HEALTH WEALTH CAREER

PART I: ENVIRONMENTAL SCAN OF VALUE-BASED PURCHASING IN BEHAVIORAL HEALTH

AUGUST 31, 2017

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services

CONTENTS

1
INTRODUCTION

This environmental scan, prepared for the Commonwealth of Pennsylvania (Commonwealth), Department of Human Services, Office of Mental Health and Substance Abuse Services (OMHSAS), provides a summary of value-based purchasing (VBP) initiatives and models for behavioral health (BH) services implemented by state Medicaid managed care programs. It is the first of three briefing papers that will also include a framework for VBP implementation to support progressive expansion of VBP for the Commonwealth's HealthChoices Behavioral Health (HC-BH) program and an evaluation tool to support the review and approval of VBP proposals.

OMHSAS requested an overview of the most successful VBP models, along with performance measures, populations and/or services included or excluded, contract requirements, and implementation timelines, the associated federal authority required and lessons learned. While the information from all states did not specifically address each of these issues, Mercer was able to find key information and themes that inform this report. The identified models are resources for building the HC-BH VBP framework in Pennsylvania. States that have implemented VBP within environments similar to Pennsylvania's BH managed care model (i.e., carved-out contracts), are highlighted within this review. However, because most of the VBP models and strategies found in the literature involve contracts with integrated BH programs (i.e., carved-in contracts) Mercer has also included some information on these for context and comparison purposes. Lastly, this paper provides recommendations for OMHSAS to consider in developing its VBP framework for HC-BH.

2
VALUE-BASED PURCHASING

VBP is a term used to describe numerous ways purchasers can link payments to quality indicators and better value, such as improved health outcomes, cost management and effective care coordination. The most common VBP models include Pay for Performance (P4P), bundled rates or payments for episodes of care, shared savings models, and population-based rates (capitation). Many states have begun incorporating VBP for BH services into their integrated managed care programs in response to the U.S. Department of Health and Human Services' announcement of goals to reward high quality care by moving away from traditional fee-for-service (FFS) payments into alternative payment models (APMs).

In this document, Mercer will describe numerous state approaches to BH-related VBP followed by a description of specific BH-related VBP models feasible for implementation in the HC-BH program.

STATE EXAMPLES OF BEHAVIORAL HEALTH VALUE-BASED PURCHASING

The following sections highlight numerous state examples of BH-focused VBP models. More detailed information is located in **Appendix A**, including state, required authority and adopted quality metrics.

Most BH VBP models identified through our research operate within a BH carve-in or other integrated care model or are moving in that direction. While VBP models exist in BH carve-out programs, these initiatives currently generally focus on P4P and case rate models, with very limited adoption of other, risk-based APMs allowed under managed care. In 2011, 20 states, in addition to the Commonwealth, had some level of BH carve-out.[1,2] Since that time, nine of the 20 states have moved toward integrated care models and, as of early 2017, only 11 carve-outs remain.[3]

Arizona is an example of a carve-in model. Arizona has a statewide specialty managed care model in which three Regional Behavioral Health Authorities (RBHAs) provide integrated BH and PH services to Medicaid enrollees with a serious mental illness (SMI), a minimum of 5% of total payments are linked to VBP strategies and the RBHAs choose the quality metrics. [4] Additionally, the Arizona Healthcare Cost Containment System (AHCCCS), Arizona's state Medicaid agency, implemented a VBP strategy that introduced a different fee schedule for clinics that deliver integrated BH and PH care.[5] This allows integrated clinics with integrated primary care to receive a 10% increase in the fee schedule. AHCCCS also recently launched a Targeted Investments Program with funding from the Centers for Medicare and Medicaid Services (CMS) to develop VBP arrangements to build the necessary infrastructure for integrated care.[6]

New York State and Tennessee are also considered innovative statewide managed care carve-in programs for individuals with a BH diagnosis. New York also has a specialty managed care carve-in model.[7] Updates to New York's "VBP Roadmap" include two VBP options related to BH:[8]

- The integrated primary care bundle option holds providers responsible for the cost and quality of services for 14 chronic BH and PH conditions, including, for example, depression, anxiety, substance use, and trauma.

- The total care VBP option for special needs populations is for providers who work with eligible subpopulations, such as those with significant BH needs covered under New York's Health and Recovery Plans (HARPs).

Under Tennessee's Medicaid program, TennCare, each contracted managed care organization (MCO) is responsible for all BH and PH services and long-term services and supports.[9] They later added a program called Tennessee Health Link, which incentivizes care coordination for members with serious BH conditions.[10] In addition to FFS payments, Health Link providers are eligible for practice transformation support, new activity payments, and outcome payments (up to 100% based on quality and efficiency metrics).[11] This program also has interesting examples of episode-based bundled payments for BH conditions that could be used in a carve-out environment as well. These are more fully described in **Appendix A** and **Appendix B**.

The more unique VBP arrangements specifically for populations with serious mental health and/or substance use conditions are found in Massachusetts and Maine.[12] The MassHealth (Massachusetts' State Medicaid program) Accountable Care Organization (ACO) initiative, which is scheduled to launch in December 2017, has three ACO models, one of which involves a carve-out vendor.[13] For the carve-out, the ACO vendor contracts directly with the Executive Office of Health and Human Services (EOHHS). P4P and payments for care management and engagement are the primary VBP models. In year one, the contractor can propose up to four P4P measures including the measure methodology and improvement targets. The measures and the baseline performance must be approved by the EOHHS. The contractor can propose a minimum of four new P4P measures each year. The model also includes engagement performance incentives based on the number of participants.

Maine's Medicaid ACO for individuals receiving services in Accountable Communities (AC) is another VBP program that could potentially be implemented in the Commonwealth. It uses multiple strategies to ensure successful integration of care, such as incorporating BH measures in the quality score for ACs to assess outcomes and to ensure providers are not withholding services to retain savings. It includes BH services in the shared savings payment model with a choice of one- or two-sided financial risk for providers.[14]

VALUE-BASED PURCHASING FRAMEWORKS

Several states are using the Health Care Payment Learning and Action Network (LAN) APM as their framework for VBP. See **Appendix C** for the LAN and other frameworks described in this section. The LAN was developed by the U.S. Department of Health and Human Services in partnership with several stakeholders, the Centers for Medicare and Medicaid Services (CMS), several states, and other providers to define the different levels of VBP models according to risk and complexity.[15] The levels range from one to four, with increasing risk and rewards. Health care systems are being encouraged to move toward LAN APM category three (APMs with payments based on targeted cost performance) and category four (population-based payments/full risk) in appropriate markets with appropriate patient populations. However, efforts at implementing VBPs for BH are newer and examples of full-risk implementation are scarce.

New York developed its own Roadmap as a framework to classify VBP according to levels of financial risk assumed by the provider, with levels ranging from zero to three.[16] [17] Similar to the LAN framework, there is greater financial risk with each level. Providers may enter at level one (upside shared savings with no downside risk), but are expected to eventually advance toward levels two (upside and downside risk-sharing) and three (prospective payments based on PMPM). New York's approach is also consistent with the LAN framework.

The Commonwealth also developed its own framework for the HC-PH program. The adopted HC-PH VBP framework, consistent with the LAN and New York State frameworks, includes P4P, Patient-Centered Medical Homes (PCMHs), shared savings, bundled payments and full-risk/ACO models, with progressive phasing up of more advanced, risk-based models over a three year period. OMHSAS wants to implement a VBP framework for the HC-BH program that is similar to the HC-PH framework, but appropriately adapted to accommodate BH services. While the four models in the HC-PH framework are also applicable to BH, there are unique considerations or necessary adaptations for HC-BH to consider, which are discussed below.

Pay-for-Performance

Providers receive bonuses or reductions in payments based on meeting targets for quality.[18] A recent literature review of the effect of P4P on BH care suggests external incentives do lead to positive outcomes.[19] While P4P initiatives are an older version of VBP and have tended to emphasize quality, P4P has evolved over time to include more cost and utilization measures that fit with more advanced VBP strategies.[20] It is important to note that most P4P strategies include a "withhold" of provider payments up front that are later used to provide rewards if providers meet performance requirements. More advanced models of VBP, such as a bundled rate, pay for the total cost plus an incentive if the provider meets outcomes and quality criteria, thus are more attractive to providers that have the capacity to manage a bundled rate.

At this point, P4P models remain a foundational component of VBP, especially because not all providers have the capability or the member volume to move into risk-sharing models. As providers with significant member volume gain experience with P4P and other alternative payment approaches, further movement along the risk-sharing continuum may be possible, but there will likely be certain providers unable to advance beyond P4P because they do not have the volume or technical capacity to manage financial risk. For these reasons, advancing beyond P4P as rapidly or as dramatically as expected in the HC-PH framework may not be feasible for many BH providers.

BH-MCOs have already begun implementing P4P strategies in the HC-BH program and should be encouraged to enhance and expand upon these initiatives with current and new providers. For example, Community Care provides incentives to providers of Assertive Community Treatment (ACT) to reduce utilization of inpatient mental health services by ACT members. According to Community Care, tiered earnings are available from a bonus pool created by withholding 20% of the established ACT service rate. Providers can earn the full 20% withhold and up to a 10% additional bonus amount if they meet the overall target of reducing the average inpatient mental health cost per person (i.e., $9,000 or less during the calendar year). Providers must also stay under an established cap for total ACT service utilization cost per person per year of $25,000. [21]

Health Homes and Care Coordination

PCMHs are unique to the PH treatment environment, while terms such as health homes and care coordination are more commonly used in BH. Additionally, while health homes are not a specific VBP, they do allow for enhanced Medicaid reimbursement of comprehensive case management for a predetermined amount of time, through Section 2703 of the Affordable Care Act (ACA). For individuals with SMI, health homes are required to provide integrated health and BH care, as well as additional services, such as transitional care, follow-up and referrals to supportive services.[22] Nineteen states have established health homes through approved state plan amendments under Section 2703. [23, 24] It is also worth noting that other VBP models can be added to the health home, such as bundled services.

Maine has an interesting model that supports a BH home for eligible adults and children. It includes a partnership between a licensed community mental health provider (called the Behavioral Health Home Organization, BHHO) and one or more primary care Health Home practices to manage the BH and PH needs of eligible adults and children.[25] In addition to the care coordination aspects of the health home, it fully capitates the BHHO and Health Home practices separately.

Under the HC-BH carve-out model, OMHSAS already has several health home model and care coordination initiatives that advance BH and PH integration. These include the Chronic Care Initiative (CCI), [26] Targeted Case Management, the seven developing Certified Community BH Clinics (CCBHCs) and the 45 Centers of Excellence (COEs) that offer integrated treatment for opioid addiction and are designated as health homes. Performance goals for care coordination or for outreach that leads to early access, improved outcomes and efficiencies can be measured and used as a VBP strategy. While recognizing that the COEs are financed through Commonwealth general funds, VBP purchasing strategies could be utilized and coordinated with any Medicaid financing for the eligible populations served by the COEs.

Shared Savings

Bailit and Hughes describe shared savings as “a payment strategy that offers incentives for provider entities to reduce health care spending for a defined patient population by offering them a percentage of any net savings realized as a result of their efforts.”[27] They also described the trajectory of shared savings since 2012, when the Medicare Shared Savings Program emerged. While shared savings models were introduced in early managed care programs, but were not readily adopted, Bailit and Hughes’s study of 27 shared savings programs found that many shared savings arrangements occurred mostly in primary care practice medical home programs and in ACO-like payment arrangements with broad patient populations.[28]

Key considerations in the use of shared savings include:

- There must be agreement on how to determine whether savings were achieved in order to develop a meaningful incentive for the provider and protections that the savings are not a random variation in costs.
  - For BH carve-outs, this step will also require advance planning to determine the BH services that will be included in the shared savings calculation, particularly if the PH plan has some responsibility for BH services. Most likely savings will be attributed only for BH services that are

provided and funded through the BH-MCO (services in the capitation) even when the outcomes of the BH intervention reduce other PH costs.

- The BH-MCO and the payer will need to offer provider tools, such as timely performance data with targets and benchmarks, and the ability for providers to manipulate the data. As a starting point, providers must have technical knowledge and information systems capability to manage the data or they will require help in these areas.
- Competing performance measures can harm the effectiveness of shared savings.
- There is the need to continuously refine the shared savings payment model to maximize its effectiveness.[29]

Opportunities to use the shared savings program in Pennsylvania could include the CCBHCs once fully established as well as other sizeable providers where the volume of care is large enough to track, trend and identify savings.

Bundled Payments/Episode of Care

These payments to providers are based on expected costs related to a defined episode or a bundle of related services.[30] Financial and quality performance accountability for the episode of care is included in this payment arrangement. Several states are using episode-based/bundled payment models (e.g., Ohio, Arkansas, and Tennessee). Episode-based models present an opportunity to move toward provision of evidence-based practices (EBPs) and could be a successful VBP strategy for the Commonwealth. For example, the Ohio State Health Innovation Plan has a two-part approach:

- Shifting from FFS to episode-based by incentivizing best practices for defined conditions, and
- Population-based payment models focused on prevention and care management to improve quality and Total Cost of Care (TCoC).[31]

Tennessee is gaining experience with financing episodes of care for specific conditions such as anxiety, attention deficit hyperactivity disorder, and oppositional defiant disorder. Additional information on Tennessee and Ohio are described in **Appendix A** and **Appendix B**.

Bundled payments can also be used to fund specific EBPs that OMHSAS, Primary Contractors and BH-MCOs want to advance. For example, when a bundled payment for an EBP covers the cost of training, certification, staffing and ongoing supervision, and payment is tied to achieving both fidelity and predefined outcomes, the bundled payment supports quality and effective utilization. OMHSAS has already considered use of bundled payments (case rates) for ACT, Inpatient Psychiatric Care and First Episode Psychosis. At least one BH-MCO is using a P4P model for ACT, which could evolve to a bundled payment as noted earlier in this document. Functional Family Therapy and Multi-systemic Therapy are other EBPs that could be considered for VBP if the payment is tied to achieving both fidelity and pre-defined outcomes.

Another example of a bundled payment is the Prospective Payment System (PPS) utilized by Federally Qualified Health Centers and the emerging CCBHCs. There are two models of PPS payments. The first model is a single rate per day for an eligible encounter with a client, which is developed based on the costs accrued by the clinic and divided by the encounters. The second model is based on a monthly case mix rate with separate reimbursement rates for specific diagnosis.[32] OMHSAS could incorporate

the CCBHC pilot programs and the PPS into VBP baseline measures and growth goals. The PPS Medicaid dollars could be quantified and applied to HC-BH VBP Framework spending targets (once finalized) and considered in the bundled payments category.

The BH-MCOs may also be using bundled payments or case rates for services that are either cost effective alternatives to state plan or waiver services, or allowed by managed care rules for alternative payment arrangements. As part of the VBP implementation strategy, OMHSAS may want to quantify which of these could be considered as a VBP arrangement and also applied to the HC-BH VBP Framework spending targets (once finalized).

Full Risk/Accountable Care Organization/ BH- Accountable Care Organizations

Typically, ACOs are large hospital and physician practices that form integrated care networks and assume responsibility for the health of their patients, the quality of care, and costs. ACOs first emerged during discussions about the ACA in 2012 and have been supported through CMS' Medicare program.[33] Providers may "buy in" to the ACO or participate as subcontractors, often sharing financial risk for outcomes. Although ACOs originally focused on Medicare, in April 2016 there were 838 active ACOs across the U.S. in all states covering Medicare, Medicaid and commercial health plan members.[34,35] Under ACOs, providers agree to provide coordinated care and be held financially accountable for outcomes and costs, with payment arrangements that can include capitation, bundled payments, shared savings (most common payment approach), with two-sided or upside only risk and P4P.[36,37] They are eligible for shared savings linked to achieving quality and spending targets. By their intended nature, ACOs were designed to integrate BH and PH care. Similar to health homes, the ACO itself is not a VBP strategy, but ACOs were constructed to promote the use of VBP.

One issue noted by a key informant was the rush by providers to prepare for ACO participation following the emergence of ACOs. A significant challenge for public BH systems has been the lack of resources that results in serving a portion of enrolled members at the appropriate level of care and limited technology, such as EHR and reporting systems that can track utilization and outcomes.[38] Among the range of readiness activities pursued by providers was the consideration of forming Independent Practice Associations (IPA) as a means to address the infrastructure requirements (technology, utilization management, contracting and quality reviews) for participation in in ACOs.

While the legal and regulatory requirements for establishing IPAs are different in each state and the legal requirements for formation of ACOs would require further research, there may be mechanisms for providers to voluntarily form a legal entity that is ACO-like and would allow them to contract as a group with the BH-MCO and participate in various VBP arrangements. This offers them resources (funded by each provider participant) when shared that can support technology and quality requirements and spreads the risk for smaller providers.

While the Commonwealth does not have an integrated ACO model, the option of developing specialized BH-ACOs could be considered as a longer term strategy for management of VBP. Alternatively, BH providers could form independent practice associations or network groups to develop a continuum of care that is attractive to the Commonwealth, Primary Contractors and their BH-MCOs. By developing an umbrella organization, the administrative costs of EHRs and technology to support the management of utilization, costs and quality can be spread across multiple providers. BH providers

could also join existing ACOs in the Commonwealth. This latter strategy would require collaboration among the PH-MCOs and the BH-MCOs to develop joint strategies that share and account for financial risk. Formation or participation in ACO-like entities may enable BH providers to utilize a varied range of VBP strategies due to the administrative tools available through these organizations.

In summary, shared savings with variations to risk, based on how it is defined, is the strategy most commonly utilized by providers, while a full-risk strategy is least common. Key informants provided the advice to proceed through the different levels at a pace that supports managed care entities and providers with developing the expertise to implement the VBP models along a continuum of risk sharing. They also discussed the importance of working with the plans to annually increase the number of covered lives paid under a population-based contract with shared savings and with risk sharing. The key informants also suggested maintaining P4P for those providers who have limited member volume and infrastructure to allow for their participation in some form of VBP.

3
PERFORMANCE MEASURES

A table of sample performance measures utilized for BH VBPs by state can be found in **Appendix D**. While there is increasing progress on the development of performance indicators, valid and reliable outcome measures for assessing BH quality, particularly measures that are recovery-oriented and track meaningful progress, are lacking.[39] To advance the development of recovery oriented outcomes, Mercer recommends assigning a percentage of the VBP dollars to recovery measures. These measures should be developed based on lessons already learned by OMHSAS, the Primary Contractors, the BH-MCOs and other stakeholders, and include substantial input from individuals with lived experience and their family members, including peer and family support specialists and recovery specialists, who are actively working within the HC-BH program. Professional input and evidence from the literature should also guide their development.

Implementation of valid measures can take time. Utilizing structure and process measures, rather than relying strictly on outcome measures, in the early stages of VBP implementation can also allow for a "phased-in measurement approach" for VBPs in BH to set the groundwork for reliable data collection and eventual advancement to outcome measurement. Bailit stresses the importance of defining a vision and specifying outcomes, while giving plans flexibility to determine how they achieve those outcomes. He also discusses the need to continuously refine metrics over time.[40] A broad attainment measure for high-need populations is in development by the National Committee for Quality Assurance (NCQA), which uses quantitative scales to measure the degree of individual goal attainment.[41]

Strategies to promote effective reporting include the following:

- Clearly defined measures: For example, if one BH-MCO measures readmission within seven (7) days, but does not count any readmission within 24 hours of discharge, the data will be skewed.
- Accurate reports: The data/report utilized to demonstrate outcomes and rewards or penalties must be consistent with the experience of providers and other stakeholders to promote confidence in the VBP program.
- Accessible and timely reports: Providers will need timely performance reports from the BH-MCO to improve performance, particularly "real time" performance needs.
- Transparency: Once measures are clearly defined and accurate, it will be important to publicize the results of the performance improvements.

4

SUMMARY OF LESSONS LEARNED

Extensive evidence of the features and factors impacting the successes (or failures) of VBP programs could not be found in the literature, based on their relative newness. However, interviews and materials shared by key experts[42] in this area, and resources provided by the Center for Health Care Strategies (CHCS), identified important factors of successful VBP programs.

- Engagement of stakeholders (e.g., Primary Contractors, BH-MCOs, providers, etc.) in design and implementation discussions;
- Assessing readiness (e.g., technology and infrastructure for data access and sharing);
- Ensuring staff truly understand the VBP model(s) and are prepared to negotiate their inclusion;
- Identifying staff with BH expertise to help build trust with providers;
- Offering technical assistance to Primary Contractors, BH-MCOs and providers; and
- If applicable, ensuring adequate volume to absorb financial risk.

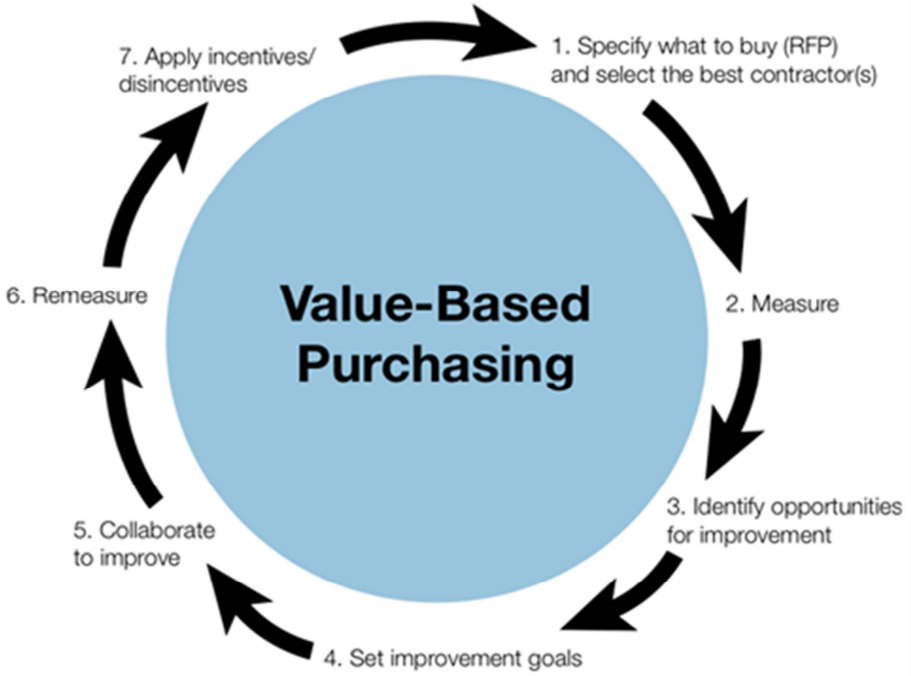
A recent article from Hospitals and Health Networks[43] highlighted seven best practices for success in value-based contracting, including:

- Recognizing that one size may not fit all; different populations may require different interventions;
- Addressing the members with the highest costs to impact population health management;
- Investing in staffing for at-risk care;
- Examining ability to scale;
- Partnering with other organizations to positively impact outcomes;
- Thinking through what to measure, how you will measure it and how that information will improve the organization; and
- Maintaining a focus on improving quality.

Bailit identified the following key steps for implementation of VBP.[44]

- Use Request for Proposals to identify plans that have experience and/or will be willing partners in advancing care delivery and payment reform;
- Contract with plans that commit to specific requirements for advancing alternative payment arrangements with their network providers;
- Give plans leverage with the delivery system to advance care delivery and payment reform, if appropriate;
- Consider options for regulatory leverage to advance payment reform through commercial insurers;
- Encourage plan actions to increase transparency of quality (and cost) information; and
- Align performance measurement across purchasers.

Bailit also described the VBP Implementation Cycle model as illustrated below, stressing the importance of persistence and continuous modifications over time. [45]



There are various points of entry into VBP arrangements. A major decision for any state looking to implement VBP is the extent to which it desires to be prescriptive and responsible for VBP program design and management. Though the goal is to move toward those higher levels of risk and complexity, there are not many examples of states working within those highest levels just yet, especially for BH-VBP. Rather than moving to a full-risk model, the advice from key informants and the literature suggests setting up a good infrastructure, informed by input from a variety of stakeholders, and taking gradual steps toward advancing the VBP model toward full risk arrangements.

APPENDIX A

OVERVIEW OF STATE MODELS WITH BEHAVIORAL HEALTH VALUE-BASED PURCHASING

STATE	BH DELIVERY MODEL	VBP STRATEGIES	ELIGIBLE PROVIDER	AUTHORITY REQUIRED
Arizona[46]	Specialty managed care carve-in	RBHAs provide integrated BH and PH services to Medicaid enrollees with an SMI. Link 5% (minimum) of total payments to providers to one or more of several VBP strategies, and must choose the quality metrics to link to the payment approaches. • Incentives to improve BH coordination in primary care; • P4P contracts; • Bundled or episodic payments; shared savings and/or risk; and • Performance-based capitation strategies.	Not found in the literature	1115 waiver: MCO contract requirements
Massachusetts[47]	Statewide ACO implementation (began 7/1/17) Carve-out BH ACO for individuals with SMI	• Partnership Plans receive a prospective, monthly capitation payment, subject to a risk corridor, like MCOs. • Primary Care ACOs receive a TCoC target. After each year, MassHealth will assess the performance of each Primary Care ACO against its TCoC target, and will make a shared savings payment if the ACO has achieved savings, or require the ACO to pay a shared losses payment if the ACO has losses against the target. • MCO-Administered ACOs receive a TCoC	ACOs must serve a minimum number of 20,000 members for Partnership Plans; 10,000 for Primary Care ACOs; and 5,000 for MCO-Administered ACOs.[49]	DSRIP, 1115 waiver

STATE	BH DELIVERY MODEL	VBP STRATEGIES	ELIGIBLE PROVIDER	AUTHORITY REQUIRED
		target. MCOs will perform the assessment on TCoC performance and make or receive payments for their MCO-Administered ACOs.[48]		
Maine	Medicaid ACO for individuals receiving services in ACs and BHHO CMHCs act as AC	• Shared Savings/Loss Models I and II — including BH services in the shared savings payment model with the choice of one- or two-sided financial risk. • Incorporating BH measures in the quality score for ACs to assess outcomes and to ensure providers are not withholding services to retain savings.	• Model I — requires minimum of 1,000 members. • Model II — requires minimum of 2,000 members.[50]	State Plan
New York[51]	Statewide managed care carve-in/ specialty managed care carve-in for individuals with specific chronic conditions, including BH.	• Total care for the general population, integrated primary care bundle, maternity bundle and total care for special needs subpopulations.	• Minimum of 25,000 Medicaid members (excluding dual eligibles) attributed for a Total Care for Total Population contract; • 5,000 Medicaid members (excluding dual eligibles) attributed for a total care for subpopulation contract; • Minimum of 10,000 dually eligibles for the Managed Long-Term Care subpopulation contract.[52]	DSRIP, 1115 waiver
Ohio[53]	State Innovation Model, Comprehensive Primary Care Initiative; statewide	Episode-based payments	• Practice with 5,000+ attributed Medicaid individuals and national accreditation; or • Practice with 500+ attributed Medicaid individuals determined through claims-only data at each attribution period and NCQA III accreditation; or	State Plan

STATE	BH DELIVERY MODEL	VBP STRATEGIES	ELIGIBLE PROVIDER	AUTHORITY REQUIRED
	roll-out of PCMH.		• Practice with 500+ attributed Medicaid individuals at each attribution period and enrolled in Medicare Comprehensive Primary Care Plus.	
Tennessee[54]	Statewide managed care carve-in for individuals with a BH diagnosis and/or meets related utilization criteria	Episodes of Care/Bundled payments	• Community Mental Health Centers or other qualified provider with at least 250 attributable members across all MCOs.	State Plan

APPENDIX B

EXAMPLES OF BEHAVIORAL HEALTH EPISODE OF CARE DEFINITIONS

EXAMPLES OF BH EPISODE OF CARE DEFINITIONS								
BH EPISODE	**STATE**	**Principle Accountable Provider**	**TRIGGER**	**AGES**	**DURATION**	**QUALITY METRICS**	**MINNIMUM CARE REQUIREMENT**	**ACCEPTABLE/ COMMENDABLE THRESHOLDS**
Anxiety	**Tennessee**[55]	Provider with the plurality of visits for anxiety during episode window	Professional claim with primary diagnosis of anxiety (must not occur in ED or during hospitalization), confirmed by 2nd professional claim with primary diagnosis of anxiety within 180 days to count as trigger.	7–64 years	180 days	• Percentage of valid episodes that meet minimum care requirement • Percentage of valid episodes where patient <18 has at least one prescription for benzodiazepines (lower rate = better performance) *Not tied to gainsharing:* • Percentage of valid episodes with one or more anxiety-related hospitalizations or ED visits (lower rate = better performance) • Percentage of valid episodes with follow-up within seven days of hospitalization or ED visit	Five visits/claims during the episode window	Not available

EXAMPLES OF BH EPISODE OF CARE DEFINITIONS								
BH EPISODE	**STATE**	**Principle Accountable Provider**	**TRIGGER**	**AGES**	**DURATION**	**QUALITY METRICS**	**MINNIMUM CARE REQUIREMENT**	**ACCEPTABLE/ COMMENDABLE THRESHOLDS**
						• Percentage of valid episodes that include condition-related medication • Percentage of valid episodes that include assessment • Average number of therapy or level I case management visits per valid episode • Percentage of valid episodes with ≥6 filled Rx for benzodiazepines for patient ≥18 years		
Attention Deficit and Hyperactivity Disorder (ADHD)	**Arkansas**[56]	Provider responsible for the largest number of claims within the window	• Level I: Either two medical claims with ADHD primary diagnosis or medical claim with ADHD primary diagnosis, as well as	6–17 years	4–12 months	• To pass: – Percentage of episodes with completion of either Continuing Care or Quality assessment certification (90% minimum) • To track: – Complete Quality Assessment certification (for beneficiaries new to the provider) or Continuing	Minimum case volume per provider is five total cases per 12-month period	**Level I:** $2,223/$1,547 **Level II:** $7,112/$5,403

EXAMPLES OF BH EPISODE OF CARE DEFINITIONS								
BH EPISODE	**STATE**	**Principle Accountable Provider**	**TRIGGER**	**AGES**	**DURATION**	**QUALITY METRICS**	**MINNIMUM CARE REQUIREMENT**	**ACCEPTABLE/ COMMENDABLE THRESHOLDS**
			pharmacy claim for ADHD treatment medication • Level II: Completed Severity Certification in addition to the above.			Care certification – Percentage of episodes classified as Level II – Average number of physician visits/episodes – Percentage of episodes with medication – Percentage of episodes certified as non-guideline concordant • Percentage of episodes certified as non-guideline concordant with no rationale		
Attention Deficit Hyperactivity Disorder (ADHD)	**Tennessee**[57]	Provider with plurality of visits for ADHD during the episode window	Professional claim with ADHD primary diagnosis code; professional claim with primary diagnosis of ADHD specific symptoms and secondary diagnosis code	4–20 years	180 days	• Percentage of pharmacy claims for long-acting stimulants, by age category (higher rate = better performance) • Average number of therapy visits per episode for ages 4–5 years *Not tied to gainsharing:* • Utilization of Evaluation and Management (E&M) and medication	Five visits/claims during episode window	$1,959.60/ Varies by MCO

EXAMPLES OF BH EPISODE OF CARE DEFINITIONS								
BH EPISODE	**STATE**	**Principle Accountable Provider**	**TRIGGER**	**AGES**	**DURATION**	**QUALITY METRICS**	**MINNIMUM CARE REQUIREMENT**	**ACCEPTABLE/ COMMENDABLE THRESHOLDS**
			from among ADHD trigger codes.			management • Utilization of therapy by age • Utilization of level I case management • Utilization of medications by age • Follow-up within 30 days of trigger visit		
Attention Deficit Hyperactivity Disorder (ADHD)	**Ohio**[58]	Provider with plurality of ADHD-related E&M and medication manage-ment visits	Professional claim with diagnosis of AD/ADHD	4–20 years	180 days	• Percentage of valid episodes that meet minimum care requirement • Percentage of valid episodes with no coded BH comorbidity for which patient received antipsychotics *Not tied to gainsharing:* • Percentage of valid episodes of patients 6–12 years old including follow-up visit within 30 days of Rx • Percentage of valid episodes of patients 3–5 years old including BH medications	Five visits/claims during episode window	Not available

EXAMPLES OF BH EPISODE OF CARE DEFINITIONS								
BH EPISODE	**STATE**	**Principle Accountable Provider**	**TRIGGER**	**AGES**	**DURATION**	**QUALITY METRICS**	**MINNIMUM CARE REQUIREMENT**	**ACCEPTABLE/ COMMENDABLE THRESHOLDS**
Oppositional Defiant Disorder (ODD)	**Arkansas**[48]	Provider responsible for largest number of claims within the episode	Three medical claims with an ODD primary diagnosis	6–17 years	90 days	• To pass: – Percentage of episodes with completion of either Continuing Care or Quality assessment certification (90% minimum) – Percentage of new episodes in which beneficiary received BH meds (20% maximum) – Percentage of repeat episodes for which the beneficiary received BH meds (0%) – Percentage of episodes resulting in beneficiary remission (40% minimum) • To track: – Percentage of episodes with >9 visits over >30 days – Average number of visits/episodes	Minimum case volume for providers is five cases per 12-month period	$2,671/$1, 642

EXAMPLES OF BH EPISODE OF CARE DEFINITIONS								
BH EPISODE	**STATE**	**Principle Accountable Provider**	**TRIGGER**	**AGES**	**DURATION**	**QUALITY METRICS**	**MINNIMUM CARE REQUIREMENT**	**ACCEPTABLE/ COMMENDABLE THRESHOLDS**
						– Average number of behavioral therapy visits per episode – Percentage of episodes certified as non-guideline concordant – Percentage of episodes with >9 therapy sessions over a period of 30+ days and of which >7 are family therapy sessions (CPT 90846 or CPT 90847)		
ODD	**Tennessee**[59]	Provider with plurality of visits for ODD during episode window	Professional claim with ODD primary diagnosis code; professional claim with primary diagnosis of ODD specific symptoms with secondary diagnosis code	4–18 years	180 days	• Medication with no comorbidity • Prior ODD diagnosis • Utilization (excluding medications) • Utilization of therapy and level I case management	Six therapy and/or level I case management visits during episode window	$2,194.70/Varies by MCO

EXAMPLES OF BH EPISODE OF CARE DEFINITIONS								
BH EPISODE	**STATE**	**Principle Accountable Provider**	**TRIGGER**	**AGES**	**DURATION**	**QUALITY METRICS**	**MINNIMUM CARE REQUIREMENT**	**ACCEPTABLE/ COMMENDABLE THRESHOLDS**
			from ODD trigger codes					
ODD	**Ohio**[50]	Provider with plurality of ODD-related E&M and medication management visits	Professional claim with diagnosis of ODD	4–20 years	180 days	• Percentage of valid episodes that meet minimum care requirement • Percentage of valid episodes with no coded BH comorbidity for which patient received antipsychotics *Not tied to gainsharing:* • Average number of therapy visits per valid episode • Percentage of valid episodes with no coded BH comorbidity for which patient received BH medications • Percentage of valid episodes with claim of ODD as primary or secondary diagnosis in year prior to episode start	Five therapy visits during episode window	Not available

APPENDIX C

VALUE BASED PAYMENT FRAMEWORKS

LEARNING AND ACTION NETWORK (LAN) APM FRAMEWORK			
1	**2**	**3**	**4**
FFS payments not linked to quality and value.	FFS payments linked to quality and value via: 1. Foundational payments for infrastructure and operations. 2. Pay for reporting. 3. Rewards for performance. 4. Penalties for performance.	APMs built on FFS with payments based on targeted cost performance via: 5. Upside gainsharing; 6. Upside gainsharing/ downside risk; or 7. Bundled/episodic payments.	Population-based payments which are either: 8. Condition-specific; or 9. Comprehensive (e.g., global or capitated per member per month [PMPM] payment).

NEW YORK STATE VBP ROADMAP RISK LEVELS			
0	**1**	**2**	**3**
Enhanced FFS. *Not considered a VBP arrangement.*	Upside shared savings with no downside risk.	Upside and downside risk-sharing.	Prospective payments on a PMPM basis for TCoC or bundled payment for specific episode of care.

PENNSYLVANIA HC-PH VBP FRAMEWORK			
MCO CONTRACT YEAR	**YEAR 1**	**YEAR 2**	**YEAR 3**
VBP Requirement	**7.5%**	**15%**	**30%**
VBP Models			
1. **P4P**	Any combination of models 1–5		
2. **PCMH**		At least 50% of the 15% must be from any combination of models 2–5	
3. **Shared Savings**			At least 50% of the 30% must be from any combination of models 3–5
4. **Bundled Payments**			
5. **Full Risk/ACOs**			

APPENDIX D

SAMPLE PERFORMANCE MEASURES

PERFORMANCE MEASURES UTILIZED FOR VBP IN BH			
	Measure	**Measure Type**	**Measure Steward/Source**
General Quality	• Reduction in inpatient admissions • Reduction in ED admissions • Follow-up after hospitalization for mental illness (within 7 and 30 days)	Outcome	HEDIS
Access	• Emergency screening and crisis assessment (95% seen within two hours) • Urgent outpatient evaluation (95% offered appointment within two calendar days) • Routine outpatient evaluation (95% offered appointment within 14 calendar days) • Outpatient follow-up visit (95% seen within 14 calendar days) • Extended hours (at least nine hours beyond 9:00 am–5:00 pm on business days)	Process	
Coordination of Care	• Agreements with other clinics for medical management, co-management, etc. • Member services and support: – Peer support groups meet during nine months of the year – Client satisfaction survey – Materials pertaining to client rights and responsibilities and education sources	Process	
SDOH	• Increase in individuals with stable housing	Outcome	
	• Increase in individuals who are competitively employed	Outcome	
Depression and Anxiety Services	• Diagnosis (Improving Mood — Promoting Access to Collaborative Treatment [IMPACT] Model)	Process	University of Washington
	• Initiation of Treatment (IMPACT Model)	Outcome	
	• Adjustment of Treatment Based on Outcome (IMPACT Model)	Process	

PERFORMANCE MEASURES UTILIZED FOR VBP IN BH			
	Measure	**Measure Type**	**Measure Steward/Source**
	• Symptom reduction (IMPACT Model)	Outcome	
	• Readmission to mental health inpatient care within 30 days of discharge	Outcome	IPRO
	• Potentially avoidable complications	Outcome	HCI3
	• Anxiety severity	Process	GAD-7 scale
	• Antidepressant medication management	Process	HEDIS
	• Utilization of the PHQ-9 to monitor depression symptoms for adolescents and adults	Process	HEDIS
Substance Use Disorder (SUD) Services	• Continuing Engagement in Treatment • Continuity of care within 14 days of discharge from any level of SUD inpatient care • Initiation/Utilization of Medication-Assisted Treatment (MAT) for alcohol dependence • Initiation/Utilization of MAT for Opioid dependence	Process	Washington Circle Group
	• Reduction in individuals using drugs or alcohol	Outcome	
	• Follow-up after ED visit for alcohol and other drug dependence	Process	NCQA
	• Potentially avoidable complications	Outcome	HCI3
	• Connection to Community Recovery Supports	Process	OASAS
	• Use of pharmacotherapy for individuals with alcohol use disorders • Use of pharmacotherapy for individuals with opioid use disorders • Follow-up after withdrawal management	Process	ASAM/Cigna (piloting)
Other	• Adoption of one EBP • Effective management of individuals with co-occurring disabilities • Care offered in at least two specialties • Cultural competence	Process	

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