Moving forward With Value Based Care/Purchasing and Certified Community Behavioral Health Clinics

My Background

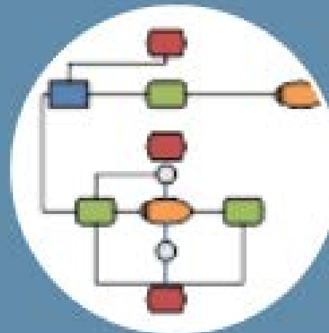
- Medical Director for National Council for Behavioral Health
- Practicing Psychiatrist in a Community Health Center
- Distinguished Professor, Missouri Institute of Mental Health, University of Missouri St. Louis
- Previously
  - Medicaid Director for Missouri
  - Medical Director Missouri Department of Mental Health

2008 through 2010
Suddenly A New Environment

- 2008 - MH and SA Parity Act
- 2009 – Economic Crisis
- 2009 – HIT Act
- 2010 – Health Care Reform

Insurance Reform

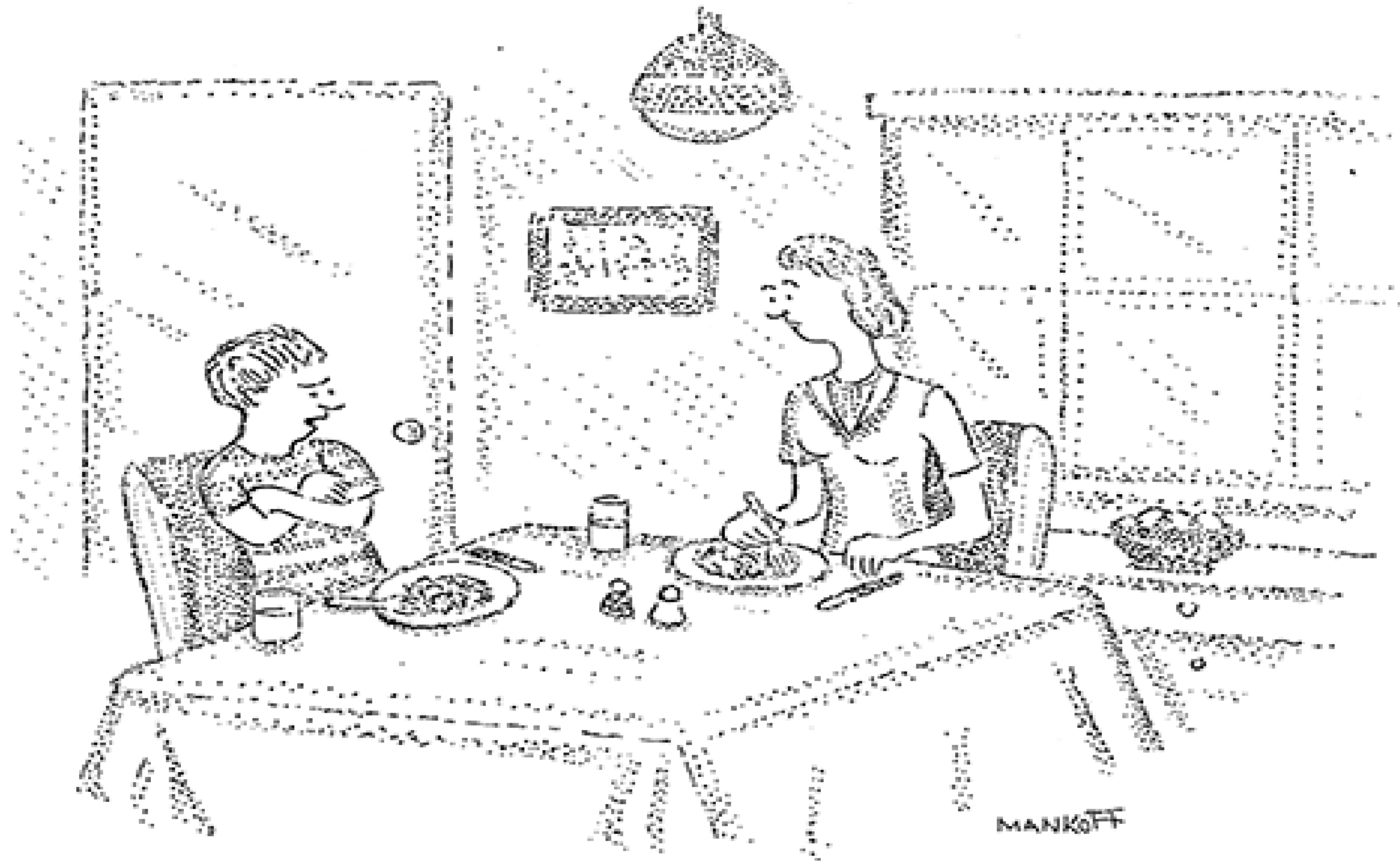
Coverage Expansion



Delivery System Redesign

Payment Reform

Healthcare Reform



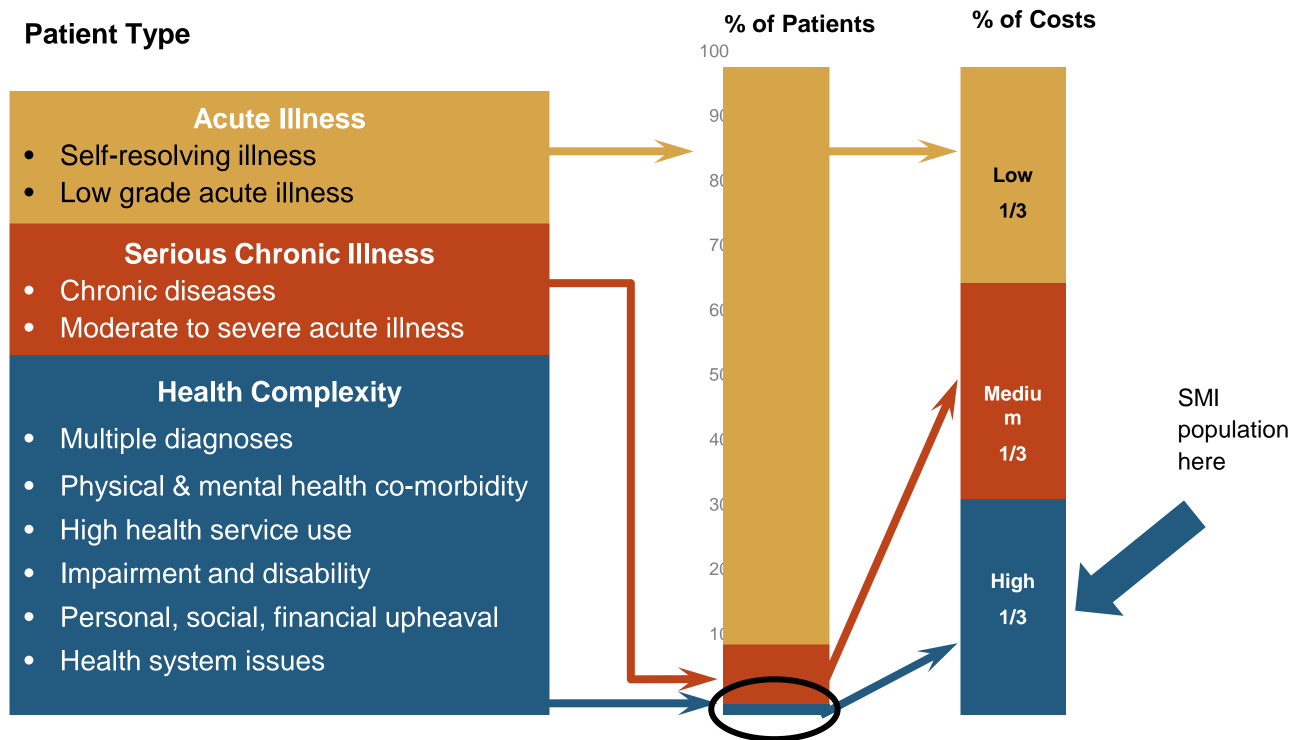
"I say it's government-mandated broccoli, and I say the hell with it."

"These new regulations will fundamentally change the way we get around them."

Drivers of Increased Demand for Behavioral Health Care

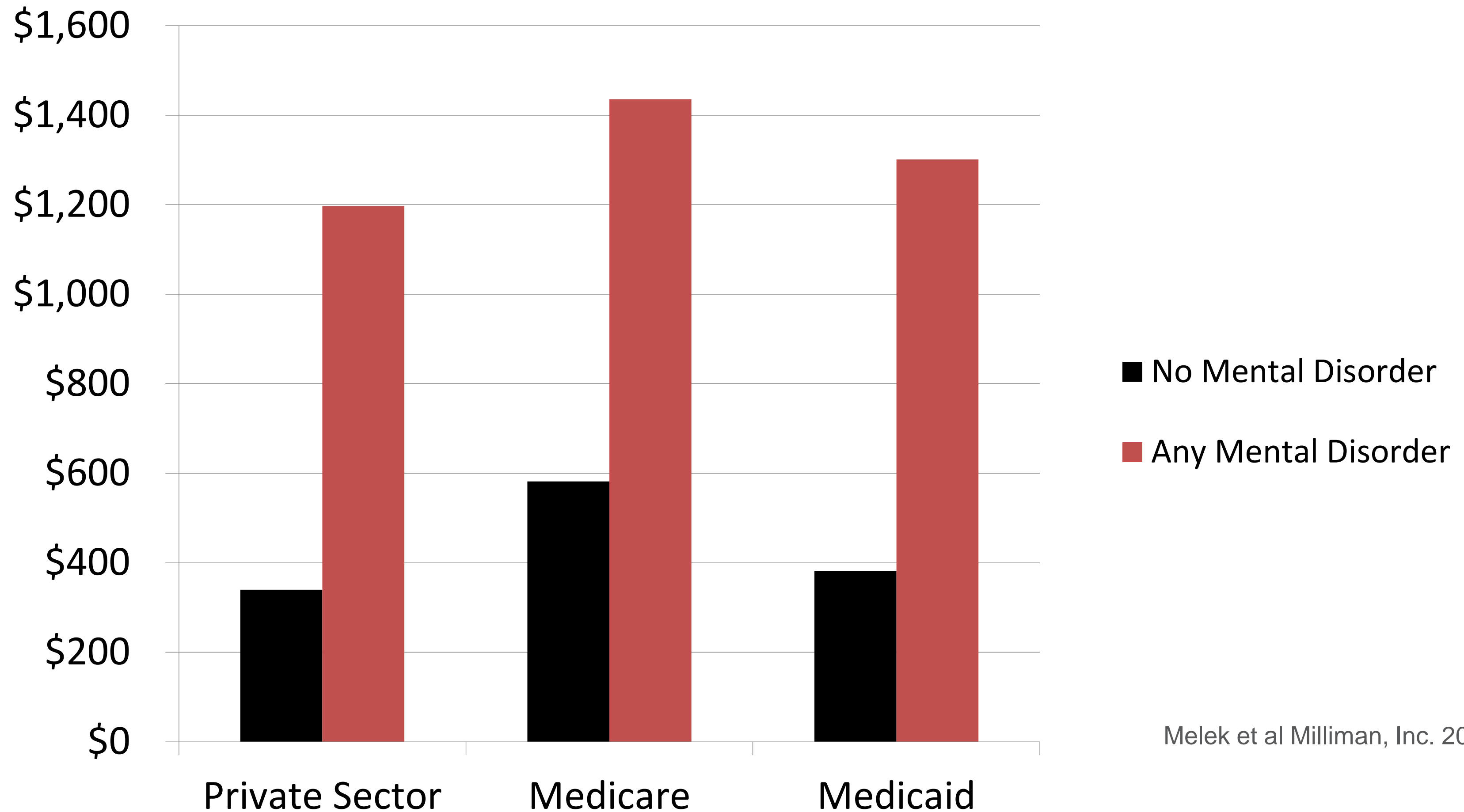
- ACA Insurance reforms and Medicaid expansion substantially increases behavioral health coverage for adults
- ACA requires newly covered populations meet the parity requirements of Wellstone Domenici Parity Act
- Multiple parts of ACA require or incentivize integration of Behavioral Health and general medical care
- Stigma continues to drop releasing pent up demand
- In responding to recent press coverage of mass shootings increasing mental health services is more popular than gun control

Cost of Health Complexity



Adapted from Meier DE, J Pall Med, 7:119-134, 2004

Per Member Per Month Costs



Risk Management to 10,000 Feet

- The basic mechanism by which insurance works is pooling risk, but…
- Until Implementation of Insurance Reforms under the ACA in 2014 the predominant US business model and insurance was to segment risk
  - Pre-existing illness exclusions
  - Lifetime limits
  - Sub- capitation of parts of the total benefit
  - Medical rating
- Medicaid and Medicare functionally provide reinsurance coverage for the commercial insurance industry by covering the populations with the highest and least controllable costs
- Medicaid in particular is used to cover populations and conditions that are considered not fiscally feasible and the rest of the insurance market
- Insurance reforms under the ACA have forced payers to focus more on the actual management of care were previously they focused on the avoidance of fiscal risk
- As a result payers have become highly motivated to share fiscal risk with anyone else they can find

Payer Public Goals

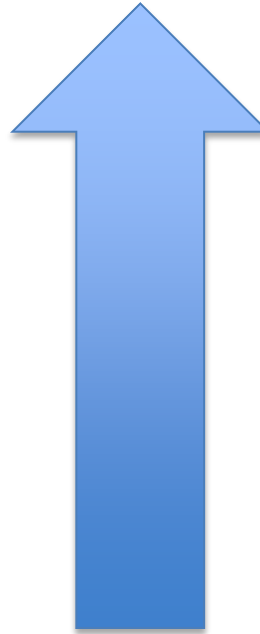
- Lower rates of emergency room use
- Reduce in-hospital admissions and re-admissions
- Reduce healthcare costs
- Decrease reliance on long-term care facilities
- Improve experience of care, quality of life and consumer satisfaction
- Improve health outcomes
  - HEDIS indicators
  - Management of health conditions

What Payers Really Want

- Lower Costs (Utilization)
- Better Care (Quality)
- Both only pay if
  - Savings Occur
  - Quality meets explicit measured results
- Predictability
- Integration with BH (but don't know what that is)
- Social Determinants addressed (but don't know how to)
- You (and everyone else) to Share Their Risk

Delivery System Trends

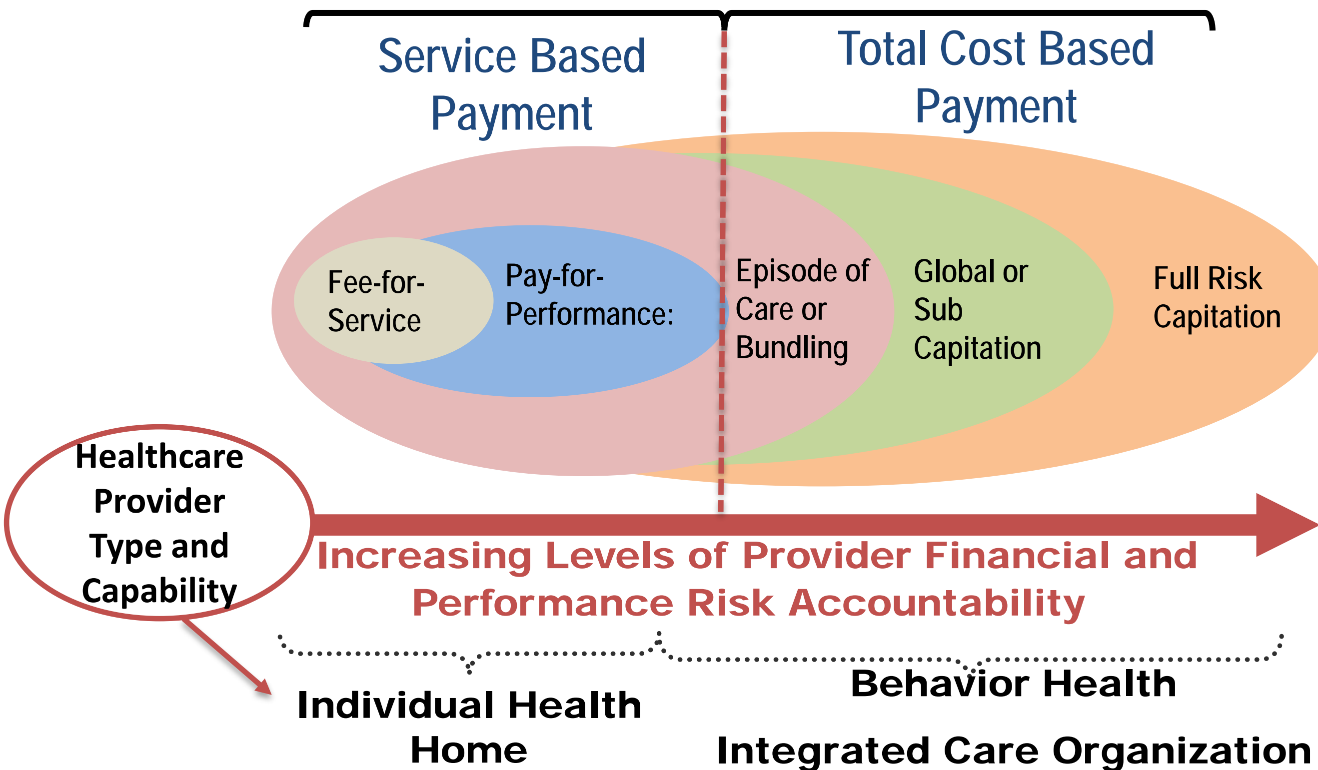
Growing interest in value-based purchasing



Growing awareness that access to behavioral health is a big problem

Various Payment Arrangements from Fee for Service to Value Based Care

Aligning Reimbursement to Incentivize the Desired Outcomes

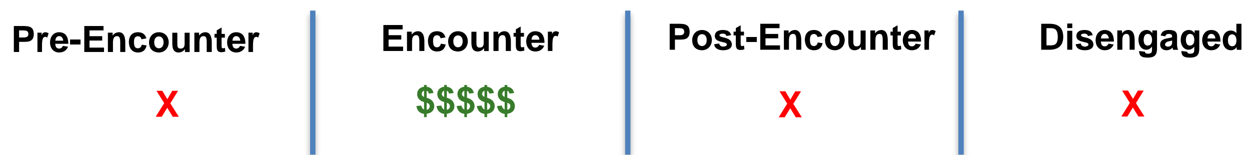


Value Based Payment Arrangements Require:

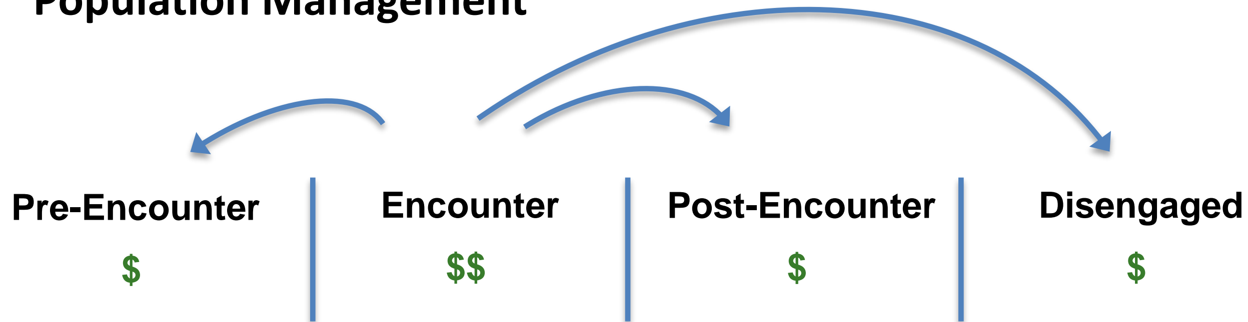
- A health system network designed around the patient's care and service needs
- Provider HIT infrastructure
- Data systems for managing and reporting financial and performance risk

...from encounters...to ongoing management

- Fee-For-Service



Population Management



What is a **Population Health Management?**

- Not just a Healthcare benefit
- Not just a program or a team
- It's a system and an organizational transformation

Population Management Principles

- Population-based Care
- Data-driven Care
- Evidence-based Care
- Patient-centered Care
- Addressing Social Determinates of Health
- Team Care
- Integration of Behavioral and Primary Care

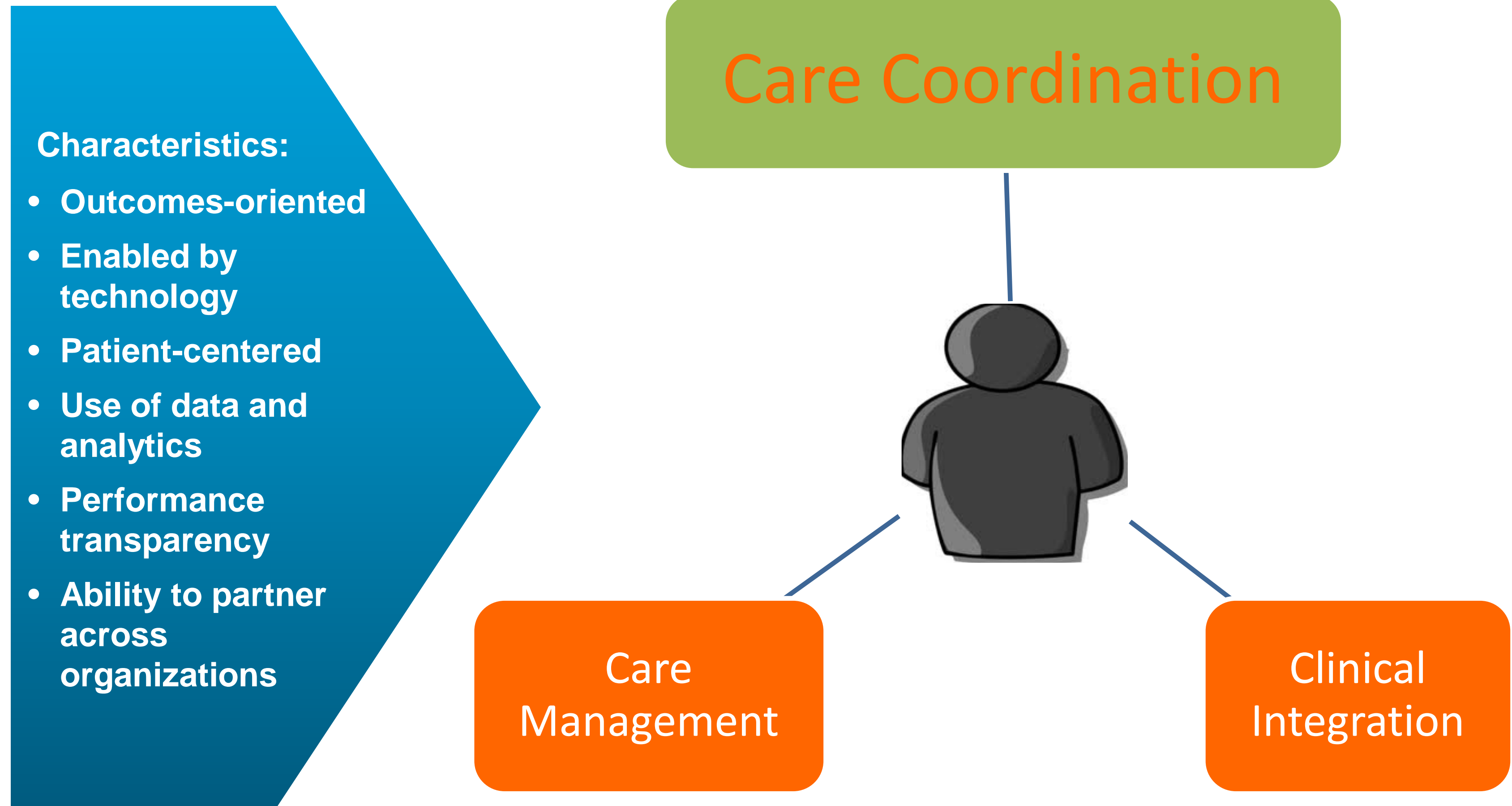
Population-Based Care

- Don't rely solely on patients to know when they need care and what care to ask for and from whom - use data analytics for outreach to high need/utilizer patients
- Don't focus on fixing all care gaps one patient at a time - choose selected high prevalence and highly actionable individual care gaps for intervention across the whole population
- The population-based health care provider is the public health agency for their clinic population

Population Management

- Selects those from whole population:
  - Most immediate risk
  - Most actionable improvement opportunities
- Aids in planning:
  - Care for whole population
  - New interventions and programs
  - Early identification and prevention
  - Choosing and targeting health education

Important Provider Competencies



How do you deliver PHM in any care setting?

Assess

Stratify

Implement Solutions

Measure & Report

Data-Driven Care

- Patient Registries
- Risk Stratification
- Predictive Analytics
- Performance Benchmarking
- Data Sharing

Data You Need to Manage

- Eligibility/Enrollment Registry
- Payment System
- Work Process Tracking
  - Data reporting
  - Use of HIT Care management tools
  - Staffing as required and turnover
  - Attending training and Conference calls
- Aggregate Outcomes
- Individual Patient Look-Up/Drill down

Data Sources

- Claims – Broad but not Deep, already aggregated
  - Diagnosis
  - Procedures including Hospital and ER
  - Medications
  - Costs
- EMR Data Extracts – Deep but not Broad, need aggregating
- Practice Reported – Administrative Burden
  - Metabolic Values – Ht, Wt, BP, HbA1c, LDL, HDC
  - Satisfaction and community function – MHSIP
  - Staffing and Practice Improvement
- Hospital Stay Authorization – Hospital Admissions

Data Uses

- Aggregate reporting – performance benchmarking
- Individual drill down – care coordination
- Disease registry – care management
  - Identify care gaps
  - Generate to-do lists for action
- Enrollment registry – deploying data and payments
- Understanding – planning and operations
- Telling your story – presentation like this

Varieties of performance measures

- Process measures vs Outcome measures
- Quality of care measures vs Utilization of service measures
- Patient status measures
  - Symptom measures
  - Functional measures
  - Satisfaction measures
- Reporting versus Managing
  - HEDIS measures

Issue – What is the Baseline?

- Options
  - Same patients Pre/Post
  - Compared to a control group
  - How long is the base period
- What Services/Costs are In/Out?
- On Performance Measures
  - What/whose data is used
  - What diagnosis, persons, procedures are excluded?

Why Share Data

What gets measured gets done

Principles

- Use the data you have before collecting more
- Show as much data as you can to as many partners as you can as often as you can
  - Sunshine improves data quality
  - They may use it to make better decisions
  - It's better to debate data than speculative anecdotes
- When showing data ask partners what they think it means
- Treat all criticisms that results are inaccurate or misleading as testable hypotheses

More Principles

- Tell your data people that you want the quick easy data runs first. Getting 80% of your request in one week is better than 100% in six weeks
- Treat all data runs as initial rough results
- Important questions should use more than one analytic approach
- Several medium data analytic vendors/sources is better than one big one
- Transparent benchmarking improves attention and increases involvement

Most Important Principle

- Perfect is the enemy of good
- Use an incremental strategy
- If you try figure out a comprehensive plan first you will never get started
- Apologizing for a failed prompt attempt is better than is better than apologizing for missed opportunity

PLANNING

Much Work Remains to be Done before We Can Announce Our Total Failure to Make Any Progress.

Six Population Health Management Services

- Care Management
- Care Coordination
- Managing Transitions of Care
- Health Promotion
- Individual and Family Support
- Referral to Community Services

Comprehensive Care

- Identification and targeting of high-risk individuals
- Monitoring of health status and adherence
- Identification and targeting care gaps
- Individualized planning with the patient

Population Health Management Delivery Models

- Health Homes
- Person Centered Medical Home
- Federally Qualified Health Center (FQHC) and Certified Community Behavioral Health Center (CCBHC)
- Accountable Care Organization

It's Not All Risk Bearing Managed Care

- No at risk MCOs – 11 States
- States with Managed Care but Special Populations excluded or voluntary
  - ID 12 states
  - SMI 7 States
- States with Managed Care but Specialty Services carved Out
  - MH Outpatient 9 states
  - MH Inpatient 7 states
  - SUD Outpatient 7 states
  - SUD Inpatient 6 states
- Over 90% in at Risk Managed Care – 18 States
- Capitated Managed Long Term Supports and Services - 25 states

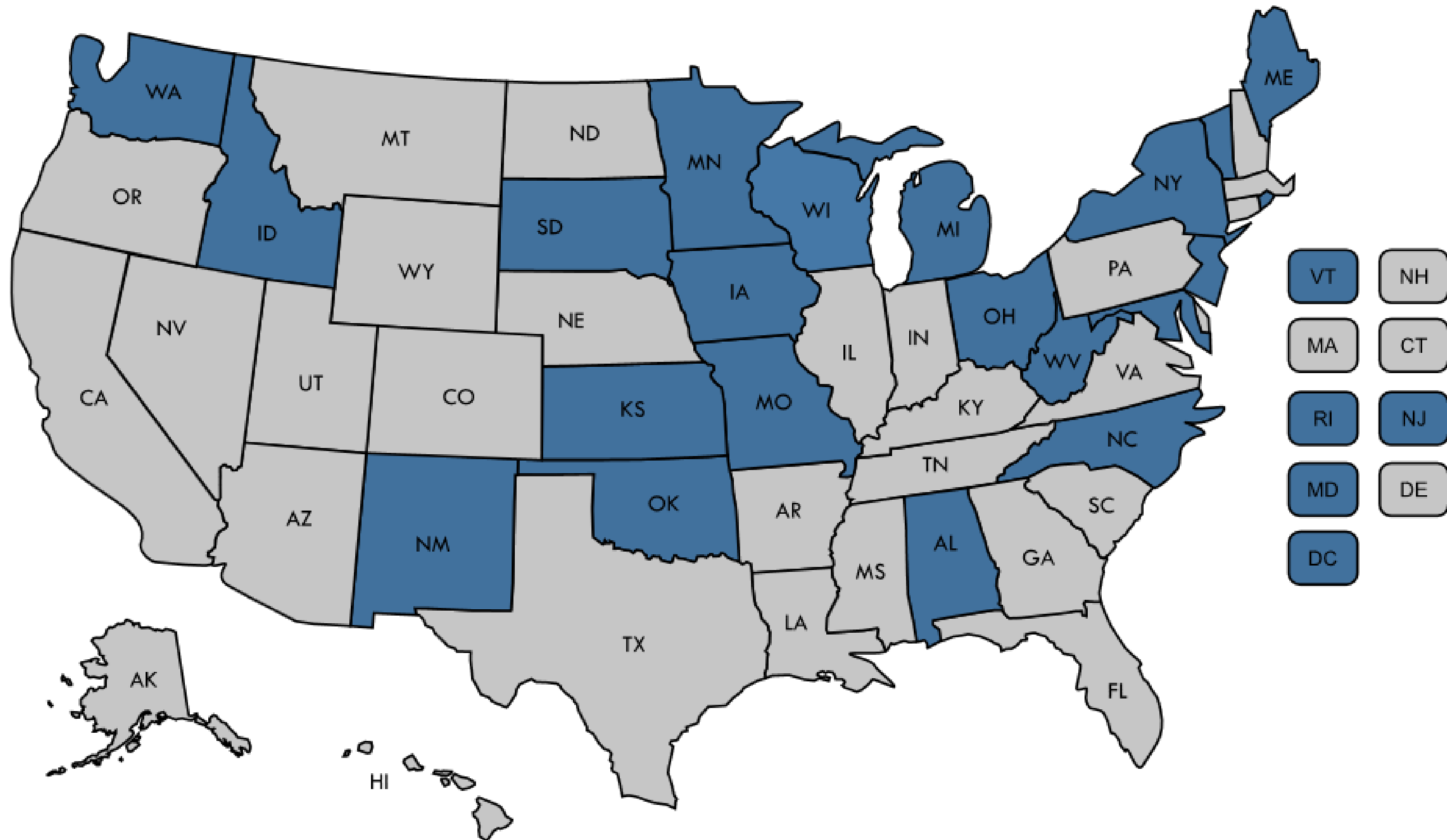
Delivery System and Payment Innovations

• Person Centered Medical Homes (PCMH)	30 states
• Primary Care Care Management (PCCM)	12 states
• ACA Health Homes (HH)	22 states
• Certified Community BH Centers (CCBHC)	21 states
• ACOs	14 states
• Episode of Care Payments	7 states
• Delivery System Reform Incentive (DSRIP)	10 States
• Payments to IMDs by 20220	
– MCO “in-lieu-of”	31 states (CT after 2020)
– 1115 IMD Waiver	9 states
– SUPPORT Act States Plan Option	5 states

Defining health homes

- Provides states the option to cover care coordination for individuals with chronic conditions through health homes
- Bundled Per Member Per Month (PMPM) rate
- Services by designated providers, a team of health care professionals or a health team
  - Comprehensive care management
  - Care coordination
  - Health promotion
  - Comprehensive transitional care
  - Individual and family support
  - Referral to community and support services
- Eligible Medicaid beneficiaries have:
  - Two or more chronic conditions,
  - One condition and the risk of developing another, <u>or</u>
  - At least one serious and persistent mental health condition

May 2017- 21 states have a total of 32 approved Medicaid health home models



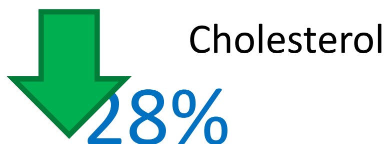
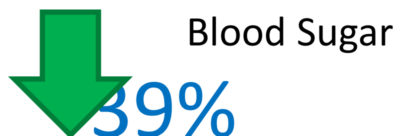
- Payments for HH services will be paid PMPM, not unit by unit
- Service needs will be identified by patient health history and status
- Outcomes will be measured by groups of clients (i.e., by organization, region, medication used, and co-morbid conditions).

Six CMS Required Health Home Functions

1. Care Management
2. Care Coordination
3. Managing Transitions of Care
4. Health Promotion
5. Individual and Family Support
6. Referral to Community Services

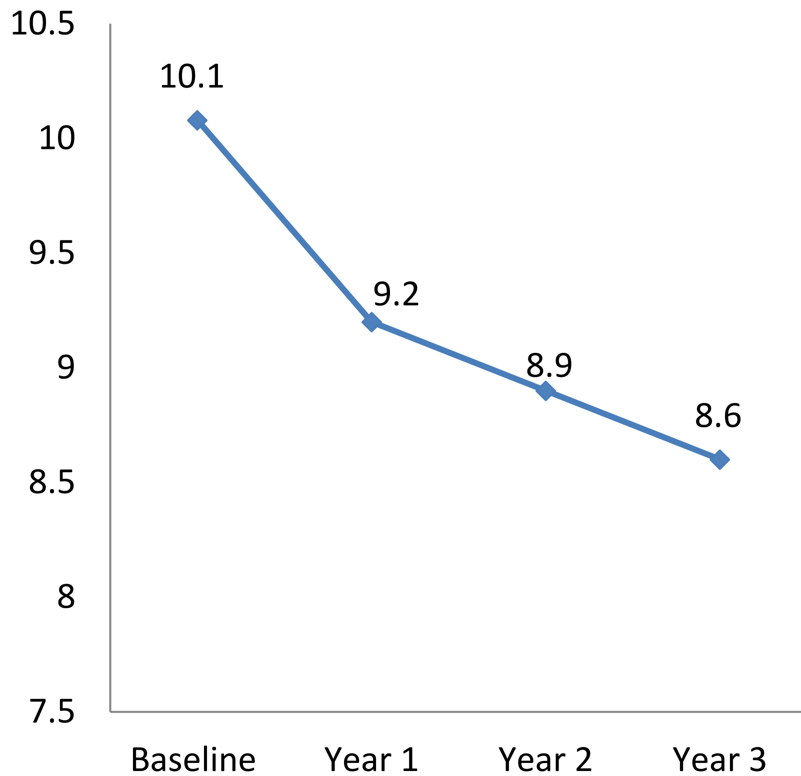
- Nurse Care Managers (1FTE/250pts)
- Care Coordinators (1FTE/500pts)
- Health Home Director
- Behavioral Health Consultants (primary care)
- Primary Care Physician Consultant (behavioral health)
- Learning collaborative training
- Next day notification of hospital admissions

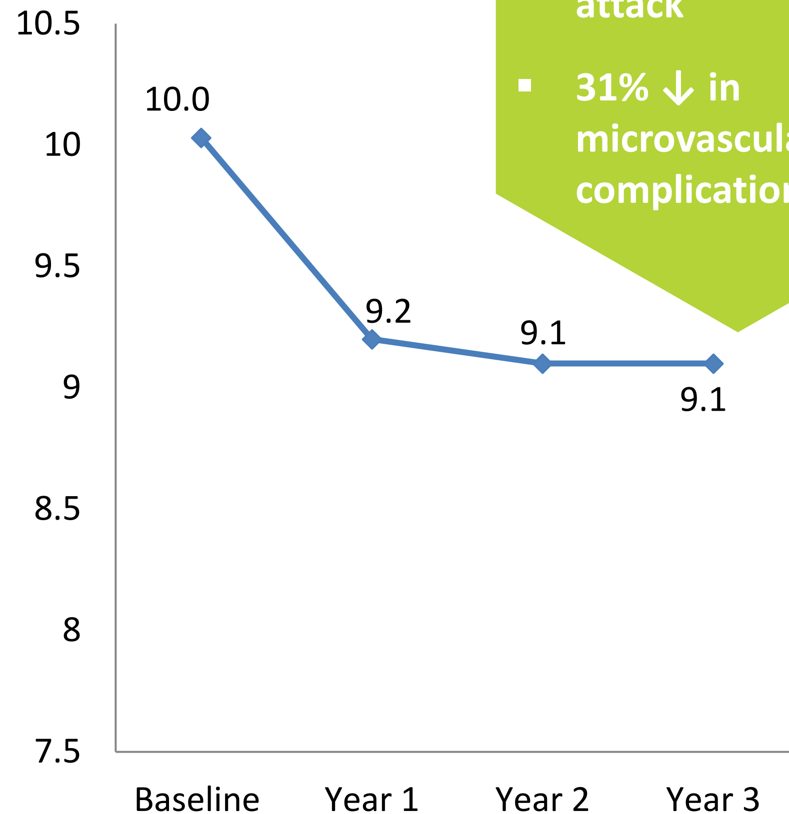
Case Study #1: Missouri Outcomes

COST SAVINGS (first year)	HEALTH MEASURE IMPROVEMENTS (Feb 2012 – Jan 2014)	REDUCTIONS IN HOSPITALIZATIONS IN THE FIRST YEAR
Missouri Health Homes have saved an estimated $36 million/$31 million from BHH	 Cholesterol 28% Blood Pressure 30%  Blood Sugar 39%	[illegible].1%

A1C Levels Over Time

About 7% had uncontrolled A1c levels

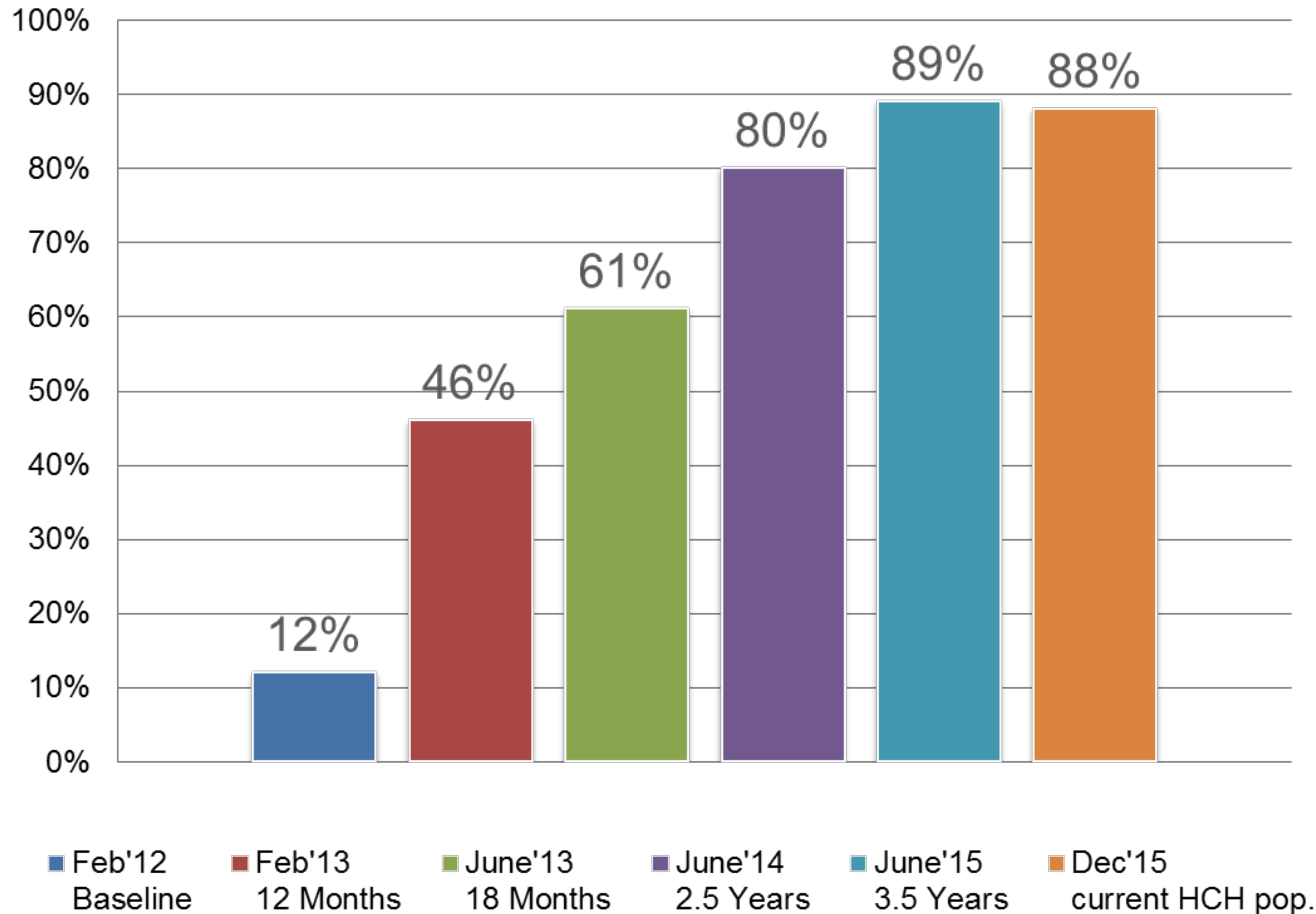




1 POINT DROP IN A1C

- 21% ↓ in diabetes related deaths
- 14% ↓ in heart attack
- 31% ↓ in microvascular complications

Metabolic Syndrome Screening



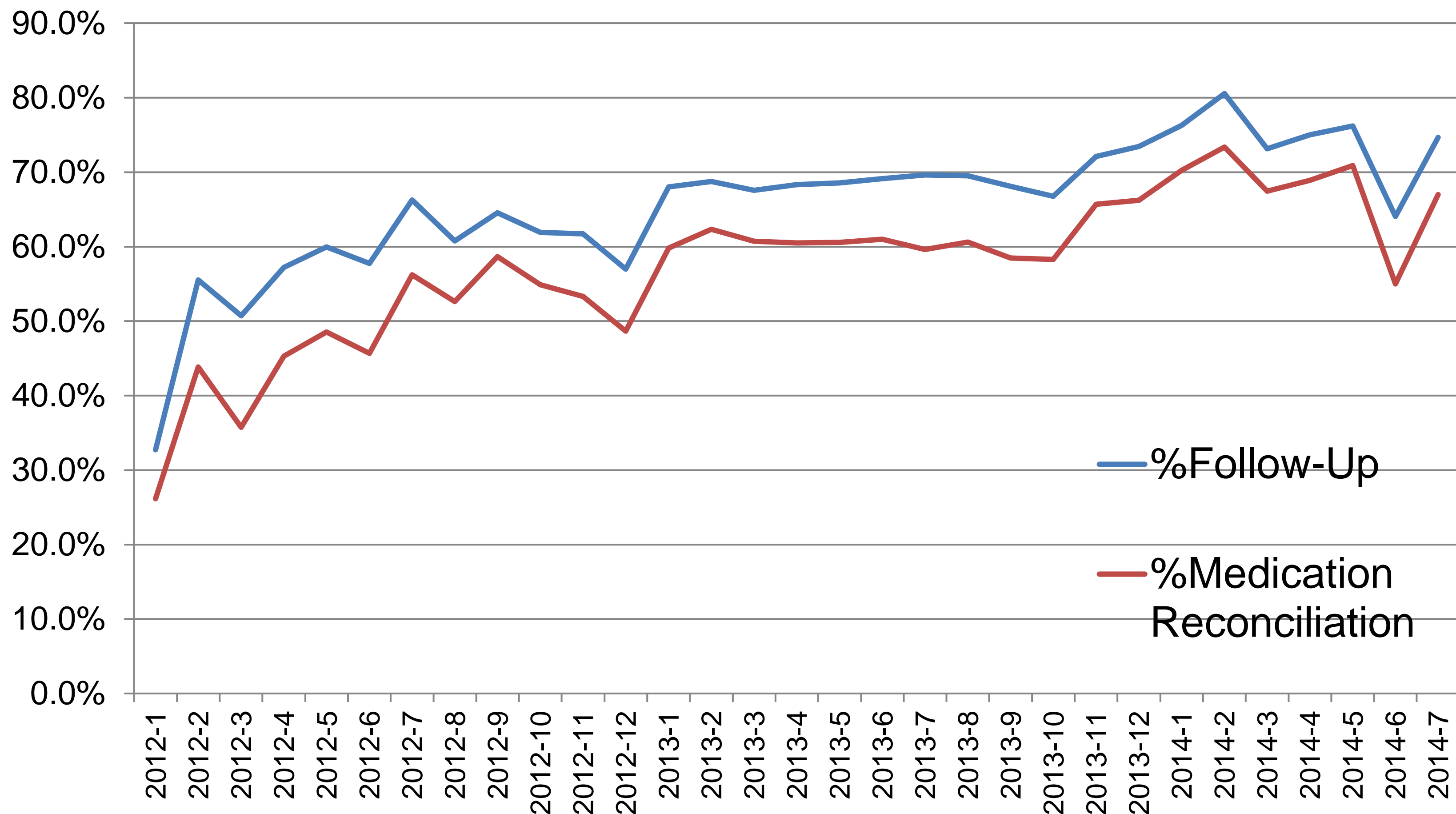
All CMHC Health Homes have attained a completion rate above 80%!

N= 6,553 (at 3.5 years)

N= 20,648 (Dec 2015)

Data source: CMT

Hospital Follow-up and medication reconciliation within 24 hours of discharge Jan 2012 through July 2014



Certified Community Behavioral Health Center (CCBHC)

- 8 State Medicaid Demonstration began July 2017
- Patient Eligibility – required to serve all BH
- Payments - Cost based Prospective Payment from Medicaid for outpatient BH
- Services – list of evidence based BH services
- State Certified
- Must file annual cost report, and performance data

CCBHCs provide a financial foundation to…

Participate in VBP

- Data infrastructure
- EHR/HIE
- Assertive care coordination
- Population health management
- Sophisticated management of clinic finances

Alleviate the crisis in access

- Workforce expansion
- Access supported by technology
- Increased service capacity
- Evidence-based, non-billable activities

The CCBHC Landscape

Two funding tracks, plus state options

- Medicaid demonstration
- Federal grant funding
- Some states (e.g. Texas) moving forward with their own CCBHC adoption

CCBHC Reported Measures (9 Required)

Potential Source of Data	Measure or Other Reporting Requirement	NQF Endorsed
EHR, Patient records, Electronic scheduler	Number/percent of new clients with initial evaluation provided within 10 business days, and mean number of days until initial evaluation for new clients	N/A
EHR, Patient records	Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up	0421
EHR, Encounter data	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) (see Medicaid Child Core Set)	0024
EHR, Encounter data	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	0028
EHR, Patient records	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	2152
EHR, Patient records	Child and adolescent major depressive disorder (MDD): Suicide Risk Assessment (see Medicaid Child Core Set)	1365
EHR, Patient records	Adult major depressive disorder (MDD): Suicide risk assessment (use EHR Incentive Program version of measure)	0104
EHR, Patient records	Screening for Clinical Depression and Follow-Up Plan (see Medicaid Adult Core Set)	0418
EHR, Patient records	Consumer follow-up with standardized measure (PHQ-9) Depression Remission at 12 months	0710

Potential Source of Data	Measure or Other Reporting Requirement	NQF Endorsed
URS	Housing Status (Residential Status at Admission or Start of the Reporting Period Compared to Residential Status at Discharge or End of the Reporting Period)	N/A
Claims data/ encounter data	Follow-Up After Emergency Department for Mental Health	2605
Claims data/ encounter data	Follow-Up After Emergency Department for Alcohol or Other Dependence	2605
Claims data/ encounter data	Plan All-Cause Readmission Rate (PCR-AD) (see Medicaid Adult Core Set)	1768
Claims data/ encounter data	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications	1932
Claims data/ encounter data	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (see Medicaid Adult Core Set)	N/A
Claims data/ encounter data	Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (see Medicaid Adult Core Set)	0576
Claims data/ encounter data	Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (see Medicaid Child Core Set)	0576
Claims data/ encounter data	Follow-up care for children prescribed ADHD medication (see Medicaid Child Core Set)	0108
Claims data/ encounter data	Antidepressant Medication Management (see Medicaid Adult Core Set)	0105
EHR, Patient records	Initiation and engagement of alcohol and other drug dependence treatment (see Medicaid Adult Core Set)	0004
MHSIP Survey	Patient experience of care survey; Family experience of care survey	N/A

CCBHCs Across the Country

States Participating in Medicaid Demonstration	Clinics in Demo (# also Receiving Expansion Grants)	# Receiving Expansion Grants Only	Total CCBHCs
Minnesota	6	2	8
Missouri	15 (3)	N/A	15
Nevada	3 (1)	N/A	3
New Jersey	7 (4)	2	9
New York	13 (3)	5	18
Oklahoma	3 (2)	2	5
Oregon	12 (2)	N/A	12
Pennsylvania	7 (2)	1	8
TOTAL	**66**	**12**	**78**

States Receiving Expansion Grants Only	# Clinics
Colorado	1
Connecticut	1
Illinois	1
Indiana	2
Iowa	2
Kentucky	2
Maryland	2
Massachusetts	5
Michigan	9
North Carolina	1
Rhode Island	1
Texas	6
Virginia	2
TOTAL	**35**

There are currently 113 CCBHCs across the United States

CCBHC Scope of Services

Pt. Centered Treatment Planning

Outpatent MH/SA

Psychiatric Rehab

Peer Support

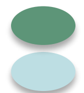
Crisis Services
Mobil Emergency
Crisis
Stabilization

Screening, Assessment, Diagnosis

Targeted Case Management

Primary Health Screening & Monitoring

Armed Forces and Veteran's Services

 Must be delivered directly by CCBHC

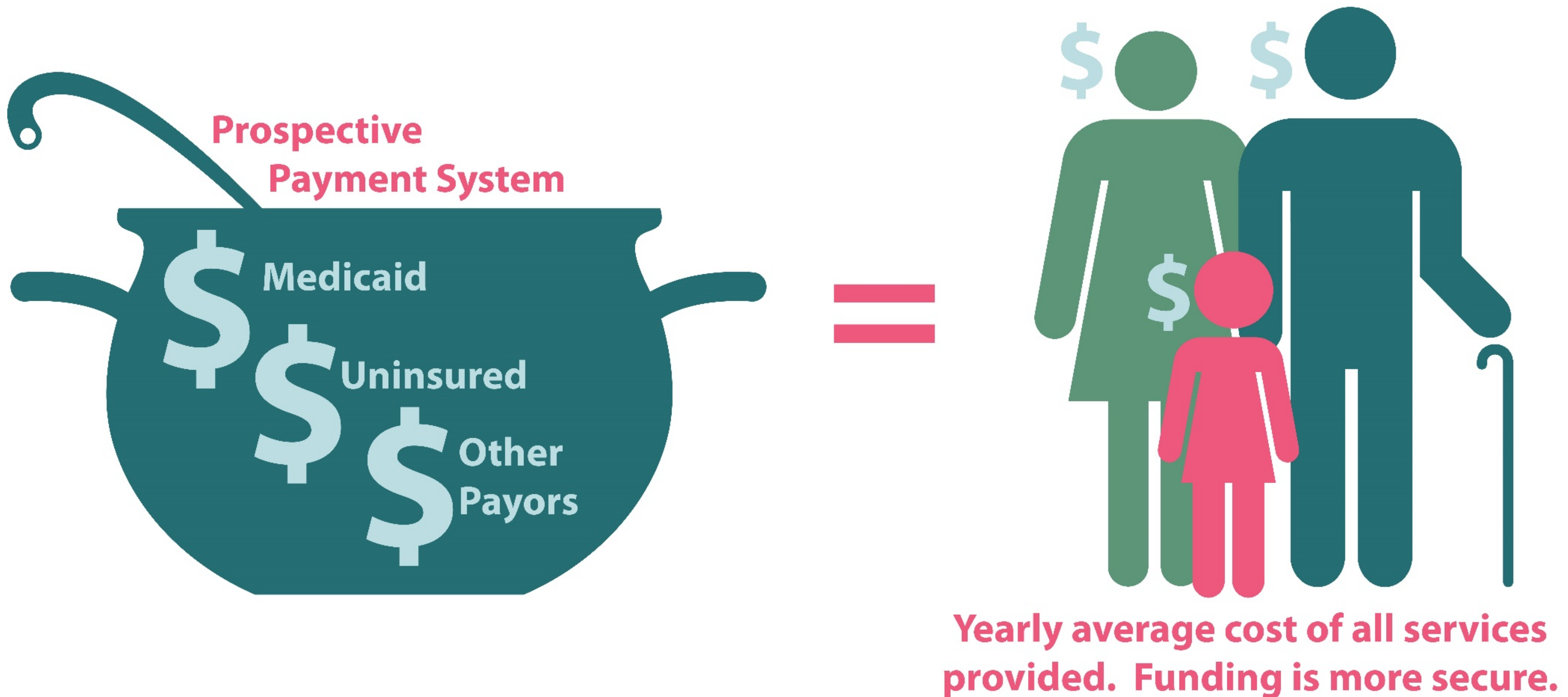
Delivered by CCBHC or a Designated Collaborating Organization (DCO)

Evidence-based practices

- **Based on community needs assessment**, states must establish a minimum set of required evidence based practices, **such as**:
  - Motivational Interviewing
  - Cognitive Behavioral individual, group, and on-line therapies (CBT)
  - Dialectical Behavioral Therapy (DBT)
  - First episode early intervention for psychosis
  - Multi-systemic therapy
  - Assertive Community Treatment (ACT)
  - Forensic Assertive Community Treatment (F-ACT)
  - Community wrap-around services for youth and children
  - And more…

CCBHC Payment

Establishment of a Prospective Payment System



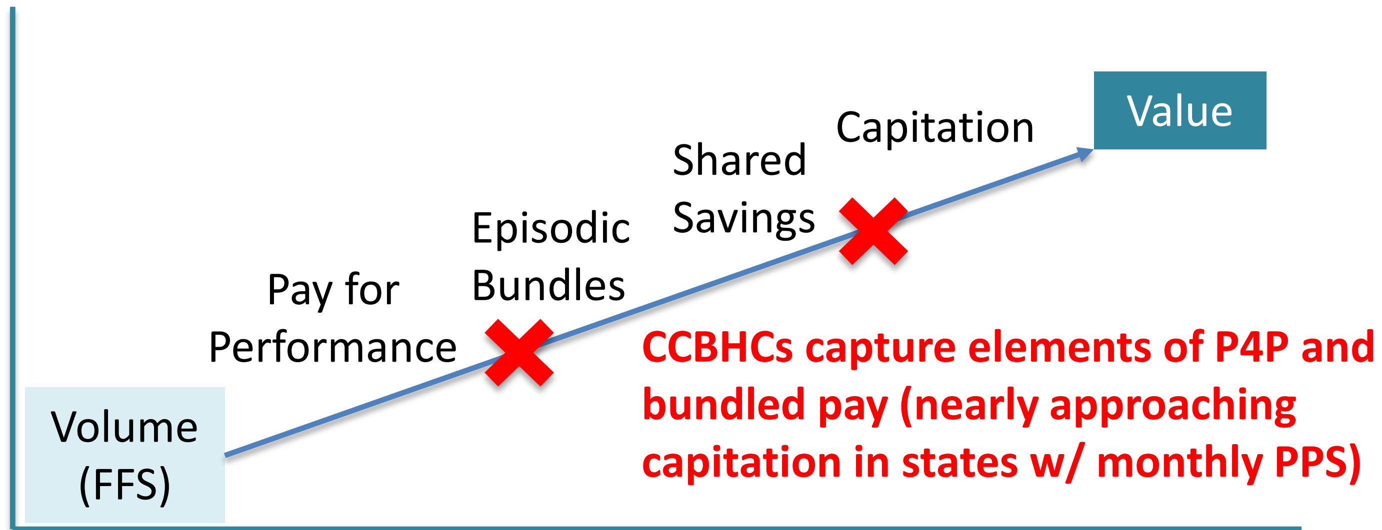
PPS vs. FFS

FFS	PPS
Low payment rates don't cover cost of doing business	Reimbursement covers anticipated cost of care for Medicaid services
Latest evidence-based practices may not be covered in a rigid FFS	Cost-based reimbursement allows flexibility and payment for innovative service delivery
Difficulty investing in services at federal level due to lack of defined category of provider	History of extra congressional investment in defined entities like FQHCs
FFS payment drives staffing mix instead of clinical staff mix being driven by needs of patients	Appropriate staffing mix covered on a cost-basis
Lack of required cost reporting means clinics usually lack accurate data of the return on investment of each treatment modality that includes all cost inputs (e.g. infrastructure and IT)	Cost-based reimburses incentivizes clinics to take a nuanced look at the extent to which infrastructure impacts patient outcomes

PPS-1 vs PPS-2

Factors	PPS-1	PPS-2
One Payment	Each day encounter occurs	Each month encounter occurs
Number of Rates	One for all patients	Several for different groups
Performance Incentive	Optional	Required
Outlier cost adjustment	no	yes
Complexity	less	more

Alternative payment models (APMs) shifting pay from volume to value



"Value" can mean may things, but commonly:

- Improve clinical outcomes & reduce cost of care for complex, chronically ill populations
- Prevent unnecessary readmissions and other costly outcomes

CCBHC Status/PPS: Driving Value

CCBHC Status

- PPS = cost-related reimbursement

Enhanced Operations

- New staff & service lines
- Redesigned access & staffing
- Technology
- Data tracking & analytics
- Internal communications/change mgmt.
- Partnership development

Better client care

- More clients served
- Population health management
- Outcome-driven

CCBHCs' Successes, 2.5 Years In

- Increased hiring / recruitment
- Greater staff satisfaction & retention
- Redesigning care teams
- Improved access to care
  - More clients served
  - Clients accessing greater scope of services (e.g. addiction care)
- Launch of new service lines to meet community need
- Deploying outreach, chronic health management outside the four walls of the clinic
- Improved partnerships with schools, primary care, law enforcement, hospitals
- Outcome-driven treatment

In the first 6 months of implementation:

87%

of CCBHCs report an increased number of patients served, representing up to a **25% increase** in total patient caseloads for most clinics

Grand Lake Mental Health (OK)

Population risk-stratification paired with assertive data tracking results in improved outcomes.

- Population stratified into four specialty groups based on severity of need and service utilization, plus standard population
- Data collection/analysis implemented to track whether clients are:
  - experiencing improvements across all dimensions of wellness
  - accessing preventive care
  - living longer, healthier lives
  - invested in their own recovery
- As consumers get better, they require lower levels of care

Grand Lake Mental Health: Outcomes to Date

2,100

Reduction in inpatient days in CY2017

"We must consistently use the data **to determine what is working and what is not.** We must do more of what is working **and be able to prove why it is working**."

12,970

Lbs lost by clients with high BMI in first year as CCBHC

161

Clients quit smoking during first year as a CCBHC

89%

Percent of youth GLMHC serves diverted from out-of-home placement in CY2017

Strategy

- Share data relentlessly and use it to make decisions
- Standardized to the extent possible - you can't use benchmarking to improve things that are not standardized
- Push forward with measurement driven care
- Integrate and treat the whole person
- Increase clinical expertise - both credential mix and individual skills
- Embrace risk and discomfort as signs of progress

What Makes it Possible?

- A Relationship of basic trust between:
  - Department of Mental Health
  - MO HealthNet (Medicaid)
  - State Budget Office
  - MO Coalition of CMHCs
  - MO Primary Care Association
- Transparent use of data instead of anecdotes to explore and discuss issues
- Willingness of all partners to tolerate and share risk
- Principled negotiation and Motivational Interviewing

DYSFUNCTION

The Only Consistent Feature of All of Your Dissatisfying Relationships is You.

Partnership Principles

DO

- Ask about their needs first
- Give something
- Assist wherever you can
- Make it about the next 10
- Pursue common interest
- Reveal anything helpful
- Take one for the team

DON'T

- Talk about your need first
- Expect to get something
- Limit assistance to a project
- Make it about this deal
- Push a specific position
- Withhold information
- Let them take their lumps

CHANGE

When the Winds of Change Blow Hard Enough,
the Most Trivial of Things can turn into Deadly Projectiles.