Value-Based Payments 101:
Moving from Volume to Value in Behavioral Health Care

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Outline

• Overview of Value-based Payment arrangements (VBPs)
• Federal and State Systems in 2016:
  – The Affordable Care Act and Medicaid expansion
  – The Medicare Access and CHIP Reauthorization Act (MACRA)’s new Quality Payment Program
• Common Provider VBP technical assistance needs
• Available resources for Providers
• Implications for States and Local Governments
• Q&A
What are VBPs?

• VBPs refer to the shift from *volume* to *value*
• Value = Health outcomes ÷ Dollars spent
• Current payment systems do not adequately incentivize prevention, coordination or integration
Fee for Service Health Care Delivered in Silos
Affordable Care Act Guided by the “Triple Aim”
Four Key Strategies

- Insurance Reform
- Coverage Expansion
- Delivery System Redesign
- Payment Reform

Healthcare Reform
CURRENT STATE

Category 1
Fee for Service
- No Link to Quality & Value

Category 2
Fee for Service
- Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment
Shifting Risk to Providers

**Episodic Cost Accountability**

- Traditional Fee-for-Service
- Pay-for-Performance
- Bundled Payments
- Shared Savings
- Partial Risk

**Total Cost Accountability**

- Full Risk

Mineral Savings Potential for Health Plans and Customers Substantial
Service Re-design

- Reduce hospital/institutional care
- Integrated and connected delivery system
- Manage “high need/cost” populations
- Leverage technology
Increasing Systems-Level Competition for CMHCs

• **Disruption** in business models, policies and partnerships

• **Changing landscape**—hospitals are expanding regionally, FQHCs are multiplying

• **Retail health**—clinics and over the counter therapies are gaining a foothold
Deeply embedded in ACO/medical home/primary care team

Address prevention & early intervention, behaviors & disorders

Provide high-value, whole-health care (health homes) to people with complex mental health and addiction conditions, in partnership with ACO/hospital systems/medical homes

Adopting “bi-directional” integration
Keys to Success for Providers: “Centers of Excellence”

• **World Class Customer Service:** “*Kind words can be short and easy to speak, but their echoes are truly endless.*”

• **Excellent Outcomes:** “*Take responsibility for making sure I receive the best possible health care.*”

• **Easy Access:** “*Be there when I need you.*”

• **Comprehensive Care:** “*Provide or help me get the health care and services I need.*”

• **Excellent Value:** “*We are accountable for both the cost and quality of care.*”
CCBHC Care Coordination Partnerships

- Federally Qualified Health Centers
- Rural health clinics
- Inpatient psychiatric facilities and substance use detox and residential programs
- Other community services (e.g. schools, child welfare, housing agencies, etc.)
- Dept. of Veterans Affairs medical centers/clinics
- Inpatient acute care hospitals
State Medicaid Experimentation

• Rapid shift to managed care — “carve in”
• Waivers of all shapes and sizes
• Population-based integration: dual eligible initiatives; Medicaid health homes; “hot spotting”
• Medicaid expansion— housing; criminal justice – and cutting state general fund dollars
• Certified Community Behavioral Health Clinics
Clinicians can choose either:

- **The Merit-Based Incentive Payment System (MIPS),** which streamlines multiple quality programs

- **An Advanced Alternative Payment Model (APM),** which allow practices earn more for taking on risk related to their patients' outcomes
Who Does MACRA Affect?

• In the short-term, MACRA will affect providers who participate in Medicare Part B;
• Long-term, MACRA will affect everyone
• MACRA will impact:
  ✓ How health care data are shared
  ✓ The measures used to evaluate performance, with a focus on care quality, outcomes and patient experience
  ✓ Availability of federally-funded technical support
Advanced APMs

• Require participants to use certified EHR technology
  Require participants to bear “more than nominal financial risk”...therefore not an option for 90%+ providers
• Only applies to 8% of all eligible clinicians in 2017
• MIPS seen as a foundation for clinicians and groups to transition to APMs
Merit-based Incentive Payment System (MIPS)

- Combines and modifies three existing programs:
  - Physician Quality Reporting System (PQRS)
  - Electronic Health Records Incentive Program (“Meaningful Use”)
  - Value-based Payment Modifier (VM)
- Adds “Improvement Activities” category
- Only applies to certain clinicians who bill Medicare Part B using the Physician Fee Schedule, are not first-year Medicare providers and exceed CMS’s “low-volume threshold”
CMS will factor in four weighted performance categories to calculate a final score between 0-100 points.

Payment adjustments in 2019 may be negative, neutral or positive based on CMS-established threshold.

- Quality
- Cost
- Advancing Care Information
- Improvement Activities
- Final Score
- PQRS
- Value-based Modifier
- Meaningful Use
### CMS Change Package:
**Primary and Secondary Drivers of Transformation**

| Patient and Family-Centered Care Design | Patient & family engagement  
Team-based relationships  
Population management  
Practice as a community partner  
Coordinated care delivery  
Organized, evidence-based care  
Enhanced access |
| Continuous, Data-Driven Quality Improvement | Engaged and committed leadership  
QI strategy supporting a culture of quality and safety  
Transparent measurement and monitoring  
Optimal use of HIT |
| Sustainable Business Operations | Strategic use of practice revenue  
Staff vitality and joy in work  
Capability to analyze and document value  
Efficiency of operation |
Provider Technical Assistance Needs

1. Training for New Workforce Competencies
2. Data - Access to and How to Use It
3. Planning - Establishing an Achievable Work Plan
4. Resources for Infrastructure
5. Implementation Support
How Providers Should Prepare

- Medicare Part B Providers: Determine Quality Payment Program eligibility and review past performance feedback
- Review and determine how to implement CMS quality measures and improvement activities
- Make sure your EHR is certified by the Office of the National Coordinator for Health Information Technology
Medicare Resources

Quality Payment Program Service Center
• 1-866-288-8912
• 1-877-715-6222
• Open Monday-Friday, 8am-8pm ET

• Quality Payment Program Online Portal
• Quality Innovation Networks (QINs) & Quality Improvement Organizations (QIOs)
The National Council Offers Resources for Providers

- Check out the National Council’s MACRA resources
- Stay up-to-date by subscribing to the Capitol Connector blog
- Join a Transforming Clinical Practice Initiative Practice Transformation Network (PTN)
Implications for States and Local Governments

- Value is defined as Features and Attributes that have:
  - Worth
  - Utility
  - Importance
  - Ability to Sustain or Grow
- Is there agreement regarding what is valuable?
- Conceptual Acceptance ≠ Ability to Implement
- Transition needs to be Managed by the State
How Value Is Assessed

Value Is Complex

Value is determined by:

- Who pays
  - States
  - Private employers
  - Consumers/Customers

- Who uses the service
  - Choices reflect more than price
  - Access, satisfaction with experience, perceived outcomes

Behavioral Health Authorities Articulate Value
Behavioral Health Role in Value Based Purchasing

- Current system - fragmented, inefficient, variation in quality & cost
- Fee-for-service billing rewards volume, not value
- Value based purchasing shifts the basis of payment:
  - Phase One - Carrots:
    - Reward quality
    - Pay more for more efficacious care
    - Share Savings Achieved with Incentive Payments
  - Phase Two – Sticks:
    - Pay less for less efficacious & lower quality care
    - Penalize readmissions
  - Phase Three – Shift Risk
    - Pay for Outcomes
    - Acuity adjusted Case Rates
    - Capitation Rates – Population Risk Management
- Need to assess/react to the impact of these changes
How VBPs Fit into Health Reform

• Health Reform Implementation
  – Phase 1: Insurance reform and coverage via the Affordable Care Act
  – Phase 2: Delivery System Reform (DSR) Initiative – “Making Healthcare Work for Everyone”
    • **Pay for what works** and help doctors, nurses and other clinicians focus on quality of care, not quantity of services & to control costs
    • **Improve the way care is delivered** by encouraging coordination and integration, and prioritizing wellness and prevention
    • **Create better access to health care information** and data so care-givers and patients have the information they need to make the best decisions possible

• Health Reform continues with or without ACA
Rapid Movement To VBPs

• Medicare Access and CHIP Reauthorization Act of 2015
  – Merit-Based Incentive Payment System (MIPS)
  – Alternative Payment Models (APMs)
  – 30% by end of 2016, 50% by the end of 2018 of payments tied to these models

• Private Payers
  – Up to 80% value based payments by 2018

• Medicaid Managed Care Is Value-Based Contract In Most States
  – Contract stipulates outcomes, quality metrics, risk assumption
  – Increased use of carve-in to integrate care
  – Specialty populations and acuity adjusted rates
  – Sub-contracting to providers - Bundled Rates
  – If services decrease treatment need or cost it will be incentivized by health system
The Impact of Risk Transfer

- Traditional rates are supposed to be cost based
- Value-based rates adjust this to reflect quality and outcomes
- Acuity adjustment addresses morbidity
- Spread of risk required to address variation of need
- Many providers under-capitalized to accept risk
- Many providers too small to accept risk
Options to Address Risk Transfer

• Grow large enough to accept risk
  – Merger
  – Acquisition

• Partner with others to share risk
  – Subcontracting
  – Specialization

• Contract without accepting risk
  – Lower margins
  – Less control

• Do not contract
Impact on State Behavioral Health Authority

• Quality and Outcomes
  – Collaboration in Medicaid contracting
    • What is important?
    • What are metrics?
  – Monitoring what other payers are covering

• Capacity
  – Changing gaps
  – Where is there risk? What can you do?

• Access standards

• Assessing population health management
Questions
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