Value-Based Payment and Behavioral Health — Pennsylvania in the Context of the National Landscape

Mindy Klowden, MNM, Director, Training and Technical Assistance
1. VBP offers a tremendous opportunity for behavioral health.

2. Behavioral Health Providers face unique, but not unsurmountable challenges to success in VBP.

3. Innovation is happening at the federal and state level.

4. Partnerships are essential for success under VBP.
Among those with a substance use disorder:
- 3 IN 8 (36.4%) struggled with illicit drugs
- 3 IN 4 (75.2%) struggled with alcohol use
- 1 IN 9 (11.5%) struggled with illicit drugs and alcohol

Among those with a mental illness:
- 1 IN 4 (24.0%) had a serious mental illness

7.6% (18.7 MILLION) People aged 18 or older had a substance use disorder

3.4% (8.5 MILLION) 18+ HAD BOTH substance use disorder and a mental illness

18.9% (46.6 MILLION) People aged 18 or older had a mental illness

See figures 40, 41, and 54 in the 2017 NSDUH Report for additional information.
Despite Consequences and Disease Burden, Treatment Gaps Remain Vast

PAST YEAR, 2017

- Substance Use Disorder (SUD) 12+:
  - No Treatment: 46.6 M
  - 92.3%

- Any Mental Illness (AMI) 18+:
  - No Treatment: 46.6 M
  - 57.4%

- Serious Mental Illness 18+:
  - No Treatment: 11.2 M
  - 33.3%

- Co-Occurring AMI & SUD 18+:
  - No Treatment: 8.5 M
  - 91.7%

- Major Depressive Episode (MDE) 12-17:
  - No Treatment: 3.2 M
  - 58.5%

See the 2017 NSDUH Report for additional information.
VBP Opportunity for Behavioral Health

• VBP is a significant opportunity for providers of behavioral health services, given that:
  – Total spending per person for individuals with a behavioral health diagnosis is nearly four times higher than for those without.
  – 20% of Medicaid enrollees who have a behavioral health diagnosis account for almost half of total Medicaid expenditures.
  – 29% of adults with chronic physical health conditions have comorbid mental health conditions.
  – 68% of adults with serious mental illness have comorbid chronic medical conditions.
The Drivers of VBP: The “Quadruple Aim”

- Population Health
- Experience of Care
- Per Capita Cost
- Provider Satisfaction
Challenges for Behavioral Health Providers in Succeeding Under VBP

- Inadequate baseline funding.
- Access to total cost of care data.
- Limited opportunity to benefit from shared savings.
- Upfront transformation costs.
- Implementing sophisticated data analytics.
- Navigating complex confidentiality laws.
- Lack of standardized outcome measures and multi-payer alignment.
Follow-Up After Hospitalization & Readmission Rates Are The Most Popular Measures For Determining Performance

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Follow-up after hospitalization</td>
<td>36%</td>
</tr>
<tr>
<td>Readmission rates</td>
<td>32%</td>
</tr>
<tr>
<td>Emergency room utilization</td>
<td>23%</td>
</tr>
<tr>
<td>Patient/consumer satisfaction</td>
<td>22%</td>
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<tr>
<td>Access to care measures</td>
<td>22%</td>
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</tbody>
</table>
Provider/Organizational Readiness for Value-Based Payment

Enhanced Data Capabilities and Continuous Quality Improvement

Coordinated Delivery Systems and Integrated Care

Culture Shift

Population Health Management Strategies

Sophisticated Fiscal and Business Practices
Basic Business Principle:

Costs < Revenues
Medicaid Health Homes for Persons With Chronic Conditions

- Section 2703 of ACA Medicaid Option – 2014
- CMS Guidance Health Homes SUD/OUD - 2019
- Targets patients with 2+ chronic conditions or SMI/SED/SUD
- Payment Model: PMPM to Provider, Enhanced FMAP for 8 Quarters. Some states layer on additional VBP.
- Six Required Services – Care Management, Care Coordination, Transitions of Care, Health Promotion/Prevention, Patient and Family Support, Access Community Services
As of March 2019, 23 states and the District of Columbia have a total of 38 approved Medicaid health home models.

States with Approved Health Home SPAs (number of approved health home models)

Alabama, California (2), Connecticut, Delaware, District of Columbia (2), Illinois, Iowa (2), Maine (3), Maryland, Michigan (3), Minnesota, Missouri (2), New Jersey (2), New Mexico, New York (2), North Carolina, Oklahoma (2), Rhode Island (3), South Dakota, Tennessee, Vermont, Washington, West Virginia (2), Wisconsin

Note that Idaho, Kansas, Ohio, and Oregon have terminated their Medicaid health home state plan amendments and are no longer providing health home services.
CCBHCs: A New Model

- **8 Demonstration States:**
  - Minnesota
  - Missouri
  - New York
  - New Jersey
  - Nevada
  - Oklahoma
  - Oregon
  - Pennsylvania

- SAMHSA 2018 Grants: 50 providers

- 113 CCBHCs Across the Country

- **Built on the concept that the way to expand care is to pay for it.**

- **National definition re:** scope of services, timeliness of access, etc.

- Standardized **data and quality reporting.**
CCBHCs: Alternative Payment Model

Prospective Payment System (PPS 1 or 2)

- Cost-based reimbursement
- Bundled payments
- Incentivizes Quality
  - Pay for Reporting
  - Pay for Performance/Quality Bonuses
Behavioral Health Provider Participation in Medicaid Value-Based Payment Models: An Environmental Scan and Policy Considerations

July 31, 2019
Center for Health Care Strategies:
Melissa Bailey, MA, LPC, Senior Fellow
Rachael Matulis, MPH, Senior Program Officer
Kelsey Brykman, MS, Program Officer

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## BH VBP Models Around The Country

<table>
<thead>
<tr>
<th>State</th>
<th>Description</th>
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<tbody>
<tr>
<td>Arizona</td>
<td>Arizona’s Health Care Cost Containment System integrated the state’s Medicaid program, and Division of Behavioral Health Services. In 2018, AZ implemented integrated Medicaid managed care contracts that cover PH and BH services while maintaining integrated plans specifically for individuals with SMI. <strong>Arizona has implemented VBP targets in MCO contracts, including for Regional Behavioral Health Authorities.</strong></td>
</tr>
<tr>
<td>Colorado</td>
<td>In 2018 CO launched its Accountable Care Collaborative 2.0 and created Regional Accountable Entities (RAEs). <strong>Behavioral health services remain capitated at the RAE level but RAEs have the flexibility to contract with providers under various payment models.</strong> Primary care services are FFS, with care coordination payments.</td>
</tr>
<tr>
<td>Vermont</td>
<td>Mental health agencies are paid through a <strong>mental health case rate</strong>. Value-based payments are made through a separate quality payment stemming from newly-appropriated funds by the legislature.</td>
</tr>
<tr>
<td>New Hampshire</td>
<td><strong>Capitated payments</strong> for community mental health providers (CMHPs) have been in place for some New Hampshire Medicaid MCOs since 2014 and will be a required model for all MCOs going forward. MCOs pay CMHPs a per member per month (PMPM) fee for four clinical eligibility categories. Payment is tied to quality, though method varies by MCO.</td>
</tr>
<tr>
<td>Tennessee</td>
<td>“Health Link,” Health Home model for individuals with SMI/SUD. Payments for care coordination and care management activities are monthly case rates. Providers are also eligible for <strong>incentive payments</strong> based on quality/efficiency metric performance.</td>
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Key Themes

1. Behavioral health providers have seen benefits from participation in VBP and CCBHC.

2. Broadly defined VBP targets for MCOs do not necessarily result in new payment models for behavioral health providers.

3. Approaches to key VBP design elements, such as attribution and governance, impact behavioral health’s level of involvement in VBP models.

4. State governance structures and policy landscapes impact the extent of VBP adoption for behavioral health.

5. Unique aspects of behavioral health conditions or provider operations may require tailored VBP policy approaches.

6. VBP provides an opportunity to address funding gaps in the behavioral health system in a way that is tied to performance and accountability.

7. Case rate or population-based payment models tied to performance may be more impactful than pay-for-performance (P4P).

8. Developing more meaningful behavioral health-focused quality measures, while reducing overall measurement and reporting burden, is needed to support VBP.

9. Behavioral health providers would likely benefit from technical assistance and infrastructure funding.
Colorado Goal: Improve the health of Coloradans by providing access to integrated physical & behavioral health care services in coordinated systems, with value-based payment structures, for 80% of Colorado residents by 2019.

Participation of up to 400 primary care practices and 4 community mental health centers.

All practices received extensive practice transformation support, and access to enhanced HIT and data.
## National Council’s Care Transitions Network

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<th>Service</th>
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<tr>
<td>Direct Practice Transformation Coaching</td>
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<td>Payer-Provider Forums</td>
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<tr>
<td>Data Dashboards</td>
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<tr>
<td>Financial Utilization Reports</td>
</tr>
<tr>
<td>Training on Evidence-Based Practices</td>
</tr>
<tr>
<td>Targeted Technical Assistance (e.g. Learning communities; Development of Resources/Materials)</td>
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Develop Your Value Proposition

- Explains what benefit your organization provides, for whom, and how you do it uniquely well.

- Builds the case that you are better positioned to meet the community’s need than your competitors.

- A living document that can be updated as needed and is tailored to different audiences.

- Should be CONCISE, CREDIBLE, and make strategic use of DATA.
VBP Requires Strategic Partnerships
Who to Partner With?

Behavioral Health & …

✓ Payers
  ✓ State Medicaid Agency
  ✓ Managed Care Organizations/BHOs
  ✓ Accountable Care Organizations

✓ Primary Care

✓ Other Health & Human Service Providers

✓ Behavioral Health Collaboratives or Independent Provider Associations
Discussion

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