Disclaimer

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Learning Objectives

- Participants will understand the continuum of “value based” and “alternative payment methodologies” and policies and trends promoting payment reform
- Participants will gain insights into changes to business and clinical models essential to succeed under different payment models
- Participants will learn outcomes and lessons learned from providers working under alternative payment models.
About the Presenter

Mindy Klowden, MNM is the Director of Technical Assistance for the Center for Integrated Health Solutions and provides individualized consultation and training to providers working to integrate primary care, mental health and substance abuse treatment. Ms. Klowden also works on health care payment and delivery system reform.

Mindy has extensive experience in community mental health, health and health care policy, and affordable housing. Immediately before joining National Council she served as the Director of Healthcare Transformation at Jefferson Center for Mental Health.

Mindy earned her Master’s degree in Nonprofit Management from Regis University and her Bachelor’s degree in Sociology from the Colorado College.

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About the Presenter

Todd Van Buskirk, LCSW, LCAC

Todd has served in various clinical roles at Porter-Starke Services (PSS) in Valparaiso, IN for 10 years. He was providing behavioral health services in a primary care setting when PSS was awarded the SAMHSA-PBHCL Grant (cohort VI) in 2013.

Todd was named Project Director and has helped manage a collaborative effort that includes three CMHCs and two FQHCs at five locations in Northern Indiana.

He enjoys the learning process and is pleased to share part of his journey with other grantees.

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About the Presenter

Aaron McHone, MBA

Master degree in Business Admin from Iowa State University

Executive Director of UnityPoint Health-Berryhill Center and ACO Executive Sponsor for UnityPoint Health – Fort Dodge

Father of 3; Husband of 1

Why I do what I do

Contact information: aaron.mchone@unitypoint.org

Key Terms

• Managed Care Organization
• Accountable Care Organizations
• Delivery System Reform Incentive Payments (DSRIP)
• Value-Based Payment
• Alternative Payment Methodology
• Advanced APMs
• Population Health Management
  • Risk Stratification
Payment Reform Continuum in Medicaid Managed Care Plans (Optum, 2016)
Policy Drivers & Trends

The Fee for Service Treadmill
Achieve outcomes

More cost effective

Value

Acceleration of Value-Based Payment - CMS

HHS Value-Based Payment Goals

2016
30% of contracts will have alternative payment models (such as ACOs or bundled payments). 85% will be tied to quality or value through programs such as VBP or readmission reduction.

2018
50% of contracts to be tied to alternative payment models and 90% to quality or value overall.

Medicare Access and CHIP Reauthorization Act (MACRA) of 2015

- Repeals the Sustainable Growth Rate (SGR) formula
- Creates a new Quality Payment Program (QPP) by streamlining existing programs (Physician Quality Reporting System, Meaningful Use, and Value-based Payment Modifier)
- Adds “Improvement Activities” Category- includes many relevant to behavioral health and care coordination

What is MACRA?

MACRA

Two tracks to choose from:

- Advanced Alternative Payment Models (APMs)
  - If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

- The Merit-based Incentive Payment System (MIPS)
  - If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.
MACRA- Affected Clinicians

- Providers billing Medicaid
- Clinicians who are newly enrolled in Medicare
- Clinicians who are significantly participating in an advanced APM
- Hospital-based and facility-based payment programs
- Clinicians and groups who are NOT paid under the Physician Fee Schedule (i.e. FQHCs and partial hospitalization programs)
- Individual clinicians and groups that fall beneath the “low volume threshold” who serve 100 or fewer Medicare recipients OR bill Medicare $30,000 or less per year

In 2017, MIPS does **NOT** apply to:
Acceleration of Value-Based Payment- Private Insurance

- In the private sector, the Health Care Transformation Task Force, made up of insurers and providers, has pledged to convert 75 percent of their business to value-based payments by 2020.

Multi-Payer Alignment

- Comprehensive Primary Care Plus (CPC+)
- State Innovation Model programs
- Aligning core quality measures, approaches to risk adjustment/stratification, and attribution or assignment.
### CQM SIMPLIFICATION: ADULTS

<table>
<thead>
<tr>
<th>Measure Condition</th>
<th>SIM Metric Title</th>
<th>Citation</th>
<th>CPC+</th>
<th>QPP</th>
<th>TCPI</th>
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</thead>
<tbody>
<tr>
<td><strong>Primary CQMs</strong></td>
<td></td>
<td></td>
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<tr>
<td>Depression</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan</td>
<td>NQF 0418 CMS 2v6</td>
<td>Depression Remission at 12 Months</td>
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<tr>
<td></td>
<td>Diabetes: Hemoglobin A1C Poor Control</td>
<td>NQF 0039 CMS 122v5</td>
<td>✔</td>
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<tr>
<td></td>
<td>Hypertension</td>
<td>NQF 0018 CMS 165v5</td>
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<tr>
<td></td>
<td>Obesity: Adult</td>
<td>NQF 0421 CMS 69v5</td>
<td>No obesity measure (not required for SIM if in CPC+)</td>
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<tr>
<td></td>
<td>Substance Use Disorder: Alcohol and Other Drug Dependence</td>
<td>NQF 0004 CMS 137v5</td>
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<tr>
<td></td>
<td>Substance Use Disorder: Tobacco</td>
<td>NQF 0028 CMS 138v5</td>
<td>✔</td>
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<tr>
<td><strong>Secondary CQM</strong></td>
<td>Asthma</td>
<td>NQF 1799 CMS n/a</td>
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<tr>
<td></td>
<td>Fall Safety</td>
<td>NQF 0101 CMS 139v5</td>
<td>✔</td>
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<tr>
<td></td>
<td>Maternal Depression</td>
<td>NQF 1401 CMS 82v4</td>
<td>✔</td>
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<tr>
<td></td>
<td>Substance Use Disorder: Alcohol</td>
<td>NQF 2152 CMS n/a</td>
<td>Alcohol &amp; Other Drug Dependence measure (above)</td>
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<td></td>
<td>Measures reported via APCD claims data automatically</td>
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<tr>
<td></td>
<td>Breast Cancer</td>
<td>NQF 2372 CMS 125v5</td>
<td>✔ (clinical) (clinical)</td>
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<tr>
<td></td>
<td>Colorectal Cancer</td>
<td>NQF 0034 CMS 130v5</td>
<td>✔ (clinical) (clinical)</td>
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</table>


### CQM SIMPLIFICATION: PEDIATRICS

<table>
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<tr>
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<th>Citation</th>
<th>QPP</th>
<th>TCPI</th>
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<tr>
<td>Depression</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan</td>
<td>NQF 0418 CMS 2v6</td>
<td>✔</td>
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<tr>
<td>Development Screening</td>
<td>Developmental Screening in the First Three Years of Life (developed by Mathematica)</td>
<td>NQF 1448 CMS – under development</td>
<td>No developmental screening measure</td>
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<tr>
<td>Maternal Depression</td>
<td>Maternal Depression Screening</td>
<td>NQF 1401 CMS 82v4</td>
<td>✔</td>
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<tr>
<td>Obesity: Adolescent</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>NQF 0024 CMS 155v5</td>
<td>✔</td>
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<tr>
<td><strong>Secondary CQM</strong></td>
<td>Asthma</td>
<td>NQF 1799 CMS n/a</td>
<td>✔</td>
<td></td>
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</tbody>
</table>


ACO GROWTH BY PAYER

Payment Arrangement Growth by Payer Type

Source: Leavitt Partners Center for Accountable Care Intelligence

Medicaid ACO Programs

Center for Healthcare Strategies, Jan 2017
What Do Behavioral Health Providers Need to Know?

- Payment methodologies are changing
- Invest in your data/IT infrastructure, and quality improvement processes
- You will need to demonstrate your capabilities around and impact on
  - Behavioral health/overall health outcomes
  - Overall health care spend
  - Population health management
Todd Van Buskirk, LCSW, LCAC
Porter-Starke Services
Valparaiso, IN

Background

• Indiana Council (CMHCs)
  • Indiana Council of Community Mental Health Centers Managed Care Work Group 2012
    • Healthcare Reform – Increased engagement to learn how insurers were responding
    • Reach out to managed care leaders and had regular meetings (group still meeting)
    • Expressed concerns – discussions
    • Not adversaries
    • Common goals – mutual benefits
    • Relationship, relationship, relationship!
Managed Care Projects

• Anthem Behavioral Health and Indiana Community Mental Health Centers
  • Enhanced Care Coordination Services
    • Anthem Medicaid
    • Targeted high utilizers (dual dx, ER, SUD, BH inpatient)
    • Structure communication between MCE case manager and CMHC case manager
    • Weekly phone calls; success/barriers
    • Adults and children
    • Standard screening & reporting process

Managed Care Projects

• MDWise
  • HEDIS measures (e.g., well-child visits; adult preventive visits; 7-day FUH)
  • MCE can earn incentive $ from State to meet targets
  • Paid an incentive for every 7 day follow up we completed for November and December 2016 (MDWise – they were trying to boost their %)
  • CMHC outreach to patients; paid based on performance
Managed Care Projects

MOMentum
A Pilot to Improve Health Outcomes for Opiate Addicted Women and Their Newborns

• Anthem Blue Cross and Blue Shield
  • Behavioral Health Quality Incentive Program (BHQIP)
  • Program Objectives
    • Improve clinical quality indicators
    • Improve member outcomes
    • Improve focus on prevention and primary care
    • Improve efficient and appropriate utilization of benefits
Managed Care Projects

- **Anthem Blue Cross and Blue Shield**
  - Behavioral Health Quality Incentive Program (BHQIP)
  - 10 CMHCs participating in Indiana
  - CMHC earns dollars when hits target rate for the BHQIP Performance Indicator

- **Who – Attributed Members**
  - Patients who are members for at least 9 of 18 months of the attribution period
  - Have had a minimum of 2 managing behavioral health visits with provider within 90 days during the attribution period

### Table 1: BHQIP 2017 performance indicators and definitions

<table>
<thead>
<tr>
<th>Indicator category and performance measurement period</th>
<th>Indicator type</th>
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</thead>
<tbody>
<tr>
<td>Acute behavioral health (BH) urgent care 30-day readmissions</td>
<td>Efficiency indicator</td>
</tr>
<tr>
<td>Emergency room (ER) utilization</td>
<td>Efficiency indicator</td>
</tr>
<tr>
<td>FCP visits</td>
<td>Quality of care indicator</td>
</tr>
<tr>
<td>Seven-day follow-up visit after mental health inpatient discharge (FUT)</td>
<td>Quality of care indicator</td>
</tr>
<tr>
<td>Follow-up care for children prescribed ADHD medication — initiation phase (ADD-I)</td>
<td>Quality of care indicator</td>
</tr>
<tr>
<td>Antidepressant medication — initiation (AMM-I)</td>
<td>Quality of care indicator</td>
</tr>
<tr>
<td>Antidepressant medication — continuation (AMM-C)</td>
<td>Quality of care indicator</td>
</tr>
<tr>
<td>Diabetic peripheral neuropathy (Diana) screening (CDC)</td>
<td>Quality of care indicator</td>
</tr>
</tbody>
</table>
Anthem BHQIP

- **Baseline Period:**
  - 12-month period preceding performance measure period used to establish the target and improvement rates

- **Performance Period:**
  - 12-month period when provider’s performance is related to BHQIP performance indicators and upon which incentive payment is based

- **Target Rate:**
  - Anthem-defined improvement of the baseline year average rate

- **Improvement Rate:**
  - If target rate not achieved, provider could earn 50% of points

- **Providers compete with themselves and could earn up to 10% of total reimbursement for Program Period**
  - Targets can be difficult to achieve
  - Systems of Care

**Anthem BHQIP - Example**

**Provider A would receive an incentive payment of $18,750 payable as a lump-sum distribution.**

**Not real data**
BHQIP

- **BHQIP Process**
  - Monthly phone calls with Anthem and other CMHCs
  - Resource sharing with other providers
  - Bi-monthly in-person visits from Anthem
  - Bi-weekly meetings with program managers (internal)

BHQIP

- **BHQIP Process**
  - Design intervention(s) to target population
  - ER utilization card (after-hours contact for PCP and MCE)
  - Increased support for transition after BH discharge (case management, Navigator)
  - Workflows to support connection to PCP (e.g., module in electronic health record)
  - Data Mining
  - Standard of Care for all patients
Managed Care Projects

- BHQIP Challenges
  - Identify a champion
  - Consistent communication/Meeting
    - Lots of other projects vying for attention
  - Accountability for tasks
  - All departments involved
    - This is a team effort – IT, billing, HIM, etc.
  - Timeliness of data – Format

Aaron McHone, MBA

UnityPoint Health-Berryhill Center
Fort Dodge, IA
Agenda

• Briefly introduce UnityPoint Health and the Berryhill Center

• Discuss the benefits to being involved in an ACO

• What is an ACO looking for?
Berryhill Center

- Community Mental Health Center
- Joined UnityPoint Health in 2008
- SAMHSA PBHCI Grantee; Cohort 8
- 53 Employees; 3 Psychiatrists, 6 ARNP’s, & 12 therapists
- $5 Million Budget or .1% of UnityPoint Health’s total bottom line

Definition of an ACO
ACO Contracts

UnityPoint Accountable Care Value-Based Contracts

South Dakota
Minnesota

Iowa
CEDAR RAPIDS

Nebraska

Value-Based Contract | Coverage Area | A/R 16
---|---|---
Medicare Next Generation ACO | 78,672 | 78,672
UnityPoint Health Self-Insured Employee Health Plan | 36,079 | 36,079
Wellmark ACO | 142,740 | 85,295
UnitedHealthcare ACO | 67,662 | 0
Blue Cross and Blue Shield of Illinois ACO | 8,087 | 0

As of June 2016

ACO Performance

UnityPoint Accountable Care vs. CPI Medical Trend

CPI Trend
Wellmark ACO
Self-Insured Health Plan
United Healthcare
MSSP
ACO vs. MCO

Similarities:
• Both “Manage Care of Beneficiaries”
• Both involve utilization targets
• Both seek to lower health care claim costs

Managed Care Organizations:
• Top down approach
• Competition among healthcare providers
• Designed to remove revenue from healthcare providers

Accountable Care Organizations:
• Bottom up approach
• Teamwork among healthcare providers
• Designed to remove cost from healthcare providers

Benefits of being in an ACO

Direct Financial Benefits
• Shared Savings
• Quality Incentives

Non Direct Financial Benefits
• APM Path with MACRA
• Grants opportunities
• ACO Waivers
• Recruiting Providers
• Marketing
• Payor relations
• Care Transformation/Cost Avoidance
What is an ACO looking for in a Mental Health Center

Vital Soft Skills:
• Honest, candid partnership
• Similar Vision and Values (Cost Report vs. Cost Reduction)
• Initiative
• Willingness to legally share data

Helpful Hard Skills:
• Access to care
• Accurate Coding
• Cultural and socio-economic competencies