SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

Preparing for Value-Based Payment in Behavioral Health and Primary Care 2018 Innovation Community-Webinar 1

Presented by: Mindy Klowden, MNM,
Director, Technical Assistance and Training,
National Council for Behavioral Health

Setting the Stage: Today's Moderator

Madhana Pandian
Associate
SAMHSA-HRSA Center for Integrated Health Solutions

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Innovation Communities 2018

To participate

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About the Presenter: Mindy Klowden, MNM

Mindy is the Director of Training and Technical Assistance for CIHS and provides individualized consultation and training to community mental health centers, primary care clinics and other health care systems and providers working to integrate primary care, mental health and substance abuse treatment. Ms. Klowden also works on health care payment and delivery system reform, and co-chairs the Colorado State Innovation Model Practice Transformation committee.

Prior to joining the National Council, Mindy served as the Director of the Office of Healthcare Transformation at Jefferson Center for Mental Health in CO. In this role, she was an advisor to executive and senior management on health care policy and trends, developed key health reform initiatives, and worked to cultivate and sustain inter-agency partnerships that support the integration of behavioral health with primary care.

Mindy has 25 years of experience in the nonprofit sector. Previous roles include working with the Colorado primary care association and with affordable housing and homeless service provider and advocacy groups.

Mindy earned her Master's degree in Nonprofit Management from Regis University and her Bachelor's degree in Sociology from the Colorado College. She is also a graduate of the Bighorn Healthcare Policy Leadership Fellowship Program.

Learning Objectives for Today

- ✓ Establish the 2018 Value-Based Payment Innovation Community; clarify participant expectations and role of the Coach/Facilitator
- ✓ Provide a brief primer on value-based payment and different payment methodologies
- ✓ Share findings from the organizational readiness assessment; provide guidance on workplans

Our Purpose

This Innovation Community will support behavioral health and primary care providers in understanding the policy and trends shaping value-based payment methodologies, the payment reform continuum, and the transformations required in clinical and business practices to succeed under value-based contracts.

Participants- 2018 Winter Cohort

- Heartland Health Outreach, Inc.
- Rincon Family Services
- Maine Behavioral Healthcare
- North Suffolk Mental Health Association
- Healthcare Alternative Systems, Inc.
- Piedmont Health Services, Inc.
- St. Mark's Place Institute
- St. Joseph's Hospital Health Center
- Family Healthcare
- Volunteers of America North Louisiana
- Nulton Diagnostic and Treatment Center
- Edgewater Health
- Sparrow Counseling and Consulting
- Arundel Lodge, Inc.
- West Texas Centers
- Community Care of West Virginia
- Horizon Behavioral Health
- Institute for Sustainable Health and Optimal Aging, University of Louisville
- San Luis Valley Behavioral Health Group
- Sequel Youth and Family Services
- Comprehensive Health and Family Services
- Terros Health

Expectations of Participants

1. Participants will take part in individual and small group coaching calls/webinars, and list serve discussions that will address the educational needs of participants and provide practical resources and tools.
2. By the end of this Innovation Community, participants will have completed a readiness assessment, identified concrete goals, and created a work plan that lays out their next steps and tools needed to achieve their stated outcomes.

The "Quadruple Aim"

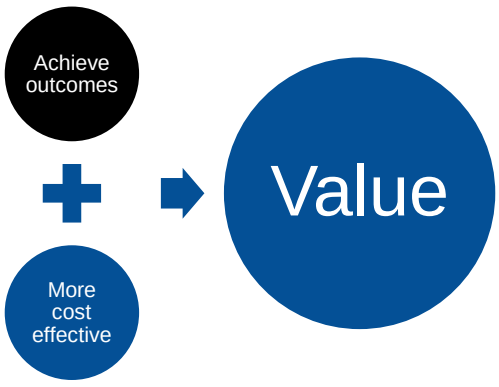
Population Health

Experience of Care

Per Capita Cost

Provider Satisfaction

What is Value-Based Payment?



The Fee for Service Treadmill

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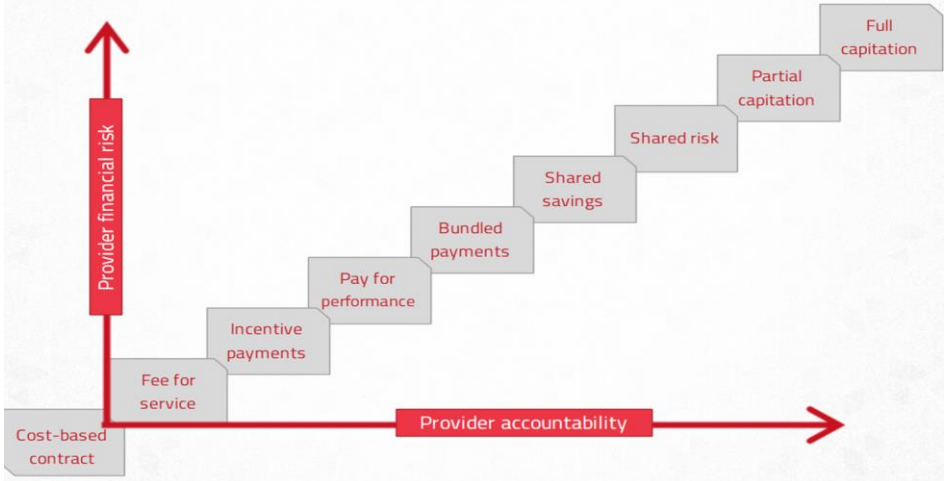
Figure 1. APM Framework (At-A-Glance)

Category 1	Category 2	Category 3	Category 4
Fee for Service – No Link to Quality & Value	Fee for Service – Link to Quality & Value	APMs Built on Fee-for-Service Architecture	Population-Based Payment
	A Foundational Payments for Infrastructure & Operations	A APMs with Upside Gainsharing	A Condition-Specific Population-Based Payment
	B Pay for Reporting	B APMs with Upside Gainsharing/Downside Risk	B Comprehensive Population-Based Payment
	C Rewards for Performance		
	D Rewards and Penalties for Performance		

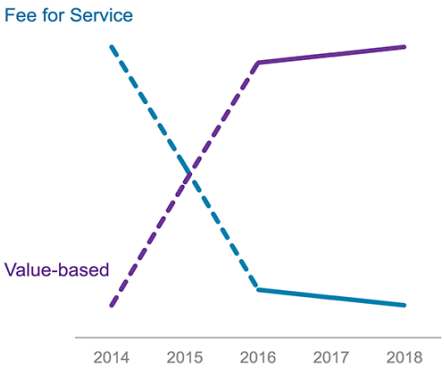
https://hcp-lan.org/

VALUE-BASED PAYMENTS

PAYMENT MODELS CONTINUUM



Acceleration of Value-Based Payment CMS



Source: HHS Press Release, January 26, 2015

HHS Value-Based Payment Goals

2016
30% of contracts will have alternative payment models (such as ACOs or bundled payments). 85% will be tied to quality or value through programs such as VBP or readmission reduction.

2018
50% of contracts to be tied to alternative payment models and 90% to quality or value overall.

HHS = Health & Human Services, **CMS** = Center for Medicare/Medicaid Services,
ACO = Accountable Care Organization, **VBP** = Value Based Payment

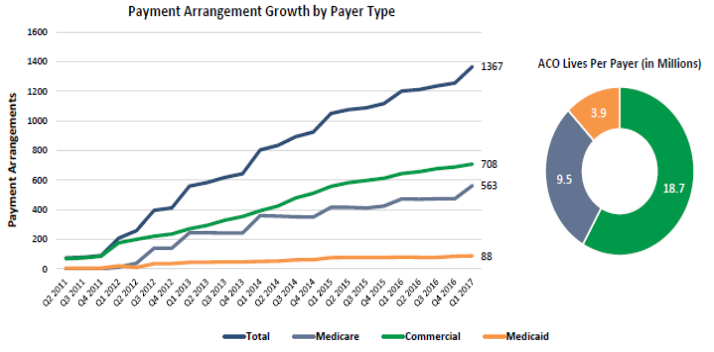
What is MACRA?

Medicare Access and CHIP Reauthorization Act (MACRA) of 2015:

- Repeals the Sustainable Growth Rate (SGR) formula
- Creates a new Quality Payment Program (QPP) by streamlining existing programs (Physician Quality Reporting System, Meaningful Use, and Value-based Payment Modifier)
- Adds "Improvement Activities" Category- includes many relevant to behavioral health and care coordination

ACO GROWTH BY PAYER

LEAVITT PARTNERS



Source: *Leavitt Partners Center for Accountable Care Intelligence*

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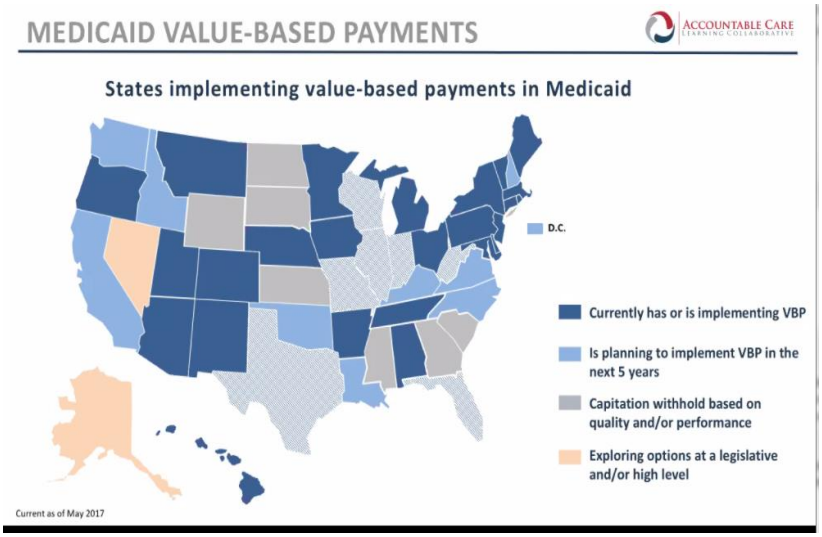

Exhibit 3: Overview of State Models

State	Program Scope	Medicaid Population Covered	Behavioral Health Delivery Model	VBP Strategy Based on LAN APM Framework*	Authority
Arizona	Statewide	Individuals with a serious behavioral health diagnosis	Specialty managed care carve-in	RBHAs choose strategies from Categories 2, 3 or 4	MCO contract requirements via 1915(b) waiver
Maine	Defined communities	Individuals receiving services in "Accountable Communities"	Medicaid ACO	Category 3	State Plan
New York	Statewide	Individuals with specific chronic conditions, including behavioral health	Managed care carve-in/ specialty managed care carve-in	Both Categories 3and 4	Delivery System Reform Incentive Payment (DSRIP) Program, 1115 waiver
Tennessee	Statewide	Individuals with a behavioral health diagnosis and/or meets related utilization criteria	Managed care carve-in	Category 2	State Plan
Pennsylvania	Statewide	Individuals with a co-occurring serious behavioral/ physical health condition	Managed care carve-out	Medicaid MCO pay-for-performance**	MCO contract requirements via 1915(b) waiver

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Certified Community Behavioral Health Clinics (CCBHCs)

- Minnesota
- Missouri
- New York
- New Jersey
- Nevada
- Oklahoma
- Oregon
- Pennsylvania

Table 1. Rate Elements of CC PPS-1 and CC PPS-2

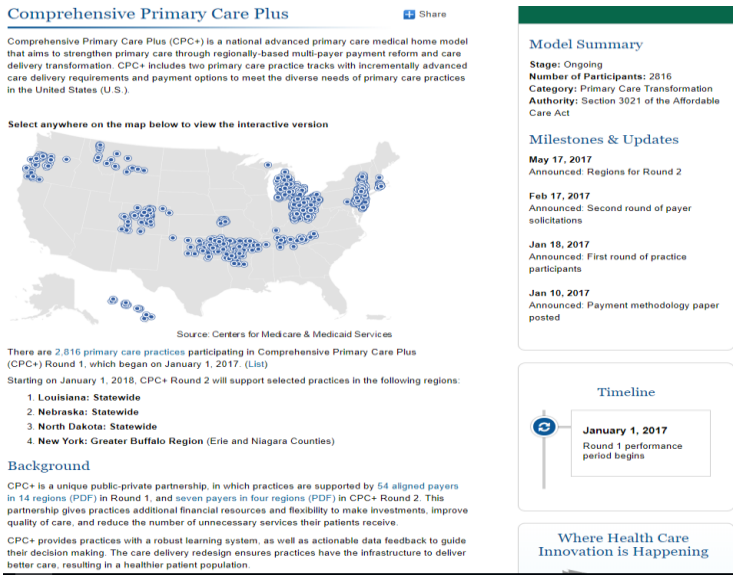
Rate Element	CC PPS-1	CC PPS-2
Base rate	Daily rate	Monthly rate
Payments for services provided to clinic users with certain conditions[12]	NA	Separate monthly PPS rate to reimburse CCBHCs for the higher costs associated with providing all services necessary to meet the needs of special populations
Update factor for demonstration year 2	Medicare Economic Index (MEI)[13] or rebasing	MEI or rebasing
Outlier payments	NA	Reimbursement for portion of participant costs in excess of threshold
Quality bonus payment	Optional bonus payment for CCBHCs that meet quality	Bonus payment for CCBHCs that meet quality measures detailed

Acceleration of Value-Based Payment-Private Insurance

- In the private sector, the Health Care Transformation Task Force, made up of insurers and providers, has pledged to convert 75 percent of their business to value-based payments by 2020.

Multi-Payer Alignment

- Aligning core quality measures, approaches to risk adjustment/stratification, and attribution or assignment



Comprehensive Primary Care Plus

Share

Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States (U.S.).

Select anywhere on the map below to view the interactive version

Source: Centers for Medicare & Medicaid Services

There are 2,816 primary care practices participating in Comprehensive Primary Care Plus (CPC+) Round 1, which began on January 1, 2017. (List)

Starting on January 1, 2018, CPC+ Round 2 will support selected practices in the following regions:

1. **Louisiana: Statewide**
2. **Nebraska: Statewide**
3. **North Dakota: Statewide**
4. **New York: Greater Buffalo Region** (Erie and Niagara Counties)

Background

CPC+ is a unique public-private partnership, in which practices are supported by 54 aligned payers in 14 regions (PDF) in Round 1, and seven payers in four regions (PDF) in CPC+ Round 2. This partnership gives practices additional financial resources and flexibility to make investments, improve quality of care, and reduce the number of unnecessary services their patients receive.

CPC+ provides practices with a robust learning system, as well as actionable data feedback to guide their decision making. The care delivery redesign ensures practices have the infrastructure to deliver better care, resulting in a healthier patient population.

Model Summary

Stage: Ongoing
Number of Participants: 2816
Category: Primary Care Transformation
Authority: Section 3021 of the Affordable Care Act

Milestones & Updates

May 17, 2017
Announced: Regions for Round 2

Feb 17, 2017
Announced: Second round of payer solicitations

Jan 18, 2017
Announced: First round of practice participants

Jan 10, 2017
Announced: Payment methodology paper posted

Timeline

January 1, 2017
Round 1 performance period begins

Where Health Care Innovation is Happening

VBP Organizational Readiness Assessment: Key Domains

1. Understanding of different approaches to value based payment: how well an organization understands the payment reform continuum and common terminology used in value-based payment.

Key Domains, continued

2. **Continuous Quality Improvement (CQI):** to what extent the organization uses an ongoing, structured approach to using quality improvement tools and data to improve organizational processes with the goal of increasing the efficiency and effectiveness of clinical and administrative services.

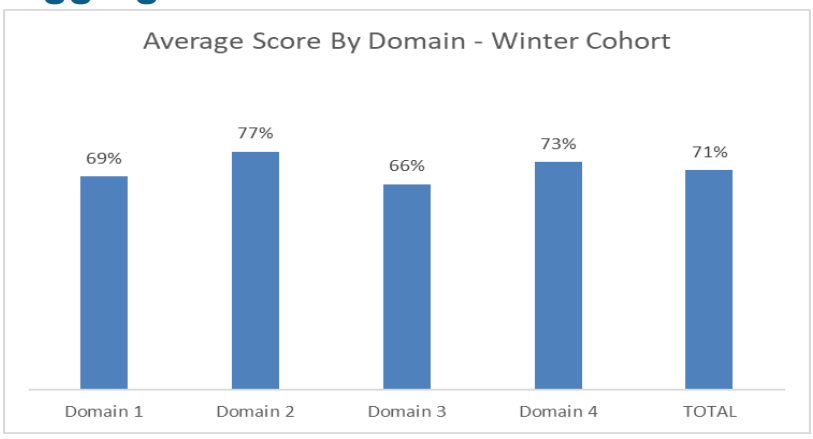
Key Domains, continued

3. **Financial Readiness**: The ability of an organization to predict, describe and analyze costs related to the execution of administrative and clinical services.

Key Domains, continued

4. **Population Health Management:** how prepared is the organization to improve the health outcomes of a group by monitoring and identifying individual patients within that group.

VBP Readiness Assessment: Aggregated Baseline Results



VBP Readiness Assessment: Opportunities for Growth/Improvement

3.8) Our organization has implemented efficiency systems such as LEAN or Six Sigma. (16 strongly disagree or disagree)

1.3) Our organization has experience managing at least one value-based contract. (9 strongly disagree or disagree)

3.9) Our organization has a strategy for coordination of payment reform strategies across different payer types. (9 strongly disagree or disagree)

4.2) Our organization has predictive analytics tools to identify patients at high risk of poor health outcomes or high utilization of services. (9 strongly disagree or disagree)

What do Payers Want?

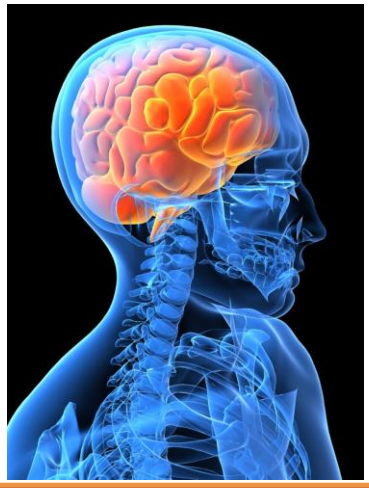
What Do Payers Want? continued

- Lower costs (appropriate utilization)
- Better care (demonstrated outcomes)
- Patient satisfaction
- Predictability
- Integration of behavioral health and primary care
- Social Determinants addressed
- Shared risk

Integrated Care and Value-Based Payment

"Mental health and primary care are inseparable; any attempts to separate the two leads to inferior care."

(Institute of Medicine, 1996)



The Impact of Integrated Care: A Sampling of the Evidence

- ✓ "High-quality evidence from more than 90 studies involving over 25,000 individuals support that the CCM (Collaborative Care Model) improves symptoms from mood disorders and mental health-related quality of life." (Millbank Fund, May 2016)
- ✓ "Integrating behavioral health and primary care, when adapted to fit into community practices, reduced depression severity and enhanced patients' experience of care. Integration is a worthwhile investment." (Journal of the American Board of Family Medicine, March 2017)
- ✓ Increasingly, reports from the field reflect that integration of behavioral health has resulted in dramatic increases in workflow productivity of the primary care team (e.g., South Central Foundation in Alaska)

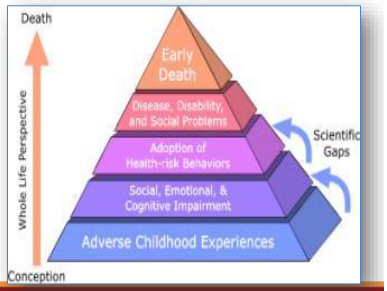
Economic Impact of Integrated Care

- ✓ Patients with chronic medical and comorbid mental health/substance use disorder (MH/SUD) conditions cost **2.5-3.5 times more as those without**
- ✓ Estimated at $293 billion more in 2012 across commercially-insured, Medicaid, and Medicare beneficiaries in the United States
- ✓ Most of the increased cost is attributed to medical services (not behavioral)
- ✓ The study concluded that "Effective integration of medical and behavioral care could save $26-$48 billion annually in general health care costs", with most of the projected reduced spending associated with facility and emergency room expenditures in hospitals.

Milliman, Inc. 2014

The Adverse Childhood Experience Study (ACES) at the Foundation of all Health

- Over 17,000 adults studied from 1995-1997
- Almost 2/3 of participants reported at least one ACE, and over 1/5 reported three or more ACEs, including abuse, neglect, and other childhood trauma
- Major links identified between early childhood trauma and long term health outcomes, including increased risk of many chronic illnesses and early death



Life-Long Physical, Mental & Behavioral Health Outcomes Linked to ACEs

- Alcohol, tobacco & other drug addiction
- Auto-immune disease
- Chronic obstructive pulmonary disease & ischemic heart disease
- Depression, anxiety & other mental illness
- Diabetes
- Multiple divorces
- Fetal death
- High risk sexual activity, STDs & unintended pregnancy
- Intimate partner violence—perpetration & victimization
- Liver disease
- Lung cancer
- Obesity
- Self-regulation & anger management problems
- Skeletal fractures
- Suicide attempts
- Work problems—including absenteeism, productivity & on-the-job injury

Common Pitfalls

- Changing the practice without changing the culture
- Not trying a “phased-in” approach
- Inadequate data systems for population health management
- Inadequate clinical quality improvement processes
- Inadequate staff training
- Poor communication (do clinical staff understand what is in the contract?!)
- Lack of productivity targets and/or inefficient processes
- Not knowing actual cost of services

Financial Challenges

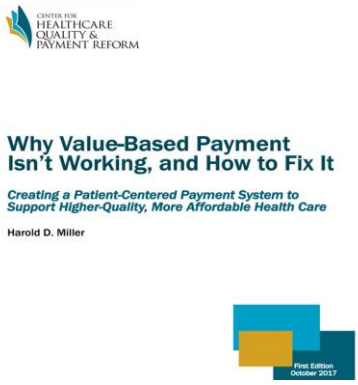
Forecasting:

- Do we know our actual unit costs?
- Do we know our utilization patterns? Do we have competency around predictive analytics?
- Can we accept the risk? Even if its “upside only?” How much can we accept?
- How will it impact cash flow, profitability, and our need for financial reserves?
- What new services, staff, and infrastructure do we need to be successful? How do we need to budget for this?

What Data Do You Need to Succeed?

- Utilization patterns
- Morbidity risk
- EHR data
  - Needs aggregating
  - Supplement with disease registries, care management software
- Claims data
- Patient satisfaction data
- Hospital admissions, readmissions and Emergency Room utilization

Is Value Based Payment Achieving Its Intended Goals?



"None of the "value-based payment" and "value based purchasing" systems that are commonly being implemented today truly correct the problems with Fee-for-Service payment. Moreover, they can create new problems for patients that do not exist in the Fee-for- Service system, such as risks of under-treatment and reduced access to care, and they can create new administrative burdens for healthcare providers that can also reduce access to quality care or lead to consolidation of providers and ultimately to higher prices for services."

"Bundled payment approaches pose significant operational challenges…the payment system must account for differences in the illness severity of different patient populations…In the absence of adequate case mix adjustment, providers may not want to care for the sickest patients for fear of being financially liable for their inherently more expensive care. On the other hand, if the bundled payment amount is significantly higher for patients who are sicker or more complex, providers may try to code patients as being sicker. "

-Rand Corporation https://www.rand.org/pubs/technical_reports/TR562z20/analysis-of-bundled-payment.html

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Next Steps…

- Group webinar February 7th 3pm ET
- Do background reading
- Develop organizational workplan
- Schedule individual coaching calls

S.M.A.R.T. Goals

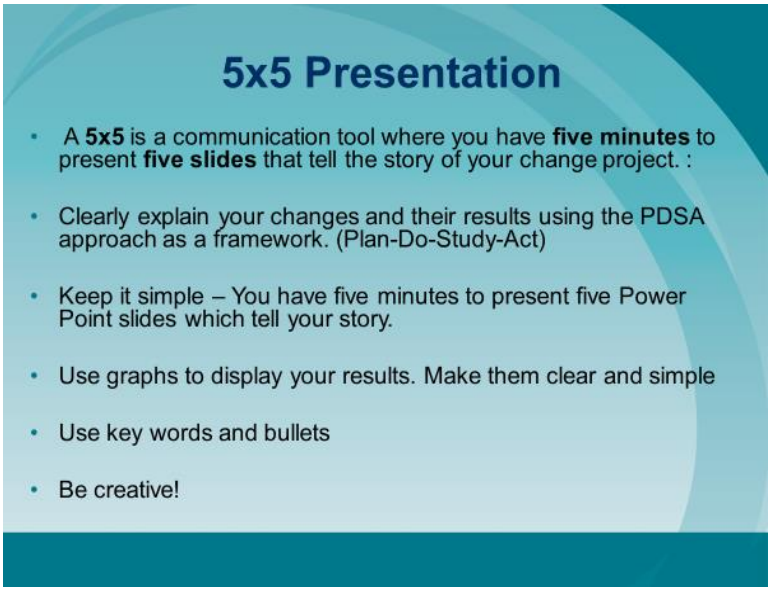
Specific
Measurable
Attainable (or Actionable)
Realistic
Timebound

Sample Agency Goals, VBP Innovation Community

- By May 30, implement a professional development plan to increase staff readiness to succeed under value based payment
- By May 30, develop a continuous quality improvement process to track outcomes and use data to inform clinical processes and protocols
- By May 30, develop a potential case rate for a defined scope of services that can be proposed to a payer
- Other goals – what will make your participation worthwhile?!

SAMPLE Workplan

Goal(s)	Objective(s)	Action Step (s)	Person(s) Responsible	Timeline(s)	Notes
By May 30, 2018, XYZ agency will be ready to track outcomes on key performance indicators, thus preparing the agency to success under a pay-for-performance contract	Develop a continuous quality improvement process to track outcomes and use data to inform clinical processes	1. Create CQI team to meet monthly 2. Conduct analysis of what data is currently available (data mapping) 3. Identify which key performance indicators are most important to track 4. Implement rapid cycle improvement processes	Betsy Cohen, COO Danny Klein, CQI Director	1. By Feb 28 2. By March 31 3. By April 30 4. By May 30	Data sources to include EHR, care management software, Medicaid claims, grant specific access database



Recommended 5X5 Content

- What you set out to do (agency goals)
- How you did it
- What went well (achievements)
- Challenges encountered and how you overcame them
- Impact
- Next steps

Discussion