Practice Transformation Academy

CEO Call #1

Tuesday, September 5, 2017
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Envolve Health
Let’s get to know each other…

**Roll Call**: Who is on the line? Type in your name, title and organization.
What brings us here today?

THE WORLD OF MEDICAL REIMBURSEMENT, AS WE KNOW IT, WILL END SOON
Value is

\[
\frac{\text{Quality}}{\text{Cost}}
\]
Level Setting: PTA Overview

• Program Goals
  – Build readiness for value-based payment arrangements
  – Cultivate strategic internal champions for value-based payment arrangements

• Duration: March 2017-2018

• Structure
  – Mix of in-person and virtual technical assistance and coaching
  – Two cohorts: National and Care Transitions Network
Outcomes

By the end of the Academy, participants will have:
• Cultivated buy-in among internal stakeholders;
• Developed a committee structure to operationalize transformation;
• Created a concrete work plan that prioritizes organizational efforts;
• Established compelling value propositions through the utilization of data;
• A comprehensive quality improvement and project management strategy.
Who We Are

- 26 agencies
- Community Mental Health Clinics, Substance Use Treatment Clinics, Hospitals, FQHCs/Community Health Centers/Primary Care Clinics, one Mobile Health Provider, and other
- Geographic location:
  - 12 urban
  - 7 suburban
  - 2 rural
  - 5 urban, suburban, and rural
- 14-3,500 employees
States Represented

Connecticut
Florida
Georgia
Kansas
Maryland
Massachusetts
Nevada
New Jersey
New York
Ohio
Pennsylvania
Tennessee
What We’re Doing

Sample Stretch Projects

• Implement a risk stratification process targeting high-risk, high-cost patients
• Develop a metrics based program scorecard integrating financial and clinical
• Develop care pathways for high risk populations
• Decrease wait times for patients/clients to get an appointment
• Reduce hospitalization and readmission to detoxification level of care by 25% for high risk patients
• Data driven decision-making and using data to improve service delivery and demonstrate value
Mid-Point Check In

- Steering committee and leadership buy-in
- Clearly defined, measurable outcome
- Identified set of data to measure outcomes
- Evolving workplan
- Mid-year meetings

**National Cohort**: September 12
**CTN**: September 19
Value Based Contracting

Presented by Kelley Grayson, VP Network Development and Contracting, Cenpatico/Envolve People Care
What are Value-Based Payments or Value Based Purchasing Models?

- **Payment or Models** that reward (pay) for improved quality, outcomes, and costs. A shift to value-based reimbursement models creates a new paradigm where care is delivered by an entire coordinated care community sharing in the responsibility—and risk—of outcomes and costs, touching almost every part of health care delivery operations.
What are Alternative Payment Models & Methodologies?

- Various reimbursement strategies that pay for Value as opposed to Volume….a shift away from FFS.
- Typically start with FFS + quality incentive and then “RAMP” to more risk-based models.
- Models that “bundle” reimbursement for multiple services as part of an episode of care. Example case rate or DRG.
- Models that pay an enhanced encounter rate or even capitated rate which is inclusive of services outside of the provider’s normal scope of care ...designed to promote integrated care approach.
- They encourage efficiency by allowing Provider more flexibility on how the $’s are spent to provide care.
- They always, always, always should include Quality and/or Efficiency Measures.
Our Work in the Reimbursement Continuum

- Fee-for-service
- Performance based contracting
- Shared savings
- Bundled and episodic payments
- Shared risk
- Capitation + performance based contracting

Small % of financial risk: Low accountability
Moderate % of financial risk: Moderate accountability
Large % of financial risk: Maximum accountability

Examples:
- P4P/shared savings contracts with qualified facilities and outpatient providers
- SUDS medication-assisted therapy (MAT) providers
- DRG
- ACOs, medical-behavioral integration in health homes
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<tr>
<td><strong>CMS Framework for Value-Based Payments or Alternative Payment Models</strong></td>
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<td><strong>Population-Based Payment</strong></td>
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<tr>
<td>FEE FOR SERVICE - NO LINK TO QUALITY &amp; VALUE</td>
<td>FEE FOR SERVICE - LINK TO QUALITY &amp; VALUE</td>
<td>APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE</td>
<td>POPULATION - BASED PAYMENT</td>
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<td>Foundational Payments for Infrastructure &amp; Operations (e.g., care coordination fees and payments for HIT investments)</td>
<td>APMs with Shared Savings (e.g., shared savings with upside risk only)</td>
<td>Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</td>
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<td>Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)</td>
<td>APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</td>
<td>Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)</td>
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<td>Pay-for-Performance (e.g., bonuses for quality performance)</td>
<td>Risk Based Payments NOT Linked to Quality</td>
<td>Integrated Finance &amp; Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)</td>
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**3N** Capitated Payments NOT Linked to Quality
Negotiations: What You Should Know

• **QUALITY:** Almost all value based models will require you to meet quality/efficiency metrics. You need to understand what these measures are and how you are performing on them today.

• **FINANCIAL RISK:** In an APM, you need to understand what if any risk is being agreed to on your part and whether or not your organization can tolerate that risk. Learn what terms like “leakage, shared risk, full risk, upside only, capitation, partial cap, DOFR & downside risk” mean. Understand what member attribution means and how that works.

• **LEGAL:** APMs that are bringing multiple providers together in order to participate in a shared reimbursement deal will require legal review. Be sure you understand how patient information will be protected; how your organization will be paid; what credentialing and/or contractual requirements need to be met; etc.

• **REPORTING:** Most if not all of these models will require some type of reporting. Be sure you understand how this requirement impacts you and your organization.
Pool Size – Does it Matter?

- The biggest risk with any value based contract is not having a big enough panel in order to “normalize” the data/outcomes.
- When you have a sample size of less than 1000, the data becomes too easily distorted due to the possibility of outliers or non-compliant/non-responders.
- Providers should work together to form affiliations whereby they “pool” their patient panels in order to achieve a meaningful sample size which will reduce the risk of having outlier data influence the outcome.
Example of a P4P Shared Savings Model

All CMHCs collectively participate in a quality pool which is funded using a % of paid claims calculation.

Member/patient attribution uses rolling 15 month logic whereby a patient is attributed to a CMHC based on having been seen by that CMHC at least one time in past15 month period. Members are excluded from attribution if multiple affiliations established (< 3%).

Program Administrator is appointed by Provider Association and that individual serves as the Program lead.

Baseline for Quality Measures is derived and goals finalized.

Monthly performance reports are shared via SFTP site with the individual CMHC’s as well as the Program Administrator.

Each CMHC is eligible to receive a % of the quality bonus pool $’s if they meet or exceed Program requirements. Program requirements include the minimum expectation related to meeting or exceeding Quality Measure goals.
Program Measures

APM - Metabolic Monitoring for Children & Adolescents on Antipsychotics

SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia

SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

7-day post discharge follow up

Inpatient all-cause readmissions
Patient Demographics - Age
## Baseline to Current

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>Goal</th>
<th>Current (thru Aug)</th>
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<td>APM</td>
<td>39.23%</td>
<td>41.19%</td>
<td>40.69%</td>
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<tr>
<td>SAA</td>
<td>53.93%</td>
<td>56.63%</td>
<td>54.60%</td>
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<tr>
<td>SSD</td>
<td>75.24%</td>
<td>79.00%</td>
<td>75.70%</td>
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<td>Inp 30-day Readmit</td>
<td>17.33%</td>
<td>16.46%</td>
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<td>7 day follow up</td>
<td>75.30%</td>
<td>79.06%</td>
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Baseline: Jan 1 2016 - Dec 31 2016 with runout thru Feb 28 2017

Current: April 1 2017 thru Aug 1 2017

*Current reporting period % show improvement over baseline in all categories except 7-day follow up.*
Inpatient Readmit Cost Savings  
(4/1/2017 – 8/1/2017)

- 17.33% was 2016 Inpatient Readmit Baseline.
- Current (thru Aug) Inpatient Readmit rate has decreased by 4.85%.
- Using 2016 cost data, the 4.85% reduction translates into inpatient readmission cost savings of $275,579.
Example of Complex Care

Services are categorized into three programs – Bundled Payment by Acuity

- MRO Bundle
  - 694 Members
  - 54.65%
- Complex Care
  - 74 Members
  - 5.83%
- MRO Bundle & 7/30 – Day FUH
  - 172 Members
  - 13.54%
- 7/30 – Day FUH
  - 276 Members
  - 21.73%
- MRO Bundle & Complex Care
  - 30 Members
  - 2.36%
- 7/30 – Day FUH & Complex Care
  - 15 Members
  - 1.18%
- All 3 Threshold Services
  - 9 Members
  - 0.71%
Examples of SUD APMs

▪ **CCBHCs** – Certified Community Behavioral Health Clinic incentivized through an encounter rate for BH services, Physical Health screening and care coordination, in addition to Substance Use Disorder services. If no SUD in-house, then designated collaborating organization (DCO) negotiated with SUD provider.

▪ **ACPs** – Accountable Care Program where “select” or “narrow” network developed to support full continuum of care.

▪ **MAT/OTP** – SUD programs designed to promote addiction recovery. Payer typically will negotiate bundled payment rate plus include Quality/Efficiency metrics (ex reduction in Inpatient Detox/Rehab for members treated).

▪ **Quality/Efficiency** – Participate in pay for performance (P4P) programs. Ask payers about them when you are negotiating. All payers have requirements around encouraging participation in these programs.
About 13.5% of spend is SUD (Primary DX codes of F10-F19) in IN.

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<tr>
<td>Grand Total</td>
<td>86.66%</td>
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Are You Ready For A Value-Based World?

• **Develop Your Support Team:** As utilization/care coordination moves from payer-led to provider-led, providers will need to structure how to manage a bundled payment and stay within financial allowances.

• **Invest in IT:** Providers need to generate and monitor patient utilization reports, validation of encounter data submissions, financial utilization reports by member, quality performance targets.

• **Develop programs around payer needs:** Most VBPs will ask for something extra clinically – timely patient access, outcome accountability, process measures – and providers should be building programs that a payer can then purchase.

• **Understand Risk Stratification:** SUD is a big driver in today’s health care landscape. Payers are using risk stratification tools to “predict” cost of care and promote pre-emptive treatment protocols.

• **Networking/Marketing:** Payments will be tied to providing more of a full array/continuum of services. You will potentially need to partner with other providers in order to take advantage of the new models.
Who are your Payor Contacts?

• Most MCO’s/MBHO’s will funnel contracting requests through their Network Management teams. Most Providers direct point of contact is their Provider Relations Representative; however, for some Providers, the Clinical team or even their market-specific Contracting representative is their point of contact. Reach out to these folks and request a meeting to discuss VBC options.

• Most MCOs/MBHOs have what are called “off the shelf” models they use to support P4P initiatives. These P4P initiatives are typically upside only, Quality-based contracts.

• If you are looking to negotiate a partial or full risk-based contract (includes bundled payment arrangements or capitation), then this will require financial analysis and will always be negotiated by the Network Contracting team. The Contracting teams employed by the Payors are sometimes specialized in what they do. For example, some just manage day-to-day contract maintenance (ex Amendments & new provider requests); and some just specialize in recruiting new providers for new or expansion markets.

• For bigger Payor entities, there are typically Contractors that specialize in VBC/Network Innovation aka Payor Strategy. Let your PR person know that you are interested in VBC and have them facilitate a meeting with this specialized contracting team.
Q & A