



&

New York State
Collaborative of BH IPAs

The Value of Community Behavioral Health Providers & Their Networks

PREPARED BY HEALTH MANAGEMENT ASSOCIATES
Credits & Supporting BH IPA List In Addendum

EXECUTIVE SUMMARY

People with mental health (MH) and substance use disorder (SUD) conditions are heavy utilizers of healthcare services. Medicaid spending on people with MH conditions is nearly four times as high as for other enrollees,¹ and nearly half of all Medicaid spending is for enrollees with behavioral health conditions, even though they represent just 20% of the Medicaid population.²

As a result, **the success of healthcare transformation depends on our ability to meet the behavioral health needs of New Yorkers.** And as COVID-19 has worsened MH and SUD and there will be a greater need for MH and substance use services as a result of the pandemic.³

Fortunately, **behavioral healthcare works.** It improves outcomes and reduces the costs of treating medical conditions. Behavioral healthcare is especially effective at reducing costs and improving outcomes when it is integrated in meaningful ways with medical services, especially primary care,^{4,5,6} and healthcare providers prefer working in settings with behavioral healthcare integrated.⁷ Finally, patients and their families deserve integrated treatment and services across the continuum of care.

Policymakers and payers need behavioral health services integrated into the service delivery system if they are to deliver on the promise of their transformation agendas, but payers can only integrate behavioral healthcare if there is a behavioral healthcare provider who is able to interface effectively. Behavioral health providers have and continue to invest in the infrastructure necessary to securely exchange data about clients in a closed loop, manage to outcomes, respond rapidly to clients in need 24x7x365, and manage the complex administrative tasks associated with success in value-based contracts.

Behavioral health providers with scale are necessary to take accountability for population health outcomes, but the behavioral health provider community is fragmented and chronically underfunded. Independent Practice Associations (IPAs) enable community behavioral health providers to come together rapidly to establish a system of population health care; build technology infrastructures needed to capture, exchange, analyze, and utilize data; develop the needed workforce; interface with billing, claiming, credentialing, and other healthcare delivery administrative systems; and negotiate contracts that enable value-based behavioral healthcare. **IPAs of behavioral health (BH) providers fill a critical role, enabling the success of healthcare transformation agendas.** Across the country, nascent BH IPAs and other similar BH provider platforms have begun to show the promise of organized BH delivery systems.

Happily, New York State (NYS) invested in the development of behavioral health IPAs through the Behavioral Health Value Based Payment Readiness Program.⁸ Now we just need to create the policy, regulatory, and payer environment necessary to be successful and sustainable.

POLICY RECOMMENDATIONS FOR PROMOTING BH IPAS & MAXIMIZING THEIR POSITIVE IMPACT

- 1. Facilitate access to data for BH IPAs by enabling them to access the Medicaid Data Warehouse and including data sharing requirements in future managed care contracts.*
- 2. Include BH IPAs in network adequacy definitions for Medicaid MCO Contracts to ensure that Medicaid beneficiaries have access to integrated behavioral health care and revise the definition of valid VBP Level 2 or 3 arrangements to include BH IPAs.*
- 3. Fund a Phase 2 Infrastructure Program to provide the BH IPAs additional time to realize the goals of the BH VBP Readiness Program.*

BEHAVIORAL HEALTH IPAS ARE ESSENTIAL TO THE SUCCESS OF NEW YORK'S HEALTHCARE TRANSFORMATION AGENDA

Policymakers in Washington, DC and state capitals, including Albany, are wrestling with ballooning healthcare spending, which is growing at nearly 5% per year and is approaching 18%⁹ of the United States economy, double the average costs in other wealthy countries.¹⁰ Medicaid consumes nearly one-fifth of state budgets,¹¹ and Medicare accounts for 15% of federal spending.¹² The private sector also shares this financial burden; health insurance makes up more than a quarter of non-wage compensation, and accounts for over 8% of consumer spending.¹³

And yet, we in the United States have a much greater disease burden than other comparable countries, and worse measures of access and quality.¹⁴ Our mortality rates are higher¹⁵ as are our rates of medical, medication and lab errors.¹⁶

In short, we as a nation are spending an exceptional amount of money on healthcare, and our health outcomes do not reflect that investment.

As a result, many states, including New York, have implemented aggressive transformation agendas to achieve the triple aim of improved outcomes, lower costs, and better patient experience.¹⁷ A primary methodology for making this transformation occur has been the rollout of Alternative Payment Methodologies (APM) that pay for value over volume as a means of driving accountability for outcomes into the delivery system. Between 2013 and 2018 the number of states and territories implementing APM that drive toward Value-Based Payments (VBP) in their Medicaid systems grew seven-fold, and 48 states (including the District of Columbia and Puerto Rico) now have VBP strategies in their Medicaid policies.¹⁸ Medicaid systems are following the lead of both commercial payers and Medicare (both fee-for-service and Medicare Advantage) in the move to APM,¹⁹ and more than nine in ten payers think APM activity will increase.²⁰

We as a nation are spending an exceptional amount of money on healthcare, and our health outcomes do not reflect that investment.

APMs are complicated, difficult, and require significant infrastructure at the provider level. In a VBP environment, providers take on many of the tasks traditionally performed by managed care organizations (MCOs), such as utilization review, disease management, and claims administration.²¹ As a result of this complexity, many states, including New York, are relying on the largest providers in their delivery system to lead accountable provider led entities (PLE). In New York, the vast majority of DSRIP funds went to the largest healthcare delivery systems in the state to incent them to lead the transition to a value-based environment. Facilitating this transition and ensuring the success of the delivery system in operationalizing these new models, is a core role for government and other payers at this moment in the delivery system's evolution.

As payers and policymakers consider how to facilitate the transition to APMs, they need to understand the reality explained over 20 years ago when David Satcher's Report of the Surgeon General on Mental Health acknowledged the "inextricably intertwined relationship" between medical and mental health.²² That was already more than fifty years after the World Health Organization enshrined in its Constitution that "Health is a state of complete physical, mental, and social well-being."²³ There is, simply put, no health without mental health. That was true 20 years ago, it was true four centuries before that when Rene Descartes postulated mind body dualism,²⁴ and it is still true today.

BEHAVIORAL HEALTH IS ESSENTIAL TO THE SUCCESS OF HEALTHCARE TRANSFORMATION EFFORTS

How people behave has a much bigger impact on their health outcomes than the healthcare they receive.²⁵ Behavioral health disorders are the largest cause of disease burden,²⁶ and the costliest conditions²⁷ in the country. And the presence of a behavioral health condition makes treating most medical conditions much more expensive.²⁸ Behavioral health conditions affect nearly one in five Americans. Few get the treatment they need.²⁹

Payers spend disproportionately on people with behavioral health conditions. They account for 80% of all Medicaid spending, even though they are only 20% of Medicaid recipients.³⁰ Their per capita costs are nearly four times those of their peers without behavioral health disorders.³¹ And adults in Medicaid populations are disproportionately involved in health and non-health public sectors (i.e., human services, housing, and criminal justice).³² Commercial payers are in a similar position. Fifty-seven percent of commercial healthcare spending is on people with behavioral health conditions.³³ The costliest healthcare recipients are people with mental illness,^{34,35,36,37} and SUD,^{38,39,40} and their high costs are persistent.⁴¹ **Behavioral health conditions are widespread** and worsening due to the pandemic. There is a bidirectional association between mental health and COVID-19; COVID-19 is associated with increased psychiatric diagnoses, and individuals who had a psychiatric diagnosis in the previous year are more likely to contract COVID-19.⁴²

*It simply will not be possible to bend the cost curve of healthcare without enlisting the behavioral health provider community in the effort.*⁴³

Fortunately, **behavioral healthcare works.** It improves outcomes and reduces the costs of treating medical conditions. Behavioral healthcare is especially effective at reducing costs and improving outcomes when it is integrated in meaningful ways with medical services, especially primary care,^{44,45,46} and healthcare providers prefer working in settings with behavioral healthcare integrated.⁴⁷

The challenge, of course, is that the behavioral health provider community is fragmented, and has spent decades living with funding methodologies that have impeded their ability to develop robust infrastructure. There are over 11,000 mental health facilities⁴⁸ and nearly 16,000 SUD facilities⁴⁹ in the US; 666 mental health facilities and 806 SUD facilities are in NYS.⁵⁰ This compares with only 1,800 nongovernmental health systems⁵¹ and 275 (and consolidating) Medicaid managed care organizations.⁵² A history of net deficit contracts has left a provider community with razor thin margins, paltry fund balances, and fraying infrastructure. This underfunded, underappreciated, and insufficiently capitalized industry is not prepared for the complex, infrastructure-intensive move to APM.

Value Based Payment Models for BH are in early stages. Adoption of VBP is more mature in the primary care/physical health space than in the behavioral health industry. **BH VBP models are still emerging and because of the importance of behavioral health to controlling costs, state and federal policymakers have prioritized BH system and access improvements to control spending.**⁵³ BH industry adoption of VBP still has growing pains. Providers across the country have articulated challenges such as:

- Lack of MCO or health system engagement with behavioral health providers
- Regulatory and contracting barriers
- Designing payment models appropriate for behavioral health providers, that compensate for inadequate reimbursement rates and unreimbursable services⁵⁴

Policymakers and payers need behavioral health services integrated into the service delivery system if they are to deliver on the promise of their transformation agendas, but payers (MCOs or PLEs) can only integrate behavioral healthcare if there is a behavioral healthcare provider who is able to interface effectively. Accountable entities need partners who have the infrastructure necessary to securely exchange data about clients in a closed loop, manage to outcomes, respond rapidly to clients in need 24x7x365, and manage the complex administrative tasks associated with success with VBPs.

This leaves policymakers in a bind.

If healthcare providers attempt to build their own behavioral health capacity, they do not benefit from the decades of experience, relationships, expertise, and program development that has happened in the community behavioral health sector since President Kennedy signed the Community Mental Health Act in 1963. And, as we have seen time and again across the country, when medical providers stretch into behavioral healthcare, they focus on the less acute populations, and the lower-need clients, thus limiting the value of their services to the community or for bending the cost curve.⁵⁵

If, on the other hand, policymakers choose to rely on the existing community behavioral health infrastructure, they are forced to confront the decades of underfunding that have led to crippled infrastructures and insufficient funds for investing in building capacity and transforming clinical practice. Only the very largest behavioral health providers have the capacity to engage in VBP meaningfully; the others lack the infrastructure needed to interface with the delivery system and operationalize new models of care (and care management) for complex populations. In short, **behavioral health providers with scale are necessary to take accountability for population health outcomes.**

There are two ways to get behavioral health providers with scale: through mergers or with Independent Practice Associations (IPAs). Policymakers can wait for a massive wave of provider mergers, which have begun in the nonprofit sector and are well underway in for-profit behavioral healthcare.^{56,57,58} However, that strategy will likely prove problematic, as even under the most optimistic projections, it will be decades before the Boards of Directors of hundreds of nonprofit behavioral health providers in New York decide to merge, negotiate mergers, and navigate the Byzantine maze of governmental approvals needed to effectuate a merger.

IPAs, on the other hand, enable community behavioral health providers to come together expeditiously to establish a system of population health care; build the necessary technology infrastructures to capture, exchange, analyze and utilize data; develop the workforce; interface with billing, claiming, credentialing, and other healthcare delivery administrative systems; and negotiate contracts that enable value-based behavioral healthcare. IPAs of behavioral health providers fill a critical role, enabling the success of healthcare transformation agendas.

Happily, NYS invested in the development of behavioral health IPAs through the Behavioral Health Value Based Payment Readiness Program launched in 2018.⁵⁹ Behavioral health IPAs are already emerging all across NYS (and in many others), and they are already, even at this nascent stage, delivering on the promise of better outcomes, efficient infrastructure, collaborative service delivery transformation, and effective interface with the healthcare delivery system. While behavioral health IPAs are new, there is a track record of success in precursor initiatives that have similar traits, and as detailed below, the early results both in New York and elsewhere in the US are encouraging.

New York has made the investment to establish behavioral health IPAs. Now we just need to create the policy, regulatory, and payer environment necessary to enable them to succeed. The stakes are high; the success of our transformation of the delivery system depends on it.

THE ROLE OF THE BEHAVIORAL HEALTH IPA

BEHAVIORAL HEALTH IPAS ENABLE CLINICAL INTEGRATION

The integration of medical and behavioral healthcare offers huge benefits to clients, payers, policymakers, and providers. BH IPAs provide essential connective functions that enable disparate service providers to function as a delivery system, offering people with behavioral health conditions access to seamless, coordinated, integrated care.

In New York City, **Coordinated Behavioral Care IPA** (CBC) developed the Pathway Home™ care transitions model. CBC has operationalized and successfully managed sixteen Pathway Home teams that have served over 2,750 individuals. CBC found members had significantly fewer psychiatric inpatient days/month during (M=1.84, p<.001) and after enrollment (M=1.88, p<.001) compared to prior to enrollment (M=7.1). Mean months with outpatient behavioral health visits increased from 45% prior to 76% during enrollment (p <.001) and was sustained on follow-up (67%, p=.008). A similar pattern emerged for health home services (32%, 60%, and 50%). CBC significantly improved outcomes for high utilizers of psychiatric inpatient services, with sustained impact on long-term follow-up.

Behavioral health IPAs create an **organizational structure that produces a shared vision across providers** through a collaborative decision-making process. For example, **Value Network IPA**, in western New York has focused on creating and implementing IPA standards of care across the network to improve transitions of care and medication adherence in order to reduce utilization of the Emergency Department (ED) and Inpatient Hospitalization. They met bi-monthly with partner entities to provide education and best practices, engage and support in rapid-cycle quality improvement and implementation, and share lessons learned. Their efforts led to a VBP contract in 2020 with BCBS of Western New York focusing on seven HEDIS quality metrics and two HEDIS utilization metrics. They achieved a 25% improvement in initiation and engagement of alcohol or other drug dependence treatment and a more than 3% improvement in antidepressant medication adherence (acute phase). In 2021 they have added a Level 1 Total Cost of Care component (TCoC) to the BCBS contract and added a contract with Monroe Care Plan IPA to serve Molina Healthcare patients using a similar TCoC model.

Behavioral health IPAs also enable a higher level of workforce development, which can help to address the chronic shortages of qualified personnel and high rates of turnover in the behavioral health care delivery system.

Behavioral health IPAs also enable a higher level of workforce development, which can help to address the chronic shortages of qualified personnel and high rates of turnover in the behavioral health care delivery system. They are organized to provide training and support to their workforce to ensure the successful transition to value-based payments and in so doing promote the financial sustainability of a provider network which has historically been starved of resources. In New York City, for example, **AsOne Healthcare IPA** brought their practice members together to increase access to Opioid Use Disorder services, specifically Medication Assisted Treatment (MAT). AsOne trained their members' staff and helped their members adapt workflows to interface more effectively with inpatient services. They achieved a 3.3% increase in the percentage of clients initiating SUD treatment between February 2020 and January 2021 despite the pandemic.

BH IPAs **enable connectivity that ensures effective and timely communication across the care team** on behalf of the client. This enables effective identification of gaps in care through shared data, practices, and workflows. Only collaboratively can providers develop the data infrastructure that is necessary to provide seamless care. In the Hudson Valley, the **Coordinated Behavioral Health Services IPA** (CBHS) has developed a network-wide referral solution called ConnexRX. Through ConnexRX CBHS has already processed over 2,000 referrals, deepened the linkages inside and outside their network, and achieved their target quality outcomes.

CLIENTS RECEIVE HIGHER QUALITY CARE

Clients receive better **whole-person care** from an entire network of providers founded upon an established, mutually agreed upon set of evidence-based and promising clinical practices and guiding principles. Guiding principles widely endorsed by the behavioral healthcare industry include person-centered care and care planning, recovery and trauma-informed focus and strengths-based, culturally and linguistically competent engagement. With a network of providers that operate collectively under a common rubric, clients will be more likely to engage and stay in treatment that supports their recovery trajectory and overall health.

Fragmented care and discoordination undermine providers' ability to holistically support client recovery. Complex care needs a systemic infrastructure (an "ecosystem") comprised of regionalized networks of organizations that collaborate to serve individuals with complex health and social needs. Complex care needs go beyond treatment to mitigating the barriers and social risk factors that impede access to care, an approach that must be culturally responsive, person-centered, trauma informed, team-based, data-driven, and whole-person focused.⁶⁰

For example, the **Advance Health Network (AHN) and Recovery Health Solutions (RHS) IPAs**, which function as one IPA covering Long Island and New York City, have developed the Walk with ME treatment plan approach supported by a multi-disciplinary, integrated team implementing patient focused treatment plans addressing recovery, medical, mental health, social needs, and therapeutic readiness utilizing person-centered best practices. And **AsOne Healthcare IPA** has developed a Complex Families Treatment Model delivered by a multi-disciplinary care team that treats families as a whole where one or more member has a BH diagnosis, a physical health diagnosis, and high utilization.

IPAS ENABLE EFFICIENT INFRASTRUCTURE DEVELOPMENT

All providers in the network, whether they are treatment providers or social service organizations will have streamlined communication and referral workflows and technology platforms to track and monitor coordination activities, achieving a synchronicity in services that prioritizes the **right care for clients in the right time, in the right setting**. A clinically integrated network is an ideal support system for clients to receive individualized care navigation to mitigate healthcare system complexity.⁶¹ Cogency IPA, for example, initiated a care coordination system with functionality that facilitates screening, intake, and closed loop referrals across the provider network. This care coordination process also identifies and addresses social drivers of health concerns.

IPAS ENABLE COLLECTIVE NEGOTIATION OF PAYER CONTRACTS FOR VBP

Behavioral health IPAs are essential when payers and policy makers want to move to value based payments. Only by bringing together and integrating a wide range of behavioral health providers can the behavioral health delivery system bear risk for outcomes. If the state or any payer wants to align financial incentives to drive improvements in health outcomes for the most complex and expensive recipients of care, behavioral health providers are vital. And only by bringing those providers together through an IPA structure can they distribute risk sufficiently to bear it.

Successful shared-savings models can enable re-investment of savings into the IPA to continue to enhance the quality of service delivery, data sharing, and performance reporting.

For example, both CBHS and the **Northwinds Integrated Health Network IPA**, in the North Country, have had success in Level 2 VBP contracts, and **Engagewell IPA**, in New York City recently announced a Level 2 VBP contract with Amidacare.

Under their contract Northwinds has achieved outcomes well in excess of the state averages on key system metrics. Eighty-nine percent of people discharged from inpatient detox, and 72% discharged from an inpatient rehabilitation stay, are seen in an outpatient setting within 14 days, both at least 20 points better than the state average. They are demonstrating similarly impressive results in mental health outcomes, where 62.7% of adults discharged from an inpatient mental health stay are seen within one week of discharge, nearly eight points better than the state average.

GOVERNMENT SAVINGS ULTIMATELY BENEFIT CLIENTS

Provider networks can deliver system and **cost efficiencies that translate to a higher volume of people served** at a lower price with better care. The data sharing potential among networked providers serves to reduce service duplication, thus freeing up capacity to serve more individuals with the right care, at the right time, and in the right amount. Provider networks that invest in data warehouses to collect and share information offer the potential for **data analysis that can drive better decisions around resource allocation across State and local needs**. For example, CBHS and CBC have developed a joint venture called Innovative Management Services New York (IMSNY), which has developed a data warehouse and business intelligence system. The system enables *Target Tracks*, easy-to-follow workflows that identify the crucial components necessary to achieve quality metrics, and include key interventions, data needed to track outcomes, points at which complimentary service lines can interface, and the outlines for network level coordination.

MANAGED CARE ORGANIZATIONS BENEFIT FROM THE ESTABLISHMENT OF BH IPAS

As many plans are newer to covering safety net BH services than medical services, it behooves the plans to partner with BH networks to benefit from bi-directional collective communication and collaboration because IPAs are a close knit set of providers rooted in their communities with a deep understanding of the populations they serve and higher likelihood of coordinating care more successfully than the plan's care management structure alone.⁶² And there are administrative savings, as single signature contracts covering entire networks are enabled by BH IPAs.

BH networks are establishing coordinated credentialing frameworks. Credentialing a higher volume of BH providers adds to managed care network's value proposition, wherein provider organizations are able to demonstrate an ongoing level of service quality, population reach, geographical coverage, compliance, and data collection infrastructure in order to join.

NEW YORK STATE'S BEHAVIORAL HEALTH IPAS ARE ALREADY DEMONSTRATING THEIR VALUE

FINDINGS FROM THE STATE'S PSYCHIATRIC SERVICES AND CLINICAL KNOWLEDGE ENHANCEMENT SYSTEM (PSYCKES)

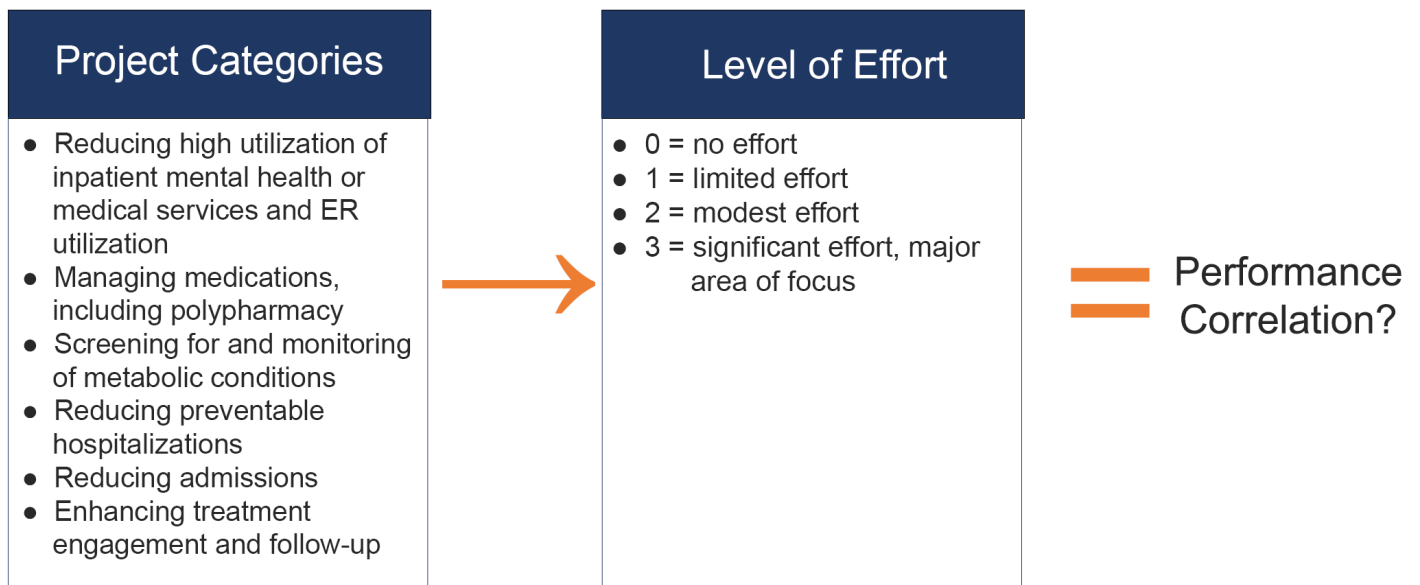
PSYCKES is New York's secure, HIPAA-compliant web-based platform for sharing Medicaid claims and encounter data and other state administrative data designed to support data-driven clinical decision-making and quality improvement for the State's BH population. The system collects all general medical, behavioral health, and residential utilization data from the subset of NYS Medicaid enrollees (currently or previously enrolled) who have a BH claim. PSYCKES includes:

- Fee for service claims data
- Managed care encounter data
- Medicaid service data of enrollees who are dually eligible (have both Medicare and Medicaid coverage)

PSYCKES uses quality indicators to inform treating provider networks or care managers to support clinical review, care coordination, and quality improvement. Examples of key metrics tracked include:

- Diabetes monitoring for individuals with diabetes and schizophrenia
- Medication adherence for individuals with schizophrenia
- Antidepressant use for individuals with depression
- Inpatient and emergency department (ED) utilization, and rates of hospital readmissions, and preventable hospitalizations

HMA conducted an analysis of data from 14 behavioral health BH IPAs formed with support from the Behavioral Health Value Based Payment Readiness Program. Data for 67 indicators were pulled from PSYCKES during the last quarter of 2020. A detailed explanation of our methodology is below.



The relevant 67 PSYCKES indicators were assigned to each of the Project Categories. We then looked for correlations between outcomes in those areas and the level of effort BH IPAs reported in those areas. Flag rates across the BH IPAs were averaged to capture a benchmark for the BH IPA “peer group.” The level of effort reported by the responding BH IPAs varied significantly by project category. Twelve of 14 reported either some or a lot of effort on reducing high utilization, and nearly as many (10 of 14) reported focusing on enhancing treatment engagement and follow-up.

The findings are promising.

At the project category level, the BH IPAs reporting **significant effort** outperformed other areas of the state in several areas:

- Treatment engagement and follow-up
- High utilization relating to the use of clozapine
- Medication management excluding polypharmacy
- Preventable hospitalizations

These results represent meaningful numbers of Medicaid members whose clinical outcomes improved:

- 9,800 more people received follow-up visits following inpatient or emergency stays
- More than 1,100 high utilizers of mental health, inpatient, and ER services had lower than expected overall service usage
- Nearly 800 patients had greater than expected medication adherence or rates of discontinuation
- More than 350 patients, more than expected, appear to have received metabolic screening and monitoring

The strong performance of the New York BH IPAs is consistent with the experience of their colleagues around the country.

BEHAVIORAL HEALTH NETWORKS (INCLUDING IPAS) ACROSS THE COUNTRY

STATES ARE ATTEMPTING TO MANAGE CARE THROUGH BEHAVIORAL HEALTH NETWORKS

While Behavioral Health network formation has increased across the country, most networks are still too new to demonstrate significant impact on outcomes. Nonetheless, in other states, models integrating networks of BH providers have emerged, and as in New York, their early results are promising. They are demonstrating the potential of networked behavioral health providers to improve outcomes and have a meaningful impact on the cost of caring for the large number of Americans with BH conditions. While the structure of the BH network differs from state to state, their prevalence in policymakers' designs are indicative of their importance to a well functioning delivery system.

Arizona, Colorado and Oregon have all formed their own structures for regional accountable behavioral health networks that have capitated payment structures with their respective State Medicaid Managed Care plans. More detail about these states can be found in the Examples of State BH Networks section in the Addendum.

Below is a summary of the different models of behavioral health IPA or IPA-like initiatives across the country. Their outcomes demonstrate the possibilities for clinical and cost if care improvements when behavioral health providers come together in an environment that supports their success.

BH NETWORKS HAVE DEMONSTRATED PROMISING OUTCOMES

Illinois Health Practice Alliance (IHPA) — Improvements in care coordination metrics

Illinois Health Practice Alliance (IHPA) is a clinically-integrated behavioral health network promoting health, recovery, engagement, and choice to clients across the State of Illinois. IHPA serves Medicaid beneficiaries with a full continuum of BH services across the State in partnership with a variety of payers. The IPA has 105 practice members and offers an integrated information system platform with modules for claims management, population health, and care management, allowing IHPA to align incentives, deliver improved health outcomes, and positively impact the overall cost of care. Using HealthEC as their care management platform and in collaboration with Centene, IHPA has been able to achieve noteworthy outcomes on care coordination metrics in their first year of operation:

IHPA Improvements in Care Coordination Metrics			
Metric	Month 1 Results	Month 12 Results	Percent Improvement
Care Transitions	68%	100%	32%
Health Risk Screenings	30%	48%	18%
Health Risk Assessment	44%	89%	45%
Care Plan Completion	36%	75%	39%

CommCARE — Improvements in hospitalization follow-ups

CommCARE is a not-for-profit, CARF-accredited behavioral health management organization based in Kansas City, Missouri that works in collaboration with Community Behavioral Health Centers and other providers to continually improve access to affordable, high quality, and effective behavioral health services. CommCARE consists of 28 behavioral health organizations across the State and serves over 200,000 clients. CommCARE engaged with United Healthcare/Optum in a VBP arrangement to improve the 7 and 30-day hospitalization follow-up rates between September 2019 through December 2020.

CommCare Improvements in 7 & 30-Day Hospitalization Follow-Up Rates					
Metric	Baseline (1/1/18- 4/30/19)	Quarter 1	Quarter 2	Quarter 3	Overall % Improvement
Overall 7-day Follow-up Rate	31.1%	36.4%	37.6%	38.5%	7.4%
Overall 30-day Follow-up Rate	63.1%	66.8%	67.5%	69.1%	6.0%

The first three quarters show noteworthy improvements in CommCARE's 7- and 30-day follow-up rates. Their VBP plan for 2021 will add medication adherence for anti-depressants, antipsychotics, and mood stabilizers.

Tufts Health Plan: Designated Facility Program — Improvements in utilization of bed days leading to positive operating margin

In 1990, Tufts Health Plan (THP) created a Designated Facility (DF) Program for their commercial managed care membership. This program contracted directly with regional providers of inpatient and intensive outpatient behavioral health and SUD services. Providers had to meet specific program criteria, which included not only the provision these services; providers had to have the capacity to screen and manage patients and demonstrate positive quality scores.

Within 90 days of inception, the program achieved a 50% decrease in bed-days per 1000;⁶³ this decreased rate was maintained for at least seven years.

POLICY RECOMMENDATIONS FOR PROMOTING BH IPAS AND MAXIMIZING THEIR POSITIVE IMPACT

After two years of learned lessons post State incubation funding efforts, witnessing the emergence of promising national and local data trends and VBP models, and experiencing the evolution of our networks and the power of our collaborative relationships, the NY BH IPAs present the following recommendations to support a strong infrastructure that promotes barrier-free access to quality, integrated BH care in New York. We continue to advocate for deep stakeholder engagement between the State, MCOs and behavioral health providers to design BH VBP arrangements that are financially sustainable, address resource gaps, and are truly reflective of quality services and outcomes.⁶⁴

1. FACILITATE ACCESS TO DATA

- Enable BH IPAs access to the Medicaid Data Warehouse. New York State should partner with State designated entities with access to the Medicaid Data Warehouse and require these entities to provide BH IPAs access to the Medicaid Data Warehouse data.
- Include a data sharing requirement in future contracts with Medicaid managed care plans and Performing Provider Systems (scope to be determined) so that BH IPAs can leverage existing infrastructure investments and access necessary utilization, cost, and other data to enable them to develop proposals for alternative payment arrangements in a VBP environment. It would be wasteful for BH IPAs to create a parallel data warehouse and data analytic capacity with public funding that duplicates what the plans and PPSs already have in place.
 - Plans have developed member data systems using funds from Medicaid premiums. BH IPAs can benefit greatly from better understanding the potential for service initiatives by viewing population data that is not Protected Health Information (PHI). Plan data can greatly enhance a BH IPA's understanding of system access problems, gaps in care, utilization patterns, and quality improvement issues.

2. INCLUDE BH IPAS IN NETWORK ADEQUACY DEFINITIONS FOR MEDICAID MCO CONTRACTS

- Promulgate behavioral health (BH) network adequacy criteria for entities entering into VBP Level 2 and VBP Level 3 contracts to ensure Medicaid beneficiaries have access to BH care. As it stands, NYS has standards for health plans' network adequacy, but not for the VBP contractors that are entering into TCoC contracts. This omission can lead to barriers for Medicaid beneficiaries trying to access community-based BH care and increased use of higher levels of care. NYS should require that each VBP Level 2 and 3 contractor meet behavioral health network adequacy criteria. Criteria would set minimum behavioral health service coverage and capacity ratios per 1,000 Medicaid lives by county to provide access to the full range of NYS-licensed behavioral health services for Medicaid beneficiaries. VBP Level 2 and 3 contractors should be able to meet network adequacy criteria by contracting with BH IPAs which have already been vetted by OMH/OASAS as comprehensive networks.
- Revise the NYS definition of what constitutes a valid VBP Level 2 or 3 arrangement for a health plan. It currently reads "risk bearing contracts without SDH and CBO requirements will not meet the

Plans have developed member data systems using funds from Medicaid premiums. BH IPAs can benefit greatly from better understanding the potential for service initiatives by viewing population data that is not Protected Health Information (PHI).

definition of VBP.” We propose a modification to say that “risk bearing contracts without SDH and CBO requirements AND without appropriate participation (to be defined) of one or more legal entities that have met the criteria to receive NYS funding as a Behavioral Health Care Collaborative, will not meet the definition of VBP.” We recommend that the State include this revised language in health plan contracts, as well as in NYS guidance and requirement documents for plans and VBP contractors.

3. FUND A PHASE 2 INFRASTRUCTURE PROGRAM TO PROVIDE THE BH IPAS ADDITIONAL TIME TO REALIZE THE GOALS OF THE BH VBP READINESS PROGRAM

- Building on the successes of the BHCC requires additional funding. A variety of factors (including payor hesitancy, pandemic-related restrictions, and lack of contractual precedent) have delayed fully realizing the potential of the networks and infrastructure that the BH IPAs have created. To facilitate the advancement of BH VBP contracting, the BH IPAs need to receive additional funding to compensate for these unavoidable delays. Please refer to the memorandum “2021 BH IPA Infrastructure Investment Request” in the Addendum for further justification and clarification on this issue.

ADDENDUM

BEHAVIORAL HEALTH CONDITIONS ARE WIDESPREAD AND UNDERTREATED

Behavioral health conditions affect nearly one in five Americans. Few get the treatment they need.⁶⁵ Of those aged 12 and older who needed substance use treatment, only 11 percent received treatment at a specialty facility.⁶⁶ Of those who needed but did not receive treatment, one third did not receive it due to affordability.⁶⁷ Similar to SUD treatment, cost was a barrier to care for 45.2 percent of adults with any mental illness (AMI) and 54.7 percent of adults with serious mental illness (SMI). Access and affordability issues prevent people from getting the care they need to improve their lives.

Co-occurring mental health and SUD conditions are common and prevalence is rising. Nearly four percent of all adults in the U.S. have AMI and at least one SUD, and over one third of them have co-occurring SMI and SUD. Not even two thirds of adults with co-occurring AMI and a SUD receive treatment for both conditions, and barely half of adults with co-occurring SMI and SUD do.⁶⁸

Behavioral health conditions likewise often co-exist with medical conditions.⁶⁹ Across payers, most of the beneficiaries treated for a BH disorder have four or more comorbid conditions (or 57.8% on Medicaid; 82.9% on Medicare; and 79.2% of dual eligibles). Medical conditions can exacerbate BH conditions, and BH conditions can make caring for medical conditions difficult.

COVID-19 HAS WORSENERED THE INCIDENCE OF MH AND SUD ACROSS THE COUNTRY

There will be a greater need for MH and substance use services as a result of the pandemic.⁷⁰ There is a bidirectional association between MH and COVID-19; COVID-19 is associated with increased psychiatric diagnoses, and individuals who had a psychiatric diagnosis in the previous year are more likely to contract COVID-19.⁷¹ In addition, the social isolation and loneliness brought about by social distancing is already having negative mental health impacts,⁷² in addition to the increased mortality that comes from being isolated.⁷³ COVID has already led to skyrocketing alcohol consumption, which can exacerbate mental health problems, particularly anxiety and depression.⁷⁴

As of September 2020, there was an increase of seven million unemployed Americans since the pandemic started, for a total of nearly 13 million unemployed.⁷⁵ Job loss is associated with increased depression, anxiety, distress, and low self-esteem, and higher rates of SUD and suicide.⁷⁶ More than half of those whose employment or income has been impacted by COVID-19 report negative MH impacts from worry or stress, with those with lower income experiencing the burden more intensely than those with higher income.⁷⁷ As a consequence, the pandemic has escalated the need for BH services as shown below.

MORE PEOPLE NEED BH SUPPORT

- COVID-19 has been associated with an increase in psychiatric diagnoses, i.e., anxiety, depression, trauma-related disorders, and substance use to cope.¹²³
- Industry experts anticipate a significant rise in suicides as related to increasing rates of unemployment.¹²⁴
- SAMHSA has cited a “10-fold increase in the use of the Disaster Distress Helpline.”¹²⁵
- Lockdowns have triggered an increased proportion of ED visits for suicide attempts¹²⁶

BUT THE BH SYSTEM IS STRUGGLING

SAMHSA reports on Behavioral Health Organizations as of September 2020 that:

- 92.6% have reduced operations
- 31% of patients have been turned away, cancelled or rescheduled
- 61.8% have closed at least one program
- 46.7% have laid off or plan to lay off staff
- 82.9% do not have PPE to last two months
- 62.1% can survive financially less than three months
- They are experiencing difficulty in reopening treatment facilities for lack of adequate space to deliver services because of 6 foot social distancing rules¹²⁷

PEOPLE WITH MH AND SUD CONDITIONS ARE HEAVY HEALTHCARE UTILIZERS

Medicaid spending on people with mental health conditions is nearly four times as high as for other enrollees,⁷⁸ and nearly half of all Medicaid spending is for enrollees with BH conditions, even though they are only 20% of the Medicaid population.⁷⁹ On average it is two to three times more costly to treat patients with chronic medical and comorbid MH and SUD conditions than to treat those without comorbidities, with the additional healthcare costs for all commercially insured, Medicaid, and Medicare beneficiaries at over \$400 billion per year.⁸⁰

Adults with BH needs spend more on their medical care than BH care by a large margin. BH services account for only 15% of their healthcare spending.⁸¹ Of that, nearly half is spent on prescription drugs; less than a quarter of it goes to office-based visits.⁸² The average cost of care for an adult treated for a BH condition is over \$18,000, and nearly twice that among people dually eligible for Medicaid and Medicare.⁸³ The national average spend for medical care is less than \$11,000.⁸⁴ Spending correlates with comorbidities; four-fifths of all spending on adults treated for BH conditions is spent on patients with at least four comorbid conditions.⁸⁵

Public payers cover 59 percent of mental health spending and 69 percent of SUD treatment costs.

NYS-specific data

Nearly 1.3 million New Yorkers have a SUD.⁸⁶ Over one million New York residents have an alcohol use disorder and 444,000 have a drug use disorder.⁸⁷ Only 110,000 of these individuals receive treatment, a number that has declined in recent years⁸⁸ despite growing rates of overdose deaths.⁸⁹

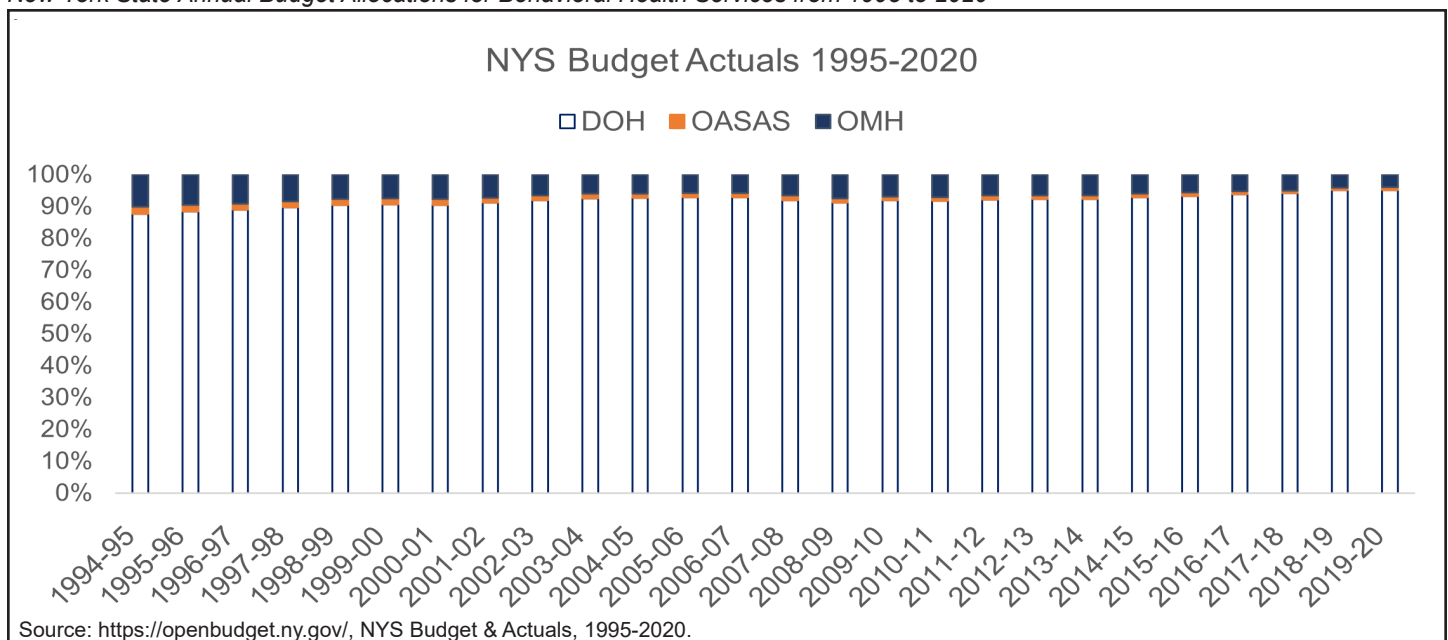
Over 2.6 million New Yorkers have AMI, and 560,000 have SMI.⁹⁰ Nearly one million New Yorkers are estimated to have depression. Over 400,000 have bipolar disorder and nearly 175,000 have schizophrenia.⁹¹

Nearly three times as many New Yorkers are hospitalized for mental illness than the national average,⁹² and they have longer stays when they are hospitalized.⁹³ And although average lengths of stay have declined in recent years, the pace of improvement has lagged major medical conditions.⁹⁴ The cost of a mental health hospitalization in New York is nearly \$40,000,⁹⁵ almost \$14,000 more than the national average.⁹⁶

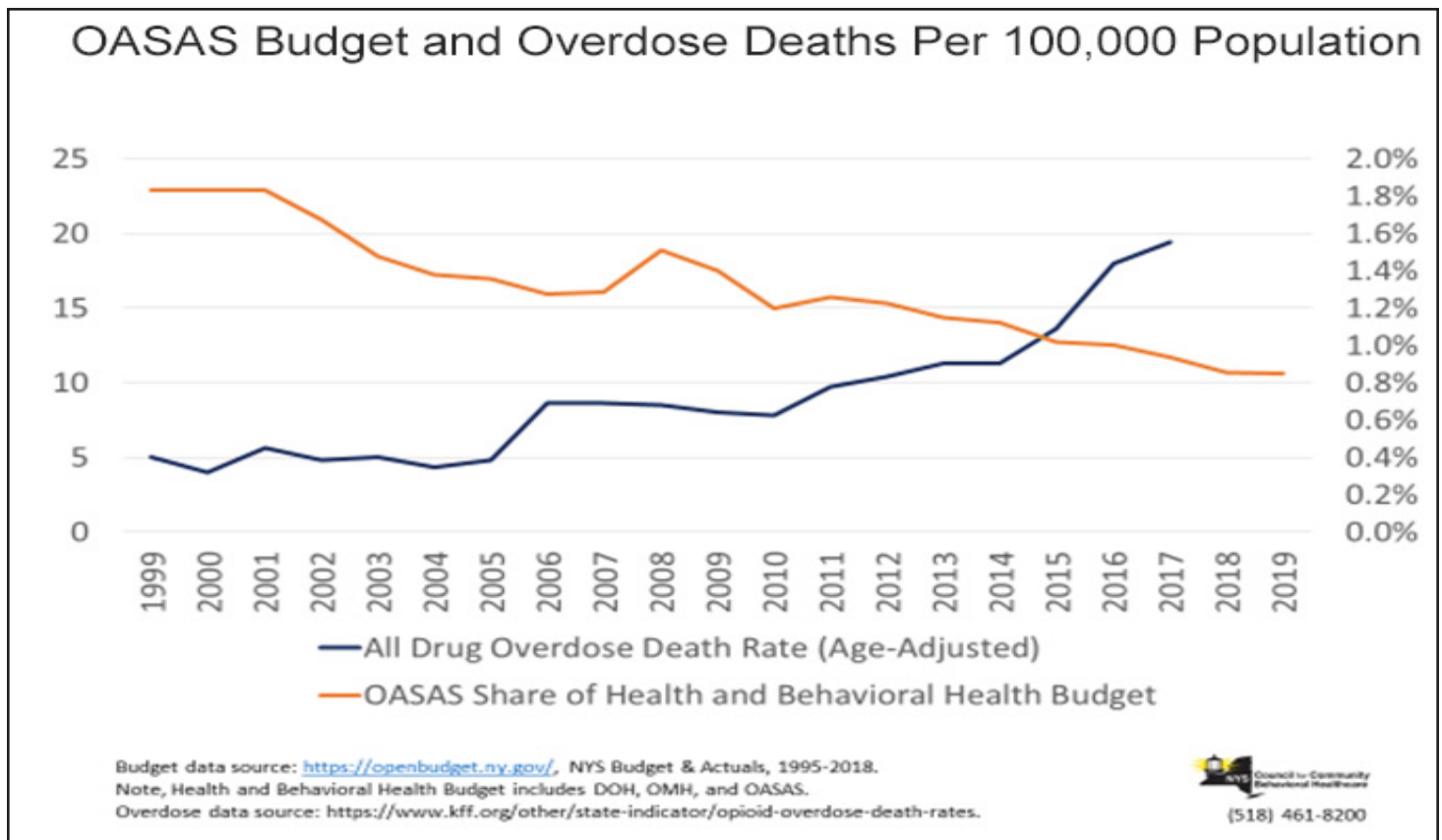
YET STATE BUDGET ALLOCATIONS OVER TIME HAVE NOT CHANGED

The DOH allocation from the NYS Budget has remained fairly consistent over the last 25 years in proportion to the allocations for OMH and OASAS. However, over the last 10 years, the proportion of funds allocated to OASAS and OMH has shrunk. Medicaid state budget allocations represent approximately 28% of the DOH budget. Based on an estimate provided by Jason Helgeson⁹⁷ BH services account for approximately 18.3% of Medicaid spending; therefore approximately 5.1% of DOH spending is on BH.

New York State Annual Budget Allocations for Behavioral Health Services from 1995 to 2020



As demonstrated below, the comparison of the overall drug overdose death rate to the OASAS budget during the last 20 years has shown an inverse relationship—opioid deaths are going up while the OASAS share of the Health and Behavioral Health budget are going down.

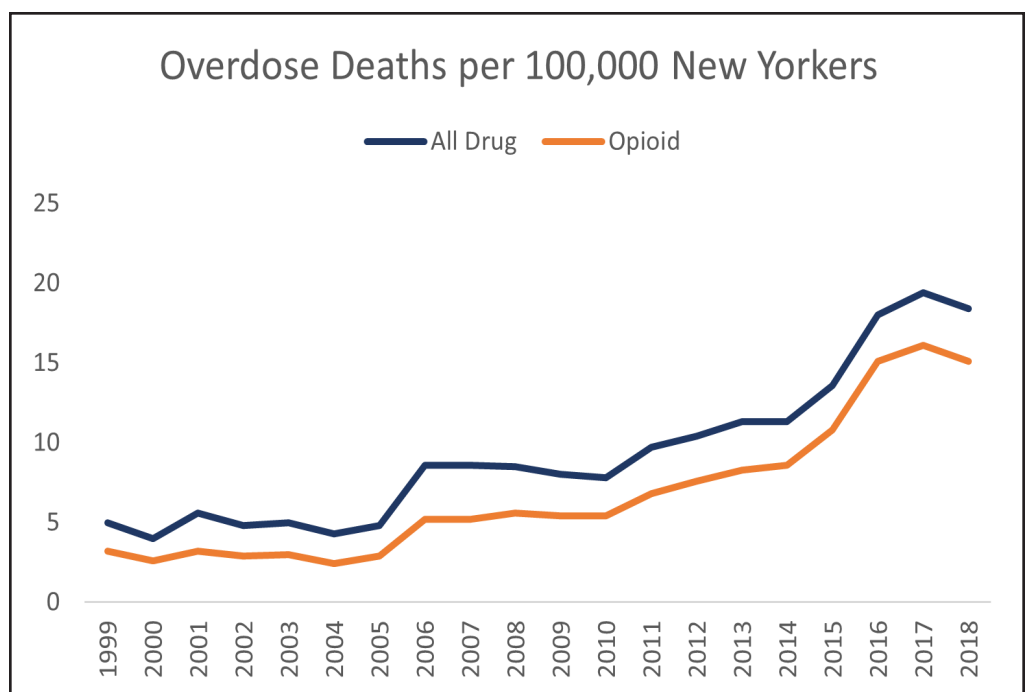


IT'S GETTING WORSE

There is substantial opioid use in New York and the impact of the epidemic is growing over time. From 2015 to 2018 all drug overdose deaths in New York increased from 2,761 to 3,719, of which opioid overdose deaths made up the largest portion of drug overdose deaths, increasing from 2,178 to 3,011 during the same period.⁹⁸ In 2018, 34 percent of all SUD treatment admissions were for a primary substance of opioids, and from 2009 to 2018 there was an increase of over 19,000 SUD opioid-related treatment admissions.⁹⁹

Likewise, the statewide suicide rate has climbed in recent years.

While the New York City rate has been relatively stable, the rate in the rest of the state has increased by 27% since 2000.¹⁰⁰



BEHAVIORAL HEALTH TREATMENT WORKS

CLINICAL OUTCOMES

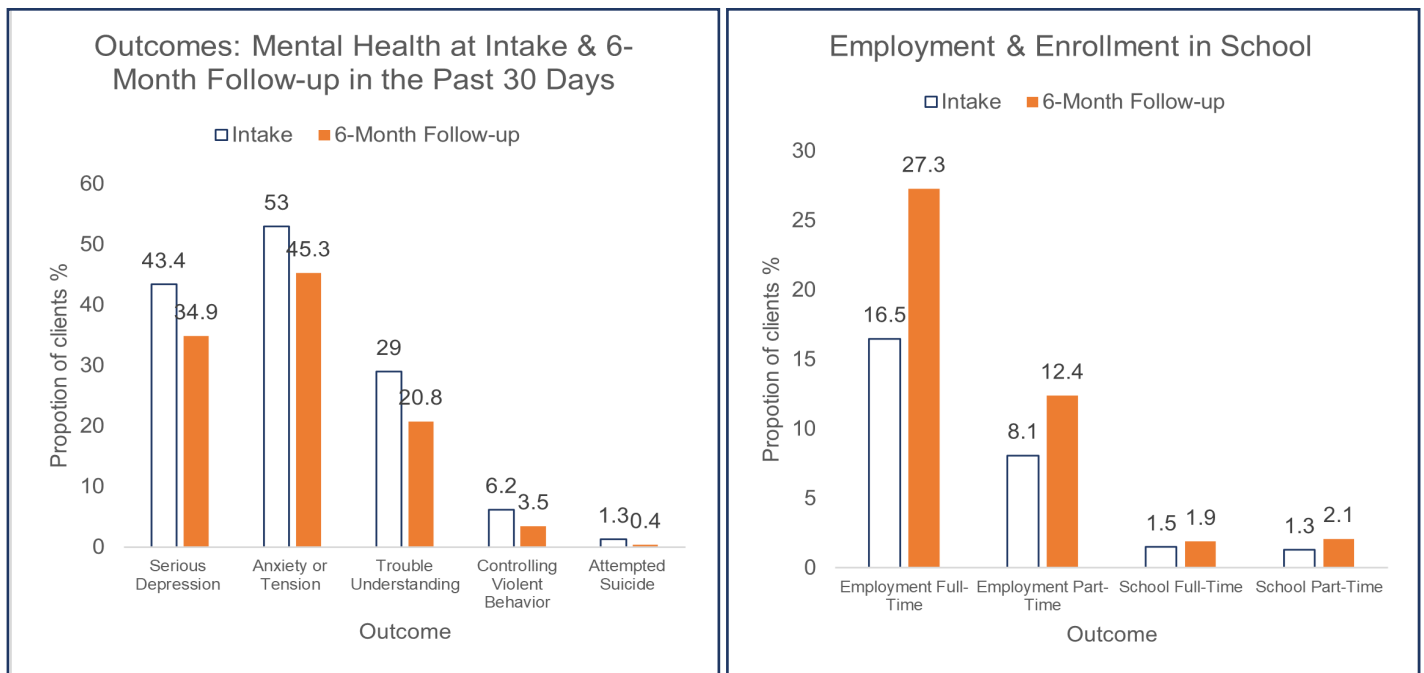
Clinical treatment improves health outcomes for individuals suffering from mental and medical health conditions.

- Depending on the severity of illness and patient preference, medication can be prescribed in conjunction with psychosocial treatments, or each treatment method can be utilized singularly. For example, for individuals living with moderate or mild mental health conditions, psychotherapy alone can work.¹⁰¹
- Assertive Community Treatment (ACT) has repeatedly demonstrated a reduction in inpatient utilization and continuation of outpatient care.¹⁰²
- Treatment for individuals with co-occurring disorders can have an effect on overall health, not solely for the condition targeted for intervention. A range of literature demonstrates the positive impact of cognitive treatment methods in managing pain intensity, depression, anxiety, physical wellbeing, and quality of life in individuals with chronic pain.¹⁰³
- Based on a systematic review and meta-analysis of adolescent substance use treatment effectiveness adolescents in almost all types of treatment showed reductions in substance use, with assertive continuing care, behavioral therapy, cognitive-behavioral therapy (CBT), motivational enhancement therapy (MET), and family therapy being the most effective treatment models.¹⁰⁴

SAMHSA has recently reported significant progress in outcomes related to its distribution of State Opioid Response (SOR) Grants. For clients served through SOR funding during October 2018 through September 2020, SAMHSA reported the following results:¹⁰⁵

1. All outcomes improved over the 6 months suggesting that the SOR program was effective
2. Most outcomes improved noticeably, especially abstinence and employment/education
3. All mental health outcomes showed improvement at 6-month follow-up
4. Full-time employment and schooling rates, both increased by over 60%.

State SOR Grant Intake and 6- Month Follow-Up Client Progress on Outcomes	
Outcome Description	Percent Change
No alcohol or illegal drug use	+46
No arrests within the last 30 days	+4
Employed/enrolled in school	+54.7
Connected in their community	+4.9
Permanent place to live	+31.4
No illicit-substance related consequences	+31.9



ON COSTS

Access to behavioral health treatment dramatically reduces overall medical costs. Among a population analyzed during the 18 months pre and post SUD treatment, researchers found the SUD treatment group had a 35 percent reduction in inpatient costs, 39 percent reduction in ED costs, and a 26 percent reduction in total medical costs, as compared to the control group.¹⁰⁶ The cost and health impact of SUD extends to family members as well. Family members of patients with SUD were more likely to have medical diagnoses than their control group counterparts.¹⁰⁷ **KP also found that when SUD patients remained abstinent at one-year after treatment initiation, the healthcare cost disparity among their family members disappeared.**

Investing in treatment at the state level has a quick turnaround and high return on investment.

Washington state rolled out a SUD treatment expansion initiative in 2005 which expanded funding for alcohol or other drug treatment by \$32 million for adults (primarily those on Medicaid and General Assistance) and \$6.7 million for youth in households with incomes below 200 percent FPL.¹⁰⁸ In 2009, Washington medical costs were \$414 lower for disabled Medicaid enrollees receiving SUD treatment, compared with the untreated population.¹⁰⁹ Prior to the initiative the State was facing an 11 percent per year rate of increase in healthcare costs for their Medicaid disabled SUD population; after the State's SUD treatment expansion the growth in healthcare costs slowed to 2.8 percent per year.

Further, high cost patients with mental health conditions cost about 30 percent more than high cost patients without mental health conditions.¹¹⁰ The differences between these two populations can be leveraged to close the cost gap. Specifically, high cost mental health patients are younger, less likely to experience other chronic conditions, and more likely to be hospitalized. Researchers found these characteristics can be addressed through early intervention.¹¹¹ Mental illness typically occurs prior to other chronic conditions. **Early identification and treatment of mental health needs can serve as a signal to providers to monitor this population for co-occurring physical health conditions, preventing increased costs down the line.**

In *Making the Business Case for Payment and Delivery Reform*, this Robert Wood Johnson Foundation publication highlights:

- With the cost of the treatment added in, there was a net cost offset of \$252 per month or \$3,024 per year
- For individuals with opiate-addiction, cost offsets rose to \$899 per month for those who remain in methadone treatment for at least one year¹²⁸

BENEFITS OF HEALTHCARE INTEGRATION (PRIMARY CARE INTO BEHAVIORAL HEALTHCARE)

Industry evidence points to successful cost containment and improved service utilization as a result of integrated physical and behavioral health care.¹¹² New frameworks have been published to support behavioral health clinic integration of primary care, but reverse integration continues to be slow due to inadequate reimbursements to cover health and care coordination services.

BH clinics within an IPA infrastructure that has matured into a clinically integrated network may have more opportunities to integrate care as they are able to benefit from VBP models that incorporate a more accurate assessment of these costs.¹¹³

EXAMPLES OF BEHAVIORAL HEALTH NETWORKS FORMING ACROSS THE COUNTRY

ARIZONA: REGIONAL BEHAVIORAL HEALTH AUTHORITIES (RBHAS)/ TRIBAL REGIONAL BEHAVIORAL HEALTH AUTHORITIES (TRBHA)

Population characteristics

RBHAs and TRBHAs are responsible for managing the whole health of people with serious mental illness (SMI) including managing the delivery of medical services for this population.¹¹⁴ For those with SMI and SUD, a SMI diagnosis qualifies them for TRBHA coverage. For individuals with SUD but no SMI, their medical care is managed by the acute care MCO and their BH services remain carved out.

Network construct

These contracts require that the RBHA provider networks include **Provider Network Organizations (PNO)**, which are similar in structure to independent practice associations. RBHA PNOs are networks of community mental health centers, supportive housing providers, crisis providers, and hospitals contracted directly with the RBHAs, although RBHAs also contract directly with individual independent providers.

Payment structure

RBHAs and TRBHAs are paid through a capitated payment structure.

COLORADO REGIONAL ACCOUNTABLE ENTITIES¹¹⁵

Population characteristics

On July 1, 2018, new Regional Accountable Entities (RAEs) in Colorado began serving as the single entity responsible for coordinating both physical and BH (defined as mental health and substance use disorder) for Health First Colorado (Colorado's Medicaid Program) members and administering the capitated BH benefit. RAEs are responsible for developing and managing a network of primary care physical health and BH providers to ensure access to appropriate care for Health First Colorado members.

Network construct

RAEs can determine which providers they credential to participate in their network and they must demonstrate network adequacy to the Department of Health Care Policy and Finance. BH providers that should be part of the RAE network include:

- Community Mental Health Centers
- Federally Qualified Health Centers
- Hospitals including psychiatric hospitals
- Independent BH providers
- Non-physician BH practitioner groups
- BH providers employed by a Primary Care Medical Provider
- Rural Health Centers
- SUD providers

Payment structure

BH providers are paid by RAEs through a capitated payment structure.

OREGON COORDINATED CARE ORGANIZATIONS (CCOS)

Population characteristics

In 2012, the Oregon Health Plan (the state's Medicaid program) implemented an innovative managed care model in which the State funds integrated BH (mental health and substance use disorder), physical health, and dental services through local health entities called Coordinated Care Organizations (CCOs). Updated goals in 2019 focused on improving BH system and address barriers to access and on integration of care. In October 2019, the Oregon Health Authority (OHA) signed contracts with 15 organizations to serve as coordinated care organizations (CCOs) for the Oregon Health Plan's nearly one million members. On January 1, 2020, the 15 CCOs began serving OHP members statewide.

The new contracts set new requirements for CCOs to improve care for OHP members and hold down cost increases in Oregon's Medicaid program. The contracts represent the largest procurement in state history, totaling more than \$6 billion for the 2020 contract year.¹¹⁶ These policies make CCOs more accountable for developing a person-centered mental health and substance use disorder (behavioral health) system.

Network construct

- Each CCO must have a governing board with the majority of its board representation from entities that share in the financial risk of the organization. Board members must represent the community's health care delivery system, health care providers and community members. In addition, the CCO is required to have a Community Advisory Council (CAC) to address consumer and community needs. The CAC includes community members (who make up the majority of the CAC), along with representatives of the counties served by the CCO.
- CCOs are fully accountable for BH benefits for enrolled members under their global budgets.¹¹⁷
- CCOs are governed locally. State law says CCO governance must include:
 - Major components of the health care delivery system
 - Entities or organizations that share in financial risk for the CCO
 - At least two health care providers in active practice
 - A primary care physician or nurse practitioner
 - Mental health or substance use treatment provider
 - At least two community members
 - At least one member from the CAC

Payment structure

Increase value and P4P (to improve outcomes in hospital care, maternity care, BH, oral health, and children's healthcare). Oregon Health Plan's 2019 policies aimed to:

- Increase CCOs' use of VBPs with providers to:
 - Require annual, CCO-specific VBP growth targets
 - Achieve a 70 percent VBP goal by 2024
- Increase CCOs' support of Patient-Centered Primary Care Homes (PCPCHs) by requiring VBPs for PCPCH infrastructure and operations
- Provide technical support and align payment reforms with other State and federal VBP efforts

MICHIGAN: PREPAID INPATIENT HEALTH PLANS OR REGIONAL ENTITIES

Background

In 1997, Michigan's Community Mental Health centers (CMH) became the risk-based managed care organizations for the State's Medicaid BH benefit. Under two concurrent federal Medicaid waivers [1915(b) and (c)] the State of Michigan developed shared risk contracts with the its CMHs. Between 1997 and 2014, those managed care contracts were held by CMHs. Since 2014 the contracts have been held by public Regional Entities formed and governed by the CMHs. These Regional Entities are known in federal parlance as the state's Prepaid Inpatient Health Plans (PIHPs).

In its published performance report, the Community Mental Health Association of Michigan attributes successful outcomes of its public mental health system to the following factors:

- Longstanding strong performance against the state-established and nationally recognized performance standards
- Nation-leading rates of de-institutionalization
- High rankings against national standards of BH prevalence and access to services
- Proven ability to control costs over decades
- Pursuit of healthcare integration
- Use of evidence-based and promising practices and the infrastructure to support their use¹¹⁸

Performance against state benchmarks

Of note in this report is the BH provider system’s outperformance of the State’s established performance benchmarks in child and adult inpatient psychiatric readmissions. **The Michigan Department of Health and Human Services set this standard at “no greater than 15%” and in sampled quarters across 2018 and 2019 for both populations the system achieved 8.64% and 11.71% readmission rates respectively for children. For adults, the samplings for 2018 and 2019 were 10.54% and 11.34%, respectively.**

A review of the thirty-eight (38) data points, covering timeliness for pre-admission screenings, face-to-face assessments, service starts and readmission rates, across the quarter examined during the two most recent fiscal years, indicated that Michigan’s public mental health system met or exceeded the state-established standards for thirty-seven (37) of the thirty-eight (38) standards measured.¹¹⁹

Progress on De-institutionalization

Michigan use of State Hospitals	Rest of the Country’s use of State Hospitals
2.37 per 100,000 State residents	40.39 per 100,000 residents in rest of country

Michigan’s public BH provider system has demonstrated a significantly impactful commitment to deinstitutionalization and community-based care. The use of state psychiatric beds, by the rest of the country is 17 times higher per capita than that of Michigan.¹²⁰

Cost Control Performance

	Michigan Public mental health System per Enrollee Rates	National Medicaid per Enrollee Rates	Cumulative Savings over National Medicaid 1998-2015	National Commercial Insurance per Enrollee Rates	Cumulative Savings over Commercial 1998-2015
Cumulative increase 1998-2015	71.88%	118.32%	Over \$5B	201.16%	Over \$13.9B

The report correlates cost control achievements to the following factors:

1. Michigan’s Community Mental Health System (CMH) demonstrated active management of comprehensive and closely aligned service and support provider networks and with a role as central community convener. The System plays multiple roles as both the core provider, as well as purchaser of services, and simultaneously “designs, organizes, pays, evaluates, and refines the services and supports network while also holding the role of convener of community efforts to address a range of health and human service needs.”¹²¹
2. CMH is guided by a whole person orientation, with attention to social determinants of health, and a person-centered planning approach.
3. “High medical loss ratios (high level of funds spent on services - low overhead/administrative costs): Low administrative costs and no profits drawn out of the system allow for 94% of the funds received by the public mental health system to be used to provide services in the year in which the funds were received or in future years. This 94%, the system’s medical loss ratio, is far below that of traditional private health plans – ratios that hover around 85% - underscoring the commitment by the public system to ensure that as many of the Medicaid dollars that it manages, as possible, are used for services and supports to the Medicaid beneficiaries who rely upon this system.”¹²²

4. CMH has made an impact through whole person orientation and healthcare integration efforts including:
 - “Addressing a range of social determinants of health through a whole-person orientation by working closely with a range of healthcare and human services in the consumer’s home community
 - Weaving the services offered by the CMH and provider network with the care that families and friends provide
 - Using other consumers as peer supports and advocates on behalf of the persons served
 - Using an array of both traditional services (psychiatric care, psychotherapy, inpatient psychiatric care) and nontraditional services (housing supports, employment supports, homebased services).”

Additional achievements in health integration and evidence-based practices (EBP) infrastructure

The State’s Community Mental Health Association conducts an annual review of all healthcare integration initiatives that weave BH with primary care. Their 2019 study identified over 600 healthcare integration efforts across the state that included: physical health-informed mental health services (health screenings, provider communications and identification of the lack of primary care provider); co-location initiatives; and multi-sector collaborations on high-utilizers.

The Michigan Department of Health and Human Services has invested in long-standing partnerships with all system components – Community Mental Health Centers, Regional Entities/PIHPs, providers and the CMH Association – to build an infrastructure that supports EBP training for thousands of practitioners; fidelity review and guidance teams [Michigan Fidelity Assistance Support Teams (MIFAST)], which provide and evaluate fidelity and efficacy through peer-led technical assistance; statewide training guidelines, and centralized dissemination of best practices.

TUFTS HEALTH PLAN – DESIGNATED FACILITY PROGRAM

Background

In 1990, Tufts Health Plan (THP) created a Designated Facility (DF) program for their commercial managed care membership. This program contracted directly with regional providers of inpatient and intensive outpatient BH and SUD services. Providers had to meet specific program criteria, which included not only the provision of these services; providers had to have the capacity to screen and manage patients and demonstrate positive quality scores.

For this report, HMA interviewed Lisa Whittemore, who oversaw the original DF program for THP.

Attribution methodology

Attribution included all THP members aged 16+ with an assigned PCP in a defined contracted network region – no BH diagnosis was required. Each DF was assigned to multiple regional networks. The attribution target for a lower acuity population enabled a lower per member per month capitation rate. The challenge in this model was changing primary care and BH provider referral streams so that they directed their patients to the assigned DF in their network. At inception, provider networks and managed care for BH were generally non-existent.

Our interview source for this program oversaw one DF, which started with 16,000 members and grew to 60,000 members over the course of her seven-year tenure.

Services

The DF program was only responsible for inpatient and intensive outpatient services for THP members who presented for SUD or mental health issues and were located in the DF contracted region. These providers worked collaboratively with THP to ensure members received appropriate services. Ambulatory behavioral health services were managed by the plan and the plan maintained the network. The designated providers received a capitated payment for these services.

Program design

At the program’s inception, each DF had flexibility to create the program design resulting to variation across DFs. Under Ms. Whittemore, the program’s operational success hinged upon deep relationships: with each outpatient BH provider in each of the networks, and with the large primary care providers in each network.

Developing these trusted relationships helped to shape provider referral practices to direct patients to this specific DF versus other “out of network” large hospitals like McClean or Massachusetts General. Ms. Whittemore also implemented the following program design elements which centered on the mission to mitigate the risk of high BH utilization:

- 24 hour capacity to screen any DF member either in the ED or in an ambulatory setting (depending on clinical presentation)
- Implementation of more rigorous individualized risk assessments for each patient
- Collaboration with outpatient BH providers to engage and collaborate with challenging patients, including managing those patients when an outpatient provider was not available
- Provision of intensive individual visits in the ED or in outpatient settings in lieu of inpatient hospital or intensive outpatient services when possible
- Visits to assigned members in hospital or primary care offices for patients in crisis
- Deeper relationships between BH and primary care providers to collaborate

Outcomes

Within 90 days of inception, the program achieved a 50% decrease in bed-days per 1000; this decreased rate was maintained for the seven years of Ms. Whittemore’s tenure as program director. Despite the low PMPM payment, the increase in patient volume led to a positive operating margin for the first time in the history of the program.

The program continues today and has been successful in managing members’ acute BH and SUD needs. Additionally, THP BH staff work side-by-side with medical care managers as one team to ensure there is seamless coordination of members with physical and BH needs.

2021 BH IPA INFRASTRUCTURE INVESTMENT REQUEST

REQUEST SUMMARY

The New York State Behavioral Health BHCC/IPAs submit this request for \$60 Million to support Phase 2 implementation of the Behavioral Health Care Collaborative Initiative. Funds are requested to:

1. Address contracting delays resulting from the COVID-19 pandemic
2. Develop APM / Bundled Payment Demonstration Pilots for BH Services and Episodes of Care
3. Develop Centralized Infrastructure to Support Data Analytics and Systems, Quality Management, Payment Distribution and Billing/Claims Systems
4. Establish Risk Pools and Models to Incrementally Transition to Increasing Risk and Reward

INTRODUCTION

New York State Behavioral Health Independent Practice Associations (BH IPAs) were launched in 2018 with funding from the OMH / OASAS through the Behavioral Health Care Collaborative (BHCC) Initiative to develop infrastructure to support integrated care so that behavioral health providers could secure VBP contracts with payers. Unfortunately, the payer-side of the market was not ready for nor incentivized in any way to engage in such contracts. Despite a strong focus on sustainability in BHCC implementation, beyond the initial investment in Phase I of \$60 Million, no plan is yet in place to address the challenges identified and facilitate necessary change approaches. BHCC/BH IPAs are also well positioned as strong networks to help ensure continuity and facilitate future state initiatives as Regional Planning Councils (RPCs) are phased out. Considerable progress and efforts have been made by BH IPAs to achieve the goals of the BHCC Initiative, but more is needed to fully realize the State's vision.

After an extremely challenging year confronting racial inequities and upending life as we knew it due to COVID-19, the BHCC / BH IPAs are now requesting that NYS DOH, DFS, DOB, OMH and OASAS join together to support the implementation of a Phase II of NYS's effort to organize and build networks within the BH sector whose services have become increasingly strained and needed. Further funding is required, equal to the amount previously provided with new goals that address the current environment and lessons learned from Phase I. Funding would be used to support the following related initiatives:

1. ADDRESS CONTRACTING DELAYS RESULTING FROM THE COVID-19 PANDEMIC

Prior to 2020, BH IPAs were focused on relationship development with Managed Care Organizations and health systems including creation of pilot projects, exploration of APMs and in some instances VBP contract negotiations with payers. This changed rapidly as the health and behavioral health systems encountered massive shifts in day-to-day operations, requiring focus to be diverted. In the case of health systems, entities turned to the testing and treatment of individuals with COVID, provider and equipment shortages, and the development of effective telehealth strategies. Funds that could have supported pilots shifted toward equipment and technology and staff devoted to innovation projects were deemed "non-essential" or reassigned to support COVID shifts. Managed Care Organizations, faced with an uncertain financial future within their provider networks, put an indefinite hold on contract negotiations. During this unprecedented period, BH IPAs pivoted to support the immediate needs of behavioral health providers. We believe that it will take time before providers, MCOs and health systems fully return to "normal" operations.

2. APM / BUNDLED PAYMENT DEMONSTRATION PILOTS FOR BH SERVICES AND EPISODES OF CARE

The NYS's Value Based Payment Roadmap only peripherally addressed the potential role of BH providers in the move to VBP, yet the work to integrate BH providers remains both worthwhile and necessary. As NYS DOH rethinks its Total Cost of Care approach, there are proactive and positive approaches that support the market in integrating BH providers into VBP Contracts with MCOs, ACOs, Medical IPAs, etc. These related approaches include:

- A model for attribution that meaningfully links behavioral health clients to behavioral health providers
- The development of BH-focused APMs and bundled payment templates focused on specific episodes of care or BH and other services integrated with BH.
- Advanced service and infrastructure integration between health and behavioral health

Funding for BH IPAs testing these approaches would support infrastructure, relationships, and needed capacity building for BH providers and MCOs that currently do not have a model to “value” BH interventions.

The move to VBP is not a short-term goal and requires both upfront investment by and trust between both providers and payers to succeed. We must develop a proactive pathway, supported by funding to jumpstart this process. Unfortunately, at the outset, we cannot focus immediately on return on investment (ROI) as ROI cannot be demonstrated or achieved until integrated BH contracts are live and functioning. Instead, ROI must be viewed as a long-term goal. The best path to successfully achieving ROI and improved outcomes is to start with demonstration pilots that incentivize and reward VBP collaborations between payers and BH providers to develop data and information to better quantify the potential benefits.

The best path to successfully achieving ROI and improved outcomes is to start with demonstration pilots that incentivize and reward VBP collaborations between payers and BH providers to develop data and information to better quantify the potential benefits

Finally, developing these models may support easier collaboration among BH IPA networks across NYS, making it easier to create more centralized infrastructure to support multiple BH IPAs in various regions, with various population (e.g., Homeless) or condition focuses (e.g., SUD or MH) or with unique models of care (e.g., Family or Harm Reduction focus). It is widely accepted among most BH IPAs that they cannot build independent systems (e.g., data, finance, quality) and must find a way to work together. However, this effort will require specific funding as well.

3. DEVELOP CENTRALIZED INFRASTRUCTURE TO SUPPORT DATA ANALYTICS AND SYSTEMS, QUALITY MANAGEMENT, PAYMENT DISTRIBUTION AND BILLING/CLAIMS SYSTEMS

Any level of VBP contract will require significant infrastructure to support it. However, after decades of negative margin funding, BH providers are not positioned to fund this infrastructure themselves.

Therefore, it is not enough to talk about the importance of managing data, instead we must fund the managing of data at the provider and BH IPA network level. Funds to support network infrastructure could focus on developing centralizing supports like data aggregation, analytics, quality management, payment distribution, and billing and claims systems and other complex and costly infrastructure. Currently each network is approaching this in isolation at significant cost to networks and to the state.

4. RISK POOLS AND MODELS TO INCREMENTALLY TRANSITION TO INCREASING RISK AND REWARD

VBP Models have the potential to provide significant revenue for nonprofit community-based BH providers through shared savings, quality incentives, capitated, case or bundled rates paid per member per month. By the very nature of nonprofit organizations, any revenue beyond costs must be invested back into the mission of each organization, thereby further enhancing community services for vulnerable populations. Funds may be used for increased innovation and implementation of evidence-based practices, integration of care,

infrastructure development and more. When successful, this approach can drive improved quality of and access to care, improved outcomes, and reduced costs. It will also serve to both build and stabilize critical mental health and substance use resources, needed even more due to the increased suffering and death related to the pandemic. This is the promise of VBP.

However, community-based BH providers will not be able to move along the risk/reward spectrum without the ability to finance the initial risk amount needed to fund reserves, etc. In addition to funding to support initial moves toward risk, other methods to design risk corridors which limit overall provider exposure and prevent risk from becoming a de-stabilizing factor. The approaches will incentivize BH IPAs to engage in VBP contracts and consider taking on increasing amounts of risk while also increasing potential returns. Shared savings and other financial benefits of VBP contracting will support ever expanding scope and scale of contracts as they grow which in turn require higher reserves, increased investment, and increased benefit to the mission of nonprofit providers. The initial investment here is designed to start the engines so to speak and once started expansion can occur and increasingly sophisticated risk-sharing arrangements will succeed. Regardless, providers do not have the upfront capital required to engage as equal partners at the negotiating table.

SUMMARY

Since the inception of the BHCC program and associated funding in 2017, BH IPAs have developed a significant amount of infrastructure to drive integrated care, measure and manage data across networks and improve service delivery. However, due to market circumstances and timing, including the COVID-19 pandemic additional funding is needed to ensure that the State's BH VBP goals are achieved and that BH IPAs can maintain and even enhance their operations while the health systems and MCOs reopen their normal network development operations post COVID.

With additional funding, and additional time, the BH IPAs can expand or forge relationships with MCOs and health systems to create strategic partnerships which can bring innovation to the integration of behavioral and physical health. The BH IPAs can meaningfully participate in the risk-sharing arrangements that are sought under any APM/VBP mandates. Finally, BH IPAs are positioned to lead in the response to increased mental health and substance use challenges resulting from the COVID-19 pandemic.

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