Value Based Purchasing (VBP)
Technical Assistance for Primary Contractors (PCs)
and Behavioral Health Managed Care Organizations (BH-MCO)

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services (OMHSAS)

May 20, 2020
Agenda

1. Overview of VBP Initiative
2. Using VBP to Inspire and Drive System Change
3. Roadmap of How to Get There
<table>
<thead>
<tr>
<th>Year</th>
<th>Activity</th>
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</table>
| **Year 2** | • June 30, 2020:  
  • Calendar Year (CY) Accomplishments and Outcomes Due  
  • CY Actual Data Submission |
| **Year 3** | • June 30, 2021:  
  • VBP actual expenditures for contract cycle July 1, 2019–June 30, 2020 will be adjusted to an evaluation period of an 18-month contract cycle (July 1, 2019–December 31, 2020)  
  • Actual Expenditures and Outcomes and Accomplishments reports due |
| **Year 4** | • October 1, 2020:  
  • State Fiscal Year contracts are to submit VBP proposals outlining initiatives for Year 4 (CY 2021)  
  • January 1, 2021:  
  • Proposed Launch of VBP Standardized Transitions to Community (TC) Program, Phase 1 |
Proposed Transitions to Community VBP, Phase 1

- Proposed Required for all PCs in 2021:
  - Standardized performance measures tied to payment for Inpatient (IP) Psychiatric services:
    - NQF#0576 (FUH) — Follow-Up After Hospitalization for Mental Illness (FUH)
    - PA Specific (Readmission) — 30-day all-cause unplanned readmissions following psychiatric hospitalization in an IP psychiatric facility
  - Standardized data collection and sharing for all IP and Outpatient (OP) providers involved in the TC VBP program
## Facts about Alternative Payment Arrangements and VBP

<table>
<thead>
<tr>
<th><strong>Definition</strong></th>
<th><strong>Participation Requirement Per Contract</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alternative Payment Arrangement (APA)</strong></td>
<td>Any of the various contractual agreements for reimbursement that are not a traditional Fee Schedule model. The plan must demonstrate that the arrangement is cost-effective or cost neutral.</td>
</tr>
</tbody>
</table>
| **VBP** | Payment strategies that align with improved quality and efficiency of care by rewarding providers for their measured performance across the dimensions of quality. These arrangements are to be paid for out of the savings generated through better quality of care and are expected to be budget neutral. | Yes. Contract Year 2020 and 2021:  
- 20% of the medical expenses must be expended through VBP strategies.  
- At least 50% of the 20% must be from a combination of moderate or large financial risk categories. |
APA vs. VBP: Quality and Monitoring Requirements for PCs

**APA**
- Must monitor if expected quality outcomes are met.
- Must monitor if cost effectiveness/cost neutrality outcomes are met.

**VBP**
- Quality and monitoring are inherent in the payment arrangement between the BH-MCO and Provider.
- Routine quality and performance outcomes are reviewed by PCs and BH-MCOs to monitor behavioral health system through VBP.
- PC, BH-MCO and provider collaborate and agree on the frequency of quality monitoring, performance and triggers for payment.
Annual VBP Proposals are Due October 1

PCs monitor arrangements continuously, but no less than quarterly, and provide updates to OMHSAS as requested.

Outcome and Accomplishments Report due the last day of the sixth month after the Contract Year

Annual VBP Proposals are due the last day of the sixth month after the Contract Year

APA Descriptions and Approval Form needs to be submitted 45 days prior to implementation.

Actual medical spend financials (Part A) due the last day of the sixth month after the contract year.

APA Annual Update Form due 90 days after the end of each contract period.

Resubmit APA Descriptions and Approval Form if there are changes to the approved APA.

APA is required to be submitted with a VBP Proposal anytime the BH-MCO and provider payment arrangement falls outside traditional Fee Schedule model.
APA and VBP Financial Risk

Level of Financial Risk

- Performance-Based Contracting
- Bundled Payment/Case Rates, Shared Savings/Risk
- Capitation

Degree of Care Provider Integration and Accountability
Savings can be Documented in Multiple Ways

**Assertive Community Treatment (ACT)**
- One year in ACT
- Annual Total Cost of Care: $20,000

**Hospitalization**
- 12-month stay in Mental Health Residential Facility ($84,000 annually)
- 12-months of supporting a individual with multiple institutionalizations where each hospitalization/Emergency Room visit costs $600–700 per day ($72,000 annually on average)
Calculating Savings for VBP Arrangements

PC VBP payment strategies must:

- Be submitted annually for OMHSAS approval
- Be cost neutral
- Be self-funded by the PCs or paid for through expected savings
- Be documented in the proposal to show performance baselines, thresholds, triggers for provider payment
• Method for “assigning” individuals for total cost of care calculations without requiring them to “enroll” with particular providers:
  – There are various ways to do this “assignment”
• Typically an individual is only involved in a single VBP model:
  – Ensures that the same savings is not “used” multiple times
  – Centers for Medicare & Medicaid Services guidance does not allow savings to be used twice/same client in two VBP models
Questions
Using VBP to Inspire and Drive Change
Value Proposition for System Change

• Individuals with behavioral health conditions experience worse health outcomes and incur higher costs:
  – Higher rates of chronic physical conditions, poor social outcomes, and early mortality
  – Overall spending is more than four times higher
  – Rates of potentially avoidable hospitalization are 2–14 times higher
  – Majority of increased spending is on physical health conditions
Opportunities to Create Value

VBP can only reduce spending and improve outcomes by altering how care is delivered and who delivers it:

- Support delivery of high-quality care
- Increase prevention or early intervention services
- Support recovery, wellness, and increased community tenure
- Improve patient experience of care
- Reduce preventable acute care utilization
- Reduce unwarranted variation between providers
Aligning Service Delivery to Value

• Structure payments to enable changes in service delivery:
  ✓ Promote greater access to care, including through flexible criteria thresholds
  ✓ Incentivize specific services, use of providers or allied health professionals (e.g., peer supports)
  ✓ Enable greater provider flexibility to meet specific patient needs
  ✓ Promote greater care coordination across care transitions — reduce potentially avoidable complications

• Support simplified provider billing and more predictable provider payments
Identifying Value in Patient Journey: Bipolar Disorder Example

- Diagnosis of bipolar disorder
- Admission for psychiatric IP treatment
- Readmission for psychiatric IP treatment
- Diagnosis of co-occurring substance use disorder

- Receive early intervention strategies
- Receive evidence-based therapies and treatment, education
- Increased coordination during care transitions
- Receive screenings, referrals and treatment for co-occurring conditions

- Opportunities to Incentivize Value
  - Increased community tenure
  - Increased wellness

- Poor health outcomes
- High acute care utilization

Pennsylvania Department of Human Services
Road Map of How to Get There
Roadmap to Value

Payer — Provider Collaboration to Target a Clinical Problem or Program Area

Select Measures

Calculate Performance Score

Determine Baselines and Thresholds

Payer and Provider Collaboration, Discussion and Negotiation

Using Data Array to Group Providers

Run the Data

Use Data to Set Financial Thresholds

Link Payment to Performance
Which Group of Providers would be Targeted for This VBP?

<table>
<thead>
<tr>
<th>Bipolar Outpatient + Inpatient Provider Combinations</th>
<th>Number of Members</th>
<th>Sum of BH Outpatient + Inpatient Cost CY2018 per month</th>
<th>Average BH Outpatient + Inpatient Cost/Member CY2018 per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brown</td>
<td>15</td>
<td>$88,523</td>
<td>$5,902</td>
</tr>
<tr>
<td>Future</td>
<td>20</td>
<td>$118,031</td>
<td>$5,902</td>
</tr>
<tr>
<td>New Life</td>
<td>18</td>
<td>$53,822</td>
<td>$2,990</td>
</tr>
<tr>
<td>One Care</td>
<td>12</td>
<td>$35,881</td>
<td>$2,990</td>
</tr>
<tr>
<td>Technology</td>
<td>60</td>
<td>$173,377</td>
<td>$2,890</td>
</tr>
<tr>
<td>Twin Hope</td>
<td>22</td>
<td>$33,459</td>
<td>$1,521</td>
</tr>
<tr>
<td>Provider Coalition A Subtotal</td>
<td>147</td>
<td>$503,094</td>
<td>$3,422</td>
</tr>
<tr>
<td>Crandon</td>
<td>40</td>
<td>$1,163,781</td>
<td>$29,095</td>
</tr>
<tr>
<td>Galligan</td>
<td>30</td>
<td>$531,140</td>
<td>$17,705</td>
</tr>
<tr>
<td>Stuever</td>
<td>15</td>
<td>$170,724</td>
<td>$11,382</td>
</tr>
<tr>
<td>Provider Coalition B Subtotal</td>
<td>85</td>
<td>$1,865,645</td>
<td>$21,949</td>
</tr>
<tr>
<td>State Total</td>
<td>4,290</td>
<td>$38,674,350</td>
<td>$9,015</td>
</tr>
</tbody>
</table>
Using Data to set Thresholds

AVERAGE COST PER INDIVIDUAL PER PROVIDER

$11,000 75%
$9,000  Average
$5,951  Median
$3,000  25%

HOSPITAL AND OUTPATIENT PROVIDER COMBINATIONS
### Quality Metrics Thresholds

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Needs Improvement Threshold</th>
<th>Acceptable Threshold</th>
<th>Shared Savings Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission to mental health IP care within 30-days of discharge</td>
<td>12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FUH for mental illness within 7 days and 30 days</td>
<td>70%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality metrics not linked to gain sharing (i.e., informational only):</td>
<td></td>
<td>$11,000</td>
<td>$5,915</td>
</tr>
<tr>
<td>• Adherence to Mood Stabilizers for Individuals with Bipolar Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>During the first 12 weeks of treatment the percentage of patients with bipolar disorder:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Who receive monotherapy with an antidepressant agent?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Who receive a recommendation for an adjunctive psychosocial intervention, including evidence-based therapies?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Who receive education and information about their illness and treatment?</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
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 receives a shared savings amount, but based on values above the shared savings limit.
The **Needs Improvement Threshold** is the dollar amount that delineates the providers between the payback and the neutral zone.

The **Acceptable 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.
• This section will cover how to:
  – Determine performance benchmarks
  – Calculate performance score
  – Linking performance to payment
<table>
<thead>
<tr>
<th>Improvement Goal</th>
<th>Absolute Goal</th>
<th>Industry Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Desired change or improvement</td>
<td>• Value desired for all entities</td>
<td>• Performance of similar entities</td>
</tr>
<tr>
<td>• Example: Assess whether a provider reduced its own readmission rate by at least two percentage points</td>
<td>• Example: Assess whether a provider’s readmission rate was less than 10%</td>
<td>• Example: Assess a provider’s performance on readmission on a percentile distribution</td>
</tr>
<tr>
<td>• Encourages improvement, regardless of baseline performance</td>
<td>• Sets a motivating goal that is achievable by all providers over time</td>
<td>• Fosters competition, but may hinder collaboration; may require risk adjustment</td>
</tr>
</tbody>
</table>
Example: Use of Improvement and Absolute Benchmarks

**DISPARITY MEASURE: ED UTILIZATION AMONG MEMBERS WITH MENTAL ILLNESS**

Emergency department utilization among members with mental illness in 2017 and 2018, by CCO.

- Jackson Care Connect: 88.2, 104.0
- Willamette Valley Community Health: 100.5, 111.4
- Eastern Oregon: 87.8, 123.2
- PacificSource Gorge: 97.8

2018 benchmark: 92.9

Lower is better

Source: Oregon Health System Transformation CCO Metrics 2018 Final Report
Calculating a Performance Score and Linking to Payment

- **Pass/fail**
- **Point assignment**
- **Measure/domain weighting**
- **Composite score**

**Performance Score**

- **Calculate Performance Score**
- **Determine bonus amount**
- **Determine withheld amounts re-paid**
- **Determine share of savings (or risk) payments**
- **Adjust normal payments (fee-for-service or capitation)**
## Linking Performance to Payment

<table>
<thead>
<tr>
<th>Technique</th>
<th>Description</th>
<th>Example</th>
</tr>
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<tbody>
<tr>
<td>Gate</td>
<td>Defines a minimum qualification or “gate” for earning payment (e.g., a fixed bonus, set amount of savings). Can be a percentage of maximum available points or meeting benchmarks on selected quality measures.</td>
<td><strong>Tennessee Oppositional Defiant Disorder Episode</strong>: The minimum care requirement is set at six therapy and/or level I case management visits during the episode window to be eligible for gain sharing (&gt;= 30%).</td>
</tr>
<tr>
<td>Ladder</td>
<td>Defines a tiered “ladder” where the amount of financial incentive increases as performance increases. Ladder can extend “below ground” with poor performance generating a financial penalty.</td>
<td><strong>Medicare’s Hospital Readmission Reduction Program</strong>: A penalty program that evaluates “excess readmission rates” to determine if penalties are to be assessed (payment reductions capped at 3%).</td>
</tr>
<tr>
<td>Gate and Ladder</td>
<td>Defines a minimum qualification for payment, but also the ability to earn increased payments by performing better.</td>
<td><strong>Vermont Medicaid Shared Savings Program</strong>: If accountable care organization does not achieve 55% of available points, no shared savings earned. A higher percentage of savings can be earned with improved performance.</td>
</tr>
</tbody>
</table>
Example: Gate and Ladder for Vermont’s Medicaid Shared Savings Program

<table>
<thead>
<tr>
<th>Percentage of available points</th>
<th>Percentage of earned savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>55%</td>
<td>75%</td>
</tr>
<tr>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>65%</td>
<td>85%</td>
</tr>
<tr>
<td>70%</td>
<td>90%</td>
</tr>
<tr>
<td>75%</td>
<td>95%</td>
</tr>
<tr>
<td>80%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Quality Gate
Considerations for Payment Triggers Based on Performance

- Keep it simple
- Use absolute (not relative) targets
- Be aware of care stinting:
  - Use performance measures to help ensure VBP cost targets not unintentionally motivating providers to deliver less care than needed
- Avoid payment withholds
Payer — Provider Collaboration, Discussion and Contract Negotiation
Questions and Answers

Thank you for your attendance!