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Paying for Value in Medicaid: How states are leveraging payment to improve the delivery of SUD services

As overdose fatalities increase, reaching a historic peak of over 100,000 deaths in 2020, states are continuing to invest in strategies to improve access to treatment for individuals with substance use disorder (SUD). This rise highlights the issues posed by the COVID-19 pandemic to SUD providers. Disruptions and changes in service delivery, and resulting changes in payment, have posed challenges to efforts to increase access to treatment. Policymakers in some states are starting to use the payments they make to providers and managed care plans as effective levers to increase both treatment access and service quality in their Medicaid programs. This toolkit, which is based on state interviews and documentation, examines Medicaid payment strategies that four states (Arizona, New York, Oregon, and Pennsylvania) use to improve SUD treatment for Medicaid beneficiaries.

Why Use Payment to Improve SUD Service Delivery?

While states have made significant investments and improvements in SUD services and systems, the increase in overdose fatalities during the COVID-19 pandemic,[i] along with chronically low rates of engagement in treatment,[ii] indicate an ongoing need for innovative policy strategies to improve access to and quality of SUD services. Several leading states have begun using payment — to providers and/or to managed care organizations — to target improvements in SUD systems.

Defining Key Terms

Substance Use Disorder Treatment Services: According to the Substance Abuse and Mental Health Services Administration, "Substance use disorders occur when the recurrent use of alcohol and/or drugs [both legal and illegal] causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home." SUD treatment services address those impairments and can include medications to control cravings, group and individual counseling, and peer support. This often requires significant care coordination and social determinant supports for employment, housing, and transportation.

The experience of the four study states (Arizona, New York, Oregon, and Pennsylvania) indicates that payment is an effective lever for improving the delivery of SUD treatment for Medicaid beneficiaries. For example, Oregon requires its Medicaid managed care organizations (called coordinated care organizations or CCOs) to report their performance on a set of quality measures and offers CCOs financial incentives to improve performance on a subset of those measures. Oregon's evaluation of the 1115 waiver under which they established the CCO program found that the financial incentives they had put in place were associated with improved performance among SUD providers. All four states have

indications that their efforts are having an impact: SUD providers and services are being included in value-based payment (VBP) arrangements; SUD providers are building the infrastructure needed to thrive under VBP; and, in some cases, performance on SUD quality metrics is improving.

State officials from all four states reported that they viewed their efforts to improve SUD services as part of broader efforts to improve behavioral health services in their Medicaid programs. Oregon officials emphasized that their work to foster VBP for behavioral health providers arose from a robust public engagement process. Stakeholders in Oregon believed that it was important to integrate behavioral health and primary care and that to achieve that goal Medicaid providers needed the incentives and flexible funding typically offered by VBP. State officials in the other three states also emphasized that they were seeking to improve service integration and provide whole-person care by better integrating behavioral health (including SUD treatment) and physical health care for Medicaid beneficiaries. Of the four states, Pennsylvania is the most explicit about this goal.

Using payment strategies to improve SUD services is challenging for several reasons. SUD is a stigmatized condition, which can make screening, identification, and engagement in treatment more difficult than for other chronic conditions. The chronic nature of SUD presents challenges in measuring meaningful performance improvements — a key component of any VBP model. For example, return to use is a typical feature of SUD, making simple clinical metrics, such as negative urine drug screenings, ill-suited for use in quality measurement. Moreover, narrow operating margins, workforce shortages, and generally smaller patient populations mean that payment strategies must incent provision of high-value care but not endanger the financial viability of SUD providers by transferring too much risk to them. State officials echoed these concerns and noted that SUD providers may not be ready to take on financial risk, especially not as solo practices. Each of the study states considered these challenges in developing their payment strategies.

Defining Key Terms

Value-based payment and alternative payment models: Value-based payment (VBP) models tie provider payment to performance in producing quality outcomes and, often, savings. For example, a provider could earn a share of the savings they produce through performance on a set of quality metrics. State Medicaid agencies (and other payers) have moved to increase use of alternative payment models (APMs) that qualify as VBP to incent providers, including SUD providers, to improve health outcomes and contain cost. Many states use the APM Framework, which classifies APMs based on the extent to which they reward value rather than volume of services to plan their efforts and measure progress. Although most early VBP efforts centered on primary care, more payers are considering ways to include SUD services and providers in their APMs.

"If you look at what we have worked on from 2015 to the present, at the heart of it are the individuals and making sure that all of their needs are served. ...Whole-person care has been the driving force of what we have worked on."

—Pennsylvania Medicaid official

"There is always tension around VBP when one of the intentions is bending the cost curve. How do you do that and continue to support patients and providers?"

—Arizona Medicaid Official

Arizona's Strategies

Arizona Strategies at a Glance

1. Targeted Investment Program uses payment to integrate care, including SUD treatment, at the point of service.
2. Differential Adjusted Payment Strategy rewards providers, including SUD providers, for adding specified capacities.
3. Alternative payment model initiative rewards managed care organizations (MCOs) for performance in increasing value-based payment (VBP) expenditures and improving performance on a set of clinical outcome measures, including one SUD measure.

Arizona operates a number of managed care programs but has three main MCO programs that deliver behavioral health services: MCOs participating in the Arizona Health Care Cost Containment System's Complete Care program provide behavioral and physical health services to most beneficiaries; Regional Behavioral Health Authorities, which are all MCOs, provide behavioral and physical health services to beneficiaries with severe mental illness (SMI) who do not qualify for long-term services and supports (LTSS); and MCOs participating in the Arizona Long Term Care System-Elderly and Physical Disabilities (ALTCS/EPD) program provide physical and behavioral health, as well as LTSS, to all beneficiaries who are at-risk for institutionalization. Arizona has implemented three payment strategies seeking to improve the delivery of SUD services.

State-directed payments enable states to require managed care plans, including MCOs, to pay a defined group of providers using a specific payment model that is uniform across all plans. Arizona's Targeted Investments (TI) Program leveraged state-directed payments to support the creation of 13 integrated clinics, including some federally qualified health centers (FQHCs), where co-located primary care and behavioral health providers (including SUD providers) deliver services to justice-involved individuals. For the first three years of the program, the clinics earned incentives by achieving milestones marking progress in creating the infrastructure needed to provide integrated care. For example, in the second year of the program, participating clinics had to show that the practice had "reliable and consistent access to at least one physician who can prescribe buprenorphine," one form of medication for opioid use disorder (MOUD), and by the end of the third year of the program, they had to "provide three examples of meeting the MAT [medication-assisted treatment] guidelines for members with opioid addiction."

In years four through six, the TI payment model shifted. All MCOs are now required to make incentive payments to participating clinics serving justice-involved individuals based on their performance on two measures: Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (14-day) and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (34-day). Arizona also created a quality improvement collaborative and provided other supports, such as performance dashboards, to these clinics. Arizona Medicaid is currently negotiating a renewal of this program with the Center for Medicare & Medicaid Services (CMS).

Arizona also leveraged state-directed payments to create its differential adjusted payment (DAP) strategies. DAP strategies are implemented in both fee-for-service and via MCO contracts. DAP rewards providers who achieve specific performance milestones with a fee-for-service rate increase for selected services. MCOs are required to pass through a corresponding rate increase to contracted providers who achieve the milestones. In the 2022 contract year, 12 types of providers, including integrated clinics, behavioral health clinics, and behavioral health providers, may earn rate increases. Among other potential milestones, behavioral health outpatient clinics and integrated clinics will be awarded a 0.5 percent rate increase on all claims if they integrate their electronic health record system with the American Society of Addiction Medicine Continuum Software Integration software, which fosters uniform assessment of patients with addictive, substance-related, and co-occurring conditions.

Finally, Arizona's Alternative Payment Model Initiative is a performance incentive program that is funded by a 1 percent withhold from all capitation payments. It rewards MCOs that meet VBP targets with the amount of the incentives determined by each MCO's performance on a set of quality measures. The set includes the measure Use of Opioids at High Dosage. All MCOs have to report performance on the measure, but that performance is only weighed into payment to ALTCS/EPD.

New York's Strategies

New York Strategies at a Glance

1. VBP Roadmap sets VBP expenditure targets and defines VBP models, including some that seek to improve the care of Medicaid beneficiaries with SUD.
2. Medicaid managed care quality incentive program awards MCO capitation rate adjustments based on MCO performance on a set of measures, including SUD measures.

New York operates its Medicaid program under a Section 1115 demonstration waiver (§1115 waiver), now called the New York Medicaid Redesign Team. Under this waiver, most Medicaid beneficiaries are enrolled into MCOs. However, there are multiple types of MCOs serving different populations, including mainstream Medicaid managed care (MMMC) plans that serve most Medicaid beneficiaries; managed long-term care (MLTC) plans for beneficiaries who qualify for home and community-based services (HCBS), and health and recovery plans (HARPs) that provide the same services as MMMCs plus HCBS services to those diagnosed with SMI and/or SUD. New York has implemented two strategies that use payment to improve SUD services.

In 2014, New York received approval from CMS to add a Delivery System Reform Incentive Payment (DSRIP) program into its §1115 waiver. DSRIP programs operate under §1115 waivers and enable states to make payments to qualified providers for implementing infrastructure and care transformation projects. The approval authorized the state to spend up

to $8 billion over five years to transform the delivery system. One goal of the DSRIP program was to shift 80 percent of Medicaid spending into VBP models. The state developed a VBP Roadmap to define, manage, and measure this goal. It allows for multiple types of VBP arrangements that target different populations. The latest iteration of the VBP Roadmap includes models that target SUD services or providers. For example, MCOs that execute a total cost of care contract for the general population are required to base their shared savings and risk distributions on quality measures for specific domains, including SUD. State officials report that several MCOs have VBP models in place with SUD providers that feature incentives or shared savings. Most models include both the HARP and mainstream populations. Although the DSRIP program ended in 2020, New York Medicaid continues to pursue the VBP goals and, in December 2021, issued a draft update of the VBP Roadmap.

The New York model contract attaches a financial penalty for failure to meet the annual VBP targets specified in the VBP Roadmap. Both the targets and the penalty are defined in the VBP Roadmap. As of April 2020, the target required MCOs to make at least 80 percent of all their expenditures via a VBP model that, at a minimum, offered providers a share of any savings they generated. Further, for fully capitated plans, at least 35 percent of all expenditures were required to be made via a payment model that both offered providers a share of any savings and required them to pay a share of any losses. State officials report that the MCOs met these goals in 2020 and, as of February 2022, the contractual requirements remained in place. While the targets and penalties do not call out SUD providers or services, payments for SUD treatment would be factored into the calculation of both the VBP expenditure targets and penalties, thus incenting MCOs to include both SUD providers and SUD services in their VBP arrangements. Further, SUD performance measures are included in the measures sets that are approved for use in determining shared savings/losses in VBP arrangements (Table 1).

Table 1: SUD-Related Measures Approved for Use in VBP Arrangements by Managed Care Plan Type: 2021

Measures	Behavioral Health/HARP	HIV/AIDS	Integrated Primary Care	Maternity Care
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	X	X	X	X
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	X	X	X	X
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence	X	X	X	
Use of Pharmacotherapy for Alcohol Abuse or Dependence	X	X	X	
Pharmacotherapy for Opioid Use Disorder	X			
Follow-up after High-Intensity Care for Substance Use Disorder	X			
Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence	X			

State officials observed that their DSRIP program enabled behavioral health (and other) providers to gain comfort with VBP models and implement the infrastructure needed to thrive under such models. For example, officials observed that the DSRIP program had fostered the formation of networks (e.g., independent practice associations) of mental health and SUD providers. Officials believed that these networks would be well-equipped to implement VBP models that share risk because networks are more able to move measures and better able to spread financial risk than individual providers. In August 2021, the state submitted a concept paper for a new §1115 waiver that proposes to capitalize on these advances. Among these proposals is a requirement that MCOs engage in VBP contracts with groups of providers that include networks of behavioral health providers along with primary care providers. Also, newly created health equity regional organizations would be tasked with developing regional consensus on VBP models for specific subpopulations, including the SUD population. As of February 2022, Medicaid officials continue to work with CMS to develop a new §1115 waiver.

New York has also created a Medicaid managed care quality incentive program that awards capitation rate adjustments based on plan performance. Three of the measures included in that process relate to SUD treatment:

1. Initiation and Engagement of Alcohol and other Drug Dependence Treatment (Composite Rate)
2. Initiation of Pharmacotherapy upon New Episode of Opioid Dependence
3. Follow-up after Discharge from the Emergency Department for Alcohol or Other Drug Dependence: 7-day rate

Since the program was implemented in 2001, New York reports that overall the performance of Medicaid MCOs has improved and the gap between Medicaid and commercial plan performance has narrowed.

Oregon's Strategies

Oregon Strategies at a Glance

1. Coordinated care organization (CCO, Oregon's term for MCOs) contracts require CCOs to implement VBP for behavioral health providers by 2022.
2. CCOs can earn incentives based on their performance on a set of quality metrics, including SUD measures.

In 2012, Oregon's Medicaid agency launched its coordinated care organization (CCO) program under a §1115 waiver. At that time, the state began contracting with regionally based CCOs (Oregon's name for its MCOs) to deliver Medicaid-covered services, including SUD services, to program participants. CCOs are community-governed organizations that bring together physical, behavioral, and oral health care providers to deliver coordinated care for their members. CCOs receive per member-per month (PMPM) payments and are also eligible to receive annual incentive payments based on their performance in delivering access to high quality care. Oregon pays CCOs incentives for performance on a set of measures, and two of these measures address SUD care: Alcohol and Drug Misuse Screening and Initiation and Engagement of Alcohol/Drug Abuse or Dependence Treatment.

In preparation for the second phase of this program (CCO 2.0), the state engaged in an extensive stakeholder process and assessed the performance of the CCOs under CCO 1.0. This process highlighted the need, in CCO 2.0, to improve the behavioral health system (both mental health and SUD) and increase use of VBP. According to the CCO 2.0 waiver request, one goal of CCO 2.0, which launched in January 2020, is to "build on transformation of Oregon's Medicaid delivery system with a stronger, expanded focus on integration of physical, behavioral, and oral health care through a performance-driven system with the goal of improving health outcomes and continuing to bend the cost curve." In January 2020, Oregon Medicaid launched CCO 2.0.

Under their contract with the state, CCOs are required to implement VBP for behavioral health providers by 2022. CCOs can choose payment models and providers that they believe will succeed, so it is still unclear whether they will choose to enter into VBP contracts with SUD providers. State officials commissioned a baseline evaluation that was released in early 2021 that found that CCOs were making progress in this area, and the evaluators identified a handful of CCOs that already had models in place. The specific models described were implemented with networks of behavioral health providers that included both mental health and SUD providers. Similar to its approach in other areas, Oregon Medicaid is supporting these initial efforts with technical assistance and plans to strengthen their requirements as state, CCO, and provider experience grows.

Pennsylvania's Strategies

Pennsylvania Strategies at a Glance

1. Managed care plans that deliver physical health services (PH-MCOs) and those that deliver only behavioral health services (BH-MCOs) are required to meet VBP expenditure targets.
2. Integrated care plan program provides incentives for PH-MCOs and BH-MCOs to better integrate physical and behavioral health.
3. Hospital quality improvement program provides incentives for hospitals to improve follow-up to opioid use disorder (OUD)-related emergency department visits.
4. PH-MCOs and BH-MCOs required to pay OUD centers of excellence a per member-per month payment for months in which they provide a care management service.
5. PH-MCOs required to pay maternity care-bundled payment program providers a share of savings based on their performance on a set of quality measures, including an SUD measure.

Pennsylvania enrolls most Medicaid beneficiaries into its managed care program, referred to as HealthChoices. In HealthChoices, physical health care services are delivered to most Medicaid beneficiaries by physical health MCOs (PH-MCOs). Dual eligibles and most beneficiaries who qualify for long-term services and supports (LTSS) receive both physical health care services and LTSS through Community HealthChoices (CHC) MCOs. Most behavioral health services are delivered by prepaid inpatient health plans referred to as BH-MCOs. The Medicaid agency does not contract directly with the BH-MCOs but rather contracts with county governments, referred to as "primary contractors." In turn, each primary contractor contracts with a single BH-MCO that serves all Medicaid beneficiaries in the county (or counties in the case of multi-county coalitions). Pennsylvania employs five major strategies to leverage payment to improve SUD services. Two target managed care plan payments, and the others target provider payments.

Since 2017, Pennsylvania has required its PH-MCOs to pay a percentage of their total expenditures via VBP models and began requiring BH-MCOs to do so in 2018. The percentages increase each year. In 2020, PH-MCOs were required to pay 50 percent of expenditures via VBP, and BH-MCOs were required to pay 20 percent. Further, both types of MCOs had to pay at least half of their VBP expenditures via medium- or high-risk models that incent providers both to improve quality and contain cost (e.g., shared savings, shared risk, bundled payments, global payments). Additionally, at least 75 percent of VBP payment strategies that are medium- and high-risk must incorporate at least one community-based organization (CBO) that addresses at least one social determinant of health (SDOH) domain, and 25 percent of VBP payment strategies that are medium and high risk should incorporate one or more CBOs that together address two or more SDOH domains. The extent to which these arrangements include SUD providers or services is not known, but state officials reported that some arrangements do include them.

Since 2014, Pennsylvania's Integrated Care Plan (ICP) program has paid incentives to PH-MCOs and primary contractors to better integrate physical and behavioral health for HealthChoices members with serious mental illness (SMI). In 2021, Pennsylvania Medicaid

allocated $20 million for incentive payments ($10 million for incentives to PH-MCOs and $10 million for incentives to primary contractors). Primary contractors are not required to share any incentives earned with their contracted BH-MCOs. To earn incentives, the primary contractor must meet both process and outcome requirements. The primary contractor must prepare an annual program report that includes information about the level of physical and behavioral health needs of its members, the number of ICPs developed, and how frequently the BH-MCO notified the PH-MCO of a hospital admission within one day. The incentive amount earned depends on each contractor's performance on eight quality measures, including Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. PH-MCO requirements are very similar to those of primary contractors, and incentives are distributed based on performance on the same eight measures. (See appendix E of the program standards and requirements for primary contractors and appendix B(2) of the model contract for PH-MCOs.)

Phase 2 of the Pennsylvania Hospital Quality Improvement for Opioid Use Disorder program, which launched in May 2020, includes a VBP model. Phase 1 offered hospitals payments for implementing up to four clinical pathways into OUD treatment. Phase 2 incents the use of the pathways. Participating hospitals are measured on their performance in providing OUD treatment within seven days to HealthChoices members who are seen in the hospital's emergency department for OUD. Hospitals that improve performance against a benchmark or improve their performance against their previous year's performance receive an incentive payment. Hospitals that qualify for both payments receive both payments. Pennsylvania has allocated $35 million for the payments. Although causality is difficult to establish, state officials report that they have seen an overall increase in the percentage of individuals initiated into treatment in seven days.

The remaining two strategies target provider payments but are implemented through managed care contracts as state-directed payments.

1. Since 2016, PH-MCOs and primary contractor/BH-MCOs have been required to pay opioid use disorder centers of excellence (OUD-COE) a bundled payment for care management services. OUD-COEs, some of which are FQHCs, receive a PMPM payment for any month in which the member receives at least one specified care management service. (See Exhibit G of the model contract and Appendix G of the program standards and requirements.) By 2021, participation had grown from 45 entities to over 70, providing care at about 100 sites. State officials report that the OUD-COE have produced increases in access to OUD treatment and decreases in both emergency department utilization and hospitalizations related to opioid overdose.

2. As of 2021, PH-MCOs are required to participate in a maternity care-bundled payment program (Exhibit B(7) of the model contract) that offers maternity care providers an incentive payment that consists of a share of program savings. Among the measures that must be used to determine the amount of shared savings a provider earns is Initiation of Alcohol and Other Drug Abuse or Dependence Treatment. Pennsylvania hopes that in 2022 about 25 percent of all live births will be paid for via this payment model.

Key Takeaways and Lessons Learned

Discussions with officials from the four study states about their experiences in leveraging payment to improve SUD services revealed several key takeaways and lessons learned:

States used similar combinations of Medicaid payment strategies to improve SUD treatment. All four of the study states offered MCOs some form of incentive payment for improving performance on a set of measures that included one to three specific to SUD. All four states also sought to broadly increase provider participation in VBP by requiring managed care plans to make a specific percentage of expenditures, including SUD expenditures, via VBP models, and some of these models included SUD providers.

In addition, both Arizona and Pennsylvania used the state-directed payment provisions of the federal managed care regulations (42 C.F.R. Part 438.6) to implement specific uniform provider payment models via managed care contracts. Both states included FQHCs among the providers that qualify for the payments. Payment models implemented under these provisions must be developed for a defined group of providers and be uniform across all managed care plans. Medicaid agencies need to obtain CMS approval of these arrangements before implementing them and annually thereafter. CMS offers states guidance in developing these models.

States strengthened their Medicaid managed care plan and provider requirements and moved to more advanced payment models as state, provider, and plan VBP readiness grew. All four states built on their previous experience in using financial incentives to improve MCO performance. They also built on their years of experience in leveraging provider payment to improve a range of services and previous efforts to better integrate physical and behavioral health and improve behavioral health services. All four states plan to continue to evolve their strategies as their knowledge base grows and new opportunities arise.

States chose similar measures to incorporate into payment strategies based on similar considerations. These four states consistently tied Medicaid payments to the same or very similar measures. All four states included the measure Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment in one or more of their payment strategies. In addition, New York and Pennsylvania both included a measure of follow-up after an emergency department visit for either alcohol and other drug dependence (New York) or OUD (Pennsylvania). Oregon includes a measure of Alcohol and Drug Misuse Screening in its CCO incentive measure set. In interviews, some state officials made clear links between SUD and the social determinants of health — and New York included measures of housing, employment, and arrests among those that MCOs and providers could include in their VBP arrangements for the HARP population. State officials

> *"In addition to aligning with the core set [of Adult Health Care Quality Measures for Medicaid] and other measures of success as established by our federal regulator, we chose measures that aligned with our commitment to reducing system fragmentation."*
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> ***—Arizona Medicaid Official***

considered many of the same factors when selecting measures, including payment strategy goal, alignment across state programs and with national measure sets (e.g., the CMS Core Measure Sets), improved performance to produce value/increase quality, and the ability of the plan/provider to change.

States will continue to evolve their Medicaid payment models and measure sets. As states and providers become more comfortable with VBP models and gauge existing metrics for both process and patient experience, they can consider other elements of SUD care for potential measures. Initial exploration and implementation of VBP for SUD has been approached cautiously, as some SUD providers were unfamiliar with the nuances of Medicaid billing and VBP. As VBP shows success in states, however, policymakers are deliberating on additional opportunities to expand this type of payment by considering other components of care within the SUD treatment continuum. New York officials, for example, reported that they were interested in adding measures of continuity of care after detoxification, medication measures, and continuing engagement in treatment to the measures they recommend for use in VBP.

Further, the current landscape of SUD funding includes multiple opportunities for states to support providers and build infrastructure in ways that can support VBP. For example, federal grants, including the State Opioid Response and Substance Abuse Prevention and Treatment block grants, can be used by states to engage providers and grow treatment capacity. These grants, administered by single state agencies (SSA) for behavioral health, provide an opportunity for state agencies to work in concert to build treatment infrastructure, including through provider development.

Medicaid managed care plans and behavioral health providers needed technical assistance in addition to financial incentives. State Medicaid officials observed that both managed care plans and behavioral health providers needed technical assistance as well as payment incentives to improve delivery of SUD services. In the area of behavioral health and SUD the assistance included helping Medicaid providers produce measures and implementing the practice improvements needed to improve performance on the measures. These states also offered both providers and managed care plans information to help them understand the various VBP models that could be used. All four states produced written resources to support provider efforts, such as Pennsylvania's resource guide for OUD-COE and New York's guidance for behavioral health providers transitioning to VBP. Oregon also sought to help its CCOs by producing a webinar to help them plan for implementing VBP for SUD.

In addition, all four states offered in-person and virtual learning opportunities. Arizona and Pennsylvania formed learning collaboratives to support their efforts. Arizona's Targeted Investments Program (TIP) Quality Improvement Collaborative (QIC) helps participants meet TI performance requirements. Thus, it brings together teams from participating organizations to learn about both producing measures and implementing practice

> *"There was a big spectrum of where providers were on their learning curve (with respect to MOUD). It took us over a year to stand up our learning network, but once we did, it was like night and day."*
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> ***—Pennsylvania Medicaid Official***

improvements for Medicaid enrollees. Pennsylvania contracted with the University of Pittsburgh to create a learning collaborative to support their OUD-COE program. Oregon provided this assistance through its Transformation Center, which is a state office created to support innovation across the health care system. Finally, New York used its DSRIP funding to offer Medicaid providers and MCOs in-person and virtual learning opportunities.

States' efforts are having a positive impact. The four states report that as a result of their efforts Medicaid managed care plans and providers are adopting VBP models that include SUD providers/services — creating the potential to reap the improvements on quality, health outcomes, and cost that VBP is designed to produce. Further, these states have anecdotal evidence that providers are better prepared to enter VBP arrangements and, in a few cases, that their strategies are having the anticipated impact.

All four states report that, to date, most Medicaid managed care plans are meeting their VBP expenditure targets. It is difficult, however, to assess how much of these expenditures are for SUD services or go to SUD providers. However, both Arizona and Pennsylvania do know that their state-directed payment programs (e.g., Arizona's TI program) engage SUD providers/services in VBP models because the models are defined in the Medicaid managed care contracts. In addition, all four states know that SUD services and providers are included in VBP arrangements, although they cannot quantify that activity. For example, New York's approach of defining acceptable VBP models in its VBP Roadmap enables state officials to be certain that total cost of care arrangements consider the cost of SUD services when calculating shared savings. They also know that any model implemented for Medicaid beneficiaries with SUD or mental health conditions factor provider performance on at least one relevant measure into payment. New York officials have also observed that both mental health and SUD providers in Medicaid have gained familiarity and comfort with VBP and, over the course of the state's DSRIP program, have better organized themselves to effectively engage in VBP arrangements. As a result, officials believe that Medicaid MCOs and providers are now prepared to move further into VBP for SUD treatment.

> *"From 2014 to 2020 every single measure has improved, at least a little. The medication for OUD [measure] in particular, has improved a lot."*
> ***—New York Medicaid Official***

Although causality is difficult to determine, both Arizona and Pennsylvania have documented improvements on performance measures associated with the state-directed payment models. For example, providers participating in Arizona's TI program serving justice-involved adults were required to provide access to medication-assisted treatment (MAT) and received incentive payments for achieving relevant milestones. Arizona officials report that their data show an upward trend in the percent of people with OUD who receive MAT. Pennsylvania pays hospitals participating in their Quality Improvement for Opioid Use Disorder program an incentive for improving their performance in providing OUD treatment within seven days to Medicaid members who are seen in the hospital's emergency department for OUD — and state officials report that they have seen an overall increase in the percentage of individuals initiated into treatment in seven days.

Summary

The experience of the four study states indicates that state Medicaid agencies can leverage payment to improve the delivery of SUD services. These four states implemented strategies that leverage Medicaid's payments to managed care plans, to SUD providers, and for SUD services. They succeeded in moving some SUD providers and services into VBP models, and there are some indications that the programs are producing improvements in care. However, there is still a lot of work to be done to further these efforts — and although these states report promising results, all of them recognize that they will need to continue to revise and evolve their efforts as their experience grows. Nonetheless, the strategies developed by these states, and their experience in implementing them, can inform other states seeking to improve SUD services.

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