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INSIGHT

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Value-Based Purchasing in Pennsylvania

Contributed article from Richard S. Edley, PhD, President and CEO of Rehabilitation and Community Provider's Association

There is perhaps no issue more important and more talked about in managed behavioral healthcare at this time than Value Based Payment/ Purchasing (VBP). Every conference, every article, every hallway conversation- you had better know what VBP is, or at least look intelligent when it is raised. So, what is VBP? Simply put it is a move away from traditional fee-for-service to alternative reimbursement structures with quality/ performance incentives. But why the move away from the fee-for-service (FFS) system that has existed so long in healthcare? ***See Value-Based Purchasing in Pennsylvania on Page 2***

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Potential Economic Impact of Integrated Medical-Behavioral Healthcare

Continually escalating healthcare costs have prompted payers to seek ways to improve member health while reducing the rate of growth of healthcare claim expenditures. Integrating medical and behavioral healthcare (IMBH) advances have been driven by both primary care providers as well as behavioral healthcare practitioners. ***See Economic Impact on Page 3***

A 360 Degree View of the Entire Community…

"Solutions that target population health and precision medicine will have the edge in a value-based care environment… at the end of the day, they will drive solutions to better care and to lower financial costs." – *Adrian Zai, Research Director, Partners eCare.*

Without the right data, simply defining, identifying and driving change with a target population is impossible.

EHR's are really not designed to be scientific repositories to optimize better care, they are optimized for better billing.

Combined claims data, available medical data and socioeconomic data reflecting the social determinants on health – things like education and literacy levels, income and ethnicity, can account for more than 40 percent of variation in outcomes. "Social determinants of health data are almost as important a variable as blood pressure," – *Joe Conte, Executive Director; Staten Island Performing Provider System.*

Excerpts from **HiMSS** *Whitepaper; 360-Degree View of the Community;* www.himssmedia.com

Value-Based Purchasing in Pennsylvania (Continued)…

There is nothing inherently "wrong" with FFS methodologies, but it must be acknowledged that FFS has a built-in disincentive to increase utilization and, therefore, billing. That is not to say that providers behave in that way, it is simply acknowledging that this is the route to maximize revenue under a FFS system. And unless there is an additional administrative layer or function wrapped in, there is no quality component built into traditional FFS reimbursement. VBP fixes, or at least attempts to address, these issues.

In being an alternative reimbursement methodology, there is no incentive to maximize units, sessions, days- whatever the billing metric is. Rather the provider is paid for the episode, day, or period. If it takes the provider 10 units or 20- it does not necessarily matter to the reimbursement.

Further, VBP adds a quality/ performance piece that allows for additional reimbursement to providers if they hit certain agreed upon targets. This could be any measure that is deemed important, such as avoidance of hospital admissions or emergency room visits.

Interestingly, while VBP is the hot topic today it is actually not new. As an example, in 1997 Community Behavioral HealthCare Network of Pennsylvania (CBHNP; a provider owned managed care organization in PA) developed a contract with Blue Cross Northeast PA (BC-NEPA) that was so innovative it won a national Blue Works Award at the time. It just was not called VBP because the term did not exist. *See the article "A Historical Model of Value-Based Purchasing" – provided on page 4, outlining how the historical program worked.*

The program was extremely successful- financially and clinically over many years. So, what was learned? What was in place that allowed it to be successful? Here are a few key factors:

1. It was a true partnership and collaboration between payer and provider(s).
2. It was a true shared risk/reward model where incentives were aligned.
3. It was a model that was clear and understandable.
4. Quality metrics were straightforward and could be analyzed by the providers with readily available data in real time.

Recently (on June 21, 2018) the Pennsylvania Department of Human Services (DHS) and the Office of Mental Health and Substance Abuse Services (OMHSAS) held a session on Value Based Purchasing which included a presentation by the National Governors Association (NGA) and McKinsey and Company. National models were reviewed as well as early Pennsylvania examples from the 5 behavioral health managed care organizations (BH-MCOs) along with their provider partners. It was a very positive meeting and hopefully will lead to some additional interesting and creative models here in Pennsylvania. This discussion is especially important as the BH-MCOs are now required to have a

Hospitalizations for Opioid Overdoses – 2016 to 2017

↑ 12.7% **Heroin Overdoses** – hospital admissions for heroin overdose went up 12.7% between 2016 and 2017, the lowest increase in recent years. Average annual increases were about 24% between 2011 and 2016.

↓ 2.2% **Pain Medication Overdoses** – hospital admissions for pain medication overdose decreased 2.2% between 2016 and 2017.

$32 Million – in 2017, opioid overdose admissions were an estimated $32 million in payments.

PA Health Care Cost Containment Council; June 2018

percentage of their contracts in VBP models with the percentage growing annually.

At the meeting I reaffirmed that VBP is the right thing to do at this phase in managed care, with the following concerns:

1. Many of the models being discussed in Pennsylvania begin with a provider withhold (10-20%) right off the top. In the BC-NEPA model described herein, the providers voluntarily instituted a 10% withhold but this was in lieu of the removal of numerous onerous traditional processes and the elimination of potential bad debt. In some of the VBP models being implemented, the withhold is simply an immediate financial hit to the provider that may be earned back along with other quality incentives. This approach needs to be carefully reviewed.
2. As professionals in the field we tend to gravitate toward very complex and complicated models. If the data cannot be easily collected, tracked, and understood, then the model needs to be questioned. There is nothing wrong with simplicity.
3. Many Pennsylvania models are claims based and it is often stated that results cannot be fully known until a full claims run out has occurred. This could be 9 months or more of waiting while performing in the dark against metrics in place.

VBP is a tremendous opportunity for payers and providers to come together and align financial and quality incentives that is simply not possible in traditional FFS models. Further, if costs are reduced- or at least kept level or stable- while improving the quality and outcomes, the consumer wins as well. As Pennsylvania moves into this model, we hope that the collaboration of all parties continues and grows.

Economic Impact (Continued from Page 1)

Medical costs for treating patients with chronic medical and comorbid mental health / substance use disorder (MH/SUD) conditions are two to three times higher on average compared to those individuals who do not have those comorbid MH/SUD disorders. The projected additional healthcare costs incurred by people with behavioral comorbidities are estimated to be $406 billion in 2017 across commercially insured, Medicaid, and Medicare beneficiaries nationally. It is estimated that $38 billion to $68 billion (Figure 1) can be potentially saved annually through effective integration of medical and behavioral care. To put these national projected savings in context, the total national expenditures for mental health and substance abuse services is projected to be approximately $240 billion in 2017. These projected cost savings represent 16% to 28% of all spending for MH/SUD services.

FIGURE 1: PROJECTED HEALTHCARE COST SAVINGS THROUGH EFFECTIVE INTEGRATION (NATIONAL, 2017)

PAYER TYPE	ANNUAL COST IMPACT OF INTEGRATION
COMMERCIAL	$19.3 - $38.6 BILLION
MEDICARE	$ 6.0 - $12.0 BILLION
MEDICAID	$12.3 - $17.2 BILLION
TOTAL	**$37.6 - $67.8 BILLION**

Potential Economic Impact of Integrated Medical-Behavioral Healthcare, Updated Projections for 2017; Milliman Research Report, January 2018

A Historical Model of Value-Based Purchasing

In the article "Value-Based Purchasing in Pennsylvania", contributed by Richard S. Edley, PhD, President and CEO of Rehabilitation and Community Provider's Association (see reference on Page 2), an early model of value-based purchasing was implemented in 1997 by Community Behavioral HealthCare Network of Pennsylvania (CBHNP) with Blue Cross Northeast PA (BC-NEPA). The outline below describes the approach:

Participants

- *Thirteen CBHNP community mental health and drug and alcohol agencies and hospitals agreed to an alternative reimbursement and managed care model with BC-NEPA. Representatives from CBHNP and BC-NEPA met monthly to review all data- financial/ utilization and quality- and to discuss gaps, issues, and program adjustments.*

Project Design

- *BC-NEPA paid a monthly sub-capitated rate to CBHNP (a lump sum per member per month (PMPM) rate) which equaled the expected utilization/ cost of the 13 providers. CBHNP allocated the capitation to each of the providers based on expected utilization and expenditures for that month. The model is called a "contact capitation" with no "catchment areas" or covered lives. Locations and services overlapped so prediction of utilization was based on contacts with consumers expected, based on historical utilization trends.*
- *A risk/reward corridor was set up around a global "per-member-per month" (PMPM) and projected expenditures for the entire behavioral health pool, including the contact capitation plus fee-for-service (FFS) costs. CBHNP, and the providers, were at risk (up to a maximum) for these expenditures but could also get back a reward if costs decreased below the target. Providers met with CBHNP quarterly to review contact capitation to adjust prospectively.*
- *Providers voluntarily agreed to a 10% withhold against their monthly contact capitation payments to guard against the potential financial risk. The value tradeoff to the providers was that they did not have to wait for payments, nor the administrative overhead of authorizations, utilization management, claims submissions, service denials, or bad debt resolution. Moreover, the 10% withhold would be repaid to the provider with interest if it was not utilized.*
- *Fee-for-service providers outside of CBHNP were managed separately through traditional managed care, including fee-for-service payments and utilization management.*

Quality

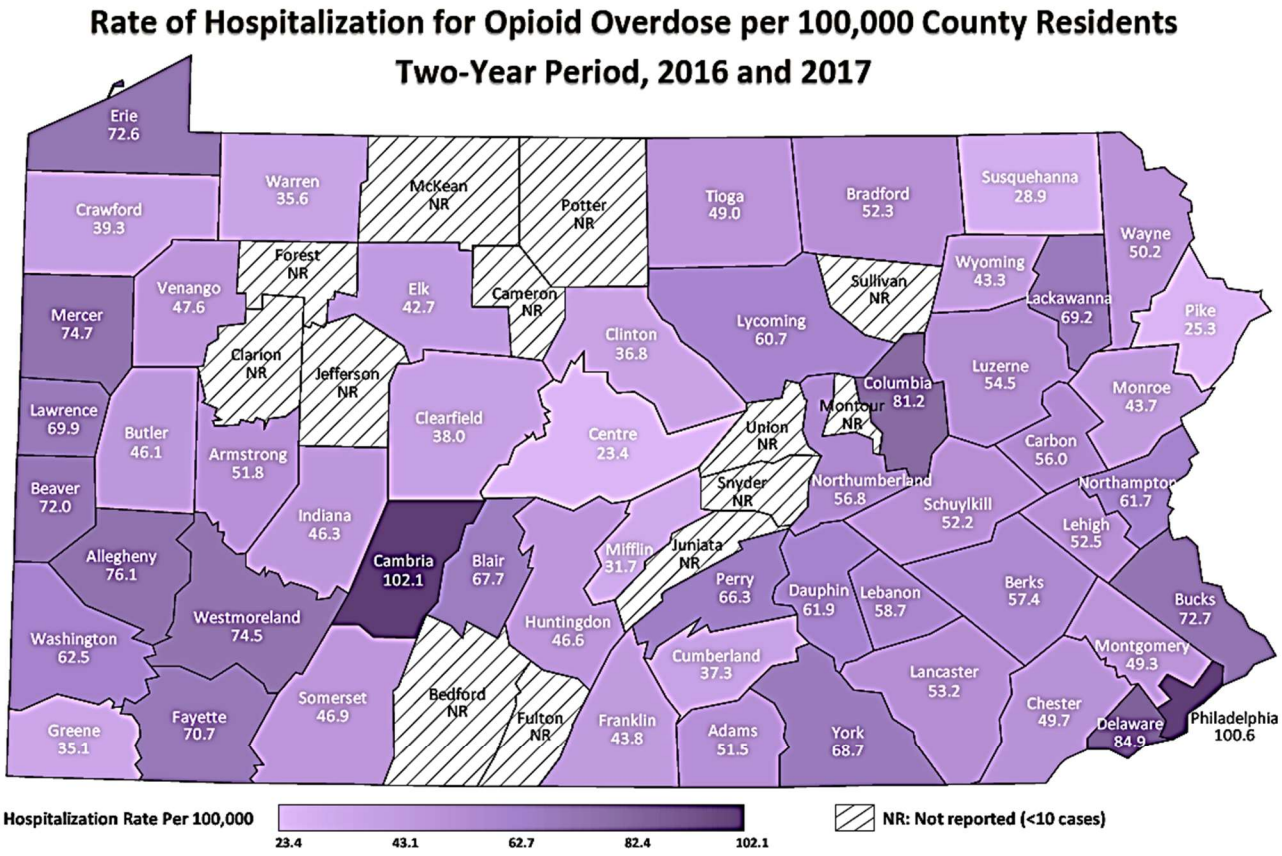
- *BC-NEPA set aside a funding pool to reward CBHNP and their providers based on three simple and measurable quality metrics: 1) Referrals to their depression management program; 2) Inpatient re-admissions within 30 days; and, 3) Outpatient appointments on discharge from inpatient services within 7 days.*

Lessons learned in models like the one described above become very useful guides in mapping the course for new ways to pursue new and innovative ways to provide value-based purchasing.

Rate of Hospitalizations for Opioid Overdose per 100,000 County Residents

Statewide, there were 64.6 hospitalizations for opioid overdose per 100,000 residents in the two-year period 2016 and 2017. Rates vary by income, education, race/ethnicity and gender…

- By Income – the rate was 122.0 per 100,000 for lower income residents (residents living in areas with an average income of less than $30,000).
- By Education – the rate was 113.7 for residents living in areas where less than 10% of the population has a bachelor's degree.
- By Race / Ethnicity – the rates for black (non-Hispanic) 67.5, white (non-Hispanic) 65.9, and Hispanic 50.4.
- By Gender – the rate was 77.8 for males and 52.1 for females.



Note: The county rates shown in the map above reflect the rate of hospitalization for opioid overdose (heroin and pain medication combined) for the two-year period, 2016 and 2017 (reporting two years of data minimizes effects of lower volume in some counties). Note that higher rates for some counties might be dependent on larger numbers of residents with high risk characteristics (e.g., factors related to income, race/ethnicity and gender). County rates were not adjusted for these population differences so that important effects of these patient characteristics were not masked by such adjustment.

Final Thoughts…

"Do what you can, with what you have, where you are."
Theodore Roosevelt

INSIGHT is published monthly by COMCARE, a program of the County Commissioner's Association of Pennsylvania (CCAP). If you wish to provide comments or feedback, please forward your comments to Lucy Kitner or Michele Denk at COMCARE at the following email addresses: lkitner@pacounties.org; mdenk@pacounties.org. *Thank You.*