

Medicaid Innovation Accelerator Program (IAP)
Medicaid Value-Based Payment Approaches for Substance Use Disorder
October 26, 2017

Hannah Dorr: [intro logistics]

Tyler Sadwith: I'm the project lead for the substance use disorder track of the Medicaid IAP. [intro remarks on IAP webinars] Today we're focusing on key considerations and options for selecting, designing, and implementing value-based purchasing (VBP) in the Medicaid program for substance use disorder care. Our goal for today is that states will learn about other states' approaches to SUD within a common framework for thinking about and planning VBP models.

We'll begin with a brief introduction on how this IAP fits into the IAP Learning Series. Then we situate today's SUD disorder within a framework of alternative payment models developed by the Healthcare Plan Learning and Action Network. We'll highlight examples of VBP approaches for SUD within Medicaid that fall under that framework. We will explain key considerations for planning and developing a VBP program for SUD. Our speakers:

Katherine Griffith (KG), senior advisor, Medicaid IAP: Brief intro and overview

Suzanne Fields (SF), our moderator, is a faculty member and senior advisor for Healthcare Policy and Financing at University of Maryland School of Social Work, and clinical worker with over 20 years of experience. Her work has spanned multiple settings including Medicaid, mental health, and substance use, children's services, child welfare, and managed care. She has moderated several of our previous webinars.

John O'Brien (JO), is a senior consultant at the Technical Assistance Collaborative, with more than 30 years of experience in behavioral health systems design, financing, and implementation. He has worked with Medicaid, mental health, and substance abuse authorities in many states to develop Medicaid waivers, state plan amendments, and federal grant applications. At TAC John directs their work on substance use disorders with emphasis on helping states increase access to services, integrate with primary care, and reduce unnecessary costs to support effective systems.

Allison Hamblin (AH), is senior vice president at the Center for Health Care Strategies. She leads the center's programming for Medicaid beneficiaries with complex needs in partnership with Kaiser Permanente and the Robert Wood Johnson Foundation on several targeted initiatives. Ms. Hamblin also directs CHCS's work in advancing pay for success financing approaches and supporting the sustainable spread of Project Echo for Medicaid financing.

Rachel Matullis(?) (RM), is a senior program officer at the Center for Healthcare Strategies, where she works on advancing accountable care organizations (ACO) and VBP models, including working on the Medicaid ACO Learning Collaborative and under the IAP on efforts on VBP and financial simulations. Previously she worked to develop evaluation and outcome reports and assisted with VBP for Magellan Behavioral Health in Pennsylvania, and she has worked on Medicare payment policy issues for the U.S. Government Accountability Office.

Now Katherine Griffith.

KG: I want to review the IAP. It is Medicaid-based technical support models funded by CMMI, Center for Medicare and Medicaid Innovation. It is led by the Center for Medicaid and CHIP Services. We support state Medicaid agencies with their delivery system reforms through various types of technical support

modalities such as one-on-one technical assistance and webinars and peer-to-peer learning, and then ___[00:06:02][cut off], such as this national webinar. This is a series. On this next slide you can see it is the third in a series of VBP webinars we hosted over the last few weeks and will be hosting through next week. [materials posted on website]

JO: Many of you may be familiar with the alternative model framework set forth earlier this year. The framework had a continuum of VBP arrangements that are broadly used by the healthcare industry and can be applied, and as you will see in some of the examples I will talk about, to payment arrangements for substance use disorder services. There are four categories. The far left category is probably where most of the substance use disorder payment arrangements lie, at least in terms of payment from states or from plans to providers, and that's on a fee-for-service basis with no specific tie to quality. While there may be a specific expectation that there's reporting, oftentimes that reporting is not tied to additional payments. In addition, I would contend that there is a pre-category to category 1 where there are still a good chunk of substance use disorder services that are purchased through non-risk-based monthly contractual arrangements through grant resources.

The second category of alternative payment methods (APM) do have some activity in substance use disorder VBP arrangements, both in the area of pay for reporting as well as pay for performance. While not specifically cited in the examples we're about to talk about, if you look at Washington State and some of what they're doing with their accountable communities of health, they are implementing some strategies for substance use disorder that are specific to opioids, and looking at some pay for reporting and pay for performance strategies in future years around prevention, treatment, and recovery. But for the most part the payment from the state of the plans to the providers are still going to be based on a fee for service model.

The third category and as well as the fourth APM category changed the payment methodology. Category 3, APM, could use episode payments for a certain set of procedures. These are more likely to address payments that are for individuals that have more acute care needs versus long-term conditions. Category 3 also includes payment from savings, sharing those savings with plans or providers. Most likely you will see in Category A's, APMs in that third category, shared savings with upside risk, versus Category B in terms of sharing risk in general, especially as it relates to substance use disorders. There has been a fair amount of discussion about Category B within Category 3 about the extent to which substance use disorder providers or behavioral health providers in general can share risk, especially the downside risk, given some of their ability to be able to have some solid and healthy cash reserves. It doesn't mean that substance use disorder providers can't participate in downside risk; it's just a little bit limited at this point in time.

The fourth APM is population-based, usually, but not solely, using capitation for specific conditions or specific strategies, such as integrating behavioral health and physical healthcare. While this APM is fairly prevalent, there aren't as many strategies that are using Category 4 APM with quality measures specifically for substance use disorders.

I'd like to walk through examples of those three categories that link payment to quality, Categories 2-4. In the first example, the State of Oregon, they were using an APM to specifically improve the rate of screening, brief intervention, and referral to treatment for unhealthy alcohol use. As you may know, the Oregon delivery system model uses coordinated care organizations (CCO). Those CCOs are a network of healthcare providers who work together in local communities to serve people who participate in their Medicaid program in the Oregon health plan. A key focus of the CCOs is prevention so ESPERT(?) fits nicely into the state's overall strategy.

Oregon has created bonus payments for certain measures and one of those measures is screening and brief intervention. They have developed a performance bonus payment structure that if the CCO qualifies for the bonus payment that payment is made at the end of the year. Payments are made on improvement from either the baseline or the achievement of a particular benchmark. In Oregon, just for some background on the initiative, there was already momentum for improvements on the take-up on the screening and brief intervention. There was significant work being done by one of the local in-state universities and the state had a myriad of technical assistance vehicles in order to provide practitioners with assistance in how to do good screening and brief intervention. Process-wise they did a literature review of the ESPERT measures and they pulled together some thought leaders from their SUD community to develop not only the measures but also the process for what the rollout was going to be for ESPERT.

Initially they developed a pilot program to test out the measures and the process before going statewide with the measures and then going live in 2013. There were some challenges in terms of the implementation, at least two if not more. During this time there were some changes from the ICD9 to the ICD10 code during the process, and that created some challenges in terms of reporting. What I think the providers and CCOs in the state learned is that using encounter data or claims data had its own set of challenges. It may not have been as specific information to be able to create the information needed in terms of whether or not a CCO qualified for their bonus payment.

The good news that came out of this process is that regardless of some of these challenges the product or rollout really created a good deal of interest in increasing screening for unhealthy alcohol use. Oregon is in the process of taking a step back and relooking at their measures. They're trying to figure out what is the correct metric, the right numerator and right denominator, and also looking at the possibility of how to be able to track this measure perhaps not necessarily through an encounter data or claims data process but through their electronic health records. They're looking to relaunch their ESPERT strategy as part of their CCO performance payments in 2019.

The second example is a Category 3 example on the APM continuum. In this example we have a few health plans using bundled payments as a strategy to increase the number of individuals receiving medication, for instance, for treating a substance use disorder. The major driver according to some plans we talked to was certainly the increase in the number of individuals with substance use disorder that were participating in the Medicaid program, but certainly the number of plan members that these particular plans were seeing that had an opioid use disorder. At least with bundled payments, the IAP did some work in this area over the past years, with some examples of how certain states or locales were creating bundled payments. I encourage you to look at the IAP website for this information in addition to what I'm going to talk about in this example.

These two plans we talked to approached these fairly similarly, which is they used a single monthly payment for a group of services, labs, psychiatry group and individual therapy, as well as other outpatient services as part of their monthly payment. It did not include pharmacy. That was separate from this particular payment. They looked at how to be able to develop payments really for different time frames. Some payment rates for maybe the first month that included induction of MAT and then payments for maintenance efforts. That would be ongoing months. Part of the payment for those ongoing months is attached to outcomes before bundled payments in and of themselves is not necessarily a pay for performance strategy or a VBP, but there were some outcomes attached as part of that bundled rate specifically based on the length of time someone remains in treatment. That was more the focus of the maintenance program.

The plans I talked about are implementing this APM across settings. They are implementing those both within the context of residential detoxification as well as outpatient specialty substance use disorder providers.

The third example is from New York, which is using their ACOs as their vehicle for their APM strategy. Their VBP strategy is focused on four chronic conditions, one of them being substance use disorder. A significant driver of this strategy is to improve better integration of physical health with substance use disorder care. Two activities New York is undertaking are worth noting. One is they are developing a set of metrics that will be part of their VBP strategy. Second is piloting how these metrics will be used in combination with an APM in their managed care contracts. As we speak, they're testing out the process and are currently revising their measures.

For measures they've created several categories. As on the slide, Category 1 are those measures that are reliable and valid. All plans participating in the VBP strategy must report on these measures. For those plans that do well in this area, they are offered a 50/50 shared savings arrangement. Category 2 measures are being used as well but these measures require more testing and more validation. Plans are not required to report these measures but they can elect to report them. If they elect to report the measures, they are offered a 90/10 shared savings arrangement. In Category 3, the measures in those categories are more aspirational. They may not necessarily be valid and may not have the reliability of Categories 1 and 2, but if ACOs do in fact report these measures, they also receive some savings from progress on these particular measures.

Some of what New York is trying to achieve here is directly related to better integration of physical health and substance use disorder care. Here's where New York is now. They are now in the process of piloting some of what they're trying to do in this strategy with their MCOs and they're contracting with providers. They're providing support and assistance with measures, both at the plan level and the provider level. They're testing elements of the process, and the feedback that has been received so far is that the plans have been supportive of the efforts to be able to move into a VBP arrangement for some of the substance use disorder metrics.

CMS does have an IAP with a track specific to VBP. NORC, who will provide technical assistance to 10 states, has done a VBP webinar earlier this month. In that webinar, they outlined the design elements for a VBP effort. As states consider their VBP efforts, these design elements are critical. The decision points as part of that VBP model are fairly straightforward:

- Be clear about the population you're going to focus on. It can be as wide as what Oregon was doing, which looked at anyone that might be at risk for unhealthy alcohol use to New York that might be more specific focusing on individuals with substance use disorders or specific substance use disorders like opiates, or looking even at individuals with specific mental health needs.
- Be clear about the services included. As you saw in the second example, the plans that were trying to incorporate VBPs as part of increasing the use of medication in specific treatment were very specific about what services were included as part of that monthly bundle.
- Be very clear about financial performance and benchmarking, so identifying what the VBP is going to be based off of, whether it's going to be an increase from a baseline or are you going to benchmark what the expectation is.
- The quality of the performance measure, and again going back to New York that had three different types of categories of measures, one being very valid and reliable and the third being more aspirational.
- Attribution of patients and risk adjustment do go hand-in-hand, both in terms of the patients that a plan or particular provider is serving and the extent to which they are or aren't able to make

that big of a dent in their VBP efforts or the strategies to implement the interventions that will in fact get them the VBPs.

So those are the contexts one should think about as they're developing their VBP effort.

SF: Thanks for that overview in terms of the LAN framework, more specifically the SUD-specific examples, and especially the design elements, the six design elements that CMS throughout this series is continuing to highlight to support states in understanding.

Now questions through the chat box:

What considerations would you have for states in those beginning stages of trying to develop an SUD-specific VBP arrangement? Whether specific to SUD or housed within the six elements of designing a VBP model, what elements would you want to highlight for listeners?

JO: First, include the affected stakeholders in your planning strategy. That not only includes the plans as well as the providers responsible for implementing the interventions, but including the recovery community as part of the conversation of what should be included in a VBP approach makes sense.

Second is timing. While quicker and faster is always good, we have seen that it takes time to be able to roll out these strategies. It's just not a matter of reporting metrics—you're now paying not only for the reporting of those metrics but actually the improvement of those metrics, so the stakes, while they're high with just generally reporting, they're higher when you're attaching money to those payments. Some of that takes time, both in terms of making sure you're getting the metrics and process right but also making sure that everyone's on the same page.

Two other things I would suggest are making sure that the carrots and sticks are large enough to make a difference. If you are interested in moving the needle but carrots and sticks don't look sufficient to the recipient of the VBP, you may not necessarily get the progress you want to see.

Last but not least, build in process improvement efforts to correct anything you might see as you begin the rollout of those VBP strategies.

SF: You highlighted a range of VBP SUD examples and some were SUD-specific VBP efforts. Some were broader based, a focus on whole population or whole health or part of ACOs and multiple different goals. What specific recommendations do you have about aligning SUD-specific goals within those broader VBP efforts or whole health efforts?

JO: The good news is we are actually seeing activity as it relates to SUD in each one of those categories. What states are struggling with is what should be the VBP efforts for SUD across any one of those. Part of it is being clear about what's going to be important to move the needle on. I don't think, for instance, we have to go back and have the conversation on return on investments for substance use disorder treatment. I think payers get that. But what's more helpful is to say here is what we need to improve on. For instance, there is lots of interest in increasing the access to medications as treatment, and agreeing upon what the goals should be is probably the most important step. Then working back from that goal to figure out what are the strategies, what are the interventions, and what's the data you're going to be able to use or obtain to be able to measure the changes both interventions have created, and last but not least, how to arrange the VBP for the particular intervention.

So it's not necessarily engagement on this particular issue; it's being more focused on what part of substance use disorder do you want to focus on for your VBP.

SF: There are questions about engagement of stakeholders. Could you share thoughts about engagement of beneficiaries in care and stakeholders in these VBP efforts, which often create uncertainty and anxiety about their potential impact? Could you share examples, ideas, recommendations?

JO: The examples I shared from Oregon and New York and to some extent the planning samples did have some initial engagement strategies that were helpful. In particular, the most recent one in New York really was a strategy at the local level for the CEOs, plans and state to identify individuals in those communities to be able to get good input on what should be some goals for their VBP effort. When I talked to payers about VBP in general, the beneficiary, the person who's often the end result of any good intervention, was not always at the table when some of these conversations were being had. I'm happy to see, at least in some examples we talked about today and in a few other states moving forward with VBP effort, in the beginning they're including people in recovery, family members, community organizations that have to address substance use disorder—especially with the opiate crisis law enforcement, EMS, others—as part of the strategies. More so to talk about the interventions but also to talk about the rewards for being successful in their intervention efforts.

SF: Our next speakers are Allison Hamblin and Rachel Matullis.

AH: This is Allison and I'm here with my colleague, Rachel Matullis. We are here to talk about high-level considerations for overall VBP program design as it relates to individuals with substance abuse disorder and promoting access and quality of care related to substance use treatment services. John a moment ago reminded us of the frameworks, the design elements, that have been a consistent theme throughout this webinar series.

I want to differentiate what Rachel and I will speak about today. While our comments are absolutely connected and reinforcing of the design element, we're going to take the conversation a bit more to the 30,000-foot level, and in contrast to thinking about design of specific payment approaches and specific payment models, really think about high-level policy and program design considerations, as you think of the array of payment models you might be considering designing and implementing as it relates to SUD. Where possible we'll link that to the design elements but I want to make that distinction about in what level of the atmosphere our remarks are intended to land.

The considerations we are going to share with you are informed by the works we at the Center for Healthcare Strategies are doing with a number of states as it relates to VBP and specifically around SUD issues. Also informed by some recent environmental scanning we've done around what are the specific considerations for developing and implementing VBP in behavioral health environments.

Next slide. One of our first high-level considerations and that's thinking about program design issues in the context of local and state level market and some goals. Each of you are thinking where do we begin here; how do we incorporate SUD-specific payment models in our overall VBP strategy. It's really important to think about those questions in the context of your overall SUD system goals and where you're headed from a programmatic and policy perspective. For example, many of you are actively looking to build out your continuum of SUD-treatment services across various levels of care or maybe you're looking specifically to build out discrete levels of care where you may have gaps in your system, or to encourage and promote specific evidence-based practices.

Some of you, particularly in response to the opioid epidemic, may be looking to increase access to medication-assisted treatment, perhaps in specific regions where that capacity is more limited. Some of

you may be interested more specifically in increasing quality of care. Maybe you have a pretty robust system or more robust access than some other states but your principal interest is in raising the bar on the quality and outcomes being delivered in specific settings.

As another final example, many of you are really actively pursuing an integration agenda. So perhaps you are thinking about VBP and SUD contacts with an integration frame and how you can be using payment incentives and payment reform to support this broader integration goal.

As a related point to thinking about this in the context of your overall system goals, it's also really important to connect this specific line of inquiry around what else is going on in your state in terms of delivery system and payment reform efforts that have bearing on the SUD treatment system. Similar to some of the goals I mentioned, some of you are pursuing or are implementing 1115 waivers specifically to expand the continuum of SUD treatment services. Many states are actively integrating behavioral health services in a managed care environment and may be in early stages of that journey of managed care transformation or perhaps have moved what was formerly a fee for service system into a managed and organized delivery system. Some of you are incredibly focused on your response to the opioid epidemic. All these other major policy drivers or big areas of focus for delivery system reform are of course equally connected to what you might otherwise pursue through your VBP strategy. So it's just a nice reminder to make sure we're thinking about VBP as one additional lever that can help drive that overall strategy and making sure we're connecting the dots across the initiatives.

Also thinking about not only what's going on in the Medicaid environment in your state but what's going on with other payer initiatives. Are there opportunities to connect with other activity and payment reform initiatives in various regions or throughout your state and making sure again that to the extent there are opportunities to bring in other key actors and to make sure that initiatives are aligned across payers, that you're exploring all these opportunities to use them.

The second key consideration we want to highlight today is the critical importance of engaging stakeholders in the design and implementation process. John alluded to this a moment ago in response to the first question Suzanne posed his way. This is a nice opportunity to underscore that further. Particularly given where the SUD treatment system is on a relative basis with respect to data capacity, information system connectivity, financial and operational capacity, and John, I'm not sure he used the term Category Zero but he referred to the notion of a Category Zero where in some states fee for service is either new or in place for only a portion of services or providers. In some cases SUD treatment services may still be operating on a contract funded basis. So really recognizing where the starting point and status quo is in terms of provider payment arrangements is critically important.

The other factor in the context of needing to think about stakeholder engagement is where we are with quality measures in this area, again on a relative basis compared to other areas of clinical focus for VBP at the moment. Given all these factors that highlight that SUD and SUD providers may be on the earlier side of the evolutionary scale with respect to some of the capacities important to support and enable VBP to be successful and achieve its goal, it's all the more important to have a really robust stakeholder engagement process, not only upfront in the design phase, but as John mentioned, really to support ongoing process improvement and making sure that the right voices are at the table for the whole journey and not just at the start.

The benefits, which I'm sure familiar to most you, of having a really robust stakeholder engagement strategy are:

- Really enabling a transparent process around the development of a payment methodology, particularly checking back to the design elements, that you think about the financial benchmarking and attribution methodologies.
- Making sure that there's as good of an opportunity for stakeholder input and transparency as possible is incredibly important to support the successful rollout of these efforts.
- To make sure that the right voices are at the table and helping us think through the design of these models in the most strategic and effective way possible. As listed on the slide here, stakeholders around the table include providers and other members of the recovery community.
- To help identify possible inefficiencies in the model you're thinking about that could be remedied. There are opportunities to really get voices in the mix to identify treatment gaps not being addressed and accordingly where the most impactful areas of improvement are, where VBP can really drive that improvement.
- It increases the ability of the group at large to avoid unintended consequences. In John's examples, we talked about some efforts across states and plans to move towards bundled payments, for example for medication-assisted treatment. In some of our work recently we spoke with a state that had an interesting experience with some aspects of a bundled payment for medication-assisted treatment, and specifically around the loss of accountability and ability to track whether or not counseling was being delivered as robustly and according to evidence-based practice as the state would have otherwise liked to have been able to monitor. The state ultimately decided to rebundle that package of services and remove counseling from the bundle to be able to have that greater accountability and ability to track and monitor the extent to which counseling services were being delivered. It's one interesting example of how we can't always anticipate the downstream impact when we put some of these models together and having more voices around the table increases the chances we will identify those possibilities.

I mentioned provider capacity restraints a moment ago. Taking a second here to really highlight how critical this is in context of the SUD treatment system. Again just recognizing that there is tremendous variation across and within states in terms of provider capacity, but recognizing that by and large there are more gaps in this area than perhaps in other areas of the healthcare system. So really thinking about VBP can be used as another mechanism to really develop and support and further build out that capacity. Rachel will talk more later about where some activity, particularly in Categories 1 and 2, is, focusing on infrastructure development, etc. But really be mindful of existing provider capacity and really thinking about VBP as a lever to build out and support the development of that capacity in particularly high-opportunity areas.

Also VBP can really be an effective mechanism to just promote increased activity in certain areas. We saw the example of ESPERT in Oregon. So where in some states there are priorities around increasing access and increasing just the scope of services available, VBP can provide a potentially powerful lever to increase the incentives for providers to be performing certain functions and building out certain services on the continuum and so forth.

We briefly mentioned technical assistance on this slide but I'll leave that for Rachel to talk in more detail.

The last topic I'll cover is quality measurements. Obviously this is a critical area for all VBP efforts. It's not VBP if it's not tied to quality in some way, shape or form, and as John reminded us earlier, a lot of the effort at the state and frankly national level is focused now on developing a more robust set of quality measures around SUD.

A key design consideration is figuring out which quality measures your state will use. Will you use nationally endorsed measures or will you revert to homegrown measures that may fill in the gaps for where we lack for consensus measures, high fidelity measures, and validated measures in the field. On the nationally endorsed front, we see a lot of attention to the initiation and engagement measure. We see increasing interest in the followup after discharge from emergency department measure. Many of you are probably familiar with the fact that the National Quality Forum endorsed three measures earlier this year around opioid overuse and specifically focused on prescribing patterns related to use of high-dose opioids and prescriptions from multiple prescribers. Those are all measures gaining attention, interest and use across states.

Another effort of the National Quality Forum in collaboration with the IAP was a report issued a few months ago, I think September, by the NQF-IAP Coordinating Committee, which looked at measures in all the IAP domains and as it relates to SUD recommended for consideration 24 SUD-specific measures and another five measure concepts. That report is publicly available and as a resource that would be helpful to your state as you think about the landscape. There's obviously a need for consideration around process and outcome measures. I would say, and look for Rachel to talk about this further to see where we're seeing more activity in this area, from my limited perspective we're seeing plenty of activity on the process side. I think that might be in response to both some questions around are there good outcome measures out there? Perhaps we have better process measures right now than we have outcome measures in that spirit of trying to encourage, promote and boost the level of activity and access within the system.

Onto homegrown measures, there's quite a few states out there doing some really interesting things with measures at the state level. Some states are using a treatment episode data set. Other states are using the national outcome measures to develop performance measures. Kansas and Connecticut are examples there. Some states are using data derived from standardized screening tools, and Massachusetts is an example. John spoke about Oregon's ESPERT activity and the evolution of the data collection effort associated with that. I also mention in New Jersey the recently announced enhanced case management initiative for individuals with opioid use disorder, which includes incentive payments that would be tied to performance on an array of measures that my understanding is the state will be developing classifications for in the near term. There are some really interesting areas, such as relapse prevention, overdose prevention, recidivism, housing, and employment, and a broad array of outcomes I'm sure we all agree are highly connected to effective SUD treatment.

My last comments are again just thinking about the key questions that states should be asking themselves as they look to select from available measures, so perhaps to develop some homegrown measures in this area. Really thinking about the feasibility of data collection. So what data are available? What electronic data are available specifically in the SUD treatment setting? How will that data be collected? Recognizing some limitations associated with reliance on administrative claims data. Understanding if there's an alternative option available is it reasonable to think you can collect sufficient EHR data to support it or should you be thinking about record reviews and audits and so forth. Going back to the design elements, really thinking about how you want to establish those benchmarks. Perhaps thinking about in earlier phases rewarding improvement and focusing there as opposed to the need to hit a particular benchmark again, depending upon the maturity of your system and where performance currently stands. These are great opportunities for stakeholder engagement. Rachel will lead us through remaining high-level considerations.

RM: I'm going to take over on slide 31, which is looking at how some of these considerations should be incorporated when you're thinking about implementing SUD VBP programs in a managed care environment. This is important because at this point 39 states are offering services to Medicaid

beneficiaries, at least a portion of them through some sort of risk-based managed care contracting. I will start off with some higher-level considerations and then give more specific examples.

One key question in thinking about implementing SUD VBP arrangements in the managed care environment is how flexible or proscriptive do you want to be? One example of a consideration here is do you want to require or encourage the use of a specific delivery system reform to help enhance VBP for SUD treatment. For example, some states have used their Medicaid ACO programs as a lever to help integrate and incorporate some VBP aspects that include SUD treatment.

Another key question is how if at all do you want to build VBP targets that look at the percent of all managed care payments that need to be in some sort of qualified VBP arrangement. If you do use targets do you want to ramp up those VBP targets, and potentially consider ramping those up a little more slowly for your substance use disorder providers relative to maybe other physical health-related providers?

Then what counts as a qualified VBP arrangement? States are increasingly using the HCP LAN framework that has already been discussed today as a way to incorporate VBP language and targets their managed care contracts. So that is an option not as open to states and that not many states are using, although you don't have to do that. States such as New York are basing their VBP programs and roadmaps around similar language although they have tweaked that based on the specific goals and interests of their states.

Another consideration is that given that the behavioral health field as we discussed is a little bit further behind in some of these areas, such as data and infrastructure, that you could potentially consider evolving what's going to count in terms of a VBP arrangement over time. You can also set different targets for different plans, which is something we've seen states such as Virginia implement into their contracts.

To make it more concrete I'm going to walk through a few examples for a few different states. I'm going to start off with a few examples that err on the side of being a little bit more proscriptive and discuss examples that are more flexible, and then finally a hybrid approach.

First, the State of Minnesota has a Medicaid ACO program that's known as the Integrated Health Partnership program. Its ACO model incorporates SUD treatment and provider accountability for cost and quality. What that means is that when they're developing their total cost of care targets, ACOs want to try to come in under it in order to earn shared savings. SUD treatment services are included in that total cost of care benchmark. Minnesota also includes SUD quality measures as part of how it assesses the IHPs quality performance. As an example, it uses that initiative and engagement measure that Allison mentioned earlier.

Next, Tennessee has adopted an episode of care payments as one of the statewide VBP approaches. It has a relatively aggressive plan to adopt over 70 episode of care payments for a wide variety of conditions, procedures, and services by 2020. One of the proposed episode of care payments that Tennessee plans to implement is for SUD treatment. Again this is not scheduled until 2020 but I wanted to give states an example of the kinds of things states are doing in this area.

Those are two more proscriptive examples of how SUD VBP approaches can work in a state, Arizona has adopted a more flexible approach. It essentially sets some targets (we'll discuss in next slide) that it wants plans to meet in terms of being in qualified VBP arrangements, but does not dictate the specific model or payment arrangement that it needs to be. Yet another purchase(?) [01:00:40] we talked a little bit about already is moving plans toward more sophisticated VBP approaches over the life of the contracts. That could look something like starting with Category 2 in years one and two of a contract and then years three through five trying to move more into Categories 3 and 4.

On this slide, we provide an example that drills down a little bit more into what Arizona does for its behavioral health VBP targets. Arizona has specialty integrated plans for adults with SMI that are able to pick from a menu of VBP options listed in the bullets here. Generally speaking, in some cases they mirror the HCP LAN framework. One reason we wanted to include here the percentage of payments that need to be in qualified VBP arrangements, both over time for the behavioral health plans as well as for the acute physical plans, is so you can see how the numbers compare. You can see that they both ramp up over time but that the behavioral health targets ramp up somewhat more slowly again to allow for that difference in behavioral health provider capacities that we talked about today.

As a final key consideration, we also think it's very important to think about providing technical assistance, not just to the providers but also to the health plans for states operating in a managed care environment. Here we outline New York's approach. They have a couple different opportunities aimed to help people along in terms of their knowledge and understanding of different DBT arrangements. One opportunity they have is something known as the Community Technical Assistance Center of New York and the Managed Care Technical Assistance Center of New York, sometimes known as CTAC and MCTAC. These were originally developed in preparation to new providers from operating in a fee for service environment to a managed care environment. However, the state has leveraged that capacity in that organization to help behavioral health providers as the state moves along to a VBP approach. Then New York also offers separate VBP universities. We outlined here that you can get a sense of the types of topics covered and the spacing of those topics just for reference's sake.

We want to highlight some new work that CHS is doing in partnership with John O'Brien at the TAC. This new work is being conducted with support from the Malzone(?) Charitable Trust, and it's a study that's looking at VBP arrangements being used specifically to accelerate integration of SUD treatment and primary care. We wanted to highlight some early findings. These include:

- VBP models are in fact being implemented, particularly in response to the opioid epidemic. We are finding some states and plans with a particular interest in trying to increase access to care. They are looking to increase access to providers who can offer medication-assisted treatment in primary care settings. So they're developing VBP arrangements primarily from what we're seeing early on in HCP LAN framework as I think John and Allison already mentioned. We're seeing VBP arrangements in Category 2, so specifically working a lot of efforts around Category 2A, looking at infrastructure development, helping to train providers and get them certified in waivers to offer buprenorphine treatment.
- Effective training and adequate payments are essential, again especially for medication-assisted treatment given that primary care physicians are quite busy and that treating patients with opioid use disorders can be quite time-intensive. So just making sure that services and payments are adequate.
- Underscoring what's been brought up a few times today, that there is need for more robust quality measurement in substance use disorders. Most certainly what we're hearing is that most of these VBP arrangements are using some sort of process-related measure, and we know there's a lot of work being focused on moving that more towards looking at recovery outcomes.

A few key takeaways from today's webinar are:

- Developing a VBP program for substance use disorder is a challenging process. It does require careful consideration of the programmatic elements as well as the VBP design elements talked

about today. These elements should definitely be considered in the context of your current state goals as well as infrastructure.

- As also mentioned, you should also try to incorporate stakeholder feedback if possible.
- You should really design programs that meet the plans and providers where they are. So if that meets your VBP program starts somewhere along the Category 2 HCP LAN program, there's nothing wrong with that as you build plan and provider and in some cases state ability to move onto Categories 3 and 4.

SF: Questions: *Let's start with engagement of stakeholders and of beneficiaries. What are specific examples of processes and approaches that can be fruitful for states, providers and health plan partners to engage stakeholders?*

AH: One of the things that in our experience has been really helpful in the states where we've been directly involved is specifically around the quality measurement approach, developing a multi-stakeholder work group. It doesn't necessarily have to be limited to quality measures but it can be helpful to really focus the attention of a multi-stakeholder group like that on some very specific elements. Perhaps there could be stakeholder work groups for various design elements, but quality measurement might be a particularly valuable opportunity for that feedback. A state could convene a representative group across the continuum of key voices, ranging from plans and providers to individuals and families and other representatives of the recovery community, as well as perhaps and to the extent available some subject-matter experts who could weigh in on technical expertise on the development of measure specifications and helping the group to understand what's available in terms of endorsed or other validated measures. That is one concrete suggestion; there are certainly others. But really having a work group at the table to take on some of that responsibility so this doesn't end up being a design element forced upon the provider community but one rather that engages them and recognizes that this is an area where the "field" is less well-developed and could really benefit from multiple voices in the mix.

SF: *You both mentioned that VBP efforts typically require access to data. That immediately takes us to issues around EHR, that data infrastructure within the mental health and substance use arena. Could you provide additional insights/thoughts about how states are supporting providers to be involved in VBP arrangements, especially in situations where they may not have robust EHRs to rely on?*

RM: Certainly states, especially when they are starting early off in the HCP LAN category framework, don't necessarily need to have that same level of clinical data or data you would get from an EHR that you might need later in the HCP LAN framework. So we are seeing some states just beginning their journey with infrastructure payments to providers, for example to get them up to speed and adequately trained. You could also include infrastructure payments to help get your providers to have EHRs implemented and/or to make meaningful use of them. We do also in some cases see states or plans include EHR implementation or meaningful use as a quality measure. Allison?

AH: On the SUD side I would just add that a lot of the activity we've seen, particularly as Rachel mentioned in the primary care arena and from efforts to use VBP to promote integration of SUD treatment in primary care, just as one concrete example we've seen a lot of interest in providing incentive payments in various forms for primary care physicians to become waived to prescribe buprenorphine. That's an example of something that wouldn't require any underlying EHR capacity in terms of being able to monitor, and it really is providing some kind of upfront incentive for physicians or other PCPs to take that step to begin treating substance use in some form in their environment. Just one example of hopefully a long list of VBP arrangements that can be successfully implemented really in the absence of a robust EHR system or substantial HIE connectivity among SUD providers.

SF: *You mentioned medication-assisted treatment and cited several examples about MAT. As we're focused on the alignment of these VBP efforts with key SUD-specific goals, MAT is a core element of an effective SUD delivery system. Can you speak to ways that a higher quality, better performing MAT with better access within system networks itself could specifically be incentivized?*

AH: This is an area which seems to be one of the center points of activity in this overall space we're talking about today. John talked about some of the efforts to move towards bundled payment arrangements for MAT to include all the screening and lab testing, counseling, perhaps pharmacy, perhaps not, associated with evidence-based approaches to MAT. That seems an area that is getting a lot of initial focus across states with really varying approaches so in some cases it's a bundled payment strategy. In some cases, as we mentioned, states are moving away from a fully bundled payment strategy because they really want to provide more direct incentives to encourage the counseling piece, where they may not be seeing the level of activity there or the connection from what they would otherwise hope from the literature.

But we're also seeing in many places a real interest in using VBP arrangements to really just boost the level of activity and increase access to VBP in various settings of care. That's being done in a number of ways. In some cases, again, as mentioned a moment ago, providing an incentive just for becoming waived perhaps or providing some additional incentives under Category 2 frameworks to be performing certain activities and delivering certain services in the suite of requirements for MAT delivery. There's quite a few __[01:15:57] there.

I'd say some of the more recent conversations we've had with plans who are really actively looking at VBP specifically around MAT, in terms of outcome measures, our sense is that people are moving pretty fairly cautiously with respect to outcome measures tied to VBP arrangements in this context right now, working closely perhaps with a small set of early adopting providers in their network to identify a set of measures that are first just to be reported but not actually moving towards paying for performance on those outcome measures until they all gain a little bit more experience with the model. We're seeing some early movement there, but again a fair amount of caution given where we are in understanding what are the right and most effective outcome measures for some of these domains. Rachel or John?

RM: I'll add one thing. There are for some test measures out there, and actually HHS put out a report in 2015 that looked at measures for opioid and alcohol use for MAT. I would reiterate the point John made earlier about some states that are using some mandatory measures that are known to be valid and reliable but also testing some of these newer measures. I would advocate that you potentially consider looking into some of these other measures that are out there to add into your VBP program.

JO: While I would encourage states certainly to consider MAT as a focus for VBP, it also makes sense to make sure there's nothing on the books that are creating barriers to creating access to MAT. I know that a number of states are very interested in expanding of course the number of providers, especially waiver prescribers, who can offer MAT. But they're also wanting to increase where that happens in terms of sites and so there's sometimes things on the books that prohibit a prescriber from being in a particular site and offering MAT. So as a precursor to VBP, make sure there's nothing that might be on the books that gets in your way of meeting some of your goals around a VBP.

SF: *For many states they're operating in a context of having multiple MCO or health plan partners. As all three of you are talking about the implementation of VBP arrangements, with oftentimes an emphasis on what the MCO can do within its plan for its beneficiaries, what are your thoughts about ways to implement VBP in systems that have multiple MCO partners, particularly for both the state to understand the very impact or learnings that could be happening? Should they be coordinated? Should they be allowed to*

happen independently? And what that means also for providers in terms of if they have business arrangements with multiple MCOs as well?

RM: First, I think that to the extent that the state can think about and factor in the ramifications of having multiple plans on providers that are going to potentially have multiple VBP contracts, more specifically some states that have multiple plans and are allowing for more flexible VBP arrangements will at a minimum try to at least standardize the quality measures. Potentially even standardizing and providing a menu of quality measures that plans and providers could use, both to help alleviate different plans incentivizing different measures, but even within a given measure, specifications can be used differently. That's one approach.

Another is to think about again where the state is best positioned to standardize something versus where it makes more sense for the managed care plan to specify something. Just one more example: In Tennessee, with an episode of care arrangement, it actually allowed the MCO to define the cost benchmarks and some of the risk adjustment, in part because the plans paid different rates. That was a specific design element of the VBP program that made more sense to delegate to the MCOs rather than to try to have it standardized at the state level. So just taking the time to step back and look at each of those VBP design elements and figure out who is best positioned to do what and what would put the least burden on providers and alternative routes.

JO: Two thoughts I had about this. One of the examples I have seen in some of the ones I referenced, it was sometimes a one-off that one MCO did as it relates to a VBP. So it wasn't necessarily coming from the employer or the state as a requirement or voluntary option to participate in a VBP; the plan just figured it out itself with a cadre of providers willing to enter into those arrangements. In some cases when that happens, when there are multiple plans in the market, other plans follow suit for a variety of reasons.

Second, in my conversations with the plans they're trying to figure out how to implement a VBP strategy that includes interventions, especially on the Medicaid side, that aren't necessarily part of the traditional array of services that are offered in the state plan. Again trying to figure out if there are some performance improvement strategies that they could include as part of the new MLR regulations that might be helpful to address MAT as well as other types of SUD interventions.

SF: *John, back to a question you answered early on. As we think about beneficiaries with substance use needs, they are getting care from multiple providers—medical care, physical healthcare, perhaps mental health care as well as perhaps SUD care. As we think about some of the specifics around attribution, John, you talked making sure that the carrot and stick were robust enough to support or move the needle a bit towards change. Allison and Rachel, you talked about needing to think through some of those specific ways that managed care could approach attributing value. What are some recommendations the three of you could offer about what needs to be considered when trying to understand the impact of SUD providers within these risk or shared savings arrangements, given all the services that are received?*

JO: This is a fairly large issue in the substance disorder world because you do at many times have so many providers involved in someone's care at different points in the continuum. There has been some discussion, for instance, around followup at the emergency department and what's the best way to think about a VBP that's related to moving the needle on that particular measure. Some of the discussions have been some sort of initial payment, maybe two-part payment, maybe one payment, the initial payment to the ED provider to make the referral and then the followup payment is specifically for the followup that occurs, if and when that followup provider successfully engages that individual more along the lines of initiation and engagement. Again, some discussion—and I haven't necessarily seen this actionable yet, but that's one example that comes to mind.

RM: I think again circling back to those VBP design elements, this is where some of these considerations really matter and where the rubber hits the road. But part of the importance of the data collection and sharing is to help with this exact issue, to be able to accurately track where, when and how a person is receiving services as well as what types of services they're receiving. So just thinking that to the extent that you have that good and accurate data, that thinks about where a person receives a plurality of their services could be a telling sign, although of course not the only sign. Attribution methodologies to figure out what services you're going to attribute to which provider is a really important part of the model.

Finally, just in terms of thinking about attributing success, there's a lot of emphasis in VBP more generally, not just in SUD, in thinking about patient-reported outcomes and a patient's experience. That's one good way to help tease out a patient's experience with respect to the SUD treatment system. A last point is that as we move toward more integrated healthcare and a more team-based approach, it's possible that given what John said, a number of providers are ideally touching members that have substance use disorder issues, so it may become less and less important—especially in models like ACOs—to be able to specifically point your finger to a specific provider, but really to know that there's a whole team offering services that help a member improve.

AH: I'll wrap up with a pretty simple message. The good news on the SUD side is there's plenty of opportunity to start simply and to begin the VBP journey with providers in areas where it's less complicated to answer some of these questions. I would encourage states to take advantage of opportunities for simplicity as they start down the path.

SF: Thank you all for participating. We hope you will continue to participate in the IAP VBP webinar series.

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