



**Green & Healthy
Homes Initiative®**

Overview of GHHI's Value-Based Care Work for IL HFS Value Based Care Group

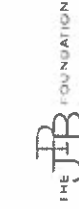
**September 6, 2019
Chicago (and Springfield), IL**



Innovative Healthcare Financing Projects



Funders



- Allegheny County - UPMC and Allegheny Co. Health Department
- Baltimore - Priority Partners MCO
- Buffalo - Oishei Children's Hospital and IHA MCO
- Chattanooga - green|spaces and Erlanger Children's hospital
- Chicago - Presence Health, Elevate Energy, & NextLevel MCO
- Cincinnati - People Working Cooperatively
- Connecticut Medicaid and CT Greenbank
- Grand Rapids - Priority Health MCO, Healthy Homes Coalition of West Michigan, HealthNet of West Michigan
- Houston - UnitedHealthcare & Baylor
- Houston - Community Health Choice MCO
- Indiana - Indiana Joint Asthma Coalition
- Iowa - Healthy Homes Des Moines and IME (Iowa Medicaid)
- Marin - Contra Costa Health Services & MCE
- Memphis - Le Bonheur Children's Hospital & UnitedHealthcare, Amerigroup, and BlueCare
- Minneapolis - MN Energy Efficiency For All
- New York City - Affinity Health Plan, AIRnyc, & AEA
- New York City - LIISC and Healthfirst MCO
- New York Medicaid and NYSEDA
- Oregon - Community Services Consortium
- Philadelphia - National Nursing Care Consortium
- Richmond City Health District and DMAS (VA Medicaid)
- Rhode Island - State Medicaid and Integra Accountable Entity
- San Antonio - SA Asthma Collaborative
- Salt Lake - University of Utah Health Plans and Salt Lake County
- Springfield - Health New England MCO, Baystate Health, Public Health Institute of Western Mass
- Worcester - UMass Memorial Hospital

Chicago projects

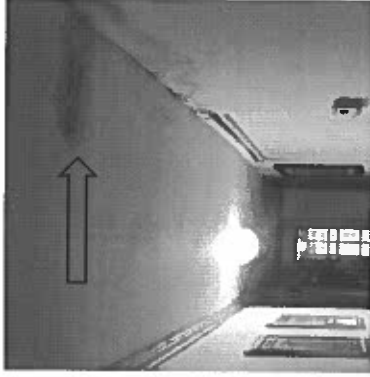


Home-based asthma pilots

Testing an evidence-based model by connecting clinical and community-based capacities to address root causes of asthma.

- Philanthropy and community benefit dollars supporting startup; now exploring ways to sustain services.

AMITA	Warm referrals from ED RT's
SUHI	Asthma education home visits
Elevate Energy	Home assessment; home repairs



Right: pilot home has moldy drywall by bathroom, kitchen, and hallway. Mold and moisture is a key asthma trigger.

Preliminary results

Phase 1: West Side

- Dec 2017 to Sept 2018
- 20 participants with severe asthma
- Average 56% increase in ACT scores
- Large reductions in OP and IP services (so far; outcomes evaluation in progress)

Phase 2: Roger's Park

- Began spring 2019
- Additional 10 participants; pilot in progress

Next Level Health claims analysis

In addition to pilot development, GHHI is leading a separate project with NLH to analyze claims data of asthma "high flyers" to determine potential cost savings from reducing ED and IP admissions through a home visiting program.

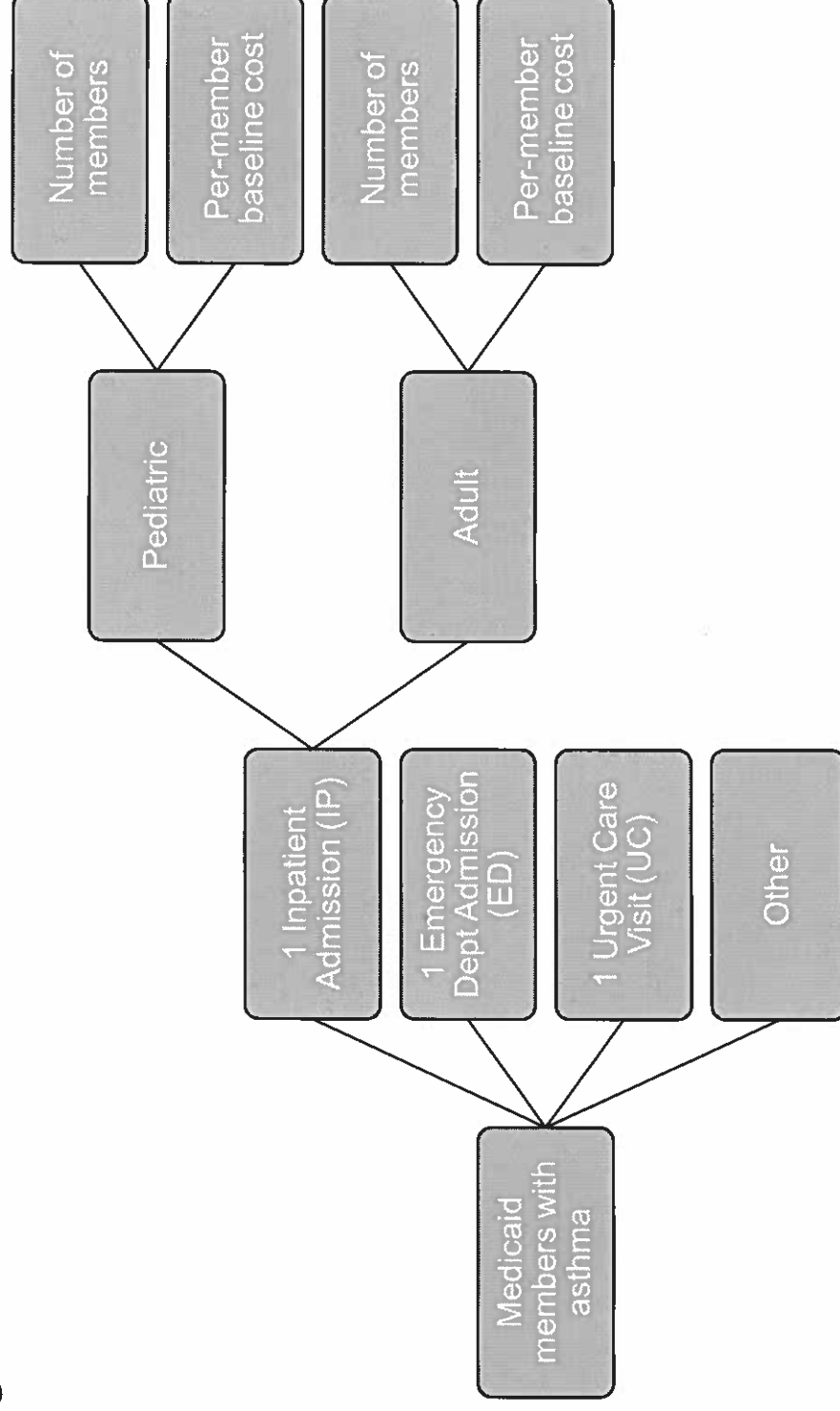
Options for using healthcare resources for housing services



Hospital Community Benefits <i>Any age (un- & under-insured)</i>	Chicago: assessment and remediation of asthma hazards (pilot)
CHIP State Plan Amendment <i>Children</i>	Michigan: \$119M to remediate lead hazards Maryland: \$14M to remediate asthma and lead hazards
Medicaid Managed Care Organizations <i>Any age</i>	Michigan: assess and remediation of asthma triggers (pilot) Maryland: assess and supplies to mitigate asthma triggers Utah: assess and remediation of asthma triggers
Medicaid Home & Community Based Services <i>Older adults, disabled</i>	Most states: home accessibility modifications
Medicaid Demonstration Waivers (1115) <i>Any age</i>	Oregon: 'flexible services' includes air conditioners for asthmatics North Carolina: Healthy Opportunities pilot includes home repairs, rental assistance
Medicare Advantage <i>Older adults (65+)</i>	St. Louis: 'supplemental benefits' includes home repairs for fall prevention

Target Population Identification

Working with Medicaid and Health Plan Data

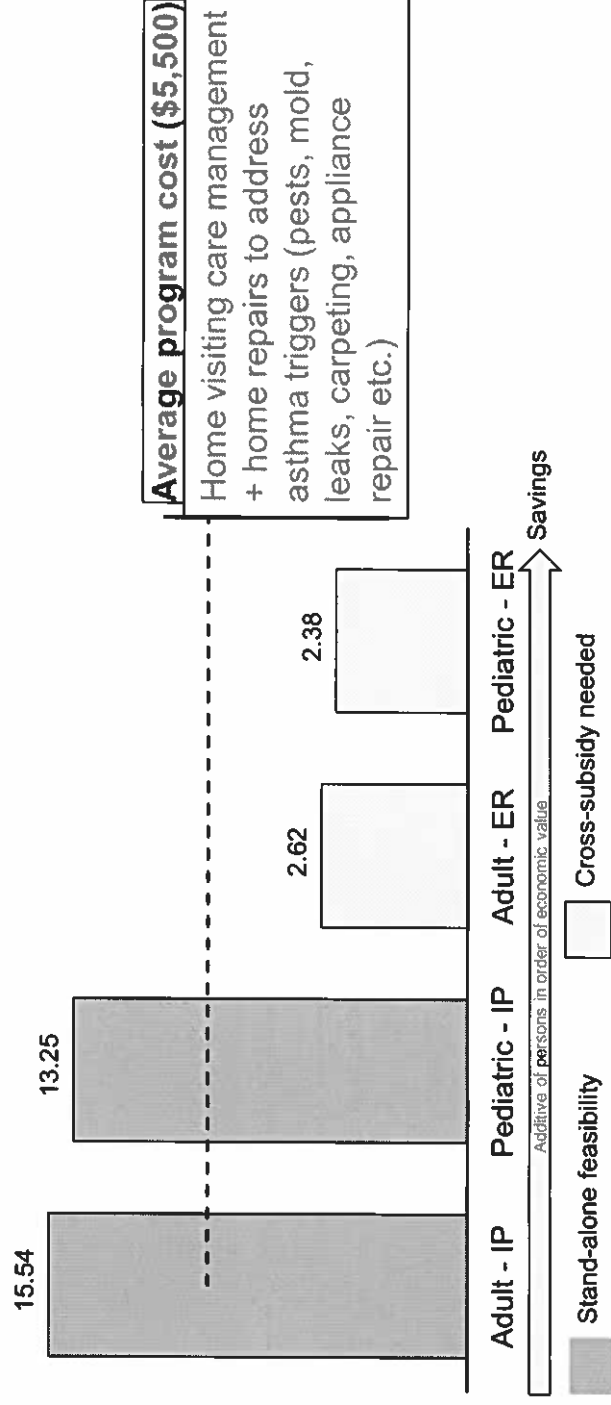


Economic Analysis (Asthma Example)

Subpopulation stratification



Cost-savings projections by subpopulation
\$ thousands per enrollee, log scale



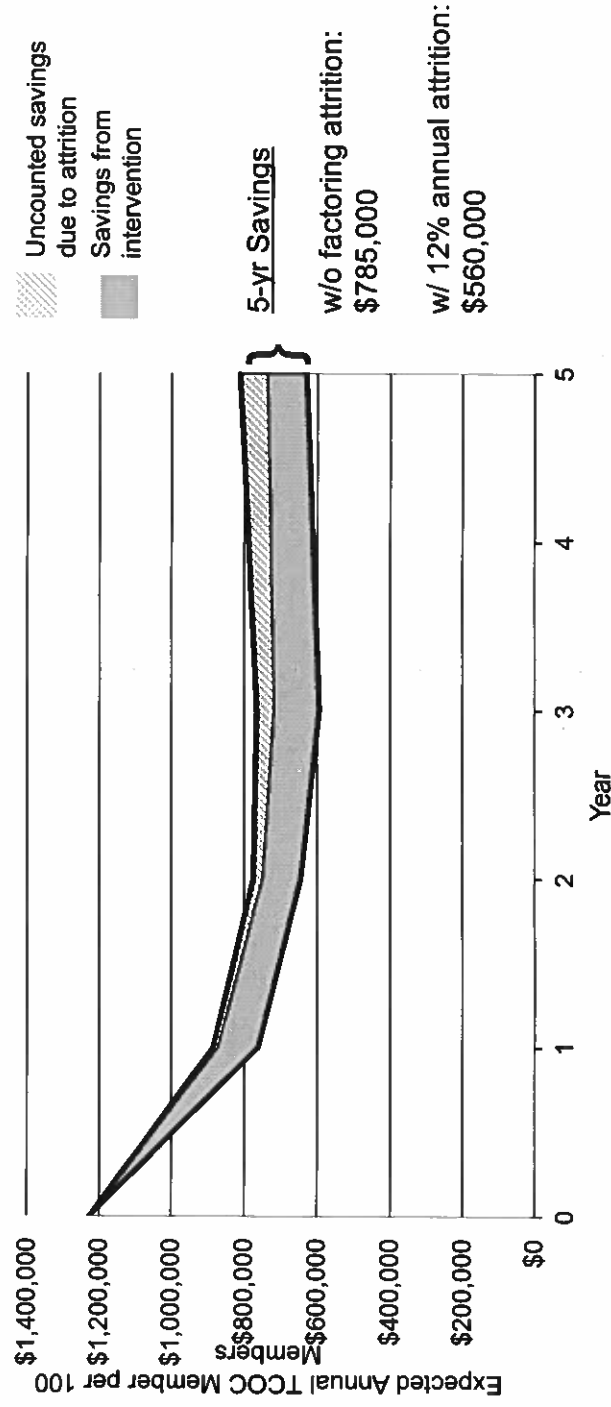
Utilizing Actuarial Analysis



Expected savings calculations assume:

- 'Reversion to mean' in costs following year 0 'trigger' event (e.g. hospitalization)
- Up to 40% reduction in utilization of asthma-related medical services by year 3
- 12% annual attrition, meaning those members are no longer counted in the savings estimates

Group of 100 children with at least one asthma-related hospitalization



State-wide Cross Sector Partnerships: New York Healthy Homes VBP Pilot



Asthma-related services

- In-home asthma self-management education, including a home environmental assessment
- Integrated pest management, asthma trigger reduction supplies and housing interventions to reduce identified triggers

Home injury prevention services

- In-home resident education and home environmental assessment
- Household injury prevention remediation interventions to reduce fall risks and other injury risks

Energy efficiency services

- Home energy audit to identify energy loss and opportunities for improved energy performance
- Energy efficiency intervention services based on identified needs and in-home education on energy efficiency measures

Technical Assistance/Market Supports

(to advance HH interventions as part of VBP contracts)

- Implementation/administration service, including application intake and coordination of service providers
- Impact evaluation to validate outcomes (healthcare cost savings, energy savings)
- Development of a model/standard contract for MCOs
- Training support to intervention service providers



STEP 1: Initial \$10 million pilot from NYSERDA Clean Energy Fund (rate payer dollars)

STEP 2: Medicaid MCO Co-investment through VBP requirements (years 2 and 3)

Connecticut: Project Goal Over Three Phases



- To provide a **comprehensive analysis** of the economic, technical and operational **feasibility** of a statewide model for housing, health and energy services in Connecticut.
- To identify **sustainable support** via innovative strategies for public, private and philanthropic investment in housing, health and energy services, including outcomes-based Medicaid investment, philanthropic support and leveraged public investment.
- To design models that **leverage and expand Connecticut's existing framework for Utility Rate Payer-Funded Energy Efficiency Services** to implement a comprehensive statewide housing, health and energy services model.

PHASE I Complete

- Asset and Gap Analysis (Pre-Feasibility Research)
- Convenings

PHASE II Summer 2018-Summer 2019

- Feasibility Research (Medicaid ROI analysis)
- Convenings
- Pilot Design

PHASE III 2019-2021

- Multi-site pilot implementation
- Evaluation
- Recommendation for statewide model

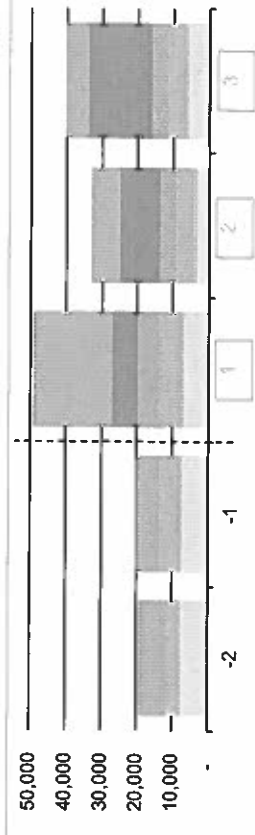
CT: Estimating 3-year Cost of Falls to Medicaid

An estimate of Medicaid cost impact was made by comparing average costs in the 3 years following a fall with the two years prior to the fall. The analysis is restricted to HUSKY members 50+ and not using long-term care services at time of fall, and then grouped by HUSKY plan.

HUSKY A/D – Inpatient Trigger

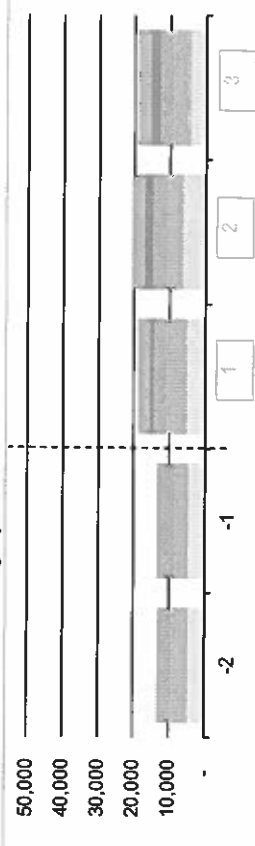
Estimated 3-year avg. fall-related costs: \$62,000
Members/year in this category: 125

Annual Avg Total Cost of Care



HUSKY A/D – ED Trigger

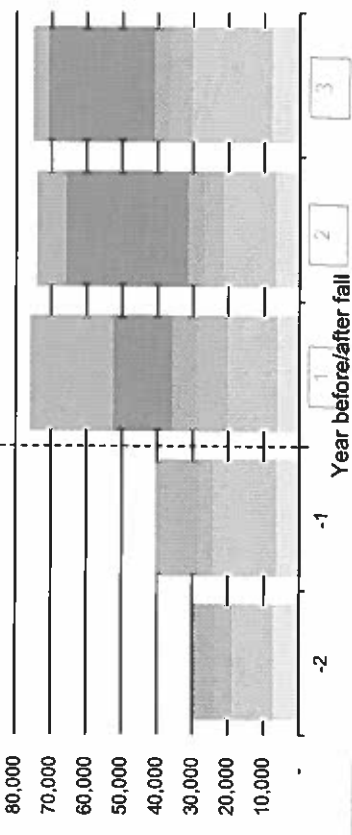
Estimated 3-year avg. fall-related costs: \$19,000
Members/year in this category: 1,000



HUSKY C – Inpatient Trigger

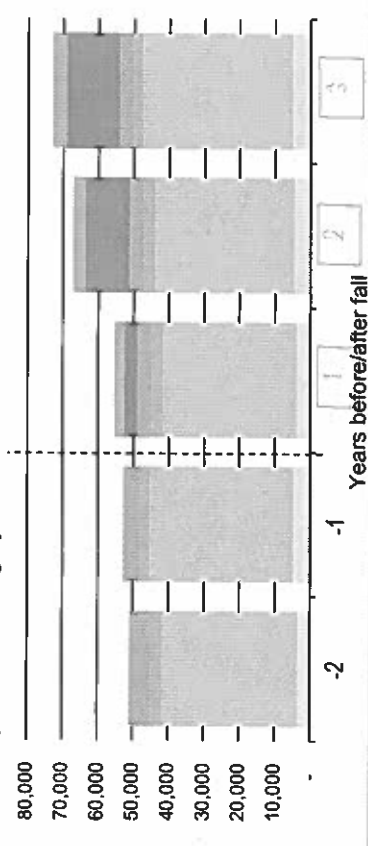
Estimated 3-year avg. fall-related costs: \$150,000
Members/year in this category: 65

Annual Avg Total Cost of Care



HUSKY C – ED Trigger

Estimated 3-year avg. fall-related costs: \$41,000
Members/year in this category: 500

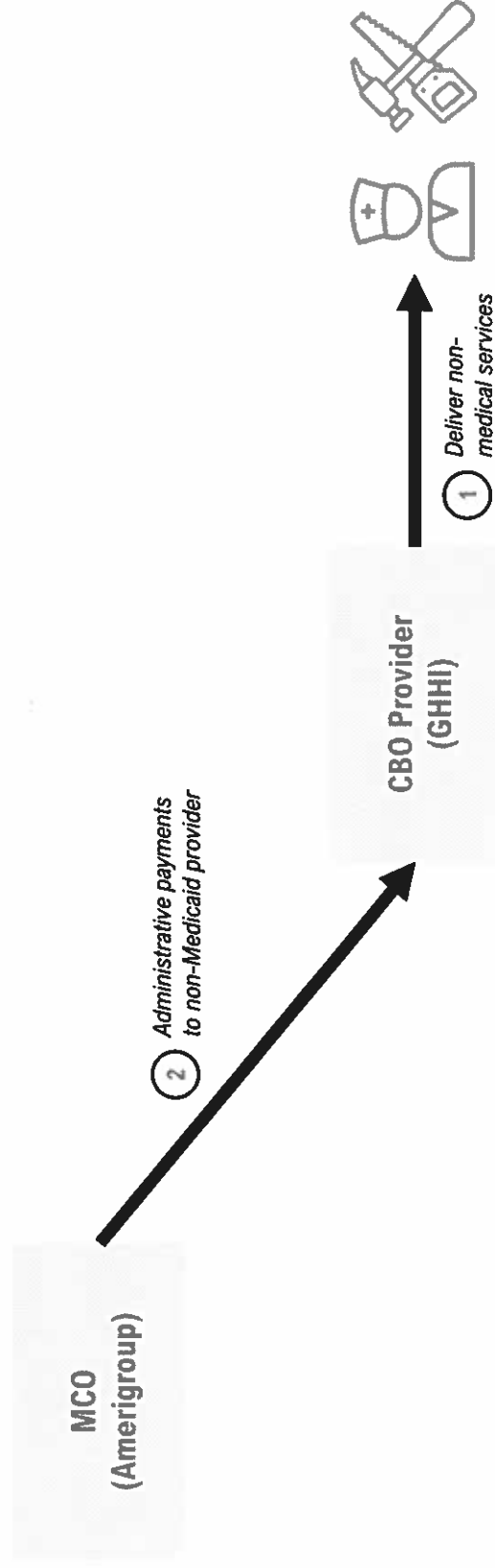


- Inpatient - Med.
- Inpatient - Instit. (e.g. SNF)
- Professional (e.g. physician)
- Outpatient (e.g. ER)
- HCBS/Home Services
- Rx

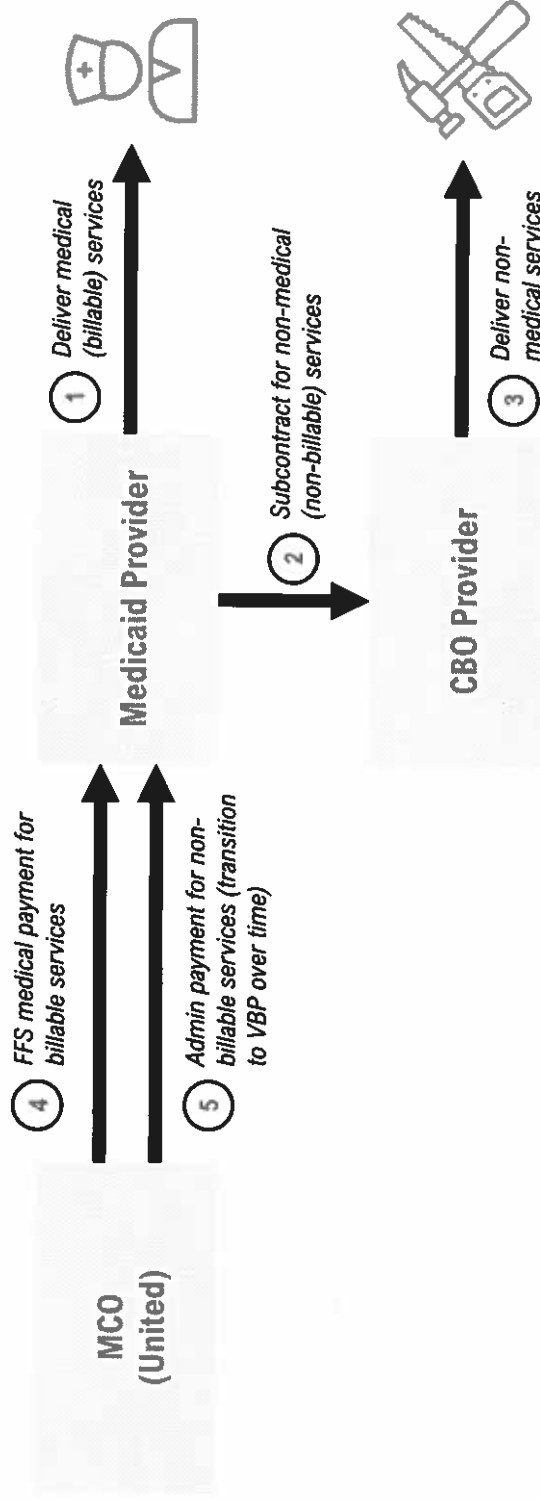
Healthy Homes Contracts with Plans

	Baltimore, MD	Houston, TX	Salt Lake City, UT	New York, NY
Medicaid MCO	 Amerigroup An Anthem Company	 UnitedHealthcare	 HEALTH PLANS UNIVERSITY OF UTAH	 Affinity Health Plan
Healthy Homes Contractor	 Green & Healthy Homes Initiative*	 Girling Community Care An Affiliate of Keeler at Home	 Salt Lake County	 AFFINITY ENERGY
Home Visiting Organization	 Green & Healthy Homes Initiative*	 BCM Baylor College of Medicine	 HEALTH PLANS UNIVERSITY OF UTAH	 Healthy has an address
Housing Scope	Assessment Consumer Supplies	Assessment Consumer Supplies Home Modifications	Assessment Consumer Supplies Home Modifications	Assessment Consumer Supplies Home Modifications
Payment Type	Per member set payment (vendor agreement)	Per member per month + value-based contract (proposed)	Per member set payment (vendor agreement)	Retrospective outcomes payment based on TCOC savings
Why?	Cost Savings Pilot lowered TCOC 33% (\$2,544) over 12 mo (Amerigroup calc)	MCO requirement Texas requires certain portion of MCO spending to be on VBP	Cost Savings Pilot lowered TCOC 67% (\$686 prmpm) over 6 mo (UUHP calc)	MCO Requirement Affinity required to have VBP and CBO contracts to address SDOH

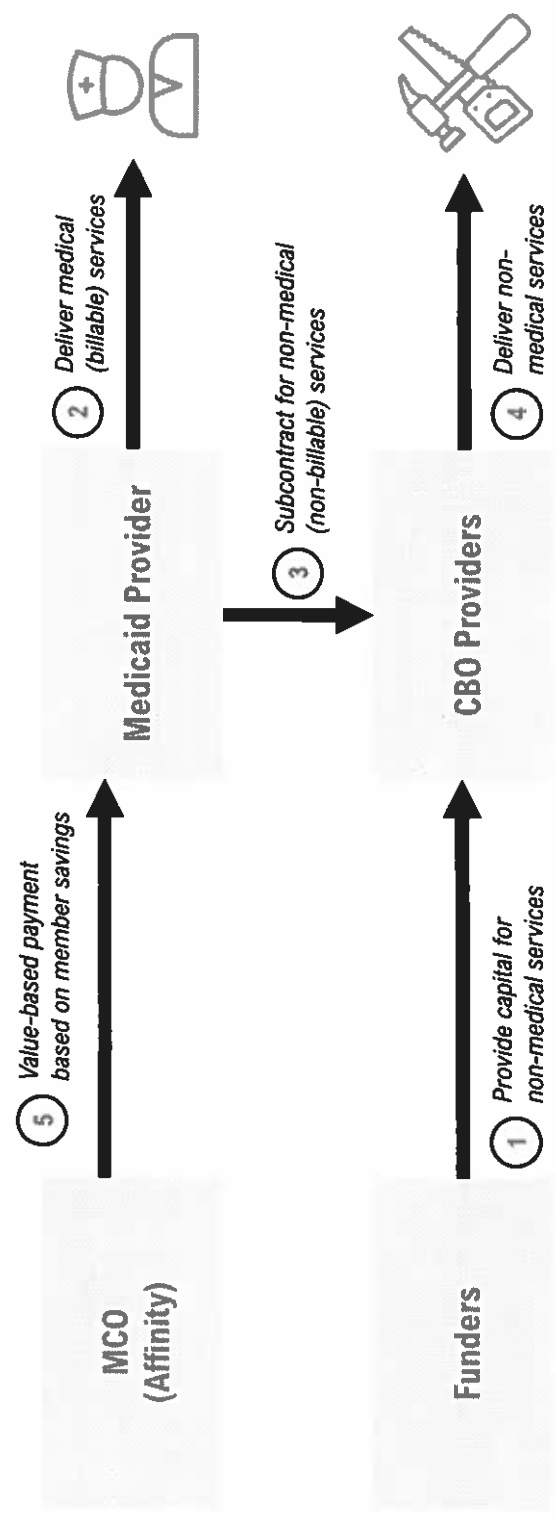
Payment Model: Maryland (Amerigroup)



Payment Model: Houston (UnitedHealthcare)



Payment Model: New York City (Affinity Health Plan)





Selected Publications

- Value-Based Purchasing: Making Good Health Good Business
- Capitalizing on the Health Impacts of Improving Housing Conditions (Practical Playbook II)
- Value-Based Purchasing Authority: 2016 Managed Care Regulations and Pay for Success
- Contract Options for Value-Based Purchasing Innovation: Financing the Transition from Volume to Value-Based Payments with Pay for Success
- Outcomes-Based Payments: How to Pay for What Works in Public Health
- Evaluating Medicaid Value-Based Purchasing Arrangements: How to Align Innovation Financing by Pay for Success within Medicaid Value-Based Purchasing Programs
- Health Services Initiatives: Using a CHIP State Plan Option to Address Asthma Among Children in Low-Income Households
- Community Health Worker Medicaid Reimbursement State Plan Amendment
- Preventing Falls with Healthy Homes
- Healthy Homes and Asthma: A Healthy Housing Blueprint to Improving Asthma Outcomes
- Using Pay for Success to Invest in Social Determinants of Health: A Short Guide for Policymakers, Funders, and MCOs
- New Jersey Lead Poisoning Prevention Action Plan
- Weatherization and its Impact on Health Outcomes
- Pay for Success for Lead Poisoning Prevention: How to Leverage Performance Contracting to Address Lead Poisoning in the United States



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An Overview of People with Intellectual and Developmental Disabilities (I/DD) and Community-Based Organizations that Support Them
Discussion with Value-Based Workgroup

August 2, 2019

Profile of People with I/DD

- Population Representation
 - Public I/DD Spending = \$1.73 billion (nearly entirely Medicaid)
 - HCBS Waivers
- Medicaid Representation
 - Blind/Disabled = 11% Medicaid population; 38% Medicaid spending
 - I/DD HCBS services remain carved out for LTSS
- Co-occurring Conditions
 - Mental/Behavioral Health
 - Physical Health
- Health Care System Utilization
 - Acute Care
 - ER
 - Psychiatric In-Patient
 - Primary Care
 - Long Term Services and Supports
 - Prescription Medication
 - Therapies and Ancillary Services

I/DD Service Delivery System

- State Operated Developmental Center (SODC)
- Intermediate Care Facility for Developmentally Disabled (ICFDD)
- Home and Community Based Service (HCBS) Agency-Based
- HCBS Family-Based
- Students with IEP due to I/DD
- People with I/DD not connected to state resources

Questions/Challenges

- Size of dual-eligible population and actual I/DD Medicaid-only enrollees
- Lack of direct access to I/DD enrollees
- Limited expertise with I/DD population among health care providers
- Future of HCBS LTSS system
- I/DD CBO experience/expertise with managed care/value-based arrangements

Opportunities

- Impact ER utilization
- Psychiatric hospitalization deflection
- Post-acute hospitalization rehabilitation
- Specialized training and condition management programs
- Case management
- Peer Support
- Expansion of specialized clinics and outpatient services
- HEDIS measure compliance

Business Process Management

5 Steps to Success in Value-Based Care



Introduction



Reimbursement in healthcare is moving towards value based models, both from private payers and the Centers for Medicare and Medicaid Services. That is, reimbursement will be based more and more on the quality of care provided. This can be seen in the Federal government's MIPS program and in rewards from private payers for certification as patient-centered medical homes. High quality care is the goal of Accountable Care Organizations.

How can a healthcare organization provide ever better quality? How can providers move ever closer to the Triple Aim: providing better quality care at a lower cost with an ever better patient experience? I have talked to many organizations who want to reach this goal but have a difficult time doing so. An approach that I know works to help them move forward is to use the steps of Business Process Management and it is used by many businesses to help them reach their goals. It is taught in colleges for business majors and is taught in some universities for healthcare providers.

This short e-book will serve as an introduction to Business Process Management for healthcare providers. Most of the illustrations are from the healthcare industry and there are a few from other industries and businesses too. Providers who carefully read the material can apply the lessons to their own services and see rewards for doing so.

I suggest that you identify a critical process at your site and apply the steps to it along with a team chosen to do the work. Be sure that everyone is familiar with the steps of BPM. You may want them to read the overview and then one unit at a time as you move through the steps. Feel free to copy and share the material. Effectively managing processes is not meant to be done by one person.

I hope that you find the material useful. If you have any questions, please feel free to contact me at t.bryant@alumni.utexas.net or find me online at Bryant's Healthcare Solutions.



Business Process Management

Much of what we do, whether at work or in our personal lives, involves routine processes. For example, driving a car to shop at our favorite grocery is routine, not requiring much thought even though we focus on being careful. At work we may greet our customers or patients with routine greetings, although we try to be friendly. These routines do not require a lot of thought. Instead, our minds adopt patterns for these routines rather quickly as it saves a lot of energy, according to recent brain research. So, if most of what we do is routine, then we need to make sure that the patterns or *processes* involved in these routines are effective and customer- or patient-centered.

Before proceeding too far, let me define what a process is. According to the American Society of Quality (ASQ), a process is “A set of interrelated work activities characterized by a set of specific inputs and value added tasks that make up a procedure for a set of specific outputs.” To illustrate this, I will examine a portion of the process of checking a patient in at an outpatient clinic. The input is information given by the patient—name, nature of visit and insurance coverage. The value added tasks are the questions from the person checking in the patient. For instance, “Do you still have the same insurance? May I see your card?” Doing this provides value for the clinic as it provides a means of billing for the services. The outputs are the recorded responses of the patient.

For the best outcomes that are predictable for both patients or customers and the provider or business it is necessary to understand the many processes at a provider site and effectively manage the processes. This function is called Business Process Management by quality professionals and was the focus of an article in the May, 2015, issue of *Quality Progress*, the flagship publication of the ASQ—"Process Primer".

Failure to actively manage the processes at your work site may have many unintended consequences that affect the bottom line. Let me return to the check in of the patient mentioned above as an example. Suppose the receptionist asking for the current insurance information of the patient finds out that the patient has just enrolled in Medicare. When asking for the insurance card the patient supplies his/her Medicare card. This seems fine but suppose the patient is in a Medicare Advantage program and, being new to Medicare, does not supply that card. Then, when the clinic files a claim, it will be denied and the billing staff will have to contact the patient to find out how to resolve the problem. This extra work is costly and time wasting. It could have all been avoided if the check-in routine included asking Medicare patients if they are using a Medicare Advantage payer.

According to the article "Process Primer" there are five pillars of Business Process Management (BPM):

1. Identifying top priority, critical processes.
2. Validating customer (patient) requirements.
3. Documenting the processes.
4. Developing process measurements.
5. Managing and improving the processes.

These pillars should be actively addressed and managed by site executives and leaders and staff trained to address them. Managing business processes requires training of staff and/or use of professionals who are experts in the field. Typically, quality experts trained in the use of lean six-sigma methodology or similar approaches are capable of providing guidance in BPM for a site. Many organizations provide training for staff in the use of the basic tools of lean six-sigma, including the Medical Management Group Association.

Identifying Critical Processes

There are many processes at a work site. It would take too much time and effort to identify and manage them all. Thus, it is necessary to identify which are most critical to patient and practice outcomes. These should be actively managed to insure optimal, predictable outcomes that satisfy the patients and customers. After the most critical processes are under control and producing predictable, effective outcomes, staff can move on to managing less critical processes.

Validate Customer Requirements

It is very important that customer needs are understood and being met. In healthcare, this approach is being patient-centered. Processes that directly impact patients, such as the provision of clinical care, must be focused on the needs of the patient. It is key that providers actively work to understand these needs. Other staff who have contact with the patient must also be patient-centered.

Not all customers are patients, though. For instance, the work of the billing staff has a direct impact on the financial health of the provider group; the customers of the billing staff are the office management and the rest of the staff. I would consider the processes that they use critical to the health of the provider organization. Thus, it must be managed so as to produce optimal outcomes.

Model the Processes

The current state of all critical processes need to be understood. One of the best ways to do this is to use mapping tools such as flowcharts, value stream mapping or software that allows the mapping of the details of a given process. According to "Process Primer", this includes people, systems, information, materials, tools and equipment, and documentation.

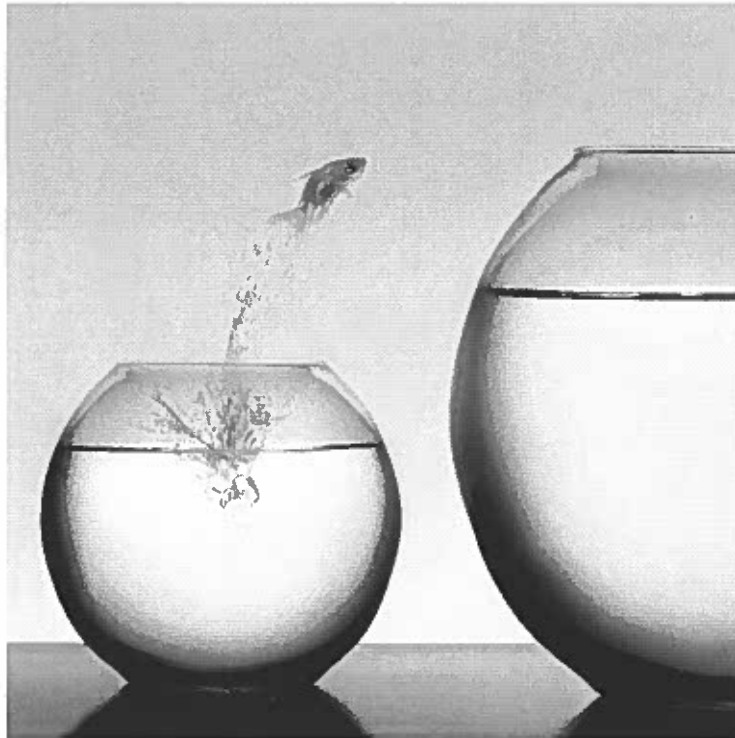
Develop Process Measurements

For a process to be managed key indicators must be identified and measured. At a clinical site these could include population level health outcomes, such as the average blood pressure of patients with diabetes. For billing it could be the number of claims in AR that are 60 days past due. Let me emphasize that it is not sufficient to have just one key indicator per process. Rather, measurements should be taken at various stages of the process to insure best management.

Manage and Improve a Process

Once key processes are identified, mapped and indicators are being measured as well as patient requirements identified the best providers will work to continuously improve the processes in order to insure ever better outcomes. This will provide ever-improving outcomes for patients and providers.

The best businesses and providers will be actively engaged managing and improving their processes. Although Business Practice Management is complex the time spent on it has a tremendous impact on the health of patients and the business of the provider. In the face of the changes in reimbursement to providers BPM is critical to the health of the provider.



Identifying Critical Processes

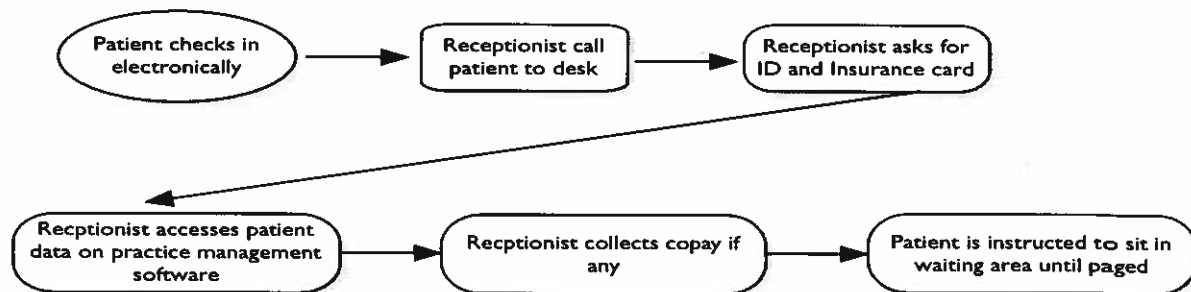
Why is it necessary to actively manage key or critical processes? In order to thrive in a changing reimbursement and regulatory environment key processes need to be optimized and new ones implemented. In a recent speech, the CEO of Metro Health, Mike Faas, located in Wyoming, Michigan, stated that in order to succeed his organization needed to form new partnerships with regional providers. He stated that one goal was to keep patients out of the hospital and to treat them more effectively by primary care physicians. Patient panels for physicians would need to almost double in size from the current average of 2000. The best way to do this was to improve processes at the primary care site with teamwork and to establish better communications with partners. I believe that this strategy will be necessary for most hospital groups.

The passage of the Medicare Access and Chips Reauthorization Act (MACRA) focuses on improved outcomes for patients and new payment options for physicians. Eligible providers must choose one of two options in order not to have their reimbursements cut. One way to do this is through quality reporting: Merit-Based Payment Systems (MIPS). MIPS will be based

upon four measures—quality, efficiency, meaningful use of EHR's and clinical practice improvement activities; all are process based.

If management and improvement of key processes will increase in importance soon (the best providers and businesses are already involved in this) it will be necessary for us to understand what processes are and understand how to identify key processes.

I believe that the American Society of Quality has some of the best resources available for understanding and improving processes (I am a member). As found in Chapter 1, they define *Process* as “A set of interrelated work activities characterized by a set of specific inputs and value added tasks that make up a procedure for a set of specific outputs.” One of the best ways to see processes is to organize the activities of the process into a flow chart or, as used in Lean Healthcare, a value stream map. Below you will find a very simple flow chart of checking in a patient at an outpatient clinic. Not every activity is included in this flow chart, only the key ones. It is not necessary to state every activity in a flow chart. The level of detail in a flow chart is determined by its use. The following one details the key interactions between the receptionist and patient. Other steps that could be included would be the notification to providers that the patient has checked in and is ready to be seen. Thus, the check-in process:



There are many processes, many interrelated, at a site, whether it is a provider, manufacturing, or business site. It is not possible to identify all of them in most circumstances. For the success of a business it is necessary to manage and improve the critical ones. After these are managed and continuous improvement implemented, less important processes can be focused upon.

How does one identify key processes? I believe that one should use the following steps, which I will explain in more detail afterwards:

1. Form a leadership team to identify the key processes
2. Identify criteria that can be used to gauge importance of a process
3. Leadership seeks to understand basic steps of processes being examined
4. Decide which processes are critical and sort them by order of importance

Decisions about critical processes need to be decided by the leaders and executives of a provider or business. In order to manage and improve processes leadership must be engaged and be

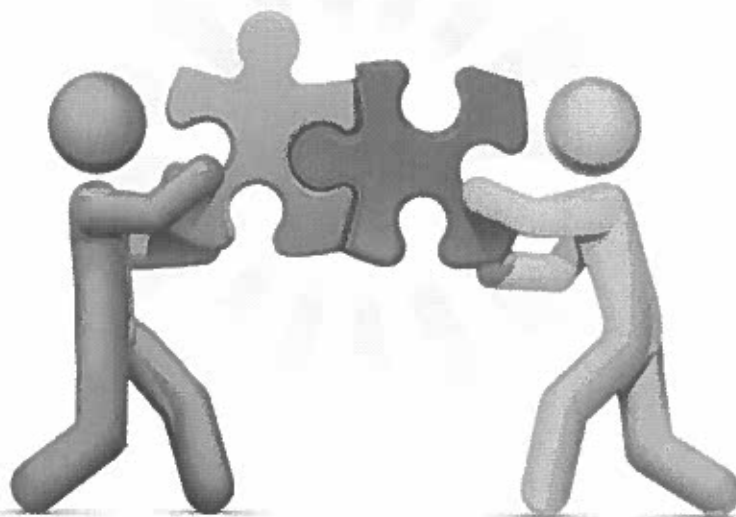
supportive. Also, leadership is likely the only group aware of all the important processes at a site. Thus, they must be initially involved in setting priorities.

In order to rank and prioritize processes some agreed upon criteria must be defined. One criterion might be the cost of the failure to manage the process. For example, if physicians and clinical staff do not keep up with their certification process, an outpatient clinic could fail. If a food manufacturer does not insure the safety of its food by inspection it may be heavily fined. Another criteria besides monetary costs could be the meeting of regulations. For example, if banks fail to have adequate reserves they can be fined by the Federal Reserve.

It is necessary for each leader on the decision team to understand the basic steps of the processes under consideration. If they do not, it will be difficult to prioritize the processes. If a leader(s) do not know the basic steps he should go-and-see the process in action.

Lastly, all the processes under consideration should be ranked by the leadership team in order of importance based upon the criteria decided upon by the team. The first ones should be focused upon. A timeline for improving the management of the process should be set and a champion from the team identified to oversee its improvement and management.

As you can see, identifying key process at a site is very important to the health of any business. Failure to do so will lead to the loss of potential revenue and negatively impact customers and patients. Identifying the key processes takes time and effort by leadership but is well worth the investment. The steps identified will lead to an effective identification and prioritization of key and critical processes.



Knowing What Your Patients Want

Can you imagine having a farmers supply store in downtown San Francisco? It seems highly unlikely to me. There would be few sales. Having such a store there is an example of a business out of touch with its market. To be successful, businesses must supply the right product or services to the right customer in the right place and at the right time.

Should healthcare providers worry about such? Do they need to focus on the customer, the patient? While location is important for providers, does the delivery of services matter? After all, healthcare providers provide a service that is universally needed.

It so happens that the way services are provided makes a difference. With the right services provided in the right way providers will reap many benefits, including patient loyalty, better outcomes for the patient and better income for the practice. I believe that we can all agree that better patient engagement is one of the key factors to better health outcomes. But there is more than engagement between patient and clinicians that drives outcomes for patients and that improves loyalty.

In a recent survey members of the Medical Group Management Association (MGMA) stated that several services helped improve patient satisfaction and engagement. Among them were flexible hours so that patients could have better access to clinicians, variety of communication styles, help with cost containment and management, and care management. Members stated that patients wanted other ways to communicate with physicians and staff, such as electronic patient portals and secure email. Since many more patients have high deductible policies they appreciate help in managing their copays and deductibles. Letting a patient know before services are provided what their costs will be and helping with making arrangements for paying their share if need be puts them much more at ease. Patients also like help in changing their lifestyles if chronic conditions make it necessary.

I am not advocating that providers supply everything that patients want, even if saying 'No' to a request can be difficult. My own physician has said 'No' to some of my requests because it makes good financial sense to do so for the practice; his group is part of an ACO. For instance, recently when I asked if I could be tested for allergies to see which bees and wasps I was allergic to, he said 'No'. My reactions to stings was not severe yet and I should carry an epi pen with me when I am outside in the summer and spring in case I was stung and began to have a reaction. There are many instances when physicians should deny patient requests. For instance, recent research shows that 84% of physicians still prescribe antibiotics for runny and stuffy noses in spite of the fact that research shows this is the wrong thing to do, as it builds up antibiotic resistant bacteria.

It is important that medical providers find out what their patients want that will lead to better outcomes for all. It would be a waste of time and resources to provide services from a list such as those from the MGMA survey above if patients do not want some of those services. Perhaps almost all of the patients in your practice have easy access to services; they do not need more flexible hours. How, then, can you find out what your patients want that you are willing to provide?

There are several good ways to find out from your patients what new services they want or what services you provide that could be improved. Working with a team made up of various office and clinical staff, providers can use focus groups, advisory groups, surveys and patient feedback to staff to find ways to satisfy their patients. It is necessary to use teams to develop and implement these strategies to get patient input so as to get a good variety of ideas and questions.

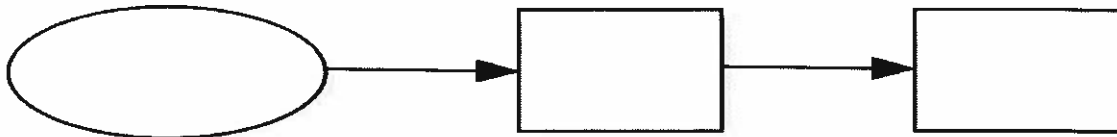
A focus group is a good way to get ideas to improve your practice which you can then test to see if the suggestions are good. You can conduct a focus group using your own staff as leaders or you can hire a professional to help with this. A professional will definitely get better results but you can certainly conduct one yourself if you follow a few simple steps. One, have a goal for the focus group, such as, "How can our group help improve our services so as you (the patients) believe your needs are better met?" Then, your staff team can help create a set of questions and inquires that can be used while conducting the session. Then, choose a moderator to move the session along and a recorder to write down the response of the patients. Finally, invite some of your patients to be a part of the focus group. I would use no more than 8 or 9 in the session. You may want to provide a reward for their participation.

Another way to find out your patients needs is to create a survey. Your team should help develop the questions for the survey. You may have your patients fill out the survey when they

come in for a visit. If you want a broader group of responders, you may take time to do a phone survey of your patients. One member of the MGMA reported recently that his group has staff members call several patients each day over a period of time to collect responses to a survey.

Another effective way to get some insights is to collect feedback from patients during their encounters with your staff. Patients will sometimes let members of your staff know what could be better at your practice. Staff should be trained to write down these suggestions or have the patient write down the suggestion and hand it back to the staff. These suggestions can then be reviewed later at a staff meeting so that the suggestions can be further explored and the staff member who collected the suggestion can add further details. Such suggestions can be used in focus groups or in future surveys.

Changing your services, adding more services, will help satisfy your patients which will lead to better outcomes and improve patient loyalty. Loyalty is important as it is easier to treat a returning patient than a new one; it is also more cost effective to treat returning patients as it generally takes less time to treat them. Further, loyal patients will recommend you to their family and friends as well as provide good feedback on sites that measure patient satisfaction and on social media web sites. Using some of the tools that I described will help you find out what your patients want.



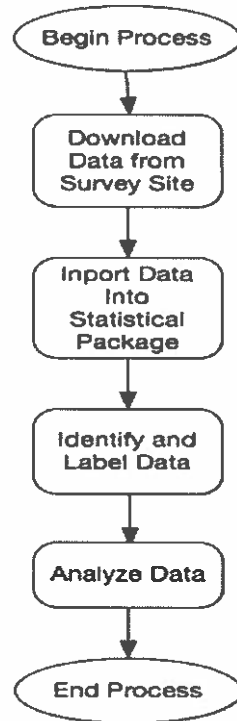
Model the Process

Cooking is a process that involves specific, orderly steps with well-defined inputs. For some recipes slight variations are allowed but the basic steps and ingredients must be maintained for a good product. For instance, when my wife makes a marinara sauce, she uses crushed tomatoes, salt, onions, garlic, basil, red wine, fennel and parsley. I, on the other hand, use the same ingredients except the fennel but add a bit of sugar and oregano. The steps in making it are the same for both of us: brown the garlic and onion in olive oil and then add the rest of the ingredients and simmer for about a half hour to an hour.

In business, manufacturing and service industries such as healthcare most activities are performed with well-defined processes. In manufacturing there is no room for variation in order to produce a best quality product. In service industries, there may be some variations as in the slight variations of making marinara but the best outcomes are achieved if each task is performed essentially the same. There is more room for variation in the clinical side of healthcare as an orthopedic surgeon may choose to use tissue from the patellar tendon or hamstring to repair a ruptured ACL. Nevertheless, using standardized processes generally results in best outcomes and these processes should be **modeled**, according to the structure of Business Process Management, which I have been discussing.

Modeling a process allows for standardization and identification of best steps to use. If each person in a process adopts the standardized process then outcomes will be predictable, thus pleasing the clients and patients. It also eliminates waste, thus producing savings for the business or provider.

Modeling a process can involve paper and pencil or computer software. Most is done with software now. Two common ways to model a process are to use flowcharts or value stream maps, which are used in Lean process management. I have created a simple flowchart which models the process that I use to analyze data that has already been collected for a client. It is:



Since I am the only one who employs this process there is no variation; I am consistent from one application to the next for different clients.

What are the components found in process models? Generally, there should always be a definite beginning and end point. Besides the physical steps you may want to include some are all of the following: people involved in the process, information and data, materials, tools, and environmental factors. These are always used in value stream maps.

You may believe that the processes at your site are fairly standard but the 'present state' of a given process may be quite variable. This is especially true if a process has never been documented. For instance, when a medical assistant is escorting a patient to an exam room at an outpatient clinic, she may stop and take the patient's weight and measure her height before proceeding to the exam room. Another MA may take the weight and not measure the height.

To see if there is wide variation in a process that is unacceptable because it leads to errors or poor outcomes, a team of those involved in a process should work with a process champion (a person designated to own a process and optimize it) to 'map the current state' of a process. It is during the mapping of the current state that the variations will appear. In fact, it may appear that there is very little standardization occurring at all.

I was working with a hospital group once and we were mapping the check-out process. In working with the administration and nurses we found that there was a wide variation in how the check-in staff was notified that there was an empty bed available. In fact, there were many workarounds for this process that had been developed by the floor nurses as the standard process did not work well. So, we made a present state map that represented the steps generally used by most staff. Then, we created a 'future state map' that represented the steps that all should use

and that was best in notifying the check-in staff of the availability of beds on a unit. After creating the future state map, the process champion worked with the team to develop a plan to implement the new process and make sure that it was consistently followed by all involved staff. This included identifying indicators that could be measured to indicate the success of the implementation.

One of the important steps that a process champion must do before meeting with the process improvement team is to take a *gemba walk*. This involves the champion going to the place where a process occurs and patiently watching it unfold. She should do this several times and with different staff involved. By observing the process unfold she will be able to assess the amount of variability in the current state. The champion should also observe a process after it has been successfully implemented to be sure that there is no backsliding to the previous state of the process which was probably highly variable and unsatisfactory.

As you can see, to get best outcomes, a process should be explicitly mapped. From this map, a standardized future state map can be created so that all will carry out the process in the same way, thus providing predictably good results. Patients and clients will be happier, staff will be pleased and the providers will be rewarded with increased income.



Measure It!

“What gets measured gets improved” is a common business adage. A restatement of it is “What gets measured gets managed”. I believe that this is quite true but want to add that experience and intuition are important components of an improvement program. If you want to improve patient and client outcomes, then you must actively engage in business process management and a key component of this is developing a metric system to measure your processes and outcomes.

Engaging the customer or patient, striving to satisfy them is an important strategy to retaining them and improving outcomes, whether it be better health or increased sales. Thus, it is very important to measure engagement and satisfaction so there is a basis to measure improvement.

Let me give you an example of this from a population level health management program that I have been involved with for over eight years. The program is a social norms campaign at a local high school whose goal is to drive down alcohol and drug use by the students.

At the beginning of the program the principal and staff of the high school worked with my group whose main goal was to drive down the amount of alcohol, marijuana, tobacco and other drugs that students used to ‘get high’. Getting high has many negative consequences for young people whose brains are still developing. With this goal in mind my team developed a program that

included an annual survey of students at the high school that would provide information on the current use of these substances by the 'average' student as well as other data that could provide data for messages that would be used to alter the behavior of the students. The first survey provided a baseline against which data from future surveys would measure progress. The data collected gave very accurate measures of the progress of the campaign. The accuracy of the data was assured as actions were taken to remove the input of those who lied on the survey.

The engagement of the students in the program was through messages on posters posted in classrooms that stated the actual use levels of the substances by students. For instance, one month the posters in the classrooms stated that "Students at XX High School believe that 73% of their classmates use marijuana. In reality, 87% do not." The posters correct the misperceptions of the students. When doing this, according to social norm theory, actual use of the substances decline over time. The engagement has been very successful. Alcohol use has declined 91% and the use of marijuana has significantly declined since 2012, when it reached its peak. Only 5% of students use tobacco products. The leadership of the school and community are very pleased with the outcomes so far.

The data we collect not only provides measures of success but it also helps guide our messaging from year to year. For instance, in for the past two years we have been focusing on marijuana use.

How can you use this approach to improve outcomes for your patients and clients? Following are some basic steps that will help you develop successful processes or programs that is based upon metrics:

1. **Set high priority goals that focus upon improving outcomes.** I am sure that you can identify many goals for your site but it is necessary to identify the critical few that are key to success. Having too many goals may dissipate the energy needed to accomplish the most important goals. Focus on patients' and clients' needs and wants.
2. **Identify measures that indicate progress in reaching your goals.** Use measures that indicate progress in improving the outcomes but also that measure the processes used in reaching the outcomes. Do not use too many measures as this too will require too much energy and effort.
3. **Implement the metric program.** Assign responsibility to someone to oversee the metric program, the identified measures, and to report progress to management and the team that supports the improvement efforts.
4. **Act upon the data to further improve the outcomes and processes.** It is necessary to identify attainable goals that can be attained in a given amount of time. Once the goals are reached you should set higher goals.

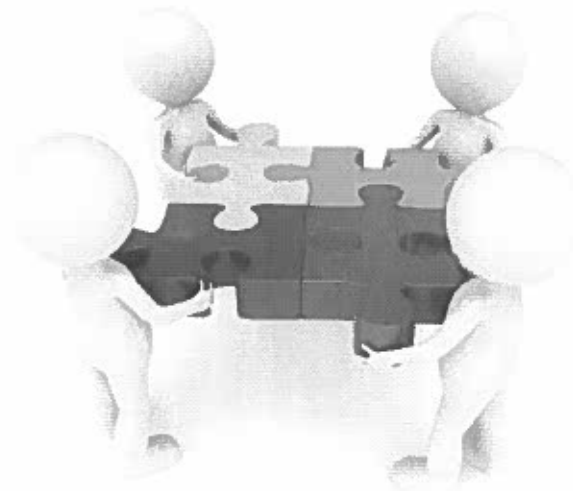
Another view of these steps are SMART GOALS: Specify, Measurable, Assignable, Realistic, and Time Orientated.

An example of this in a clinical setting could be:

1. Specify: the average A1c level in a physician's panel of diabetic patients will be less than 6.5.
2. Measurable: the clinicians measure the A1c level of each diabetic quarterly and also monitor the diet and exercise habits of the patient through the use of an online journal available on a patient portal.

3. Assignable: the progress of each patient is followed by a nurse coordinator who is a part of the clinical practice.
4. Realistic: the goals of the patient outcomes are realistic based upon the baseline measurements obtained at the setting of the goals and measured at a population level.
5. Time orientated: the clinical staff expects to reach the goals within one year.

Many programs set goals to achieve but fail to establish a metric program to measure progress in reaching the goals. The failure to measure outcomes means that the energy expended to reach the goals is like a stab in the dark—the providers hope that they reach their goals but they really do not know if they do. Intuition and experience may indicate success but without the addition of measurements it is almost impossible to know the impact of the efforts to reach the goals.



Improving Your Outcomes

Do you want to deliver outstanding results for your patients, your clients? Do you want to deliver the triple aim of healthcare—patient-centered care at a lower price with better population level outcomes? If the answer is ‘Yes’, then you need to continuously improve the quality of the care that you deliver, the service that you supply. I believe that this is the goal of most providers.

If you are ready to adopt the steps of Business Process Management that have been described above, then you are ready to move on the last step—managing and improving your processes. As you may recall, the previous steps were:

1. Identifying top priority, critical processes.
2. Validating customer (patient) requirements.
3. Documenting the processes.
4. Developing process measurements.

Many organizations after implementing these four steps move on to actively manage their processes, their services. I do know some that do not. Such a waste of effort, I believe. Armed with the information collected and developed in the first four steps action must be taken to address the findings. Energy must be spent to manage the most important processes so that the quality of care does not suffer. From my experience, this is what most provider and service organizations do. They collect data on their most important processes and identify patient requirements and then keep performing the same processes over and over. They are not interested in actively addressing changes that lead to better outcomes.

Consider a group of primary care providers who have been engaged in patient care for many years. The majority of their income comes from fee-for-service activities. They have many patients who have Medicare. They do work to meet government mandates such as advancing care information. Their focus is primarily on fee-for-service activities. In the next few years their returns for these activities will steadily erode as CMS switches over to the MACRA (Medicare Access and CHIP Reauthorization Act of 2015) requirements. They may excel in managing the fee-for-service processes at their site, but still their income will erode.

Healthcare providers who not only seek to manage their processes and meet patient requirements but also seek to improve the quality of their care will most likely see increases in revenue at their site. If they work on the triple aim—work continuously to improve their outcomes—then they will be rewarded by private payers and CMS.

What are some examples of continuous improvement projects that lead to hitting the triple aim? Houston Methodist Hospital works hard to improve patient health by concentrating on population level health management supported by data collection. Houston Methodist owns seven hospitals, a long-term care facility and contracted specialty and primary care physicians. They have stratified their patients into groups including a high-risk pool. Methodist Hospital provides case management services to this group. Over a six-month period recently they moved 50% of the high risk patients to a low-risk pool, thus hitting the triple aim.

Patient-centered medical homes are another example of primary care providers working to improve patient outcomes by focusing on the patient. Mercy Health Physician Partners of West Michigan is certified as a patient-centered medical home by the NCQA. They focus on patients with care plans tailored to the patient. Included in access to care is a well designed patient portal.

Another avenue to hitting the triple aim is through Accountable Care Organizations. Recently CMS added another contract model for ACO's—the Next Generation ACO Model. This model provides several ways to manage risk in a capitated environment. The hope is that more organizations will sign contracts with CMS to provide care in this model.

There are many tools that can be used to improve the quality of care at a lower cost. Healthcare quality improvement managers use programs such as Lean 6 Sigma, Plan-Do-Check-Act cycle and Total Quality Management. Each has a different focus but all are built upon collecting data as a part of business process management and looking at patient and customer requirements. The American Society of Quality and the Institute for Healthcare Reform have many resources that address these quality improvement programs.

The culmination of any business process management program is to continuously improve the service or care offered. In healthcare, this is known as the triple aim—lowering costs while focusing on the patient with population level management programs. There are many approaches to achieving the triple aim. Any program hoping to continuously improve should adopt strategies and methodologies that resonate with their staff and leadership whether it be Lean Six Sigma, Total Quality Management or Plan-Do-Check-Act cycle. Using these or similar tools will lead to ever better outcomes for all involved.

Conclusion

This concludes my brief introduction to Business Process Management. I hope that you find the material useful and find many ways to apply it to work and processes at your site. I find that businesses that focus on following the steps faithfully generally experience some success. The difficulties usually encountered is to keep applying the steps continually and maintaining any accomplishments. It is very easy to backslide.

If you find that you have some success but wish to accomplish even more, I will be glad to help. Just email me at t.bryant@alumni.utexas.net or contact me through the website of Bryant's Healthcare Solutions.

Alternative Payment Model: *The NH CMHC Experience*

February 28, 2019

Prepared by:
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Executive Director

NH Community
Behavioral Health
ASSOCIATION

HELMS & COMPANY
INC.

Agenda

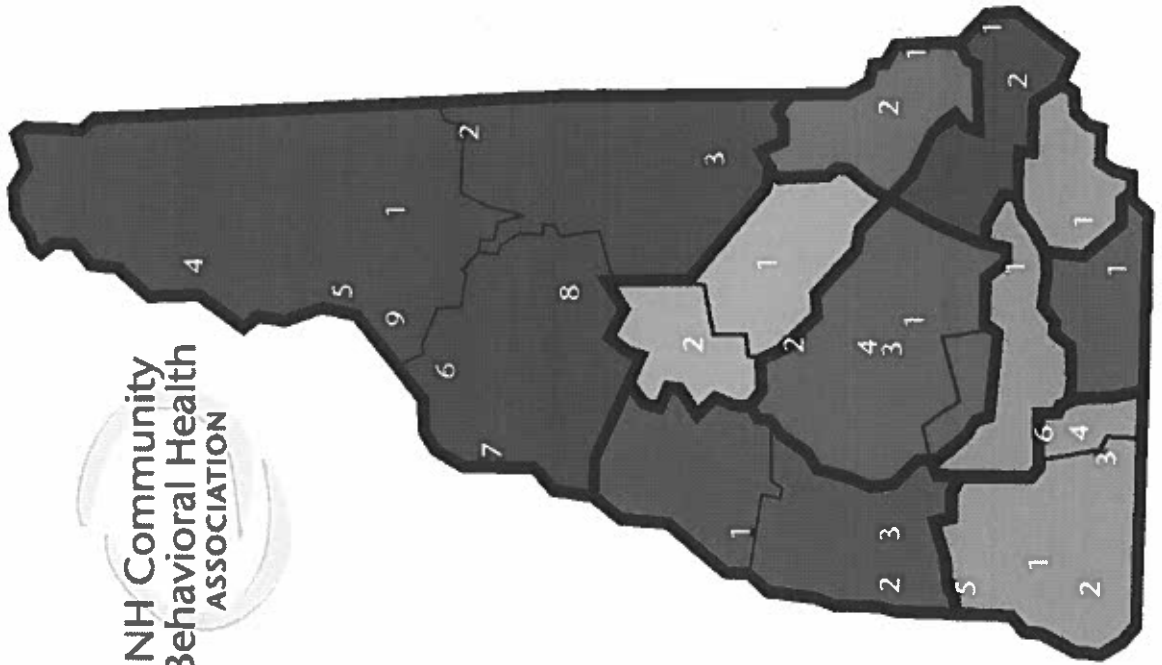
- I. Introduction – NHCBHA
- II. Background – Why Develop an APM?
- III. CMHC Payment Model
- IV. Challenges & Opportunities
- V. How Are We Doing?
- VI. Discussion & Q&A

NHCBHA - Who are we?

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- ❖ All 10 Community Mental Health Centers, geographic designation under NH statute
- ❖ Association formed in 2002
- ❖ Administrative & government relations components
- ❖ Project management, data analytics & business development
- ❖ “Messenger” model system for engaging MCOs

**NH Community
Behavioral Health
ASSOCIATION**



NH Community
Behavioral Health
ASSOCIATION

1. Berlin
2. Conway
3. Wolfeboro
4. Colebrook
5. Groveton
6. Littleton
7. Woodsville
8. Lincoln
9. Lancaster

1. Lebanon
2. Claremont
3. Newport

1. Laconia
2. Plymouth

1. Concord
2. Franklin
3. Penacook
4. Boscawen

1. Keene
2. Winchester
3. Jaffrey
4. Peterborough
5. Walspole
6. Antrim

1. Nashua
Mental Health Center of
Greater Manchester
1. Manchester

1. Portsmouth
2. Exeter

1. Dover
2. Rochester

1. Derry

Background

Why develop an APM?

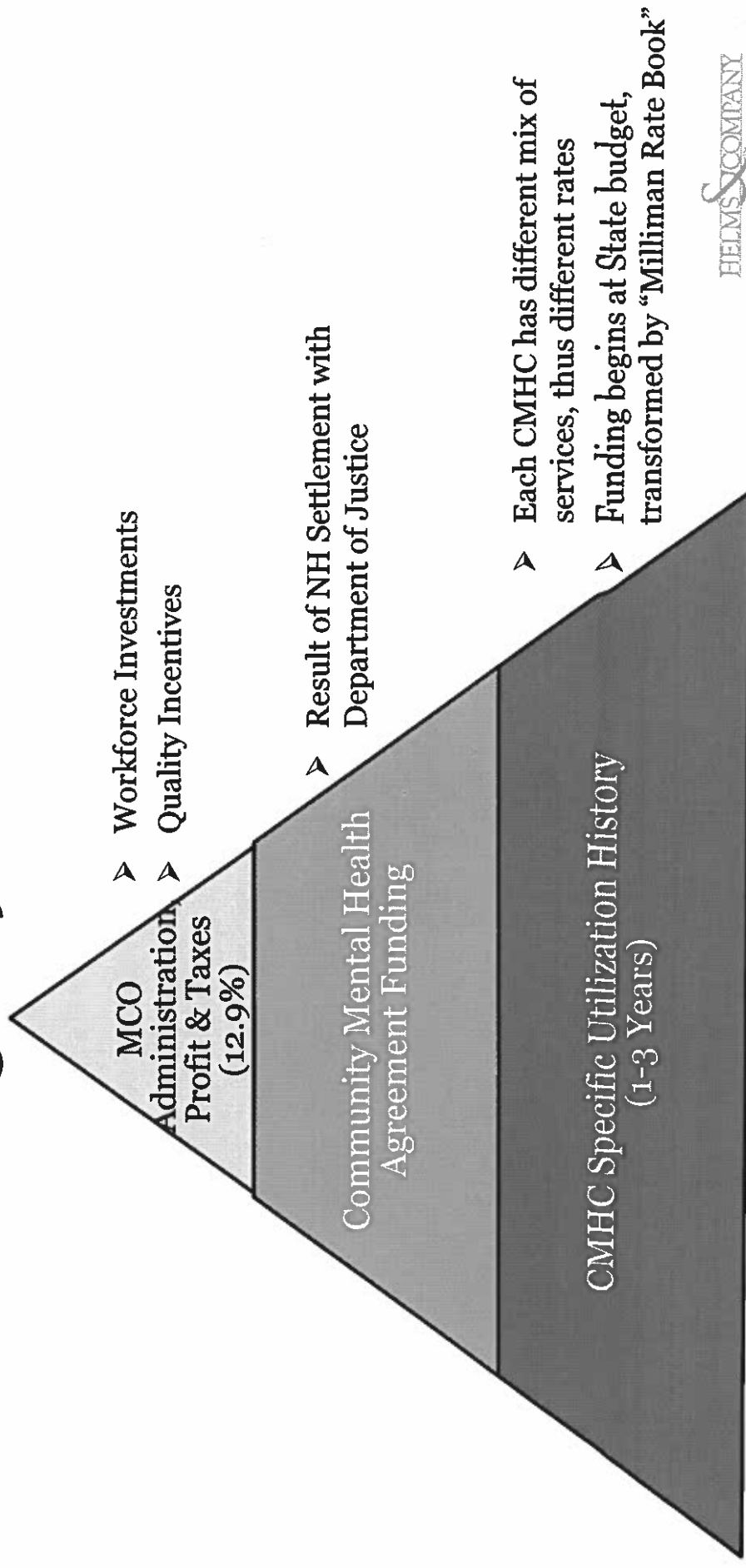
- ❖ NH Medicaid Managed Care begin in 2013
 - Initially meant to exclude “chronically ill” however mental health was rolled into phase 1 implementation
 - Began with 3 MCOs, after one year, 2 MCOs remained
 - MCOs wanted “traditional” fee-for-service tools, prior authorizations, referrals, etc. – significant administrative burden
- ❖ NH Legislature highly critical of fee-for-service structures in mental health for a decade prior to managed care

Background

Why develop an APM?

- ❖ NH DHHS had tried several models that produced “winners” & “losers” – each one failed
- ❖ CMHC utilization, year over year was dropping significantly as a result of workforce pressure
- ❖ “Milliman Rate Book” governing how MCOs get paid used 3 years of historical spend in MH & added 10.9% for MCO administration/profit & 2% premium tax

Basic Economic Construct Influencing Payment Model



CMHC Payment Model

- ❖ Capitated payment based on 4 clinical eligibility categories
 - Severely Persistently Mentally ill – SPMI
 - Severely Mentally ill – SMI
 - Severely Emotionally Disturbed – SED
 - Low Utilizer – LU
- ❖ Prospective monthly payment – On or about 15th of the month – CMHCs provide “client file”
- ❖ Quality Incentive Program for performance against agreed upon metrics – up to 2% of spend

CMHC Payment Model

- ❖ Maintenance of Effort (MOE) key component for payer & provider – essentially measures performance to a “baseline” – creates “goal posts” around the capitation
 - Example: 80% of revenue must be utilized on services, measured based on the Medicaid fee schedule, anything lower is returned to MCO
- ❖ Shadow billing like fee-for-service is necessary to measure performance and meet encounter reporting requirements for the DHHS and CMS

CMHC Payment Model

- ❖ This is not a fee-for-service system settled to a negotiated capitation – it is a capitation system measured by fee-for-service encounters
- ❖ Specific code sets of services with modifiers are included in the capitation
- ❖ Quality metrics are either predetermined by DHHS / MCO agreement or negotiated
- ❖ Model excludes new service development & substance use services – both paid fee-for-service

CMHC Payment Model

- ❖ Rates negotiated annually as a function of the “State (Milliman) Rate Book” (Crucial element)
 - This limits funding of new services – Remember MCOs are paid based on historical spend & future service assumptions
 - The timing of rate book approval means our APM will always have a reconciliation element since negotiation on rates can not occur until it is finalized

CMHC Payment Model

- ❖ The “6-Month” Rule
 - The State actuary (Milliman) developed criteria for capitated payment that says if a person is rendered a service, capitation is guaranteed for 6 months. Upon each service encounter, the clock restarts
 - CMHCs may discharge patients sooner if not engaged in treatment, some suggest it’s a liability issue
 - Important to have systems capable of a clinical discharge separate from business / operational discharge in order to maximize the economic opportunity

Challenges & Opportunities

- ❖ Aligning MCO/payer business functions with provider business functions, try to avoid manual effort whenever possible
- ❖ Creating business functionality that supports the APM; patient definitions, services covered, reimbursement for services outside the APM, etc.
- ❖ MCO/payer consistency in talent – creating a broad understanding of the APM, shifting the culture

Challenges & Opportunities

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- ❖ Defining quality & improving patient outcomes
- ❖ Reconciliation, reconciliation, reconciliation
- ❖ Back office functions; APMs can sometimes challenge traditional back office functions, simple issues like revenue cycle management, posting cash to patient accounts, coordination of benefits can be turned inside out by APMs

Challenges & Opportunities

- ❖ Sustainability of the APM can be tricky; APMs for public sector business are not solely a provider-payer negotiation. State & Federal policies, revenue streams & budgeting play a key role
- ❖ Documenting the intent of the APM & relationship among the parties – no contract language is perfect

Challenge & Opportunities

- ❖ Workforce productivity – CMHCs maximizing the APM seem to have productivity standards for staff. This enables them to perform better against the MOE & command greater share of the available dollars
- ❖ CMHC use of licensed & “non-licensed” clinicians creates friction with typical MCO measurements under HEDIS

How are we doing?

- ❖ Since our APM begin, all CMHCs have experienced greater economic return than fee-for-service would have provided – approximately 5%-15%
- ❖ All economic benchmarks of CMHCs have improved
- ❖ Workforce investment has begun
- ❖ Operational issues CMHCs faced in the beginning have “mostly” resolved

How are we doing?

- ❖ The APM has completely changed the conversation
 - DHHS & Legislature completely supportive
 - Investments in Mental Health resulted
 - DHHS mandated our model upon MCOs contractually
 - DHHS created a Directed Payment Model through CMS waiver to increase investments in key areas – \$5M
 - DHHS uses mental health as an example for other systems of care – goal of 50% of Medicaid spend on APMs by end of 2020

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Questions & Answers

HELM'S & COMPANY

Moving Toward Value-Based Payment for Medicaid Behavioral Health Services

*By Michelle Herman Soper, Rachael Matulis, and Christopher Menschner,
Center for Health Care Strategies*

IN BRIEF

States, health plans and providers are beginning to develop value-based payment (VBP) arrangements to pay for Medicaid behavioral health care services. VBP approaches shift 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. Many state Medicaid programs have developed VBP approaches to improve quality and slow cost growth for physical health services, but these advances have been slower to emerge in Medicaid behavioral health programs. This brief, produced with support from the California Health Care Foundation, describes how innovative states and Medicaid managed care organizations (MCOs) are building upon models developed for physical health services and incorporating VBP arrangements into behavioral health programs. It explores key challenges in implementing VBP models in behavioral health settings related to quality measurement, provider capacity, oversight considerations, and privacy and data-sharing constraints. Lastly, it highlights considerations to help states advance these models, and suggestions to support MCOs and providers with more effective program implementation.

Public health care payers are increasingly changing the way they pay for health care services through value-based payment (VBP) arrangements. VBP generally refers to activities that move away from the traditional fee-for-service (FFS) payment system, which rewards volume, to alternative payment models that reward high-quality, cost-effective care.¹ The Department of Health and Human Services (HHS) announced in 2016 that it aims to move 50 percent of traditional Medicare FFS payments into alternative payment models that reward efficiency and high-quality care by 2018.² State Medicaid programs have embraced VBP efforts as well: In a year-end 2016 annual survey of state Medicaid directors, nearly 40 percent reported plans to expand VBP arrangements in the following year.³

Most VBP arrangements in Medicaid currently support the delivery of physical health services. However, states, health plans and providers are gradually becoming more interested in transitioning to similar payment models for Medicaid behavioral health services. At 26 percent of total national spending, Medicaid is the largest payer in the nation for behavioral health services.⁴ Spending for individuals with a behavioral health diagnosis is nearly four times higher than for those without. Furthermore, the nearly 20 percent of Medicaid beneficiaries who have a behavioral health diagnosis account for almost half of total Medicaid expenditures.⁵ There is increased recognition that the use of VBP in Medicaid holds promise to improve quality and slow cost growth. However, VBP strategies have been slow to emerge in Medicaid behavioral health programs.

This brief, produced with support from the California Health Care Foundation, describes innovative programs implemented by state Medicaid programs and Medicaid managed care organizations (MCOs) that use VBP arrangements in behavioral health care settings serving individuals with

significant behavioral health needs. Most of the examples describe payment levers that states and MCOs use to improve provider practices, but the brief also includes a state approach to using payment to improve MCOs' delivery and coordination of behavioral health services. The examples also describe current Medicaid behavioral health delivery system models that are a foundation and, in some cases a catalyst for, states and MCOs to accelerate new payment models. Lastly, it provides insights gleaned from expert interviews with state Medicaid officials, MCOs, behavioral health agency administrators, and policy researchers about challenges associated with implementing VBP for Medicaid behavioral health services as well as suggestions to help states advance these models.

Behavioral Health Payment and Delivery Reform Landscape

Defining Value-Based Payment Arrangements

There are several frameworks for VBP, but one commonly used model — created by the Department of Health and Human Services (HHS) in collaboration with partners in the public, private, and non-profit sectors — is the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model (APM) framework.⁶ The LAN framework is increasingly used as a tool by the Centers for Medicare & Medicaid Services (CMS), states, and to some extent by private payers, to establish consistent terminology and to define the levels of risk in, or sophistication required for, types of VBP models. Exhibit 1 provides descriptions of provider payment models from the APM framework.

Exhibit 1: LAN Alternative Payment Model (APM) Framework⁷

Category 1: FFS payments not linked to quality. FFS payments are based on the number and units of service provided, without linkages to, or adjustments for, provider reporting of quality data, or performance on cost or quality data.

Category 2: FFS payments linked to quality and value. FFS payments are adjusted based on other factors, such as infrastructure investments, whether providers report quality data (pay-for-reporting), and/or performance on cost and quality metrics (pay-for-performance). This may also include a penalty disincentive, i.e., a lower or withheld payment if providers do not produce quality indicators, or report events or procedures that are harmful and were avoidable.

Category 3: Alternative payment models based on FFS. Payments are based on FFS, but provide mechanisms to more effectively manage services. Providers must meet quality metrics to share in cost savings, and payments are based on cost performance against a target. Models may include:

- **Shared savings/shared risk.** Also referred to as “upside” or “downside” risk respectively, providers must meet a total-cost-of-care target for some/all services for an attributed set of patients. If actual costs are below projections, providers may keep some savings or may also be at risk for higher-than expected costs.
- **Bundled or episode-based payments.**⁸ A single payment to providers for all services needed to treat a given condition (e.g., maternity care) or to provide a given treatment (e.g., hip replacement). Providers receive an inclusive payment for a specific scope of services to treat an “episode of care” with a defined start and endpoint.

Category 4: Population-based payments. Payments are structured to encourage providers to deliver coordinated, high-quality care within a defined budget. Payments may cover a wide range of preventive, medical, and health improvement services. Examples include global or capitated per-member-per-month payment, which may include both physical and behavioral health. Plans or providers bear the financial risk for the cost of treatment.



LAN recommends that, over time, the U.S. health care system move toward payment models in Categories 3 and 4, while recognizing that this will not be readily achievable in every market (such as in rural areas), or for every patient population.⁹ Payments made to providers under VBP approaches need to be linked to quality or demonstrate value in some way, such as achieving improved health outcomes, choosing evidence-based processes, managing the costs of care, and implementing effective care coordination strategies.¹⁰

With the majority of Medicaid beneficiaries receiving services via managed care, states are also increasingly using MCO contracts as a vehicle to increase the number of providers paid under VBP arrangements. General approaches to promote VBP within managed care include: (1) requiring MCOs to adopt a standardized VBP model to reimburse providers; (2) requiring MCOs to make a specific percentage of provider payments through approved VBP arrangements; (3) requiring MCOs to participate in a multi-payer VBP alignment initiative; and/or (4) requiring MCOs to launch VBP pilot projects subject to state approval.¹¹

In addition, states may also adjust payments to MCOs based on quality metrics and efficiencies to drive behavioral health outcomes and advance integrated models. For example, states have developed MCO-level pay-for-performance incentives or withhold arrangements, in which states retain or “withhold” a portion of capitation payments that are returned to MCOs for meeting specific contract requirements. These differential payments to MCOs can help to align incentives across plans and providers and offer another mechanism for states to help ensure that Medicaid dollars are being spent on high-quality, efficient care.

Medicaid Behavioral Health Delivery System Models

Delivery system models are often the vehicles *through which* VBP arrangements, such as pay-for-performance, shared savings, and bundled payments, are implemented. The number of states implementing behavioral health delivery system initiatives — including a focus on integrating behavioral health with other medical and social supports — has rapidly expanded. In a recent annual survey conducted by the National Association of Medicaid Directors, 15 state Medicaid directors in 2016 cited behavioral health reform as a top priority for the upcoming year.¹²

Integrated care can better align system incentives and increase health plan or provider accountability for managing a more complete range of services, which is important for this population with high comorbidity rates. In addition, the high service use and spending for individuals with behavioral health conditions often does not just reflect behavioral health service utilization. Nearly 70 percent of those with behavioral health issues have a co-occurring physical health condition, including conditions associated with tobacco and alcohol use, such as chronic obstructive pulmonary disease, asthma, and chronic liver disease and cirrhosis.¹³ In many cases a small percentage of overall costs for this population are attributed to mental health services.¹⁴

States are using a number of different Medicaid managed care arrangements to drive integration and quality improvement delivery reform efforts across behavioral and physical health services, including:

- **Carve-in.** A number of states (e.g., Tennessee) have “carved-in” Medicaid behavioral health services. Under a carve-in system, MCOs receive a payment to manage both behavioral and physical health services, among other services as relevant. As of 2016, 16 states currently provide or are planning to offer behavioral health services through an integrated managed care benefit — up from just a handful a few years prior.¹⁵
- **Carve-out.** Some or all behavioral health benefits are separately managed by a specialized behavioral health organization or by the Medicaid state agency on a FFS basis. Some states with specialized behavioral health organizations (e.g., Pennsylvania) have established requirements to increase collaboration and accountability between contracted entities that manage physical and behavioral health services. Meeting these requirements often entails greater coordination of providers on the ground.
- **Specialty managed care model.** A few states (e.g., Arizona) use these programs for individuals with serious behavioral health conditions. Specialty behavioral health organizations manage all benefits, including physical health benefits, which are carved into the program.

States have also launched provider-based delivery system reforms to improve Medicaid behavioral health services, which include a platform for VBP initiatives. Although these models are typically provider-led, Medicaid managed care plans may be involved to varying degrees, ranging from contracting directly with these providers, to sharing partial or full responsibility for service delivery.¹⁶

- **Health Homes.** Medicaid health homes were created through Section 2703 of the Affordable Care Act, which contains provisions that allow Medicaid to reimburse eligible providers for comprehensive care management services for a set time. Fourteen of the 21 states and the District of Columbia that have implemented Medicaid “health homes” have created models for individuals with serious mental illness.¹⁷ These programs, often centralized in a behavioral health provider’s office, must offer several services including comprehensive care management, transitional care and follow-up, and referrals to community and social support services.
- **Accountable Care Organizations (ACOs).** These models seek to improve care coordination and delivery by holding providers financially accountable for health outcomes and costs of their patient population. A few states are requiring ACOs to report behavioral health quality metrics, to involve behavioral health providers in care coordination and related activities, and to link some of these metrics to payment. ACOs are most often reimbursed under shared savings or shared savings/shared risk payment models.
- **Certified Community Behavioral Health Centers (CCBHCs).** CCBHCs were created through Section 223 of the Protecting Access to Medicare Act, which established a demonstration program to expand access to behavioral health services in community-based settings. Eight states were selected at the end of 2016, under which participating clinics will receive enhanced Medicaid funding. To become certified as CCBHCs, clinics must provide a comprehensive range of behavioral health services and meet several requirements related to staffing, access, care coordination, data collection and quality, among others. CCBHCs will be reimbursed under a prospective payment system (PPS), under which states can either make quality bonus payments or incorporate a payment structure that is linked to quality outcomes.

Lastly, the federal government and states are advancing efforts to fight opioid abuse, which has become one of the deadliest epidemics in U.S. history and one that disproportionately affects Medicaid beneficiaries.¹⁸ In February 2015, for example, CMS began working with six states through the Medicaid Innovation Accelerator Program (IAP) to help them pursue strategies to improve states' substance use disorder delivery systems, including developing payment mechanisms for substance use services that incentivize better outcomes.¹⁹ CMS plans to publicly share "starting point" resources on designing episodes of care and payment bundles for medication-assisted treatment (MAT) services delivered to individuals with opioid dependence.²⁰ Pennsylvania has implemented 45 Centers of Excellence designed to integrate behavioral health and primary care for Medicaid enrollees with an opioid use disorder.²¹

Exhibit 2: Behavioral Health VBP Models in Primary Care

Although not a focus of this paper, there are also a growing number of examples of state, MCO, and provider efforts to use VBP models in primary care settings into which behavioral health providers and treatment are incorporated. Approximately 40 percent of mild-to-moderate behavioral health conditions are treated in primary care settings.²² For example, the Collaborative Care Model (CCM) (developed at the University of Washington) is a team-based approach for treating depression and other common behavioral health conditions in primary care. Teams include a primary care physician, care manager, and a consulting psychiatrist. The five core principles of the model include:²³



Patient-centered team care: Primary care and behavioral health providers collaborate using shared care plans that incorporate patient goals and targeted outcomes.



Population-based care: Care teams track and follow-up with individuals who are not improving. Mental health specialists provide caseload-focused consultation, not just ad hoc advice.



Measurement-based treatment: Treatment plans use symptom-rating scales to track clinical improvement. "Stepped care" systematically adjusts or intensifies treatment for patients that are not improving.



Evidence-based care: Patients are offered psychotherapies and medications that are proven to work in treating the target condition.



Accountable care: Providers are reimbursed for quality of care and clinical outcomes — not just the volume of care provided.

Recent research found that incorporating incentive payments that linked 25 percent of total provider payments into CCM models resulted in improved provider fidelity to key elements of CCM as well as improved patient depression outcomes.²⁴

Implementing VBP in Medicaid Behavioral Health Programs: Innovative State Examples

This section provides examples of innovative VBP models in behavioral health settings in five states: Arizona, Maine, New York, Pennsylvania, and Tennessee. Exhibit 3 provides a brief overview of each state's model.

Exhibit 3: Overview of State Models

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

*VBP strategy determined by CHCS analysis of reviewed state and health plan documents and comparison to the LAN APM Framework Final White Paper published on January 12, 2016.

**The LAN framework does not directly apply, because payments flow from the state to MCOs, as opposed to providers.

Arizona

The Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program, contracts with three Regional Behavioral Health Authorities (RBHAs) that operate statewide through a specialty managed care arrangement to provide integrated behavioral and physical health services to Medicaid enrollees with serious mental illness. AHCCCS has developed several VBP initiatives to improve quality outcomes as well as advance integrated care for these individuals.²⁵ Beginning in October 2015, AHCCCS added contractual requirements for RBHAs to link, at a minimum, five percent of total payments to providers to VBP strategies. AHCCCS expects this minimum threshold to grow in coming years. RBHAs may choose one or more of several VBP strategies, including:

(1) incentives to improve behavioral health coordination in primary care; (2) pay-for-performance contracts; (3) bundled or episodic payments; (4) shared savings and/or risk; and (5) performance-based capitation strategies.²⁶ During the first contract year, most RBHAs elected to use performance-based strategies. One RBHA implemented a capitated approach with some larger provider organizations the following year. RBHAs must also choose the quality metrics to link to these payment approaches. During the first year, some used HEDIS measures such as reductions in inpatient and emergency department admissions, and follow-up with behavioral health providers within seven days post-discharge. One included measures related to social determinants of health (SDOH), such as increasing the percentage of individuals in stable housing arrangements and those who are competitively employed. Another used a measure on the reduction in individuals using drugs or alcohol.

AHCCCS has launched other initiatives to encourage physical-behavioral health integration at the provider level. Last year, it implemented a value-based differential payment model that rewards providers who meet specific delivery system goals, including integrated clinics that provide both physical and behavioral health services. These clinics may receive a 10 percent rate increase for billing certain physician services.²⁷ In January 2017, AHCCCS received funding from CMS to launch a Targeted Investments Program that will allow health plans to make payments to, and develop VBP arrangements for, providers who are building infrastructure to support integrated physical and behavioral health care management.²⁸

Maine

Maine developed its Medicaid ACO program, known as the Accountable Communities (AC) program, in 2014. Maine defines its AC program as provider-owned and driven entities (i.e., Lead Entities) that are responsible for a defined population's health and have shared accountability for both cost and quality.²⁹ Maine is one of a few states with ACO models to use multiple strategies to help ensure successful integration of behavioral and physical health services in its AC program by:³⁰

- **Including behavioral health services in the payment model** through a shared savings payment model, in which the Lead Entities can choose to accept one- or two-sided financial risk. Under the one-sided model (Model 1), ACs may receive shared savings if they meet quality performance standards, but they are not liable for shared losses. Under the two-sided model (Model 2), ACs share in a greater percentage of the savings if they meet quality expectations, but they may also incur losses. To promote integration of behavioral health, Maine includes spending on behavioral health services in its total cost of care (TCoC) benchmark, which is the projected cost estimate used to assess whether ACs have generated savings and/or incurred losses during the performance year.³¹ Including behavioral health services in the TCoC benchmark creates a powerful incentive for ACs to effectively provide and coordinate physical and behavioral health services, since costs for both of these services are accounted for when shared savings are calculated. In addition, Maine requires ACs to include behavioral health providers, and provides integration support within behavioral health practices, such as facilitating implementation of data-sharing tools.

- **Incorporating behavioral health measures in the quality score for ACs** to assess whether quality indicators and patient outcomes have improved, and to ensure that providers are not withholding health services in order to retain savings. Maine includes four behavioral health measures in its AC quality scoring: (1) follow-up after hospitalization for mental illness (tied to payment); (2) initiation and engagement of alcohol and other drug dependent treatment (tied to payment); (3) out-of-home placement for children and adults (reporting only); and (4) cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (reporting only).

New York

New York's "VBP Roadmap," a multifaceted strategy document developed in 2015 that was required as part of the terms and conditions of New York's comprehensive 1115 waiver, outlines the state's vision for Medicaid payment reform and alignment with federal, commercial, and other state initiatives.³² A 2016 updated roadmap describes four VBP options that providers and MCOs may use, under which they may choose different payment arrangements and levels of financial responsibility, ranging from shared savings only to prospective payments that largely replace FFS payments.³³ Two of these options are specifically related to behavioral health: (1) the Integrated Primary Care Bundle (which includes all care for most prevalent chronic conditions in New York Medicaid); and (2) Total Care for Special Needs Populations.

Under the Integrated Primary Care Bundle, providers are responsible for the cost and quality of services provided for 14 chronic conditions related to both physical and behavioral health, including but not limited to: asthma; hypertension; bipolar disorder; depression and anxiety; substance use; and trauma. The Total Care for Special Needs Populations implements VBP arrangements with providers who work with a subset of eligible subpopulations, including individuals with significant behavioral health needs who are covered under New York's Health and Recovery Plans (HARPs). New York recently carved Medicaid behavioral health services into its MCOs. MCOs that meet specific criteria for managing specialty behavioral health services may be certified as HARPs. HARPs offer expanded community-based benefits to individuals age 21 and older with significant behavioral health needs.

In late April 2017, to support VBP waiver activities, New York announced the launch of Value-Based Payment Pilots, a two-year program for selected MCOs and providers to transition to VBP arrangements.³⁴ Of the 13 different pilot contracts, four focus on provider groups that are serving individuals enrolled in HARPs or are involved with integrated primary care. The pilot organizations will receive support from the Department of Health and will help the state by providing lessons learned and sharing best practices for statewide VBP implementation.

On a related note, the New York Behavioral Health Clinical Advisory Group – comprised of leading experts and stakeholders tasked with evaluating subpopulations and conditions to be included in VBP arrangements – recommended that providers track outcomes related to social determinants of health (SDOH) and be reimbursed via a "Pay-for-Reporting" system. In 2017, VBP efforts involving the HARP-eligible population will include 32 core performance measures, including three measures related to SDOH outcomes.³⁵

- Percentage of members who maintained/obtained employment or maintained/improved higher education status;
- Percentage of members with maintenance of stable or improved housing status; and
- Percentage of members with reduced criminal justice involvement.

Several VBP pilots will look specifically at the impact of the use of such measures.³⁶ Overall, the HARP measure set is intended to encourage providers to meet high standards of patient-centered clinical care and care coordination across multiple care settings.

Tennessee

TennCare — Tennessee’s Medicaid program — is a comprehensive carve-in model under which each contracted MCO is responsible for covering all physical and behavioral health services, as well as long-term services and supports (LTSS). On December 1, 2016, TennCare launched Tennessee Health Link, a program that incentivizes enhanced care coordination for TennCare members with serious behavioral health conditions.³⁷ Under this program, care teams associated with a mental health clinic or other behavioral health setting provide whole-person, coordinated behavioral and physical health care for an assigned panel of members.³⁸ Using “repurposed” funding from a former case management service, Health Link providers may offer a new set of services to help members manage physical and behavioral health needs. These may include extensive coordination across providers, transitional care to manage discharges and other transfers, and referral to and follow-up to access social supports. Health Link providers are eligible for other types of compensation in addition to standard FFS payments, including:

- **Practice transformation support:** Payments from the MCOs to make clinical and organizational changes required to perform as successful Health Links.
- **New activity payments:** A set rate for each attributed member for each month specific services are delivered. These services are not traditionally covered under FFS, such as creation of care plans, care coordination, and patient and family support.
- **Outcome payments:** Health Link providers can earn up to 100 percent of possible outcome payments based on performance on core quality and efficiency metrics. Health Link providers are evaluated on 15 measures that assess efficiency (five measures, such as all-cause hospital readmissions, emergency department visits, mental health inpatient utilization, etc.) and quality (10 measures, such as psychiatric hospital readmission rates and antidepressant medication management; initiation and engagement of alcohol and drug dependence treatment; body mass index and comprehensive diabetes care; etc.).³⁹ Outcome payments to Health Link providers depend on the extent to which providers meet or exceed state- and MCO-established thresholds for each measure.⁴⁰ In order to be eligible for outcome payments, providers must surpass expectations for at least four of 10 quality measures, and demonstrate improved efficiency (i.e., better results on efficiency metrics during the performance year). The first performance period for the Tennessee Health Link program is calendar year 2017, with the first outcome payments to be made to qualifying providers in August 2018.

Pennsylvania

State-to-MCO payment arrangements may align incentives for provider-level VBP programs and promote spending on Medicaid services that support high-quality, effective care. Pennsylvania is a “carve-out” state, in which Medicaid behavioral health services are separately managed by counties, in collaboration with Behavioral Health Managed Care Organizations (BH-MCOs), while physical health services are managed by Physical Health Managed Care Organizations (PH-MCOs).⁴¹ Pennsylvania’s Department of Human Services oversees the HealthChoices program, the state’s mandatory managed care program for Medicaid enrollees. On January 1, 2016, the department launched the Integrated Care Plan Pay-for-Performance (ICP P4P) Program⁴² to improve quality and reduce expenditures through enhanced care coordination across the PH-MCOs, BH-MCOs, and providers for individuals with serious, persistent mental illness.⁴³ This program is based on two pilots, developed under the SMI Innovations Project, a project coordinated by the Department and the Center for Health Care Strategies in 2009, which tested approaches to integrating physical and behavioral health care services for adult Medicaid beneficiaries with serious mental illness (SMI) and co-occurring physical health conditions.⁴⁴ The pilot reported significant reductions in emergency department use, all-cause hospital readmissions, and mental health hospitalizations.

Under the ICP P4P program, the Department established a \$20 million-dollar funding pool for calendar year 2016, with \$10 million allocated to each type of MCO, and split up among plans based on the percent of enrollees served. BH-MCOs and PH-MCOs earn incentive payments based on annual compliance with three key process improvements tied to five performance measures:

1. **Member stratification:** All members in the targeted population must be stratified into one of four quadrants: (1) high physical/high behavioral health needs; (2) high physical health/low behavioral health needs; (3) low physical health/high behavioral health needs; and (4) low physical/low behavioral health needs. BH-MCOs and PH-MCOs must share data in order to stratify and re-stratify members every six months.
2. **Integrated care plan/member profile:** At least 500 PH-MCO members and 0.25 percent of the BH-MCO eligible population (per contract) must receive an integrated care plan that has been used in care management activities by both the BH-MCO and PH-MCO. This includes the collection, integration, and documentation of key physical and behavioral health information that is easily accessible in a timely manner to people with designated access.
3. **Hospitalization notification and coordination:** Each PH-MCO and BH-MCO must notify the other of hospital admissions within one business day, and coordinate discharge and follow-up.

Compliant PH-MCOs and counties (counties may decide to share these payments with their contracted BH-MCOs) may receive payments based on five performance measures:

1. Initiation and engagement of alcohol and other drug dependence treatment;
2. Adherence to antipsychotic medications for individuals with schizophrenia;
3. Combined physical health and behavioral health 30-day inpatient rate for individuals with serious, persistent mental illness;

4. Emergency department utilization for individuals with serious, persistent mental illness; and
5. Combined physical health and behavioral health inpatient admission for individuals with serious, persistent mental illness.

Each of these measures are weighted equally and receive 20 percent of allocated funding for each plan.⁴⁵ Payments will be based on improvement, calculated from the base measurement year of 2015, to the initial intervention year of 2016.⁴⁶ The first payout for the ICP is scheduled for August 31, 2018. While it is still too early to assess initial outcomes, representatives from Community Care Behavioral Health (Community Care), a BH-MCO that serves more than 1.6 million individuals in 39 counties in Pennsylvania, reported that the program has already led to improved coordination and cooperation between plans. In addition to state efforts, see Exhibit 4 for a description of Community Care's Assertive Community Treatment (ACT) pay-for-performance initiative.

Exhibit 4: Community Care Behavioral Health's ACT Pay for Performance Initiative⁴⁷

Community Care is one of Pennsylvania's BH-MCOs and part of University of Pittsburgh Medical Center (UPMC). It manages behavioral health services for Medicaid members in Allegheny County on behalf of the county. With the goal of reducing inpatient mental health utilization (IPMH), it implemented a pay-for-performance program for Assertive Community Treatment (ACT) services, an evidenced-based model focused on community treatment and habilitation.

ACT includes an interdisciplinary team of 10 to 12 practitioners who serve about 100 consumers, resulting in a staff-to-consumer ration of approximately one to 10.⁴⁸

In 2014, Community Care collaborated with: (1) two ACT providers in Allegheny County; (2) the Allegheny County, Office of Behavioral Health; (3) Allegheny HealthChoices Inc. (AHCII); and (4) a Consumer Advisory Committee. Under this arrangement, ACT providers could earn up to 110 percent of the current fee schedule rate for ACT services, with 80 percent of payments for all services rendered. Providers could earn the remaining 20 percent by reducing IPMH utilization (funded by withholding 20 percent of the established ACT service rate) and up to a 10 percent bonus amount if they met the overall target of reducing average IPMH cost per person to \$9,000 or less during the calendar year. Providers had to remain within a total ACT service utilization cost cap per person per year.

ACT providers have achieved impressive results. In 2014, both providers earned the full 20 percent withhold amount and the maximum bonus earnings of 10 percent. Providers A and B achieved a 64 and 28 percent reduction in the average inpatient cost per person per year, respectively. In 2015, both providers further reduced the average inpatient cost per person per year. From the baseline year measure, Provider A achieved a 76 percent reduction and Provider B achieved a 72 percent reduction in inpatient costs per member per year. More recently, Community Care moved to a pay-for-performance bonus that also rewards providers who improve competitive employment rates among ACT recipients.



Challenges and Considerations

Key challenges in implementing VBP models in behavioral health settings include: (1) quality measurement; (2) provider capacity; (3) oversight; and (4) privacy and data-sharing constraints. Below are considerations to help states address these challenges as well as suggestions to support MCOs and providers with more effective program implementation. Many considerations were gleaned from expert phone interviews that included state Medicaid officials from Arizona; health plan representatives from Tennessee, New York, and Pennsylvania; and other health policy experts and researchers who focus on payment and quality measurement issues in behavioral health services.

Quality Measurement

Compared to physical health, there are fewer nationally endorsed or recognized quality measures for behavioral health. Many of the behavioral health quality measures currently used in state and federal payment and delivery system reform efforts are process-oriented and focus on mental health (see Exhibit 5 for broad domains for quality measurement). At the time of this brief, the National Quality Forum (NQF) — a nonprofit organization that evaluates and endorses measures — had 653 endorsed quality measures, with 55 of those addressing behavioral health conditions. Only nine of these 55 behavioral health measures are outcome measures, in contrast to the physical health arena, which has seen broad development and implementation of outcome measures in recent years. Fifteen of the NQF-endorsed behavioral health measures are specific to substance use disorder. NQF has reported that behavioral health is a “gap area” and is working to test new measures that address measurement gaps. While states and MCOs are generally not bound to selecting measures endorsed by NQF, identifying measures deemed valid and reliable is often a key step in the measure selection process.

One challenge with measuring quality in behavioral health settings is due to basic differences in care model philosophies between physical and behavioral health care. There are more quantifiable outcome measures for physical health, such as those based on medical test results, or the presence or absence of easily identifiable physical symptoms. Recovery-based care models, which some behavioral health systems have taken steps to move toward, encourage individuals to establish personal recovery goals based on their needs, strengths, preferences, capacities, and desired health and quality of life outcomes.⁴⁹ Ideally, these programs use recovery-oriented metrics to measure meaningful patient progress as defined by the individual and focus on wellness, stability, and

Exhibit 5: Select Quality Measure Domains

- **Structural:** Assesses features of a health care organization or clinician relevant to its capacity to provide health care.
- **Process:** Focuses on steps that should be followed to provide good care.
- **Outcome:** Assesses the results of health care.
- **Patient-Reported Outcome:** Focuses on a patient's reports concerning observations of and participation in health care.



Source: Centers for Medicare & Medicaid Services. *Quality Measures Inventory User Guide and Data Dictionary*. 2016. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/CMS_Inventory_User_Guide.pdf.

functionality. However, a lack of recovery-oriented measures that are widely accepted by behavioral health stakeholders represents another measurement gap for behavioral health services. To date, these concepts have been difficult to standardize and link objectively to payments.

There are several emerging strategies that could help address these challenges. First, several interviewees noted that although most programs' end goal is to improve health outcomes, using structural and process measures rather than outcome measures (especially during the first few years of a program) can help providers develop the structural components for measuring outcomes in a standardized and longitudinal way and advance to reliable data collection and accurate outcome measurement down the road. Further, focusing on process measures in early stages of VBP programs is particularly relevant in behavioral health, where evidence-based care delivery and performance measurement lags behind physical health. In addition, providers' performance on behavioral health process measures for all payers — Medicaid, Medicare, and commercial payers — tends to be lower compared to performance on physical health process measures, indicating that there is still much room for improvement on those measures. For example, recent data suggest that fewer than five percent of individuals with alcohol use disorder within the past year received related treatment from a health care practitioner.⁵⁰ To address these concerns, a phased-in measurement approach to help prepare providers to assume additional accountability and financial risk might include: (1) a focus on infrastructure measures (e.g., achieving behavioral health home certification, implementing electronic health records with specific functionalities, or hiring care coordinators); (2) quality measure reporting (e.g., collecting patient-level information on depression screenings and social factors such as housing, employment, and family supports); and (3) process measures (e.g., antidepressant medication management). Two of the most commonly used behavioral health process measures in state and federal VBP programs include screening for clinical depression and follow-up plan, and follow-up after hospitalization for mental illness.

Second, there is progress being made across the nation to expand measures around substance use disorders. For example, in May 2016, Cigna announced its partnership with the American Society of Addiction Medicine (ASAM) to improve treatment for people suffering from substance use disorders. Through this partnership, Cigna will provide claims data to ASAM and Brandeis University to test three new behavioral health measures: (1) use of pharmacotherapy for individuals with alcohol use disorders; (2) use of pharmacotherapy for individuals with opioid use disorders; and (3) follow-up after withdrawal management. CMS is also developing and testing a new measure that adapts ASAM's "use of pharmacotherapy for individuals with opioid use disorder" measure for the Medicaid population. In addition, in January 2017, NQF endorsed three quality measures related to opioid overuse.

Health care leaders in behavioral health are also increasingly testing measures related to SDOH. For example, in addition to New York — which is collecting quality data on employment, education, housing, and criminal justice, as noted earlier in the brief — Massachusetts is testing non-traditional quality measures for its ACO program that it will be launching in December 2017. These measures relate to utilization of "flexible services," which include non-medical services to address social needs and social service screening.⁵¹

Lastly, the National Committee for Quality Assurance (NCQA) is developing a broad goal attainment measure for high-need populations that indicates a pathway toward recovery-oriented outcome measurement. This proposed approach uses quantitative scales to help measure the degree to which an individual attains his or her goals, a concept that could be particularly useful in the field of behavioral health, where recovery goals and pathways may vary significantly from person to person.⁵²

Provider Capacity

VBP programs require fundamental changes in the way providers are paid and measure progress, and many behavioral health providers require assistance in developing the capacity to meet new requirements and practices. Behavioral health providers often lack the billing and data collection and reporting capacity to implement VBP models. They must also have the appropriate and often expensive technology platform or other infrastructure to access and share data. Providers may not have the capital to make early investments to assume risk, cover start-up expenses, or manage finances in new payment models when they are not paid per service or by case.

States and MCOs should consider adopting data collection, reporting, and risk arrangements slowly to ensure time to build providers' organizational and financial capacity. For example, providers may not assume risk initially to allow more time to build infrastructure and gain experience with new clinical and business practices. The amount of provider support required before a VBP program launches depends on providers' level of comfort, technological preparedness, and other resources, as well as the extent to which the new VBP model changes practice models and overhauls payment arrangements. Some interviewees suggested launching new programs via a smaller pilot or a phased-in approach, such as:

- **Year 1:** Pay providers for participation in a VBP initiative and reporting on structural measures, while maintaining a traditional FFS or case rate arrangement.
- **Year 2:** Pay providers for meeting process measures, while maintaining a traditional FFS or case rate arrangement.
- **Year 3:** Pay providers for meeting process and/or outcome measures, with providers assuming some amount of risk for these performance measures.

In addition to phased-in contracting, states and MCOs can support providers in developing successful programs in other ways. Offering technical assistance to MCOs and providers — or requiring MCOs to offer supports to providers — can be a worthy investment. Interviewees recommended assessing providers' technical assistance needs and offering tailored support, either internally or with a contracted vendor. Recommended topics include: billing, reporting, data collection processes, and care delivery model design. For common issues, structured learning collaboratives with participating providers, ideally convened in-person, may provide a valuable opportunity to discuss common challenges, collaboratively identify solutions, and network with other providers to address similar issues. States and/or MCOs could give providers intermittent feedback on their progress to confirm whether they are moving in the right direction or could benefit from support. Exhibit 6 provides an example of Colorado's Practice Transformation strategy, which provides comprehensive supports to primary care practices and community mental health centers that offer integrated care.

Exhibit 6: Colorado's Practice Transformation Strategy

A major component of the Colorado State Innovation Model (SIM) is to advance a Practice Transformation strategy to tie integrated physical and behavioral care to value-based payment. In addition to supporting 400 primary care practices that offer behavioral health services, Colorado launched the Bi-Directional Integration Demonstration Pilot, which established integrated, comprehensive care in four community mental health centers. To support these providers in developing the infrastructure and clinical capacity to provide integrated care and meet requirements for payment reforms, Colorado established multi-faceted provider supports including: (1) intensive practice coaching and targeted consultation for adapting to VBP models and addressing other specialized integration challenges; (2) customized practice facilitation and clinical HIT advisory services; (3) creating “toolboxes” of practice transformation models, templates, resources, and best practices; and (4) bi-annual learning collaboratives.⁵³



In designing these programs, states and MCOs should ensure they have an accurate understanding of the start-up costs related to staffing, technology, and other infrastructure that behavioral health providers would have to bear, and should consider what start-up costs states or MCOs could directly fund. One MCO interviewee provided an example of a model that was carefully designed with minimal incremental costs to providers, except for paying for a nurse to join the provider setting to help case managers in behavioral health clinics with individuals with complex physical health conditions. The MCO covered this expense initially, and eventually providers could earn financial incentives to pay for the nurse themselves.

Because most state, MCO, and provider experience with VBP models is in physical health, it is important for states and, as applicable, MCO leadership to identify program management staff with behavioral health expertise. This can ensure that efforts address behavioral health providers' unique challenges during a transition to a new payment arrangement, and can better support troubleshooting with providers during implementation. Based on their behavioral health expertise, these individuals can help generate buy-in and trust with providers.

Lastly, given the volume of reform initiatives underway in most states, it is important to consider other related federal, state, and local initiatives and to try to minimize provider burden and ensure multi-payer alignment. States may want to consider adopting the LAN framework across programs to guide VBP development and encourage consistent use of terminology for VBP approaches. Doing so would offer the added benefit of better aligning with CMS efforts. In addition, states may consider aligning VBP strategies with CMS' Quality Payment Program, which launched in January 2017. Although this program is focused on Medicare provider reimbursement, aligning VBP strategies with other programs could ultimately help reduce the administrative burden on states, plans, and providers.

Oversight and Collaboration

Involving MCOs, providers, and other stakeholders as relevant in design and implementation discussions is important to program development and oversight. For example, states can collaborate with MCOs and providers to seek input in determining quality measures. Doing so can build trust

among stakeholders, and result in measures that are more achievable for providers and better reflect the needs of the patient population. Being transparent about how a payment methodology is developed and recognizing reporting burdens will also aid in building providers' trust.

At the same time, it is important for states to strike the right balance between flexibility and prescriptiveness in VBP program design. The right balance differs across states and appears to be driven by existing state oversight approaches as well as MCO and provider capacities and preferences. For example, Tennessee has consistent and clearly defined requirements for all MCOs and behavioral health providers who participate in VBP arrangements. Representatives from one of Tennessee's MCOs indicated that they appreciate the level of instruction, uniformity, and guidance from the state that, coupled with a high degree of MCO and provider engagement during the design phase, contributed to smooth program implementation. Conversely, Arizona gave MCOs more latitude to choose the type of VBP model and quality measures under a broad framework, resulting in several models that are targeted to different populations and providers. Pennsylvania lands in the middle: all MCOs and providers have to report on the same quality measures, but have flexibility with designing operational processes to meet common goals. All interviewees noted that some structure upfront was helpful to provide initial guidance for implementing programs, and many appreciated some level of flexibility post-transition.

Privacy and Data-Sharing Constraints

A key component of any VBP program is access to timely, reliable, and accurate data. On the payer side, such data is needed to operationalize various components of VBP programs, including performance measurement, financial benchmarking, and patient attribution.⁵⁴ On the provider side, data is needed to assess the quality and cost of care; coordinate care; identify high-cost, high-need patients; and develop targeted quality improvement activities. While there are numerous challenges facing providers related to behavioral health data access and sharing, including lack of or incompatible electronic health record systems, one specific challenge involves the laws and regulations governing the confidentiality of a substance use disorder patient record. Title 42 of the Code of Federal Regulations (CFR) Part 2 — often referred to as 42 CFR part 2 — imposes restrictions upon the disclosure and use of alcohol and drug abuse patient information.⁵⁵ This regulation was designed to minimize stigma associated with receiving treatment for a substance use disorder by reducing concerns about disclosure of records. Negative consequences linked to disclosure may include loss of employment, housing, or child custody; discrimination by medical professionals and insurers; and/or arrest, prosecution, and incarceration. These privacy protections are important, but 42 CFR Part 2 and in certain cases state law have also created challenges for delivery system and payment reform efforts involving health care integration and information exchange. For example, Pennsylvania's ICP P4P program does not include any sharing of data on substance-use related admissions or treatment.

However, changes made to 42 CFR Part 2 in January 2017 were designed to improve the regulation by facilitating health integration and information exchange while maintaining privacy protections.⁵⁶ Selected changes include allowing patients to disclose their information using a general designation to individuals and/or entities (e.g., designated treating providers). Changes will also allow CMS-regulated entities, including ACOs, to perform necessary audit and evaluation activities. However,

unlike other patient-level health care data protected under the Health Insurance Portability and Accountability Act of 1996, Part 2 data still require patient consent to be used by others, even treating providers, except in limited circumstances.

Looking Ahead

There is growing interest among states, the federal government, MCOs, and providers in using payment levers to improve Medicaid behavioral health outcomes, encourage integration with physical health, and decrease unnecessary utilization and spending. These efforts are mostly new, reflecting several challenges with implementing VBP in a behavioral health setting. However, states, MCOs and providers are demonstrating considerable interest in testing new models and applying some of the gains achieved through VBP models for physical health services to behavioral health. There is great opportunity to address challenges and support successful programs that improve quality and reduce cost growth for people with behavioral health conditions.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

This brief was produced with support from the California Health Care Foundation. To learn more about the foundation, visit www.chcf.org.

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IMPACT OF

**MEDICAID
GROWTH**

72 MILLION+
REASONS TO ATTEND

Adapting Behavioral Health to Integration and Value Based Purchasing: Lessons Learned

PRESENTED BY:

Don Fowls, MD
President

Don Fowls and Associates
Scottsdale AZ

September 23, 2016



Medicaid Health Plans of America
mhpa2016

Conflict of Interest Disclosure: Faculty/Planning Committee/Reviewers/Staff

Participating speakers and planning committee members, in “Lessons Learned in Integrated Care and Value Based Purchasing in Arizona” session have the following conflict of interest to disclose relative to the content of the presentation:

Don Fowls, MD: Consultant with clients but do not believe they are relevant and do not create a conflict of interest. For the current talk for MHPA, serves as a consultant to Relias Learning and does not receive a fee from them and discloses this at the talk as well.

MHPA16

Overview

- Considerations related to Behavioral Health
- Integration
- Managing Complex, High Cost Members
- Value Based Purchasing
- Culture Change and Workforce Development

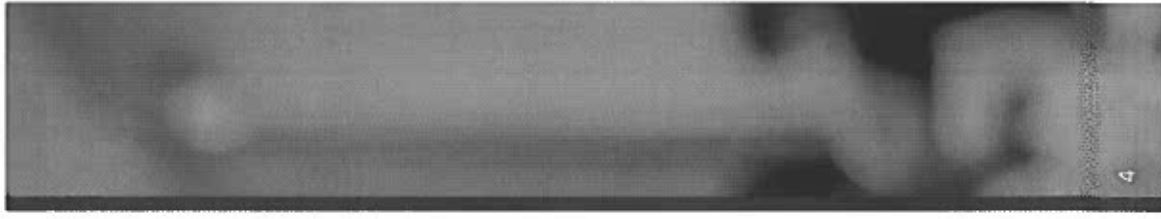
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Considerations related to Behavioral Health

- A national history of carved out medical, behavioral and psychosocial services
 - Siloed functions and communication
 - All levels
 - Very different cultures and ways of doing things
- Significant differences between these worlds and even within behavioral health
 - Types of benefit plans and covered services
 - Populations (within BH)
 - Providers and networks
 - Payment models
 - Misaligned incentives
- Non-integrated data
- Results
 - Tough on members and their families
 - Expensive



Moving to Integrated Models

What works?

- Leadership and culture change – integration at all levels
- Get everyone focused on member outcomes – the whole person
- Critically important to engage members – the use of peers and peer supports
- Adapt models of integration and best practices to member needs and practical realities
- Leverage strengths - rich array of service, good relationships, technology
- Use integrated data and analytics to identify and track members and providers

Moving to Integrated Models

What works?

- Accurate assessment by individuals who have the experience and expertise
- Active, multidisciplinary teams with a team lead and plan
- Proactive communication supported by technology
- Addressing psychosocial factors like housing, employment, corrections, social skills
- Developing a systems of care approach
- Measuring performance towards outcomes – real life and KISS
- Develop the workforce: educate, train and support staff
- Moving to alternative, value based payment models

Integrated Care Management: Adaptive Models

Patient Centered Medical
Home

Person Centered Health
Home

Assertive Community
Treatment (ACT)

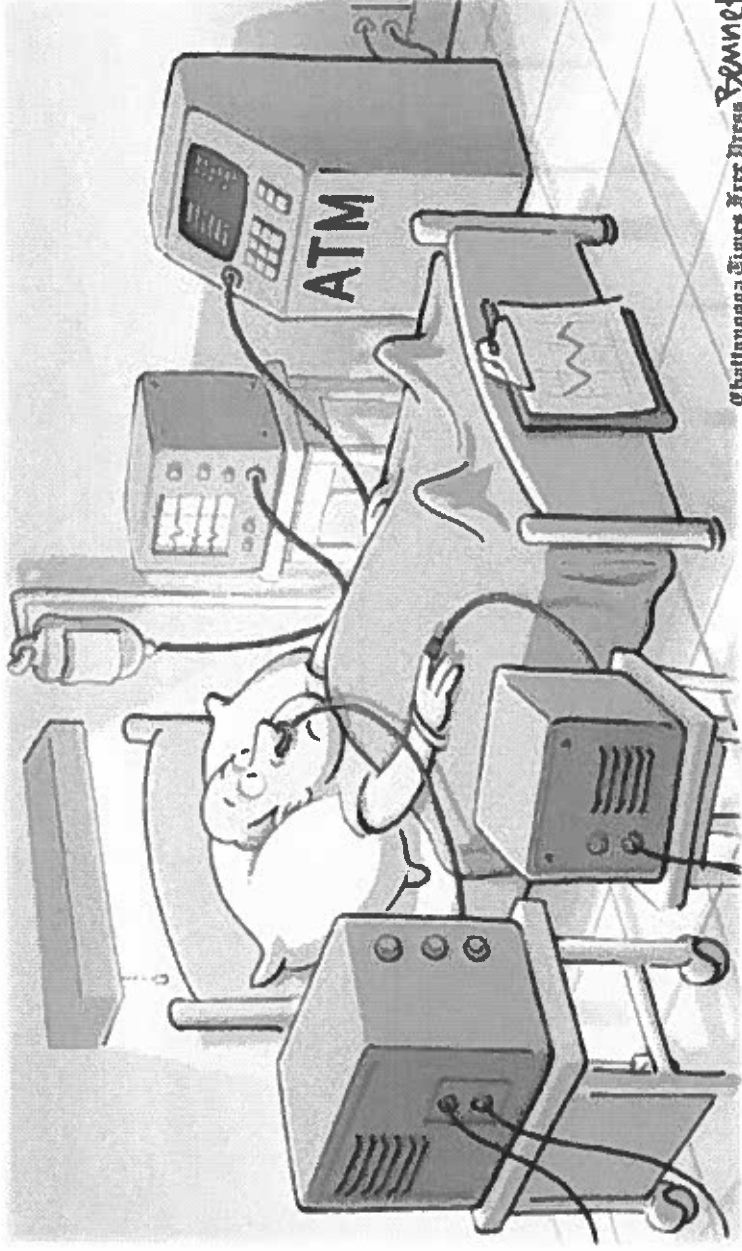
ACOs

FQHCs

Specialty Programs

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High Needs/ High Cost Members



Chattanooga Times Free Press Bennett

High Needs/High Cost Members – Profiles

Serious Mental Illness (SMI)

- A small percentage (< 5% of total eligible population) can drive up to half the BH health care costs
- 20% of SMI can drive over half of these
- 2/3 have substance abuse problems
- 2/3 have one chronic medical condition, half have two, and 1/3 have three or more
- Participate in CMHC settings but not in medical

Non-SMI Adults

- Chronic physical conditions with co-morbid mental health and substance abuse
- Drive high costs on medical side
- Substance abuse including prescription drug abuse is a major driver
- Attend PCP office but not behavioral health

Children and Adolescents

- Diverse population in part related to age
- Co-morbid behavioral health and developmental disabilities make assessment, treatment and management difficult
- Substance abuse is a major driver
- Transition age youth present a unique set of problems

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High Needs/High Cost Members - Profiles

Complex physical and behavioral health needs

- Crisis episodes
- Emergency department (ED) and inpatient admissions
- Substance use/abuse
- Polypharmacy

Critical psychosocial supports needed

- Housing
- Employment
- Criminal justice involved
- Not engaged or empowered

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High Needs/High Cost Members Care Management

What works?

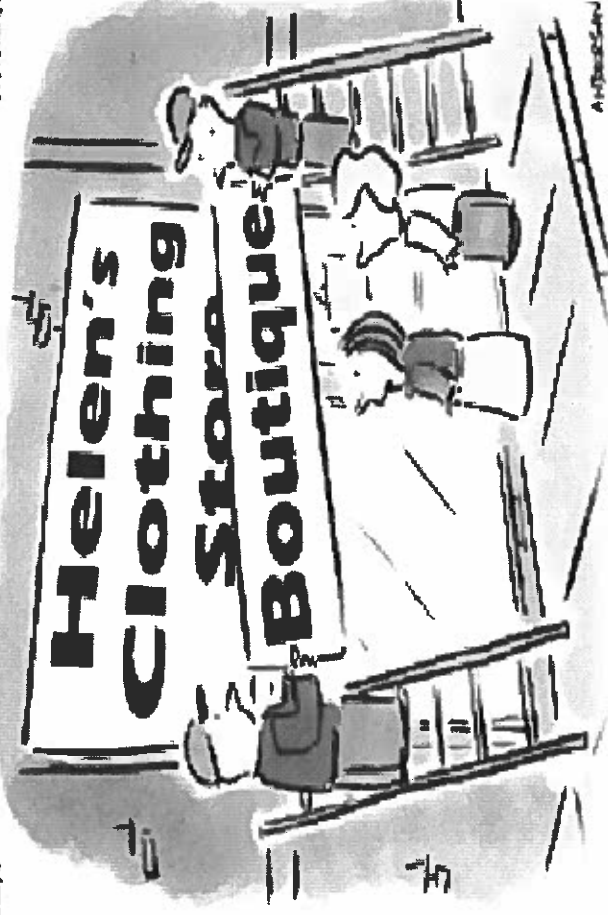
- Manage those who benefit from management, not those who don't
- Meet them where they are – member engagement is the key
- Identify members with integrated clinical data analytics – share data
- Accurate assessment by individuals who have the experience and expertise
- Multidisciplinary teams with an integrated care plan and team lead
- Address psychosocial factors like housing and employment
- Adapt specific interventions to specific populations
- Proactive communication supported by technology
- Measure performance towards outcomes
- Develop a collaborative process that continually measures, provides feedback, communicates, learns, and adapts
- Take time to develop the culture, support and train the staff

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Value Based Purchasing (VBP) What is it?

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"We're not changing anything, we just
wanted to charge more."

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Value Based Purchasing (VBP) What is it?

HealthCare.Gov Defn

Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

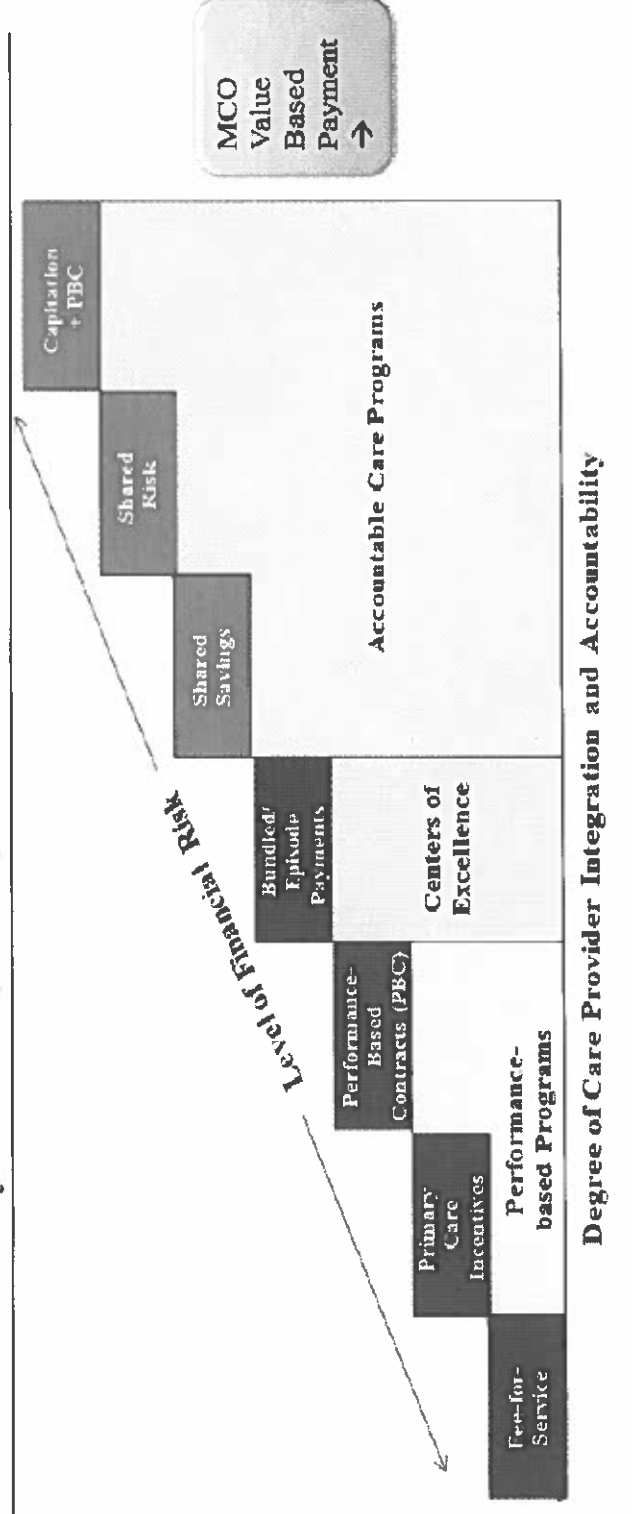
Value = Outcomes/Costs

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Value Based Purchasing A continuum

Value-based Payment (VBP) Models



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Value Based Purchasing

Key Principles for Success

- Establish a clear vision and timeline – payment models must align with desired outcomes and results
- Member focused
- Collaborative and transparent
- Integrated data and clinical analytics to
- Measure performance and outcomes
- A process that learns and continually improves
- Clinically driven, then integrated with ops and finance
- It accounts for practical realities internally and externally
- Technology supports – EHR, HIE, telemedicine
- Develop the workforce – training, education, culture
- Know that change does not come easily

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Considerations in Behavioral Health and Integration

- A legacy of block payments and lawsuits
 - Community Mental Health Act of 1963 – part of President Kennedy's New Frontier Program: combines Medicaid and other funds
 - The pros and cons of lawsuits
- Siloed at all levels
- Unique infrastructure, staffing and ways of doing things
- A lack of good, integrated data
- Safety net including BH crisis
- Proceed mindfully: do something, but do something right

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Transitioning from Block Payments

- Why it can be difficult to move to fee for service, bundles, or capitation initially
- One approach: move to pay for performance by adding performance measures to the block
 - A portion of potential payment is tied to performance on defined measures
 - Target desired result
 - Include BH, medical and psychosocial measures
 - Include HEDIS and compliance measures
 - May start with process but move to outcomes
 - Bonuses or penalties may be based on performance
 - Can include a share of savings or losses

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Transitioning from Block Payments

- Develop contracts that align behavioral and physical health providers
 - Define who will do what: mixed services protocol
 - Case management and complex, high cost members
 - BH members getting stuck in EDs
 - Align incentives
 - Shared performance measures
 - Share savings and losses
- Establish alternative payment models based on the funding from block
 - Bundled payments
 - Capitation
 - Set risk corridors – balance change vs protection

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Bundled Payments

- **An opportunity to align incentives for providers serving the same members and conditions.**
 - Captures all units of service and costs from all providers for a specific condition.
 - Bundles these into a case rate payment over a period of time that may be related to a cycle of care.
 - All payments to all providers come from this bundle
- **An opportunity to evolve intelligently**
 - Performance and outcomes measures are used to identify and continually improve best practices, refine the bundling model, and add bonuses or penalties based on performance.
 - Over time centers of excellence are identified for referral
 - Potential conditions for bundling payments derive from the data based on those receiving services

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Capitation

Capitation is an interesting option

- Allows for management of a special population at a local level
- Provides flexibility to allocate dollars where they're needed
- Less admin burden
- Engages the provider who has an incentive to continuously improve quality
- Less overtreatment

There are potential problems

- Providers at risk may fail and compromise the safety net
- Incentive to provide less care
- Potentially less flexibility for members
- Certain needed services may get undervalued, eg, BH

Capitation

Capitation drives a different level of management: the lessons of the 80's

- A solid organization with leadership that can manage and produce results
- A clinical model of care
- Managed care infrastructure
- Financial strength
 - An ability to count and live within a budget
 - Reserves and reinsurance
- An ability to balance clinical, operational, and financial considerations
- An ability to adjust and innovate
- Good partners and an aligned network

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MODEL PROS and CONS

<u>MODEL</u>	<u>PROS</u>	<u>CONS</u>
PAY FOR PERFORMANCE	• A way to get started • Minimum risk to safety net • Targets desired results over time • More or less dollars based on performance	• Reinforces fee for service • More narrowly focused on one provider and some performance measures • More difficult to create a system of care or evolve
BUNDLED PAYMENTS	• Organizes everyone around conditions to impact • Aligns financial incentives • Uses data, measures outcomes, and supports development of systems of care and centers of excellence	• Focuses only on special need or population – what about the rest? • Accurately determining the bundle and how it is distributed • Members choosing different providers

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MODEL PROS and CONS

<u>MODEL</u>	<u>PROS</u>	<u>CONS</u>
CAPITATION	• Guaranteed volume and income • Encourages management at the local level with more flexibility and less admin burden • Money follows the member and establishes a relationship w patient and Less overtreatment	• Providers at risk may fail and in public systems compromise the safety net – must have the ability to accept and manage risk • Incentive to provide less care • Certain needed services may get undervalued, eg, BH

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Integrated Care and Value Based Payment Models

Person Centered Health
Home
Pay for Performance
Shared Savings and Risk

Patient Centered Medical
Home
Shared Savings and Risk
Capitation

Assertive Community
Treatment (ACT)
Bundled payments
Capitation

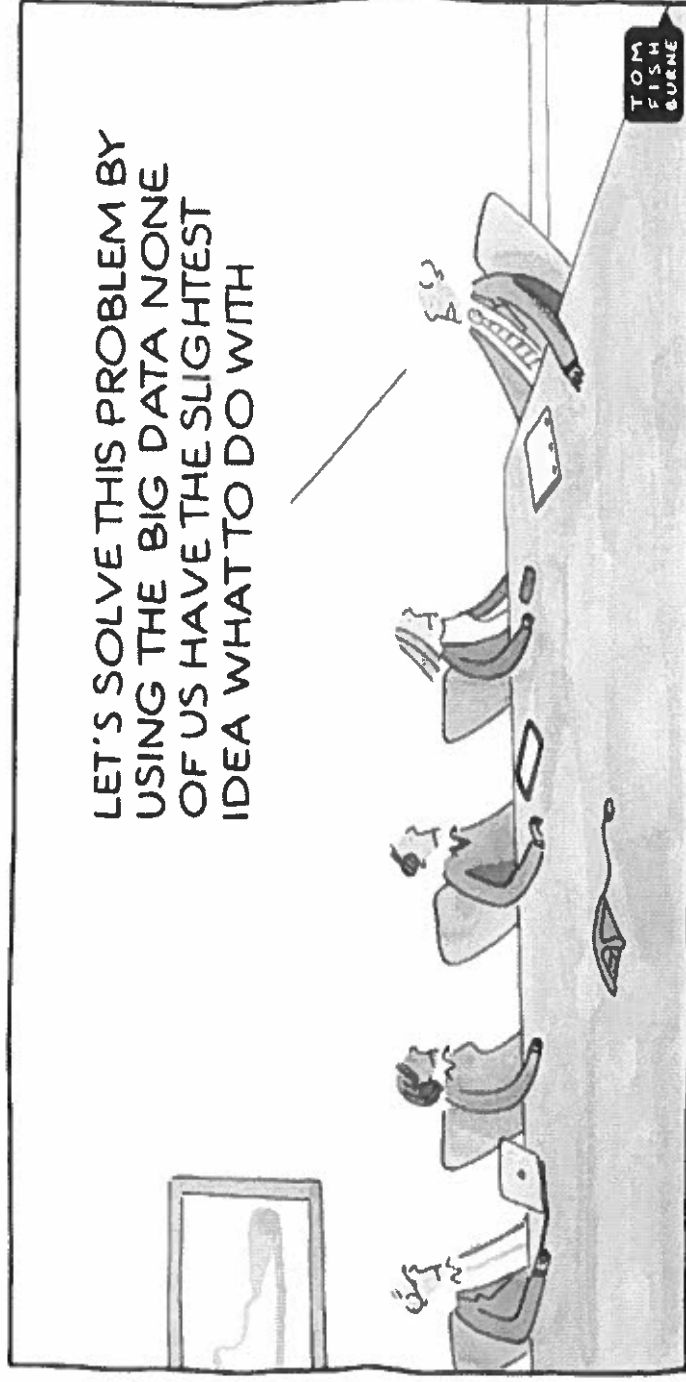
ACOs
Shared Savings and Risk
Capitation

FQHCs as group
Shared Savings and Risk
Capitation

Specialty Programs
Bundled Payments
Capitation

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The Biggest Challenge - Changing the Culture



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The Biggest Challenge - Changing the Culture

- Takes many things
 - Leadership
 - Focus on member and outcomes
 - Collaboration
- Expect the unexpected
- Workforce development and training at all levels
 - Multimodal
 - Scale through online training
 - Performance and outcome measurement
 - Develop a process that learns, communicates, adapts

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Thank You!

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To: IARF Executive Directors & CEOs

From: Cyrus Winnett, VP of Health & LTC Policy

Cc: Josh Evans, President/CEO

Sarah Myerscough-Mueller, VP of I/DD Policy

Re: Summary – ANCOR Whitepaper – VBP and Alternate Payment Models

ANCOR Whitepaper: Advancing Value & Quality in Medicaid Service Delivery for Individuals with Intellectual & Developmental Disabilities

IARF's national affiliate, ANCOR, has released a whitepaper entitled Advancing Value & Quality in Medicaid Service

Delivery for Individuals with I/DD. ANCOR CEO, Barbara Merrill, says "APMs and VBP open the door to further risk and

disruption, but also potentially extraordinary opportunity to advance quality." This white paper was developed by a

team of experts, including ANCOR staff and members, former CMS officials and national healthcare experts. It is the first

of its kind of I/DD policy, and serves as a guide as I/DD services and supports across the country move toward alternative payment models

The following summary highlights three primary areas of the report – research findings, payment principles and recommendations developed by ANCOR. [Click here to access the complete report.](#)

Research Findings

- Community providers add significant value to the lives, health and well-being of people with I/DD and their families
- Providers' expertise and experience should help drive I/DD delivery system reforms, including development of APMs
- APMs have potential to strengthen quality and outcomes, but key challenges have not yet been addressed
- APMs must advance broader policy objectives for I/DD services, including community integration, individual independence, and caregiver supports
- Most APMs are relatively new, and have been developed incrementally
- The impact of these APMs as outcomes, cost and quality of care for people with I/DD is not yet clear
- It is also unclear to what extent the models are advancing key policy objectives for services for people with I/DD

14 Payment Reform Principles for I/DD Services

1. Promote continuity and stability of services, reflecting that many individuals with I/DD have needs that span their lifetimes and that services are in many cases provided on a 24/7 basis by agencies, paid caregivers, and/or family caregivers
2. Promote maximum flexibility and utilization of risk sharing and sharing of cost savings mechanisms
3. Assure continued access to services, and, where possible, expand access to individuals on waiting lists
4. Assure payment rates fund adequate direct support compensation to attract and retain a stable, skilled, qualified workforce
5. Achieve a high level of quality and outcomes, including outcomes that are not medical in nature (such as independence, equality of opportunity, and economic self-sufficiency)
6. Promote a full range of services and supports needed to address the diverse needs of people with disabilities (including services such as competitive employment)
7. Promote coordination of physical health services with LTSS and behavioral health
8. Support self-direction for any individual/family who opts to self-direct
9. Reduce system complexity and administrative burdens
10. Promote provider autonomy in the delivery of services
11. Promote the use of technology where it is an efficient and effective means of supporting quality service delivery and delivering quality and outcomes for individuals

12. Assure high levels of accountability and transparency to providers, individuals and governments and assure effective and efficient use of resources
13. Provide payments based on actuarially sound rates
14. Promote development of direct support workforce to bolster I/DD service provision

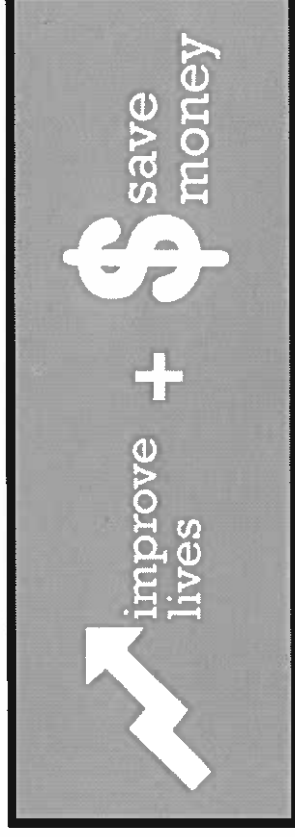
13 Recommendations for Current and Future APMs for I/DD Services (allow for innovation while minimizing risk)

1. Specific value-based payment approaches should be developed to incentivize the delivery of desired lifelong outcomes for people with I/DD.
2. To promote outcomes, efficiency, and flexibility in service delivery, models should move toward risk-based and/or global payments to providers at a measured pace and with robust risk adjustment.
3. For APMs to be successful, significant advances in measuring quality and outcomes for people with I/DD are needed. In initial stages, tying value to measures used for CQL accreditation is an example of an approach to explore.
4. APMs should maintain access to necessary services and promote continuity and stability for individuals, families, and providers.
5. APMs should foster integration of physical health, behavioral, and LTSS and support coordination of I/DD services led by providers/interdisciplinary care teams who have experience and expertise with individuals' needs.
6. APMs should reduce administrative burdens, administrative layers and promote flexibility in service provision while maintaining accountability and sound stewardship of public dollars.
7. APMs should incentivize technology to promote a more efficient service delivery system and an adequate and sustainable workforce.
8. APMs should promote person-centered planning and opportunities for individual choice and control in service provision, and accelerate progress toward greater community integration.
9. Payment models for LTSS should continue to move toward fostering independence, individual well-being, and community integration. They should encompass medical services but not impose a medical model.
10. APMs should be overseen with a diverse governance model that actively involves individuals, families, providers, and state/country governments. Regardless of APM approach, a state oversight role remains important.
11. The transition to new models should not be rushed. Models should be developed with transparent, iterative processes. The consequence of moving too fast are significant, and range from placing individuals at risk and provider dislocation to undermining broader system goals for promoting community integration.
12. Models should be responsive to individuals' changing needs and ensure access to necessary LTSS services across the lifespan.
13. Efforts to further engage providers and other stakeholders in this process should continue.

IARF thanks ANCOR for their investment into creating this informative whitepaper, and for their continued leadership on the evolving program and financial landscape for I/DD services and supports. We look forward to working with ANCOR to ensure that any movement toward alternative payment models in Illinois is thoughtful, incremental, and will increase capacity and outcomes.

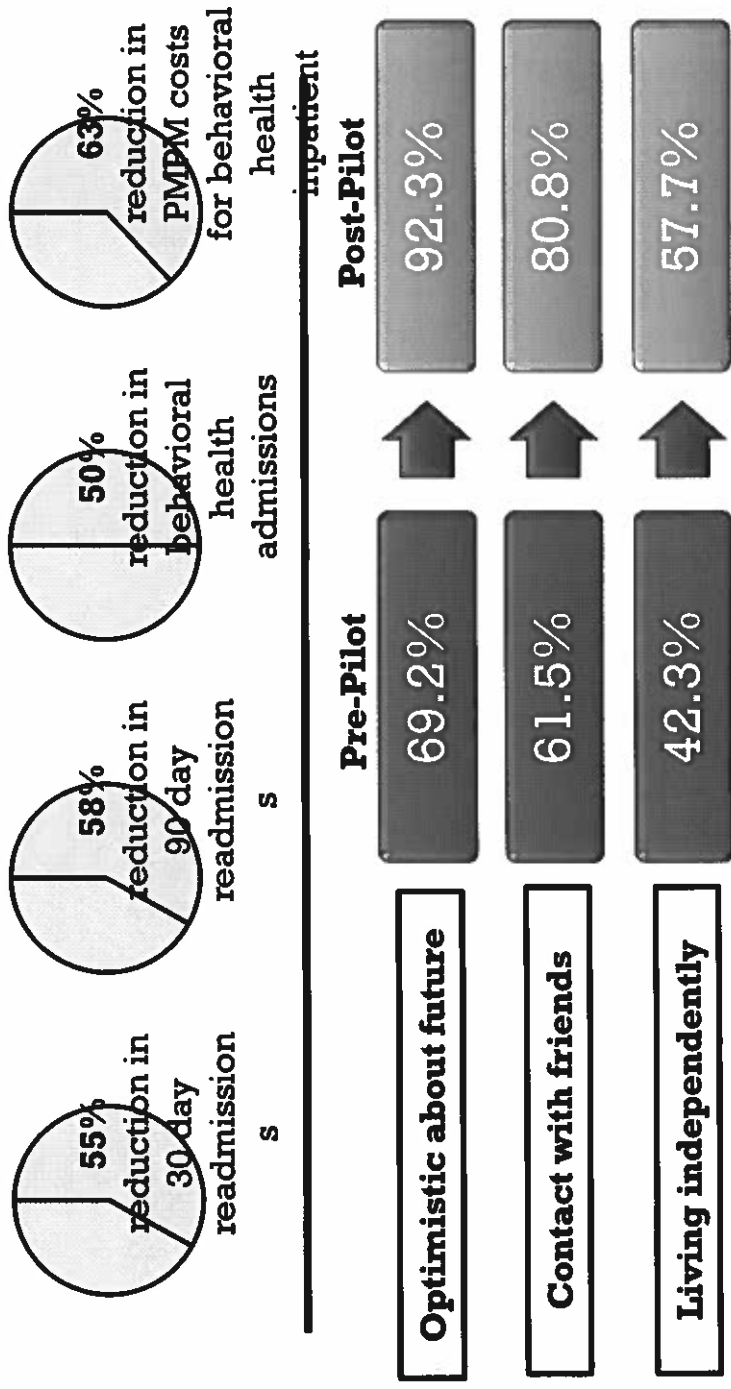
Please do not hesitate to contact Sarah Myerscough-Mueller (smyerscough-mueller@iarf.org) with any questions you may have.

THRESHOLDS-ILLINICARE PILOT PHASE 1



- 50 highest cost, complex needs with BH issues were targeted
- Thresholds teams relentlessly pursued these members in the community
- Assertive, multi-disciplinary team deployed
- Engaged ~85% into care
- Innovative PMPM payment structure
- Measured 12 months pre/post

PILOT OUTCOMES



PHASE 2: 7-DAY FOLLOW UP & LINKAGE

On the inpatient psychiatric unit

- Thresholds' staff engage every person on the unit in a process collaborative discharge planning as early as possible.

At discharge

- Thresholds staff meet the person at the door, making sure they have somewhere to go, often driving them home.

After discharge

- Thresholds visits people in the community, connects with outpatient care, drives to first appointments, transitions to care.

OTHER HIGH RISK/HIGH UTILIZER PILOTS

- Cigna/Healthspring
- Humana/Beacon
- Aetna Better Health

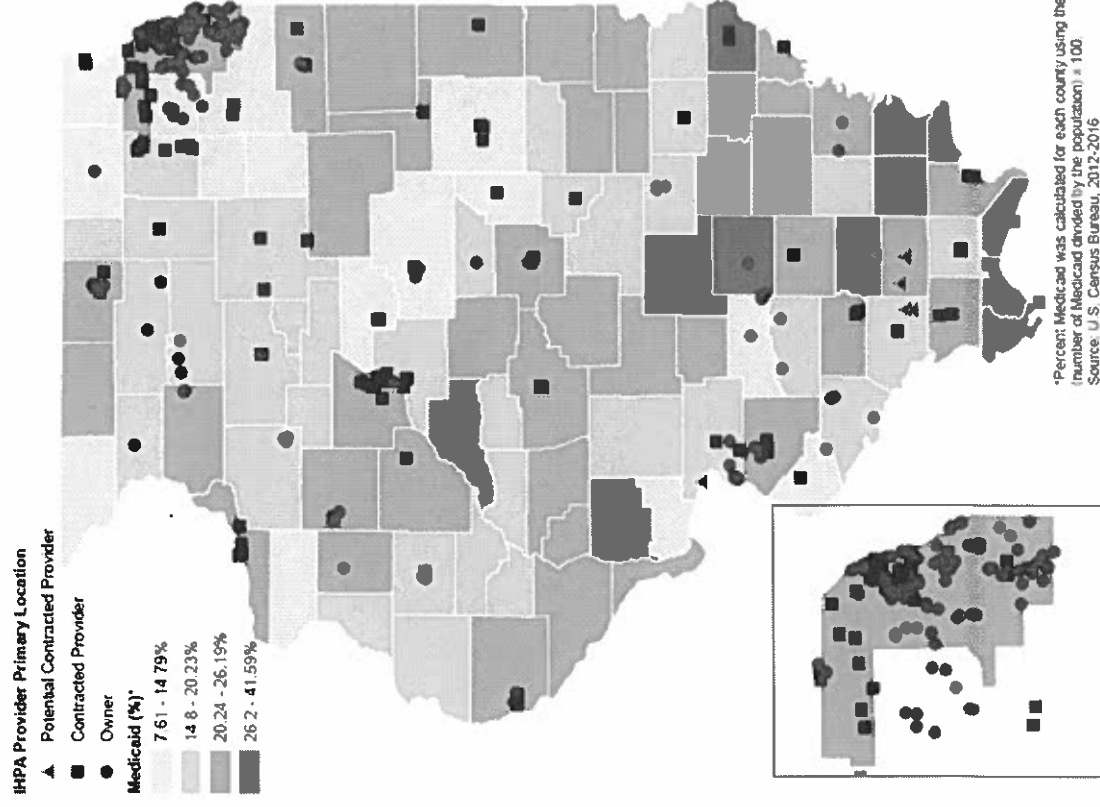
LESSONS LEARNED

- **VBP is a huge lift for health plans and providers**
- **Necessary ingredients:**
 - Focus and resources
 - Structure (communication, reporting, coordination)
 - Data (UM, claims, ADT)
 - Agreed upon outcomes, clear contracting
- **Scale is crucial but unattainable in pilots**

Illinois Health Practice Alliance



- Statewide Network of 75 Community Behavioral Health Providers
- Created to Drive Engaged Outpatient Care for SMI Clients
- Experienced Management Team
- Implemented Initial Value Based Payment (VBP) Contract June '19
- Integrated Health Home Objectives Incorporated into the Care Model
- Management Services Organization (MSO) Processing Claims, Providing Provider Support and Case Management Infrastructure/Supports
- Population Health System (HealthEC) in Place to Support Effective Care Coordination
- Closed >1,500 Care Coordination Deliverables in <75 days





Our Goals

IHPA is a state-wide Behavioral Health IPA leveraging expertise of provider and health plan partners

- Align providers and allow opportunity to invest in shared infrastructure
- Create an organization that streamlines contracting with MCOs and allows providers to enter into new arrangements that include value-based incentive dollars
- Work together to transform practices and provide supports necessary to be successful
- Allow providers visibility and access to claim, payment, and performance data
- Develop model of care to drive quality and efficiency
- Promote primary care/behavioral health collaboration and demonstrate improved outcomes

What Is Our Value Proposition?

Catalyst to enable Value Based Care and Integrated Health Homes



Current

IHPA

MCO/Network Contracting

- **Complex:** multiple contracts require need to manage provider engagement, credentialing and other administrative activities with each organization

• **Efficient:** Single contract with minimal administrative overhead; IHPA supports MCOs in provider enrollment

Payment Models

- **Outdated:** FFS based only; unpredictable cash flow; onerous reconciliation

• **Value-Based:** FFS +

incentives; MCOs and providers benefit from enhanced quality and aligned incentives

Compliance

- **Transactional:** MCO monitors and responds to multiple providers and organization with varying clinical sophistication and infrastructure

• **Self-directed:** IHPA is sole interface with MCOs creating consistent rules with all IHPA BH organizations

Technology/Data

- **Siloed:** Systems not integrated with MCO or other providers; data limited to individual provider services

• **Accessible:** Claims and performance data; care management platform; real time updates; predictive risk stratification modeling; BH/physical health visibility enabled

Care Management

- **MCO Centralized:** Often reliant on telephonic outreach to members; limited coordination with providers; screening, assessment, and care plan duplication between plan and providers

• **Provider Engaged:**

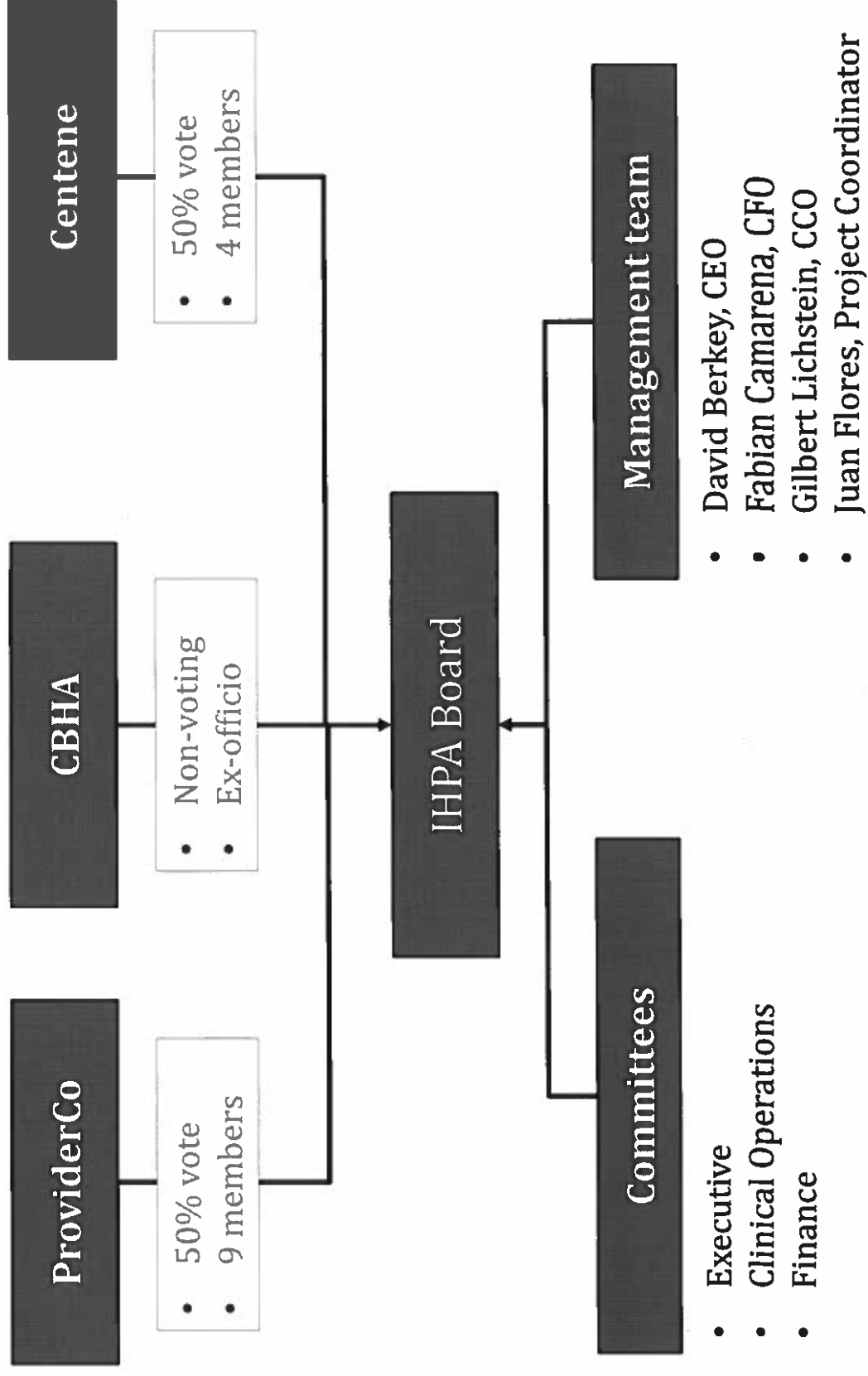
Embedded care managers; shared assessment and care plan capability; leverage expertise of plan and providers



How Did it Happen?

- 18 Month Development Timeline
- Significant Investments from the Payor/Provider Partnership
- Health Plan contributed the Consulting Support for Development
- Providers Contributed Hours of Development and Planning Time
- Providers Directed the Clinical Model Development for Approval of the Board

How Are We Governed?



What Drives Our Success?

- Comprehensive VBP Provider Readiness Assessment and implementation plans.
- IHPA University Training Program with Mandatory Attendance.
- Buy-In of Diverse, Statewide, Provider-driven Network Focused on Collaborative Learning and Sharing Best Practices
- Clinical activities meet the members where they are, in person, with clinicians they know and trust.
- Data integration allows claims history and analysis alongside organized workflow and task list.
- Providers see how medical conditions impact member participation in behavioral health treatment – “they were missing out on treatment when they needed it most”
- Flexible data platform that host a treatment documents (IM+CANS) and is built to link to a variety of databases.



IHPA Growth Plan

- IHPA has implemented an aggressive growth plan driven by Provider interest.
- The plan targets the addition of 11 new Providers by 12/31/19.
 - Four Provider Contract Executed
 - Nine Pending
- Second MCO agreement by 12/31/19.
 - Working to Alleviate MCOs Concerns Related to Joint Venture Structure.

Value Based Agreement

- Capitated Agreement for Outpatient Behavioral Health Services (rules 132/140, 2060/2090)
- Providers Receive Enhanced FFS and Incentivized for:
 - Pay for Reporting
 - PCP Wellness, ED Follow Up for BH and AOD, Depression Medication Management, Training Attendance
 - Pay for Performance
 - 7/30 Day BH FUH, Initiation and Engagement of AOD Treatment
 - Shared Savings through Total Cost of Care Incentive
- Monthly Care Coordination Meetings with Providers, Plan and IHPA team.



IHPA Integrated Health Home Objectives

- IHPA Drives Delivery of a Model of Care that Addresses the Goals of IHH:
 - Comprehensive Care Management
 - *Daily task list for care management deliverables*
 - Care Coordination and Health Promotion
 - *Claims and care management data access to provide full view of client history*
 - Transitional Care
 - *Focused on transitions of care to ensure successful engagement in outpatient care*
 - Individual and Family Support
 - *Delivering whole person care*
 - Referral to Social Services and Fulfillment of Social Needs
 - *Food*
 - *Housing*
 - *Employment*

**Illinois Health
Practice Alliance**

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IHPA
**Illinois Health
Practice Alliance**



Provider Data Summary

Org Overview

Enrollment

Financial

Contracting

Facility Utilization

ER Reports

Professional Utilization

Pharmacy Utilization

Risk Analytics

Quality Measures

Custom Reports

Line of Business

MSSP

Coverage Type

CMS MSSP

Health Plan

MSSP A2105

Time Period

2017

View Report

Click Here To Modify Report Criteria

Overview

Specialist Referral Summary

Professional Services

Profiling Summary

Profiling Summary- Custom

KPI-Trends

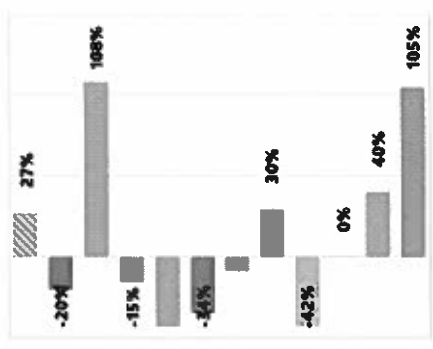
KPI-Trends DB

KPI-Member Details



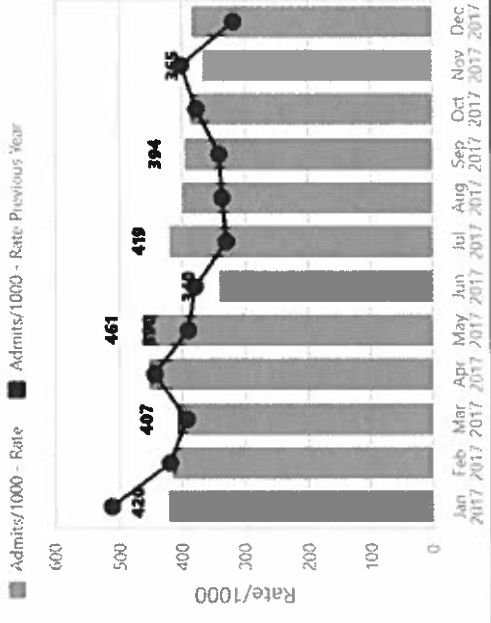
Organization Summary Dashboard

Org - Variance to Benchmark (%)



Metric	Variance to Benchmark (%)
Admits	-20%
Advanced Imaging	27%
Bed Days	-15%
ER visits	-10%
Home Health Visits	-43%
Out Patient Surgeries	30%
PCP Visits	0%
PMPM	40%
Quality Total Compliance	105%
Re-admission Summary	105%
SNF Admits	105%
SNF Bed Days	105%

Org - Monthly Trend by Year



Month	Admits/1000	Rate
Jan 2017	420	420
Feb 2017	407	407
Mar 2017	461	461
Apr 2017	407	407
May 2017	419	419
Jun 2017	394	394
Jul 2017	365	365
Aug 2017	365	365
Sep 2017	365	365
Oct 2017	365	365
Nov 2017	365	365
Dec 2017	365	365

Admits= 404 ; BM= 318

Advanced Imaging= 621 ; BM= 775

Bed Days= 3297 ; BM= 1585

ER visits= 607 ; BM= 716

Home Health Visits= 2059 ; BM= 3531

Out Patient Surgeries= 115 ; BM= 173

PCP Visits= 9074 ; BM= 9842

PMPM= \$1202 ; BM= 925

Quality Total Compliance= 29 ; BM= 50

Re-admission Summary= 17 ; BM= 17

SNF Admits= 94 ; BM= 67

SNF Bed Days= 3367 ; BM= 1639

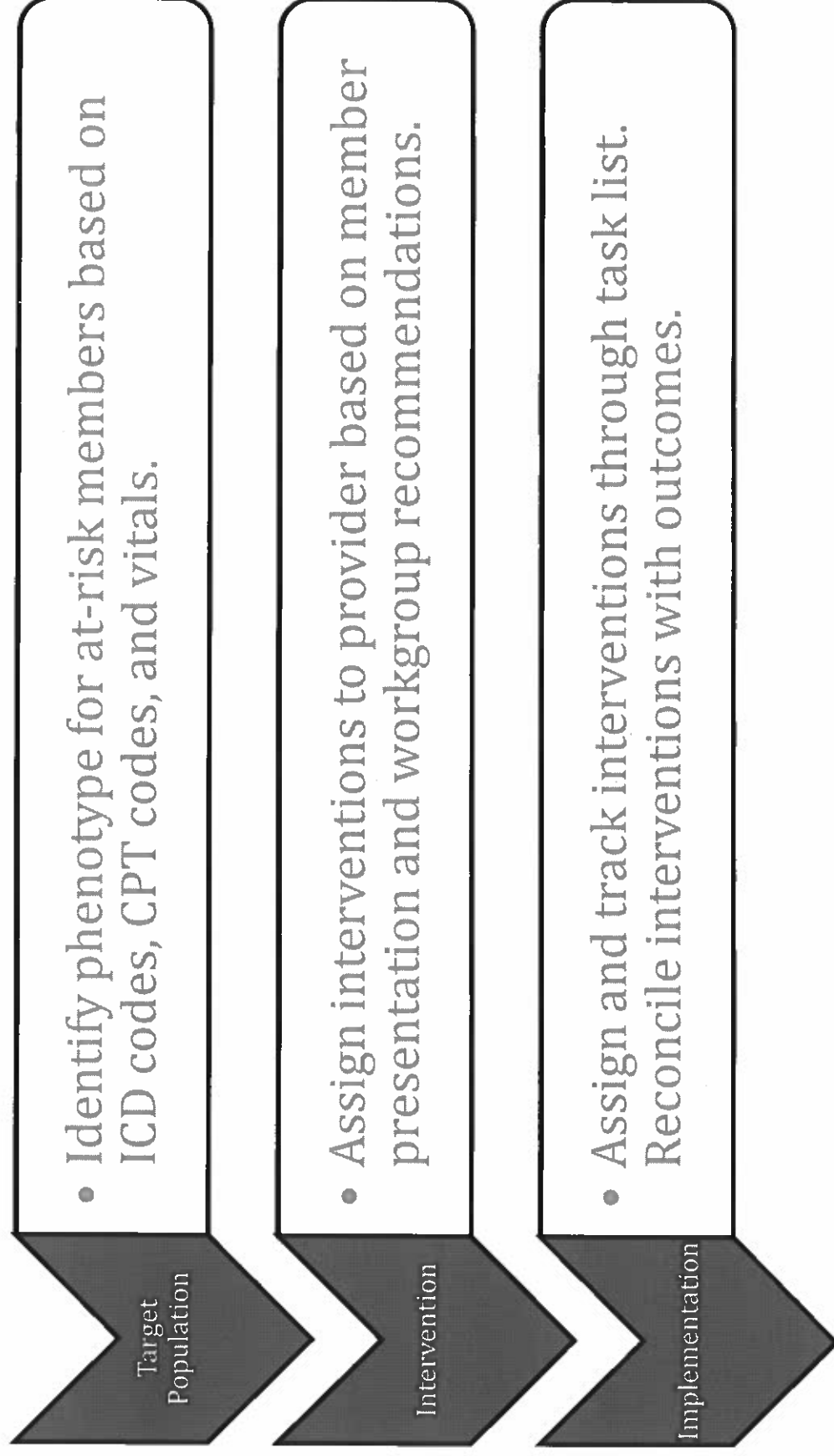
* For this measure, if the KPI is ...

Quality Measurement Monitoring

- Quality Measures
- Custom Reports
- Client Reports
- Executive Dashboard



Sample Case Study: Pre-Term Births





I/DD- specific issues

- What do predictive analytics say about at-risk members for choking, drowning, and bowel obstruction?
- Task list can be used to orchestrate interventions for at-risk members
- Examples
 - Interventions to address maladaptive eating strategies
 - Medications and diagnoses associated with constipation, provider education around the warning signs of constipation in the I/DD community



Structural Challenges

- Division of labor between behavioral health vs physical health in care coordination
- Elimination of Administrative Burden
 - HRS, HRA, IM+CANS, SUPR Assessments
- Integration of HealthEC/Provider EMRs
- Access to ED utilization information
 - In discussion with Patient Ping pending HFS ADT timing