Provider Readiness - Providing A Framework For Value-Based Purchasing

Darryl Donlin, LCSW, MBA - Senior Associate, OPEN MINDS
Steve Remillard, MA, DC, Bureau Director, Department of Human Services | OMHSAS
April 26, 2018
Agenda

I. Setting The Stage For Value-based Purchasing In Pennsylvania
II. Preparing For Success With Value-based Purchasing
III. Case Study: Core Competencies For Value-based Purchasing
IV. Sharing Value-based Purchasing Model Case Scenarios
V. Next Steps
VI. Questions & Discussion
Today’s Speaker

Darryl Donlin, LCSW, MBA
Senior Associate, OPEN MINDS

Areas of Expertise

- Managed care program operations
- Marketing strategy, marketing planning, and marketing management
- Business development and customer relationship management
- Clinical program design and development

Professional Highlights

- Vice President, Network Operations, New Directions Behavioral Health
- Director, Community Resources, Bergen’s Promise
- Senior Manager, Solution & Segment Marketing, The Trizetto Group
- Director of Marketing, Catalyst Health Solutions
Today’s Speaker

Steve Remillard, MA, DC
Bureau Director, Department of Human Services | OMHSAS

Areas of Expertise

- Variety of mental health settings, including inpatient, outpatient, partial, SAP and incarceration
- Value-based reimbursement
- Optimizing health through integrated care strategies
- Academic teaching and researching positions

Professional Highlights

- Bureau Director for Quality Management and Data Review at the PA Department of Human Service’s Office of Mental Health and Substance Abuse Services
- Masters Degree in Clinical Psychology
- Doctor of Chiropractic Medicine
- Professor of Psychology and Integrated Care concepts
I. Setting The Stage For Value-Based Purchasing In Pennsylvania
VALUE-BASED PURCHASING (VBP)
THE CORE CONCEPT

Encouraging providers and purchasers to

- Rethink
- Reengineer
- Transform

how care is delivered while achieving higher quality outcomes and controlling cost growth.
### OMHSAS VBP Framework

<table>
<thead>
<tr>
<th>Risk Category (Small, Medium, Large)</th>
<th>VBP Model</th>
<th>Description</th>
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<tbody>
<tr>
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<tr>
<td>S</td>
<td>1</td>
<td><strong>Performance-based Contracting (PBC):</strong> Contracts in which payment is linked to provider performance and requires providers to undertake specific activities or meet certain benchmarks for services. These contracts may include incentives and penalties, caseloads and Pay-for-Performance.</td>
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<tr>
<td>L</td>
<td>6</td>
<td><strong>Capitation + Performance-based Contracting:</strong> This payment arrangement adds performance based contracting as a supplemental incentive to a capitation contract.</td>
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<tr>
<td>CONTRACT YEAR</td>
<td>YEAR 1 (CY2018)</td>
<td>YEAR 2 (CY2019)</td>
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<tr>
<td>VBP Requirement</td>
<td>5%</td>
<td>10%</td>
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<tr>
<td>VBP Models</td>
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<tr>
<td>1. Performance-Based Contracting (S)</td>
<td>Any combination of models 1–6.</td>
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<tr>
<td>2. Bundled and Episodic (M)</td>
<td>At least 50% of the 10% must be from a combination of models 2–6.</td>
<td>At least 50% of the 20% must be from a combination of models 2–6.</td>
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II. Preparing For Success With Value-Based Purchasing
High-Level Roadmap To Value-Based Purchasing Readiness

Understanding Population Health Management

Leveraging Data Analytics

Defining Target Populations

Developing Customized Interventions

Selecting Performance Measures

Defining Outcomes

Selecting Most Appropriate VBP Methodology

Developing Organizational Infrastructure

Reassess, Refine, Recalibrate
Purchasers Are Moving To Value-Based Purchasing – Achieving The Triple Aim

Value-Based Purchasing:

- **Lowers per-capita spending** by creating better interventions and focusing on value over volume of services.
- **Improves quality of care, outcomes, and population health** by directly linking provider payment to quality and outcomes.
- **Enhances consumer experience and satisfaction** through a new focus on patient engagement and education as a means to achieve quality benchmarks.
Population Health Management Is The Key

- A population health management (PHM) program strives to address health needs at all points along the continuum of health and well-being through participation of, engagement with, and targeted interventions for the population.

- The Pareto Principle or 80/20 rule where 80% of the effects come from 20% of the causes

- In health care, 50% of the costs come result from 5% of the population

- PHM prioritizes what is happening with the 5% and then address other segments of consumers

**PHM Goal**

Maintain or improve the physical and psychosocial well-being of individuals through cost-effective and tailored health solutions
Understanding Important Data Clusters & Trends

Capturing patient-specific data from across the patient population accomplishes crucial PHM steps:

1. Segment population into key patient groups (demographic, diagnosis, disease state, spend, utilization, etc.)
2. Create sub-groups of patients based on risk level
3. Develop evidence-based interventions that address root causes of risk

Important Data Elements

- Member demographics
- Health plan coverage type
- Primary care physician
- Co-pay
- Diagnosis
- Lab results
- Medication
- Social determinants/life domain challenges
Defining High Risk High Need Consumers

- Consumers with behavioral disorders are often ‘superutilizers’ of health care resources.
- Undiagnosed and/or untreated behavioral health conditions hinder the treatment of a wide range of medical conditions.
- Consumers with behavioral disorders and comorbid chronic medical conditions have higher average costs than those consumers without comorbid conditions.
- Lack of integrated care coordination – addressing the medical, behavioral, and social needs of consumers - results in poorer outcomes and higher cost per consumer.

The total cost of care for Medicaid consumers with a comorbid medical condition and behavioral health diagnosis is **3 to 5 times** more than members with only a medical diagnosis.
Question:

How does my organization know if we are selecting the right target population to focus our efforts and improve quality of service delivery and outcomes?
Improving Patient Outcomes Using Evidence-Based & Customized Interventions

- Increase the consistency of care delivery to improve the chances of achieving optimal treatment outcomes by following evidence-based guidelines.
- Create customized patient interventions based on root cause of risk factors.
- Together these factors will improve patient outcomes across the targeted population.

Examples of Evidence-Based Practices:

- Motivational Interviewing
- Cognitive-behavioral Therapy
- Relapse Prevention
- Family Intervention
Substance Abuse & Mental Health Services Administration (SAMHSA) Resource

Examples of Evidence-Based Practices

- Illness Management and Recovery
- Integrated Treatment for Co-Occurring Disorders
- Supported Employment
- Assertive Community Treatment
- Family Psychoeducation

Making The Process Easier And More Relevant

Important Considerations

- Analyze and track the clinical information being captured in the data warehouse that can be used to demonstrate improved performance over time.
- Ensure quality improvement goals are focused and clearly connected to improving clinical performance.
- Verify selected measures and outcomes to address contractual requirements of the funding entity (such as government, managed care organization, employers, etc.).
- Sync reporting of performance measures with value-based contractual requirements. (For example, 30 day readmission rates, follow-up after hospitalization for mental illness, initiation/engagement of alcohol and other drugs, etc.)
- Work with payers to identify baseline for selected measures.
## Most Commonly Used Performance Measures Of Specialty Provider Organizations, 2016-2018

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
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<tbody>
<tr>
<td>Follow-up after hospitalization for mental illness</td>
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<td>Emergency room utilization</td>
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<tr>
<td>Readmission rates</td>
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<td>Patient or consumer satisfaction</td>
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<td>Use of evidence-based care protocols</td>
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<td>Access to care measures</td>
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<td>Diabetes screening for people with Schizophrenia using an antipsychotic</td>
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<tr>
<td>Antidepressant medication management</td>
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<tr>
<td>Appropriate referrals to other providers</td>
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<tr>
<td>Depression monitoring via PHQ-9</td>
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<td>Medical collaboration</td>
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<td>Involvement of family/significant other</td>
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<tr>
<td>Initiation/engagement of alcohol and other drugs</td>
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<tr>
<td>Diabetes care – blood sugar controlled</td>
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<td>Adherence to antipsychotic medication for people with schizophrenia</td>
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<td>Use of depression screening and follow-up</td>
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*Where Are Behavioral Health & Social Service Organizations With Value-Based Reimbursement? The Numbers Are In*

## Measure Performance With Defined Outcomes

### Measuring Treatment Response

Measuring treatment response is an effective quality measure.
- Depression screenings
- Initiation and maintenance of antidepressant medication therapy
- Depression remission
- Identification and treatment of substance use disorders

### Process Measures

These typically illustrate provider or consumer adherence to care improvement processes and are substitutes when outcomes may be difficult to calculate.
- Scheduling appointments for 7- and 30-day follow-up after hospitalization for mental illness
- Treatment initiation and engagement benchmarks for substance use disorder
- Notification of inpatient admission

### Outcome Measures

These are quantitative outcomes that demonstrate whether or not a targeted goal was achieved.
- Actual percentage for 7- and 30-day readmissions
- Actual percentage of “kept appointments” for 7-and 30-day follow-up after hospitalization for mental illness

### Social Determinants Of Health Measures

Many behavioral health conditions contribute directly to deficits in social determinants of health. Measurements of social determinant outcomes can illustrate high quality behavioral health outcomes.
- Employment status
- Housing status
- Education status
- Quality of life
- Independent living

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Question:

What type of measure would be more important to track – a process measure or an outcome measure?
Reimbursement Moving From Volume To Value To Support “Integrated Care Coordination”

Compensation Continuum By Level Of Financial Risk

- **Small % Of Financial Risk**
  - Fee-for-service
  - No Financial Accountability
  - Management Via 100% Case By Case External Review
  - Passive Involvement

- **Moderate % Of Financial Risk**
  - Performance-Based Contracting
  - Moderate Financial Accountability
  - Internal Ownership Of Performance Using Internal Data Management
  - Provider Engaged

- **Large % Of Financial Risk**
  - Bundled & Episodic Payments
  - Full Financial Accountability
  - Internal Ownership Of Performance Using Internal Data Management
  - Provider Active In Management

- **Shared Risk**
  - Shared Savings

- **Capitation**
  - Capitation + Performance-Based Contracting
  - Providers Assumes Accountability
Value-Based Payment Models As Defined by HealthChoices:

- **Performance-based Contracting**
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III. Case Study: Core Competencies For Value-Based Purchasing
Financial Management & Leadership Core Competencies For Value-Based Purchasing Readiness

1. Strategic Alignment Around Population Health
2. Culture Of Innovation
3. Workforce Adequacy
4. Revenue Cycle Effectiveness
5. Claims & Encounter Reporting
6. Value-Based Payment Capabilities
7. Financial Performance Monitoring
Value-Based Readiness Case Study: Spectrum Health & Human Services

A New York State case study with many similarities to Pennsylvania

New York is investing $8 billion for comprehensive Medicaid delivery and payment reform primarily through a Delivery System Reform Incentive Payment Program (DSRIP).

The state roadmap aims to have 80 – 90% of all managed care payments to providers using value-based payment methodologies by mid-year 2020.

The state will use a prospective payment model based upon a daily rate with a value-based component.
Strategic Alignment Around Population Health Management

Alignment of leadership around population health management, adequate technology infrastructure, and financial resources to accept risk and deliver outcomes.

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Challenges</th>
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</table>
|• Reorganize leadership structure from a program-centric structure to a client-centric structure breaking down program silos  
• Build out data collection, management, analysis, and reporting infrastructure|• Educate staff and create an organizational vs. program view of clients, resources, and outcomes  
• Create a data model that incorporates components of costs, revenues, operational efficiencies, and clinical outcomes|
# Culture Of Innovation

Ability to develop new service models, staff openness to change, and commitment to adapt and realign current services.

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<td>• Work with managed care organizations to identify gaps in care and services to fill</td>
<td>• Current environment makes it hard to innovate and maintain current levels of service and quality</td>
</tr>
<tr>
<td>• Promote managers who embrace change and allow staff to “think outside the box”</td>
<td>• Innovation often has to start by using existing capacity and stretching already limited resources</td>
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Workforce Adequacy

Ability to attract and retain the right level of staff and complement of specialized positions, talent, and experience.

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<td>• Create an organizational training plan focusing on current best practices</td>
<td>• Create ways to incentivize and reward staff for efficiency and effectiveness</td>
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<tr>
<td>• Make hiring decisions based on future needs</td>
<td>• Address competition from the private and public sector for specialized skill sets and experienced employees</td>
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<tr>
<td>• Regularly evaluate pay scale and benefit packages</td>
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Revenue Cycle Effectiveness

Ability to align clinical, operation, and financial processes to meet contractual requirements and maximize cash flow.

**Opportunities**
- Review revenue cycle policy, procedures, and workflows and build in efficiencies
- Quantify your expectations and evaluate against these standards
- Determine your Revenue Cycle Management (RCM) metrics and benchmarks and review them regularly

**Challenges**
- Create strong working relationships with your payers at the individual employee level
- Being patient, but firm, with your payers as they discover and fix their errors as reimbursement methods change
Claims & Encounter Reporting

Ability to capture, analyze, and report granular utilization data to payers.

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<tr>
<td>• Understand your billing systems and assure that you can regularly capture clean, accurate, and timely data</td>
<td>• Keep pace with technological advances and rapidly improving capacity for data capture, reporting and analysis</td>
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<tr>
<td>• Provide your management and supervisory staff with self-service analytic tools and data visualizations</td>
<td>• Build data models that move beyond encounters and measures operational efficiencies, financial performance and clinical outcomes</td>
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## Value-Based Payment Capabilities

Ability to track data, manage contractual outcomes, and meet requirements to earn value-linked payments.

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<td>• Define your client populations, identify them in your EHR and billing system, and aggregate your data at the population level</td>
<td>• Retooling current accounting cost center structure to easily capture costs at the population level</td>
</tr>
<tr>
<td>• Develop methods to capture costs and revenues at the population level, as opposed to the traditional program level</td>
<td>• Identify, capture, and book value-based payments separately</td>
</tr>
<tr>
<td>• Clearly understand your contract outcomes and cost targets, and evaluate performance against goals</td>
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# Financial Performance Monitoring

Ability to monitor actual financial results against contracts, budgets, and forecasts.

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<td>- Create budget models that set standards and expectations for key financial drivers to support fiscal viability</td>
<td>- Find, train, and retain expertise in fiscal modeling and financial scenario construction</td>
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<td>- Measure actual performance against expectations regularly, understand environmental variances, and make adjustments accordingly</td>
<td>- Truly understanding population health management and it’s financial implications</td>
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IV. Sharing Value-Based Purchasing Model Case Scenarios
Bundled Payments – Substance Abuse

Optum Behavioral Health’s Bundled Payment for Medication Assisted Treatment (MAT)

Optum Behavioral Health pays addictions treatment providers a single, bundled payment for medication-assisted treatment.

This bundles MAT, psychosocial supports, labs to monitor adherence, and counseling into a single, standardized monthly payment.

Providers are given enhanced payment for meeting quality measures.

This payment mechanism:
- Decreases the consumer’s out-of-pocket costs and improves adherence to care
- Improves provider adherence to person-centered care and best practices

Results

- Fewer Emergency Room (ER) Visits: 35%
- Fewer Inpatient Admissions: 25%
- Less Total Medicaid Spend: 35%

Monitored a cohort of consumers and conducted a six month before and after analysis after finishing the program.
Bundled Payments – In-Home Treatment With Targeted Case Management

New Directions Behavioral Health’s Bundled Payment for Assertive Community Treatment Teams (ACT)

New Directions Behavioral Health contracts with community mental health centers to provide enhanced “ACT” services through a weekly bundled payment.

Services include: “on-site meet and greets” that occur prior to discharge from inpatient facility, in-home therapy by independently licensed clinician, full assessment, targeted case management, weekly collaboration with ND case managers and reporting.

Payment mechanism:
- Per Case weekly bundle
- Three different CPT codes high, medium and low rates to mirror level of clinical intensity
- Provides win-win for provider and payer

Results
- Lower Cost Per Case After 90 Days (50%)
- Fewer Readmissions After 90 Days (28%)
- Fewer ER Admits After 90 Days (71%)

Results based on before and after analysis of admission into program. Savings per member was $4,981.
Assertive Community Treatment (ACT) – This model was described as a 24/7 health home without walls – or ACT team intensive. Each ACT team has 100 consumers, costing $1.6 million per team. This model is financed with performance-based capitation.

A portion of potential payment was tied to performance on defined measures centering on access, quality, satisfaction, and utilization/cost.

Performance Metrics

- **Fewer** Inappropriate ER visits For Assigned Consumers
- **Less** In Readmission Rates
- **More** Employment
- **More** Stable Housing Rates
- **More** Primary Care Practice (PCP) Visits

Mercy Maricopa’s Value-Based Care Programs
V. Next Steps
Reassess, Refine, Recalibrate

- Evaluate Outcomes
  - Recalibrate Customized Interventions
  - Review Financial Mgt. & Leadership Structure
  - Re-evaluate Data Analytics
  - Refine The Population
Is Your Organization Ready For Value-Based Payment?

Key Considerations

- Do you have the current financial management resources and leadership structure to move down this path?
- What is your existing data analytics capability to gain insight into what is happening with your highest cost consumers?
- What clinical outcomes measures provide the most impact?
- What types of clinical programs and providers are producing the best results for your most challenging consumers?
- What steps are being taken to improve the consumer experience and become engaged in the treatment process?
Resources

- Value-Based Payment Hits The Tipping Point

- Where Are Behavioral Health & Social Service Organizations With Value-Based Reimbursement? The Numbers Are In

- Remaining Profitable In The Transition To Value-Based Payment

- The Tech Checklist For Value-Based Contracting Success

- Value-Based Reimbursement As Clinical Best Practice Driver
VI. Questions & Discussion
OPEN MINDS market intelligence and technical assistance helps over 180,000 industry executives tackle business challenges, improve decision-making, and maximize organizational performance every day.

Mental Health Services  •  Chronic Care Management  •  Disability Supports & Long-Term Care
Addiction Treatment  •  Social Services  •  Intellectual & Developmental Disability Supports
Child & Family Services  •  Juvenile Justice  •  Adult Corrections Health Care