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Paying for Value in Behavioral Health: What California Can Learn from Other States' Medicaid Programs

FEBRUARY 2020



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About the Foundation

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I. Key Findings

State Medicaid programs are actively pursuing models of behavioral health value-based purchasing (VBP). To obtain a general understanding of the scope and nature of these activities, reviews were conducted of well-publicized initiatives in three state Medicaid programs that have adopted different types of behavioral health VBP models:

Vermont. The state's hub and spoke model has increased access to addiction treatment in the state, while the more recent Mental Health Payment Reform, Residential Substance Use Disorder Treatment Case Rate, and Applied Behavior Analysis Case Rate methodologies are attempting to expand behavioral health VBP to new types of services.

New York. The Behavioral Health VBP Readiness Program has invested considerable resources to assist behavioral health providers with forming networks that can participate in total cost of care and other VBP arrangements.

Tennessee. The state's Health Home program — Tennessee Health Link — has improved the ability of community mental health centers to serve high-need members, while the Episodes of Care program has demonstrated a promising new approach to VBP for discrete behavioral health conditions.

Total Cost of Care Models a Poor Match for Behavioral Health Providers

This review of these diverse initiatives suggests that states have either assumed from the outset or concluded through experience that behavioral health providers are unlikely to be lead contractors in total cost of care VBP arrangements (i.e., arrangements in which a group of providers assumes financial risk for the total cost of care for an attributed population, regardless of where services are delivered). This view is markedly different than the predominant vision being articulated by state Medicaid agencies and the Medicare program for physicians and hospitals, which

are being encouraged and expected to form accountable care organizations (ACOs) and other entities that can assume risk for the total cost of care.

The total cost of care model appears ill-suited for behavioral health providers for several reasons: the complexity of dividing responsibility for total cost of care across physical health and behavioral health providers, lack of capital and infrastructure to manage downside risk, the inability of behavioral health providers to influence the full continuum of care, and the lack of standardized managed care contracting templates for behavioral health VBP. In many states, though, behavioral health providers and the networks they form may have an opportunity to participate in total cost of care VBP arrangements as subcontractors to or partners with larger, integrated provider organizations that are driven by hospitals or primary care organizations.

Promising Practices: Episodic and Bundled Payment Models

In contrast, this review found evidence of state support of and initial success with episodic or bundled payment VBP models, which focus on a discrete behavioral health treatment, event, or diagnosis. There are early signs that these models can enhance access to certain types of behavioral health services and improve the quality of care. And the models are adaptable to states, like California, that carve out behavioral health coverage under Medicaid.

What About Cost Savings?

However, while episodic or bundled payment behavioral health VBP models have shown early promise in improving access and quality outcomes without increasing overall Medicaid expenditures, it is still unclear if they can generate meaningful cost savings. If these models are going to be adopted widely across state Medicaid programs, they may need to be adjusted to better target cost reduction in addition to improvement of access and quality.

II. Background

Introduction

In recent years, state Medicaid programs and the US health care system as a whole have shifted from traditional fee-for-service (FFS) payment methodologies toward VBP models. While FFS rewards providers based on the volume of their services, VBP aims to incent the delivery of high-quality medical care and improve outcomes while reducing unnecessary health care spending. To date, most VBP efforts have focused on physical health, with organizations led by large health systems or other integrated networks of physicians typically assuming financial accountability for the

total cost of care for an assigned population or for a bundle of physical health services. However, given the significant share of Medicaid dollars spent on enrollees with serious mental illness (SMI) and substance use disorders (SUDs), there is increasing interest among state Medicaid programs in exploring ways to expand VBP to behavioral health providers and services.

This report attempts to offer guidance to state Medicaid programs and other stakeholders on the lessons learned by states that have sought to develop innovative behavioral health VBP initiatives. Section III summarizes the recent experiences of three states whose Medicaid programs have experimented with different types of behavioral health VBP models:

Medicaid Managed Care Behavioral Health Delivery Models

Carve-out model. Enrollees receive coverage of behavioral and physical health services from different payers. Under these models, coverage of behavioral health services may be provided through either a separate managed care plan or through FFS. Examples include California, which provides coverage for physical health and non-specialty mental health services through mainstream managed care plans (MCPs), specialty mental health services through county mental health plans (MHPs), and SUD treatment through county Drug Medi-Cal delivery systems.

Fully integrated managed care. Medicaid enrollees receive coverage of all physical and behavioral health services through the same managed care plan. There are no carve-out plans or separate managed care plans for individuals with significant behavioral health needs. Examples include Washington, which covers physical and behavioral health care needs for most Medicaid enrollees through its Integrated Managed Care delivery system.

Specialized MCOs for enrollees with significant behavioral health needs. Enrollees with significant behavioral health needs receive all health care coverage, including physical and behavioral health, through special, separate managed care entities. Examples of this model include North Carolina, which beginning in

2021 will require individuals with significant behavioral health needs to enroll in Behavioral Health Intellectual/Developmental Disability Tailored Plans, which will be operated by entities separate from the state's Standard Plans (which will enroll most Medicaid enrollees beginning in 2020).

Separate product lines for enrollees with significant behavioral health needs. Enrollees with significant behavioral health needs receive all health care coverage, including physical and behavioral health, through specialized managed care products, which may be operated by insurance carriers that also offer mainstream managed care products in the same state. Examples include New York, which delivers an integrated physical health, mental health, and SUD benefit through several specialized managed care products (in addition to offering mainstream managed care plans for most Medicaid enrollees). In New York, individuals with significant behavioral health needs receive coverage through separate Health and Recovery Plans (HARPs), while individuals living with HIV/AIDS have the option to enroll in HIV Special Needs Plans (SNPs). Medicaid MCOs are permitted to offer more than one product line simultaneously, and several operate both HARPs and HIV SNPs in addition to mainstream managed care plans.

Sources: Margaret Tatar and Athena Chapman, *The Medi-Cal Program: An Overview*, CHCF, February 2019, www.chcf.org; "Apple Health Managed Care," Washington State Health Care Authority, n.d., www.hca.wa.gov; "Behavioral Health I/DD Tailored Plan," North Carolina Dept. of Health and Human Services, n.d., medicaid.ncdhhs.gov; and "Health and Recovery Plans (HARPs)," New York State Office of Mental Health, n.d., www.omh.ny.gov.

Vermont, New York, and Tennessee. The descriptions and assessments of these models are based on interviews with key stakeholders in each state and a broad review of publicly available materials. Section IV synthesizes key lessons learned from these states, including their challenges, successes, failures, and adjustments. Finally, Section V includes a discussion of California-specific considerations. This includes an overview of the existing Medi-Cal behavioral health system, with a focus on managed care structures and existing payment methodologies for behavioral health services. The conclusion synthesizes key lessons for Medi-Cal based on the analysis of other states' efforts.

To create meaningful and appropriate incentives, a state's behavioral health VBP model must align with the delivery and payment model for behavioral health services in that state's Medicaid program. Thus, for purposes of evaluating behavioral VBP options, it is important to keep in mind that there are four primary models that states have adopted to cover behavioral health under Medicaid. These models are summarized below. Section V discusses the relevance of California's model in particular.

Defining VBP

VBP arrangements take a number of forms but share the central aim of tying reimbursement to performance on measures of quality, clinical outcomes, and/or cost. A common framework for categorizing VBP is the Alternative Payment Model (APM) framework, developed by the Health Care Payments Learning and Action Network (HCP-LAN). The framework organizes VBP models into four categories with escalating levels of financial accountability and required provider sophistication (see Figure 1, page 6).¹

Category 1 includes FFS arrangements with no link to quality or value; until recently, most payment arrangements for health care services fell into this category.

Category 2 includes pay-for-reporting and pay-for-performance models, which allow providers to earn incentive payments from payers on top of regular FFS payments. **Category 3** includes shared-risk models, which preserve the underlying FFS payment structure

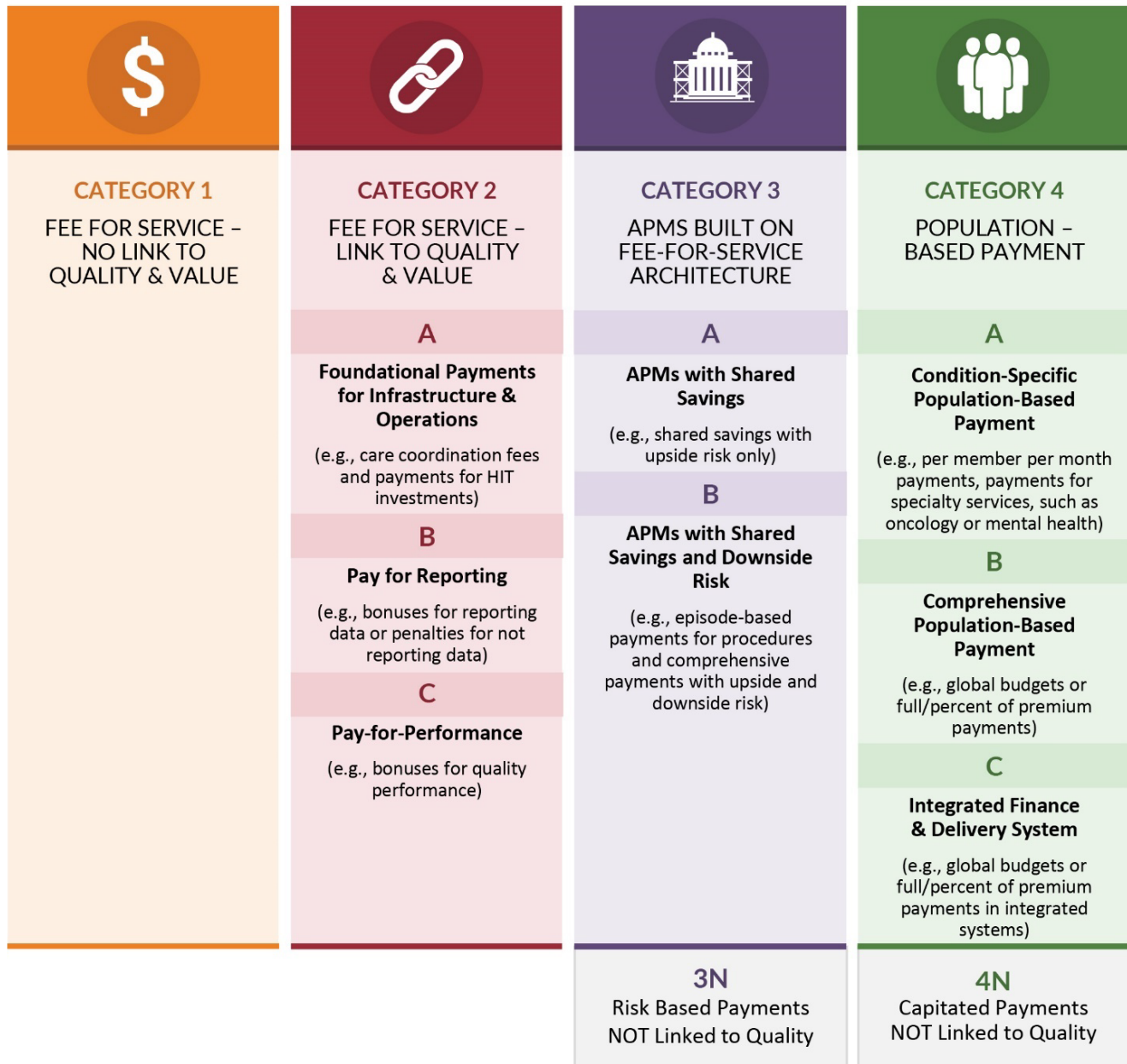
but include retrospective accountability for cost and quality; this can include models with accountability for total cost of care or more narrowly defined models focused on discrete bundles of services or episodes of treatment. **Category 4**, the most sophisticated level, includes models that establish defined budgets for providers for a certain population; this includes models such as global budgets or capitated arrangements.²

Estimates suggest that the majority of health care payments are now made through VBP arrangements. As of 2017, 59% of payments were made through HCP-LAN category 2 arrangements or higher, with 34% of payments falling into categories 3 or 4. Adoption has been most widespread in Medicare Advantage and Medicare FFS, with 50% and 38% of payments falling into categories 3 and 4, respectively, in 2017. However, commercial and Medicaid payers are not far behind, with 28% and 25% of payments falling into categories 3 and 4, respectively, in 2017.³

Less than one of every five dollars spent on behavioral health care is tied to VBP.

While overall adoption of VBP has progressed in recent years, VBP efforts have largely been concentrated on physical health providers and services. For example, many state Medicaid programs have developed ACO models, which are typically led by hospitals and/or PCP groups that agree to assume responsibility for the total cost of care. The same is true for Medicare, which has invested heavily in the development of the similarly structured Medicare Shared Savings Program. Although behavioral health may be included in the benefit package that the ACO is responsible for managing, behavioral health providers rarely play a leading role in these arrangements. Less than one of every five dollars spent on behavioral health care is tied to VBP, with most such arrangements falling into HCP-LAN category 2. Only about one in 10 payments is linked to capitated or other population-based arrangements, or episodic or bundled payment models.⁴

Figure 1. Framework for Alternative Payment Models



Source: *Alternative Payment Model: APM Framework*, Health Care Payment Learning and Action Network/MITRE Corporation, 2017, hcp-lan.org (PDF).

III. Landscape Assessment: Medicaid Behavioral Health VBP

In order to assess the progress of behavioral health VBP models to date, a comprehensive scan of related programs and payment models was conducted across three states: Vermont, New York, and Tennessee. These states were selected for their commitment to innovative behavioral health payment and care delivery models and for their varied Medicaid delivery system structures; this allowed the drawing of a broad range of lessons relevant to behavioral health VBP.

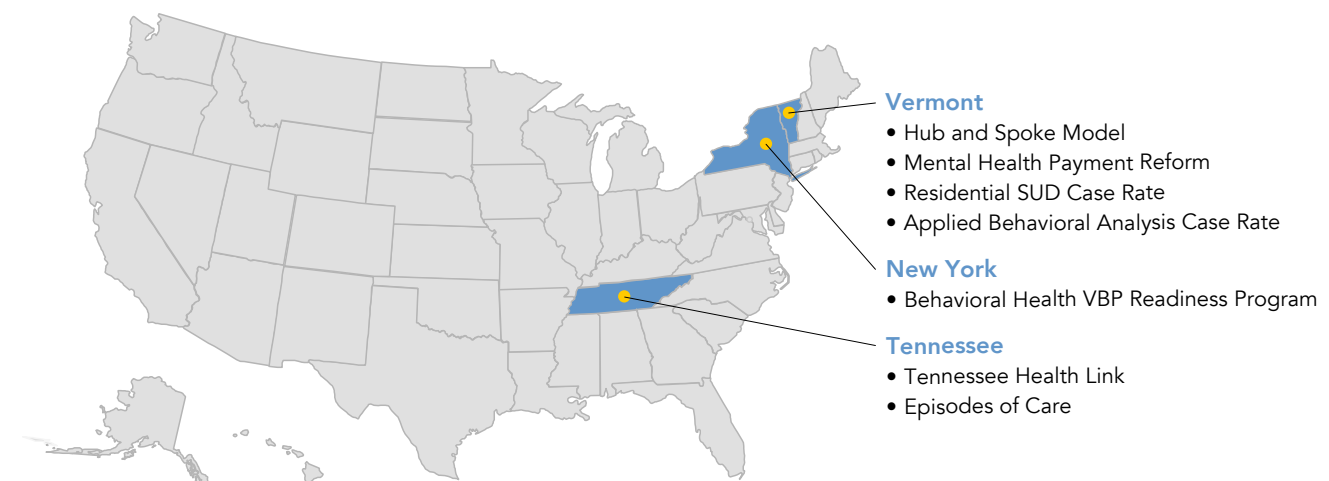
The landscape assessment relies on publicly available documents — such as managed care contracts, provider manuals, policy guidance, and waiver documents — about each state’s initiatives to describe key details of their models. Also, interviews were conducted with Medicaid officials and other stakeholders in each state to gather feedback on successes and challenges associated with the different VBP approaches. For a full list of interviewees, refer to Appendix B.

Vermont

Vermont has long been a leader in pursuing innovative payment and delivery strategies to improve health care outcomes and reduce costs. In 2016, the state received authority from the federal government to launch the Vermont All-Payer ACO Model, which allows the state to operate a unique Medicare ACO model and commits it to achieving targets across all major payers related to health care quality and outcomes, growth in per capita health care spending, and provider participation.⁵

In recent years, the state has also pursued a number of strategies to advance VBP specifically for behavioral health services. In 2012, the state launched the “hub and spoke” model for delivering and financing medication-assisted treatment (MAT) for individuals with opioid use disorder (OUD). This model has been highly successful in Vermont in improving access to treatment and has since been adopted by multiple states, including California. Beginning in 2019 Vermont also rolled out several other initiatives aimed at advancing VBP for behavioral health services, including its Mental Health Payment Reform initiative, episodic payments for residential SUD treatment, and a new case rate payment methodology for applied behavior analysis (ABA) services.

Figure 2. States and Programs of Focus



Source: Manatt, Phelps & Phillips.

SUMMARY • Vermont

Managed Care Structure

In 2017, Vermont received authority under the state's Section 1115(a) Medicaid demonstration waiver to implement a unique Medicaid delivery system model with greater flexibility to align with the state's All-Payer ACO initiative. Under the waiver, the state now operates a public managed care–like delivery model, with the Department of Vermont Health Access (DVHA) serving as a nonrisk prepaid inpatient health plan subject to all applicable federal managed care regulations. Through this model, the Vermont Agency of Health Services makes capitated payments to DVHA, which contracts with Medicaid providers and other public agencies to deliver service to Medicaid beneficiaries and performs the functions of traditional managed care plans, including administering utilization controls and providing care management.⁶

Behavioral Health VBP Models

Hub and spoke model. Opioid Treatment Programs (OTPs) serve as “hubs” for delivering all facets of MAT and are reimbursed through a bundled rate for OTP services and separately for Medicaid Health Home services. Community-based providers delivering MAT services (the “spokes”) receive Medicaid-financed, specialized staffing support at no cost to the practice, and consultation and referral support from the hubs.

Mental health payment reform. Community mental health centers receive a prospective monthly case rate based on an expected caseload and are also eligible to receive value-based incentive payments for performance on outcome measures.

Residential SUD case rate. Residential SUD treatment providers are provided a per-admission rate based on the individual's SUD diagnosis and comorbidities that covers the entire length of an individual's stay regardless of the number of days.

ABA case rate. Behavior analysts and other providers treating individuals with autism spectrum disorder are paid a prospective monthly payment for all ABA cases during the month based on the expected number of treatment days.

Hub and Spoke Model:

Bundled Rate for MAT

The hub and spoke model aims to improve access to MAT for individuals with OUD by creating closer links between different types of MAT providers across the state, while providing funding for enhanced services.

Under this model, “hubs” are federally recognized OTPs with the necessary staff and expertise to treat high-acuity OUD cases and individuals in the early stages of recovery. Hubs provide daily dosing and therapeutic services and are authorized to dispense all FDA-approved medications indicated for treating OUD, including methadone. To supplement traditional MAT services, hubs may provide enrollees with additional services authorized under a Medicaid Health Home state plan amendment, including comprehensive care management, care coordination, referral to community and support services, transitional care management, and individual and family supports. Hubs also serve the critical function of supporting office-based opioid treatment (i.e., outside of the OTP setting) by providing training and expert consultation to primary care providers and other clinicians treating individuals with OUD in the community (i.e., the “spokes”).

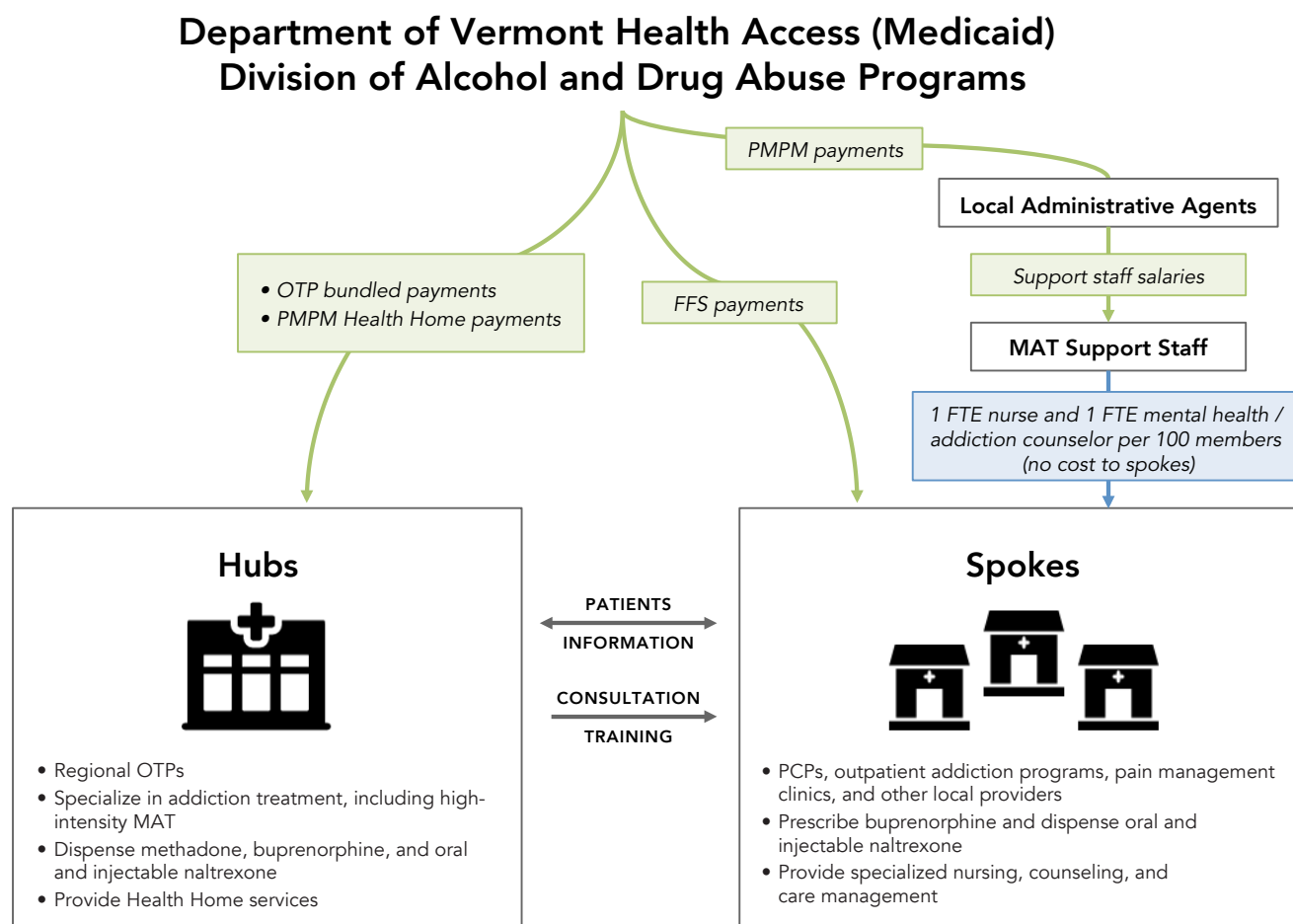
Spokes are general medical practices with clinicians who are authorized through a federal waiver to prescribe or dispense buprenorphine;⁷ under the Vermont model, the spokes have access to additional staff resources as well as referral and consultation links to the hubs. Spokes are generally primary care or family medicine practices that treat low-acuity OUD patients and those who have transitioned out of a hub; treatment typically includes medication prescribing in addition to weekly or monthly visits. To stimulate participation in the model and support community-based providers treating individuals with OUD, all spokes have access to one full-time equivalent nurse and one licensed mental health or addiction counselor per 100 patients. The additional staffing support is financed by the Medicaid program and made available to spokes at no cost. These staff members provide specialized support services for patients with OUD, including counseling and care management supports. Depending

on practice size, support staff may be embedded full-time within a specific practice or may split their time between multiple smaller sites. Spokes also have access to expert consultation on OUD treatment best practices from the hubs and may refer complex cases to a hub regardless of insurance status.⁸

The hub and spoke model relies on several different payment streams to support the program’s enhanced staffing configuration and additional support services. Vermont Medicaid pays the hubs a monthly bundled rate for each enrolled OTP patient; this covers methadone dispensing and counseling services, while buprenorphine and naltrexone are acquired separately under a “buy and bill” model.⁹ Hubs may also bill for

a separate monthly Health Home rate for patients that receive at least one Health Home service during the month. Spokes and local pharmacies are reimbursed as usual; spokes bill Medicaid on a FFS basis for evaluation and management services, while pharmacies bill Medicaid for prescribed medications. To finance the support staff for the spokes, Medicaid pays administrative contractors known as Local Administrative Agents (LAAs) to undertake all hiring and staff deployment functions (i.e., nurses and counselors supporting spokes are employed by the LAA, which deploys them into the community based on practice need). Vermont Medicaid currently pays LAAs \$163.75 per member per month, which is based on the number of unique patients for whom Medicaid paid an OUD medication

Figure 3. Hub and Spoke Model



Source: “Hub and Spoke,” Vermont Blueprint for Health, n.d., blueprintforhealth.vermont.gov.

pharmacy claim over the previous three-month period. Spoke providers have access to support staff based on patient volume at no cost to the practice.¹⁰

Evidence from Vermont suggests that the hub and spoke model has been successful in promoting access and improving quality, with patients treated under the model showing substantial improvements in health status. Program participants report substantial reductions in opioid and other illicit drug use, increased housing stability, and improved family life and emotional health. Evidence also suggests that the program has been roughly cost neutral, despite substantial investments in additional services, and may be leading to reduced spending growth over time.¹¹ Despite additional expenditures under the model, a 2018 evaluation by the Vermont Blueprint for Health found no statistically significant difference in total per member per year (PMPY) spending in 2017 for individuals receiving MAT (\$17,122) compared to those receiving other OUD treatment (\$16,256). While PMPY payments for pharmacy and spoke staffing were, as expected, higher for individuals receiving MAT, this was largely offset by reductions in spending elsewhere, including on inpatient services (\$2,117 for the MAT group vs. \$3,513 for the non-MAT group) and outpatient services (\$1,139 vs. \$2,008). Furthermore, expenditures on the MAT group have grown more slowly since 2011 than expenditures for individuals with OUD who are not engaged in MAT (5% from 2011 through 2018 compared to 9.8%).¹² This suggests that while the hub and spoke model has not yet been a vehicle for reducing overall Medicaid expenditures, it has improved health outcomes and access to care without substantially increasing costs. And if expenditures for individuals receiving treatment through the model continue to grow more slowly, the program could demonstrate net savings in the near future.

Stakeholders closely involved with the design of the model cite several key factors underlying its success in improving access to treatment and improving treatment outcomes, even without evidence to date of overall cost savings. The enhanced OTP bundled rate combined with Medicaid Health Home payments has created greater financial certainty for the hubs and

allowed them to provide the full complement of MAT support services beyond just medication and counseling. As a result, the number of OTPs in Vermont has increased from five before the launch of the program to nine as of 2019; the program has also managed to completely eliminate wait lists (which were as long as 500 enrollees in 2014) despite doubling the number of individuals engaged in treatment since program launch.¹³ On the spoke side, access to additional support staff (i.e., nurses and mental health / addiction counselors) at no cost has also substantially reduced barriers to waived PCPs offering MAT services. This allows practices to focus on treating patients while minimizing nonreimbursable time spent on managing the care of more complex patients. Finally, robust collaboration between hubs and spokes ensures that spokes are properly equipped to deal with complex cases that may require the expertise of addiction specialists, and small primary care practices are much more likely to accept patients with an OUD in need of MAT as a result.¹⁴ The number of MAT prescribers in spokes has doubled since the launch of the program, from 114 in 2013 to 235 in 2018.¹⁵

Other Behavioral Health VBP Initiatives: *Case Rate Payments*

Building on the success of the hub and spoke model, Vermont launched several new behavioral health VBP models in 2019 under the authority of the state's Section 1115 demonstration waiver. These models rely on case rate payment methodologies for different sets of services and attempt to align financial incentives for providers to encourage the provision of evidence-based, high-quality care while reducing growth in health care spending. While representatives from the Vermont Medicaid program were hopeful that these programs will help to drive improvements in cost and quality, demonstrated outcomes are not yet available since the programs were only implemented in 2019.

Mental Health Payment Reform: *Case Rate Payment Methodology for Community Mental Health Centers*

The Vermont Department of Mental Health (DMH) is responsible for directing publicly funded mental health services in the state, including providing for the

delivery of mental health services to Medicaid enrollees as a contractor to the Vermont Medicaid program and administering state-funded mental health services. Under this dual mandate, DMH contracts in each region of the state with private, nonprofit community mental health centers known as Designated Agencies (DAs) for adults, and Specialized Service Agencies (SSAs) for children and families. DAs and SSAs are responsible for ensuring needed services are available to eligible individuals in their respective regions through delivery of services, program planning, service coordination, and outcome monitoring. Currently, there are 10 DAs and two SSAs in Vermont.¹⁶

The DMH Mental Health Payment Reform initiative, which launched at the beginning of 2019, established a new payment methodology that covers the majority of mental health services delivered by DAs and SSAs through a single per member per month (PMPM) case rate payment. The goals of this initiative include driving improvements in quality and outcomes while delivering more predictable payments to providers, simplifying the billing process, and providing flexibility to deliver services in accordance with patient-specific needs. The new payment methodology provides prospective case rate payments for both children and adults based on a target caseload for each DA and SSA. Each month, DA/SSAs receive a lump sum payment for all case rate services regardless of the actual volume or intensity of services provided. Prospective payments are determined by dividing each DA/SSA's expected annual budget allocation by a target caseload developed using historic data to arrive at a prospective PMPM amount. At least annually, prospective case rates are reconciled against each DA/SSA's actual caseload; DA/SSAs that serve a caseload of at least 90% of their target caseload based on historic data may keep all prospective payments, but funds may be recouped by DMH if a DA/SSA serves less than 90% of the target caseload. The case rates are also supplemented by separate value-based payments, which DMH finances by withholding a portion of the approved adult and child case rate allocations. DAs and SSAs can access value-based payments by successfully reporting on required measures and based on performance outcomes across select measures.¹⁷

Most services provided by DAs and SSAs are covered under the case rate. For adults, this includes emergency services, community rehabilitation and treatment, and outpatient services. For children, it includes emergency services, enhanced family treatment, outpatient services, and transitional living programs, and employment and life skill programs¹⁸ DAs/SSAs may also receive outlier payments on a case-by-case basis in situations where an individual's treatment is likely to significantly impact utilization covered by the case rate. A limited set of services continues to be paid for outside of the case rate; this includes school-based services, job training programs, eldercare, care at private nonmedical institutions, and certain other services funded with state general fund dollars or federal grants.¹⁹

Residential SUD Case Rate:

Per-Admission Case Rate

DVHA also launched in 2019 a new case rate payment methodology for residential SUD treatment. In contrast to the previous per diem payment model for residential treatment, the new methodology reimburses residential treatment providers with a per-admission rate that covers the entire length of an individual's residential stay, including both residential detoxification and residential treatment. The goal of the new methodology is to complement existing policies that encourage providers to align treatment decisions with the American Society of Addiction Medicine (ASAM) criteria and provide a disincentive for providers to keep individuals in residential treatment for longer than is clinically appropriate.²⁰

The new methodology provides a per-admission rate of between \$3,532 and \$4,803, with variation in the payment amount based on the SUD primary diagnosis and certain co-occurring clinical and social factors (similar to diagnosis-related group payment methodologies used by Medicare and other payers). Providers receive an enhanced per-admission rate for individuals diagnosed with alcohol or benzodiazepine addiction (an increase of approximately 14% per admission relative to other SUD diagnoses). For all SUD diagnoses, the base rate (i.e., the rate paid for individuals with no co-occurring disorders) can be further increased by

up to 19% depending on co-occurring diagnoses that can be expected to increase the duration and intensity of residential treatment.²¹ For residential stays of less than three days, providers are reimbursed \$220 per diem.²²

Applied Behavior Analysis Case Rate:

Tiered Monthly Case Rate

Vermont also implemented a new case rate reimbursement methodology in 2019 for its ABA benefit. Eligible Medicaid enrollees include individuals under age 21 with a diagnosis of autism spectrum disorder or an early childhood disability with Medicaid as their sole source of coverage (ABA is reimbursed on a FFS basis for those with insurance coverage in addition to Medicaid). To access the case rate, qualified providers undergo a consultation with a DVHA autism specialist or designee.²³ During the consultation, each enrollee is assigned to 1 of 14 “tiers” corresponding to higher reimbursement based on the number of recommended treatment hours. Once consultations are complete, providers receive a single prospective payment covering all ABA components including assessment, treatment plan development, direct treatment, program supervision, parent/caregiver training, and team conferences for all ABA cases for the following month. Providers are required to submit “shadow claims” during the course of treatment, which don’t trigger payment but are used for program monitoring and year-end reconciliation.²⁴

New York

New York has taken substantial steps in recent years to advance VBP in its Medicaid program. In 2014, the state received waiver authority from the Centers for Medicare & Medicaid Services (CMS) to implement one of the most ambitious Delivery System Reform Incentive Payment (DSRIP) programs in the country. The waiver authorized the state to make up to \$8 billion in incentive payments to networks of providers with the goals of (1) reducing unnecessary emergency department (ED) utilization while spurring the development of more integrated, high-quality care delivery networks and (2) preparing the delivery system for wider adoption of VBP. Building

on DSRIP investments, the state has since established a goal of having 80% to 90% of Medicaid payments delivered through VBP arrangements by 2020. To facilitate movement toward the state’s ambitious VBP goals, the state’s “VBP Roadmap” establishes model guidelines intended to help MCOs and providers be successful in a more value-oriented delivery system. The roadmap outlines a variety of population-based models, where providers take on responsibility for the total cost of care for attributed members, and bundled/episodic arrangements, where providers assume responsibility for outcomes and the total cost of care associated with a specific illness, medical event, or condition. However, the roadmap also notes that providers and payers are free to develop “off-menu” VBP

SUMMARY • New York

Managed Care Structure

Since 1997, New York has operated a statewide Medicaid managed care program that is mandatory for most low-income adults and children. Historically, the program covered most acute, primary, and specialty care services in addition to a limited set of behavioral health and long-term care benefits; most behavioral health services were covered separately through the FFS program. In 2015, the state began integrating most behavioral health benefits into managed care, including through mainstream managed care products and specialized Health and Recovery Plans (HARPs) for individuals with significant behavioral health needs. HARPs, which are optional for eligible individuals, cover all Medicaid physical and behavioral health benefits in addition to home and community-based services, Health Home care management, and other enhanced benefits. Medicaid MCOs in New York are permitted to offer more than one product line simultaneously, and several operate both HARPs and mainstream managed care plans.

Behavioral Health VBP Models

Behavioral Health VBP Readiness Program. State-approved Behavioral Health Care Collaboratives (BHCCs) receive payments to finance the development of infrastructure necessary for success in VBP arrangements, including organizational structures, data analytic capacity, quality oversight, and clinical integration.

arrangements as long as these arrangements advance the state's overall payment reform goals. Through this approach, the state has attempted to strike a balance between standardization and allowing providers and payers the flexibility to innovate.²⁵

As part of this broader shift toward value, the state is beginning to promote VBP in behavioral health as well, with a focus in the VBP Roadmap on driving behavioral health integration along with other delivery system reform goals. The state has also launched a Behavioral Health VBP Readiness Program, which provides infrastructure funding to non-hospital-affiliated behavioral health providers to help them build the capacity to succeed in a more value-oriented delivery system.

Behavioral Health VBP Readiness Program: Infrastructure Payments to Behavioral Health Providers

The Behavioral Health VBP Readiness Program, launched in 2017–18, provides approved Behavioral Health Care Collaboratives (BHCCs) with the opportunity to access up to \$60 million in funding over three years with the goal of improving their ability to contract with Medicaid MCOs. BHCCs are networks of behavioral health providers that deliver the full complement of behavioral health services to Medicaid enrollees. BHCCs may be led by a variety of entities, including licensed nonhospital community-based mental health and SUD treatment providers, designated behavioral health home and community-based service providers, and behavioral health independent practice associations (IPAs). Readiness Program funding is directed to BHCCs through Medicaid MCOs and can be used to support both planning and implementation of behavioral health VBP-related initiatives, and to foster relationships among BHCC members, engage external consultants, and analyze data. In order to access all available program funding by the end of year three of the program (SFY 2019–20), all BHCC network providers will need to either be participating subcontractors in a HCP-LAN level 3B or higher arrangement (with the BHCC contracted at level 3A or higher) or be the primary contracted entity in a level 3B or higher arrangement.²⁶

New York stakeholders report that the Behavioral Health VBP Readiness Program has begun to spur development of critical VBP capabilities among behavioral health providers. For example, MCO and BHCC representatives noted that the program has facilitated the development of critical IT and analytic infrastructure among behavioral health providers, both through organic development of technology platforms and through partnerships with external organizations. A representative from the New York State Office of Mental Health (OMH) noted that participants have made substantial progress on organizational governance structures, which are necessary for organizing and overseeing clinical programs and the financial management of VBP arrangements (i.e., risk management, distribution of savings and losses, etc.). The OMH representative also noted that some clinical integration efforts have been developed as a result of the program, including patient triaging arrangements between EDs and behavioral health providers, shared staffing plans in rural areas, and enhanced use of telemedicine to facilitate 24/7 access to behavioral health care.²⁷

Despite these successes, stakeholders in New York said there has been little progress on actual VBP contracting between BHCCs and MCOs to date. While both the MCO and BHCC representatives expressed a desire to develop new behavioral health VBP contracts, they said that there are still not enough incentives for MCOs to engage in behavioral health-specific VBP contracting.²⁸ While the state's overarching VBP targets create a general incentive for MCOs to engage in VBP contracting, stakeholders argued that most are able to reach the targets through VBP arrangements with hospitals or medical groups, and don't need to contract with BHCCs to get there.²⁹

Stakeholders also cited a lack of readymade VBP contracting templates specific to behavioral health provider groups as a limiting factor. Medicaid MCOs frequently enter into total cost of care contracting arrangements with large health systems and other physical health providers, which has led to the development of standardized approaches and templates, but both BHCC and MCO representatives noted that

there are few analogous resources specific to behavioral health VBP. Relatedly, both the BHCC and MCO representatives stressed that attribution remains a persistent challenge for behavioral health providers, since Medicaid enrollees are already attributed to PCPs, and MCOs cannot pay out “duplicate” savings to behavioral health providers. BHCCs generally have less experience with managing financial risk, which requires the ability to track claims expenses in real time, forecast patient costs, track expenses against a budget, and other capabilities. However, stakeholders acknowledged that funding through the program may help these organizations develop this capacity by allowing them to hire staff with the necessary expertise, purchase or develop new analytic tools, or take other steps.

Finally, representatives from the MCO stressed that successful risk-sharing arrangements require control over the “whole dollar.” While behavioral health conditions drive a substantial share of physical health spending, a relatively small share of total health care spending goes toward direct financing of behavioral health services. One study found, for instance, that hospital costs per episode are 40% higher on average for patients with behavioral health comorbidities.³⁰ However, another found that only 15 cents of every dollar spent on treating individuals with behavioral health comorbidities goes toward behavioral health care.³¹ As such, the MCO representatives argued, ACOs and other VBP contractors need to be willing to make investments in behavioral health care that could lead to savings on physical health spending in order to be successful under VBP models. However, the representatives acknowledged that this model may not be workable for smaller, independent behavioral health agencies that are not affiliated with a major health system, since they are not able to access savings on physical health spending.³²

Tennessee

The Tennessee Health Care Innovation Initiative was launched in 2013 with the goals of improving quality and reducing costs in TennCare (Tennessee’s Medicaid program). The initiative is focused on three primary payment and delivery system transformation strategies: primary care transformation, episodic payments for certain discrete episodes of care, and a quality-improvement and VBP initiative for long-term services and supports (LTSS). Within the primary care transformation and episodic payment strategies, Tennessee has implemented several targeted programs aimed at advancing VBP for behavioral health services.³³

SUMMARY • Tennessee

Managed Care Structure

Tennessee was the first state in the nation to enroll all Medicaid enrollees in managed care.³⁴ Most individuals enroll through one of three statewide mainstream managed care plans, which are responsible for delivering all physical and behavioral health benefits. The state also offers several specialized managed care products for those with intellectual or developmental disabilities, aging or disabled members in need of LTSS, and parents of children in state custody. The state currently does not offer a separate managed care product for individuals with significant behavioral health needs (i.e., they enroll in mainstream plans).

Behavioral Health VBP Programs

Tennessee Health Link. Medicaid Health Home model where Community Mental Health Centers receive activity payments for the delivery of Health Home services and outcome-based payments for quality performance and continuous improvement on select utilization measures.

Episodes of Care. Providers with control over the care for a particular episode of treatment or diagnosis may receive retrospective shared-savings payments or be required to make risk-sharing payments if actual episode costs differ from a benchmark; the program has operationalized 48 episodes to date, including two behavioral health episodes: attention deficit and hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD).

Tennessee Health Link: Incentive Payments for Community Mental Health Centers

Tennessee Health Link was launched in 2016 as the state's Medicaid Health Home for adults with serious mental illness (SMI) and children with serious emotional disturbance; currently, the program serves approximately 70,000 enrollees.³⁵ Health Links are required to deliver the core set of Medicaid Health Home services, including comprehensive care management, care coordination, health promotion, transitional care, patient and family support, and referrals to social supports (LTSS). To be eligible to participate, a practice must be a recognized Community Mental Health Center (CMHC) or other provider experienced in treating TennCare members with high behavioral health needs.³⁶ Practices must also agree to adopt the state's Care Coordination Tool (CCT), a cloud-based, cross-payer tool for accessing up-to-date claims and admissions, discharge, and transfer (ADT) data on attributed members, and participate in two years of practice-transformation training.³⁷ Most eligible enrollees are assigned to a Health Link panel by their MCO using an algorithm that accounts for existing provider relationships and certain other factors; enrollees may also be assigned through a referral by a discharging hospital or through an attestation by the Health Link itself (enrollees may also choose to opt out of the program).³⁸

Health Links are eligible to receive payments through several funding streams. For the first two years of participation, Health Links are eligible for practice-transformation payments, which support practices in making necessary clinical and organizational changes to be successful under the program. Health Links also receive PMPM "activity payments" for each member receiving qualified Health Link services in a given month. Finally, Health Links also have the ability to earn outcome payments based on quality and "efficiency" performance. The quality component of the outcome payment requires meeting or exceeding performance thresholds across 10 quality metrics. The efficiency component is calculated based on improvement over the previous year across two measures: ED visits per 1,000 member months and inpatient discharges per 1,000 member months. As a result of the design of the

efficiency metrics, Health Links need to demonstrate continuous improvement in hospital utilization, which they may not directly control, in order to fully realize outcome payments in each year.³⁹

A representative from a network of CMHCs participating in the Health Link program noted that the program has provided substantial resources for the network's practices to provide enhanced services to individuals with significant behavioral health needs. The representative highlighted the CCT provided through the program as being useful for facilitating coordination across provider settings, particularly with PCPs engaged in the state's Patient-Centered Medical Home (PCMH) program, and identifying assigned enrollees in need of greater engagement.⁴⁰ They also noted that achieving outcome payments is feasible for most Health Links, and that outcome payments represent a significant share of their total revenue through the program. However, the representative did express concern that the outcome payments were beginning to show diminishing returns due to the requirement for continuous improvement on efficiency metrics.⁴¹

Episodes of Care: Retrospective Episodic Payments for Discrete Treatment Episodes

The Episodes of Care program attempts to hold providers accountable for the cost and quality of care associated with specific episodes of treatment. To date, the state has rolled out payments through the program for 48 discrete treatment episodes, while an additional 7 have been designed but not yet implemented. Episodes typically comprise all care associated with an acute treatment event, such as a coronary artery bypass graft, acute asthma exacerbation, or total joint replacement; the program has also operationalized 2 episodes focused on behavioral health care: attention deficit hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD).⁴²

Two-sided risk under the Episodes of Care program is mandatory for TennCare providers; any TennCare provider determined to have the greatest ability to influence the cost and quality of care associated with a particular episode has the opportunity to earn savings or may be required to pay back losses. Providers

determined to have the greatest influence over a particular episode, known as “Quarterbacks,” are automatically held accountable for savings and losses associated with the episode by the enrollee’s managed care plan. The Episodes of Care program does not affect how Medicaid providers bill; Medicaid providers continue to submit FFS claims as normal, even for procedures that will trigger an episode. Payments are then calculated and distributed/recouped retrospectively by the managed care plan.

The methodology for assigning savings and losses varies by episode, with the process for tracking and evaluating episode spending guided by detailed business requirements set forth by TennCare and operationalized by the state’s Medicaid managed care plans. Each episode is constructed using several key steps.⁴³

- ▶ **Identifying an episode trigger.** Episodes are “triggered” by claims that include specific services or diagnoses related to 1 of the 48 episodes identified under the program (e.g., the ADHD and ODD episodes are triggered by certain primary care-related claims with either ADHD or ODD listed as a diagnosis).
- ▶ **Identifying the episode window.** This step identifies a timeframe in which claims (and associated expenditures) may be attributed to a specific episode. The window for ADHD and ODD episodes is 179 days after the trigger start date (this is known as the “trigger window”). Episodes can also include services that occur during a specified time *prior* to the episode trigger (e.g., related labs, tests, and medications) or *after* the trigger window (e.g., postnatal services). Not all episodes, including the ADHD and ODD episodes, include pre-trigger and post-trigger services.

- ▶ **Identifying the Quarterback.** Each episode is linked to a “Quarterback” provider who becomes accountable for savings and losses associated with the episode. Quarterback status can be assigned in several ways, depending on the episode. The Quarterback can be the provider associated with the procedure triggering the episode (e.g., the clinician or group performing a total joint replacement, for the joint replacement episode) or the provider with the plurality of related visits for a particular diagnosis (e.g., the provider with the plurality of visits for ADHD or ODD during the episode window, for the ADHD and ODD episodes).⁴⁴

- ▶ **Identifying included expenditures.** Each episode includes a list of specific claim types that are included in the total episode spend. In general, included claims are those directly associated with treating the triggering diagnosis or follow-ups to the triggering procedure.

- ▶ **Developing episode-specific spending benchmarks.** Quarterbacks may earn savings if risk-adjusted expenditures related to the episode fall below a “commendable” threshold but are required to pay back losses if related expenditures exceed a level determined to be “acceptable” (regardless of where such services were delivered or by whom).⁴⁵ For the 2019 performance period, “acceptable” thresholds are established by TennCare such that the Quarterbacks with the highest risk-adjusted average annual costs across TennCare will owe risk-sharing payments; each MCO sets its own “commendable” thresholds such that total savings and losses will be equal.⁴⁶

Detailed specifications for the ADHD and ODD episodes are described in Table 1.

While TennCare has sought to provide opportunities for behavioral health providers to participate in the Episodes of Care program through the ADHD and ODD episodes, a provider from Tennessee stated that the program has had only a limited impact on their practice. The representative noted that shared-savings payments associated with the ADHD and ODD episodes were dwarfed by FFS payments and those made through the Health Link program. The representative also noted that, while it is possible to influence

total cost of care related to ADHD and ODD treatment, small caseloads and the relatively low per-episode spending serve to limit the incentive to focus on care improvements, since the total pool of available savings is relatively small (only approximately \$1.8 million in savings were achieved across 27,000 ADHD and ODD episodes in 2018; comparatively, approximately \$13.5 million in savings were achieved on the perinatal episode).⁴⁷ While Health Link is viewed by behavioral health providers as a true behavioral health VBP program, these providers generally consider Episodes of Care to be a physical health VBP program, even though it includes some behavioral health episodes.⁴⁸

Table 1. Tennessee Episodes of Care Program — ADHD and ODD Episode Specifications

	ADHD	ODD
Episode Trigger	Professional claims with an ADHD primary or secondary diagnosis* coupled with certain primary care-related procedure codes	Professional claims with an ODD primary or secondary diagnosis† coupled with certain primary care-related procedure codes
Episode Window	<ul style="list-style-type: none"> ▶ 179 days following the episode trigger ▶ May be extended if a related hospitalization beginning within the window extends beyond the 179th day 	<ul style="list-style-type: none"> ▶ 179 days following the episode trigger ▶ May be extended if a related hospitalization beginning within the window extends beyond the 179th day
Quarterback	Provider with the plurality of visits for ADHD during the episode window	Provider with the plurality of visits for ODD during the episode window
Included Expenditures	<ul style="list-style-type: none"> ▶ Hospitalizations, outpatient, professional, and long-term care claims with a primary or secondary diagnosis* for ADHD ▶ Certain related pharmacy claims 	<ul style="list-style-type: none"> ▶ Hospitalizations, outpatient, professional, and long-term care claims with a primary or secondary diagnosis† for ODD ▶ Certain related pharmacy claims
Thresholds	Acceptable: \$788 Commendable thresholds determined by each MCO	Acceptable: \$2,685 Commendable thresholds determined by each MCO
Potential Sources of Value‡	<ul style="list-style-type: none"> ▶ Use of assessments to ensure diagnostic accuracy and age-appropriateness of treatment ▶ Appropriate prescribing ▶ Reductions in unnecessary diagnostic testing and lab work 	<ul style="list-style-type: none"> ▶ Use of assessments to ensure diagnostic accuracy and age-appropriateness of treatment ▶ Reductions in the use of medication for non-comorbid ODD patients ▶ Efficient and cost-effective use of case management ▶ Efficient and cost-effective follow-up treatment

*With ADHD-specific symptoms as the primary diagnosis.

†With ODD-specific symptoms as the primary diagnosis.

‡For each episode, TennCare outlines key areas where providers may have opportunities to improve the quality and cost of care related to the episode.

Sources: *Detailed Business Requirement: Attention Deficit and Hyperactivity Disorder Episode*, Tennessee Division of TennCare, April 30, 2019, www.tn.gov (PDF). *Detailed Business Requirement: Oppositional Defiant Disorder Episode*, Tennessee Division of TennCare, April 30, 2019, www.tn.gov (PDF). *2019 Episodes of Care Cost and Quality Thresholds*, Tennessee Division of TennCare, n.d., www.tn.gov (PDF).

IV. Lessons Learned

The efforts of these three state Medicaid programs to advance behavioral health VBP have shown some initial success, but they remain works in progress. The research for this report suggests that:

- ▶ States have recognized that behavioral health providers are generally not well-suited to serving as lead contractors in total cost of care arrangements. In states that emphasize total cost of care initiatives as the predominant VBP model, behavioral health providers are more likely to play a role as subcontractors to or partners with broader provider networks led by hospitals or physicians rather than as direct contractors with MCOs or the state.
- ▶ There are early signs that narrowly focused behavioral health VBP models, such as episodic, bundled, and case rate payments targeting behavioral health providers, can improve access to and quality of care without increasing overall program costs.
- ▶ It remains to be seen if these targeted behavioral health VBP models will be able to go beyond cost neutrality and actually reduce health care expenses.

Behavioral Health Providers Are Unlikely to Lead Total Cost of Care Arrangements

Total cost of care arrangements are the predominant VBP models in many state Medicaid programs as well as in Medicare. These arrangements — where a group of providers assumes financial risk for all or most health care expenditures for an attributed population — have flourished in recent years among large health systems and other organizations of physical health providers, driven both by state-prescribed models and by direct contracting between provider organizations and Medicaid MCOs. However, this approach is unlikely to be replicated for behavioral health provider-led organizations. While a number of states have or are developing opportunities for behavioral health providers to move away from FFS and toward value, few if any have developed models that provide a pathway for groups of behavioral health providers to assume

total cost of care risk on their own. Similarly, behavioral health organizations have generally had limited success in engaging MCOs directly on VBP contracting. This is likely due to a range of factors, described below.

Duplication of Attribution

Interviewees across multiple states cited attribution as a persistent challenge that has limited the ability of independent behavioral health providers to engage in total cost of care contracting directly with payers. Attribution determines the list of enrollees for whose total cost of care a provider organization is held accountable; this process is nearly always done by linking enrollees with a PCP who provides the connection to an ACO or broader provider organization that is responsible for the total cost of care for a certain population. From the payer perspective, this is problematic for behavioral health total cost of care contracting, since it effectively could require payers to “duplicate” payments of shared savings for enrollees attributed to both a physical health and behavioral health provider in separate total cost of care arrangements. One avenue for addressing this challenge is for behavioral health providers to subcontract with physical health provider networks; this option is discussed in greater detail below.

Lack of Experience in Managing Risk

Successful participation in total cost of care models requires providers to have the necessary experience and financial resources to manage downside risk. Most state Medicaid ACO models and the Medicare Shared Savings Program require participants to demonstrate the ability to absorb downside risk or other unanticipated costs (such as high start-up infrastructure expenses) while maintaining financial solvency. For example, the Medicare Shared Savings Program requires ACOs under a two-sided risk model to have sufficient funds placed in escrow, a line of credit, or a surety bond.⁴⁹ Multiple stakeholders interviewed for this report noted that behavioral health providers generally lack access to significant capital and the experience managing risk necessary to participate in downside-risk arrangements without partnering with a larger or more sophisticated organization. Several

efforts, including New York’s Behavioral Health VBP Readiness Program, aim to address this issue through the infusion of infrastructure payments, which are intended to help behavioral health organizations build risk management capacity and other organizational capabilities necessary to be successful in VBP. However, it is still too early to tell whether these initiatives will overcome the obstacles faced by behavioral health providers in assuming risk.

Small Scale

Behavioral health providers are likely to assume responsibility for the total cost of care only for Medicaid enrollees with significant behavioral health needs. This limits the attribution pool to a smaller group of enrollees than is typically served by physical health-focused networks. The smaller scale makes it harder for behavioral health providers to recoup the investments they must make in care management infrastructure; often there are not enough savings to achieve on a small population to justify the expense. New York’s Behavioral Health VBP Readiness Program aims to address the problem of scale by facilitating the creation of networks of behavioral health providers—BHCCs—that can assume risk for their collective patient populations, but further experience is needed to evaluate whether these BHCCs will be able to amass a sufficient at-risk population to make continued infrastructure investment cost-effective.

Limited Ability to Impact the Full Continuum of Care

Total cost of care models are designed to incent a whole-person approach to quality improvement and cost reduction; by holding providers accountable for all costs associated with an enrollee’s care, providers have an incentive to develop comprehensive approaches to treatment that take into account the appropriateness of treatment as well as cost across the entire care continuum. Several interviewees noted that most independent behavioral health organizations are not well positioned to impact treatment decisions across the entire care continuum, and thus have a limited ability to impact total cost of care. Without formal business relationships with physical health networks, behavioral health providers are less able to weigh in

on referral protocols and clinical workflows, which are critical for avoiding unnecessary, high-cost procedures. Tennessee has attempted to alleviate this issue through its state-supported Care Coordination Tool (CCT), which provides Health Links with data on admissions, discharge, and transfer (ADT) events and other clinical indicators in near real time. An interviewee from a Health Link suggested that the tool has allowed their organization to be more active in identifying and engaging high-need members in treatment. However, several interviewees in Tennessee suggested that behavioral health organizations like Health Links are still struggling to make substantial progress on total cost of care contracting with MCOs.⁵⁰

Lack of Standardized Contracting Models

As total cost of care contracting has proliferated among physical health providers, payers are increasingly relying on standardized approaches to contracting that can be easily applied across multiple provider arrangements; this streamlines contracting, as it does not rely on provider organizations to develop complex payment and contracting models on their own. Multiple interviewees report that such resources are largely not available for behavioral health-specific VBP models. Representatives from Medicaid MCOs in particular pointed to a lack of standard contracting models as a barrier to greater engagement, citing the administrative burden of developing customized contracts that are not certain to result in positive returns to the payer.⁵¹

Partnerships with Integrated Physical Health Organizations May Provide an Avenue for Participation in Total Cost of Care Models

To the extent states believe that the participation of behavioral health providers in total cost of care arrangements is essential, evidence from this report’s landscape assessment suggests that the best opportunity for these providers is to engage in such arrangements as a subcontractor to, or a partner with, a health system or other larger provider organization. Interviewees from provider organizations and MCOs across multiple states report that physical health

networks engaged in total cost of care contracting recognize the value of partnering with behavioral health providers, and that they are generally interested in exploring innovative strategies for controlling overall spending by paying greater attention to the behavioral health needs of attributed enrollees. In New York, for example, interviewees pointed to instances of behavioral health provider organizations successfully entering into joint ventures with larger physical health networks in order to engage in total cost of care contracting. Under these models, the partnership contracts as a single entity with an MCO in a total cost of care arrangement, with risk-sharing arrangements between physical health and behavioral health providers determined within the partnership (as opposed to separately between physical and behavioral health providers and the MCO).⁵² This contracting model has the advantage of simplifying the contracting process from the perspective of the payer, in that it does not require the MCO to develop a special contracting vehicle for behavioral health providers or determine how to distribute savings and losses across physical health and behavioral health (these decisions are made within the partnership). It also allows independent behavioral health providers to leverage the financial and organizational infrastructure of larger provider organizations.

Early Signs That Episodes/ Bundles Improve Access and Potentially Quality

While progress on total cost of care arrangements for behavioral health providers has been slow, narrowly defined models such as episodic and bundled payments for behavioral health services appear to be gaining momentum in state Medicaid programs. These payment methodologies attempt to hold providers accountable for the cost and quality associated with a discrete set of services or diagnoses by making a single payment or setting a target price for a collection of related services. Vermont has been particularly aggressive on this front. Its bundled payment for hub providers under the state's hub and spoke model provides a single rate for most MAT services delivered

by the hubs. The state also launched three new case rate models this year, which provide prospective payments intended to cover a bundle of services, with only limited adjustments based on actual utilization (though the bundles do not yet include any physical health services). Tennessee's Episodes of Care program, which currently includes two behavioral health episodes (ADHD and ODD), similarly focuses on discrete treatment episodes and specific diagnoses by retrospectively determining savings and losses for responsible providers based on actual claims submitted. New York has also expressed interest in advancing episodic payments and other similar VBP models for behavioral health through its VBP Roadmap, but there is little evidence of these models being operationalized for behavioral health services to date.⁵³

While progress on total cost of care arrangements for behavioral health providers has been slow, narrowly defined models such as episodic and bundled payments for behavioral health services appear to be gaining momentum in state Medicaid programs.

The primary advantage of narrower models such as episodes and bundles is that they implicate only the types of health care spending that behavioral health providers are likely to have the capacity to control. For example, behavioral health providers may not be well positioned to prevent an unnecessary ED visit for chronic obstructive pulmonary disease, but are more likely to be able to influence the readmission of a patient who was hospitalized for a psychiatric disorder. This approach gives behavioral health providers an opportunity to realize financial benefits from optimizing their own treatment and care management decisions while not holding them accountable for costs that are outside of their control.

Moving from Access and Quality Improvement to Cost Containment

Existing behavioral health VBP models have shown some success in enhancing access to behavioral health treatment and improving quality outcomes, and stakeholders have broadly credited the programs discussed in this report with spurring significant and needed delivery system reforms. For example, Vermont nearly doubled the number of OTPs in the state and dramatically increased the number of individuals engaged in treatment.⁵⁴ Evaluations also suggest that the program has substantially reduced the likelihood of adverse outcomes, including ED utilization, illicit drug use, and contact with the police, while improving housing stability, family life, and emotional health for those engaged in treatment.⁵⁵ Additionally, enrollees in the Tennessee Health Link program have demonstrated improvements across a range of quality metrics, and providers have noted that the program has helped them deliver improved care to their patients by making it easier to hire care coordinators, nurses, and other staff to help manage the care of complex patients and improving the accessibility of real-time patient data through the CCT.⁵⁶

It is unclear, though, if these improvements are being driven primarily by direct infusions of new resources or by the “value-based” elements of the models. Improvements in quality and access shown through the Vermont hub and spoke model and Tennessee Health Link have been accompanied by substantial resource commitments in the form of PMPM Health Home payments, payments for spoke support staff in Vermont, and substantial investments in the CCT in Tennessee. Interviewees in Vermont cited the increased reliability and availability of resources as a critical factor in improved provider engagement with MAT. The bundled rate for OTPs has provided a stable, consistent source of funding for the hubs, and the additional Health Home payment allows for the provision of critical care management and coordination services for patients with complex needs. Funding through the model has been particularly beneficial to spoke providers, who cite both the availability of

regional hubs to receive referrals of complex cases and the availability of no-cost consultation services as driving increased participation in MAT by community-based providers. The experience of Tennessee tells a similar story, where the program’s activity payments in combination with the state-developed CCT are viewed by stakeholders as the critical lynchpin driving the program’s success.⁵⁷

Finally, there is little evidence that these models have driven significant cost savings to date. The hub and spoke model in Vermont has demonstrated lower spending growth for individuals participating in the model compared to those engaged in OUD treatment through other channels; while this may signal that the program will drive savings down the line, hub and spoke enrollees remain equally costly to treat.⁵⁸ Similarly, PMPM total cost of care for active Tennessee Health Link enrollees fell by approximately 4% from 2017 to 2018 (while costs increased by 6% for individuals who are eligible for the program but not actively receiving services). However, the level of expenditure remained substantially higher for active enrollees compared to those who are inactive (\$942 PMPM vs. \$552 PMPM in 2018).⁵⁹ The TennCare Episodes of Care program has demonstrated some of the most promising results — in 2018, Quarterbacks generated approximately \$1.1 million in savings to the state across nearly 26,000 ADHD episodes and \$726,499 across 2,000 ODD episodes.⁶⁰ However, it is unclear how much of these savings have actually accrued to providers (since benchmarks are set at the discretion of the MCOs, this likely includes some savings retained by the plans), and stakeholders in Tennessee report that these particular episodes generally constitute a small share of behavioral health providers’ overall revenue.⁶¹ While these models have driven significant delivery system reforms and appear to have improved care for patients, demonstrating the ability to achieve cost savings would further strengthen the case for their long-term viability.

V. Considerations for Advancing Behavioral Health VBP in Medi-Cal

California's Medicaid program, known as Medi-Cal, provides coverage to 13 million low-income Californians, including children, parents, the elderly, people with disabilities, and low-income adults.⁶² The program covers a robust set of physical health, behavioral health, and long-term care benefits. As the single largest purchaser of health care services in California, Medi-Cal plays a critical role in supporting the delivery of mental health and SUD treatment across the state.

Over the past several decades, Medi-Cal has transitioned a growing share of enrollees into managed care, with approximately 82% of the population enrolled in an MCP as of November 2018. In each of California's 58 counties, Medi-Cal managed care is currently delivered through one of five different models that provide varying degrees of choice between commercial, nonprofit, and publicly operated MCPs. These plans cover major medical benefits, including primary and specialty care, as well as non-specialty mental health services for enrollees with mild-to-moderate impairment of mental, emotional, or behavioral functioning. Non-specialty mental health services covered by mainstream MCPs include individual and group psychotherapy, psychological testing, psychiatric consultation, medication management, outpatient laboratory, drugs, supplies, and supplements, and any behavioral health services within a PCP's scope of practice.⁶³ Medi-Cal MCPs have some discretion over provider reimbursement arrangements. Depending on the provider type, contracting arrangements vary from predominantly FFS to full capitation.⁶⁴ (See Appendix A for more detailed descriptions of California's Medi-Cal structure.)

Reforming the Medi-Cal delivery system is a top priority of the current administration, and efforts like Medi-Cal Healthier California for All, a multiyear DHCS initiative (originally called CalAIM) are beginning to move the needle toward a more consumer-friendly, value-

oriented Medicaid program.⁶⁵ Among the Medi-Cal Healthier California for All proposals specific to behavioral health are reforming the current payment system in order to increase available reimbursement to counties for services provided and creating incentives for quality. Reimbursement for all inpatient and outpatient specialty mental health and substance use disorder services would change from Certified Public Expenditure-based methodologies to a rate schedule that instead uses intergovernmental transfers to fund the county nonfederal share.

In addition, DHCS has established a standardized Value-Based Payment Program (VBP Program) beginning in FY 2019–20, under which MCPs will be required to make incentive payments to providers who successfully meet various quality-improvement targets across four domains: prenatal-postpartum care, early childhood wellness care, chronic disease management, and behavioral health integration. The program also seeks to address health disparities by paying an increased incentive amount for events tied to enrollees diagnosed with an SUD or SMI, or experiencing homelessness.⁶⁶ The program will be financed through a \$544 million appropriation in FY 2020, including \$140 million dedicated specifically to the Behavioral Health Integration Incentive Program (BHIIP), which is open to a wide range of Medi-Cal providers, including primary care, specialty care, perinatal, hospital-based, FQHC, and behavioral health providers. Participants and MCPs will develop budgets tied to the financial value of each project, with participants receiving payment only if specific milestones are achieved.⁶⁷

While the BHIIP and proposals under Medi-Cal Healthier California for All are worthy first steps, there is still considerable room to expand upon these initiatives and pursue more ambitious models that continue to move the Medi-Cal behavioral health delivery system toward value. Below are assessments of key challenges and potential areas of opportunity for Medi-Cal as policymakers consider future reforms.

Challenges

As described in Section III, total cost of care arrangements for behavioral health providers still face significant barriers, including challenges related to duplication of attribution, inexperience among behavioral health providers with managing financial risk, small numbers of covered lives, the limited ability of behavioral health providers to influence physical health care pathways, and the lack of standardized behavioral health total cost of care contracting templates. These barriers are all present in California. Furthermore, California's unique Medicaid delivery model, with separate payers for physical health, mental health, and SUD treatment services, presents its own set of challenges to pursuing these types of models. As a result, total cost of care models involving behavioral health providers, including both state-prescribed models and subcontracting arrangements, are likely to be exceptionally challenging under the current Medi-Cal delivery system structure. Some of the key barriers include:

Barriers to State-Directed Total Cost of Care Models

Total cost of care models generally require the payer to have responsibility over most or all of the benefit package for attributed enrollees, since savings must be made available to providers regardless of whether they are generated through reductions in physical health or behavioral health expenditures. Under a carve-out model, this would require plans to distribute to providers "savings" that have accrued to a different health plan. For example, if a DMC-ODS county SUD delivery system were to enter into a total cost of care arrangement with a SUD treatment provider and actions taken by that provider resulted in a reduction in ED utilization, the county plan would be required to make a share of the savings achieved through reduced ED utilization available to that provider. However, since physical health services, including ED admissions, are not covered under the DMC-ODS model, this utilization would not have been built into the county plan's capitation payment to begin with. As a result, requiring savings distributions related to this reduced utilization would effectively impose an unfunded obligation on

the county plan, with potential implications for managed care rate setting and compliance with federal managed care regulations.

County MHPs face other barriers. Since MHPs are paid on a cost-settlement basis rather than through capitation, there is no financial benefit to the plan for reducing unnecessary utilization, whether of physical health or behavioral health services. Under a traditional managed care model, both the health plan and the provider benefit from decreases in unnecessary utilization, since the plan is permitted to disburse a share of unused capitation payments as savings. However, under the cost-settlement model, MHPs are only reimbursed by DHCS for the cost of services delivered, meaning shared-savings payments to providers would need to be financed using the plan's own resources or through another mechanism.

In states with comprehensive managed care products, both MCOs and physical health providers have an incentive to collectively manage enrollee behavioral health needs and to reduce unnecessary behavioral health utilization.

Barriers to Subcontracting Arrangements

Although subcontracting models where one or more behavioral health providers enters into a joint venture with a physical health provider network for the purposes of total cost of care contracting with an MCO has shown promise in other states, Medi-Cal's carve-out model again presents significant barriers. In states with comprehensive managed care products, both MCOs and physical health providers have an incentive to collectively manage enrollee behavioral health needs and to reduce unnecessary behavioral health utilization. This makes partnerships between physical health and behavioral health providers more attractive. However, under the carve-out model, mainstream

Medi-Cal MCPs, and thus physical health providers engaged in VBP arrangements, are not responsible for managing behavioral health spending. As a result, behavioral health providers in Medi-Cal may have a harder time engaging physical health providers on total cost of care contracting and finding workable models that align incentives across payers.

Opportunities

Bundled/Episodic Payment Models

Narrowly defined models of behavioral health VBP, such as bundled and episodic payments, could present a unique opportunity for MHPs and county SUD delivery systems to develop alternative payment approaches that are confined only to the health care services covered by each carve-out plan. For example, a DMC-ODS county could potentially develop a case rate methodology for residential SUD treatment similar to the approach used by Vermont, where all residential detoxification and treatment services are covered under a single episodic payment. The state could also consider expanding the case rate to encompass a true bundle of services, such as follow-up outpatient SUD treatment and case management. Since all such services are covered by the same county SUD delivery system, this approach could potentially overcome many of California's unique obstacles.

Comprehensive Managed Care

As long as the Medi-Cal delivery system remains highly fragmented, more ambitious behavioral health VBP efforts are likely to be extremely difficult. In order to create an environment more conducive to these types of models, California will likely need to consider integrating the managed care benefit and consolidating the number of carve-out entities (currently, some Medi-Cal enrollees may need to interact with as many as six different delivery systems, depending on their needs).⁶⁸ The state could approach this in several ways:

- ▶ *Comprehensive managed care for all enrollees.* Consolidating benefits for all or most managed care enrollees into a single delivery system would

likely create a much more favorable environment for traditional total cost of care models, such as ACOs. While behavioral health providers would likely face challenges in serving as lead contractors under these arrangements, it could create an avenue for them to participate as subcontractors. Subcontracting with physical health provider organizations is the primary mechanism by which behavioral health providers in other states participate in total cost of care arrangements by leveraging the organizational capacity of larger, more sophisticated organizations and streamlining the contracting process. Consolidating the physical health and behavioral health benefits into a single delivery system would, at minimum, open this pathway for behavioral health providers.

- ▶ *Specialized, comprehensive managed care product for enrollees with complex behavioral health needs.* As many states have moved away from the carve-out model and toward comprehensive managed care, some have taken the approach of establishing special products or plans for individuals with complex behavioral health needs. For example, North Carolina recently announced the launch of "Behavioral Health I/DD Tailored Plans," which will include additional benefits available only to those with significant behavioral health needs, intellectual/developmental disability, or traumatic brain injury; benefits available only through these plans will include residential treatment, multisystemic therapy, assertive community treatment, specialized care management, and others.⁶⁹ There is limited state experience of this practice to date, but it is possible that this managed care model could create an environment where behavioral health providers could lead total cost of care arrangements. Behavioral health providers enrolled with specialized plans would be better positioned to control a significant share of enrollee spending, as behavioral health care is likely to make up a larger share of total expenditures for this population. Additionally, these plans could potentially develop a specialized attribution model that places behavioral health providers, rather than PCPs, at

the center. While the authors have not uncovered evidence that other states are pursuing this type of “behavioral health ACO” model, California policymakers may wish to conduct further analysis and assess the viability of this option as they consider reforms under Medi-Cal Healthier California for All.

While both options would require significant restructuring of Medi-Cal, consolidating the state’s managed care delivery systems would likely create a significantly more favorable environment for the development of innovative behavioral health VBP arrangements while potentially offering other benefits, such as improving the beneficiary experience and reducing provider burden.

VI. Final Thoughts

As VBP has continued to develop across the US health care system, behavioral health providers are increasingly seeking out opportunities to engage in value-based contracting, and state Medicaid programs are exploring options for facilitating these arrangements. States like Vermont, Tennessee, and New York are experimenting with new models of behavioral health VBP, with a particular focus on episodic and bundled payment models. At the same time, behavioral health providers are attempting to move forward with direct VBP contracting with MCOs. Despite this momentum, persistent challenges unique to the behavioral health care delivery system remain. States, payers, and providers have yet to unlock streamlined mechanisms for total cost of care contracting for behavioral health providers, which will likely involve subcontracting arrangements or partnerships with physical health networks.

These challenges are particularly acute in California due to the fragmented structure of the Medi-Cal delivery system. Splitting responsibility for different parts of the Medi-Cal benefit package across mainstream MCPs, county MHPs, and county SUD delivery systems creates misaligned financial incentives and effectively prohibits behavioral health providers from engaging in total cost of care contracting directly with MCOs. To make serious progress on behavioral health VBP in Medi-Cal, the state will likely need to pursue greater financial alignment across its managed care delivery systems. Alternatively, a less disruptive route could direct resources to developing tailored models focused on discrete sets of services that work within the existing structure. While both options would likely be challenging and potentially resource-intensive, the opportunity to improve access to and quality of care delivered to the state’s most vulnerable residents while ensuring efficient use of scarce public resources should, at minimum, be explored in greater depth.

Appendix A. Overview of Medi-Cal Behavioral Health Financing and Care Delivery Systems

California's Medicaid program, known as Medi-Cal, provides coverage to 13 million low-income Californians, including children, parents, the elderly, people with disabilities, and low-income adults.⁷⁰ The program covers a robust set of physical health, behavioral health, and long-term care benefits. As the single largest purchaser of health care services in California, Medi-Cal plays a critical role in supporting the delivery of mental health and SUD treatment across the state.

Medi-Cal Managed Care

Over the past several decades, Medi-Cal has transitioned a growing share of enrollees into managed care, with approximately 82% of the population enrolled in an MCP as of November 2018. In each of California's 58 counties, Medi-Cal managed care is currently delivered through one of five different models that provide varying degrees of choice between commercial, non-profit, and publicly operated MCPs (see the box for more information on the different Medi-Cal managed care models). These plans cover major medical benefits, including primary and specialty care, as well as non-specialty mental health services for enrollees with mild-to-moderate impairment of mental, emotional, or behavioral functioning. Non-specialty mental health services covered by mainstream MCPs include individual and group psychotherapy, psychological testing, psychiatric consultation, medication management, outpatient laboratory, drugs, supplies, and supplements, and any behavioral health services within a PCP's scope of practice.⁷¹ Medi-Cal MCPs have some discretion over provider reimbursement arrangements. Depending on the provider type, contracting arrangements vary from predominantly FFS to full capitation.⁷²

Beginning in FY 2019–20, DHCS established a standardized Value-Based Payment Program (VBP Program) and will begin requiring MCPs to make incentive payments to providers who successfully meet various quality-improvement targets across four domains: prenatal-postpartum care, early childhood wellness care,

Medi-Cal Managed Care Models

County Organized Health System (COHS) Model.

In 22 counties, the California Department of Health Care Services (DHCS) contracts with one health plan created and run by the county with input from local governments, providers, community groups, and Medi-Cal enrollees. In COHS counties, all enrollees are in the same MCP. Enrollees in COHS counties may only access services through the FFS delivery system if authorized by the MCP or DHCS. Currently, 2.15 million are enrolled under the COHS Model.

Two-Plan Model.

In 14 counties, DHCS contracts with two plans: one commercial plan and one "local initiative" public plan. Local initiative plans work collaboratively with county public hospitals and other safety-net providers to support the safety-net delivery system. This model tends to be used in counties with public hospital systems and large Medi-Cal populations. Currently, 6.9 million are enrolled under the Two-Plan Model.

Geographic Managed Care (GMC) Model.

In two counties (Sacramento and San Diego), DHCS contracts with multiple commercial and nonprofit MCPs (but no local initiative plan) that compete to serve enrollees. Currently, 1.15 million are enrolled under the GMC Model.

Regional Model.

In 18 counties, DHCS contracts with two commercial MCPs (but no local initiative plan). This model, along with a similar model that operates only in Imperial County, called the *Imperial Model*, was created when the state expanded managed care into rural areas in 2013. Currently, around 376,000 are enrolled under the Regional or Imperial models.

San Benito Model.

San Benito County operates a model in which Medi-Cal enrollees can choose between one commercial plan and FFS. It is the only county in the state where managed care enrollment is optional. Just over 8,000 are enrolled under the San Benito Model.

Source: *Medi-Cal Managed Care Quality Strategy Report*, California Dept. of Health Care Services, June 29, 2018, www.dhcs.ca.gov (PDF).

chronic disease management, and behavioral health integration. The program also seeks to address health disparities by paying an increased incentive amount for events tied to enrollees diagnosed with an SUD or SMI, or experiencing homelessness.⁷³ The program will be financed through a \$544 million appropriation in FY 2020, including \$140 million dedicated specifically to the Behavioral Health Integration Incentive Program (BHIIIP). The BHIIIP is open to a wide range of Medi-Cal providers, including primary care, specialty care, perinatal, hospital-based, FQHC, and behavioral health providers. Participants will have the opportunity to participate in up to six projects focused on the following areas: maternal access to mental health and SUD screening and treatment, medication management for enrollees with co-occurring chronic medical and behavioral health diagnoses, diabetes screening and treatment for people with SMI, improving follow-up after hospitalization for mental illness, and improving follow-up after ED visits for behavioral health diagnoses. Participants and MCPs will develop budgets tied to the financial value of each project, with participants receiving payment only if specific milestones are achieved.⁷⁴

Fee-for-Service Medi-Cal

The Medi-Cal FFS delivery system provides coverage to approximately 18% of Medi-Cal enrollees, including those who have limited benefit coverage, those with a share-of-cost plan, certain people who are dually eligible, and a small number of enrollees with full benefit coverage who are not required to enroll in managed care. Enrollees may also apply for Medical Exemption Requests from DHCS, which if approved, allows enrollees with complex medical conditions to continue treatment with providers who are not participating with any MCP in the enrollee's county.⁷⁵

County Mental Health Plans

County MHPs are responsible for providing or arranging for the delivery of specialty mental health services (SMHS) for Medi-Cal enrollees with SMI who meet medical necessity criteria. SMHS include a range of more intensive mental health treatment services, including day treatment/rehabilitation, crisis services, residential treatment, inpatient psychiatric hospital treatment, intensive care coordination, and certain other services.⁷⁶ MHPs are responsible for negotiating contracts and reimbursement arrangements with a network of mental health providers in the county. They are also required to have a memorandum of understanding (MOU) in place with each MCP that enrolls people covered by that MHP. MOUs contain referral and coordination of care protocols to ensure that enrollee needs are being appropriately coordinated between the MCP and the MHP.⁷⁷ MHPs are reimbursed by DHCS under a cost-settlement model that is based on actual allowable expenditures. MHPs receive interim reimbursement from DHCS throughout the year based on interim rates paid to contracted providers and the actual cost of county-delivered services. At the end of each year, MHPs and DHCS reconcile the difference between interim amounts and audited allowable expenditures. MHPs may also claim reimbursement for administrative costs up to 15% of the actual cost of providing direct services.⁷⁸ MHPs are financed through multiple dedicated funding sources, including Medicaid, Substance Abuse and Mental Health Services Administration block grants, 1991 and 2011 "realignment" funding,⁷⁹ Mental Health Services Act funding,⁸⁰ and other local revenues.⁸¹

County SUD Delivery Systems

SUD treatment services are provided through the Drug Medi-Cal program. Under Drug Medi-Cal, most SUD treatment services for Medi-Cal enrollees are carved out of MCP contracts and separately managed by county alcohol and drug programs. Counties may operate one of two models under Drug Medi-Cal. The Drug Medi-Cal Organized Delivery System (DMC-ODS), which was authorized under the state's Medi-Cal 2020 Section 1115 waiver, is a voluntary program that allows counties to function as managed care plans for SUD treatment services and deliver an enhanced set of SUD treatment benefits. Counties that have declined to participate in the DMC-ODS demonstration or are not yet providing services under the waiver deliver SUD treatment through the "traditional" Drug Medi-Cal program, which offers a more limited set of benefits authorized under the Medicaid state plan.⁸²

Drug Medi-Cal Organized Delivery System

In 2015, California received federal authority through its Medi-Cal 2020 Section 1115 waiver to test a new model for the organized delivery of SUD treatment services for Medi-Cal enrollees. Under the new model, counties may elect to serve as managed care plans responsible for administering and overseeing the delivery of SUD treatment services to Medi-Cal enrollees residing within the county. Participating counties may make services available by providing services directly, contracting with DMC-certified providers, or contracting with an MCP to manage SUD treatment delivery on behalf of the county. Under DMC-ODS, counties are required to provide Medi-Cal enrollees a full continuum of SUD treatment services modeled after the ASAM criteria. Enrollees in DMC-ODS counties have access to all services available through the "traditional" Drug Medi-Cal program plus some additional benefits, including case management, residential SUD treatment, withdrawal management, recovery services, physician consultation, opioid treatment program (OTP) services and, at the option of the county, additional medication-assisted treatment services and partial hospitalization. The waiver also

allows the state to receive federal financial participation for services delivered in Institutions of Mental Disease,⁸³ which is generally prohibited under federal Medicaid law.⁸⁴ To date, 40 counties have chosen to participate in the program, and as of December 2019, 30 of them are providing services under the waiver. Currently, 93% of Medi-Cal enrollees reside in demonstration counties.⁸⁵

"Traditional" Drug Medi-Cal

Medi-Cal enrollees who reside in counties that are either not participating in the DMC-ODS demonstration or have not yet implemented the model receive coverage of SUD treatment services through the "traditional" Drug Medi-Cal program.⁸⁶ This program now covers less than 1 in 10 Medi-Cal enrollees. Under the traditional model, county alcohol and drug programs arrange, provide, or subcontract for the provision of Drug Medi-Cal services approved through California's Medicaid state plan. The model also has an "any willing provider" provision, under which providers have the option to contract directly with DHCS instead of with the county. Benefits available under this program — including outpatient drug-free treatment, intensive outpatient treatment, naltrexone treatment, methadone maintenance at OTPs, perinatal residential SUD treatment, and hospital detoxification — are more limited than under DMC-ODS.⁸⁷

Appendix B. Interviewees

The authors thank the following individuals for sharing their experiences with various behavioral health VBP models across the states of focus:

Amy Anderson-Winchell, LCSW
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ACCESS

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UnitedHealthcare Community Plan of Tennessee

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Mary Shelton
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Beth Tanzman
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Timothy Tremblay, MS
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Information Administrator
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Richard Tuten
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Ruth vanBergen, LPC-MHSP
Senior Vice President
Mental Health Cooperative

Pat Wang
President and CEO
Healthfirst

Gary Weiskopf
Associate Commissioner, Division of Managed Care
New York Office of Mental Health

Kyle Williamson, LPC
Manager, Tennessee Health Link
UnitedHealthcare Community Plan of Tennessee

Endnotes

1. In 2018, HCP-LAN updated the APM framework to better account for small, rural, and safety-net providers, including clarifying that category 2 payment arrangements can be an endpoint for certain provider types, reinforcing the importance of clinical outcomes in category 3 and 4 arrangements, and clarifying that payment reform should be a tool to advance delivery system reform (rather than a goal unto itself).
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5. "Vermont All-Payer ACO Model," Centers for Medicare & Medicaid Services (CMS), last updated January 16, 2020, innovation.cms.gov.
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11. Richard A. Rawson, *Vermont Hub-and-Spoke Model of Care for Opioid Use Disorders: An Evaluation*, Vermont Center on Behavior & Health at the University of Vermont, December 2017, www.healthvermont.gov (PDF).
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17. *Mental Health Provider Manual Part 1: Community-Based Mental Health Services for Children and Adults*, Vermont Dept. of Mental Health, October 2019.
18. *Payment Methodology and Billing Changes*, Vermont Dept. of Mental Health, November 2018, mentalhealth.vermont.gov (PDF).
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23. Qualified providers include board-certified behavior analysts, board-certified assistant behavior analyst, and behavior technicians with appropriate licensure and qualifications.
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25. *A Path Toward Value Based Payment: Annual Update*, New York State Dept. of Health, September 2019, www.health.ny.gov (PDF).
26. *New York State Behavioral Health Value Based Payment Readiness Program Overview*, New York Office of Mental Health, September 2017, www.omh.ny.gov (PDF); and *New York State Behavioral Health Value Based Payment Readiness Program: Applicants Webinar*, New York Office of Mental Health, n.d., www.omh.ny.gov (PDF).
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38. *Tennessee Health Link: Provider Operating Manual*, Tennessee Division of TennCare, November 29, 2018, www.tn.gov (PDF).
39. *Provider Operating Manual*, Tennessee Division of TennCare.
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