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

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Director of Training and Technical Assistance
SAMHSA-HRSA
Center for Integrated Health Solutions

Setting the Stage:
Today’s Moderator

Madhana Pandian
Senior Associate
SAMHSA-HRSA Center for Integrated Health Solutions
Slides for today’s webinar will be available on the CIHS website:

www.integration.samhsa.gov
Under About Us/Innovation Communities 2018

Listserv

Look for updates from:
value_based_care_ic_2@nationalcouncilcommunities.org
To participate

Use the chat box to communicate with other attendees

Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).
WHO WE ARE

The **SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)** is a national training and technical assistance center dedicated to the planning and development of integration of primary and behavioral health care for those with mental illness and/or substance use disorders and physical health conditions, whether seen in specialty mental health or primary care safety-net provider settings across the country.

CIHS is jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources Services Administration (HRSA), and is run by the National Council for Behavioral Health, the unifying voice of America’s healthcare organizations that deliver mental health and addictions treatment and services.

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 use disorder 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 of Arts 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

✓ Review key domains 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 Spring/Summer Cohort

- ADAPT Programs
- Adirondack Health
- AltaPointe Health, Inc.
- Avera Health
- Berks Counseling Center
- Betances Health Center
- Bluegrass.org
- Catholic Family Center
- Cenpatico Integrated Care
- Centers for Youth and Families
- Citrus Health Network, Inc.
- Comprehend,Inc.
- Cone Health Behavioral Health
- Consejo Counseling & Referral Service
- Emergence Health Network
- Family Health Center of Boone County
- Family Service Agency
- Freeman Health System
- Gateway Community Services
- Great Rivers Behavioral Health Organization

- Guild Incorporated
- Hillside Family of Agencies
- ISSAIH HOUSE
- J.C. Blair Memorial Hospital
- Koinonia Primary Care Inc
- Liberty Resources
- Logan Mingo Area Mental Health, Inc.
- Maryland Behavioral Health Administration
- Meharry Medial College
- NorthEast Treatment Centers
- Open Health Care Clinic
- Osceola Mental Health, Inc, d/b/a Park Place Behavioral Health Care
- Santa Barbara Neighborhood Clinics
- Spindletop Center
- Square Medical Group
- Tarzana Treatment Centers, Inc.
- The Link & Option Center, Inc.
- Tri-County Mental Health Services
- Upper Great Lakes Family Health Center
- Wayne County Action Program
Expectations of Participants

1. Participants will take part in 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.

Next Steps

✓ 2nd Group webinar Tuesday
   June 12th 3pm-4:30pm eastern
   with SME Julie Schilz

✓ Do background reading
✓ Develop organizational workplan
✓ May 29th - Office Hours available
✓ Use list-serv
  value_based_care_ic_2@nationalcouncilcommunities.org
The “Quadruple Aim”

- Population Health
- Experience of Care
- Per Capita Cost
- Provider Satisfaction

What is Value-Based Payment?

- Shifts the focus from traditional fee-for-service (FFS) systems that pay for volume of services to alternative payment models that reward high-quality, cost-effective care.
- There is a continuum of payment methodologies, with increasing levels of accountability and financial risk to the provider.
The CMS Framework assigns payments from payers to health care providers to four Categories, such that movement from Category 1 to Category 4 involves increasing provider accountability for both quality and total cost of care, with a greater focus on population health management (as opposed to payment for specific services).
What is MACRA?

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan legislation signed into law on April 16, 2015.
- MACRA created the Quality Payment Program that:
  - Repeals the Sustainable Growth Rate formula
  - Changes the way that Medicare rewards clinicians for value over volume
  - Streamlines multiple quality programs under the new Merit Based Incentive Payments System (MIPS)
  - Exempts physicians from MIPS if they participate in eligible alternative payment models (APMs)

  - Source: CMS
Medicaid Value-Based Payment in Behavioral Health
Source: Center for Healthcare Strategies, June 2017

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

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

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

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

VBP Organizational Readiness

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.
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.

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.

Provider Readiness for Value-Based Contracts

Do you...
- Know the actual unit costs?
- Understand the patient population?
  - Utilization patterns
  - Morbidity
  - Risk stratification
- Understand what data the clinic or program collects and/or has access to?
- Utilize continuous quality improvement?
- Utilize population health management tools?
- Know how much financial risk is acceptable?
What do Payers Want?

➢ 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 (Milliman, Jan 2018)**

- Patients with chronic medical and comorbid mental health/substance use disorder (MH/SUD) conditions cost **2-3 times more as those without**
- Projected costs for those with comorbid conditions in 2017 was estimated at $406 billion 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 “an estimated $38-$68 billion could be saved annually through effective integration of medical and behavioral healthcare”, with most of the projected reduced spending associated with facility and emergency room expenditures in hospitals.

**Potential Economic Impact of Integrated Medical–Behavioral Healthcare (Milliman, Jan 2018)**

![Figure 1: Projected Healthcare Cost Savings Through Effective Integration (National, 2017)]

<table>
<thead>
<tr>
<th>PAYER TYPE</th>
<th>ANNUAL COST IMPACT OF INTEGRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMERCIAL</td>
<td>$16.3-$38.6 BILLION</td>
</tr>
<tr>
<td>MEDICARE</td>
<td>$6.0-$12.0 BILLION</td>
</tr>
<tr>
<td>MEDICAID</td>
<td>$12.3-$17.2 BILLION</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$37.6-$57.8 BILLION</td>
</tr>
</tbody>
</table>
Adverse Childhood Experiences (ACES) At the Foundation of 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 and 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 it’s “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.”

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

<table>
<thead>
<tr>
<th>Goal(s)</th>
<th>Objective(s)</th>
<th>Action Step(s)</th>
<th>Person(s) Responsible</th>
<th>Timeline(s)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Develop a continuous quality improvement process to track outcomes and use data to inform clinical processes</td>
<td>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</td>
<td>Betsy Cohen, COO Danny Klein, CQI Director</td>
<td>1. By Feb 28 2. By March 31 3. By April 30 4. By May 30</td>
<td>Data sources to include EHR, care management software, Medicaid claims, grant specific access database</td>
</tr>
</tbody>
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## 5x5 Presentation

- A 5x5 is a communication tool where you have **five minutes** to present **five slides** that tell the story of your change project.

- Clearly explain your changes and their results using the PDSA approach as a framework. (Plan-Do-Study-Act)

- Keep it simple – You have five minutes to present five Power Point slides which tell your story.

- Use graphs to display your results. Make them clear and simple

- Use key words and bullets

- Be creative!
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
CIHS News and Resources

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Free consultation on any integration-related topic!

Thank You – Please fill out our survey following the webinar

SAMHSA’s mission is to reduce the impact of substance abuse and mental illness on America’s communities.

The mission of HRSA is to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs.

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