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

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January 10, 2017
• 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
Shifting Risk to Providers

Episodic Cost Accountability

- Minimal Savings Potential for Health Plans and Customers
- Traditional Fee-for-Service
- Pay-for-Performance
- Bundled Payments
- Shared Savings
- Partial Risk
- Full Risk

Total Cost Accountability

Substantial Savings Potential for Health Plans and Customers
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
Service Delivery Roles of Specialty Behavioral Health

- 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
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”
MIPS Scoring and Payment Adjustments

- 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.
## 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  

[Image]
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
This webinar was developed [in part] under contract number HHSS283201200021I/HHS28342003T from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.