

CHCS Center for
Health Care Strategies, Inc.

NATIONAL COUNCIL
FOR BEHAVIORAL HEALTH

**BEHAVIORAL HEALTH
PROVIDER PARTICIPATION IN
MEDICAID VALUE-BASED
PAYMENT MODELS:
AN ENVIRONMENTAL SCAN AND
POLICY CONSIDERATIONS**

IN BRIEF: Health care payers are increasingly shifting away from fee-for-service payment systems that reward volume to value-based payment (VBP) models that incentivize high-quality, cost-effective care. While increased access to and coordination of behavioral health services is a policy priority for federal and state policymakers,^{1,2} the extent to which the behavioral health system is engaged in VBP is less well understood than its physical health counterpart. With support from the National Council for Behavioral Health, the Center for Health Care Strategies conducted interviews primarily with behavioral health associations and community-based behavioral health providers, but also state officials, representatives of Medicaid managed care organizations (MCOs) and other subject matter experts, about the successes and challenges associated with implementing VBP for behavioral health in Medicaid programs. Informed by these interviews and a review of associated policy documents, this report describes: (1) an overview of the behavioral health system's engagement in VBP in the U.S. with a particular focus on 11 states, (2) VBP implementation lessons from the perspective of behavioral health providers and (3) policy recommendations for how state and federal policymakers, Medicaid MCOs and other stakeholders can support adoption of VBP for behavioral health.

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INTRODUCTION

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 that rewards volume, to alternative payment models (APMs) that incentivize high-quality, cost-effective care. Movement toward VBP gained traction in the U.S. after implementation of the Affordable Care Act in 2010. Current Department of Health and Human Services (HHS) Secretary Alex Azar has likewise made VBP one of the top HHS priorities for the country's health care system.³ State policymakers have embraced VBP efforts as well: a recent study found that 48 states and territories have implemented Medicaid or multi-payer VBP models.⁴ Given this context and the fact that improving access to behavioral health is a state and federal policy priority,^{5,6} it is important to understand behavioral health provider participation in VBP models and the impact of VBP on behavioral health systems. This is particularly critical for Medicaid, which is one of the largest sources of behavioral health funding: in 2015, Medicaid accounted for 24 percent of total mental health spending and 24 percent of spending on substance use disorders.⁷ Despite increasing adoption of VBP, the extent to which VBP policies are inclusive of specialty behavioral health and how this differs within states, across states and across different types of VBP models is less well understood than its physical health counterpart.

This report, produced by the Center for Health Care Strategies (CHCS) with support from the National Council for Behavioral Health, provides an overview of the behavioral health system's engagement in VBP across the U.S. with a particular focus on 11 states with high levels of activity. The report provides insights gleaned from a review of state policy documents and stakeholder interviews. For the 11 states included in the scan, CHCS reviewed materials such as state VBP program guidelines, quality measure sets and managed care contracts to assess state VBP activity. CHCS primarily conducted interviews with state behavioral health associations and community-based behavioral health providers (see Appendix A for interviewee list)⁸ about successes and challenges associated with implementing VBP for Medicaid behavioral health. Findings were also informed by a stakeholder meeting including behavioral health associations and provider representatives from 17 states, as well as input from state officials, representatives of Medicaid managed care organizations (MCOs) and other subject matter experts (SMEs). While the interviews generally focused on Medicaid, some interviewees also described relevant models in development with other payers. The 11 states reviewed include an array of VBP approaches: eight have implemented or plan to implement VBP targets in MCO contracts (including for physical health and/or behavioral health), four have implemented VBP models covering a comprehensive array of services (such as total cost of care [TCOC] models) and three have implemented behavioral health-specific VBP models. Additionally, three of these states participate in the Certified Community Behavioral Health Clinic (CCBHC) demonstration, which includes a prospective payment system based on expected cost of services. Overall, findings suggest that while VBP provides an opportunity to improve quality and access to behavioral health care, significant structural and policy barriers to VBP adoption exist for behavioral health providers. CHCS's analysis identified nine key themes that support successful behavioral health VBP design and implementation that can help inform ongoing efforts across the states. These themes, outlined in Exhibit 1, are detailed in the next section of this paper.

EXHIBIT 1

Key Themes to Support Successful Behavioral Health VBP Design

- 1) Some behavioral health providers have seen benefits from participation in VBP models and the CCBHC demonstration, including improvements in care delivery and increased financial stability.
- 2) Broadly defined VBP targets for MCOs do not necessarily result in new payment models for behavioral health providers.
- 3) Approaches to key VBP design elements, such as attribution and governance, impact behavioral health's ultimate level of involvement in VBP models.
- 4) State governance structures and policy landscapes impact the extent of VBP adoption for behavioral health.
- 5) Unique aspects of behavioral health provider operations may require tailored VBP policy approaches.
- 6) VBP provides an opportunity to address funding gaps in the behavioral health system in a way that is tied to performance and accountability.
- 7) Case rate or population-based payment models tied to performance would enable greater flexibility in service delivery and provide a more meaningful financial incentive than pay-for-performance.
- 8) Developing more meaningful behavioral health-focused quality measures, while reducing overall measurement and reporting burden, is needed to support VBP.
- 9) Behavioral health providers would likely benefit from technical assistance and infrastructure funding to support development of new capabilities necessary to implement VBP.

OVERVIEW OF STATE VBP POLICIES AND BEHAVIORAL HEALTH SYSTEM INVOLVEMENT

Two common state strategies to advance VBP in general and for behavioral health are: (1) implementing VBP targets in MCO contracts and (2) designing specific VBP models. Setting VBP targets is a more flexible policy strategy, allowing MCOs and providers to negotiate and implement a wide range of models to suit their specific priorities, populations and capabilities. Designing specific VBP models is a more prescriptive strategy that has the advantage of more statewide standardization in VBP models, which ensures consistency and increases ability to evaluate models. States that design specific VBP models may implement broad VBP arrangements covering a comprehensive range of services or more narrow models focusing on, for example, behavioral health services and/or populations with behavioral health needs. For a summary of VBP activity in states included in this environmental scan, see Appendix B.

VBP TARGETS IN MCO CONTRACTS

A growing number of state Medicaid programs use MCO contract language to advance uptake of VBP for physical and behavioral health. One of the most common approaches is to set statewide “VBP targets,” which typically require that a set percentage of MCO capitation payments fall within qualified VBP arrangements. As of May 2019, at least 15 states included VBP targets through either MCO contract language or Section 1115 demonstration waivers.⁹ The extent to which such VBP targets impact the behavioral health system depends, in part, on (1) whether targets occur as part of a “carve-in,” “carve-out” or specialty managed care arrangement and (2) whether the contract language explicitly references behavioral health services or providers. For more details on Medicaid managed care arrangements used for behavioral health, see Exhibit 2.

EXHIBIT 2

Medicaid Managed Care and Behavioral Health

States may provide Medicaid services under a FFS model, a managed care model or both.¹⁰ As of fiscal year 2016, 38 states used comprehensive risk-based managed care to reimburse for Medicaid services covering 69 percent of Medicaid recipients.¹¹ States can use different managed care arrangements to provide behavioral health services, including:

- ▶ **Traditional specialty carve-out.** In a carve-out, some or all behavioral health benefits are managed by a specialized organization, either a private or a public entity, which is separate from the entity managing physical health benefits.¹² Nine states currently operate a behavioral health carve-out arrangement.^{13,14}
- ▶ **Integrated financing for physical and behavioral health (i.e., a carve-in).** Thirty-one states currently provide behavioral health services through an integrated managed care benefit.¹⁵ Under a carve-in arrangement, MCOs receive a payment to manage both behavioral and physical health services, among other services.
- ▶ **Specialty managed care model.** In four states there are specialized managed care organizations or plans that manage all physical health and behavioral health benefits for individuals with serious behavioral health needs.^{16,17}

Some states use multiple types of managed care arrangements for behavioral health services with financing arrangements differing by population.¹⁸ States may also carve-in some behavioral health services, while carving-out others.¹⁹





DEFINING VBP

A number of states use the Health Care Payment Learning and Action Network (LAN) APM framework to define VBP (see Exhibit 3). For example, Washington State defines VBP as Category 2C (pay-for-performance [P4P]) or higher. Other states may decide to create their own VBP categories. For example, Pennsylvania’s Office of Mental Health and Substance Abuse Services took this approach by defining its own small, moderate and large risk VBP categories.²⁰

EXHIBIT 3

Introduction to LAN APM Framework

There are several frameworks for VBP, but the most commonly used model is the LAN APM framework, which was created by HHS in collaboration with partners in the public, private and nonprofit sectors. The LAN framework is increasingly used as a tool by the Centers for Medicare and Medicaid Services (CMS), states and private payers to establish consistent terminology and define the levels of risk in, or sophistication required for, types of VBP models.

			
<p>CATEGORY 1 FEE-FOR-SERVICE – NO LINK TO QUALITY AND VALUE</p>	<p>CATEGORY 2 FEE-FOR-SERVICE – LINK TO QUALITY AND VALUE</p>	<p>CATEGORY 2 FEE-FOR-SERVICE – LINK TO QUALITY AND VALUE</p>	<p>CATEGORY 4 POPULATION-BASED PAYMENT</p>
	<p>A</p> <p>Foundational Payments for Infrastructure and Operations (e.g., care coordination fees and payments for health information technology [HIT] investments)</p>	<p>A</p> <p>APMs with Shared Savings (e.g., shared savings with upside risk only)</p>	<p>A</p> <p>Condition-Specific Population-Based Payment (e.g., per member per month payments or payments for specialty services, such as oncology or mental health)</p>
	<p>B</p> <p>Pay-for-Reporting (e.g., bonuses for reporting data or penalties for not reporting data)</p>	<p>B</p> <p>APMs with Shared Savings and Downside Risk (e.g., episode-based payment for procedures and comprehensive payment with upside and downside risk)</p>	<p>B</p> <p>Comprehensive Populations-based Payment (e.g., global budgets or full/percent of premium payments)</p>
	<p>C</p> <p>Pay-for-Performance (e.g., bonuses for quality performance)</p>		<p>C</p> <p>Integrated Finance and Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)</p>
		<p>3N Risk-based Payment NOT Linked to Quality</p>	<p>4N Capitated Payments NOT Linked to Quality</p>

Source: *Alternative Payment Model (APM) Framework: Refresh for 2017.* The MITRE Corporation. 2017. Available at: <http://hcp-lan.org/work-products/apm-refresh-whitepaper-final.pdf>.

SETTING VBP TARGETS

State VBP targets, including for physical health and/or behavioral health services, often depend on the type of provider or VBP arrangement selected (see Exhibit 4). Many states, such as Texas and Washington, set a single annual VBP target within integrated managed care contracts that applies generally to physical health and behavioral health providers (i.e., the state defers to the plan on which types of contracted providers to engage in VBP contracting). Pennsylvania, which operates a carve-out arrangement, has set different VBP targets for physical health and behavioral health MCO contracts with relatively lower targets for behavioral health MCOs as described in Exhibit 4. Oregon recently proposed language for its new coordinated care organization (CCO) contracts that requires use of VBP within five “priority areas,” one of which is behavioral health. States such as Texas and Pennsylvania have broad VBP targets as well as sub-targets for more advanced VBP arrangements, such as capitated models. States also tend to increase VBP targets and/or encourage adoption of more advanced models over time.

EXHIBIT 4	Sample of VBP Targets in Medicaid Managed Care Contracts		
Oregon ²¹	Covers a broad set of services, additional requirements to implement new or expanded VBPs in specific areas.	In 2020, VBP will be defined as Health Care Payment Learning and Action Network (LAN) Category 2C or higher. Behavioral health is one of five priority areas for which CCOs must develop new or expanded VBP models.	CCOs must have at least 20% of their projected annual payments to providers in contracts that include a VBP component by January 2020.
Pennsylvania ^{22, 23}	Different for physical health and behavioral health managed care contracts.	<p>Behavioral health VBP defined as:</p> <ul style="list-style-type: none"> • Small risk: performance-based contracting • Moderate risk: bundled/episodic payment, shared savings, shared risk • Large risk: capitation or capitation plus performance-based contracting <p>Physical health defined as: “A model which aligns more directly to the quality and efficiency of care provided, by rewarding providers for their measured performance across the dimensions of quality.” May include gain sharing contracts, risk contracts, episodes of care payments, bundled payments and contracting with Centers of Excellence and Accountable Care Organizations (ACOs).</p>	<p>Behavioral health: 2019 behavioral health target: 10% of the medical portion of the capitation must be expended through VBP strategies. At least 50% of the 10% must be from a combination of moderate or large financial risk categories.</p> <p>Physical health: 30% of the medical portion of the capitation and maternity care revenue rate must be expended through VBP. At least 50% of the 30% must be in risk-based arrangements.</p>

EXHIBIT 4	Sample of VBP Targets in Medicaid Managed Care Contracts		
Texas* ^{24,25,26}	Covers broad set of services.	VBP models should “be designed to improve health outcomes for members, empower members and improve experience of care, lower health care cost trends and incentivize providers.” Risk-based APM must meet HCP-LAN categories 3B, 4A or 4B.	2019 target: 31.25% of provider payments must be in APM (including risk and non-risk-based) and 12.5% of provider payments must be in risk-based APM.
Washington* ²⁷	Covers broad set of services.	Category 2C or higher.	2019: 75% of MCO health care payments to providers must be within qualifying VBP arrangements. ²⁸

*Texas and Washington use the original version of the LAN framework (2016) for VBP category definition.

Behavioral Health-specific VBP Models

Some states have implemented VBP models designed specifically for behavioral health providers. A few examples include:

- ▶ **New Hampshire Capitated Payments for Community Mental Health Providers:** Capitated payments for community mental health providers (CMHPs) have been in place for some New Hampshire Medicaid MCOs since 2014 but will be a required model for all MCOs going forward. New Hampshire pays CMHPs a per member per month (PMPM) fee for four clinical eligibility categories (serious and persistent mental illness [SPMI], serious mental illness [SMI], severe emotional disturbance and low utilizers). These PMPM payments are state “directed payments” to CMHPs, meaning the payment is passed to CMHPs without MCOs taking out a portion for administrative costs or profit. The payments are linked to quality performance, but the approach varies by MCO.
- ▶ **Tennessee Health Link:** Tennessee developed a Medicaid care coordination program called Health Link based largely on CMS’s health home model for individuals with SMI and substance use disorder (SUD) diagnoses. Payments for care coordination and care management activities are monthly case rates. Providers are also eligible for outcomes payments based on quality/efficiency metric performance.²⁹ While community mental health centers (CMHCs), federally qualified health centers (FQHCs) and other mental health agencies are eligible to be Health Links, the majority of participating providers are CMHCs.
- ▶ **Vermont Mental Health Case Rate:** Mental health agencies receive a fixed prospective monthly payment at the beginning of each month and are expected to meet established case load targets by delivering at least one qualifying service to an individual in a given month.³⁰ VBPs are made through a separate quality payment stemming from newly-appropriated funds by the legislature. Measures for the program are pay-for-reporting in year 1 (2019), but in future years, these measures will focus on providers’ ability to achieve specific benchmarks that are agreed upon between the providers and the state.

- ▶ [Certified Community Behavioral Health Clinics \(CCBHC\)](#): CCBHC is a federal demonstration program authorized by Section 223 of the Protecting Access to Medicare Act and implemented in collaboration with states with the goal of improving access to and quality of behavioral health services. Eight states were selected to participate in the demonstration at the end of 2016, under which participating clinics receive bundled Medicaid funding. To become a CCBHC, clinics must meet federal certification criteria that require provision of a comprehensive range of behavioral health services as well as other capabilities in areas such as staffing, access, care coordination and quality reporting. CCBHCs receive Medicaid payment through a clinic-specific and state-approved prospective payment system (PPS) rate based on expected cost of demonstration services. The demonstration also requires provider and state reporting of quality measures.

The CCBHC demonstration may be considered a P4P model depending on the payment methodology implemented by each state. States are either required or have the option to offer quality bonus payments (QBP) to CCBHCs meeting state-determined performance goals for a set of quality measures. Seven of the eight states are incorporating QBPs into CCBHC payment.^{31, 32}

A growing number of VBP models to support identification and treatment of behavioral health conditions have also been developed by other organizations, including the Center for Medicare and Medicaid Innovation (CMMI) and provider associations. Provider associations and other relevant experts developed the addiction recovery medical home model³³ and the patient-centered opioid addiction treatment APM,³⁴ which are currently being tested for implementation with commercial payers and selected Medicaid managed care plans. Additionally, recent funding opportunities by CMMI, such as the Integrated Care for Kids model³⁵ and Maternal Opioid Misuse model,³⁶ include development of a VBP model that includes cross-system integration and is specifically designed for the services and systems (including behavioral health) that work with mothers pre- and post-natal.

VBP Models Covering a Comprehensive Array of Services

States have also developed broader VBP models that include behavioral health as part of a more comprehensive range of services. Many of these types of models, such as TCOC models or primary care-focused models, aim to improve integration of behavioral health into primary care. However, because primary care providers were not interviewed for this paper, the impact of VBP on behavioral health integration is not examined here. VBP models focused on behavioral health integration are explored in other Center for Health Care Strategies reports^{37, 38, 39} and broader VBP literature.^{40, 41, 42, 43}

- ▶ [TennCare Episodes of Care](#): Tennessee operates a comprehensive episodes of care program that covers both physical and behavioral health-related conditions, including episodes for attention deficit hyperactive disorder (ADHD) and oppositional defiant disorder (ODD). Tennessee's episode-based payment program aims to incentivize high quality and efficient care during an "episode of care" in which acute or specialist-driven health care is delivered during a specified

time period to treat a physical or behavioral condition.⁴⁴ For ADHD and ODD episodes, patients are attributed to providers with the plurality of visits for ADHD/ODD during the episode window;^{45,46} this may be primary care or behavioral health providers. Under this model, providers may be eligible to share in savings if they meet all quality benchmarks and episode spend is below a “commendable” threshold or, alternatively, owe a risk-sharing payment if episode spend exceeds an “acceptable” threshold.⁴⁷

- ▶ **MassHealth ACOs:** MassHealth contracts with ACOs to deliver physical health care, mental health care and addiction treatment to a defined group of MassHealth members. Attribution is based on the patient’s primary care provider. As a part of the model, ACOs must also work with state-contracted community partners for care management of members with significant behavioral health or long-term services and supports needs. ACOs are paid either a prospective capitated rate or achieve shared savings/shared loss against a TCOC benchmark, depending which of the three state-defined ACO models they participate in.⁴⁸ MassHealth pays community partners directly, via PMPM payments for months in which they provide outreach and care coordination supports. In the future, community partner payment will include a quality performance withhold.
- ▶ **Vermont All-Payer ACO:** Vermont’s All-Payer ACO is based largely on Medicare’s Next Generation ACO model. It uses prospective capitation for hospital services with a quality withhold and a risk corridor capped at three percent savings/losses for Medicaid. Attribution is generally based on the patient’s primary care provider.⁴⁹ Currently, services covered directly by the Department of Medicaid, including behavioral health services, are included in the cost benchmarks but mental health and substance abuse services paid through other state departments (e.g., Mental Health, Child Welfare or Early Childhood) are not. The only ACO participating in the program, OneCare Vermont, currently provides care management fees to CMHCs to support their work and the state is in discussions about how to further incorporate behavioral health into the ACO going forward. Vermont has prioritized health outcomes and quality of care targets in four areas; two relate directly to behavioral health: substance use disorder and suicide.
- ▶ Models defined through **New York’s VBP Roadmap:**⁵⁰ New York’s VBP Roadmap is a multifaceted, evolving strategy document that outlines the state’s vision for VBP in its Medicaid program.⁵¹ The current version of the VBP roadmap describes a variety of VBP options and levels of financial responsibility, ranging from shared savings to prospective PMPM or bundled payment.⁵² Two VBP options are specifically related to behavioral health: (1) the Integrated Primary Care Bundle, which includes care for the most prevalent physical and behavioral chronic conditions in New York Medicaid, including but not limited to asthma, hyper-tension, bi-polar disorder, depression and anxiety, substance use and trauma; and (2) Total Care for Special Needs Populations, which implements TCOC 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).⁵³ State guidelines recommend patient attribution based on Medicaid MCO-assigned PCP for the former and Medicaid MCO-assigned health home for the latter model, though MCOs and VBP contractors may develop alternate methodologies.^{54, 55}

Quality Measures Used in VBP Models Impacting Behavioral Health

Linking payment to quality incentives is an essential element of VBP, as defined by the LAN APM framework.⁵⁶ For an overview of behavioral health quality measure types, see Appendix C. While the majority of quality measures used in behavioral health VBP programs are considered process measures, efforts are ongoing to create outcome-based measures. The number and type of quality measures used to assess behavioral health provider performance depends, in part, on which type(s) of VBP arrangement a state chooses to implement. Overall, states with behavioral health-specific VBP models are more likely to “move beyond” traditional Healthcare Effectiveness Data and Information Set (HEDIS) measures. For example, for its Children’s Mental Health System, Vermont has proposed to assess the percentage of clients who have improved upon annual review of the Plan of Care, as well as administration of the Child and Adolescent Needs and Strengths (CANS) survey.⁵⁷ Meanwhile, TennCare’s ADHD and ODD episodes link payment to quality measures directly related to these two conditions.⁵⁸

CCBHC quality measures provide another example of moving beyond HEDIS measures in a manner that could be expanded across the behavioral health system and could inform ongoing VBP design efforts. They include a range of access-related measures (e.g., time to initial evaluation), process measures (e.g., documentation of current medications in medical records), outcome measures (e.g., death by suicide) and measures addressing social determinants of health (e.g., housing status). Additionally, the CCBHC measure set includes measures relevant to adult and pediatric populations and incorporates behavioral and physical health measures for behavioral health providers.⁵⁹

States with more comprehensive VBP models are more likely to use TCOC measures and measures addressing social determinants of health (SDOH) in addition to behavioral health measures. For example, New York’s quality measure menu for its HARP VBP model includes measures related to employment, education, housing and criminal justice.⁶⁰ Massachusetts ties ACO payment to health-related social needs screening and many behavioral health quality measures, such as depression remission or response, emergency department (ED) visits for individuals with mental illness and initiation and engagement of alcohol or other drug abuse or dependence treatment. Massachusetts also ties ACO payment to measures directly related to the Community Partners program including beneficiary engagement with Community Partners and community tenure for participating beneficiaries.⁶¹ Vermont’s ACO quality measure set includes numerous behavioral health-related measures, including initiation and engagement of alcohol and other drug abuse or dependence treatment, deaths related to suicide or drug overdose and percent of the attributed population receiving medication-assisted treatment (MAT) for opioid overdose.⁶²

LESSONS FROM BEHAVIORAL HEALTH PROVIDERS ON VBP IMPLEMENTATION

Interviews with behavioral health providers and associations suggested that many behavioral health providers see VBP as an opportunity to improve care and are actively seeking opportunities to participate in behavioral health VBP models. At the same time, many of these interviewees also described challenges with VBP policies and programs, such as lack of MCO or health system engagement with behavioral health providers, regulatory and contracting barriers and challenges designing payment models appropriate for behavioral health providers. Overall, these interviews suggested that success factors for VBP include robust stakeholder engagement, adequate behavioral health rates and predictable payment under VBP, VBP models that allow for flexibility in behavioral health care delivery and support for developing new infrastructure and staff competencies.

1 *Some behavioral health providers have seen benefits from participation in VBP and the CCBHC demonstration, including improvements in care delivery and increased financial stability.*

While many VBP arrangements discussed through our interviews are relatively new, with evaluation efforts still underway, several behavioral health providers and associations relayed that they have begun to see early successes on the ground. Some interviewees described how VBP models can provide greater flexibility and incentives to deliver holistic, coordinated care. For example, one behavioral health association interviewee described that moving from FFS to a capitation model removed the constraint of having to focus on delivering billable services, which allowed providers more freedom to deliver services they deemed to be most valuable to patients, such as additional telehealth, case management and prevention services. Additionally, many interviewees described that increased collection and analysis of quality, service and cost data resulting from VBP was beneficial for quality improvement and/or demonstrating the value of behavioral health services. For example, one behavioral health provider described how seeing trends in patient outcomes helps them better understand patient progress and needs, which helps them better advocate and care for patients.

Additionally, behavioral health providers and associations described that behavioral health services have historically been underfunded and that participation in some VBP models or federally-funded programs, like CCBHC, can allow for additional or more predictable funding for the behavioral health system, ultimately improving access to behavioral health care. For example, interviewees in CCBHC states described that the model is an important means of providing much needed additional resources to the behavioral health system as cost-based prospective payments have allowed them to hire additional staff, invest in necessary infrastructure, such as health information technology (HIT) and expand access to services.

2 *Broadly-defined VBP targets for managed care organizations do not necessarily result in new payment models for behavioral health providers.*

The experience of behavioral health providers in multiple states suggests that broadly-defined VBP targets for managed care organizations may not lead to VBP for behavioral health providers. As described in the previous section, some states set Medicaid VBP target percentages in MCO contracts that apply to all provider payments, inclusive of both physical and

behavioral health expenses. Interviews with behavioral health providers and associations in such states suggested that under these types of targets, MCOs may choose to enter into VBP contracts with physical health or large volume providers only, even when behavioral health providers express interest in VBP. Interviewees described that it can be challenging for behavioral health providers to know how to begin VBP negotiations or solicit interest from MCOs in behavioral health VBP arrangements. Specific challenges include the small sub-set of the overall target population behavioral health providers serve and the small size of many behavioral health providers. Behavioral health provider and association interviewees suggested that MCOs contracting with many small behavioral health providers may be administratively burdensome for MCOs and be an inefficient means of meeting broad MCO VBP targets. Interviewees also described how in some states that recently integrated financing for behavioral health and physical health services, MCOs may have less experience managing and contracting with behavioral providers than physical health providers. Newly contracted MCOs and behavioral health provider organizations may need to build relationships and infrastructure before negotiating VBP contracts. Additionally, interviewees described how the proliferation of broad VBP models based on primary care attribution, including some state-designed models, may also reduce MCOs willingness or ability to enter into VBP models with behavioral health providers. As will be explored in more detail, in states that promote VBP models based on primary care attribution, additional policies may be needed to promote behavioral health provider inclusion.

3 *Approaches to key VBP design elements, such as attribution and governance, impact behavioral health's ultimate level of involvement in VBP models.*

Similarly, behavioral health provider and association interviewees reported that broadly-defined VBP models, such as TCOC models covering a comprehensive range of services, do not necessarily engage behavioral health providers in meaningful ways. Such models generally base patient attribution on the patient's relationship to their primary care provider (see previous section for examples), usually making physical health providers the primary VBP contractors. Interviewees described that when VBP is contracted through physical health providers, community-based behavioral health providers often do not have a significant voice in VBP design and operations or a clearly defined role in VBP models. Moreover, physical health provider entities held accountable for TCOC in VBP models often do not have community behavioral health provider participation in the governance of these models.

Additionally, attribution drives which entity is ultimately accountable for cost and quality and, as a result, which entities are eligible to share in savings. For this reason, while physical health-focused entities may be accountable for behavioral health costs or quality measures under TCOC models, models with primary care-based attribution usually do not change payment for behavioral health provider organizations, absent additional VBP arrangements. In general, there are some issues that exist in VBP implementation across the board and need to be addressed. Behavioral health providers and associations specifically reported that VBP incentives under TCOC arrangements are often not enough to encourage such secondary VBP arrangements or shared savings between physical health and behavioral health providers. To the contrary, one interviewee described how a hospital participating in an ACO reacted negatively to demonstrated ED cost savings resulting from enhanced behavioral health

interventions. Behavioral health associations also suggested that physical health providers sometimes build new capacity for behavioral health services and care management instead of improving coordination with existing community behavioral health providers. Even when physical health organizations do engage behavioral health providers in VBP arrangements, incentives may not be impactful if payments are not large enough or predictable. One behavioral health provider reported that only some local health systems pay them performance bonuses and that there is no opportunity to negotiate such payment. This organization was able to make some operational improvements based on new payments for specific programs, but generally operate the same as they always had.

Collectively, interviews suggested that VBP may be most effective at engaging behavioral health providers when models have a clearly defined role for behavioral health providers. As described in the previous section, some states require behavioral health provider participation in VBP by designing models specifically for specialty behavioral health services and/or in which patients are attributed to behavioral health providers. Interviewees also described other potential strategies for engaging behavioral health provider in broader VBP models, such as requiring physical health providers to work with and/or share savings with community behavioral health providers for delivery of care management services or specialty behavioral health services.

4

State governance structures and policy landscapes impact the extent of VBP adoption for behavioral health.

It is widely understood that state agency structures, strategies for contracting with MCOs and behavioral health regulations can be barriers to behavioral health integration with physical health care at the clinical level.^{63, 64, 65} Behavioral health providers and association interviewees specified how these same barriers introduce challenges for behavioral health VBP. In terms of structural considerations, some behavioral health provider, association and state government interviewees explained that multiple state departments may oversee different pieces of the health care delivery system, limiting the scope of VBP arrangements that are feasible. For example, in some states, Medicaid agencies oversee payment for physical health services while other departments oversee provision of many mental health, SUD or children's services. Similarly, through behavioral health MCO carve-outs, some states contract with separate MCOs for physical health and mental health services. This lack of integration at the state and MCO level can impede development of VBP models that include physical and behavioral health services or models targeted at certain subpopulations as different entities control and are accountable for different costs. For example, behavioral health carve-outs from physical health MCO contracts may create a barrier in developing models that share savings from reduced physical health costs with behavioral health providers whose services impact physical health care.

At the same time, some associations cautioned that integrating physical and behavioral health services through managed care can be disruptive and impede VBP in the short term. Transitioning to a new contracting structure means providers may need to develop new payment processes, adapt to new regulatory guidance and develop new relationships with state or MCO contacts. For example, behavioral health associations from multiple states described that in some cases, moving from a behavioral health carve-out to an integrated MCO arrangement resulted in a shift from capitation or case rate payments for certain behavioral health organizations (not tied to quality) to FFS. Interviewees from another state described that MCO integration

resulted in behavioral health providers having less of a voice in payment design, as management of behavioral health benefits shifted away from behavioral health provider-owned MCOs. Collectively, these experiences highlight that where carve-ins may support behavioral health VBP models in the long run, they do not necessarily lead to immediate behavioral health VBP uptake, absent additional state action.

Some states have flexible VBP policies, in which MCOs and providers are given leeway to develop a wide range of VBP arrangements. Behavioral health provider and association interviewees in these states described that negotiating contracts with multiple MCOs and implementing multiple VBP arrangements can be administratively burdensome, particularly in states with a large number of health plans or in states with regional MCO contracting where provider services areas may not align with MCO service areas. For example, some behavioral health provider and association interviewees described differing quality measures across contracts as contributing to administrative burden. Others described that it can be challenging for behavioral health providers to know how to begin VBP negotiations or get MCOs interested in VBP arrangements. Interviewees also describe how contracting with multiple MCOs reduces the total patient volume that each plan has attributed to a particular provider,⁶⁶ reducing MCO incentives to negotiate with individual behavioral health providers and exacerbating challenges of developing feasible VBP models. At the same time, behavioral health providers may disagree about the level of VBP standardization that is appropriate. State and behavioral health association interviewees described that some behavioral health providers worry that standardization may hinder innovation or push organizations to take on more risk than they are able to manage. Two state government interviewees recognized the challenge of MCO contracting and described that their states are considering offering more prescriptive guidance or supporting alignment efforts on specific aspects of VBP models.

In some cases, state behavioral health regulations also impede VBP implementation by increasing administrative burden on providers or constraining how behavioral health care is delivered. Behavioral health provider and association interviewees reported that some states have behavioral health care regulations that are outdated and more burdensome than physical health regulations but may be difficult to change. One behavioral health provider interviewee with experience in physical health and behavioral health systems described that behavioral health visits require much more documentation, such as progress notes and frequent treatment plan reviews, than many physical health procedures. Interviewees reported that such regulations can impede providers from redesigning care in ways that improved efficiency or quality to meet VBP goals.

5 *Unique aspects of behavioral health provider operations may require tailored VBP policy approaches.*

Behavioral health provider and association interviewees emphasized that differences between behavioral health and physical health services, infrastructure and operations should be considered when developing VBP policies. Existing payment models for behavioral health providers may be different than for physical health providers and interviewees described how understanding these differences is necessary for effective implementation of new approaches. For example, behavioral health association interviewees from three states reported that some behavioral health providers had been paid a capitated rate by health plans under a behavioral health carve-out model, but that integrated MCOs required a move to fee-for-service, which

felt like “moving back” in some ways. In addition to differences in payment models, behavioral health providers may have more fragmented payment streams than physical health providers, in part due to the fact that behavioral health services are often paid for by multiple state departments, as described in the previous section. One state government interviewee described that prior to VBP implementation, behavioral health providers had payment streams from a variety of state entities with varying program eligibility requirements. Interviewees in this state described how one explicit goal of payment reform in this context was to reduce payment complexity and administrative burden. Overall, interviewees suggested that understanding historical behavioral health payment structures is important for developing future VBP goals and leveraging existing infrastructure to support new payment models.

Some interviewees described that factors such as the chronic nature of behavioral health conditions and quality of available behavioral health data should be factored into VBP design. Behavioral health provider and association interviewees from one state suggested that some VBP approaches that are appropriate for acute physical health conditions, such as episode-based payments based on an FFS architecture, may be a poor fit for chronic behavioral health conditions since it can be difficult to define appropriate, clinically relevant time frames for chronic behavioral health condition episodes. Similarly, another SME suggested that long-term addiction recovery would be better supported by VBP models designed to support treatment and track outcomes over multiple years, rather than shorter-term models. Beyond the nature of behavioral health care, some behavioral health provider and association interviewees described that policymakers should consider the quality or type of available behavioral health data when designing VBP models. Interviewees in one state described that, historically behavioral health providers submitted less detailed claims data to MCOs than physical health providers. As a result, historic claims data in that state were not able to accurately capture prevalence and intensity of co-occurring behavioral health conditions and patient complexity to inform VBP design.

Many behavioral health provider and association interviewees emphasized the importance of behavioral health stakeholder engagement to facilitate effective VBP policy development and inform policymakers about behavioral health system operations. Interviewees suggested behavioral health providers should be engaged early in the VBP design process, when input can meaningfully impact state policy and program decisions. Adequate time for stakeholder engagement may also be needed to overcome challenges such as initial distrust between stakeholder groups, variation in terminology or gaps in mutual understanding.

6 *VBP provides an opportunity to address funding gaps in the behavioral health system in a way that is tied to performance and accountability.*

In general, a key challenge to implementing Medicaid VBP models are the relatively low base payments that VBP arrangements are built upon. Along these lines, behavioral health providers and associations suggested that it is important for policymakers to consider historically low behavioral health payments when designing VBP models. While VBP models based on historical behavioral health reimbursement rates may allow for increased quality improvement and care delivery flexibility, holding total

payment amounts steady may not address underlying resource constraints that limit access to care. Withholding dollars from an already low reimbursement rate, a commonly used methodology to implement a payment model, is counterproductive. Instead, behavioral health providers and associations suggested that the push for VBP adoption presents an opportunity for policymakers and plans to direct additional funding to the behavioral health system. Interviewees also emphasized that behavioral health providers often provide care management and coordination with other organizations to address health-related social needs and are key strategies for reducing avoidable hospital and emergency department use and achieving VBP goals. Sharing savings across physical health and behavioral health systems in a more directed and planful way could support increased investment in evidence-based behavioral health services, particularly to the extent that savings are realized through reductions in physical health, rather than behavioral health costs. Considering the funding amounts and the provision of care management and coordination regarding related social needs would provide opportunities for the behavioral health system to engage in increased focus on high performance and outcomes.

Behavioral health providers and associations also suggested that VBP rates and cost benchmarks need to be adequately risk-adjusted to support delivery of comprehensive behavioral health services. Some interviewees described that VBP benchmarks and rates have not been adequately risk-adjusted to account for patients with varying levels of behavioral health needs. For example, interviewees mentioned the importance of understanding and adjusting rates as needed for differences in complexity between patients with behavioral health needs who typically seek services at physical health versus behavioral health providers. These interviewees suggested that patients who receive behavioral health care from specialty health providers tend to be more complex than those that seek care from primary care providers, even among populations with the same diagnosis. Behavioral health providers and associations stressed that rates upon which VBP models are built need to be robust enough to cover high-value services and interventions that may be resource intensive, such as patient engagement, care management and coordinating social services for complex populations.

7 *Case rate or population-based payment models tied to performance would enable greater flexibility in service delivery and provide a more meaningful financial incentive than pay-for-performance.*

While behavioral health provider and association interviewees did not favor one particular VBP model for behavioral health, they generally suggested that VBP policies need to move beyond P4P models to be most impactful. Many interviewees described that P4P models are one of the more commonly adopted VBP models among behavioral health providers; however, tying a relatively small percentage of reimbursement to quality measures may not offer large enough incentives or enough flexibility to behavioral health providers to significantly impact care delivery, while population-based payment methods or case rates could. Multiple behavioral health providers and association interviewees felt that such models could be most effective if, in addition to upfront cash flow, they included reduced administrative requirements and oversights (e.g., reduced claims submission requirements, removing preauthorization requirements for high-performing providers) and greater opportunity to demonstrate their contributions to and accountability for outcomes. Similarly, a health plan and a state government interviewee described reduced administrative burden on their end as a goal for VBP.

While many interviewees were optimistic about the potential of more advanced VBP models to improve care, state and behavioral health association interviewees also acknowledged that some providers may be hesitant to take on significant financial risk. While determining how much financial risk providers are able to take on is an ongoing challenge for VBP implementation in general, including for ACOs and primary care models, interviews suggested implementing risk-based models may be particularly challenging in behavioral health systems which are often comprised of mostly small providers. Many behavioral health providers are too small to develop robust infrastructure to manage risk and, in some cases, existence of many MCOs within a state may further reduce the total patient population that could be attributed to a single model. An additional challenge is that low-volume providers are subject to increased random variation in medical expenditures. Some states are encouraging, and some providers are considering, entering into new organizations or partnerships, such as independent provider associations or ACOs, to help address these issues. Payers may also consider VBP design strategies such as risk corridors, excluding catastrophic costs and truncating extreme expenditures to make models appropriate for low-volume providers.⁶⁷

8 *Developing more meaningful behavioral health-focused quality measures, while reducing overall measurement and reporting burden, is needed to support VBP.*

Overall, as adoption of VBP has led to a proliferation of quality measures, stakeholders have identified the need for quality measure alignment across programs and development of more meaningful measures.^{68,69} Behavioral health providers and association interviewees echoed and elaborated on this challenge, describing how more meaningful measures can be developed for behavioral health, especially for specialty behavioral health care. Behavioral health providers and associations reported that commonly used measures, such as HEDIS measures, are useful, but often do not capture the full range or value of behavioral health services. Several interviewees also pointed out that many National Quality Forum (NQF)-endorsed measures used in VBP models relate to treatment of depression, but few of the other wide range of conditions treated in behavioral health settings. Some interviewees favored including more outcome measures that show improved health outcomes for other populations with SMI or SUD, such as those with schizophrenia, bipolar disorder or alcohol or opioid use disorders. Some interviewees stated that there is an opportunity to include more quality measures in VBP models that demonstrate behavioral health care's broader value beyond treatment of specific conditions. For example, interviewees stated that development and inclusion of SDOH or quality of life measures would be beneficial, as behavioral health services like case management often address individuals' SDOH needs and impact overall wellness. Further, interviewees suggested that incorporation of measures into contracts that reflect physical health outcomes and care coordination for behavioral health populations may increase cross-system collaboration and help demonstrate behavioral health's impact on physical health. Finally, one SME suggested that effective outcome measurement for some chronic behavioral health conditions, for example quality benchmarks for populations with SUD, should be evaluated over a longer timeframe to account for typical recovery trajectories.⁷⁰

While behavioral health providers and associations recognize the opportunity to improve measures, they also suggested harmonizing and reducing the total number of quality measures to minimize the administrative burden caused by variations in measure sets across payers or programs. One behavioral health association shared that a particular provider tracked

approximately 60 measures: 20 MCO/county measures, 25 state measures and 15-20 federal measures. A behavioral health provider described the challenge of individual MCOs quality priorities not aligning with provider priorities or other program requirements. States recognize this issue and, furthermore, other health care providers also voice this concern. Given this concern, there may be opportunities to develop measures that cut across or can be shared by different provider types and provide states and MCOs with the information they need to gauge value as well as opportunities to streamline or coordinate between MCOs on measure sets prioritized.

9 *Behavioral health providers would likely benefit from technical assistance or infrastructure funding to support development of new capabilities necessary to implement VBP.*

Implementing new VBP models often requires development of new capabilities, investment in new IT infrastructure and hiring or retraining of staff.⁷¹ One behavioral health association described that implementation of a care coordination program required behavioral health providers to develop new skills and workflows to coordinate physical health services. Another interviewee described that lack of resources has led to behavioral health providers lagging behind physical health providers in terms of electronic health records (EHR) and analytics capabilities and are just now developing the infrastructure to support data collection, quality and cost measurement and risk stratification. Some behavioral health providers and associations suggested that they may benefit from longer policy implementation timelines or periods of time without significant policy changes to ensure enough time to develop new organizational capabilities, staff competencies and adapt to a VBP environment.

Behavioral health provider and association interviewees also noted that building capacity for timely data sharing on both provider and MCO sides is needed to support VBP, both to facilitate quality improvement and more efficient delivery of care. Interviewees emphasized that for data to be actionable, it needs to be as close to real-time as possible, which is generally not the case when sharing claims-based data. For example, one provider explained that the data they received for some specific payment models was often too outdated to make course corrections. Interviewees explained that barriers to timely data sharing include both infrastructure limitations, such as differences in IT capabilities between organizations, and resistance of some MCOs to share data.

Many behavioral health provider, behavioral health association and state government interviewees described the importance of technical assistance (TA) and/or infrastructure payments to developing VBP capabilities. An interviewee from one behavioral health association described receiving positive feedback on a TA program in which a consulting firm was hired to deliver webinars and in-person trainings on VBP. Another suggested that, in addition to the providers, MCOs could potentially benefit from TA on behavioral health care delivery models and VBP. Behavioral health association interviewees from states described how Delivery System Reform Incentive Payment (DSRIP) program⁷² funding was used for behavioral health workforce programs or to support infrastructure investments among behavioral health providers. Additionally, many states interviewed had providers participating in a CMS-funded grant program to train provider organizations on clinical design, quality improvement and business strategies to improve readiness for value-based payment arrangements.⁷³

POLICY RECOMMENDATIONS

Based on findings from the environmental scan of 11 states and interviews with behavioral health providers, behavioral health associations, state agencies and SMEs, the following recommendations are primarily targeted toward state and federal officials, MCOs and other stakeholders involved in the design and implementation of VBP initiatives:

1 *Implement a robust stakeholder engagement process that includes meaningful participation from behavioral health providers and a broad range of state agencies.*

Interviews highlighted that behavioral health payment mechanisms and structures vary significantly across states and sometimes even counties. Behavioral health care itself differs in significant ways from physical health care that may impact VBP design. For both reasons, it is important that policymakers plan and implement a robust stakeholder engagement process as they design and implement VBP policies. Stakeholders from the behavioral health community should have a seat at any “VBP table,” regardless of whether the model under consideration is a behavioral health-specific or a comprehensive VBP approach.



STAKEHOLDER ENGAGEMENT EXAMPLE^{74, 75}

To inform the implementation of MassHealth’s ACO program, the Massachusetts Executive Office of Health and Human Services implemented a series of eight work groups. Each work group focused on a specific aspect of payment and care delivery transformation, such as strategic design, payment design, attribution, certification criteria, behavioral health payment and quality improvement. Workgroups included a wide variety of stakeholders such as physical health providers, behavioral health providers, behavioral health associations, health plans and consumer advocacy organizations.

By soliciting input from behavioral health stakeholders, a state can gain valuable insight on behavioral health provider readiness for VBP, as well as information that could be used to design the optimal prescriptiveness/flexibility and determine more technical aspects of the model, such as benchmarking and risk-adjustment.

Additionally, states should engage a wide range of state entities, including mental health and SUD departments, in strategic planning for VBP if developing a comprehensive model with services crossing traditional health care silos. States and federal policymakers should also consider engaging state entities that do not directly pay for health care services, but regulate health care organizations, to help identify and remove potential policy barriers to VBP.

2 *Leverage existing behavioral health system payment models and infrastructure to support VBP goals.*

Behavioral health provider and association interviews revealed that, in some states, behavioral health providers have experience being reimbursed through non-FFS arrangements, such as capitation or case rates. Stakeholder engagement and readiness assessment activities should include review of existing payment models and discussions on how to leverage existing behavioral health provider capabilities to ensure that approaches working well provide a platform for future enhancements. For example, states carving-in behavioral health benefits to integrated MCOs could consider how to maintain any existing capitation arrangements working well for behavioral health providers and present opportunities for further accountability for performance.

3 *Adapt VBP models to include policies that further incentivize adoption of VBP for behavioral health services.*

While states are increasingly implementing VBP policies, interviews suggest that broadly defined VBP benchmarks and models in which patients are solely attributed to physical health providers may not be sufficient to lead to adoption of VBP among behavioral health providers. Under these policies, MCOs and physical health providers may not have strong incentives to enter into arrangements with behavioral health providers. To address these issues, policymakers should consider how to tailor VBP policies and models to specifically incentivize VBP adoption for behavioral health, in addition to physical health. For instance, states could consider incentivizing or requiring MCOs to enter into VBP contracting with behavioral health or low-volume providers. In states with broad TCOC models, such as ACOs, policymakers could also consider implementing policies to incentivize or require physical health providers to subcontract and share savings with behavioral health providers. Alternatively, states may consider implementing behavioral health-specific VBP models in which patients are attributed to behavioral health providers.



**BEHAVIORAL HEALTH
VBP TARGET EXAMPLE⁷⁶**

As part of Oregon's CCO 2.0 contracts, the state plans to make behavioral health one of five "priority areas" for which CCOs must develop new or expanded VBP models. By the end of 2024, new or expanded VBP approaches in all five care delivery areas must be implemented. These priority areas are coupled with broad CCO VBP targets requiring 70 percent VBP by 2024.

4 *Include sufficient financial incentives and flexibility in VBP models to allow for behavioral health care delivery improvement.*

While common, P4P models may not provide a large enough incentive or flexibility for behavioral health providers to change the way they deliver care. Policymakers should consider the feasibility of implementing more flexible approaches to payment, such as population-based payments (as defined by the LAN APM Framework) or case rates. While behavioral health providers may not be ready to implement these models immediately, policymakers could develop roadmaps for gradually enhancing provider capabilities to ultimately implement these more advanced models. Behavioral health VBP models in New Hampshire and Vermont are examples of arrangements allowing for flexibility in care delivery.

Since behavioral and physical health conditions are so closely tied,^{77, 78} the impacts of effective behavioral health care may not necessarily be realized through reductions in behavioral health spending, but rather impact physical health service utilization and cost-savings. In order to sufficiently incentivize care improvement and reductions in total cost of care and allow flexibility for behavioral health providers to improve care, policymakers should consider developing VBP models in which savings are shared across physical health and behavioral health systems. In states with behavioral health carve-outs, states may consider developing models that allow for coordination and shared savings across physical health and behavioral health MCOs. At the provider level, policymakers may need to consider a more directive approach to sharing savings across traditionally siloed physical health and behavioral health systems.

5 *Implement state policies to track behavioral health VBP models and promote transparency about VBP adoption.*

Interviewees described that in managed care states, varying VBP arrangements are often implemented across different MCOs and providers. In order to understand the VBP model landscape and plan for future policy development, states should implement processes to track the type of VBP arrangements implemented through managed care and the resulting outcomes. Such data would provide a strong foundation for evaluation of differing types of VBP arrangements.

States should also consider adopting policies to make information on existing VBP arrangements transparent to stakeholders. For states with VBP targets in MCO contracts, making an inventory of existing VBP models publicly available can help facilitate stakeholder engagement and discussions of where standardized approaches may be helpful. This information may also support provider and MCO development of new VBP models by facilitating connections between entities interesting in developing VBP and providing a starting point for negotiating new arrangements.



**EXAMPLE OF TRANSPARENT
BEHAVIORAL HEALTH VBP TRACKING**

Every year since the transition to VBP in 2012, the Texas Health and Human Services Commission has published an annual summary of the VBP plans submitted by MCOs.

6 *Support alignment and development of meaningful behavioral health quality measures and data sharing infrastructure to facilitate quality improvement.*

Current quality measures used in VBP may not comprehensively capture the value of behavioral health services and the wide range of behavioral health conditions treated in community-based settings. To maximize appropriateness of measures while reducing variation and limiting administrative burden, policy-makers should engage with behavioral health providers and MCOs to identify and align a common set of behavioral health measures and benchmarks, paying attention to defining progress or success for a variety of behavioral health conditions and subpopulations. Examples of potential measures sets follow in this section. There may also be opportunity for policymakers to incorporate existing but underutilized behavioral health measures in quality measure sets and encourage greater coordination of physical and behavioral health services by holding providers mutually responsible for shared measures, recognizing that both behavioral health and physical health contribute to outcomes. As new measures are added to quality measure sets, policymakers should also consider how to limit the total number of quality measures for which providers are held accountable in order to balance measure totality. For example, states could convene stakeholders to develop state-wide quality measure sets or menus to be used in VBP.

To support providers' ability to obtain actionable data, policymakers should consider implementing policies and investing in infrastructures that support timely data and robust data collection for purposes of performance measurement and improving the service delivery system. For example, Tennessee has implemented a care coordination tool for its Health Link program that, among other things, provides real-time admission, discharge and transfer notices to participating providers. The tool enables providers to see real-time information about members in need of follow-up, which allows providers to manually close gaps

in care. In New York, providers have access to the Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid (PSYCKES), a HIPAA-compliant, web-based portfolio of tools that, among other things, provides performance on clinical measures, individual client health reports and utilization reports that can be leveraged to better understand client utilization across the health system. PSYCKES is currently working to expand the utilization reports to include actual costs in addition to services provided.



EXAMPLE OF A QUALITY ALIGNMENT PROCESS

Pennsylvania's VBP Steering Committee was formulated in December 2018 by the Office of Mental Health and Substance Abuse Services. The workgroup agreed to identify a small number of standardized performance measures that could be used within VBP models implemented by primary contractors (e.g., counties or regions) and their associated behavioral health MCOs. As a result, the Committee created a consensus document that identified a small number of standardized performance measures within four domains: (1) outcomes, (2) member experience, (3) social determinants of health and (4) cost.

EXAMPLE OF EXPANDED QUALITY MEASURE SCOPE⁸⁰

The CCBHC initiative requires states and provider organizations to report on a defined set of quality measures. This measure set provides examples of how the scope of quality measurement for behavioral health could be expanded. The CCBHC measure set includes SMI measures, SDOH measures, pediatric measures and physical health measures for the behavioral health population and include measures that are tied to access, processes, outcomes and other physical health measures, such as:

- Time to initial evaluation
- Follow-up after ED visit for mental health or hospitalization for mental illness
- Initiation and engagement of alcohol and other drug dependence treatment
- Screening for clinical depression and follow-up plan
- Depression remission at 12 months
- Preventive care and screening: Body mass index (BMI) screening and follow-up
- Adherence to antipsychotic medications for individuals with schizophrenia
- Diabetes care for people with SMI: Hemoglobin A1c (HbA1c) poor control (>9.0%)
- Follow-up care for children prescribed ADHD medication
- Housing status (residential status at admission or start of the reporting period compared to residential status at discharge or end of the reporting period)
- Adult BMI screening and follow-up
- Controlling high blood pressure

7 *Develop standardized federal guidance that can be used by states as “guardrails” to assess the appropriateness and effectiveness of VBP models for behavioral health.*

The federal government has an opportunity to further support state policymakers by providing additional guidance on how to develop and implement VBP models. Interviews suggest states’ experiences with VBP have led to some promising approaches and common challenges that would benefit from cross-state dissemination. For example, federal guidance on considerations for implementing P4P versus more advanced models and considerations for designing provider withhold arrangements could help states develop VBP strategies. Additionally, federal guidance on more administrative aspects of VBP may be beneficial. For example, interviews suggest that states may benefit from additional guidance and tools for oversight and monitoring of VBP models implemented by MCOs. Finally, some interviewees described difficulty knowing “where to begin” in terms of designing VBP models. Federal guidance on promising practices and pitfalls for VBP in different services areas or guidance on opportunities for aligning Medicaid models with federal VBP models may help in the design and proliferation of VBP arrangements.

LOOKING AHEAD

Building the right model of behavioral health VBP is challenging, yet offers many great opportunities for improvements in access to and quality of behavioral health care, as well as outcomes across the continuum of health needs. Finding the right model or models will take time and some continued trial and error — which, without careful attention to its unique characteristics, might be difficult in the context of an already stressed system. Continued efforts to build a foundational understanding of the behavioral health system and deliberate inclusion of behavioral health stakeholders in VBP planning are critical steps in effective design processes that have the best chance of delivering desired outcomes. Through partnership between states, providers and health plans, VBP planning and implementation processes that incorporate the recommendations laid out above should create an improved chance for success.

APPENDIX A: INTERVIEWEE LIST

STATE	INTERVIEWEE	ORGANIZATION
AZ	Bahney Dedolph	Arizona Council of Human Service Providers
AZ	Emily Jenkins	Arizona Council of Human Service Providers
CO	Doyle Forrestal	Colorado Behavioral Healthcare Council
CO	Mindy Klowden	National Council for Behavioral Health
MA	Lydia Conley	Association for Behavioral Healthcare
MA	Vic DiGravio	Association for Behavioral Healthcare
NH	Roland Lamy	New Hampshire Community Behavioral Health Association
NY	Lauri Cole	NYS Council for Community Behavioral Healthcare
NY	John Kastan	The Jewish Board of Family and Children's Services
NY	Diane Novy	The Jewish Board of Family and Children's Services
NY	Patricia Perazzelli	National Council for Behavioral Health
OR	Chantay Jett	Greater Oregon Behavioral Health, Inc./Wallowa Valley Center for Wellness
OR	Cherryl Ramirez	Association of Oregon Community Mental Health Programs
PA	Monica Collins	Magellan Behavioral Health of Pennsylvania
PA	Richard Edley	Rehabilitation and Community Providers Association
PA	Tina Miletic	Rehabilitation and Community Providers Association
PA	Amanda Roth	Pennsylvania Department of Human Services
TN	Jessica S. Hill	Division of TennCare
TN	Mary Shelton	Division of TennCare
TN	Bob Vero	Centerstone of Tennessee
TN	Ellyn Wilbur	Tennessee Association of Mental Health Organizations
TX	Jolene Rasmussen	Texas Council of Community Centers
TX	Andy Vasquez	Texas Health and Human Services
TX	David Weden	Integral Care
VT	Todd Bauman	Northwestern Counseling & Support Services
VT	Selina Hickman	Vermont Department of Mental Health
VT	Simone Rueschemeyer	Vermont Care Network/Vermont Care Partners
VT	Julie Tessler	Vermont Council of Developmental & Mental Health Services/Vermont Care Partners
WA	Ann Christian	Washington Council for Behavioral Health
N/A	Alyson Ferguson	Scattergood Foundation
N/A	Amanda Mauri	Scattergood Foundation
N/A	Greg Williams	Third Horizon Strategies

APPENDIX B: VBP ACTIVITY SUMMARY

State VBP Activity	
STATE	BRIEF DESCRIPTION OF VBP ACTIVITY
Arizona	Arizona has implemented VBP targets in Medicaid managed care organization (MCO) contracts, including for Regional Behavioral Health Authorities (RHBAs) .
Colorado	In July 2018, Regional Accountable Entities (RAEs) began serving as single entity to administer physical health and behavioral health services. ⁸¹ RAEs are paid on a capitated basis for behavioral health services and have the flexibility to pay providers as they choose.
Massachusetts	Massachusetts has implemented value-based payment (VBP) targets in Medicaid MCO contracts. Massachusetts implemented a MassHealth Medicaid Accountable Care Organizations program , which includes Behavioral Health Community Partners .
New Hampshire	Through its Medicaid Managed Care program New Hampshire plans to develop a strategy to for moving 50% of their medical expenditures into qualifying alternate payment models (APMs). New Hampshire will also require its MCOs to enter into capitated payment arrangements (with quality incentives) with Community Mental Health Providers.
New York	New York implemented VBP targets in Medicaid MCO contracts, plus state-defined VBP service arrangements: (1) total care for general populations, (2) integrated primary care, (3) maternity care and (4) Total care for special populations. New York developed and funded the creation of Behavioral Health Care Collaboratives . New York is also a Certified Community Behavioral Health Clinics (CCBHC) demonstration state.
Oregon	Oregon plans to implement VBP targets in Coordinated Care Organization (CCO) 2.0 contracts . Oregon is also a CCBHC demonstration State.
Pennsylvania	Pennsylvania has implemented VBP targets in Medicaid Behavioral Health MCO and Physical Health MCO contracts. Pennsylvania is also a CCBHC demonstration state.
Tennessee	Tennessee operates a comprehensive episodes of care program with two episodes specifically related to behavioral health: attention deficit hyperactive disorder and oppositional defiant disorder. Tennessee also implemented Tennessee Health Link , a care coordination model for individuals with substance use disorder and serious mental illness, which includes outcome-based payments using quality and efficiency metrics.
Texas	Texas has implemented VBP targets in Medicaid MCO contracts.
Vermont	Vermont has designed a Mental Health Payment Reform program that provides monthly case rates with VBP incentives. Vermont also operates an All-Payer Accountable Care Organization .
Washington	Washington has implemented VBP targets in Medicaid MCO contracts.

Additional VBP Models	
MODEL	DESCRIPTION
Addiction Recovery Medical Home Model	The addiction recovery medical home model is a multifaceted payment model (part fee-for-service [FFS], part bundled payment) being pursued by the Alliance for Addiction Payment Reform. The model covers three phases of a continuum of care: pre-recovery and stabilization, recovery initiation and active treatment and community-based recovery management. The pre-recovery and stabilization phase remains FFS while the latter two phases are paid through a bundled episode of care payment. A portion of the bundled payment is tied to quality performance and providers can participate in a shared savings component as well. The model emphasizes the development of clinically integrated networks including a wide range of clinical settings and community resources to meet patient needs at different phases of recovery. This model is currently being explored for implementation by both commercial and Medicaid MCOs.
Integrated Care for Kids	Integrated Care for Kids (InCK) is a child-centered community service delivery and state payment model developed by the Center for Medicare and Medicaid Innovation (CMMI) for children under 21 years of age covered by Medicaid and the Children's Health Insurance Program. The model supports prevention, early identification and treatment of behavioral and physical health needs, including integrating care coordination and care management across settings to reduce out-of-home placements. As part of this funding opportunity, Medicaid agencies, in partnership with a lead service entity, will develop and implement an alternative payment model that includes integrated care coordination, case management and mobile crisis services; models may be built off of FFS architecture or be comprised of population-based payment.
Maternal Opioid Misuse	The Maternal Opioid Misuse (MOM) model was developed by CMMI to support the coordination and integration of care for pregnant and postpartum Medicaid beneficiaries with opioid use disorder. Under this model, CMMI will provide funding to states to address barriers to care and implement wrap-around coordination, engagement and referral activities. States will also receive milestone funding based on quality metric performance. While participating states will need to develop sustainable coverage and payment strategies to support ongoing care coordination and integration, they are not required to develop an alternative payment model.
Patient-centered Opioid Addiction Treatment	The patient-centered opioid addiction treatment (P-COAT) model is a bundled payment model for primary care-based medication assisted-treatment (MAT), developed by the American Society of Addiction Medicine and the American Medical Association. The payment model consists of two types of bundled payments to cover different phases of treatment: (1) A one-time initiation of MAT payment covers evaluation, diagnosis and treatment planning as well as initiation of outpatient MAT and (2) A monthly maintenance of MAT payment covers provision or coordination of ongoing outpatient medication, psychological treatment and social services. Bundled payments may increase or decreased up to 4% based on quality performance.

Source: CHCS analysis of publicly available documents and synthesis of key informant interviews.

APPENDIX C: OVERVIEW OF BEHAVIORAL HEALTH QUALITY MEASURE CATEGORIES

Organizations such as the National Committee for Quality Assurance, The Joint Commission, the Agency for Healthcare Research and Quality and the Centers for Medicare and Medicaid Services (CMS) have been actively involved in the creation of behavioral health-specific quality measures endorsed by the NQF, including cost, process, structural and outcome metrics.⁸² Examples of behavioral health measures include:

- ▶ **Cost/resource use measures demonstrate** resource use associated with a specified patient population, time period and/or clinical accountability. Cost/resource use measures can encompass either the “total cost of care” or be limited to a more defined set of services or conditions.
 - **Example:** Cost benchmarks for services associated with treatment of attention deficit hyperactive disorder (ADHD) and oppositional defiant disorder (ODD). (Note: No cost/resource use measures related to behavioral health had been endorsed by NQF at the time this report was published.)
- ▶ **Process measures** demonstrate a provider’s efforts, per standard best practices, to shepherd patients through the necessary processes to determine and provide treatment for behavioral health-related needs. Process measures can help identify systemic barriers to receiving behavioral health treatment.
 - **Example:** Screenings for mental health or substance use disorders, following up with patients after hospitalization for mental illness.
- ▶ **Structural measures** indicate the capacity of a provider group or hospital system to respond to those with behavioral health needs.
 - **Example:** The number of providers certified to prescribe medications for medication-assisted treatment (MAT), providers’ capacity to report behavioral health-related screening results through an electronic health system. (Note: No structural measures related to behavioral health had been endorsed by NQF at the time this report was published.)
- ▶ **Outcome measures** signify the impact of an intervention on improving health care outcomes of patients.
 - **Example:** Percentage of patients whose depression symptoms were in remission at six months, percentage of patients with an unplanned readmission to a psychiatric facility within 30 days of discharge from the initial hospitalization.

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9. CHCS analysis of publicly available state managed care organization and demonstration waiver documents in June 2019.
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