CMS INNOVATION ACCELERATOR PROGRAM WEBINAR

Leveraging Managed Care Contract Language to Improve SUD Purchasing Strategies

Hannah Dorr: [Introductory remarks and the moderator conducts a poll to determine the professions of webinar attendees]

Tyler Sadwith(?), CMS (TS): I'm a health insurance specialist at CMS and the project lead for the Substance Use Disorder (SUD) track of the Medicaid IAP. I'd like to provide a high-level background and introduce our speakers for today. The IAP was launched two years ago with the goal of improving health and healthcare for Medicaid beneficiaries by supporting state efforts to accelerate payments and service delivery reforms. Based on the feedback from states and stakeholders, we identified SUD as the first area of focus under the IAP with the goal of supporting states to introduce policy, program and payment reforms to better identify individuals with SUD, expand coverage for effective treatment, and develop payment mechanisms that incentivize better outcomes.

Under the IAP we led a high-intensity learning collaborative for a small cohort of states and we also offered targeted learning opportunities, TLOs for short, to a broader set of states. The TLOs were a monthly web-based learning series with followup deep dive sessions where states could engage with thought leaders and obtain insights from other state Medicaid agencies through facilitated peer-based discussions. Through our national dissemination efforts, we're highlighting what our learning collaborative states and TLO states found most valuable under the IAP.

For today's webinar we're expanding on a topic we've been addressing through our TLOs and with our intensive collaboratives and with states applying for section 1115 demonstrations for SUD under our 1115 SUD opportunity. The purpose and learning objectives for this webinar are to really dive deep into several aspects of purchasing and providing SUD services within a managed care environment with the goal of improving access, quality and coordination of care delivered to beneficiaries with SUD. Specifically, we will explore key elements of managed care contracting including contract language and requirements that allow states to articulate and enforce their expectations for service provision. We will also explore ways that states are engaging in partnering with their health plans to achieve objectives for their Medicaid program. We'll explore options and strategies to assess and monitor service delivery as part of a performance managing strategy to improve the care experience.

Turning to the agenda, we have invited several state partners to discuss their experience and strategies with partnering with managed care plans to effectively serve their beneficiaries. First, we will hear from Massachusetts, which has longstanding experience of providing SUD services through a managed care delivery system. Massachusetts will share their experience of being a smart purchaser of SUD benefits and will describe how they're enhancing their benefits through a section 1115 demonstration that was recently approved by CMS. We'll also have the opportunity to hear from the state of Virginia. Virginia is integrating SUD services into comprehensive managed care and is standing (?[00:04:34]) up new managed care contracting language requirements and strategies as part of their proposed section 1115 demo for SUD.

Scott Taberner is the chief of behavioral health at the Office of MassHealth. Prior to joining MassHealth, he served at the Massachusetts Behavioral Health Partnership (MBHP) as chief

executive officer for three years and chief financial officer for 10. Prior to joining the MBHP, Scott worked in state government for 20 years in a variety of roles including at the Department of Youth services, where he served as assistant commissioner. He also served on the parole board and the Senate committee on ways and means.

Brian Campbell has been working with different parts of the Virginia Medicaid program for 15 years. He has supervised the Virginia Medicaid Children's Benefit, known as the EPFDT program, and has served as a behavioral health policy analyst for the Virginia Department of Medical Assistance Services (DMAS). The integrated care and behavioral services senior program advisor, Brian assumes a lead role on the teams responsible for implementing significant program policy and regulatory changes in the DMAS integrated care and behavioral health services (ICBHS).

Suzanne Fields will serve as our moderator. Suzanne is a faculty member and senior advisor for healthcare policy and financing at the University of Maryland School of Social Work. Suzanne is a clinical social worker with 20 years of experience. Her work has spanned multiple settings, including Medicaid, mental health and substance abuse, children's services, child welfare, as well as managed care. She is a familiar voice on the IAP series, having moderated several of our previous webinars.

Suzanne Fields (S): Thank you, Tyler, and hello everyone. I'm going to begin with an overview of strategies related to being a smart purchaser of SUD services within a managed care context. Before beginning any type of managed care contracting work, any of the specifics around managed care, it's very important to be setting the stage. To set the stage is to identify what you want to accomplish with your managed care partners, whether to focus on specific aspects related to SUD such as reduction in opioid deaths, early identification and treatment, clarifying what it is you want to accomplish. That leads into the type of strategies you can identify for use with your managed care partners to attain your goals. Those strategies could include identifying services within your benefit array; improving beneficiary engagement or experience of care; and certainly related to payment reform, with payment reform being informed by quality metrics that fit back to your overall goals.

Of course within those early considerations, it's also important to be thinking about the timeline. As you move toward metrics that are much more meaningful to inform outcomes, you need to be articulating the time period in which you can be accomplishing those goals, in which the data can be available to help you inform those goals. Once you've identified what you want, that begins to set the stage for working with your health plan partners to achieve those goals. A key aspect of that is as a state purchaser you are articulating what you want, but they as your health plan partner are coming back to you and articulating how they can go about achieving that goal. That is really key for establishing innovation, thinking about different approaches. Certainly for those states who may be having multiple health plan partners involved in your activities, that can also continue the feed innovation and understanding to approach state goals and state issues that you prioritized.

Once you've begun to think through what it is you want to do, a combination of understanding process measures as well as performance measures are really integral to the work you want to accomplish. Much of what we've articulated in behavioral health and certainly specific to substance use can focus on process measures such as length of stay or ER visits. It's very important to include the addition of actual performance metrics that focus on the effectiveness or the value you want to achieve through that goal setting. This then of course ties to the type of incentives you can use to help move your system along the continuum.

We all recognizes that social factors outside of healthcare impact health outcomes, so it's very important for MCO contracts to be able to have provisions to address those social determinants of health, provisions such as assessment and screening for social determinants that are impacting healthcare, provisions regarding the implementation of interventions such as care coordination to address social determinants, and establishing metrics that track the success of those social determinant health interventions are all impression aspects to be articulating and including in your managed care contracting. These then feed into and support overall strategies related to incenting care and supporting accountability for those health outcomes.

Throughout my remarks and the remarks of our two presenters, there will be six key areas we will be focusing on specific to SUD contracting. These six areas are mirrored and found in the 1115 SUD opportunities letter issued by CMS, but they're also applicable to states pursuing managed care strategies through other authorities as well.

- The first is defining benefits and the standards of care you will use within that benefit design. It's very important to be articulating a continuum of care, a benefit array that addresses a range of needs for persons with SUD.
- Within that, recognition that certain populations have unique needs and different needs that have to be clearly articulated. As an example, adolescents with SUD issues have unique needs for engagement with family, school, educational opportunities. Many adolescents with SUD issues may be involved with other state agency systems, child welfare, and juvenile justice. Certainly what we know, evidence-based treatments such as differences in how ASAM level free services are tailored to meet the unique needs of adolescents are important to be defining within contracts. There are other specific subpopulations such as persons experiencing homelessness, pregnant women, persons from different ethnic or racial groups, language needs that are also very important to be culling out within specific contract obligations.
- As you define your continuum of care, the actual service definitions and alignment with standards of care such as ASAM are key to a robust system.
- Next, how MCOs communicate those definitions to providers – regulations, operations and policy manuals in contracts, and how flexible those processes are to update that information – are also key providers.
- Then communication to beneficiaries of care: Is it user friendly? Accessible and readily? How often updated? Is technical support provided to providers and is information provided to beneficiaries so they can understand that information that is available?
- And important in articulating your continuum of care and defining your services is communicating how you anticipate your benefit array will function. An example is that SUD providers may not be offering all levels of care in your continuum. So having MCOs articulate expectations for how care transitions will occur across providers will be very important. That can be across SUD services as people step down or step up to different levels of care they need, or across different services such as coordination with other needed mental health or physical healthcare services. And articulating how those mechanisms such as warm handoffs can be used. Care coordination, peer support services, so boots on the ground, care coordination efforts as well as different levels of care management to support those transitions and access to care.

In addition to industry standards of care informing services, it's also important for industry standards of care to inform provider qualifications, particularly how those qualifications are aligned with different services. For example, for states bringing on say ASAM level 3 services, how will states and MCOs assure that providers are qualified to deliver those services as they are defined?

Finally, as you think about establishing and using industry standards for services, it's important to ensure that those industry standards are informing the medical necessity criteria that are used across all aspects of utilization management, and that the staff using those medical necessity criteria are applying them consistently. So aspects of contract management that ensure that the processes that the MCOs are using to apply those criteria are consistently done for all beneficiaries in a cross-off (?)[00:16:46] staff. Ensuring network adequacy requirements requires a range of activities including identification of gaps, resolving or addressing those issues, and maintaining an active network to ensure that beneficiaries get access to care. It's important within those to identify the role differences between states and MCOs. For example, as states are bringing on certain services, as you're expanding SUD services in your benefit array, many states are taking on the initial assessment of understanding the provider network. So as you begin to identify providers that could be available to offer benefits that you would define in your system, at what point are there certain requirements of the MCO to use that information, to maintain and to update that information?

In addition to identifying gaps, another aspect of network adequacy is identifying those opportunities as different changes occur within counties, states and federal government. Two examples of those opportunities are recent policy changes increasing buprenorphine prescribing limits, where physicians are now able to prescribe buprenorphine to up to 275 patients. In addition, another new opportunity in July of this year was that prescribing privileges were expanded to nurse practitioners and physician assistants who pursue the required training. So again these two changes are examples of shifts in opportunities that can promote an improved network, so defining who's responsible for monitoring those gaps, identifying those solutions, monitoring those opportunities are really important aspects of managed care contracting.

In addition to identifying specific SUD measures, such as process measures related to ED visits or use of national measures such as followup after ED visits or initiating engagement, a quality measures approach also needs to clearly articulate your plans for using the information that comes from those metrics. Important steps in that process include establishing a baseline and targets for the metrics that you're using. Understanding how frequently or articulating how frequently MCOs will report on those measures, and then also being very clear with what happens with that information that is gathered. Who is it shared with? Is it publicly used? Is it used for internal purposes? How is it used in different ways at different times? Clarifying the plan around how data from metrics will be used with another key aspect of managed care contracting.

Aspects around integrating SUD with physical and mental health services is a complicated undertaking. We're very much learning what is effective. We're learning the approaches that can be most beneficial to members. Key aspects of defining in your contracts related to health integration has to do with articulating what you want to see at the plan level and what you would like the plans to communicate to happen at the provider level. So aspects from how a plan is structured, how members will be identified, whether the different models or approaches that could be used to integrate care are key aspects related to health integration to define within your managed care contracts.

Finally, the last aspect related to monitoring that performance, it's essential to be focusing your resources, especially in the environments we all operate in which resources are limited. We have to use them as efficiently and effectively as possible. It's important to be focusing those resources that you have within your own state structure related to identifying the priorities you want and establishing the mechanisms to achieve those priorities. That often

requires being very clear on a limited number of metrics you can use to move your system forward, to know if your system is working the way that you would like it to, and aligning those requirements to have those metrics work for you most efficiently. Including stakeholders in the monitoring of that effort is also a key aspect, both in the identification of metrics but understanding what that information is saying and how you can use it and incorporate it to improve your system.

Finally, within contracts is being very clear on the consequences related to the performance of your health plan and stipulating those things upfront so that you can move forward with those accountability structures, risk-reward, the full accountability structures seamlessly because they're defined in your contract.

I'd like to move to a first polling question for all participants. Select all that apply to your particular system. **Does your managed care contract that you currently have in place include any of the following elements for the provision of SUD services?**

- Strong care coordination
- Specifics for subpopulations such as persons experiencing homeless, pregnant women, and youth
- ASAM standards for provider and services
- ASAM standards for assessment
- Network adequacy
- SUD-specific quality measures
- Care coordination requirements

Respond to what your managed care contract is currently using, and we can use this information to also inform further discussion and areas to highlight with all of you. In the results, we have many requirements related to network adequacy – 75% or more related to network adequacy, and a range of requirements ensuring quality measures specific to SUD. Then we see some needs around specifics for subpopulations as well as the incorporation of ASAM.

One more polling question specific to network adequacy strategies. **Which of the following network adequacy strategies do you want to understand better?** Select all that apply.

- Identifying coverage gaps
- Understanding network adequacy requirements
- Network maintenance requirements
- Geographic access
- Transportation considerations
- Rural and frontier access issues

On the results, as you can see there's a wide array of needs of information people would be seeking further, particularly around considerations for rural and frontier areas at over 77%. We're going to be using this information to highlight during this webinar and inform further strategies of information we can share with all of you.

I'm going to move on to introduce Scott Taverner. I'm going to be available for questions during Scott's and Brian's presentations as well. Scott Taverner from Massachusetts. Welcome, Scott.

Scott Taberner (S): Hi, everyone. I'd like to share a few pieces of information from Massachusetts, a couple of lessons we've learned, and some information regarding our recent submission to Tyler and his colleagues regarding an 1115 SUD waiver that we actually submitted as part of our larger state 1115 proposal to CMS within the last several months. I also want to make sure we cover some of the lessons learned here in Massachusetts. We've got a long history of using our managed care companies, our MCOs, as well as our specialized behavioral health provider to help not only manage the behavioral health benefits for our 1.2 million managed care-eligible members here in Massachusetts, but also to innovate.

As Suzanne was describing, we've used our contracts, particularly the specialized behavioral health contract we have with the Massachusetts Behavioral Health Partnership (MBHP), which is now 20 years old, we've used that contract over at least two decades to really innovate and try to bring new services to our MassHealth members. We've done a lot within the behavioral health space generally and the SUD space in particular. Particular to SUD, one of the real keys for us has been a very close working relationship with our Department of Public Health Bureau of Substance Abuse Services (DPH BSAS). It's a well-established relationship. We here at MassHealth regard as our colleagues at BSAS as the subject-matter experts in the area of substance treatment and we build on that expertise here in the state in some very fundamental ways. Basically we utilize the support and services from BSAS, who have very well-established relationships with the provider community, the substance abuse community here in the state.

In terms of the 1115 SUD demo we've partnered on, basically well over a year ago, after receiving the guidance of the opportunity from CMS to consider submission of an 1115 SUD demo, two agencies got together at the commissioner level and basically committed to working together. That partnership actually resulted in weekly meetings between our organizations. We ultimately did pull in our managed care contractor, MBHP. We actually included them in some of our deliberations in our program design. We really felt as if that helped strengthen our overall presentation to CMS and as part of our demo, we really felt that the expertise that MBHP has in the area of mental health and substance abuse really was of enormous benefit to us and we were able to incorporate many of their thoughts. The 1115 demo waiver that we filed and had approved as part of a large Massachusetts waiver on November 4th seeks to expand SUD treatment services for all MassHealth members, not simply our 1.2 million managed care members, but our entire 1.9 million members including dually eligible Medicare and Medicaid members. We sought to include every single person who has MassHealth Medicaid coverage in the state in this expansion under the SUD waiver.

We're looking to include the full continuum of medically necessary, 24-hour, community-based rehabilitation services, services which were previously paid for exclusively by BSAS through general fund revenues. We're now working to pull those services into the MassHealth benefit in order to better coordinate care and ensure that the full benefit of SUD services is available to our members.

We're also looking to expand care coordination and recovery services to members with significant SUDs as well.

As I mentioned, we do have a very long history of including SUD services as part of our managed behavioral health care benefit here in Massachusetts, both within our MBHP contract as well as within our managed care organization contracts. What's happened over these past 20 years oftentimes is MassHealth will essentially place language into our contract with MBHP, our specialized behavioral health contractor, basically require them to develop program specifications or try to bring about quality improvements within SUD delivery

systems. We'll basically use some of the levers within that contract to incent the contractor to make these enhancements. Then what we've done historically is to then take many of those innovations, those quality improvements to the delivery system, and actually incorporate those as further changes into our MCO contracts. So we use that lever of the MBHP contractor, a specialized behavioral health contractor, to then springboard us forward and to bring some of those innovations to the entire managed care eligible population.

As mentioned, we recently had our 1115 waiver approved by CMS. This will allow us to ensure that all level 3 ASAM services are now within the MassHealth benefit and obviously provide for greater integration of SUD services for all of our members. I mentioned briefly at the outset that in addition to expanding benefits to include all residential services, we're also looking to expand coverage to include recovery support services. We've got two different models essentially we're seeking to provide. Again it's not a one size fits all. We're looking to ensure that we're utilizing these models appropriately for those individuals who would most benefit from them.

One level of service we're looking to do is recovery support coaching. Essentially here we're looking to ensure that individuals with lived experience, typically potentially paraprofessional, can serve as an advocate, a role model, a guide to an individual on their recovery journey. We're seeking to incorporate those services so that our members can have access to that advocacy and guidance. We're also looking at something we call recovery support navigator services. This particular service is actually being modeled after a program the MBHP actually developed under a CMS innovation grant a few years ago. Basically it's intended to provide care management, care coordination activities, ensure there's development of a recovery plan and that plan is being monitored and implemented for that individual, and then also assist the member in meeting other healthcare needs, physical as well as behavioral health in nature. We're going to target this to a group of individuals with significant SUD histories in the hope that we can try to improve the quality of care that they receive, better manage their care, ensure that they're receiving access to the most appropriate levels of care in a timely manner.

Anyone who's read the letter from CMS to Medicaid directors concerning the SUD 1115 opportunity will understand that CMS quite correctly is directing states to incorporate ASAM principles, ASAM levels of care into their planning and into the actual implementation of services within their state. This particular slide basically shows the process we here in Massachusetts follow and actually adhere to ASAM throughout the development process for any and all of our 24-hour substance abuse care but also non-residential services as well. Essentially, we see MBHP and their bureau BSAS as the state authority. We look to them for guidance in terms of establishment of regulatory licensing standards for SUD programming. BSAS actually incorporates into all their regulations and requirements ASAM references and incorporates ASAM fully into the process. BSAS actually then goes about licensing providers. These licenses are key for our managed care company as well. They obviously will not be doing business with any provider who is not a licensed BHP provider, so it's another means by which we're trying to build upon BHP's expertise and their role as the substance treatment experts in the state.

BSAS then will ensure that ASAM criteria are clearly articulated in their contracts with all SUD providers that they contract with. Those standards are then incorporated into our MassHealth fee for service system, so we do in fact have about 600-700,000 individuals who are not within our managed care system at this point, many of them dually eligible Medicaid/Medicare individuals. The SUD services that are available to those individuals are paid fee for service. Our fee for service regulations incorporate the BSAS reference to ASAM. We believe that that

again tries to ensure that we're closing a loop and making sure we're speaking with one voice as a state government. Our MCOs then incorporate those same BSAS standards, principles into their contracting for all their SUD models, particularly those in the 3.1 and above to 4.0 levels of care. Those principles are actually incorporated into their specific SUD contracts.

So we basically are taking BSAS's lead. They adopted long ago ASAM. MassHealth and then our MCOs followed suit with them and we've really felt as if that's been key to ensuring that we're sending a very clear message to our provider community as to program expectation.

One thing we're working on now on a pilot basis is actually an ASAM assessment tool. What we're attempting to utilize there is again the ASAM principles and ensure that we're in a position to use ASAM to identify the most appropriate level of care for each and every MassHealth member requiring SUD treatment. This is something we're very excited about. We've incorporated this into our proposal to CMS as part of our 1115 SUD demo. We think that again it's key. We see it as a means of ensuring the most appropriate SUD treatment. We also see it, as we move this instrument forward over the next couple of years, as being a very important tool that we would expect our managed care companies to utilize in conjunction with our providers.

We see this as a means by which – we hope that it will in fact take out much of the uncertainty regarding what is in fact the most appropriate level of care for a particular member and essentially make the authorization process for that particular level of care rather seamless or almost totally transparent. So we're anticipating this as being something that our MCOs and MBHP will in fact adopt, will incorporate that into our contract in the next couple of years as this particular assessment tool becomes vetted and more well-established across the continuum of SUD services. We're very excited about this. We do think that it should allow us to get a very good handle on what are in fact the SUD needs of our entire membership here at MassHealth and be able to build networks and fill gaps based on the data that we're deriving as a result of this particular instrument. Again, our managed care companies will be central to that whole process. We see them using this as a vital piece of their management of the SUD benefits.

Suzanne talked about various forms of incentives that can be placed into managed care contracts. We here in Massachusetts at MassHealth have a long history of incorporating incentives into our managed care contract, particularly into our MBHP contract. For many years the major piece by which the contractor was able to have any earnings or the majority of their earnings were tied to the successful completion of performance incentives or PI projects. These projects focus on quality improvement and quality development. The PI process is a quality process that ensures incremental system improvement by implementing outcome-focused projects. The process allowed the Commonwealth to determine if projects should be continued, expanded, and potentially added into our MassHealth contract with our MCOs. So literally using our contract with our managed behavioral health specialty provider as an incubator for many, many new program designs, building access for new services, etc.

One recent example was the development of the Massachusetts Behavioral Health Access website, basically a resource tracker, __[00:45:51] tracker, and ultimately an outpatient resource tracker, not exclusive to SUD but very much focused on those services. The full range of SUD services' availability is tracked on a daily basis and made available to providers so they can make referrals as well as to our members and the general public so they can see where, hopefully in close proximity to their home, services are in fact available. This particular piece I really can't emphasize enough the importance of the performance incentive component

within that MBHP contract over time as an incubator for new program development and other innovations here in Massachusetts.

We've also included within all our managed care contracts over time pay for performance (PFP) measures. These have largely been geared towards HEDIS measures. There are two specific SUD measures that we've historically used. One is the rate of initiation of treatment of alcohol and other drug treatment per HEDIS specification and the second, the rate of engagement and treatment of alcohol and other drug treatment, again per HEDIS specifications. What we've done is historically paid essentially a performance bonus based on the percentile that the plan achieves based on a national metric. So if they're successful in meeting the 50th percentile there'll be a modest payment made. We call that a payment essentially of a minimally acceptable level of performance. Then the 75th percentile would bring with it more substantial payment, a more substantial bonus. An MCO that would achieve a 90th percentile on those HEDIS SUD-oriented measures would be categorized as having achieved benchmarks and essentially the highest level of bonus that we would pay for that particular measure. Again, we've incorporated these right into the contract. It sends a very strong message we feel to our MCOs about what we value and how we want them to be valuing the SUD service, and the very positive measure that we've got a well-established set of metrics that we're monitoring them against, and we're literally putting money on the table to ensure that they work on those particular projects and fulfill our expectations in those areas.

I've talked a little bit about our 1115 waiver strategy. It really does have three elements of align, access and test. So MassHealth recognizes the importance of aligning incentives across the substance use treatment with those within the traditional healthcare system to ensure that all members and payers are working collaboratively to improve care for the whole person, including addressing any SUD needs that any of our members present with. By providing improved access to treatment and an ongoing recovery support, MassHealth believes individuals with SUD will have improved health and will increase their rates of long-term recovery and also will contribute to the reduced use of emergency departments and unnecessary hospitalizations. By investing more in recovery, MassHealth hopes to utilize its new SUD demonstration to test whether these innovations will stabilize and potentially reduce costs over the 5-year term of our demonstration.

In summary, these are three major lessons learned. I go back to the beginning, this is our experience that's been a key to success, is that our Medicaid agency here and our MCOs really should be closely aligned with the state agency that's setting policy, licensing, regulating, and generally overseeing SUD programs in your jurisdiction, your state. We've felt that our partnership with BSAS has been of immeasurable benefit to our members, and we can now point to another substantial benefit, which was the collaboration we had on our 1115 SUD submission. We do think it's vital – and this is closely aligned with the first point – that ASAM guidelines be directly included within program specifications for all levels of SUD treatment. That's been clearly articulated in our contracts with our MCOs and they in turn ensure that that's carried out in their contracting with their SUD network.

The last point, we really do believe we should be incentivizing MCOs to collaborate with providers of SUD services on the enhancement of all levels of care. I probably glossed over this point a little bit in my earlier remarks, but the innovation that our contractors, our MCOs and MBHP can bring to the table have been really very important to individualizing types of SUD services. For example, our MCOs basically now have specialized programs for pregnant women. We also have a set of services for dually diagnosed individuals in detoxification, so it's basically enhancing the more traditional detox program with psychiatry and being in a

position to really address both the mental health and substance treatment needs of members as they go through a detox process. So again, using that lever to up the contract to really push your MCOs and any behavioral health managed care companies you have to push them, and they in turn to push the community provider to innovate and develop more specially tailored services for portions of the population that we're serving. That's been a major part of the Massachusetts experience here as mentioned for more than 20 years.

SF: Thank you, Scott. We now invite participants to submit questions using the chat function for Scott.

The first question we received: Can you provide more details on how Massachusetts is assessing the value and quality of your SUD services? How are you conducting that ongoing monitoring related to quality?

ST: Great question. One of the ways in which we're doing it, I mentioned the two HEDIS measures that are embedded within our managed care contract. They in turn basically are trying to influence their provider networks to really focus on those key HEDIS measures. It's also a situation in Massachusetts in which, through MBHP but not exclusively (but I know them best, having been there as an employee and having run the place for a while), what MBHP does is really have a very well-integrated quality management and network management utilization management approach, in which data is collected on performance of every single provider within the network on a regular basis and is shared with those providers through the issuance of reports and also through periodic visits by network management staff. They'll go out and review the data from that particular program, that particular provider's performance measured against both regional and state-wide performance levels to show providers how exactly they stack up against other service providers. To a certain degree we're also trying to figure out how to ensure that they would be in a position to have their performance monitored even on a more regional basis now that MBHP is part of Beacon Health Options. They're actually working on figuring out how to incorporate data that would pull in not just from here in Massachusetts but potentially other jurisdictions as well.

Those are some of the major pieces but providing data, having our MCOs provide data back to their network providers is central to that. Being able to essentially, if necessary, have corrective action plans that are closely monitored by the MCOs, those are some of the major pieces by which our MCOs are trying to improve quality and ensure value.

SF: Very helpful. One additional question specific to your key challenges or lessons learned in Massachusetts related to the integration of SUD in primary care. I mentioned in my opening remarks the complexities around that integration effort of SUD, mental health and physical health. Can you speak to what you've learned in Massachusetts?

ST: Actually the most important thing that I could point to would be that we have specific metrics within all of our managed care contracts about the integration of behavioral health and primary care. MBHP supports our own primary care clinician plan. Our PCCP plan here in Massachusetts, there's very specific objectives they have that we've got embedded in the contract for them to actually support. Not only behavioral health providers but also primary care providers. Again the sharing of data concerning which primary care clinicians members of their panels are using specific services from, neighboring behavioral health providers, trying to provide some insight as to what are those combinations of primary care and community mental health and SUD services. So there's a whole set of reports available to our provider community on what are essentially the pairings of primary and behavioral health care.

Also in our new 1115, the larger 1115 waiver for the state, basically the entire document is oriented toward the integration of behavioral health and primary care through the development of accountable care organizations (ACO). Our ACO component really drives that point home repeatedly and our expectation that both our managed care companies and our ACOs will in fact ensure that the integration of physical and behavioral health is of paramount import and will be emphasized all along the way. So again we're trying to use our contracts to do that.

We could not get to all questions submitted. Now Virginia, who is currently in the process of applying for an 1115 SUD waiver. We're very happy that Brian Campbell has agreed to share some of Virginia's experiences in their planning, strategizing and preparations for implementation, along with lessons learned to ensure appropriate SUD benefit design, standards of care, their efforts around network adequacy and assessment.

Brian Campbell (BC): Thank you, CMS and Truven inviting me to share our experiences with the IAP, and for their significant technical assistance as we developed our waiver application and during the submission process. Without their collaboration we couldn't have made such significant process in a very short amount of time.

SF: Thank you. For participants to know, we're using a slightly different method with Brian. This will be an interview of some issues we've identified in understanding Brian's work and what Virginia is set up to do, so there will not be formal slides.

What was the impetus for Virginia to pursue the 1115 waiver for substance use services?

BC: Virginia, as many other states, is experiencing a significant crisis with the opioid epidemic. Their prevalence has increased significantly and as part of the strategies to address the epidemic, the Medicaid program was asked to develop a more robust substance use delivery system. That's where we took advantage of the opportunity through CMS to apply for the demonstration waiver. We're very different from Massachusetts where we had a limited substance use benefit in our Medicaid program. It consisted of community-based services only and patient services, but services were very underutilized, when you compare that to some of our potential prevalence data. So to address the opioid epidemic we really needed to develop a continuum of care and move the ASAM standards of care so that we were able to offer a residential support level, which is brand new to Virginia, because that is essential to assist people out of the hospitalization level and help them stabilize and move back to their community successfully. That would be a brand new level we are developing as part of the waiver.

We are also hoping to positively impact our pregnant women population and reduce incidents of neonatal abstinence syndrome and substance disorder in newborns, which also are increasing in the program as well currently. Again, we're just part of an initiative to address the opioid crisis and developing this new SUD delivery system that is also part of some continuing efforts to reform our Medicaid program.

SF: Given the myriad progressive goals that you had, can you talk about how you engaged the various stakeholders and persons who would be interested in what you were setting out to do? What process did you use?

BC: We're using a very comprehensive stakeholder involvement process. We're approaching this benefit design with a very aggressive timeline. We began robust stakeholder engagement beginning at the end of March and we submitted our waiver application, the final submission

at the end of November. We needed to really engage our provider associations, our member representatives, the individual voices. We need also to engage our provider groups, and we needed to engage the clinical associations such as physicians, psychiatrists, community mental health centers, and community-based service provider associations to get them at the table, have them learn as we were designing the benefit, and have them learn of the pending program changes because there would be significant changes to both provider participation standards as well as the service delivery environment as we moved into full managed care coverage.

To move the services into our managed care system, we involved our MCOs with their chief medical officers and their operational leads involved as part of our stakeholder group to design the benefit, discuss benefit management strategies. Then also, because we had so many new levels of care that we were bringing in with the initiative, we all agreed that among our various payers – we have seven MCOs and behavioral health service administrators for our fee for service population – we all agree to standardizing programs. So we needed to standardize the provider requirements to conform to ASAM; standardize reimbursement rules such as unit values, reimbursement amount; and standardize our authorization requirements in line obviously with ASAM but also have all the payers conform to a standard process.

But we had to rely on significant and very involved interagency collaboration with our state agencies and partners. Because of the complexity of the population using the substance use treatment benefits, coordinating care and delivering care involved a high level of sophisticated care coordination and a different style of service delivery due to the complex population. To pull that off successfully you really need to involve your state licensing agencies, your state practice act folks that govern your individual practitioners as well as the agency that governs the more agency-based service structures like the community mental health agencies. So there's a great deal of collaboration there. Also with our state Department of Health that regulates our hospital delivery system and also provide a great deal of physician training as well.

So we have a lot of moving parts involved with this implementation, so we needed to pull in our sister agencies, provider associations, and even the member voices that need to be part of the process. We had a high-intensity stakeholder involvement process involving weekly meetings throughout the spring. That audience grew to almost 100 people per meeting. Now we're convening on a monthly basis to go over more resolutions and discuss further implementations. But it was a very significant stakeholder process and involved significant training and outreach strategies, and you get a lot more people involved in the process, you get a lot better ideas. That's a little bit challenging to manage but __[01:11:39] outcomes that we're moving towards.

So we began implementation planning late March of 2016 and we'll be implementing this April 1st of 2017 statewide, hopefully with the support of the 1115 waiver, but either way we're moving forward with this implementation to address the opioid crisis in Virginia.

SF: Thank you. I had mentioned and Scott talked about Massachusetts efforts to incorporate ASAM standards of care in their contracts with MCOs. Can you tell us how Virginia works to include ASAM standards of care?

BC: That did involve the workgroup process to begin with. We're reviewing all the levels of care. We're reviewing the service provider capacities, the therapy requirements, and the staffing requirements of those different ASAM levels of care. So we began by reviewing all of those and defining them concretely for all the stakeholders and the managed care plans to

learn and understand. Then we took those elements and we defined them in our regulations, so we have a regulatory packet that's moving through the review process, and we're referring to those regulations throughout our managed care contracts to ensure that provider participation standards align with the ASAM program rules. We also had to translate that to Virginia's specific language.

The regulations also define how the managed care plans will administer the medical necessity criteria using ASAM, so again the contract refers to that medical necessity criteria being defined by ASAM. We will most likely have the plans purchase licenses for ASAM and then put the criteria in their benefit management systems to use, but again the regulations and the contract were aligned to require that of our covered health plans.

And we figured out our provider participation roles: in accord with ASAM standards and the health plans, we are required to enroll providers according to defined standards that are referred to in the contract and defined in the regulations. We did some centralized provider participation standards documents that we share internally with the plans. That's where we took the ASAM standards and translated them to the VA licensing structures and licensing language for our practitioners. We defined them, and the plans will be abiding by those requirements as the credentialed providers? To do that, we had to create an ASAM language that used the VA terminology, and then used the contract to refer to those structures in the regulations to enforce those contractual requirements for the health plans.

Again, what we wanted to do is develop one set standard that all the health plans have to abide by so the reimbursement structure is uniform, the provider credentialing standards are uniform, and the authorization and benefit management structures are all uniform. Essentially, we have one benefit administered by multiple payers and that will make it easier for us to attract providers into the delivery system. They may have the credentials with multiple plans, but once they get into our network, they're able to deliver services with a uniform service structure and clinical structure.

So that's been our approach and we have a lot of documents and contracts that are in various states of drafting and approval, and we should be getting several of those documents resolved in the next month or two then they could be available.

ST: Thank you. Virginia is engaged in a very thorough network capacity assessment process, and you started to mention aspects of that in your prior remarks. Can you talk a bit more about what that process entails and how you went about approaching it?

BC: The network development is probably our biggest area of concern with the implementation. With our 1115 level, as we move forward with ASAM levels of care, we are also introducing residential treatment services to our child and adult populations. With those new level 3 ASAM services, we don't really have an existing network of addiction treatment facilities to build upon. So, that's one of our biggest challenges.

Also, our existing providers were providing some kind of Virginia homegrown versions of a day treatment approach to hospitalization and intensive outpatient services. But as we standardize their service models to the ASAM role, there are some significant changes when compared to our existing model to where we're going, in terms of provider requirements and the therapeutic service structures.

So, we have to really look at this almost as a brand new implementation, and we surveyed all the MCOs and the behavioral health services administrator, Magellan, to get their providers

identified and look at their provider capacities on an ASAM level. We're taking all the providers, looking at their commercial providers plus their Medicaid providers, and taking those ___ [1:19:16] and breaking them down by the ASAM level that are assigned to them in the initial survey, and then we are able to drill down per pair, per region, and look at the ASAM capacity for the state.

So, we're using that to see which payers are struggling. We had to obtain the residential providers for example, and that particular level of care as well as the office space of the treatment services is kind of our new level. That's where we're identifying the network development needs of the implementation.

Again, we're taking the ASAM levels and analyzing them by our managed care regions, and we're seeing what their capacity is of each level of care on a regional basis. We can also drill that down to each MCO to see whom they have. Our MCOs are actually collaborating heavily to share resources and identify these residential treatment providers, so we're able to get those services up and running by implementation go live.

We've found that we do have our strengths in our hospital level of care. Hospitals have been doing different emergency services for this population, so that's a big strength. And our community-based services intensive outpatient and personal hospitalization are pretty well covered throughout the state. But again, the residential services and the office space of ____ [01:21:06] treatment of physician services are areas where we need significant growth before they're live. So, all of our network development plans were submitted the other week, and MCOs are working very rigorously to develop those levels of care where they don't have capacity in their current network.

I wanted to point out how we had to really effect our licensing standards with the service levels and how strong Massachusetts is in that regard, particularly in slot 28 and 33, they share their really good examples of how to have their licensing structure match up to the ASAM level of plans. That's a good lesson for states to use and follow that suit.

ST: Thank you Brian for that important piece and that call out. One remaining question for you before we turn to questions from participants that are starting to come in, if you could please highlight any major lessons learnt, from planning your design and your readiness efforts.

BC: Sure. It's really in regard to network development and you have to let states know that the ASAM models and outstanding models, that the specificity in each level of care regarding the provider capacities and their staffing requirements is very detailed. You need to really affect your licensing standards for the agency licenses to make sure that they align with each of these ASAM sublevels.

For example, in Virginia, with the residential level of care, we have some struggles. For intense outpatient partial hospitalization, our licensing rules match up very well. But the residential levels, 3.1 to 3.5, 3.7 have a lot of specificity that our licensing rules do not address. So we've had to manage that problem with a contract that certified those levels of care prior to the agencies getting credentialed with our health plans.

We want to standardize and certify that the agencies actually meet those level of care criteria prior to allowing them to enroll with the health plans, so that we're ensuring the health plans are enrolling providers in accord with the ASAM models, and that we have a consistency in our level of care availability throughout all the different payers.

If you don't manage that, you may have potential inconsistent applications of the benefit when you compare one payer to the next. So, that's a really important step: to offset your licensing rules and compare those to your credentialing in standards with your health payers.

And again, because VA didn't have that service available, some of our structures were not ready for that leap and we're having to use a contractor to align those levels of care for MCOs so it leads to a successful implementation.

ST: Thank you. That's very helpful. Brian, thank you so much for your remarks, and we'd like now to turn to participants submitting questions through the chat function for Brian to respond to related to the VA experience.

Several questions have come in relating to one topic: coordination of care for this population. Can you talk about how you're addressing coordination? Specifically the issue I mentioned, also that Scott mentioned: facilitating transitions between levels of care, and certainly integration to address physical health care needs as well.

BC: Yes. So we're relying on our existing managed care structures and their accreditation standards to use those care coordination processes and those requirements to integrate service delivery. By including the substance use service into our managed care environments, it's allowing the health care as well as the SUD services to be coordinated and integrated for folks, as well as including it in our duals population demonstration to integrate all the complex health care needs of those populations.

We have some contract requirements to ensure that there's a dedicated substance use care coordinator to assess needs, help coordination, and transition between levels of care. Again, that points to some requirements in our regulation to use ASAM medical and subsidy criteria, multidimensional assessment profile, and WISP profile, to assure appropriate levels of care are provided and coordinated.

ST: Thank you that's helpful. We are coming to the time where we need to wrap up this webinar. Brian, I'd like to thank you for providing such detailed information about the Virginia experience, especially as you move toward going live here in a very short time. As we move to closing the webinar, I do want to take a moment to highlight some key takeaways that we heard from all of our presenters today:

- There is a need to include specific provisions for SUD in the managed care contract, and again both MA and VA highlighted that.
- We heard about state partnerships being essential to the development contract provisions. Again, both Massachusetts and Virginia talked about that, particular to incorporation of ASAM, but certainly, incorporation of other technical assistance as you move to implementation. A single state agency for substance use could also be a key support for that implementation.
- Developing a provider network with a shared responsibility partnership between the state and the health plans is key.
- The importance of stakeholder engagement, to inform goals, to inform the quality metrics and how the program is operating.

Those are certainly the takeaways from the discussions and what we heard from the states. We have provided participants today a range of resources to further illustrate the points made, and provide additional details: all of those were sent out to you ahead of time, they can be found with these links that are provided to you here: Information from CMS related to

the managed care role, the state Medicaid directors' letters, informational bulletin specific to adult as well as youth coverage of BH services for SUD. And then incorporation of managed care options and requirements, a document produced by the national council.

We've also included contact information for Scott as well as Brian and myself. We encourage you to reach out with any questions you might have. Finally, we want to thank you for joining us for this national dissemination webinar today and for participating in our discussion around managed care contracting. Following this, you will see a screen to complete a webinar evaluation, and we would appreciate your response and your feedback. That helps guide future planning for additional webinars. Thank you again to our speakers and to all of you for participating in today's webinar.

[End of tape.]

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