4.19 Payments for Medical and Remedial Care Services

Value-Based Payments for Substance Use Disorder (SUD) Providers

The Bureau for Medical Services (BMS) will require its contracted Managed Care Organizations (MCOs) to implement value-based payment strategies for SUD provider reimbursement that promote quality, outcomes, and efficiency rather than the volume of services delivered. BMS will implement a set of outcome-based performance measures for each level of care within the addiction treatment and recovery services continuum. These measures will evaluate both individual recovery outcomes and provider performance, while promoting accountability, quality improvement, and the effective use of resources. The value-based measures utilized under value-based programs shall include, but not be limited to, the following indicators:

- Housing Stability
- Sobriety
- Criminal Justice and Child Welfare Avoidance
- Self-Sufficiency
- Provider Transition Plan

The BMS will update the Managed Care contract to include the following.

1. A value-based payment model that affords enhanced payments to providers for meeting or exceeding the performance measures and reduces payments to providers who fail to meet performance measures.
2. Specific state identified performance measures.
3. A baseline year when data is collected to establish a baseline and communicated to providers to allow notice of performance.
4. An annual review of performance measures to identify potential changes and to address quality outcomes.
5. Provisions for a provider to be de-certified, to have specific code blocked, to be terminated, or otherwise be excluded from the Medicaid program when the provider fails to meet the established performance measures for three consecutive quarters.
6. SUD system level outcomes that the value-based model shall produce with return-on-health investment measures that can be used to compare the investments in specific system of care relative to outcomes.
7. Contract amendments to require that incentive payment methodologies be actuarially sound, clearly define performance expectations and payment criteria, and comply with all applicable Medicaid managed care rate-setting requirements.