

VBP Implementation: Behavioral Health Providers

Value Based Payment (VBP) Guidance Document

Preparing for the Transition to VBP

This document is intended to help behavioral health (BH) providers prepare for and make the transition to VBP. This document covers several areas that BH providers may focus on, to streamline their transition to VBP.



Governance

A BH provider must consider how they will engage in a VBP arrangement when establishing their governance model. In many instances, a BH provider will not contract directly with a payer as a lead VBP contractor, and instead, will subcontract with a lead VBP contractor as a “provider partner”. However, BH providers can choose to serve as a lead VBP contractor, based on the factors outlined in this document. A BH Provider may choose to:

- a) become a Lead VBP Contractor and contract directly with a payer

BH providers that intend on becoming lead VBP contractors should consider the following:

- i. A provider must be a professional services Limited Liability Company (LLC) or partnership (PLLC), or professional corporation (medical group of all like professions), Accountable Care Organization (ACO) or independent physician association (IPA) to contract a VBP arrangement.
- ii. Determine if your organization is able to contract Medicaid. If not, pursue the appropriate legal structure to contract Medicaid in accordance with New York State rules and regulations.

- b) become a “provider partner”, and contract with a lead VBP contractor; essentially, becoming a subcontracted provider within a Lead VBP Contractor’s larger provider network



Stakeholder Engagement

For BH Providers that intend on becoming a Lead VBP Contactor or intend to contract a VBP arrangement directly with a payer, it is critical to engage payers early and often. Leveraging existing contractual relationships with a payer may be a successful approach. Also, consider the regional location of a payer relative to the population you cover. Amending a pre-existing Medicaid contract to meet the VBP standards (as described in the [NYS VBP Roadmap](#)) may also be an effective route, as opposed to developing an entirely new VBP contract. Remember, payers that execute VBP contracts have a vested interest in helping establish a provider network that covers the care spectrum for the population being served and that takes into account the type of VBP arrangement being contracted (whether the providers are contracted with the payer separately or together).

Evaluate your organization’s provider network to understand gaps in care. Robust provider networks that span the complete care spectrum will likely be more successful at improving the quality of care at a lower cost, thus creating a stronger potential for shared savings. Subcontracting with other provider types (including Hospitals, Health Homes, Primary Care Practitioners (PCPs), Community Based Organizations (CBOs)) and substance-use disorder services may help ensure that all points of the patient care cycle are covered, including outreach, care management, and post-discharge and recovery services. Outreach with Health Homes will be critical for BH providers, given the Health Home’s role and linkage to patients with significant BH needs.

BH Providers that may choose not to function as a Lead VBP Contractor may subcontract with a Lead VBP Contractor as a “provider partner.” In this case, BH providers must understand their value proposition and effectively communicate it to a Lead VBP Contractor, and perhaps, even the payer. Robust and sustainable BH provider groups will help strengthen the possibility of achieving shared savings on behalf of the Lead VBP Contractor’s provider network. Thus, individual BH providers may want to explore opportunities to collaborate amongst themselves to develop a single BH provider organization, capable of developing a solid value proposition that can be communicated as one.

In some cases, BH providers may not currently be part of a provider network. These BH providers should reference the ‘Business Strategy’ section of the document for key components and value propositions unique to BH providers that may help facilitate the inclusion of a BH provider into a VBP arrangement.

Finally—whether a lead VBP contractor or a provider partner—working with a Performing Provider System (PPS) in the Delivery System Reform Incentive Payment (DSRIP) program may help your organization identify other parties or organizations that are interested in contracting or establishing a VBP provider network. Working with a PPS, reaching out to a managed care plan, and forming together with other BH providers are all great options in order to engage stakeholders.



Business Strategy

A BH provider functioning as a Provider Partner or Lead VBP Contractor may consider aligning the type of VBP arrangement that the BH provider will contract with its business model or type of services the BH provider intends on providing. For example, a BH provider may elect to engage in a VBP contract for the HARP arrangement, rather than a total cost of care arrangement, where the provider may leverage the specialty of its BH services in serving a population with significant BH needs. The specific nature of BH providers establishes their value proposition in BH services. BH providers may want to consider the following key factors when developing their value proposition for communication to a payer or Lead VBP Contractor.

- a) The **Integrated Primary Care (IPC) arrangement** includes BH related chronic conditions such as Substance Use Disorder (SUD), Bipolar Disorder, and Depression/Anxiety). The IPC arrangement focuses on the integration of physical and behavioral health. BH providers are well positioned to improve the overall quality of care of patients and reduce the overall cost of care, especially as it relates to behavioral health, SUD and serious mental illness (SMI) services. This is an important factor for Lead VBP Contractors to understand, as they seek to strengthen their provider network. Likewise, it is important for BH providers to know which Lead VBP Contractors are contracting the IPC arrangement.
- b) The **HARP arrangement** is focused on adults with serious BH needs. Medicaid members with BH conditions drive a significant proportion of spend in the Medicaid program compared to mainstream Medicaid members. Again, BH providers are well positioned to support VBP provider networks in addressing the HARP population, which requires specialized care.
- c) Further compounding the complexity of the special needs population is the overlap of Medicaid members having mental illness, substance use disorder and, in some cases, a diagnoses of HIV/AIDS. The successful integration of BH providers into a VBP provider network is critical to the network’s ability to improve care and lower overall costs. In this case, the BH provider(s) can have a profound impact on the realization of shared savings. This factor is as equally important for the Lead VBP Contractor and the BH providers to understand.
 - Health Homes play a leading role in HARP members’ care management and drive member attribution in the HARP arrangement. Therefore, Lead VBP Contractors should engage Health Homes when contracting a HARP arrangement.

Lead VBP contractors and provider partners must assess their existing VBP networks to determine if these standards may be met. In many cases, networks may require the support of BH providers and community based services and/or social determinants of health interventions to meet the standards of the VBP Roadmap, but more importantly, may explore innovative practices to improve population health.



Finance

Similar to other Lead VBP Contractors, a BH provider contracting directly with a payer must examine its ability to take on risk and determine which level of VBP is appropriate to contract. As a provider moves up the levels of a VBP contract from level 1 to level 3, it will assume more financial risk. However, providers will also improve their opportunity to realize shared savings. Ultimately, the level of risk and potential to obtain shared savings is dependent on the contract negotiated between the payer and the contracting provider. BH providers can subcontract and maintain a risk-free contract with a lead VBP contractor or, if acting in a lead VBP contractor role, can consider Level 1 (risk-free, upside only) arrangements or Level 2 or 3 risk-sharing arrangements.

Whether engaging as a Lead VBP Contractor or a provider partner, a BH provider will need to have an understanding of the financial impact when entering into a VBP arrangement, based on the population served. While no simple task, providers should understand the total cost of their population, the needs of the population, and opportunities and/areas for improvement. These factors will help providers determine their potential for shared savings.



Data

Whether a Lead VBP Contractor or a subcontracted provider partner, data will enable BH providers to make more informed business decisions and provide a higher quality of care. Behavioral health providers should determine their own capabilities for obtaining and analyzing data. If BH providers lack their own “in-house” data infrastructure, they may explore opportunities to partner and collaborate with other organizations to obtain and share data and establish data analytics capabilities. At a minimum, BH providers may want to consider exploring the following key areas:

- a) The cost of care of the population they serve per a contracted arrangement, relative to the total population covered in the same VBP arrangement;
- b) Identification of “super utilizers,” meaning high utilizers and high cost-of-care Medicaid members, and more importantly, why their utilization and costs are high, and;
- c) Which specific category of service has a high rate of potentially avoidable complications or high readmission rates, and why. These areas where potentially avoidable complications, such as hospitalizations for chronic conditions, are prevalent represent opportunities for improvement, and thus, greater potential for shared savings.

Specifically, BH providers should review this information to:

- a) Consider opportunities for focused protocols targeting clients belonging to these high-need/high-risk groups; and
- b) Identify key process and outcome domains that will be priority areas for the provider network they wish to join and align their internal continuous quality improvement (CQI) processes and measures to those domains. Examples:
 - i. Repeated Acute Service Use: The BH provider should consider CQI processes that track the identification and management of crises as well as the timeliness of communications with



Health Homes and hospitals when clients are admitted.

- ii. Care Transitions: The BH provider should consider CQI processes that track timeliness of scheduling aftercare appointments following discharge and procedures for outreaching clients who fail to attend aftercare appointments.
- iii. Integrated Care: The BH provider should consider CQI processes that track clients' adherence to PH care appointments and communication with PCPs.
- iv. Engagement of High-Need Individuals: The BH provider should consider CQI processes that track adherence to appointments and prescribed treatments as well as and outreach to those who disengage from care.

A BH provider with these CQI and reporting capabilities will be appealing to larger networks that want to have an impact in these specific domains.

Although accessing data may be a daunting task for providers, there are options. BH providers may engage payers or provider partners to explore options for data sharing and analytics capabilities. PPSs are also valuable resource since relevant data outputs may have been generated by the PPS as part of their DSRIP efforts. In these cases, PPSs may wish to share data with providers, where appropriate and feasible, after securing the necessary data-sharing agreements. The NYS VBP Roadmap also establishes opportunities for data sharing among hospitals and providers when IPC and/or total cost of care for general population (TCGP) arrangements are contracted. In these specific cases, hospitals can demonstrate cooperation by sharing data with providers, particularly if the hospital receives a portion of shared savings ([VBP Roadmap](#), p 67).