Behavioral Health Providers: The Key Element of Value Based Payment Success

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Meaghan Baier, LMSW
Goals of the Presentation

• Understand the intersect between DSRIP and Value Based Payment
• Opportunities and value for behavioral health providers in VBP
• Quality Measures and Standards for behavioral health providers
Agenda

• DSRIP & VBP
• VBP levels for BH providers
• Quality Measures & Provider Performance Standards
• Quality Metrics & MCOs
• Risk/Gain Sharing & Bonus Payments
• Opportunities for behavioral health providers: BHCCs
About the McSilver Institute

The McSilver Institute for Poverty Policy and Research at New York University Silver School of Social Work is committed to creating new knowledge about the root causes of poverty, developing evidence-based interventions to address its consequences, and rapidly translating research findings into action through policy and practice.
In order to ensure our work is culturally and contextually appropriate for the populations we serve, the McSilver Institute employs a collaborative model via partnerships with policymakers, service organizations, community stakeholders, and consumers.
McSilver directs the state-funded Community Technical Assistance Center (CTAC) and Managed Care Technical Assistance Center (MCTAC), which provide a range of trainings, tools, and intensive support to help New York’s behavioral health safety net stay afloat.
Introduction to DSRIP
DSRIP Overview

• $6.42 Billion for Delivery System Reform Incentive Payments (DSRIP) – including DSRIP Planning Grants, DSRIP Provider Incentive Payments, and DSRIP Administrative costs

• DSRIP is primarily focused on:
  – reducing avoidable ER and in patient hospital use

Source: DOH DSRIP Overview Webpage
DSRIP & Value Based Payment
DSRIP and Value Based

- By waiver Year 5, all MCOs must employ non-fee-for-service payment systems that reward value over volume for at least 90% of their provider payments.
- Required to ensure that realized transformations in the delivery system will be sustainable.
- Required to ensure that value-destroying care patterns (avoidable admissions, ED visits, etc) do not simply return when the DSRIP funding stops in 2020.

There will **not** be one path towards 90% Value Based Payments. Rather, there will be a menu of options that MCOs can jointly choose from.
MCOs and Contractors can Choose Different Levels of Value Based Payments

In addition to choosing which integrated services to focus on, the MCOs and contractors can choose different levels of Value Based Payments:

<table>
<thead>
<tr>
<th>Level 0 VBP*</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP (feasible after experience with Level 2; requires mature contractors)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/IPC, FFS may be complemented with PMPM subsidy)</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient)</td>
<td>Prospective capitation PMPM or Bundle (with outcome-based component)</td>
</tr>
<tr>
<td>FFS Payments</td>
<td>FFS Payments</td>
<td>FFS Payments</td>
<td>Prospective total budget payments</td>
</tr>
<tr>
<td>No Risk Sharing</td>
<td>Upside Risk Only</td>
<td>Upside &amp; Downside Risk</td>
<td>Upside &amp; Downside Risk</td>
</tr>
</tbody>
</table>

*Level 0 is not considered to be a sufficient move away from traditional fee-for-service incentives to be counted as value based payment in the terms of the NYS VBP Roadmap.

Source: VBP Bootcamp #1
# Types of VBP Arrangements

<table>
<thead>
<tr>
<th>Types</th>
<th>Total Care for General Population (TCGP)</th>
<th>Integrated Primary Care (IPC)</th>
<th>Care Bundles</th>
<th>Special Need Populations</th>
</tr>
</thead>
</table>
| **Definition**   | Party(ies) contracted with the MCO assumes responsibility for the total care of its attributed population | Patient Centered Medical Home or Advanced Primary Care, includes:  
- Care management  
- Practice transformation  
- Savings from downstream costs  
- Chronic Bundle (includes 14 chronic conditions related to physical and behavioral health related) | Episodes in which all costs related to the episode across the care continuum are measured  
- Maternity Bundle | Total Care for the Total Sub-pop  
- HIV/AIDS  
- MLTC  
- HARP |
| **Contracting Parties** | IPA/ACO, Large Health Systems, FQHCs, and Physician Groups                                           | IPA/ACO, Large Health Systems, FQHCs, and Physician Groups                                         | IPA/ACO, FQHCs, Physician Groups and Hospitals                               | IPA/ACO, FQHCs and Physician Groups                               |

Source: VBP Bootcamp #2
Quality Measures
Quality Measures Overview

- There are a total of 29 Quality Measures
- We will emphasize the 9 high performance measures
High Performance Measures
Antidepressant/Antipsychotic

• Antidepressant Medication Mgmt (Cont)
  – Numerator: Number of people who remained on antidepressant medication for at least six months
  – Denominator: Number of people 18 and older who were diagnosed with depression and treated with an antidepressant medication
  – Unit: Percentage

• Antipsychotic Medication Adherence (Schizophrenia)
  – Numerator: Number of people who remained on an antipsychotic medication for at least 80% of their treatment period
  – Denominator: Number of people, ages 19 to 64 years, with schizophrenia who were dispensed at least 2 antipsychotic medications during the measurement year
  – Unit: Percentage
High Performance Measures
CV and Diabetes Monitoring

• CV Monitoring (CV & Schizophrenia)
  – Numerator: Number of people who had an LDL-C test during the measurement year
  – Denominator: Number of people, ages 18 to 64 years, with schizophrenia and cardiovascular disease
  – Unit: Percentage

• Diabetes Monitoring (DM & Schizophrenia)
  – Numerator: Number of people who had both an LDL-C test and an HbA1c test during the measurement year
  – Denominator: Number of people, ages 18 to 64 years, with schizophrenia and diabetes
  – Unit: Percentage
High Performance Measures
Mental Health Inpatient Follow Up

• Follow Up after MH Inpatient (30 Days)
  – Numerator: Number of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 30 days of discharge
  – Denominator: Number of discharges between the start of the measurement period to 30 days before the end of the measurement period for patients ages 6 years and older, who were hospitalized for treatment of selected mental health disorders
  – Unit: Percentage

• Follow Up after MH Inpatient (7 Days)
  – Numerator: Number of discharges where the patient was seen on an ambulatory basis or who was in intermediate treatment with a mental health provider within 7 days of discharge
  – Denominator: Number of discharges between the start of the measurement period to 30 days before the end of the measurement period for patients ages 6 years and older, who were hospitalized for treatment of selected mental health disorders
  – Unit: Percentage
High Performance Measures
Avoidable/Preventable ED/Readmissions

• Potentially Avoidable Readmissions
  – **Numerator**: Number of readmission chains (at risk admissions followed by one or more clinically related readmissions within 30 days of discharge)
  – **Denominator**: Number of people as of June 30 of the measurement year
  – **Unit**: Per 100,000 Members

• Potentially Preventable ED Visits (BH)
  – **Numerator**: Number of preventable emergency room visits as defined by revenue and CPT codes
  – **Denominator**: Number of people with a BH diagnosis (excludes those born during the measurement year) as of June 30 of measurement year
  – **Unit**: Per 100 Members
High Performance Measure
Preventable ED

• Potentially Preventable ED Visits
  – **Numerator**: Number of preventable emergency visits as defined by revenue and CPT codes
  – **Denominator**: Number of people (excludes those born during the measurement year) as of June 30 of measurement year
  – **Unit**: Per 100 Members
<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Adult Access Preventive (20 - 44)</td>
<td>Diabetes Screening (Antipsychotic Medication - Schizophrenia or Bipolar Disease)</td>
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<td>Adult Access Preventive (45 - 64)</td>
<td>Engagement of Alcohol/Drug Treatment</td>
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<tr>
<td>Adult Access Preventive (65 and Older)</td>
<td>Follow Up after MH Inpatient (30 Days)</td>
</tr>
<tr>
<td>Antidepressant Medication Mgmt (Acute)</td>
<td>Follow Up after MH Inpatient (7 Days)</td>
</tr>
<tr>
<td>Antidepressant Medication Mgmt (Cont)</td>
<td>Initiation of Alcohol/Drug Treatment</td>
</tr>
<tr>
<td>Antipsychotic Medication Adherence (Schizophrenia)</td>
<td>Potentially Avoidable Readmissions</td>
</tr>
<tr>
<td>Child Access - Primary Care (12 to 19)</td>
<td>Potentially Preventable ED Visits (BH)</td>
</tr>
<tr>
<td>Child Access - Primary Care (12 to 24 Months)</td>
<td>Potentially Preventable ED Visits</td>
</tr>
<tr>
<td>Child Access - Primary Care (25 Months to 6)</td>
<td>PQI 1 - DM Short Term Complications</td>
</tr>
<tr>
<td>Child Access - Primary Care (7 to 11)</td>
<td>PQI 7 - Hypertension</td>
</tr>
<tr>
<td>Child ADHD Medication F/U (Continuation)</td>
<td>PQI 8 - Heart Failure</td>
</tr>
<tr>
<td>Child ADHD Medication F/U (Initiation)</td>
<td>PQI 90 - Overall Composite</td>
</tr>
<tr>
<td>CV Monitoring (CV &amp; Schizophrenia)</td>
<td>PDI 90 - Pediatric Composite</td>
</tr>
<tr>
<td>Diabetes Monitoring (DM &amp; Schizophrenia)</td>
<td>Statin Therapy for Patients with Cardiovascular Disease-Received Statin Therapy</td>
</tr>
<tr>
<td></td>
<td>Statin Therapy for Patients with Cardiovascular Disease-Statin Adherence 80%</td>
</tr>
</tbody>
</table>
Provider Performance Standards
Basics

• Be collaborative
• Listen
• Understand payer needs
• Meet timelines and reporting needs
• Develop infrastructure
Performance Standards

• Standards will vary
• Based on payer needs
• Change overtime
• Individual vs. Network
Quality Metrics in MCO Rate Settings, Risk/Gain Sharing and Potential for Bonus Payments
Quality Metrics in MCO Rate Settings

• Quality Metrics Drive
  – Bonus/Incentive Payments
  – Member auto enrollment preferences for high quality plans to drive market share

Data Sources Used

• New York’s Quality Assurance Reporting Requirements (QARR)
  – QARR is largely comprised of National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) and state-specific performance measures.

• Consumer Assessment of Healthcare Providers and Systems (CAHPS®): National satisfaction survey methodology

• Preventions Quality Indicators using the Agency for Healthcare Research and Quality (AHRQ) and NYS Department of Health compliance information.
Risk/Gain Sharing & Bonus Payment

• Bonus Payment
  – Pay For Performance (P4P)
  – Incentive Pay

• Risk/Gain Sharing
  – Population Health
  – Includes Total Care
  – Address Both Cost and Quality
  – Multiple Levels of Risk/Gain Sharing
Levels of Risk/Gain Sharing

- Bonus Payment – No Risk, Small Gain
- Upside Gain Only Total Care – No Risk, Small Gain
- Downside Risk and Upside Gain – Risk, Larger Gain
- Capitation – High Risk/High Gain
VBP Readiness
Background and Overview—
Behavioral Health Care Collaborative (BHCC)
BH VBP Readiness Program
Background and Program Overview

Provides funding to selected BH providers who will form Behavioral Health Care Collaboratives (BHCC) and support four VBP Readiness areas: Organization, Data Analytics, Quality Oversight, and Clinical Integration

Source: NYS BHCC VBP Readiness Forum October 2017
BH VBP Readiness Program
Background and Program Overview
The final deliverable is that BHCC leads and network members are either:

• Participating in a Level 2 or higher arrangement as a Level 1 provider network
  OR
• A contracted entity in a Level 2 or higher arrangement

***If no Level 2 or higher arrangement is available in the BHCC’s service area, participating in a Level 1 VBP arrangement with an MCO or other payer is acceptable.

Source: NYS BHCC VBP Readiness Forum October 2017
BHCC Eligibility

- BHCCs must include the full spectrum of regionally available BH programs as defined in application.
- Exclusion of these programs due to unavailability or unwillingness to participate will not disqualify the BHCC.
- A BHCC cannot be a single provider.
- BHCCs must also seek participation from affiliate providers, as defined later in this presentation.

Source: NYS BHCC VBP Readiness Forum October 2017
BHCC Network and Affiliate Providers

Network Providers: OMH Licensed Article 31 or OASAS Certified Article 32 non-hospital community-based organizations and BH HCBS providers that create the BHCC. They control the use of BHCC funding and collectively meet BHCC requirements.

Affiliate Providers: include, but are not limited to, hospital and community physical health providers, non-Medicaid providers, and providers addressing the social determinants of health. They are critical partners in achieving VBP goals and should be connected to any BHCC. They may only receive BHCC funds through a contract as payment for work-for-hire at the discretion of the network providers.

Source: NYS BHCC VBP Readiness Forum October 2017
BHCCs: Creating a Collaborative

BHCCs MUST include:

• a full spectrum of regionally available BH service types
• peer-run agencies
• CCBHCs
• community rehabilitation providers
• smaller agencies
• community-based programs addressing social determinants of health
• hospitals or Article 28 licensed providers including hospital operated Article 31/32
• Health Homes (HH)

Source: NYS BHCC VBP Readiness Forum October 2017
BHCCs: Creating a Collaborative

BHCCs must make a good faith effort to include:

- Performing Provider Systems (PPS)
- Federally Qualified Health Centers (FQHCs)
- State-run programs
- Primary care providers
- Other physical health providers

****Exclusion of these programs due to unavailability or unwillingness to participate will not disqualify the BHCC****

Source: NYS BHCC VBP Readiness Forum October 2017
BHCCs: Creating a Collaborative

BHCCs will not qualify if:

• It does not meet the minimum weighted average threshold, as described later in this presentation

• A single BHCC provider makes up more than 60% of the weighted percentage average of the three BHCC Lead and Network provider metrics (defined later)

• Children’s BH Services claims exceed 50%

Source: NYS BHCC VBP Readiness Forum October 2017
VBP Readiness Areas

- Readiness Areas support VBP understanding and implementation among coordinated networks.
- Funds support and prepare community-based behavioral health programs to develop sustainable, data-informed collaborations among BH, physical health, and support services.

Source: NYS BHCC VBP Readiness Forum October 2017
VBP Readiness Funding

• Anticipate $60 million will be available over a three-year funding period to support BHCC readiness activities, dependent on State and Federal approval.

• In Year One, SFY 2017-18, it is anticipated that $10.5 M will be available to BHCCs in the NYC/ LI region; and $9.5 M in rest of state.

Source: NYS BHCC VBP Readiness Forum October 2017
BH VBP Readiness funding is limited

To be approved as a BHCC, the Lead and Network providers must meet at least 2.5% of the BH metric snapshot as described for the funding region they have applied to serve.

Source: NYS BHCC VBP Readiness Forum October 2017
Final Deliverable

Lead and Network Providers must

• Contract with an entity in a Level 2 or higher arrangement

OR

• Participate in a Level 2 or higher arrangement as a Level 1 provider network

****If no Level 2 or higher arrangement is available in the BHCC’s service area, participating in a Level 1 VBP arrangement with an MCO is acceptable

Source: NYS BHCC VBP Readiness Forum October 2017
Additional Resources

• New York State DOH
  https://www.health.ny.gov/health_care/medicaid/redesign/dsrip

• MCTAC  Value Based Payment Resources
THANK YOU