Value-Based Purchasing in Behavioral Health

March 28, 2017

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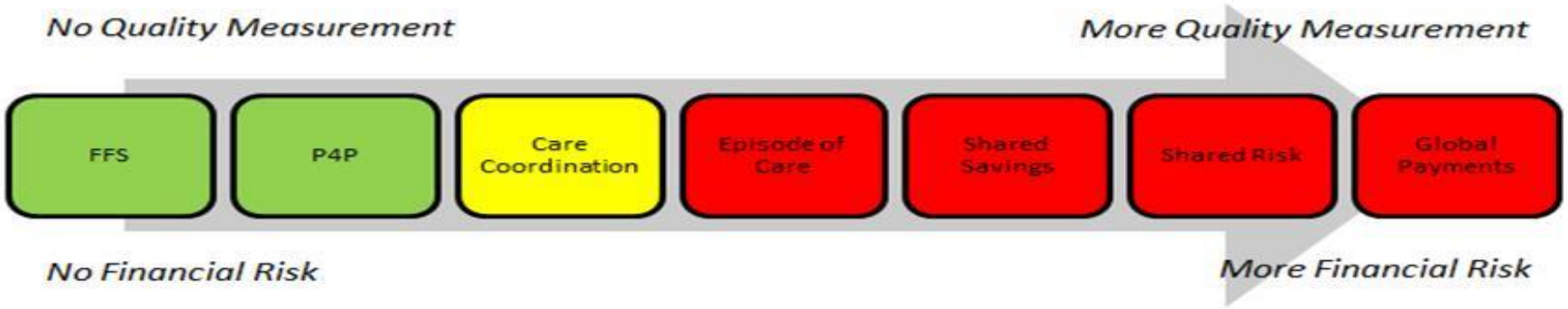
Today's Goals

- Provide a point of reference and framework for value-based purchasing (VBP).
- Gather stakeholder input for move to value-based purchasing in behavioral health.
- Identify current value-based purchasing activities.
- Identify potential for value-based purchasing activities.

The Triple Aim

- Enhanced consumer experience and satisfaction.
- Better quality of care, consumer outcomes, and population health.
- Lower per-capita cost of care.

Value-Based Payment Programs



Source: DFS Report (http://www.dfs.ny.gov/reportpub/payment-reform-report.pdf)

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HealthChoices Physical Health Managed Care Program

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2017 Agreement Language

- Setting specific targets for value-based purchasing.
- Increasing year over year value-based purchasing.
- Requiring patient-centered medical homes.
- Encouraging use of Accountable Care Organizations (ACOs).
- Improving access to quality care.
- Improving the provider experience.

VBP Model Strategy

Value-Based Purchasing			
MCO Contract Year	Year 1	Year 2	Year 3
VBP Requirement	7.5%	15%	30%
Value-Based Purchasing Models			
1. Pay for Performance	7.5% may be from any combination of models 1, 2, 3, 4 or 5	At least 50% of the 15% must be from any combination of models 2, 3, 4 or 5	At least 50% of the 30% must be from any combination of 3, 4 or 5
2. Patient Centered Medical Home			
3. Shared Savings			
4. Bundled Payments			
5. Full Risk / Accountable Care Organizations			

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MCO Reporting Requirements

- January 1 - MCOs must submit VBP yearly plan.
- Quarterly - MCOs must report on their progress.
- June 30 of subsequent CY - MCOs must submit a report of accomplishments from prior year to include:
  - Explanation of purchasing arrangements by provider.
  - Dollar amount spent for each arrangements.
- June 30 report will be used to determine compliance in meeting Agreement goals for the subsequent year.

Holdbacks/Financial Penalties

- Within 60 days after receipt of their report (August 30), DHS will notify the MCO of their compliance or non-compliance.
- MCO has 30 days to respond.
- If the Department finds an MCO noncompliant, there will be a reduction in a future capitation payment.
- The reduction will be equivalent to one percent (1%) of the prior December's capitation.

VBP and Data Sharing

Timely and actionable data to providers is critical to the success of VBP.
Expectations for data sharing:

- Identify high-risk patients.
- Care gaps, including those related to quality measures used in the VBP.
- Service utilization and claims data:
    - Inpatient
    - Short procedure unit
    - Emergency department
    - Radiology
    - Lab
    - Durable medical equipment and medical supplies
    - Physician services
    - Home health services
    - Prescriptions

Patient-Centered Medical Homes (PCMH)

The PCMH model of care includes these key components:

- Whole-person focus on behavioral health and physical health.
- Comprehensive focus on wellness, acute conditions, and chronic conditions.
- Increased access to care.
- Improved quality of care.
- Team-based approach to care management/coordination.
- Use of electronic health records (EHR) and health information technology to track and improve care.

Patient-Centered Medical Homes (continued)

MCOs are expected to:

- Contract with high-volume providers in their network who meet the requirements of a PCMH.
- Make payments to their contracted PCMHs.
- Collect quality, related data from the PCMHs.
- Reward PCMHs with quality-based enhanced payments.
- Develop a learning network that includes PCMHs and other MCOs.
- Report annually on the clinical and financial outcomes of their PCMH program.

PCMH and Data Sharing

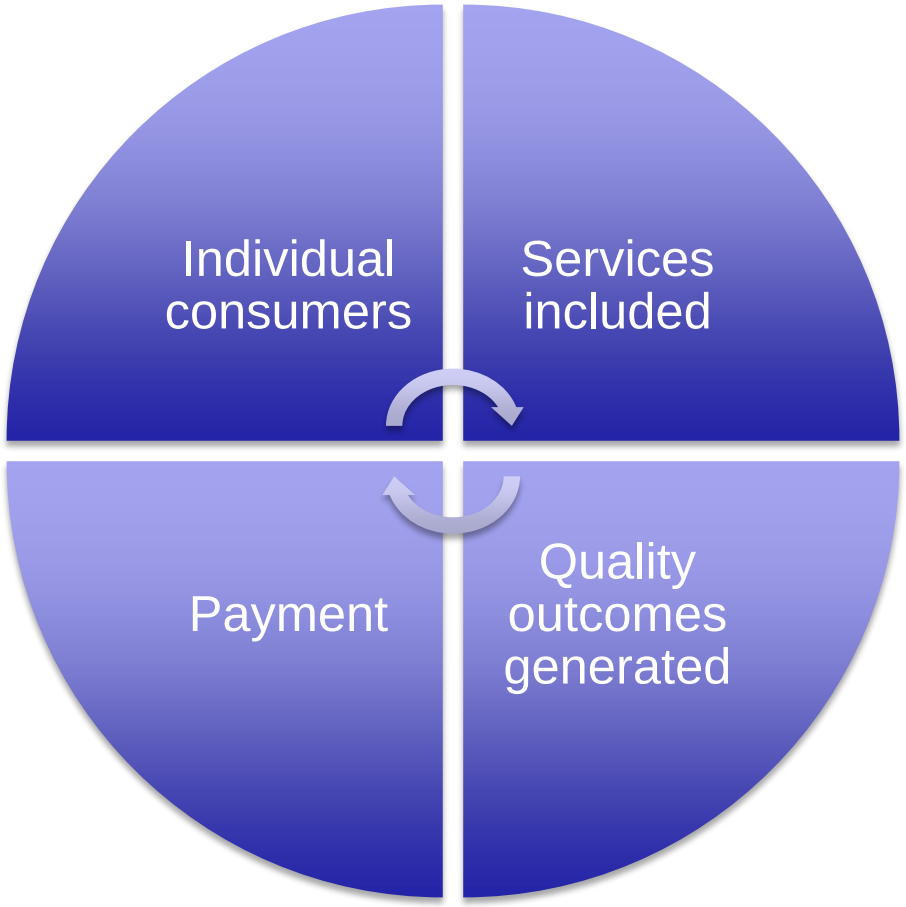
The MCO must provide timely and actionable data to its PCMHs, including, but not limited to:

- Identification of high-risk patients.
- Comprehensive care gaps inclusive of gaps related to quality metrics used in the value-based payment arrangement.
- Service utilization and claims data across clinical areas such as inpatient admissions, outpatient facility (SPU/ASC), emergency department, radiology services, lab services, durable medical equipment and supplies, specialty physician services, home health services, and prescriptions.

Where to Begin

- **Pay for Performance (P4P)** Provider (or MCO) payments for meeting or exceeding pre-established benchmarks often paid in addition to FFS payments.
- **Care Coordination** Payment for a specific time period to ensure coordination across multiple services.
- **Episode of Care Payment (**Bundled Payment or Case Rate) Payment for all services to treat an individual for an identified condition during a specific period of time.

Value-Based Payment



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Opportunities within Behavioral Health

- **Pay for Performance (P4P)**
  - Behavioral Health Specific P4P
- **Care Coordination**
  - Centers of Excellence (COE)
  - Certified Community Behavioral Health Clinics (CCBHC)
  - Physical Health / Behavioral Health Integration
- **Episode of Care Payment**
  - Assertive Community Treatment (ACT)
  - Inpatient Psychiatric Case Rates
  - First Episode Psychosis (FEP)

Measuring Quality

- **Process measures:**
  - Follow-up after in-patient stays
  - Engagement in treatment
  - Retention in treatment
- **Change in health care usage:**
  - Readmission rates
  - Inpatient stays
  - ER utilization
- **Social and functional measures:**
  - Employment
  - Housing stability

Contract Requirements Decisions

- Dates of implementation
  - Percent required for each year
  - What is included in the percent
  - Required reporting
- Prior approval of MCO Plan
- Incentives or penalties to the MCOs

QUESTIONS?

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