DATA TRACK: IDENTIFYING DATA AND REPORTS NEEDED FOR VBP SUCCESS

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ROADMAP TO VALUE: USE OF DATA

1. Select Target Population and exclusions
2. Choose the VBP Topic Area
3. Set Goals and Performance Measures
4. Calculate the Potential for Interventions to Make an Effect
5. Run the baseline data and set thresholds and payments
6. Implement and Run Data Monitoring
7. Determine Data Needs
8. Achieve Value
FOCUS ON THREE DATA USES WITHIN VBP

• Identification of projects with value
• Setting/determining alternative VBP payments
• Dashboards for on-going monitoring
IDENTIFICATION OF TOPICS WITH VALUE
USE OF DATA TO IDENTIFY VBP PROJECTS
WHERE IS THERE ROOM FOR IMPROVEMENT?

Value

Decrease Costs

Improve Outcomes
**EXAMPLE 1: INDIVIDUALS IN CONGREGATE CARE**

**Define the Target Population**
- Individuals living in Congregate Care

**Set Treatment Goals**
- Prevent hospitalizations through preventive and primary care

**Calculate Potential to Improve Care**
- Potential Improvements:
  - Improve assessments (diagnosis/treatment)
  - Improve case management/follow-up
  - Prevent of hospitalization
<table>
<thead>
<tr>
<th>Provider</th>
<th>Number of Members</th>
<th>Sum of Inpatient Cost CY2018</th>
<th>Average Inpatient Cost/Member CY2018</th>
<th>Sum of BH Inpatient Cost CY2018</th>
<th>Average BH Inpatient Cost/Member CY2018</th>
<th>Total Pharmacy CY2018</th>
<th>Total Pharmacy Paid/Member CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown</td>
<td>15</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$2,908</td>
<td>$193</td>
</tr>
<tr>
<td>Future</td>
<td>20</td>
<td>$507</td>
<td>$25</td>
<td>$-</td>
<td>$-</td>
<td>$8,205</td>
<td>$410</td>
</tr>
<tr>
<td>New Life</td>
<td>18</td>
<td>$4,871</td>
<td>$271</td>
<td>$-</td>
<td>$-</td>
<td>$12,095</td>
<td>$671</td>
</tr>
<tr>
<td>One Care</td>
<td>12</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$-</td>
<td>$38,900</td>
<td>$3,242</td>
</tr>
<tr>
<td>Technology</td>
<td>60</td>
<td>$26,419</td>
<td>$440</td>
<td>$-</td>
<td>$-</td>
<td>$32,014</td>
<td>$534</td>
</tr>
<tr>
<td>Twin Hope</td>
<td>22</td>
<td>$2,582</td>
<td>$117</td>
<td>$-</td>
<td>$-</td>
<td>$9,066</td>
<td>$412</td>
</tr>
<tr>
<td>Provider Subtotal</td>
<td>147</td>
<td>$34,379</td>
<td>$233.87</td>
<td>$-</td>
<td>$-</td>
<td>$103,188</td>
<td>$701.96</td>
</tr>
<tr>
<td>State Total</td>
<td>4,290</td>
<td>$2,796,000</td>
<td>652</td>
<td>179,581</td>
<td>42</td>
<td>$11,083,000</td>
<td>$2,583</td>
</tr>
</tbody>
</table>
EXAMPLE 2: QUALITY OF CARE FOR INDIVIDUALS WITH ODD

Define the Target Population

Patients diagnosed with oppositional defiant disorder (ODD)

Set Treatment Goals

Assessment and diagnosis leads to parent management training, family therapy, problem-solving skills training, social skills programs, and school-based programs. Medication is typically not prescribed to non-comorbid ODD patients

Calculate Potential to Improve Care

Potential Improvements:
• Improve assessments (diagnosis/treatment)
• Reduce medication for non-comorbid patients.
• Improve case management/follow-up
• Prevent of hospitalization and RTF stays
DATA SUPPORTING PARTICIPATION IN VBP

AVG. COST PER INDIVIDUAL PER PROVIDER

PROVIDERS WITH PLURALITY OF VISITS

GP 1
GP 2
GP 3
GP 4
Determine VBP Model Basics

Set Goals and Performance Measures

Goals:
- Provide quality outpatient services that meet the minimum care requirements
- Reduce overall spend including hospitalizations and RTF costs

Performance Measure:
- Percent of individuals meeting minimum care

Determine Data Needs

Data Needs:
- Eligibility member level data
- Participating provider data
- Claims Extract for institutional claims, professional claims and pharmacy claims at the patient level

Reporting:
- Quarterly report to the provider with the plurality of visits
DATA USED TO SET THRESHOLDS

PROVIDERS WITH PLURALITY OF VISITS

AVERAGE COST PER INDIVIDUAL PER PROVIDER

$2700
$1364
$1100
### Quality Metrics Thresholds

<table>
<thead>
<tr>
<th>Minimum care requirement (6 therapy and/or 1 case management visits during the six months following assessment)</th>
<th>Acceptable Threshold</th>
<th>Commendable Threshold</th>
<th>Shared Savings Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>70%</td>
<td>$2,685</td>
<td>$1,364</td>
<td>$1,100</td>
</tr>
</tbody>
</table>

Quality metrics not linked to gain sharing (i.e., informational only):
- Medication with no comorbidity
- Prior ODD diagnosis
- Utilization (excluding medication)
- Utilization of therapy and case management
DATA USED TO SET PAY FOR PERFORMANCE REIMBURSEMENT

ILLUSTRATIVE THRESHOLD PERFORMANCE

The Commendable Threshold is the dollar amount that delineates between the neutral zone and Incentive. If average cost is lower than the Commendable limit, the provider receives a shared savings amount, but based on values above the shared savings limit.

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DATA USED TO SET SHARED RISK PAYMENTS

ILLUSTRATIVE THRESHOLD PERFORMANCE

The Acceptable Threshold is the dollar amount that delineates the providers between the payback and the neutral zone.

The Commendable Threshold is the dollar amount that delineates between the neutral zone and shared savings.

If average cost is lower than the shared savings limit, the provider receive a shared savings amount, but based on values above the shared savings limit.
**Reporting and Payment Timeline for Providers**

**Performance report**
- Rolling report showing historical data

**Reporting timeline assumptions:**
- Quarterly reporting frequency
- 12 month performance period
- 3 month claims lag
- 4-8 weeks to produce, QA and distribute reports
- All performance reports (in blue) will include expected penalty and reward calculations

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**First Performance Period CY2020**

- Q1
- Q1+Q2
- Q1+Q2+Q3
- Q1+Q2+Q3+Q4

**Second Performance Period CY2021**

- Q1
- Q1+Q2+Q3+Q4 (Prelim)
- Q1+Q2+Q3+Q4 (Final)

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CY2019 base report

Q1 Performance report covers full period and estimates payback/shared savings

Provider receives two reports: performance report covering full period with final payback/shared savings and Q1 report of next performance period
## Actual Results Based on CY2017

<table>
<thead>
<tr>
<th>Projected Cost Per Individual</th>
<th>Actual Cost Per Individual</th>
<th>Estimated Savings Per Individual</th>
<th>Percent Savings Per Individual</th>
<th>Number of Individuals Meeting the Criteria</th>
<th>Total Estimated Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,364</td>
<td>$1,187</td>
<td>$177</td>
<td>15%</td>
<td>2,129</td>
<td>$377,683</td>
</tr>
</tbody>
</table>

**2,129 individuals meeting criteria**

<table>
<thead>
<tr>
<th>Minimum care requirement (&gt;= 70%) - Six therapy visits and/or one case management visit in six months following assessment</th>
<th>CY 2016</th>
<th>CY2017</th>
<th>Target Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>73.3%</td>
<td>64.2%</td>
<td>Increase</td>
<td></td>
</tr>
</tbody>
</table>

*Red text = negative movement*
Want to encourage EBPs for specified target populations

Reimbursement models often don’t include costs for on-going training, fidelity, certification, low caseloads and travel

Many community-based EBPs require on-going fidelity monitoring and certification including ACT, MST, FFT & DBT

Proven outcomes and cost benefits when implemented with fidelity – but benefits may accrue to the taxpayer
Staffing – Low Caseloads
- Four teams of 4 MA level therapists
- Licensed supervision

Certification and Training
- Training/Certification costs

Administrative Costs – Travel
- 10% to 20% overhead
- Supplies
- Travel expenses

$7,300 per child

Lower Productivity
- Lost time due to training, travel, and documentation
- Small caseloads
- Only about 3.5 hours spent with children and families on average day
**MST IS AN EBP ALREADY PROVEN COST-EFFECTIVE TO TAXPAYERS**

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Total Benefits</th>
<th>Taxpayer Benefits</th>
<th>Non-Taxpayer Benefits</th>
<th>Costs</th>
<th>Benefits Minus Costs (Net Present Value)</th>
<th>Benefit to Cost Ratio</th>
<th>Chance Benefits will Exceed Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>MST</td>
<td>$14,134</td>
<td>$3,876</td>
<td>$10,258</td>
<td>$(7,973)</td>
<td>$6,161</td>
<td>$1.77</td>
<td>76%</td>
</tr>
<tr>
<td>MST for Juveniles Convicted of Sex Offenses</td>
<td>$14,459</td>
<td>$3,823</td>
<td>$10,636</td>
<td>$(9,056)</td>
<td>$5,404</td>
<td>$1.60</td>
<td>63%</td>
</tr>
<tr>
<td>MST for Juveniles with SUD</td>
<td>$11,851</td>
<td>$3,657</td>
<td>$8,193</td>
<td>$(7,964)</td>
<td>$3,887</td>
<td>$1.49</td>
<td>52%</td>
</tr>
</tbody>
</table>

Source: Washington State Institute for Public Policy
MST
• 94 days in MST ($11,000)
• 9 months in lower level care ($26,000)
• Total: $37,000

RTF/Hospitalization
• 12 month stay in RTF ($46,208)
• 12 months of supporting a child with multiple institutionalizations where each hospitalization/ER visit cost $4,765 on average ($70,600 to $77,300)
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Using Data for Successful VBP Development: Various targets and approaches

• Multisystemic Therapy (MST)
  • Three providers in the Capital Area counties
    (PA Counseling, Adelphoi Village, Hempfield Behavioral Health)
  • OMHSAS VBP Model 2: Bundled and Episodic (Case Rates)

• Keystone Rural Health Center, Chambersburg
  • Single Provider in Franklin / Fulton counties
  • OMHSAS VBP Model 1: Performance Based Contracting

• Family Based Mental Health Services (FBHMS)
  • 9 providers in the Capital Area
  • OMHSAS VBP Model 2: Bundled and Episodic (Case Rates)
VBP Development Process

Step 1: Primary Contractor (CABHC, TMCA) and PerformCare joint analysis

General Considerations

• Meeting the Year One 5% financial threshold
  Amount of dollars involved
  Review of historical data

• Meeting defined quality and/or cost objectives
  Triple Aim and OMHSAS goals

• High probability of provider buy in and success

• A manageable operational process for BH-MCO and Provider(s)

• Planning ideally starts 1 year ahead of time
Step 2: Collaborative process with provider(s), BH-MCO, and Primary Contractor

General Considerations

• 6-12 month process of regular meetings and discussion
• Setting the goals
• Clinical vs. financial considerations
• Review of the proposal
• Data needs, frequency, timeliness, and responsibilities

Step 3: Implementation schedule and project management

• Execution is sometimes the most difficult
Multisystemic Therapy: Why Chosen?

- Evidence-based Practice (EBP) – MST is an intensive family and community-based treatment program that addresses all environments that impact high-risk adolescents and their families.

- Designed to avoid out of home placements (juvenile justice and mental health cost avoidance) with documented outcomes in this area

- Defined treatment period of 3-5 months (12-20 weeks)

- Established providers (3) with an existing weekly case rate Alternative Payment Arrangement.

- An established MST outcomes tool: PIDR (Program Implementation Data Report)
Multisystemic Therapy: Data and Approach

Baseline APA Case Rate Data:

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>Consumers</th>
<th>Units Per Consumer</th>
<th>Episode LOS</th>
<th>Cost Per Episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROV 1</td>
<td>17</td>
<td>83</td>
<td>100</td>
<td>$ 7,785</td>
</tr>
<tr>
<td>PROV 2</td>
<td>86</td>
<td>98</td>
<td>86</td>
<td>$ 7,345</td>
</tr>
<tr>
<td>PROV 3</td>
<td>92</td>
<td>125</td>
<td>97</td>
<td>$ 7,937</td>
</tr>
<tr>
<td>Grand Total</td>
<td>195</td>
<td>110</td>
<td>92</td>
<td>$ 7,645</td>
</tr>
</tbody>
</table>

% OF CASES COMPLETING TX (85% GOAL)

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>% with parenting skills necessary to handle future problems</th>
<th>% with improved family relations</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROV 1</td>
<td>74.0%</td>
<td></td>
</tr>
<tr>
<td>PROV 2</td>
<td>85.6%</td>
<td></td>
</tr>
<tr>
<td>PROV 3</td>
<td>87.1%</td>
<td></td>
</tr>
</tbody>
</table>
Multisystemic Therapy: The Year 1 (Not End) Product

VBP Payment Model

• For 2018-19, the payment model is a modified weekly case rate with associated quality bonuses.
  • Provider self management features:
    No minimum service requirements, but claims must be submitted (service delivered) for the weekly case rate.
    After initial prior authorization, no concurrent review of hours delivered
    • Upon discharge, maximum of $600 incentive payment ($200 for each of three achieved outcomes per case)
      Retention, Parenting Skills, Family Relations
Keystone Rural Health Center: Why Chosen?

- Unique situation - Largest single BH provider, and multi-specialty PH provider. Excellent integrated care opportunities.

- Interest and experience of provider with VBP.

- The current Prospective Payment System (PPS) limited BH-MCO ability to collect/monitor key data, including 7 day routine access.
  Payment methodology – PPS rate + VBP Incentive
  OMHSAS VBP Model 1: Performance Based Contracting

- Concurrent roll-out of the DLA-20 (Daily Living Activities-20) by the Primary Contractor. VBP would provide opportunity for early adoption.
Keystone Rural Health Center: Data and Approach

- Collaboration and negotiation of the 3 parties (provider, BH-MCO, Primary Contractor)
  - DLA-20 (Primary Contractor)
    Research-backed outcomes measurement tool, the Daily Living Activities-20, that could be used across services and age groups.
  - Routine Access (BH-MCO)
    Missing system for collecting routine access performance data.
    Known problem area
  - Interest in expanding evidence-based service (Provider)
    Outcomes-Based Pilot Program for use of Transcranial Magnetic Stimulation (TMS) for Members with Major Depressive Disorder and Bipolar Disorder, episode depressed.
Keystone Rural Health Center: TMS 6-month Results

![Graph showing HAM-D Baseline and HAM-D Ending for 14 patients.](image-url)
Keystone Rural Health Center: Routine Access 6-month Results

<table>
<thead>
<tr>
<th></th>
<th>7 day access</th>
<th>30 day access</th>
<th>2019-20 7 Day Access Target</th>
<th>2019-20 30 Day + Follow Up Access Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Therapy</td>
<td>1% (1/93)</td>
<td>1% (1/93)</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td>Child Therapy</td>
<td>0% (0/77)</td>
<td>0% (0/77)</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td>Adult Psychiatry</td>
<td>4.9% (11/221)</td>
<td>38.5% (85/221)</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td>Child Psychiatry</td>
<td>10.2% (23/226)</td>
<td>35.8% (81/226)</td>
<td></td>
<td>50%</td>
</tr>
</tbody>
</table>

- Keystone developed a routine access reporting methodology, shared quarterly with PerformCare.
- VBP Year 2 includes agreed upon initial targets
- Keystone service model changing to integrated care clinicians
Keystone Rural Health Center: DLA-20 6-month Results

New therapy patients- 54
Completed DLA 20- 34 (63%)
Avg initial score 3.51

- > 6.0 Adequate Independence, no significant to slight impairment in functioning
- 5.1- 6.0 Mild Impairments, minimal interruptions in recovery
- 4.1- 5.0 Moderate Impairment in functioning
- 3.1- 4.0 Serious Impairments in functioning
- 2.1- 3.0 Severe Impairments in functioning
- < 2.0 Extremely severe impairments in functioning

• By end of VBP YR 1, Keystone successfully moved to file transfer process of all DLA-20 score information.

• Administer the DLA-20 to outpatient therapy clients ages 7+ at initial assessment and subsequently at every treatment plan update (120 days), and at discharge (when possible).
Family Based Mental Health Services (FBMHS): Why Chosen?

- A common and extensively used Medicaid service in PA
- Designed to avoid out of home placements
- A specifically defined treatment period of 32 weeks
- Established providers (9) of varying size
Family Based Mental Health Services (FBMHS): Approach

• Tiered Case Rates:

<table>
<thead>
<tr>
<th>Case Rate 1</th>
<th>Covers 0-84 days in Tx (0-12 wks.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Rate 2</td>
<td>Covers 85-168 days in Tx (12-24 wks.)</td>
</tr>
<tr>
<td>Case Rate 3</td>
<td>Covers 169-224 days in Tx (24-32 wks.)</td>
</tr>
<tr>
<td>Case Rate 4</td>
<td>Covers 225+ days in Tx (32+ wks.)</td>
</tr>
</tbody>
</table>

*Case Rate 3 is the desired tier with the highest financial incentive*

• CANS Outcomes
Family Based Mental Health Services (FBMHS): Preliminary Results

Do “successful” Tier 3 FBMHS cases demonstrate cost avoidance by reduced OOH placements?

<table>
<thead>
<tr>
<th>Length of Stay (Days)</th>
<th>Discharges</th>
<th>MH Inpatient</th>
<th>RTF</th>
<th>CRR Host Home</th>
<th>All Placements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) 1-84 days</td>
<td>254</td>
<td>12</td>
<td>10</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>2) 85-168 days</td>
<td>251</td>
<td>12</td>
<td>25</td>
<td>2</td>
<td>39</td>
</tr>
<tr>
<td>3) 169-224 days</td>
<td>1,053</td>
<td>49</td>
<td>12</td>
<td>3</td>
<td>64</td>
</tr>
<tr>
<td>4) 225+ days</td>
<td>81</td>
<td>6</td>
<td>6</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>1,639</td>
<td>79</td>
<td>53</td>
<td>11</td>
<td>143</td>
</tr>
</tbody>
</table>

PerformCare