioral/ physical health condition	Managed care carve-out	Medicaid MCO pay-for-performance**	MCO contract requirements via 1915(b) waiver

*VBP strategy determined by CHCS analysis of reviewed state and health plan documents and comparison to the LAN APM Framework Final White Paper published on January 12, 2016.

**The LAN framework does not directly apply, because payments flow from the state to MCOs, as opposed to providers.

Arizona

The Arizona Health Care Cost Containment System (AHCCCS), the state’s Medicaid program, contracts with three Regional Behavioral Health Authorities (RBHAs) that operate statewide through a specialty managed care arrangement to provide integrated behavioral and physical health services to Medicaid enrollees with serious mental illness. AHCCCS has developed several VBP initiatives to improve quality outcomes as well as advance integrated care for these individuals.²⁵ Beginning in October 2015, AHCCCS added contractual requirements for RBHAs to link, at a minimum, five percent of total payments to providers to VBP strategies. AHCCCS expects this minimum threshold to grow in coming years. RBHAs may choose one or more of several VBP strategies, including:

(1) incentives to improve behavioral health coordination in primary care; (2) pay-for-performance contracts; (3) bundled or episodic payments; (4) shared savings and/or risk; and (5) performance-based capitation strategies.²⁶ During the first contract year, most RBHAs elected to use performance-based strategies. One RBHA implemented a capitated approach with some larger provider organizations the following year. RBHAs must also choose the quality metrics to link to these payment approaches. During the first year, some used HEDIS measures such as reductions in inpatient and emergency department admissions, and follow-up with behavioral health providers within seven days post-discharge. One included measures related to social determinants of health (SDOH), such as increasing the percentage of individuals in stable housing arrangements and those who are competitively employed. Another used a measure on the reduction in individuals using drugs or alcohol.

AHCCCS has launched other initiatives to encourage physical-behavioral health integration at the provider level. Last year, it implemented a value-based differential payment model that rewards providers who meet specific delivery system goals, including integrated clinics that provide both physical and behavioral health services. These clinics may receive a 10 percent rate increase for billing certain physician services.²⁷ In January 2017, AHCCCS received funding from CMS to launch a Targeted Investments Program that will allow health plans to make payments to, and develop VBP arrangements for, providers who are building infrastructure to support integrated physical and behavioral health care management.²⁸

Maine

Maine developed its Medicaid ACO program, known as the Accountable Communities (AC) program, in 2014. Maine defines its AC program as provider-owned and driven entities (i.e., Lead Entities) that are responsible for a defined population's health and have shared accountability for both cost and quality.²⁹ Maine is one of a few states with ACO models to use multiple strategies to help ensure successful integration of behavioral and physical health services in its AC program by:³⁰

- **Including behavioral health services in the payment model** through a shared savings payment model, in which the Lead Entities can choose to accept one- or two-sided financial risk. Under the one-sided model (Model 1), ACs may receive shared savings if they meet quality performance standards, but they are not liable for shared losses. Under the two-sided model (Model 2), ACs share in a greater percentage of the savings if they meet quality expectations, but they may also incur losses. To promote integration of behavioral health, Maine includes spending on behavioral health services in its total cost of care (TCoC) benchmark, which is the projected cost estimate used to assess whether ACs have generated savings and/or incurred losses during the performance year.³¹ Including behavioral health services in the TCoC benchmark creates a powerful incentive for ACs to effectively provide and coordinate physical and behavioral health services, since costs for both of these services are accounted for when shared savings are calculated. In addition, Maine requires ACs to include behavioral health providers, and provides integration support within behavioral health practices, such as facilitating implementation of data-sharing tools.

- **Incorporating behavioral health measures in the quality score for ACs** to assess whether quality indicators and patient outcomes have improved, and to ensure that providers are not withholding health services in order to retain savings. Maine includes four behavioral health measures in its AC quality scoring: (1) follow-up after hospitalization for mental illness (tied to payment); (2) initiation and engagement of alcohol and other drug dependent treatment (tied to payment); (3) out-of-home placement for children and adults (reporting only); and (4) cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (reporting only).

New York

New York's "VBP Roadmap," a multifaceted strategy document developed in 2015 that was required as part of the terms and conditions of New York's comprehensive 1115 waiver, outlines the state's vision for Medicaid payment reform and alignment with federal, commercial, and other state initiatives.³² A 2016 updated roadmap describes four VBP options that providers and MCOs may use, under which they may choose different payment arrangements and levels of financial responsibility, ranging from shared savings only to prospective payments that largely replace FFS payments.³³ Two of these options are specifically related to behavioral health: (1) the Integrated Primary Care Bundle (which includes all care for most prevalent chronic conditions in New York Medicaid); and (2) Total Care for Special Needs Populations.

Under the Integrated Primary Care Bundle, providers are responsible for the cost and quality of services provided for 14 chronic conditions related to both physical and behavioral health, including but not limited to: asthma; hypertension; bipolar disorder; depression and anxiety; substance use; and trauma. The Total Care for Special Needs Populations implements VBP arrangements with providers who work with a subset of eligible subpopulations, including individuals with significant behavioral health needs who are covered under New York's Health and Recovery Plans (HARPs). New York recently carved Medicaid behavioral health services into its MCOs. MCOs that meet specific criteria for managing specialty behavioral health services may be certified as HARPs. HARPs offer expanded community-based benefits to individuals age 21 and older with significant behavioral health needs.

In late April 2017, to support VBP waiver activities, New York announced the launch of Value-Based Payment Pilots, a two-year program for selected MCOs and providers to transition to VBP arrangements.³⁴ Of the 13 different pilot contracts, four focus on provider groups that are serving individuals enrolled in HARPs or are involved with integrated primary care. The pilot organizations will receive support from the Department of Health and will help the state by providing lessons learned and sharing best practices for statewide VBP implementation.

On a related note, the New York Behavioral Health Clinical Advisory Group – comprised of leading experts and stakeholders tasked with evaluating subpopulations and conditions to be included in VBP arrangements – recommended that providers track outcomes related to social determinants of health (SDOH) and be reimbursed via a "Pay-for-Reporting" system. In 2017, VBP efforts involving the HARP-eligible population will include 32 core performance measures, including three measures related to SDOH outcomes:³⁵

- Percentage of members who maintained/obtained employment or maintained/improved higher education status;
- Percentage of members with maintenance of stable or improved housing status; and
- Percentage of members with reduced criminal justice involvement.

Several VBP pilots will look specifically at the impact of the use of such measures.³⁶ Overall, the HARP measure set is intended to encourage providers to meet high standards of patient-centered clinical care and care coordination across multiple care settings.

Tennessee

TennCare — Tennessee’s Medicaid program — is a comprehensive carve-in model under which each contracted MCO is responsible for covering all physical and behavioral health services, as well as long-term services and supports (LTSS). On December 1, 2016, TennCare launched Tennessee Health Link, a program that incentivizes enhanced care coordination for TennCare members with serious behavioral health conditions.³⁷ Under this program, care teams associated with a mental health clinic or other behavioral health setting provide whole-person, coordinated behavioral and physical health care for an assigned panel of members.³⁸ Using “repurposed” funding from a former case management service, Health Link providers may offer a new set of services to help members manage physical and behavioral health needs. These may include extensive coordination across providers, transitional care to manage discharges and other transfers, and referral to and follow-up to access social supports. Health Link providers are eligible for other types of compensation in addition to standard FFS payments, including:

- **Practice transformation support:** Payments from the MCOs to make clinical and organizational changes required to perform as successful Health Links.
- **New activity payments:** A set rate for each attributed member for each month specific services are delivered. These services are not traditionally covered under FFS, such as creation of care plans, care coordination, and patient and family support.
- **Outcome payments:** Health Link providers can earn up to 100 percent of possible outcome payments based on performance on core quality and efficiency metrics. Health Link providers are evaluated on 15 measures that assess efficiency (five measures, such as all-cause hospital readmissions, emergency department visits, mental health inpatient utilization, etc.) and quality (10 measures, such as psychiatric hospital readmission rates and antidepressant medication management; initiation and engagement of alcohol and drug dependence treatment; body mass index and comprehensive diabetes care; etc.).³⁹ Outcome payments to Health Link providers depend on the extent to which providers meet or exceed state- and MCO-established thresholds for each measure.⁴⁰ In order to be eligible for outcome payments, providers must surpass expectations for at least four of 10 quality measures, and demonstrate improved efficiency (i.e., better results on efficiency metrics during the performance year). The first performance period for the Tennessee Health Link program is calendar year 2017, with the first outcome payments to be made to qualifying providers in August 2018.

Pennsylvania

State-to-MCO payment arrangements may align incentives for provider-level VBP programs and promote spending on Medicaid services that support high-quality, effective care. Pennsylvania is a “carve-out” state, in which Medicaid behavioral health services are separately managed by counties, in collaboration with Behavioral Health Managed Care Organizations (BH-MCOs), while physical health services are managed by Physical Health Managed Care Organizations (PH-MCOs).⁴¹ Pennsylvania’s Department of Human Services oversees the HealthChoices program, the state’s mandatory managed care program for Medicaid enrollees. On January 1, 2016, the department launched the Integrated Care Plan Pay-for-Performance (ICP P4P) Program⁴² to improve quality and reduce expenditures through enhanced care coordination across the PH-MCOs, BH-MCOs, and providers for individuals with serious, persistent mental illness.⁴³ This program is based on two pilots, developed under the SMI Innovations Project, a project coordinated by the Department and the Center for Health Care Strategies in 2009, which tested approaches to integrating physical and behavioral health care services for adult Medicaid beneficiaries with serious mental illness (SMI) and co-occurring physical health conditions.⁴⁴ The pilot reported significant reductions in emergency department use, all-cause hospital readmissions, and mental health hospitalizations.

Under the ICP P4P program, the Department established a \$20 million-dollar funding pool for calendar year 2016, with \$10 million allocated to each type of MCO, and split up among plans based on the percent of enrollees served. BH-MCOs and PH-MCOs earn incentive payments based on annual compliance with three key process improvements tied to five performance measures:

1. **Member stratification:** All members in the targeted population must be stratified into one of four quadrants: (1) high physical/high behavioral health needs; (2) high physical health/low behavioral health needs; (3) low physical health/high behavioral health needs; and (4) low physical/low behavioral health needs. BH-MCOs and PH-MCOs must share data in order to stratify and re-stratify members every six months.
2. **Integrated care plan/member profile:** At least 500 PH-MCO members and 0.25 percent of the BH-MCO eligible population (per contract) must receive an integrated care plan that has been used in care management activities by both the BH-MCO and PH-MCO. This includes the collection, integration, and documentation of key physical and behavioral health information that is easily accessible in a timely manner to people with designated access.
3. **Hospitalization notification and coordination:** Each PH-MCO and BH-MCO must notify the other of hospital admissions within one business day, and coordinate discharge and follow-up.

Compliant PH-MCOs and counties (counties may decide to share these payments with their contracted BH-MCOs) may receive payments based on five performance measures:

1. Initiation and engagement of alcohol and other drug dependence treatment;
2. Adherence to antipsychotic medications for individuals with schizophrenia;
3. Combined physical health and behavioral health 30-day inpatient rate for individuals with serious, persistent mental illness;

4. Emergency department utilization for individuals with serious, persistent mental illness; and
5. Combined physical health and behavioral health inpatient admission for individuals with serious, persistent mental illness.

Each of these measures are weighted equally and receive 20 percent of allocated funding for each plan.⁴⁵ Payments will be based on improvement, calculated from the base measurement year of 2015, to the initial intervention year of 2016.⁴⁶ The first payout for the ICP is scheduled for August 31, 2018. While it is still too early to assess initial outcomes, representatives from Community Care Behavioral Health (Community Care), a BH-MCO that serves more than 1.6 million individuals in 39 counties in Pennsylvania, reported that the program has already led to improved coordination and cooperation between plans. In addition to state efforts, see Exhibit 4 for a description of Community Care's Assertive Community Treatment (ACT) pay-for-performance initiative.

Exhibit 4: Community Care Behavioral Health's ACT Pay for Performance Initiative⁴⁷

Community Care is one of Pennsylvania's BH-MCOs and part of University of Pittsburgh Medical Center (UPMC). It manages behavioral health services for Medicaid members in Allegheny County on behalf of the county. With the goal of reducing inpatient mental health utilization (IPMH), it implemented a pay-for-performance program for Assertive Community Treatment (ACT) services, an evidenced-based model focused on community treatment and habilitation. ACT includes an interdisciplinary team of 10 to 12 practitioners who serve about 100 consumers, resulting in a staff-to-consumer ration of approximately one to 10.⁴⁸



In 2014, Community Care collaborated with: (1) two ACT providers in Allegheny County; (2) the Allegheny County, Office of Behavioral Health; (3) Allegheny HealthChoices Inc. (AHC); and (4) a Consumer Advisory Committee. Under this arrangement, ACT providers could earn up to 110 percent of the current fee schedule rate for ACT services, with 80 percent of payments for all services rendered. Providers could earn the remaining 20 percent by reducing IPMH utilization (funded by withholding 20 percent of the established ACT service rate) and up to a 10 percent bonus amount if they met the overall target of reducing average IPMH cost per person to \$9,000 or less during the calendar year. Providers had to remain within a total ACT service utilization cost cap per person per year.

ACT providers have achieved impressive results. In 2014, both providers earned the full 20 percent withhold amount and the maximum bonus earnings of 10 percent. Providers A and B achieved a 64 and 28 percent reduction in the average inpatient cost per person per year, respectively. In 2015, both providers further reduced the average inpatient cost per person per year. From the baseline year measure, Provider A achieved a 76 percent reduction and Provider B achieved a 72 percent reduction in inpatient costs per member per year. More recently, Community Care moved to a pay-for-performance bonus that also rewards providers who improve competitive employment rates among ACT recipients.

Challenges and Considerations

Key challenges in implementing VBP models in behavioral health settings include: (1) quality measurement; (2) provider capacity; (3) oversight; and (4) privacy and data-sharing constraints. Below are considerations to help states address these challenges as well as suggestions to support MCOs and providers with more effective program implementation. Many considerations were gleaned from expert phone interviews that included state Medicaid officials from Arizona; health plan representatives from Tennessee, New York, and Pennsylvania; and other health policy experts and researchers who focus on payment and quality measurement issues in behavioral health services.

Quality Measurement

Compared to physical health, there are fewer nationally endorsed or recognized quality measures for behavioral health. Many of the behavioral health quality measures currently used in state and federal payment and delivery system reform efforts are process-oriented and focus on mental health (see Exhibit 5 for broad domains for quality measurement). At the time of this brief, the National Quality Forum (NQF) — a nonprofit organization that evaluates and endorses measures — had 653 endorsed quality measures, with 55 of those addressing behavioral health conditions. Only nine of these 55 behavioral health measures are outcome measures, in contrast to the physical health arena, which has seen broad development and implementation of outcome measures in recent years. Fifteen of the NQF-endorsed behavioral health measures are specific to substance use disorder. NQF has reported that behavioral health is a “gap area” and is working to test new measures that address measurement gaps. While states and MCOs are generally not bound to selecting measures endorsed by NQF, identifying measures deemed valid and reliable is often a key step in the measure selection process.

One challenge with measuring quality in behavioral health settings is due to basic differences in care model philosophies between physical and behavioral health care. There are more quantifiable outcome measures for physical health, such as those based on medical test results, or the presence or absence of easily identifiable physical symptoms. Recovery-based care models, which some behavioral health systems have taken steps to move toward, encourage individuals to establish personal recovery goals based on their needs, strengths, preferences, capacities, and desired health and quality of life outcomes.⁴⁹ Ideally, these programs use recovery-oriented metrics to measure meaningful patient progress as defined by the individual and focus on wellness, stability, and

Exhibit 5: Select Quality Measure Domains

- **Structural:** Assesses features of a health care organization or clinician relevant to its capacity to provide health care.
- **Process:** Focuses on steps that should be followed to provide good care.
- **Outcome:** Assesses the results of health care.
- **Patient-Reported Outcome:** Focuses on a patient’s reports concerning observations of and participation in health care.



Source: Centers for Medicare & Medicaid Services. Quality Measures Inventory User Guide and Data Dictionary. 2016. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/CMS_Inventory_User_Guide.pdf.

functionality. However, a lack of recovery-oriented measures that are widely accepted by behavioral health stakeholders represents another measurement gap for behavioral health services. To date, these concepts have been difficult to standardize and link objectively to payments.

There are several emerging strategies that could help address these challenges. First, several interviewees noted that although most programs' end goal is to improve health outcomes, using structural and process measures rather than outcome measures (especially during the first few years of a program) can help providers develop the structural components for measuring outcomes in a standardized and longitudinal way and advance to reliable data collection and accurate outcome measurement down the road. Further, focusing on process measures in early stages of VBP programs is particularly relevant in behavioral health, where evidence-based care delivery and performance measurement lags behind physical health. In addition, providers' performance on behavioral health process measures for all payers — Medicaid, Medicare, and commercial payers — tends to be lower compared to performance on physical health process measures, indicating that there is still much room for improvement on those measures. For example, recent data suggest that fewer than five percent of individuals with alcohol use disorder within the past year received related treatment from a health care practitioner.⁵⁰ To address these concerns, a phased-in measurement approach to help prepare providers to assume additional accountability and financial risk might include: (1) a focus on infrastructure measures (e.g., achieving behavioral health home certification, implementing electronic health records with specific functionalities, or hiring care coordinators); (2) quality measure reporting (e.g., collecting patient-level information on depression screenings and social factors such as housing, employment, and family supports); and (3) process measures (e.g., antidepressant medication management). Two of the most commonly used behavioral health process measures in state and federal VBP programs include screening for clinical depression and follow-up plan, and follow-up after hospitalization for mental illness.

Second, there is progress being made across the nation to expand measures around substance use disorders. For example, in May 2016, Cigna announced its partnership with the American Society of Addiction Medicine (ASAM) to improve treatment for people suffering from substance use disorders. Through this partnership, Cigna will provide claims data to ASAM and Brandeis University to test three new behavioral health measures: (1) use of pharmacotherapy for individuals with alcohol use disorders; (2) use of pharmacotherapy for individuals with opioid use disorders; and (3) follow-up after withdrawal management. CMS is also developing and testing a new measure that adapts ASAM's "use of pharmacotherapy for individuals with opioid use disorder" measure for the Medicaid population. In addition, in January 2017, NQF endorsed three quality measures related to opioid overuse.

Health care leaders in behavioral health are also increasingly testing measures related to SDOH. For example, in addition to New York — which is collecting quality data on employment, education, housing, and criminal justice, as noted earlier in the brief — Massachusetts is testing non-traditional quality measures for its ACO program that it will be launching in December 2017. These measures relate to utilization of "flexible services," which include non-medical services to address social needs and social service screening.⁵¹

Lastly, the National Committee for Quality Assurance (NCQA) is developing a broad goal attainment measure for high-need populations that indicates a pathway toward recovery-oriented outcome measurement. This proposed approach uses quantitative scales to help measure the degree to which an individual attains his or her goals, a concept that could be particularly useful in the field of behavioral health, where recovery goals and pathways may vary significantly from person to person.⁵²

Provider Capacity

VBP programs require fundamental changes in the way providers are paid and measure progress, and many behavioral health providers require assistance in developing the capacity to meet new requirements and practices. Behavioral health providers often lack the billing and data collection and reporting capacity to implement VBP models. They must also have the appropriate and often expensive technology platform or other infrastructure to access and share data. Providers may not have the capital to make early investments to assume risk, cover start-up expenses, or manage finances in new payment models when they are not paid per service or by case.

States and MCOs should consider adopting data collection, reporting, and risk arrangements slowly to ensure time to build providers' organizational and financial capacity. For example, providers may not assume risk initially to allow more time to build infrastructure and gain experience with new clinical and business practices. The amount of provider support required before a VBP program launches depends on providers' level of comfort, technological preparedness, and other resources, as well as the extent to which the new VBP model changes practice models and overhauls payment arrangements. Some interviewees suggested launching new programs via a smaller pilot or a phased-in approach, such as:

- *Year 1:* Pay providers for participation in a VBP initiative and reporting on structural measures, while maintaining a traditional FFS or case rate arrangement.
- *Year 2:* Pay providers for meeting process measures, while maintaining a traditional FFS or case rate arrangement.
- *Year 3:* Pay providers for meeting process and/or outcome measures, with providers assuming some amount of risk for these performance measures.

In addition to phased-in contracting, states and MCOs can support providers in developing successful programs in other ways. Offering technical assistance to MCOs and providers — or requiring MCOs to offer supports to providers — can be a worthy investment. Interviewees recommended assessing providers' technical assistance needs and offering tailored support, either internally or with a contracted vendor. Recommended topics include: billing, reporting, data collection processes, and care delivery model design. For common issues, structured learning collaboratives with participating providers, ideally convened in-person, may provide a valuable opportunity to discuss common challenges, collaboratively identify solutions, and network with other providers to address similar issues. States and/or MCOs could give providers intermittent feedback on their progress to confirm whether they are moving in the right direction or could benefit from support. Exhibit 6 provides an example of Colorado's Practice Transformation strategy, which provides comprehensive supports to primary care practices and community mental health centers that offer integrated care.

Exhibit 6: Colorado's Practice Transformation Strategy

A major component of the Colorado State Innovation Model (SIM) is to advance a Practice Transformation strategy to tie integrated physical and behavioral care to value-based payment. In addition to supporting 400 primary care practices that offer behavioral health services, Colorado launched the Bi-Directional Integration Demonstration Pilot, which established integrated, comprehensive care in four community mental health centers. To support these providers in developing the infrastructure and clinical capacity to provide integrated care and meet requirements for payment reforms, Colorado established multi-faceted provider supports including: (1) intensive practice coaching and targeted consultation for adapting to VBP models and addressing other specialized integration challenges; (2) customized practice facilitation and clinical HIT advisory services; (3) creating “toolboxes” of practice transformation models, templates, resources, and best practices; and (4) bi-annual learning collaboratives.⁵³



In designing these programs, states and MCOs should ensure they have an accurate understanding of the start-up costs related to staffing, technology, and other infrastructure that behavioral health providers would have to bear, and should consider what start-up costs states or MCOs could directly fund. One MCO interviewee provided an example of a model that was carefully designed with minimal incremental costs to providers, except for paying for a nurse to join the provider setting to help case managers in behavioral health clinics with individuals with complex physical health conditions. The MCO covered this expense initially, and eventually providers could earn financial incentives to pay for the nurse themselves.

Because most state, MCO, and provider experience with VBP models is in physical health, it is important for states and, as applicable, MCO leadership to identify program management staff with behavioral health expertise. This can ensure that efforts address behavioral health providers' unique challenges during a transition to a new payment arrangement, and can better support troubleshooting with providers during implementation. Based on their behavioral health expertise, these individuals can help generate buy-in and trust with providers.

Lastly, given the volume of reform initiatives underway in most states, it is important to consider other related federal, state, and local initiatives and to try to minimize provider burden and ensure multi-payer alignment. States may want to consider adopting the LAN framework across programs to guide VBP development and encourage consistent use of terminology for VBP approaches. Doing so would offer the added benefit of better aligning with CMS efforts. In addition, states may consider aligning VBP strategies with CMS' Quality Payment Program, which launched in January 2017. Although this program is focused on Medicare provider reimbursement, aligning VBP strategies with other programs could ultimately help reduce the administrative burden on states, plans, and providers.

Oversight and Collaboration

Involving MCOs, providers, and other stakeholders as relevant in design and implementation discussions is important to program development and oversight. For example, states can collaborate with MCOs and providers to seek input in determining quality measures. Doing so can build trust

among stakeholders, and result in measures that are more achievable for providers and better reflect the needs of the patient population. Being transparent about how a payment methodology is developed and recognizing reporting burdens will also aid in building providers' trust.

At the same time, it is important for states to strike the right balance between flexibility and prescriptiveness in VBP program design. The right balance differs across states and appears to be driven by existing state oversight approaches as well as MCO and provider capacities and preferences. For example, Tennessee has consistent and clearly defined requirements for all MCOs and behavioral health providers who participate in VBP arrangements. Representatives from one of Tennessee's MCOs indicated that they appreciate the level of instruction, uniformity, and guidance from the state that, coupled with a high degree of MCO and provider engagement during the design phase, contributed to smooth program implementation. Conversely, Arizona gave MCOs more latitude to choose the type of VBP model and quality measures under a broad framework, resulting in several models that are targeted to different populations and providers. Pennsylvania lands in the middle: all MCOs and providers have to report on the same quality measures, but have flexibility with designing operational processes to meet common goals. All interviewees noted that some structure upfront was helpful to provide initial guidance for implementing programs, and many appreciated some level of flexibility post-transition.

Privacy and Data-Sharing Constraints

A key component of any VBP program is access to timely, reliable, and accurate data. On the payer side, such data is needed to operationalize various components of VBP programs, including performance measurement, financial benchmarking, and patient attribution.⁵⁴ On the provider side, data is needed to assess the quality and cost of care; coordinate care; identify high-cost, high-need patients; and develop targeted quality improvement activities. While there are numerous challenges facing providers related to behavioral health data access and sharing, including lack of or incompatible electronic health record systems, one specific challenge involves the laws and regulations governing the confidentiality of a substance use disorder patient record. Title 42 of the Code of Federal Regulations (CFR) Part 2 — often referred to as 42 CFR part 2 — imposes restrictions upon the disclosure and use of alcohol and drug abuse patient information.⁵⁵ This regulation was designed to minimize stigma associated with receiving treatment for a substance use disorder by reducing concerns about disclosure of records. Negative consequences linked to disclosure may include loss of employment, housing, or child custody; discrimination by medical professionals and insurers; and/or arrest, prosecution, and incarceration. These privacy protections are important, but 42 CFR Part 2 and in certain cases state law have also created challenges for delivery system and payment reform efforts involving health care integration and information exchange. For example, Pennsylvania's ICP P4P program does not include any sharing of data on substance-use related admissions or treatment.

However, changes made to 42 CFR Part 2 in January 2017 were designed to improve the regulation by facilitating health integration and information exchange while maintaining privacy protections.⁵⁶ Selected changes include allowing patients to disclose their information using a general designation to individuals and/or entities (e.g., designated treating providers). Changes will also allow CMS-regulated entities, including ACOs, to perform necessary audit and evaluation activities. However,

unlike other patient-level health care data protected under the Health Insurance Portability and Accountability Act of 1996, Part 2 data still require patient consent to be used by others, even treating providers, except in limited circumstances.

Looking Ahead

There is growing interest among states, the federal government, MCOs, and providers in using payment levers to improve Medicaid behavioral health outcomes, encourage integration with physical health, and decrease unnecessary utilization and spending. These efforts are mostly new, reflecting several challenges with implementing VBP in a behavioral health setting. However, states, MCOs and providers are demonstrating considerable interest in testing new models and applying some of the gains achieved through VBP models for physical health services to behavioral health. There is great opportunity to address challenges and support successful programs that improve quality and reduce cost growth for people with behavioral health conditions.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

This brief was produced with support from the California Health Care Foundation. To learn more about the foundation, visit www.chcf.org.

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