Adapting Behavioral Health to Integration and Value Based Purchasing: Lessons Learned

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Conflict of Interest Disclosure: Faculty/Planning Committee/Reviewers/Staff

Participating speakers and planning committee members, in “Lessons Learned in Integrated Care and Value Based Purchasing in Arizona” session have the following conflict of interest to disclose relative to the content of the presentation:

Don Fowls, MD: Consultant with clients but do not believe they are relevant and do not create a conflict of interest. For the current talk for MHPA, serves as a consultant to Relias Learning and does not receive a fee from them and discloses this at the talk as well.
Overview

- Considerations related to Behavioral Health
- Integration
- Managing Complex, High Cost Members
- Value Based Purchasing
- Culture Change and Workforce Development
Considerations related to Behavioral Health

• A national history of carved out medical, behavioral and psychosocial services
  • Siloed functions and communication
  • All levels
  • Very different cultures and ways of doing things

• Significant differences between these worlds and even within behavioral health
  • Types of benefit plans and covered services
  • Populations (within BH)
  • Providers and networks
  • Payment models
  • Misaligned incentives

• Non-integrated data

• Results
  • Tough on members and their families
  • Expensive
Moving to Integrated Models

What works?

• Leadership and culture change – integration at all levels
• Get everyone focused on member outcomes – the whole person
• Critically important to engage members – the use of peers and peer supports
• Adapt models of integration and best practices to member needs and practical realities
• Leverage strengths - rich array of service, good relationships, technology
• Use integrated data and analytics to identify and track members and providers
Moving to Integrated Models

What works?

• Accurate assessment by individuals who have the experience and expertise
• Active, multidisciplinary teams with a team lead and plan
• Proactive communication supported by technology
• Addressing psychosocial factors like housing, employment, corrections, social skills
• Developing a systems of care approach
• Measuring performance towards outcomes – real life and KISS
• Develop the workforce: educate, train and support staff
• Moving to alternative, value based payment models
Integrated Care Management: Adaptive Models

- Patient Centered Medical Home
- Person Centered Health Home
- Assertive Community Treatment (ACT)
- ACOs
- FQHCs
- Specialty Programs
High Needs/ High Cost Members
High Needs/High Cost Members – Profiles

**Serious Mental Illness (SMI)**
- A small percentage (< 5% of total eligible population) can drive up to half the BH health care costs
- 20% of SMI can drive over half of these
- 2/3 have substance abuse problems
- 2/3 have one chronic medical condition, half have two, and 1/3 have three or more
- Participate in CMHC settings but not in medical

**Non-SMI Adults**
- Chronic physical conditions with co-morbid mental health and substance abuse
- Drive high costs on medical side
- Substance abuse including prescription drug abuse is a major driver
- Attend PCP office but not behavioral health

**Children and Adolescents**
- Diverse population in part related to age
- Co-morbid behavioral health and developmental disabilities make assessment, treatment and management difficult
- Substance abuse is a major driver
- Transition age youth present a unique set of problems
High Needs/High Cost Members - Profiles

Complex physical and behavioral health needs
- Crisis episodes
- Emergency department (ED) and inpatient admissions
- Substance use/abuse
- Polypharmacy

Critical psychosocial supports needed
- Housing
- Employment
- Criminal justice involved
- Not engaged or empowered
High Needs/High Cost Members
Care Management

What works?

• Manage those who benefit from management, not those who don’t
• Meet them where they are – member engagement is the key
• Identify members with integrated clinical data analytics – share data
• Accurate assessment by individuals who have the experience and expertise
• Multidisciplinary teams with an integrated care plan and team lead
• Address psychosocial factors like housing and employment
• Adapt specific interventions to specific populations
• Proactive communication supported by technology
• Measure performance towards outcomes
• Develop a collaborative process that continually measures, provides feedback, communicates, learns, and adapts
• Take time to develop the culture, support and train the staff
Value Based Purchasing (VBP)

What is it?

“We’re not changing anything, we just wanted to charge more.”

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Value Based Purchasing (VBP)
What is it?

HealthCare.Gov Defn

Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

Value = Outcomes/Costs
Value Based Purchasing

A continuum
Key Principles for Success

- Establish a clear vision and timeline – payment models must align with desired outcomes and results
- Member focused
- Collaborative and transparent
- Integrated data and clinical analytics to
- Measure performance and outcomes
- A process that learns and continually improves
- Clinically driven, then integrated with ops and finance
- It accounts for practical realities internally and externally
- Technology supports – EHR, HIE, telemedicine
- Develop the workforce – training, education, culture
- Know that change does not come easily
Considerations in Behavioral Health and Integration

• A legacy of block payments and lawsuits
  • Community Mental Health Act of 1963 – part of President Kennedy’s New Frontier Program: combines Medicaid and other funds
  • The pros and cons of lawsuits

• Siloed at all levels

• Unique infrastructure, staffing and ways of doing things

• A lack of good, integrated data

• Safety net including BH crisis

• Proceed mindfully: do something, but do something right
Transitioning from Block Payments

• Why it can be difficult to move to fee for service, bundles, or capitation initially

• One approach: move to pay for performance by adding performance measures to the block
  • A portion of potential payment is tied to performance on defined measures
  • Target desired result
    • Include BH, medical and psychosocial measures
    • Include HEDIS and compliance measures
  • May start with process but move to outcomes
  • Bonuses or penalties may be based on performance
  • Can include a share of savings or losses
Transitioning from Block Payments

- Develop contracts that align behavioral and physical health providers
  - Define who will do what: mixed services protocol
    - Case management and complex, high cost members
    - BH members getting stuck in EDs
  - Align incentives
    - Shared performance measures
    - Share savings and losses
- Establish alternative payment models based on the funding from block
  - Bundled payments
  - Capitation
  - Set risk corridors – balance change vs protection

10/5/2016
Bundled Payments

• An opportunity to align incentives for providers serving the same members and conditions.
  • Captures all units of service and costs from all providers for a specific condition.
  • Bundles these into a case rate payment over a period of time that may be related to a cycle of care.
  • All payments to all providers come from this bundle

• An opportunity to evolve intelligently
  • Performance and outcomes measures are used to identify and continually improve best practices, refine the bundling model, and add bonuses or penalties based on performance.
  • Over time centers of excellence are identified for referral
  • Potential conditions for bundling payments derive from the data based on those receiving services
Capitation is an interesting option

- Allows for management of a special population at a local level
- Provides flexibility to allocate dollars where they’re needed
- Less admin burden
- Engages the provider who has an incentive to continuously improve quality
- Less overtreatment

There are potential problems

- Providers at risk may fail and compromise the safety net
- Incentive to provide less care
- Potentially less flexibility for members
- Certain needed services may get undervalued, eg, BH
Capitation

Capitation drives a different level of management: the lessons of the 80’s

- A solid organization with leadership that can manage and produce results
- A clinical model of care
- Managed care infrastructure
- Financial strength
  - An ability to count and live within a budget
  - Reserves and reinsurance
- An ability to balance clinical, operational, and financial considerations
- An ability to adjust and innovate
- Good partners and an aligned network
# MODEL PROS and CONS

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<th>MODEL</th>
<th>PROS</th>
<th>CONS</th>
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<td>PAY FOR PERFORMANCE</td>
<td>• A way to get started</td>
<td>• Reinforces fee for service</td>
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<td>• Minimum risk to safety net</td>
<td>• More narrowly focused on one provider and some performance measures</td>
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<td>• Targets desired results over time</td>
<td>• More difficult to create a system of care or evolve</td>
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<td>• More or less dollars based on performance</td>
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<td>BUNDLED PAYMENTS</td>
<td>• Organizes everyone around conditions to impact</td>
<td>• Focuses only on special need or population – what about the rest?</td>
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<td>• Aligns financial incentives</td>
<td>• Accurately determining the bundle and how it is distributed</td>
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<td>• Uses data, measures outcomes, and supports development of systems of care and</td>
<td>• Members choosing different providers</td>
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<td>centers of excellence</td>
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## MODEL PROS and CONS

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| CAPITATION | • Guaranteed volume and income  
• Encourages management at the local level with more flexibility and less admin burden  
• Money follows the member and establishes a relationship w patient and Less overtreatment | • Providers at risk may fail and in public systems compromise the safety net – must have the ability to accept and manage risk  
• Incentive to provide less care  
• Certain needed services may get undervalued, eg, BH |
Integrated Care and Value Based Payment Models

Person Centered Health Home
   Pay for Performance
   Shared Savings and Risk

Patient Centered Medical Home
   Shared Savings and Risk
   Capitation

Assertive Community Treatment (ACT)
   Bundled payments
   Capitation

ACOs
   Shared Savings and Risk
   Capitation

FQHCs as group
   Shared Savings and Risk
   Capitation

Specialty Programs
   Bundled Payments
   Capitation
The Biggest Challenge - Changing the Culture

Let’s solve this problem by using the big data none of us have the slightest idea what to do with.

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The Biggest Challenge - Changing the Culture

• Takes many things
  • Leadership
  • Focus on member and outcomes
  • Collaboration

• Expect the unexpected

• Workforce development and training at all levels
  • Multimodal
  • Scale through online training
  • Performance and outcome measurement
  • Develop a process that learns, communicates, adapts
Thank You!

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