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Moving To Pay-For-Performance In Behavioral Health
HealthChoices

Brandon Danz, Senior Associate
John Talbot, Advisory Board Member
March 14, 2016
Agenda

I. Welcome & Introductions
II. Moving From Volume To Value In The Health Care Industry
III. Increasing Accountability & Coordination Across Pennsylvania Systems Of Care For Complex Patients
IV. Strategically Operationalizing The Movement To Pay-For-Value
V. Incorporating A Pay-For-Value Model Into A BHMCO System & Working With OMHSAS To Develop Alternative Payment Arrangements
VI. Building Incentives Into Your Payment Structure
Today’s Speakers

Brandon W. Danz, MHA, MPA
Senior Associate, OPEN MINDS

Areas of Expertise
- Healthcare regulatory affairs and Medicaid policy
- Development and implementation of cross-systems care management and population health models
- Assessing care improvement for high-risk patient population
- Behavioral health integration and collaboration
- Systems transformation, strategic planning, and analysis related to operational efficiency and fiscal health

Professional Highlights
- Special Advisor to the Secretary of the Pennsylvania Department of Human Services
- Delegate to National Governor’s Association Initiative on Employing Individuals with Disabilities
- Government Affairs consulting with health systems

John F. Talbot, Ph.D.
Advisory Board Member, OPEN MINDS

Areas of Expertise
- Strategic planning
- Development and implementation of payer and provider strategic alliances
- Board and management development
- Organizational reengineering and operations management

Professional Highlights
- Vice President of Corporate Strategy, Jefferson Center for Mental Health
- Former president of Colorado Care Management, a provider-sponsored network
- Served as Director of the Master’s in Health Systems program at the University of Denver
- Doctorate in Human Services Leadership
Background On OPEN MINDS

Our mission is to improve the quality of care for consumers with complex support needs by improving the performance of the organizations that support them.

**WE BELIEVE**
For organizations serving the most vulnerable populations, better management practices allow for optimal focus on care quality and outcomes.

**WE BELIEVE**
Without quality market data and access to management best practice models, available resources for serving these individuals are often wasted.

**WE BELIEVE**
Organizations serving these individuals will prosper under executive leadership that is prepared for the continuous challenges of an evolving market.
Learning Objectives

1. How to increase accountability and coordination across systems of care for complex patients with SMI & co-occurring chronic conditions who see providers in multiple settings

2. How to strategically operationalize the movement to pay-for-value

3. How to work with your BHMCO to move to incorporate a pay-for-value model into your system and to assure compliance with fraud, waste, and abuse monitoring

4. The models for building incentives into your payment structure that are timely and independent of a surplus of funding at the end of the year

5. Best practices related to pitching an alternative payment arrangement to OMHSAS
II. Moving From Volume To Value In The Health Care Industry
### Transition From Volume To Value
More Managed Care For All Populations

<table>
<thead>
<tr>
<th></th>
<th>Total Enrollment (Millions)</th>
<th>In FFS (Millions)</th>
<th>% FFS</th>
<th>In Managed Care (Millions)</th>
<th>% Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare, 65+¹</td>
<td>43.3</td>
<td>30.3</td>
<td>70%</td>
<td>15.7</td>
<td>30%</td>
</tr>
<tr>
<td>Medicare, Dual¹</td>
<td>9.6</td>
<td>6.7</td>
<td>70%</td>
<td>2.9</td>
<td>30%</td>
</tr>
<tr>
<td>Medicaid²</td>
<td>54.9</td>
<td>14.1</td>
<td>26%</td>
<td>40.7</td>
<td>74%</td>
</tr>
<tr>
<td>Commercial Insurance³</td>
<td>172.7</td>
<td>1.7</td>
<td>1%</td>
<td>171.0</td>
<td>99%</td>
</tr>
<tr>
<td>Military insurance⁴</td>
<td>6.3</td>
<td>2.0</td>
<td>32%</td>
<td>4.3</td>
<td>68%</td>
</tr>
<tr>
<td>Uninsured⁵</td>
<td>33.9</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Total U.S. Population⁶: 320,769,714**

### Sources
Transition From Volume To Value In Payment Compensation Continuum By Level Of Financial Risk

Small % of financial risk: 
- Fee-for-service
- Management via 100% case by case external review
- No financial accountability

Moderate % of financial risk: 
- Performance-Based Contracting
- Internal ownership of performance using internal data management
- Moderate financial accountability

Large % of financial risk: 
- Bundled & Episodic Payments
- Capitation
- Full financial accountability

Shared Risk: 
- Shared Savings
- Providers assumes accountability

Shared Savings: 
- Performance-Based Contracting
- Providers active in management

Bundled & Episodic Payments: 
- Capitation + Performance-Based Contracting
- Providers assumes accountability

About 40% of commercial health plan reimbursements to provider organizations in 2014 are linked to value-oriented initiatives; this compares to 11% in 2013

Source:
Top Trends In Health Care

Care Delivery

- Shift to outpatient, inpatient care volume is on a rapid decline
- Increase in Health Advisors, Care Navigators
- Telehealth use will ramp up significantly in ‘16

Mergers & Acquisitions

- Industry consolidation
- Reduced competition

Consumerism

- Employers shift more costs to individuals, interest in private exchanges
- Technology is transforming the industry

Environment

- Overall healthcare spending slowed
- Medical cost trend has slowed
- High-cost patients spark cost-saving innovations

Engagement, Physician & Patient

- Investments to guard personal health data
- Increasing focus on healthcare interoperability

New Models Of Care

- Value-based purchasing continues to replace traditional FFS
- Interest in population health mgmt will grow
- Continued formation of ACOs and PCMHs

Government, ACA & Policy

- Healthcare enrollment is increasing
- Policy, subsidies will continue

Behavioral Healthcare

- Increasing behavioral health utilization
- Growing number of outpatient behavioral health services, care delivery models are evolving
- Continued focus on integrated Med-BH
- ACOs will continue to implement strategies for mental health
# Shifting To A New Paradigm Of Care

## Moving From
- Treating Sickness / Episodic
- Fragmented Care
- Specialty Driven
- Isolated Patient Files
- Utilization Management
- Fee for Service
- Payment for Volume
- Adversarial Payer-Provider Relations
- “Everyone For Themselves”

## Moving Toward
- Managing Population
- Collaborative Care
- Primary Care Driven
- Integrated Electronic Record
- Evidence-Based Medicine
- Shared Risk/Reward
- Payment for Value
- Cooperative Payer-Provider Relations
- Joint Contracting
Models Of Integration

Expand & Scale The Person Centered & Whole Healthcare Model
- To improve clinical outcomes, we need to focus on the physical, mental, emotional, and spiritual elements of a person, while taking into account their individual preferences, needs, values, and culture

Recognizing Role Of Behavior In Health
- Behaviors influence health, health status, and the decisions we make around health

Preserving The Role Of Behavioral Health Specialization
- As a Behavioral Health Provider, we are experts in the understanding of the psychology of human behavior, managing complex care, and impacting lifestyle decision making to improve health and well-being

Coordinated
- Minimal Collaboration
- Basic collaboration at a distance
- Limited information

Co-located
- Basic collaboration on-site
- Multiple data sources

Integrated
- Close collaboration on-site with some system integration
- Close collaboration approaching an integrated practice
- Whole-person care (full collaboration in integrated practice)
- Interpreting & sharing meaningful information

Source
III. Increasing Accountability & Coordination Across Pennsylvania Systems Of Care For Complex Patients
Problem With Current “System Of Care” For Consumers With Chronic Conditions

- Multiple specialists (and multiple prescriptions)
  - Consumers with 5+ chronic conditions see 16 physicians a year with 37 office visits\(^1\)
  - Fill 50 prescriptions per year\(^1\)

- Poor follow-up from ER visits and hospitalizations
  - 20% of Medicare hospitalizations are followed by readmission within 30 days\(^2\)
  - Among Medicaid patients younger than 65 years of age, 10% were readmitted within 30 days\(^2\)

Readmissions add $15 billion in annual Medicaid & Medicare payments\(^1\)

Sources
Undiagnosed & Undertreated Mental Health Conditions

1 of 4 Americans experience some mental illness each year\(^1\)

6 of 10 Adults with mental illness received no mental health services in the previous year\(^1\)

2 of 3 Patients experiencing depression go undiagnosed in a primary care setting\(^2\)

$194 Billion is the estimated lost earnings per year due to undertreated mental health conditions\(^1\)

Sources
Incidence Of Serious Mental Illness (SMI) & Co-Occurring Chronic Conditions

When co-occurring chronic conditions present alongside mental illness & substance use disorders, annual Medicaid costs increase by 200% or more

<table>
<thead>
<tr>
<th>Condition</th>
<th>No Behavioral Health Disorder</th>
<th>With Mental Illness &amp; Substance Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma/COPD</td>
<td>$8,000</td>
<td>$24,598</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>$9,488</td>
<td>$24,927</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>$8,788</td>
<td>$24,443</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$9,498</td>
<td>$36,730</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$15,691</td>
<td>$35,840</td>
</tr>
</tbody>
</table>

“Total private insurer medical costs for children with autism is 3 to 7 times greater than for those children without autism. . .”

Rhonda Robinson-Beale, M.D.

Source
Elements Of Effective Cross-Systems Care Coordination

1. Team-based, comprehensive care management
2. Care coordination & health promotion
3. Comprehensive transitional care between health care & community settings
4. Individual & family support
5. Referral to community & social support services
6. Use of health information technology to link services

Important, as many high-risk patients experience psycho-social barriers that prevent them from improving their health.

Source
What Does Medicaid Expansion Mean For County Behavioral Health Offices?

<table>
<thead>
<tr>
<th>Under Pennsylvania’s Medicaid Expansion:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Consumers have expanded access to mental health treatment, which increases demand for behavioral health services</td>
</tr>
<tr>
<td>▪ The Patient Protection and Affordable Care Act (PPACA) requires that mental health treatment is included in the essential benefit package of Medicaid expansion</td>
</tr>
<tr>
<td>- This is pushing the issue of mental health parity in expansion states</td>
</tr>
<tr>
<td>▪ Opportunities for earlier intervention and screenings</td>
</tr>
<tr>
<td>▪ Reduced mortality for newly insured who have access to care</td>
</tr>
<tr>
<td>▪ More cross-systems, integrated care</td>
</tr>
</tbody>
</table>
What Do Market Changes Mean For County Behavioral Health Offices?

- Shifting demand for services as care becomes focused on individuals’ spectrum of health and human service needs
- Fundamental change from encounter-based reimbursement to integrated, person-centered care management, capitation, and one- or two-sided risk based on performance measures
- Relationship with payers and provider community becomes a partnership in order to manage complex cases
- Creative partnerships with ACOs, FQHCs, CCBHCs, and PCMHs to integrate care management
Focusing On The High-Cost Cases

Under value-based reimbursement, high-cost clients present the greatest opportunity to reap savings and improve outcomes.

Within the top 5%, the goal is to identify only those individuals who are most likely to benefit from improved care management.


5% of non-institutionalized individuals account for 52% of all healthcare spending.
## Diagnoses Of Super-Utilizing (SU) Clients In Three Pennsylvania Health Systems

<table>
<thead>
<tr>
<th>Social Determinant Of Utilization</th>
<th>% Of SU Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Issues</td>
<td>90%</td>
</tr>
<tr>
<td>Transportation</td>
<td>62%</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>61%</td>
</tr>
<tr>
<td>Childhood Trauma</td>
<td>58%</td>
</tr>
<tr>
<td>Housing</td>
<td>48%</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>40%</td>
</tr>
<tr>
<td>Functional Illiteracy</td>
<td>40%</td>
</tr>
<tr>
<td>Language</td>
<td>26%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>% Of SU Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>89%</td>
</tr>
<tr>
<td>Substance Use</td>
<td>57%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>54%</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>52%</td>
</tr>
<tr>
<td>COPD</td>
<td>40%</td>
</tr>
<tr>
<td>Renal Disease</td>
<td>37%</td>
</tr>
<tr>
<td>I/DD</td>
<td>25%</td>
</tr>
<tr>
<td>ERSD w/ Dialysis</td>
<td>9%</td>
</tr>
<tr>
<td>Hospice</td>
<td>3%</td>
</tr>
<tr>
<td>Frail Elderly</td>
<td>2%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>0.80%</td>
</tr>
</tbody>
</table>

*Based on 138 patients from Crozer-Keystone, Lancaster General Health, & WellSpan, as of December 31, 2013

Source
Pennsylvania

Super-utilizers in Pennsylvania Medicaid -

- 90,000 Medicaid enrollees (5% of total PA enrollment) have an annual $5.5 billion in care costs
- Five health systems have created a collaborative to address this problem:

### Target Populations Of Members Of The South Central PA High Utilizer Collaborative

<table>
<thead>
<tr>
<th>Crozer-Chester</th>
<th>WellSpan</th>
<th>Lancaster General</th>
<th>Pinnacle</th>
<th>Lehigh Valley</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with highest use of inpatient &amp; ER services within Family Medicine Residency</td>
<td>Adults 18+</td>
<td>All payer high-use patients 18 years or older</td>
<td>Adults with 2+ inpatient stays in 6 months OR 6+ ER visits in 6 months</td>
<td>Referrals from three area hospitals</td>
</tr>
<tr>
<td>IBC Medicare Advantage</td>
<td>Charity care &amp; Medicaid patients with $50,000+ in hospital charges in 12 months</td>
<td>Dual eligible with 2+ chronic conditions, 2+ inpatient stays in 6 months</td>
<td>Excludes under 18</td>
<td>More than two admissions within 6 months plus complex chronic conditions with a behavioral health component</td>
</tr>
<tr>
<td>– Patients with highest spend</td>
<td>3+ ER/inpatient/observation events</td>
<td>Greater than $10,000 cost</td>
<td>Excludes cancer, trauma, HIV &amp; under 18</td>
<td>Excludes acute conditions, pregnant, hospice candidates, cancer, &amp; mental health-only diagnosis</td>
</tr>
<tr>
<td>Excludes oncology, pregnant, mental health-only diagnoses, elective surgery, surgical complications &amp; under 18</td>
<td>Excludes under 18, pregnant, catastrophic events, trauma, cancer, and mental health-only diagnosis</td>
<td>Excludes cancer, trauma, HIV &amp; under 18</td>
<td>Excludes cancer, trauma, HIV &amp; under 18</td>
<td>Excludes acute conditions, pregnant, hospice candidates, cancer, &amp; mental health-only diagnosis</td>
</tr>
</tbody>
</table>

What Role Does Data Play In Value-Based Care?

- More standardization
- Demonstration of quality improvement over time
- Analytics informs improvements in operations
- Care coordination requires greater data sharing
- Real-time monitoring and reporting
Challenges To Integrated Behavioral Health Care Delivery In Pennsylvania

- Behavioral health carve-out assures a focus on mental health, but may present challenges to coordination and a focus on “whole-person” health.

- Quality of behavioral health data and adoption / meaningful use of EHRs has been slower in the behavioral health space due to behavioral health being carved out of the HITECH Act’s Meaningful Use incentives.

- Super protection of behavioral health and drug and alcohol data prevents data sharing opportunities to inform improvements in care across systems of care.

Pennsylvania’s Behavioral Health HealthChoices program has dramatically improved access to and quality of mental health services in Pennsylvania. Person-centered care can be achieved with the carve-out through greater collaboration between providers and payers across systems of care.

Fortunately, many providers have recognized strategic and operational advantages of having EHRs and market forces have pushed many to invest in EHR adoption without the incentives.

It is important that legal departments and clinicians have a good understanding of Pennsylvania’s data privacy laws in order to advance patient-centered care while maintaining a respect for patient privacy.
IV. Strategically Operationalizing The Movement To Pay-For-Value
Summary Of Value-Based Payment Models Already In Place In Pennsylvania’s Medicaid Program

1. Pay-For-Performance (P4P) For Medicaid MCOs & Providers
   - P4P requirements are incorporated into Managed Care Organization (MCO) contracts and the state pays bonuses to MCOs that achieve performance goals relative to a set of Health Effectiveness Data and Information Set (HEDIS) measures
   - The state also issues funding to MCOs which, in turn, establish P4P goals and pays bonuses to providers

2. Efficiency Adjustments
   - As part of the annual Medicaid MCO rate setting process, the state makes reductions to the base MCO rate for unnecessary health care utilization and costs identified through Medicaid claims data

3. Hospital Readmissions
   - The state establishes rules for reimbursing acute care hospitals for readmissions occurring within 30 days of a hospital discharge for Medicaid beneficiaries

4. Preventable Severe Adverse Event (PSAE) Policy
   - The state stipulates reimbursement rules for events in acute care hospitals for Medicaid beneficiaries that are deemed to have been preventable

Source
1A. MCO Pay-For-Performance (P4P)

Description: MCOs are eligible for bonus payments based on their performance on a set of 12 quality measures, 11 of which are currently HEDIS measures.

1. High blood pressure
2-3. Comprehensive diabetes care (2 measures)
4. Cholesterol management for patients with cardiovascular conditions
5. First trimester prenatal care
6. Ongoing prenatal care
7. Breast cancer screening
8. Cervical cancer screening
9. Emergency department utilization
10. Adolescent well-care visits
11. Annual dental visits
12. Preventable hospital admissions (non-HEDIS measure)

Continual Improvement Processes
- MCO P4P is a form of a continual improvement process, as performance is measured year-over-year.
- In early years, continual improvement measures have “low hanging fruit” which improves earning power.
- However, measures become increasingly difficult in subsequent years and performance tends to level off.
- To combat this “leveling-off” phenomenon, performance measures need to continually be reviewed and adjusted to properly incentivize MCOs.

Source
1A. MCO Pay-For-Performance (P4P) (Continued)

Up-Side Risks – *The Carrot*

- **P4P Bonus**
  - The state incorporates P4P requirements and MCO-specific goals into each MCO contract on a sliding scale, with a maximum P4P bonus of 1.5% of the MCO’s annual PMPM revenue
  - Broken down:
    - 1% of that is for the MCO’s performance in comparison to national benchmarks
    - 0.5% is for the MCO’s year-over-year improvement on each measure

Down-Side Risks – *The Stick*

- **P4P Penalty**
  - If an MCO performs at below 50% of the national Medicaid benchmark, they are penalized 0.25% of their PMPM revenue
1B. Provider Pay-For-Performance (P4P)

**Description:** Each MCO is required to operate a provider P4P program to incentivize/reward provider performance related to the same set of HEDIS measures

---

**Up-Side Risks – *The Carrot***

- **P4P Bonus**
  - MCOs use the $1.00 PMPM to provide bonus incentives to providers that meet or exceed state-defined performance measures and any additional measures defined by the MCO

---

**Down-Side Risks – *The Stick***

- **P4P Penalty**
  - While the state’s $1.00 PMPM funding goes only to bonuses, MCOs may, through their contracting practices with providers, also build in penalties or other down-side risk-bearing stipulations into contracts

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- The state funds this program, equivalent to $1.00 PMPM, and requires that MCOs pass 100% of this onto providers or return it to the state
- MCOs build required measures into provider contracts and specify which providers are eligible to participate for each measure
- Although the state dictates mandatory performance measures (which are in line with the MCO P4P measures), MCOs may include optional additional measures as well

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**Source**
2. Efficiency Adjustments

**Description:** In order to incentivize efficient care that follows clinical guidelines and reduce unwarranted variation in care quality and costs, the state makes efficiency adjustments to MCO payments to penalize unnecessarily high costs or unwarranted utilization patterns.

- Costs associated with unwarranted variation are identified at the health plan level and then aggregated to the regional HealthChoices level.
- Efficiency adjustments are made for specific procedures or services for which there exist clear clinical treatment guidelines.
- To date, adjustments have been made in:
  - Ambulatory care-sensitive conditions
  - Hospital readmissions
  - Emergency care use
  - Cesarean sections
  - Overuse of high-tech radiology
  - Pharmacy management (antipsychotic medication in children)

**Down-Side Risks – The Stick**

- **Efficiency Penalty**
  - When unwarranted patterns of utilization or costs occur for a given set of procedures or services defined by the state, the state will penalize MCOs by reducing regional base payments.
  - The threat of reductions incentivizes MCOs to enforce contract provisions with providers to adhere to clinical guidelines and maintain competitive reimbursement rates for procedures and services.
  - Exclusions are implemented for high risk patient populations and outliers (superutilizers) and other factors outside of the MCO’s control.

**Source**
3. Hospital Readmission Payment Policy

Description: This policy incentivizes acute care general hospitals serving Medicaid patients to reduce unnecessary / avoidable readmissions

- For each readmission occurring within 30 days, the state conducts a review and makes a payment determination
- The state uses DRG codes and MCO claims data associated with the hospitalization to determine to what extent the follow-up hospitalization is:
  - Related to the initial hospitalization
  - For treatment of conditions which should have been treated during the previous stay
  - For treatment of complications resulting from the previous stay

Source

Down-Side Risks – The Stick

- Readmission Penalties:
  - If the readmission is for treatment of conditions which should have been treated during the previous admission, no payment is made for that admission (outlier payment is made under certain conditions)
  - If the readmission is due to complications of the original diagnosis and the result is a different DRG with a higher payment, only the higher DRG payment is made for the episode
  - If the readmission is unrelated to the previous admission, it is considered a new admission and is reimbursed under normal rules
4. Preventable Severe Adverse Event (PSAE) Policy

**Description:** This policy places reimbursement controls on serious events that are deemed to have been preventable.

PSAEs are determined through:
- Hospital self-reporting on adverse events
- Retrospective reviews of medical records by Medicaid
  - Medicaid analyzes MCO claims data and ICD-10 diagnosis codes to flag cases
  - Medicaid then investigates outliers for possible existence of PSAE

**Down-Side Risks – *The Stick***

- PSAE Penalties
  - Pennsylvania was the first state to adopt this policy, which results in payment denial or reduction depending on the nature of the PSAE
  - The policy applies when the event satisfies each of the following conditions:
    - Was preventable
    - Was within the control of the hospital
    - Occurred during an inpatient hospital admission
    - Resulted in significant harm to the patient

**Source**
**Visible metrics**

- Actionable insights based on rich data – identification of the actions needed to improve performance

**Targeted coaching with individualized goals**

- Team collaboration for sustained motivation

**Real-time feedback**

- Recognition of great performers

- Team celebrations of great performance

**Sources:**


Shifting Strategy To Focus On Value: From the Top, Down.

- Leadership and commitment to change at the C-Suite level is a must
- Change management is successful when it occurs collaboratively with staff
- Staff input should inform the new model
- Staff training and re-training is necessary to institute a value-based culture

Source
# Financing & Cost Structures

## Payment Taxonomy Framework

<table>
<thead>
<tr>
<th>Description</th>
<th>FFS No Link To Quality</th>
<th>FFS Link To Quality</th>
<th>Alternative Payment Arrangements Built On FFS Architecture</th>
<th>Population-Based Payment</th>
</tr>
</thead>
</table>
| **Description** | Payments based on volume of services and not linked to quality or efficiency | A portion of payments are based on quality or efficiency of care delivery | • Some payment is linked to effective management of a population or an episode of care  
• Payments are still triggered by delivery of services, but with opportunities for shared savings or two-sided risk | • No link between service delivery and payment  
• Providers are reimbursed per time period and per beneficiary and are responsible for managing each individual’s care within that budget  
• Providers take on two-sided risk and must report on quality measures |
| **Payment Calculation** | Providers receive a negotiated payment for each service administered | Provider base payments are supplemented with bonuses if provider meets quality criteria | • Varies: payments can be bundled for a given episode to incentivize proper care delivered under established clinical guidelines, with providers on the hook for any preventable follow-up care | Typically a PMPM payment that varies based on:  
• Severity of illness of patient population  
• Geographic reach of provider  
• Scope of care management services offered |

Linking Provider Revenue To Clinical Outcomes
What Do Behavioral Health Providers Need To Do To Thrive In Value-Based Environment?

Assume risk in caring for defined populations
Integrate behavioral health and medical care
Develop wellness programs that improve health and reduce medical costs
Engage increasingly value-conscious consumers
Accelerate the adoption of innovations that improve the value of health care and reengineering the delivery of services
Explore the capital models required to finance this transition
• Identify change management skills and competencies that leaders need to make this happen

Source
How To Operationalize – Tactics
The Road To Value-Based Health & Human Services

Top-To-Bottom Commitment To Change
- Vertical collaboration to define new model

Set Performance Standards
- Decide what to measure and measure it

Metrics-Based Management
- Develop systems and processes to use performance measurement in management

Performance-Driven Culture
- Use performance measurement data to change the organization
Achieving Top-To-Bottom Commitment To Change

- A value-driven culture requires a top-down commitment to change
  - Executives should lead the effort from concept to reality and be actively engaged throughout the process.

- Change will likely require massive shifts in the way your organization does business
  - Line staff will only take change as seriously as the executives do
  - Strong commitment is necessary from top management

- Input from staff at all levels of the organization helps to build consensus and buy-in into the new value-driven culture
  - This can be accomplished through holding brainstorming sessions, Q&A sessions, and requesting input in every step of the implementation process

Change Starts At The Top, Not The Bottom

The Leader’s Role:

- The organization and its team are positioned and prepared
- Key managers deliver on their performance accountability
- Ensure all organizational performance measures are met
Set Performance Standards Tactics

Why Measure?

- Demonstrates quality
- Ensures effectiveness & efficiency
  - Adherence to evidence-supported treatments
  - Efficient use of resources
  - Right person, right care, right time
  - Appropriate levels of care
- Builds trust in the system from all stakeholders
- Allows for a systematic approach to improvement

What To Measure?

- Clinical importance
  - Can the measure result in actionable improvement efforts?
  - Does the measure represent a substantial deficit in care?
- Validity
  - Is there evidence supporting the relationship between the measure and the clinical outcome?
  - Is the measure easily understood, sensitive to change, or scientifically sound?
  - Does the measure allow for differences in patient beliefs and preferences for care?
  - Can the measure be “gamed” by providers?
- Feasibility
  - How easy is it to collect data across an episode of care?
  - How complete and reliable is the collection method and resulting data?
  - Is it affordable to collect the data?

Source
Metrics-Based Management Tactics

- What are your metrics measuring?
  - Process: Easy to gather, but subject to response bias and vagueness in terminology
    - “Did good care happen?”
  - Structure: Captures care elements under greatest control, but dependent upon patient care-seeking behaviors
    - “Did things not happen due to patient or provider factors?”
  - Outcomes: Assess if patient status improves, but is sensitive to differences in illness severity and presence of comorbidities
    - “Did the patient’s health improve as a result of treatment?”

- Expect measures to evolve over time.

Why Does Behavioral Health Tend To Lag Behind?

- Evidence / clinical guidelines more difficult to define
- Inadequate infrastructure to develop & implement measures
- Lack of Electronic Health Information
  - HITECH Act Incentives
  - Super-protection of data

Performance-Driven Culture Tactics

Facilitating Performance-Driven Culture

- Commitment to change from the board room to the billing department
- Iterative strategy and budgeting process
- Nimble service line reengineering and development processes
- Customer-centric performance metrics
- Automated systems to measure organizational performance
- Assigned accountability for performance
  - Who is responsible for revenue?
  - Who is responsible for program profitability?
- New role of supervisors
- New role of managers
V. Incorporating A Pay-For-Value Model Into A BHMCO System & Working With OMHSAS To Develop Alternative Payment Arrangements
Development Of Pilot Programs With BHMCOs

- What populations is the BHMCO targeting for improved care management?
- How can data exchange with the BHMCO be improved upon?

**Pilot programs need to address:**
- Targeted patient populations
  - Which diagnoses?
  - What level of illness severity?
  - Any exclusion factors?
- Risk stratification methodology of target population
- Design of care management intervention
  - What services will be offered?
  - Who will provide the services?
  - Will care coordination be person-centered?
- How data will inform the process
- Payment arrangement
Review Of Successful APAs In Use In PA
Crisis Intervention Services (CIS) In Dauphin County

- **Background**
  - CIS is required to be available 24/7 but reimbursed by Medicaid on a FFS basis
  - This is problematic as demand for CIS services can vary substantially from day to day (or night to night)
  - When payment is made based solely on utilization, it creates a financial burden because future revenue is highly unpredictable
  - Also, payment does not reflect actual costs of service

- **This APA Shifts Payment From FFS To A Monthly Retainer Payment To Providers**

- **Methodology**
  - The County analyzed data for crisis intervention utilization, establishing FY2013-14 as a base year to observe Medicaid funded services compared to total service utilization and cost
  - Unduplicated utilization reports were drafted and showed that Medicaid was underfunding its portion of total services

- **New Model**
  - Medicaid now pays a monthly retainer to the program
  - This flat fee enables the county to better forecast revenue and improve financial planning for this service because payment is not tied to widely varying utilization

- **Of Note**
  - The APA proposal included scenarios for how payment would change if utilization trended down and included requirements of providers to submit data to the BHMCO to assure sufficient monitoring

Review Of Successful APAs In Use In PA MST Services in Counties within Capital Area Behavioral Health Collaborative (CABHC)

- **Background**
  - In a FFS systems some MST providers pressure their staff to maximize billing units authorized for each child regardless of medical necessity or need
  - This creates an adversarial relationship between providers and payers, who perform utilization review to assure that services are necessary

- **This APA Shifts Payment From FFS To A Standardized Case Rate Reimbursed Weekly**

- **Methodology**
  - The Counties developed a PMPW (per-member, per-week) reimbursement for MST services by deducing a unit cost for services, outlining minimum levels of service to be provided in order to receive payment, and put in place several layers of monitoring in order to assure the continued provision of necessary services
  - The rate-setting methodology was clearly laid out by the counties, as were a listing of services eligible for reimbursement

- **New Model**
  - Under the new model, providers report on number of units (15-minute increments) provided – and are reimbursed a flat weekly fee if the number of units exceeds the minimum threshold
  - Payment is based on encounter data with quarterly utilization reports to double check for accuracy

Best Practices For Working With OMHSAS

In General

• Realize the position OMHSAS is in
• Communicate early and often
• Don’t reinvent the wheel
• Ask questions, seek advice and direction
• Strength in numbers
• If necessary, start with a pilot
• Collaborator > Adversary

Your Application

• Statement of Rationale for APA should clearly outline the benefits that will be achieved from this model and how the model will lead to more cost effective or higher quality care
• Have strong data to support your cause
• Make it clear that your methodology used to determine the payment arrangement was driven by data analytics
• Describe the process that will be used to assure strong data reporting in the new model and monitoring of cost effectiveness
• When possible, point to similar existing models in other areas, and the outcomes achieved by both models
How To Assure Compliance With Fraud, Waste, & Abuse Monitoring In A Value-Based Payment Model

**Fee-For-Service**

FWA monitoring by the MCO and the State/County focuses on accuracy of reporting, as accuracy determines reimbursement levels.

*Example of a Red Flag:* A provider who bills for more than 18 hours of service per day

**Value-Based Models**

Payment is not tied to utilization, so FWA monitoring focuses on assuring that providers are meeting minimum standards and quality measures.

*Example of a Red Flag:* A retrospective review shows that a provider’s monthly encounter data does not yield enough units of service to meet minimum reimbursement thresholds.

Provider provides a service, bills the BHMCO, and submits data as evidence of service.

BHMCO reimburses provider for that service.

BHMCO Shares data with state/county.

State/County pays BHMCO on risk basis to manage care.

FWA Monitoring!
VI. Building Incentives Into Your Payment Structure
Productivity-Based Incentives

Under A Productivity Model For Incentivizing Improved Staff Performance, Productivity Is Measured By The Number Of Hours Spent Engaged In Billable Activity

Minimum Productivity

- In these models, staff are expected to engage in a minimum number of billable hours per time period (ranging from week to month to quarter, or even annually)

- Employees receive a base salary and are then given a bonus for meeting productivity goals

- This model works well in a FFS environment, but can tend to pressure staff to engage in unnecessary billable hours

Pure Productivity

- In these models, staff salary is wholly tied to productivity

- Staff are only paid for their billable time

- This works best for contract employees, who get reimbursed only for the time that they spend doing billable activity
Revenue-Based Incentives

- Bonuses that are tied to the revenue generated by the company
- Often called “profit sharing”, these pose the least financial risk to the company because they are only provisioned in the event that the company as a whole meets a predetermined profit margin

Structure Of Incentives

- Can be based on individual performance, team performance, bonuses for achieving components to the company’s strategic plan, or as year-end bonuses

Unintended Consequences

- Be aware of unintended consequences of some structures
- For example, individual bonuses will create a highly competitive culture within the company
- Goals set too high are difficult to achieve and may attribute to low morale
- One way around this is to create a tiered bonus structure where smaller bonuses kick in at a lower minimum productivity level
Timeliness Of Incentives & Other Important Notes On Productivity

• Staff performance will be influenced by incentives only when the incentives are given in a timely manner
• E.g.: No one thinks about a year-end bonus in February... and if November comes around and the employee is not close to meeting his year-end goal, there is little incentive to keep trying

Don’t Forget About The Non-Clinicians
• While most incentives are structured around revenue-producing clinical staff, incentives can also be highly effective with support staff such as the billing department
• It is critical that incentives are matched with relevant performance goals in order to influence behavior

A Large Payer Mix Makes It Difficult To Set Productivity-Based Performance Goals
• Due to the variability in payer reimbursement for services, the existence of a large payer mix can complicate how productivity is measured
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