Arizona

In Arizona, AHCCCS, the Medicaid agency created the Targeted Investment Program (TIP) that includes incentives for providers and technical support to advance integration within the delivery system and track and achieve outcomes. Incentives are provided to participate in TIP. The program includes a Quality Improvement Collaborative operated by Arizona State University. The purpose is to support providers in across disciplines (physical and BH) to meet performance targets.

Part of the collaborative has been to focus on data collection, reporting, and use of data to drive improvements. The collaborative's website is here.

It is important to note that a requirement to participate in TIP is for providers to be active users of the state health information exchange (HIE). Providers received incentives to sign up for the HIE. Further, the HIE technology contains a platform to process social referrals that has a "close-loop" feature. AHCCCS financially supported the purchase of this platform in support of SDoH.

In Arizona, AHCCCS outlined cores values on ways health plans can add value which includes: (1) working with the community stakeholders to design and implement innovative programs, (2) recognizing that health care providers are an essential partner in the delivery of physical health and behavioral health care services, and (3) operating the Health Plan in a manner that is efficient and effective for health care providers as well as the Contractor.

Additionally, AHCCCS requires health plans to have dedicated positions that are focused on special populations and are required to collaborate with stakeholders. Examples of these required positions are court coordinator, justice system liaison, office of individual and family affairs administrator, adult behavioral health member liaison, child behavioral health member liaison, and housing specialists.

See the information above about the TIP program. Also here is a link to AHCCCS' webpage on TIP. The page outlines the requirements, performance measures and milestones to be achieved by the different provider types. Additionally, at the bottom of the webpage, there is information on how CMS supports the funding of incentives to participate.

In Arizona, AHCCCS has included the following in their contracts to support rural health providers:

- The Contractor is encouraged to use Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs) and FQHC Look-Alikes in Arizona to provide covered services, while the Regional Behavioral Health Authorities have been incorporated into the managed care system. FQHCs/RHCs and FQHC Look-Alikes are paid unique, cost-based Prospective Payment System (PPS) rates for the majority of non-pharmacy ambulatory Medicaid-covered services. The PPS rate is an all-inclusive per visit rate.
- Rural Hospital Pass-Through Payment: In accordance with A.R.S. § 36-2905.02 and A.A.C. R9-22-712.07, rural hospitals, as defined in A.A.C. R9-22-712.07, shall receive additional payments from

AHCCCS in order to increase inpatient reimbursement. The Contractor shall be required to pass-through payments to qualifying rural hospitals.

Additionally, AHCCCS has a Differential Adjusted Payment (DAP) program that aims to distinguish providers that have committed to supporting designated actions that improve patients' care experience, improve members' health and reduce the cost of care growth. Providers who meet the criteria are provided a % increase in their payment. Rural Substance Abuse Transitional Agencies are one provider type that can apply to be part of the DAP program and get enhanced reimbursement.

In Arizona, through their 1115 waiver, AHCCCS has allows operated a statewide program that has mandatory enrollment with a managed care plan and has several specialty health plans such for the following populations: elderly and physically disabled, individuals with developmental disabilities, individuals with a serious mental illness, and children/youth in the care and custody of child welfare.

If an individual needs to transition from one health plan to another and during annual enrollment in which members can select an alternative health plan, AHCCCS has outlined requirements within their operational policies that can be found here.

In Arizona, before the last procurement, AHCCCS enhanced its program guidance documents to clarify expectations of care management, care coordination, and case management. The approach includes reimbursement for providers to deliver care coordination and receive reimbursement through care management codes. AHCCCS medical policies can be found here. AHCCCS required that offerors responding to the last RFP address how they would know of gaps in care and what efforts they would be engaged in to enhance collaboration across system stakeholders and coordination of care.

Additionally, in Arizona, one core strategy that has been used to address the needs of individuals with complex needs (both physical and behavioral health) is to have a robust continuum of behavioral health services with a focus on support services, such as skills training, peer and family support, housing support, employment support, transportation, and other support services. AHCCCS also conducts fidelity monitoring reviews to ensure that individuals with a serious mental illnesses and children's services are being provided in accordance with best practices. Arizona has examples of reports assessing that priority services (peer and family support, supported employment, supported housing, and assertive community treatment) are being delivered to individuals with a serious mental illness.

New York

In New York, the Office of Mental Health (OMH), the State's oversight entity for Mental Health, and the Department of Health (DOH), the Medicaid agency, developed consistent standards for payment during the first two years of the transition to ensure financial stability for organizations transitioning to

contracting and Managed Care. The State also developed standard requirements for utilization management and contracting that applied to all Managed Care organizations to assure there were no limitations or administrative hurdles that could be barriers to individuals with BH conditions accessing needed services.

The State of New York developed Special Needs Plans (SNPs) for individuals with Serious Mental Illness (SMI). Health And Recovery Plans (HARPs) provide enhanced Health Home-level care management for eligible individuals and cover a more robust set of benefits, which include Home and Community Based Services (HCBS) to ensure wraparound community-based supports for individuals with qualifying diagnoses.

Vermont

Vermont's service delivery structure enhances access and is well-designed for a rural state. The state mental health authority (DMH) is authorized to select a regional network of core providers, known as Designated Agencies, which deliver both intensive and other outpatient services.

In Vermont, the state Medicaid agency designed a payment reform with the network of core mental health providers, which are known as Designated Agencies (DAs) and are selected by the state mental health authority. Although Vermont does not have traditional managed care, the managed care entity in Vermont, a statewide ACO, is required to work closely with Designated Agencies on service delivery. The ACO model and quality program operate to encourage the payer to work with and support the regional providers selected by the DAs.

The statewide ACO contract has quality incentives that include a slate of nationally normed and implemented quality measures, many of which emphasize behavioral health access to care. Quality Performance Measures for the ACO include:

- 30-day follow-up after discharge from the ED for alcohol or drug dependence
- 30-day follow-up after discharge from the ED for mental health
- Initiation of alcohol or other drug dependence treatment
- Engagement of alcohol or other drug dependence treatment
- Screening for clinical depression and follow-up plan

In fact, the statewide ACO in Vermont has provided infrastructure and technical assistance training to the DAs, both to improve quality performance and to encourage access to care that will help contain costs.

Because the ACO care model emphasizes integration of care and cost containment, and because of the important role played by the DAs in the overall system, ACO member care teams include participants from the appropriate DA.

Under that model, which is inclusive of all Medicaid services, DAs receive a case rate for each unique child or adult served.

- Rates are based on historical expenditures and are paid prospectively at the beginning of each month.
- In order to avoid disincentives to provide care, agencies are expected to meet established caseload targets by delivering at least one qualifying service to an individual in a given month.
- Value-based payments are made through a separate quality payment – in essence a withhold from the case rates

Although establishing prospective case rate payments for providers can create perceptions that providers will be disincentivized from delivering care, the Vermont model shows that such a model can include mechanisms to ensure access is well-maintained. First, the state obligates the plans to meet historical expectations of access. Second, the state puts providers at-risk for quality performance.

Pennsylvania

In Pennsylvania, Primary Contractors in the HealthChoices program, including those behavioral health managed care organizations (BH-MCOs) under direct contract with the Department of Human Services (DHS), are allowed to retain Capitation revenues and investment income that was not expended during the Agreement period to reinvest in programs and services in their County. These funds, called Reinvestment Funds, must be spent in accordance with a Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (OMHSAS) approved reinvestment plan. Reinvestment Funds provide a unique opportunity for a financial incentive to reward sound financial management practices and allow the creative use of funds to fill identified gaps in the service system, test new innovative treatment approaches, and develop cost-effective alternatives to traditional services that may create cost offsets for State Plan Services. Reinvestment is one mechanism used to achieve the Commonwealth's expectation for the continuous quality improvement of a comprehensive treatment system that not only supports recovery for persons with mental health issues, including drug and/or alcohol treatment needs, but for the family support structure as well. Payments are based on meeting a Benchmark/Goal and an incremental improvement calculated from the previous HEDIS/PAPM 2021/MY of 2020 to the HEDIS/PAPM 2022/MY 2021.

Pennsylvania also has the third-highest rate of drug overdose deaths in the country in 2017, according to Centers for Disease Control and Prevention (CDC). Pennsylvania established the Centers of Excellence

(COE) as one solution to the growing overdose crisis within the state, as well as a solution to the barrier of engaging and retaining clients with OUD in treatment. The Pennsylvania Department of Human Services (DHS) selected 45 centers including primary care practices, hospitals, Federally Qualified Health Centers, substance use disorder (SUD) treatment providers, and single county authorities. The COEs were designed to engage the community to identify all persons with OUD and make sure every person with OUD achieves optimal health. This means COEs take care of the whole person, including OUD treatment, physical health treatment such as diabetes management, and mental health treatment such as anxiety or depression treatment. It also means that COEs provide hand-in-hand support to every person with OUD, including providing every person with OUD a peer who helps the person process all steps in the recovery process and providing every person with a community-based care management team who helps the person identify, organize, obtain, and sustain treatment/non-treatment resources. The COEs across the commonwealth have also created community-based care management teams to assist with care coordination and recovery support for their clients. The community-based care management teams consist of a diverse group of providers, including Licensed Clinical Social Workers, counselors, Certified Recovery Specialists, nurses, peer navigators, care managers, and physicians. The care management teams work together to ensure that clients' care is coordinated across all domains and that all treatment and non-treatment needs are addressed, either through on-site services or through referrals. The individual also engages with recovery support personnel who walk side-by-side with clients through their recovery journey. Recovery support personnel are integral members of the care management team and often provide support for clients during off hours and weekends.

Value-based Purchasing (VBP) is DHS' initiative to transition Providers from volume to value payment models for the delivery of behavioral health services. VBP Payment Strategies and VBP Models are critical for improving quality of care, efficiency of services and reducing costs. The Department has developed an aligned VBP framework that consists of both VBP Payment Strategies and VBP Models. VBP Payment Strategies define the mechanism by which the Providers are paid by the BH-MCO. VBP Payment Strategies are tiered by three levels of risk: low, medium, and high. VBP Models define a way to organize and deliver care and may incorporate one or more VBP Payment Strategies as ways to pay Providers. The Department is categorizing VBP Models into recommended models and required models. PH-MCOs, Primary Contractors and their BH-MCOs, CHC-MCOs, and CHIP-MCOs can form integrated VBP Models. Primary Contractors and BH-MCOs should work towards integrating VBP Models because addressing behavioral health needs can improve physical health outcomes, and vice versa. Additionally, Primary Contractors are required to incorporate Community-Based Organizations within VBP agreements to help address the Social Determinants of Health (SDOH). The Primary Contractor and its BH-MCO must enter into VBP Payment Arrangements with Providers that incorporate approved VBP Payment Strategies. The Department

retains the ability to accept or reject any proposals to count toward the required VBP medical spend percentage. The approved VBP Payment Strategies are tiered as low-risk (Performance-based Contracting), medium risk (Shared Savings, Shared Risk, Bundled Payments), and high risk (comprehensive Global Payments). VBP Payment Arrangements must include quality benchmarks containing financial incentives or penalties, or both, without which the Department will reject the arrangement as counting towards the required VBP medical spend percentage. Primary Contractors and their BHMCOs can also layer additional non-financial incentives, such as the elimination of prior

authorization requirements for high-performing Providers, as long as financial incentives are also in the arrangement.

Pennsylvania's Community Based Care Management (CBCM) Program requires that the Primary Contractor and its BH-MCO shall submit CBCM proposals that improve behavioral health outcomes, and solely utilize partnerships with Community-Based Organizations (CBOs) and providers that encourage the use of preventative services, mitigate Social Determinants of Health (SDoH) barriers, and reduce healthcare disparities. The Primary Contractor and its BH-MCO may submit proposals that include collaborations with PH-MCOs. The Primary Contractor and its BH-MCO shall only use funding for CBCM services that have been approved by the Department in writing.

Pennsylvania in 2020 also established RAHCs is to serve as a forum for regional strategic health planning and coordination of community-wide efforts to improve health outcomes across each region in the state. They are focused on areas of high burden of disease and on demographic groups impacted by health disparities within the HealthChoices Zone, in order to identify the root causes of those disparities and to establish strategies and interventions to address those root causes of these disparities. The RAHCs use state and community-based health assessments, regional Social Determinants of Health (SDoH) needs assessments, as well as any other specific health indicators, as the basis to advance population health planning. The membership of the council should reflect the racial and ethnic diversity of the HealthChoices Zone and be a part of a statewide RAHC learning network developed by the Department, so each RAHC can learn best practices from one another in improving population health, reducing costs, improving health equity, and addressing SDOH needs. They also provide CBOs technical assistance that is available on consultation.