

Medicaid Managed Care for Members with Mental Health Conditions and/or Substance Use Disorders:

Emerging Use of Value-Based Care Models

DECEMBER 2016

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EXECUTIVE SUMMARY

Medicaid managed care organizations (MCOs) are increasingly turning to value-based care models to improve the quality and reduce the costs of care for Medicaid members. Value-based care models direct care to focus on the delivery of high quality, holistic, and integrated care and services. MCOs help providers leverage care coordination, data analytics, and performance measurement and improvement in the delivery of value-based care. Many MCOs have implemented, with their provider partners, value-based care models for individuals requiring complex and ongoing care, co-ordination, and support, such as members with multiple chronic conditions. Anthem's affiliated plans have done this through their Provider Quality Incentive Program and other value-based initiatives that encourage quality and cost management to reduce inpatient admissions and emergency room (ER) visits and improve patient outcomes.

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Increasingly, MCOs are looking towards value-based models aimed at improving the quality of care for individuals with mental health conditions and/or substance use disorders (MH/SUD). Value-based models aimed at individuals with MH/SUD not only encourage the delivery of higher quality mental health care or substance use treatment, but also encourage providers, who may have only managed physical aspects of an individual's care or only offered mental health services, to now offer a more holistic approach to care. The result is better care, delivered with a focus on prevention, recovery, resiliency, and wellness.

Value-based care models encourage primary care providers to conduct MH/SUD screening, intervention, medication management, and treatment referrals when their reimbursement is aligned with appropriate MH/SUD quality and performance indicators. These models can also be employed in high-volume MH/SUD providers, such as Community Mental Health Centers (CMHCs), which see a large number of individuals who may not seek care for their physical health conditions. These efforts center on population management and holistically supporting individuals through coordinated and integrated care and services that address MH/SUD and physical health needs.

MCO integration of physical health, mental health, substance use disorder, and pharmacy benefits (i.e., full "carve-in") is foundational to managing and utilizing value-based models in collaboration with providers across the spectrum of health care services. This system-level integration permits MCOs to understand the full array of costs, savings, and outcomes for members and to design programs and incentives for their provider partners that take a holistic view of a member's care.

POTENTIAL FOR VALUE-BASED CARE MODELS TO IMPROVE CARE FOR MEMBERS WITH MH/SUD

The use of value-based models of care for individuals with MH/SUD is relatively new; however, it holds significant promise. Medicaid members with MH/SUD have typically received care in a system that rewards providers for the volume of care that they deliver rather than for prevention (or for "population health") and better health outcomes for members. These members also have faced the added burden of navigating a "siloeed" system in which they obtain physical and MH/SUD services from different providers in a range of inpatient, outpatient and community settings, often with little or no coordination among providers.

The growing focus on value-based care models reflects the data showing that individuals with MH/SUD now account for much of states' Medicaid spending. In 2015, one in five Medicaid enrollees had a primary or co-morbid mental health or SUD diagnosis, but these individuals accounted for nearly half of total Medicaid expenditures, with more than \$131 billion spent on their care.¹ At the same time, there is deep concern about the health and wellbeing of these members, who, despite the high cost of their care, may not receive the supports and services that lead to recovery and wellness.²

It is in this context that value-based care models may represent a particularly important tool for improving care for Medicaid members with MH/SUD. In programs where MCOs take on the management of physical and MH/SUD as well as pharmacy benefits, they have the ability to leverage cost and quality data to assist providers in improving coordination of care and health outcomes for members, including those traditionally treated in those silos.

Outcomes for Individuals with MH/SUD

- **Poor health and social outcomes:** Individuals with serious mental illness (SMI) die approximately 25 years earlier than those without SMI, typically due to treatable chronic physical conditions.³
- **High rates of costly co-occurring physical conditions:** Medicaid enrollees with mental health or SUD diagnoses are considerably more likely to have a number of concurrent chronic medical conditions – including cancer, cardiac disease, hypertension, kidney disease and arthritis – than those without a mental health or SUD diagnosis.⁴
- **Higher costs:** Health care costs for individuals with co-occurring chronic physical conditions and a mental health condition are 60 percent to 70 percent higher than for people with chronic physical conditions alone; if the person also has a SUD, costs are nearly three times higher.⁵
- **Major source of “super utilizers”:** From 2009 – 2011, over half of the Medicaid-only enrollees in the top five percent of expenditures had a mental health condition, and one-fifth had a substance use disorder.⁶ In 2015, 71 percent of high-expenditure Medicaid enrollees with an SUD had also been diagnosed with one or more co-occurring mental health conditions.⁷

FACTORS ACCELERATING INTEREST IN VALUE-BASED CARE MODELS FOR MEMBERS WITH MH/SUD

Along with the poor outcomes and high costs often associated with MH/SUD, a number of larger trends in Medicaid and broader delivery system reform efforts are accelerating MCOs' use of value-based care models for Medicaid members with these conditions:

- **Growth in Medicaid enrollment.** With 32 states now covering lower-income adults up to 138 percent of the federal poverty level and millions of Americans stepping forward for coverage in light of the individual mandate, the number of Medicaid members jumped to 72.4 million by February 2016 – an increase of 15.1 million compared to the average enrollment in the months prior to the first open enrollment period in October 2013.⁸ The vast majority of this enrollment growth is driven by newly eligible adults, many of whom are at an increased risk for MH/SUD and enrolled in MCOs.⁹
- **More robust mental health and substance use disorder benefits in Medicaid.** The creation of an essential health benefit package in Medicaid for newly eligible adults and expansion of mental health parity laws have strengthened the MH/SUD benefits available to Medicaid members. As states find themselves playing a larger role in financing MH/SUD services, they are increasingly looking to ensure that they are purchasing high-quality, outcomes driven care with their investment, not simply rewarding providers based on the volume of care that they deliver. Many states have turned to MCOs to manage these benefits in an integrated fashion with more traditional physical health and pharmacy services.
- **Focus on integration.** At the system-level, more states are moving to full carve-in models where MCOs are responsible for managing and integrating physical health, mental health, SUDs, and pharmacy benefits for members. Some states and MCOs have been integrating MH/SUD with physical health for years, but recent federal developments like the Affordable Care Act

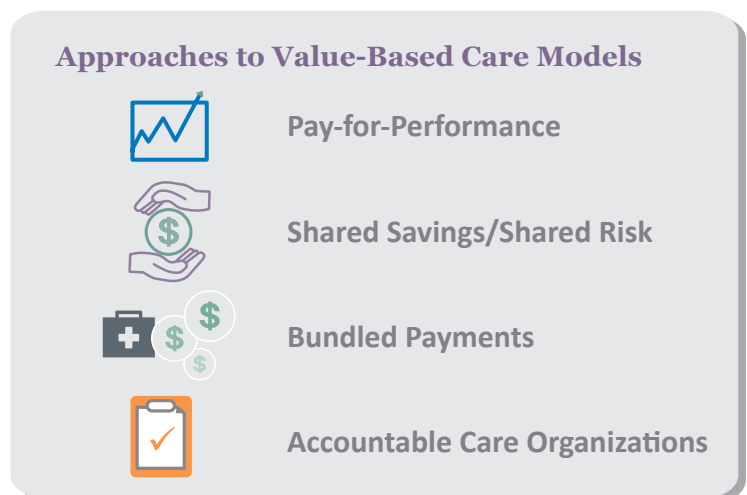
have accelerated the pace of integration and shifted emphasis toward value-based care. These changes pave the way for MCOs to support practice-level integration, such as Anthem’s affiliated plans’ PC-INSITE model, which integrates mental health professionals into primary care settings to promote more holistic care for patients. PC-INSITE places a mental health professional on site to provide assistance with screening, referral, and follow-up for patients in need. In another example, Anthem’s affiliated plans place registered nurses in CMHCs to provide support and referrals to patients. In many other states, Anthem’s affiliated plans and other MCOs are implementing health homes to integrate care for members with MH/SUD. Carve-in models drive the adoption of value-based reimbursement models for providers who share in the risk for delivering high-quality, lower cost, and holistic care.

- **New requirements for use of value-based payment models by MCOs.** Originally designed to promote state accountability for Medicaid 1115 waiver funds being distributed to hospitals through uncompensated care pools, Delivery System Reform Improvement Project (DSRIP) Waivers increasingly are being used by CMS as a tool to promote use of alternative payment methodologies in Medicaid managed care. In its 2014 approval of New York State’s \$8 billion DSRIP waiver, CMS required the state to ensure that 90 percent of Medicaid managed care payments to providers would use value-based methodologies by 2019.¹⁰ More recently, CMS included a similar requirement in New Hampshire’s DSRIP waiver—designed to improve MH/SUD care—and in California’s request for a renewal of its DSRIP waiver.¹¹ In April 2016, CMS also issued a Medicaid managed care regulation that will phase out pass-through payments to hospitals, nursing facilities, and other providers over time unless they are tied to value-based payment models or delivery system reform initiatives. These changes and the inclusion of value-based requirements in DSRIP waivers show CMS’ interest in driving greater use of value-based payment models in Medicaid managed care.

APPROACHES TO VALUE-BASED CARE MODELS FOR INDIVIDUALS WITH MH/SUD

As the National Association of Medicaid Directors (NAMD) has noted, value-based care initiatives are “rapidly becoming the payment paradigm in Medicaid – with approaches ranging from accountable care organizations and health homes to pay-for-performance and bundled payment models.”¹² A March 2016 NAMD study found a “substantial amount of value-based purchasing activities happening among state Medicaid programs,” with two-thirds of the 34 states participating in the study reporting that they have implemented or are currently planning value-based payment reform initiatives.¹³ The more established efforts appear to be primarily focused on moving away from volume-based care, improving quality, and reducing the rate of growth in overall expenditures. More recently, plans are working to leverage value-based reimbursement to drive care and services toward efforts that improve outcomes for members with MH/SUD.

Value-based care models for Medicaid members with MH/SUD are structured along a continuum in terms of complexity and risk sharing. To date, MCOs have largely relied on value-based care models that minimize the risk exposure of MH/SUD providers, such as pay-for-performance initiatives. This reflects the recognition that many non-institutional MH/SUD providers – such as some CMHCs and small independent providers – do not yet have the financial sophistication and data infrastructure required to manage population health outcomes in a value-based payment model. There is relatively low uptake of electronic health records (EHRs) among MH/SUD providers, in large part because they were excluded from the federal EHR incentive program.¹⁴ In addition, SUD patient record confidentiality provisions (42 CFR Part 2) limit the ability of many Medicaid substance abuse treatment providers to participate in electronic information exchange. Moreover, some providers, particularly SUD providers and mental



health clinics, have relied heavily on state and local funding to pursue their mission, and, as a result, they do not always have extensive experience contracting with commercial plans and MCOs. It is anticipated MCOs will work with providers, who are critical parts of MH/SUD provider networks, to assist in them in meeting contracting requirements.

Over time as providers and MCOs gain further experience working together to implement value-based care, they are expected to pursue approaches with greater risk sharing and accountability. The major types of value-based care models are described below. They all are designed to move away from volume-based care toward value-based reimbursement for providers. For members with MH/SUD, this can include ensuring that they are receiving integrated health services; are engaged in maintaining, guiding, and improving their own health; and are afforded every opportunity to live and thrive in the community. Although each type of model is described separately, MCOs may design initiatives that employ more than one such strategy.

Behavioral Health Quality Incentive Program¹⁵

As part of an ongoing effort to engage MH/SUD providers and provide them with incentives to improve care and increase integration with physical health care services, several of Anthem's affiliated plans recently launched a Behavioral Health Quality Incentive Program (BHQIP) in a number of markets where the plans manage fully integrated physical health, mental health, pharmacy, and SUD benefits. Designed for CMHCs and high-volume non-CMHC MH/SUD provider groups, the program offers a bonus payment to providers based on their performance on a specified set of quality and efficiency measures.

Measures: Program measures are designed to drive improvements in quality and increase integration, as well as align with state Medicaid quality initiatives. Measures are refined over time to ensure their continued relevance and appropriateness for members with MH/SUD. Current measures focus on:

- Decreases in mental health or SUD inpatient readmission rates
- Decreases in emergency room visits
- Increases in primary care physician visits
- Follow-up after discharge from hospitalization for treatment of a mental health condition
- Follow-up care for children prescribed ADHD medication
- Adherence to antidepressant medication for adults diagnosed with major depression

Payments: Providers are eligible to receive a year-end bonus if they successfully meet targets on the measures. The bonus amount is calculated as a percentage of their underlying total annual fee-for-service reimbursement.

Visit-Based Attribution Methodology: Plans will use claims data to retrospectively attribute patients to their primary MH/SUD provider for the purposes of evaluating provider performance and generating patient panel reports to be shared with providers

Provider Engagement: Local health plan leaders worked closely with MH/SUD providers in designing the BHQIP to ensure provider engagement and that program design and performance measures align around a commonly held set of goals.

Expansion to Inpatient Mental Health and SUD Facilities: In recognition of the critical role played by facilities that provide inpatient mental health and SUD care, Anthem's affiliated plans are considering a similar incentive program for these provider types.

Pay-for-Performance

Pay-for-performance (P4P) programs offer providers financial incentives tied to their performance on select measures. The incentives typically take the form of a bonus for meeting quality and outcome metrics in addition to the provider's fee-for-service or other base compensation, though in some programs providers who fail to meet specified measure targets can face penalties. To tailor such models to members with MH/SUD, P4P models use quality measures linked to important mental health and SUD objectives, such as timely follow-up, bridge appointments, comprehensive discharge planning after inpatient hospitalization, screening and treatment for mental health and SUD treatment needs during primary care, and promoting adherence to medication among adults with MH/SUD. Since P4P models do not require providers to take on risk, they often are a first step for MCOs interested

in engaging MH/SUD providers in value-based models to reduce hospitalizations and emergency room admissions and incentivizing primary care providers to more fully integrate mental health and SUD screening, treatment, and referral into their practices.

Examples of States' Use of Bundled Payments in Medicaid for MH/SUDs

In 2012, Arkansas launched the episode-based component of its multi-payer Arkansas Health Care Payment Improvement Initiative. Since then, a total of 16 episodes have been implemented, two of which are focused on MH/SUD – Attention Deficit/Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD).²² In the Arkansas approach, providers submit claims and additional information that Medicaid and commercial payers use to identify the provider primarily responsible for a patient's care during a given episode – or, the "Principle Accountable Provider" (PAP). At the end of a set time period (typically 12 months), payers retrospectively review qualifying clinical episodes to calculate an average cost per episode for each PAP that is then compared to specified "acceptable" and "commendable" levels of costs.²³ If the provider's average cost exceeds the acceptable target threshold, the PAP must return a portion of the excess costs; if the average cost falls below commendable levels and the PAP meets required quality measures, the PAP is eligible to share in the savings. Providers regularly receive detailed cost and quality information for each episode type to aid them in meeting cost and outcome objectives. Early results have shown changes in practice patterns, including an increase in adherence to ADHD guidelines and a reduction in therapy visits.²⁴

Tennessee is creating a program similar to the one in Arkansas for members enrolled in Medicaid managed care plans. The state's Medicaid agency (TennCare) is leveraging SIM grant funds to implement an episode-based payment initiative. The initiative will soon include ADHD and ODD episodes of care, and the agency is considering including a range of episodes related to MH/SUD – including anxiety, PTSD, schizophrenia, depression, bipolar disorder, and conduct disorders – in future phases of implementation.²⁵ Medicaid MCOs are contractually obligated to participate in the initiative but are given some flexibility in program design. For example, while the "acceptable" cost threshold is set by TennCare, MCOs each set "commendable" thresholds according to their own approaches.²⁶

Bundled Payments

Under episode-based payments, also known as bundled payments, instead of making a separate payment to each provider for each of the services that he or she provides for a condition or course of treatment, the MCO pays a single, pre-established amount for the services attributable to a specific health event (e.g., a hip or knee replacement) or health condition (e.g., asthma) over a specified period of time. This approach is designed to encourage providers to coordinate care across multiple settings and generate financial and clinical accountability for outcomes. Bundled payments can be prospective or, more commonly, retrospective. Under the latter approach, providers typically receive payment as they normally would in accordance with a fee-for-service schedule, but actual expenditures are later reconciled against the pre-set price for the episode.¹⁶ If the provider has kept costs below the pre-set price and succeeded in meeting quality metrics, he or she is eligible to keep all or a portion of the difference. If costs exceed the pre-set price, the provider is required to return payments incurred above the set limit.¹⁷ Bundled payment arrangements vary in their degree of complexity. In a simple bundled payment arrangement, an individual provider receives a single payment for a defined episode of care, for example, an obstetrician who receives a set payment for all services related to a pregnancy and delivery. In more complex bundled payment arrangements, multiple providers are paid a set amount for treatment of a specified condition and must decide how to appropriately divide the payment and related risk among themselves.

The use of bundled payments generally has been very limited to date, with a recent Catalyst for Payment Reform study showing that in 2014 only 0.1 percent of all commercial, in-network payments took place under bundled payment models.¹⁸ However, this is changing; CMS recently implemented the Comprehensive Care for Joint Replacement (CJR) model that mandates bundled payments for joint replacements in certain Medicare fee-for-service markets. Additionally, the March 2016 NAMD report found that seven of the 34 states responding to the study had implemented or are considering implementing a bundled payment program in Medicaid.¹⁹

In the mental health and SUD space, bundled payments are uncommon due to challenges that include lack of consensus on treatment regimens or on which complications should be included in episode- or condition-related costs.²⁰ One exception is Arkansas, which is known for its use of a bundled payment for ADHD in its Medicaid program. In addition, a few states, such as Tennessee, are currently engaged in new efforts to expand use of bundled payments for MH/SUD in their Medicaid managed care programs.²¹ Similar to P4P, these efforts can be implemented across multiple payers and within managed care and fee-for-service. However, bundled payments are complex to administer, difficult to set up, and require a large volume of patients, thus making them challenging to implement for both providers and MCOs.

Shared Savings/Shared Risk

Shared savings payment models offer providers that meet quality measures and contain health care spending for a defined patient population the potential to share in some of the savings. As this payment model evolves, providers may assume downside risk (i.e., share in any cost overages) in addition to sharing in savings. As described below, shared savings/risk programs are increasingly being incorporated into Accountable Care Organization contracting structures and Health Home models, across payers.

Importantly, providers are not eligible to share in savings unless they meet quality metrics. In the context of members with MH/SUD, these outcome measures might, for example, include improving screening and assessment rates for common MH/SUD in primary care settings; increasing patients' engagement in their care delivery plans; and reducing the rate of avoidable hospitalizations for psychiatric conditions. In practice, though, it is still common for shared savings plans to exclude MH/SUD costs,²⁷ reflecting the traditional silos that long have existed between physical and MH/SUD providers. MCO integration efforts can help overcome these barriers by offering a single source of data, and point of accountability, for the cost and quality of members' physical health, behavioral health, and pharmacy benefits.

Accountable Care Organizations (ACOs)

Although there is no commonly-accepted, standard definition of an "Accountable Care Organization" (ACO), the term has generally come to refer to a group of providers that agree to provide care to a defined population and to share responsibility for its outcomes. ACOs often bear risk for quality and cost outcomes under a shared savings/risk approach with MCOs. If the ACO meets quality standards and achieves savings relative to a benchmark, it can share in the savings and, in some instances, it may also share in the risk of costs exceeding the benchmark.

ACOs are viewed by many as an important tool for promoting better treatment of MH/SUD and greater integration of health care.²⁸ They are relatively new for state Medicaid programs, with just six states reporting that they had ACOs in place for at least some of their Medicaid members in FY 2014. However, MCOs can also create or contract with ACOs on their own. As with the other value-based efforts described above, the treatment of MH/SUD in state-driven ACO models is evolving and data showing their effectiveness is limited. Some include MH/SUD in the total cost of care, while others do not because the ACO does not have a formal relationship with mental health or substance use disorder providers. However, ACOs have the greatest potential to improve outcomes if they take a holistic approach to health care, focusing on quality and costs of care across physical health, mental health, SUDs, and pharmacy benefits. ACOs should be deployed in concert with Medicaid MCOs, leveraging their infrastructure and expertise with regard to risk management, data collection, quality reporting, performance measurement and improvement, and population health analytics.²⁹

IMPORTANCE OF QUALITY METRICS

The fundamental premise behind value-based care models is that MCOs can use incentives to encourage providers to deliver high-quality care, and that it is possible to evaluate and measure when such care is being provided. As a result, it is critical to establish appropriate quality metrics for value-based care models aimed at members with MH/SUD even though the science of doing so remains an evolving field. The major challenges include some issues that arise in any quality measurement effort, such as the need to have a balanced set of measures that address both common and low-incidence conditions; to minimize the administrative burden of measurement; and to ensure providers do not focus on the outcomes being measured to the exclusion of other important objectives.

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At the same time, it is widely recognized that there are some unique challenges associated with measuring MH/SUD outcomes, as well as significant gaps that exist in the currently available measures for members with MH/SUD. In a 2015 article, Dr. Harold Pincus, Co-Chairman of the National Quality Forum's (NQF) committee on the consensus development of MH/SUD measures, and his co-authors decried the lack of robust, appropriate quality measurement on mental health and SUD care.³⁰ He noted that, as of July 2015, only 31 of the 611 measures endorsed by the NQF were mental health or substance use measures, four of which were at the interface of mental health and SUD treatment with general medical care.

Moreover, the existing measures tend to be focused on clinical outcomes or interventions (e.g., whether an individual received appropriate follow-up within 7 days or a month after release from the hospital due to a psychiatric condition and screening rates for high Body Mass Index among individuals with severe mental illness) and insufficiently account for the many other issues that can impact health outcomes for individuals with MH/SUD. For example, while valuable, these measures do not address key outcomes such as whether providers are effectively integrating care; whether individuals are receiving assistance with social issues, such as housing, that can directly affect health outcomes for individuals with MH/SUD; and whether members are engaged in developing and following their own care plans.

Federal and state policymakers, as well as leaders in the measurement community, are continuing to work to improve MH/SUD measures. Both the developers and endorsers of measures, organizations such as the National Committee for Quality Assurance (NCQA) and the NQF, are working with federal agencies to address the "gap" areas associated with mental health and SUD treatment.³¹ They are increasing the number of measures related to integration of physical health, mental health and substance abuse; member sense of control and engagement in their own care; psychosocial needs; community integration; and improved functioning. Indeed, in December of 2015, the Center for Medicaid and CHIP Services (CMCS) announced the addition of four new measures to the core set of Medicaid measures used by states for adults and children.³² Of the four new measures, three were directly related to MH/SUD: use of multiple antipsychotics in children and adolescents; use of opioids prescribed by multiple providers at high dosages (excluding people with cancer); and diabetes screening for people with schizophrenia or bipolar disorder who are taking antipsychotic medications. In light of this work, states, plans and providers can expect that there will be a broader suite of measures available to support value-based purchasing arrangements aimed at improving care of members with MH/SUD.

CONCLUSION

Value-based care models have the potential to improve the quality of care provided to Medicaid members with MH/SUD by: incentivizing the identification, treatment, and management of MH/SUD as well as physical conditions; fostering integrated care; promoting person-centered care that facilitates patient engagement; and tackling the psychosocial challenges that can accompany or exacerbate mental health conditions or SUDs. In most places, the use of these models is in the early stages, reflecting: the current capacity of providers to engage in such arrangements; the current state of quality measurement for members with MH/SUD; and the new but rapidly accelerating focus among payers on using value-based care models.

Over time, MCOs will gain a stronger evidence base for determining the most effective value-based models for Medicaid members with MH/SUD. To accelerate the use of value-based models, MCOs can continue to work with state partners to move toward fully carved-in benefits to allow for system-level integration of MH/SUD services with physical health services. This integration is foundational to managing and utilizing value-based models and capturing the full array of costs, savings, and outcomes for members.

This paper is one of several issue briefs focused on integrating care for physical health and mental health and substance use disorders; the others are available at <http://antheppublicpolicyinstitute.com>. The Anthem Public Policy Institute gratefully acknowledges the support of Manatt in the research and writing of this paper.

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