National Dialogues on Behavioral Health

Value Based Purchasing

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Brief View of Beacon Health Options

- Headquartered in Boston; more than 70 locations in the US and UK
- 5,000 employees nationally serving 50 million people
- 200+ employer clients, including 45 Fortune 500 companies
- Programs serving Medicaid recipients in 27 states and DC
- Serving 8.5 million military personnel, federal civilians and their families
- Partnerships with 100 health plans

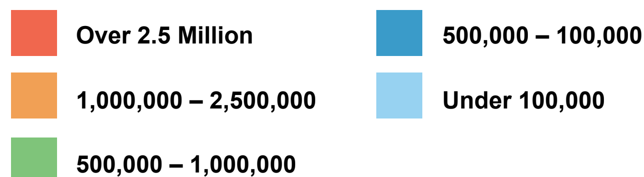
Beacon Health Options Footprint

U.K.

Alaska

Hawaii

MEMBERSHIP



CENTERS

BROAD REACH IN THE US AND UK

5,000 employees nationally and in the U.K., serving 50 million people

LEADER IN QUALITY

NCQA- and URAC-Accredited Companies

KEY OPERATIONAL AREAS

- UM/CM
- QM
- IT
- Customer Service
- Data Analytics
- Reporting
- Processing
- Sales Support

LINES OF BUSINESS

- Commercial
- EAP
- Exchange
- Federal
- Medicaid
- Medicare

The Challenge for BH Systems

Behavioral Health Systems

- States have been slow to launch system contemporization
- FFS conversion is a full-time, multi-year endeavor. Managed Care will follow
  - A lot at risk
  - FL: -10%; KY: -33%; MA -15%; MD -15%; NH -12%; NY -6%
- Providers are fragmented

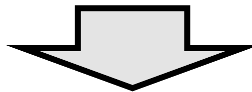
Physical Health Systems

- Provider consolidation is well underway
  - Hospitals and physician groups
- Pace-car states with respect to payment reform innovation
  - Medicare, Commercial, PCMH
- Financially strong, politically powerful entities

The Value in VBPs

An effective approach to align provider-payer incentives:

- Improve health service delivery
- Improve health outcomes
- Positively impact total medical expenses
- Support and reward high-quality, cost-effective care
- Increase member compliance, participation, and satisfaction with care
- Use social supports, family, and community resources to maintain members in the community
- Intervene on member's behalf in advance of a crisis
- Integrate behavioral health into primary care settings



Empowers providers to do their best clinical work by efficiently allocating their time and effort **and compensating them** on the total value created

State of play: VBP for Behavioral Health

- No single answer, rather, **a range of options exists** for value-based BH purchasing
- VBPs are most effective when the **goal** is **clearly articulated upfront,** e.g., to ensure continuation of care for people with opioid addiction, to improve access via same-day clinics or to reduce variation in clinical practice.
- Most BH providers are **small scale, under-capitalized and not prepared to share risk**. This is slowing the development of VBP efforts.
- **Re-defining outcomes measures** is necessary. HEDIS measures are important but not enough. Outcomes measurement in BH is difficult but not impossible. Industry innovators are experimenting with the role of new technologies to collect outcomes data across cycles of care. More than just utilization metrics.
- **Widespread variation in the quality** of BH care provided across the nation. Beacon is committed to driving **payment reform** for behavioral health because of the opportunity it presents to improve outcomes for the members we serve.

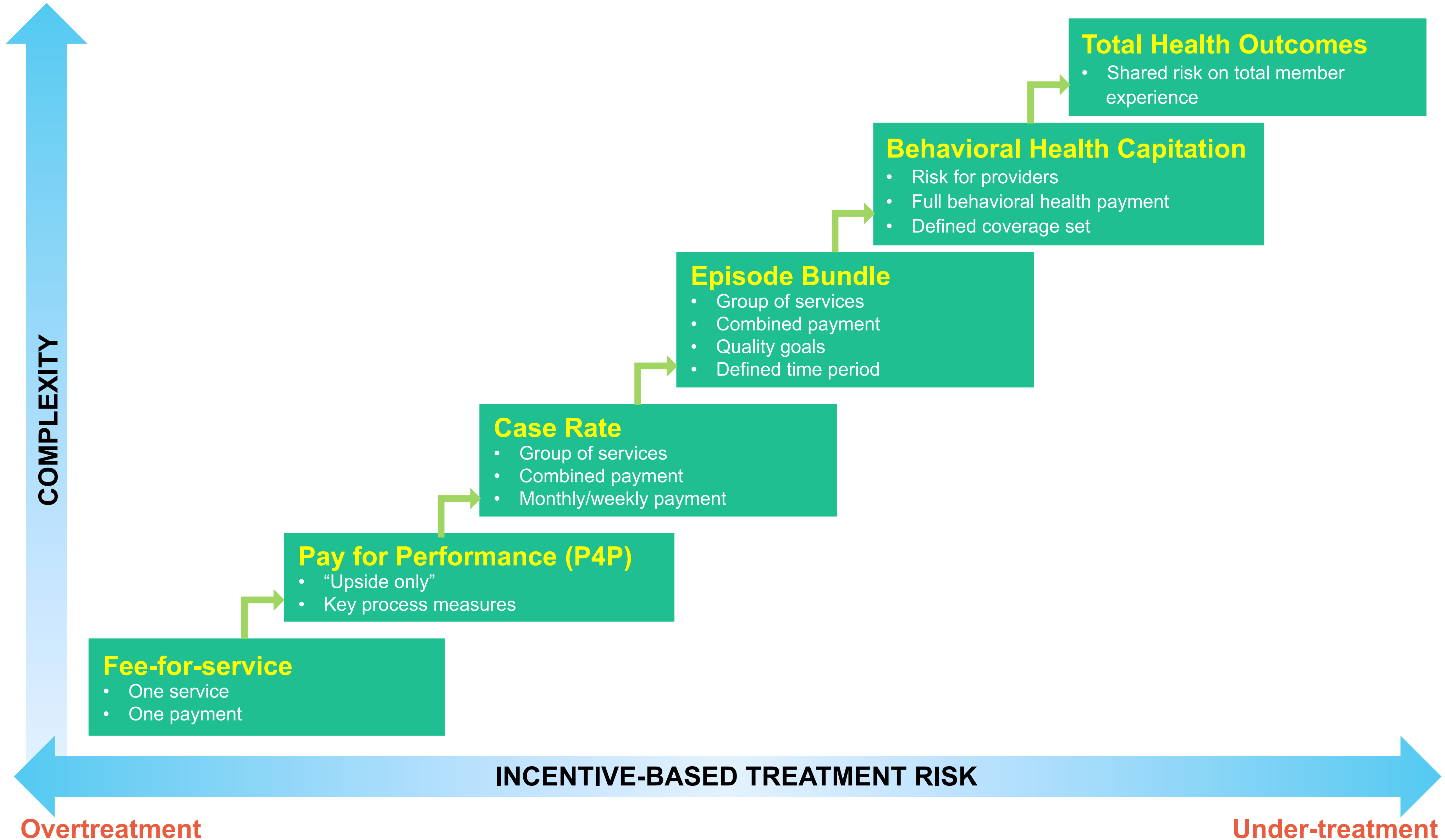
Yet behavior health is still an after thought in recent wave of VBPs

- Many **high-profile value-based payment pilots** around the country; yet BH not included in a meaningful way
- Some examples of **mature "ACO" markets** include Illinois, Florida, and Southern California; BH is outside capitation arrangements or "carved-out"
- DHA demonstration project, Maryland Multi-payer Patient Centered Medical Home Program (MMPCMHP), does **not include BH**

Behavioral health's historical role has minimized participation to date

- BH is a "**second class citizen**" in VBPs: BH spend, while huge in a BH context, is small relative to everything else, so it is left out from VBP models
- **Lack of strong outcomes measurement regimes** that definitively identify best-in-class provision of BH services
- BH service provision **lacks the diagnostic clarity and robust evidence base** that VBP has been built on in medical care (eg. knee replacement)
- BH providers, while interested in VBP, have **small balance sheets and zero experience** managing VBP risk, so the first project will be a leap of faith, and an exercise in planning

VBPs are a spectrum of options; requiring the right mix of incentives and complexity to get desired outcomes

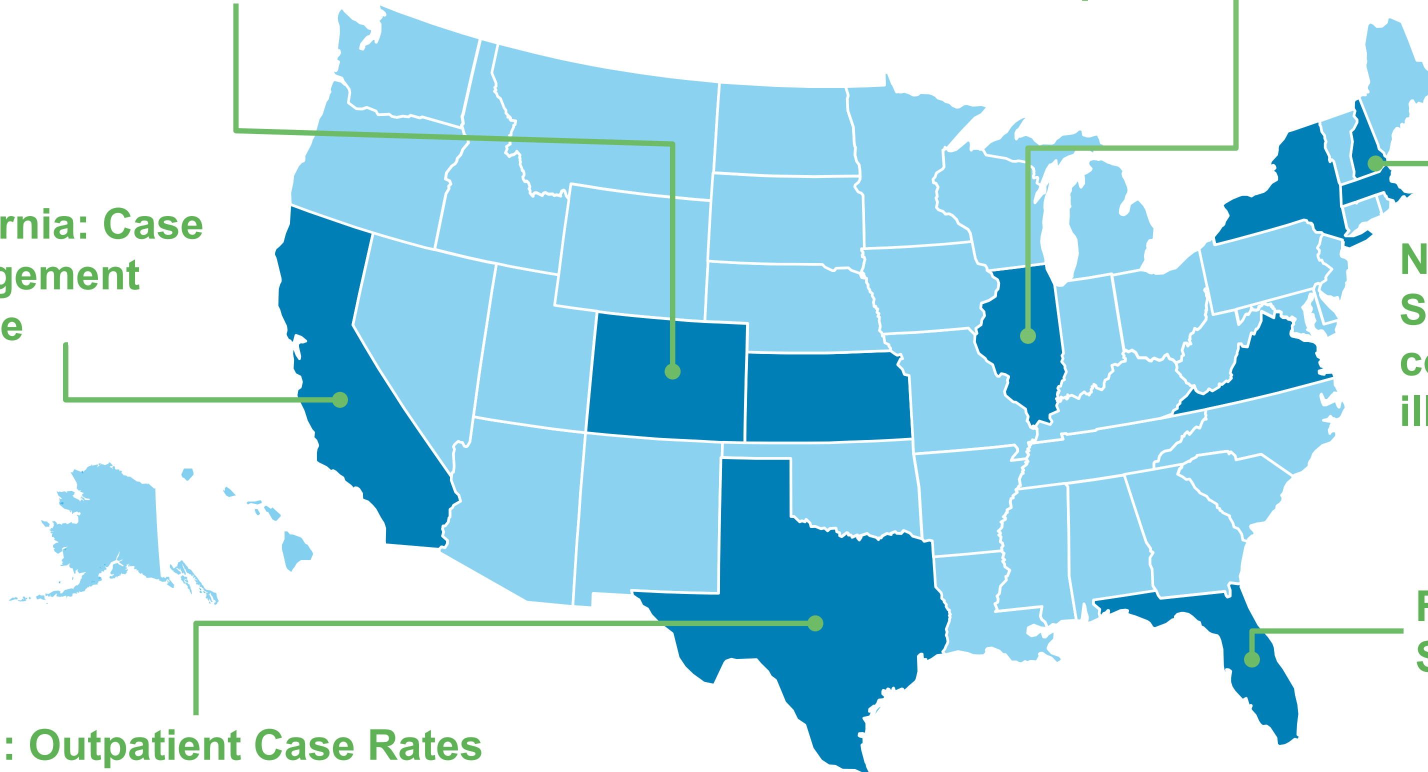


The emphasis on VBPs is unlikely to ebb any time soon

- **RFPs** and ensuing **contracts include commitments** to VBPs strategies, including numeric targets (even if they are not well thought out)
  - NY – glide path to having 85% of payments through VBP structures, case rates for care transitions
  - MA -- ending its managed care program to move to ACOs; bundled rates for SUD MAT treatment
  - FL – Medicaid sub-capitation
  - Oregon, Colorado, Alabama are all Medicaid programs organized around provider-led structures
- Those **providers with real VBP experience actually like them**
  - Cash flow, predictability, flexibility, clinical innovation, etc.
- For BH specifically, lack of evidence notwithstanding, providers and payers both believe that **more good than harm is occurring**
- Washington remains a wildcard, but **continued growth of VBPs** likely

Beacon is paying hundreds of millions of dollars in BH provider alternative payments today

Beacon has implemented ambitious value-based payment programs in Colorado, Texas, Florida, California, and more



NY VBP: case rate with high volume OP providers to connect members to Health Home

Problem Statement

NY members, especially HARPs, are **not being adequately connected to services** ahead of crises and after an IP stay, resulting in **high IP utilization and readmissions**

Proposed Clinical Solution

Engage with **high volume OP providers** such as the CBC IPA to:

1. Outreach and engage hard to find members and **connect them to services**
2. Hire therapists/Care Managers to work with members starting at end of IP stay to **provide bridge appointments** and **transition to OP care**

Proposed VBP Solution

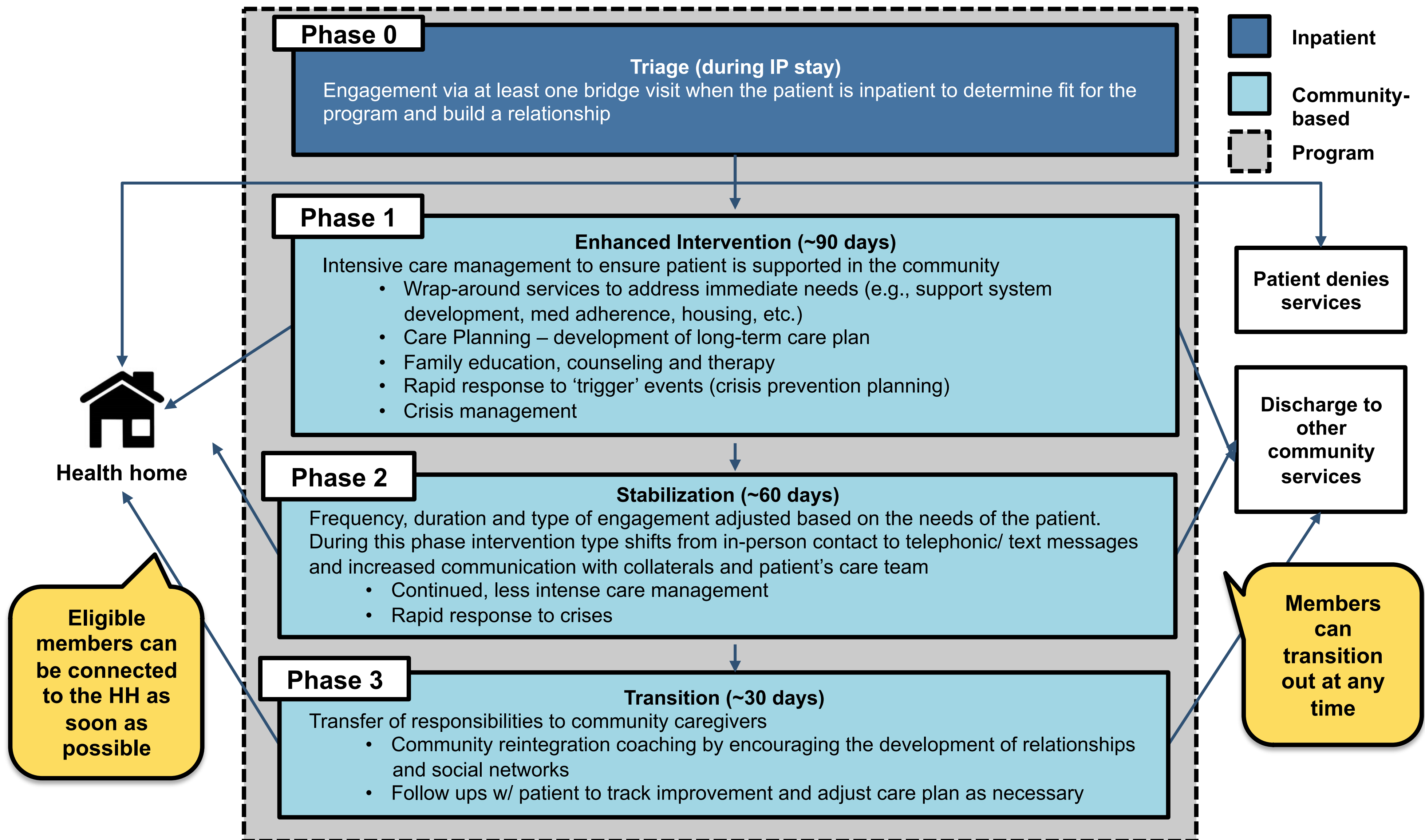
Beacon to pay a case rate for therapist/engagement specialist based on **# of members engaged** (or flat monthly rate to cover the FTE's salary)

Potential for shared savings tied to reduced readmissions

Key Questions:

1. What is the role of the health home? If we are duplicating services, can we demonstrate effectiveness to the state?
2. How do we leverage our plan partners?
3. What do we need to prepare for implementation?

NY VBP - OP transition of care : 6 - 9 month program encompassing three phases; payment via episode rates



MA VBP: An OP MAT bundle with Column Health will expand access to high-quality MAT

Elements of comprehensive OUD care[1]

- Psychosocial services
- Pharmacotherapy
- Community support system
- Clinical Case Management
- Drug Screening

OP MAT bundle structure

- A OP MAT treatment case rate incorporates outcomes metrics and bonus payments to effectively **align financial incentives with high-quality treatment**
  - MAT dosing is bundled with therapy and wrap-around supports
  - Opioid use disorder (OUD) and co-morbid mental health diagnoses are **co-managed** by single care team
  - Program is available for Beacon members seeking MAT treatment for opioid use disorder
- The case rate structure is based on the **phases of treatment for patients in MAT**. This creates a dynamic continuum of patient progress toward intended treatment outcomes:
  - **Intake phase**, including assessment, MAT induction, treatment planning and stabilization
  - **3 maintenance phases** with decreasing service levels through which the member progresses by achieve recovery plan goals
- Quality metrics will be used to award **P4P incentives** based on successful care outcomes:
  - Metrics include IP readmissions rate, MAT adherence, and patient quality of life assessment
- As part of strategic partnership between Beacon and Column Health, Column will **rapidly expand its services** to mutually agreed on locations in markets with **shortage of MAT providers**

FL VBP: sub-capitation focused on stability

PROGRAM SNAPSHOT

Type of VBP	BH Sub-capitation
# of Providers	6
Client(s)	Prestige
Members	~230k
Regions	NW, Central and SE Florida
LOCs	Mostly outpatient, some IP
Population	Medicaid TANF/SSI SMI

- Some FL providers were struggling to stay in business in current rate environment
- Beacon agreed to enter into VBP contracts with providers **to give revenue predictability and provide stability to the BH system in FL**
- **Membership is allocated by region** and is determined by the plan's eligibility on the 5th of each month*
- Providers are **required to submit encounters** for the services provided to each member

* Members are not attributed to individual providers. Providers are paid a PMPM rate proportional to its historical share for every member within each particular region

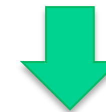
Take a “problem statement” approach to VBPs

STANDARD APPROACH:
DECIDE TO INNOVATE AND THEN DETERMINE WHY

- Many organizations make a **determination to follow a specific path for reasons unclear**
  - Senior leadership may pronounce an edict
  - Key customer may ask/demand it
  - Policy environment may encourage it
- We can think of this as **“innovation for innovation’s sake,”** where we may learn something amazing…or not
- **Hard to determine if the innovation made an impact** as you are searching *ex post* for what you are looking to impact/ change

BETTER APPROACH:
DEFINE PROBLEM TO SOLVE, THEN EVALUATE INNOVATION

- We believe in a **“problem statement” approach to innovation**, including value-based payments
- Spend considerable time to ***accurately define the outcome we are trying to achieve*** and to lay out how we will know if we achieve it
- Then we **break the problem into components** and determine where, if anywhere, innovation has a role to play



Simple concept, but it requires diligence to keep out the noise and focus on the problems and the desired results

What problem are you trying to solve? Be clinically led. Avoid fads.

VBPs may be helpful

- Length of stay
- Readmission rates
- Community-based medication assisted treatment
- SMI Total Cost of Care

ACCESS – scheduling flexibility at scaled centers in dense geographies to create "BH Urgent Care"

FFS may be more helpful

- New treatment modalities
  - FEP engagement, CBT for suicide
- Prescribing
- Seek and Find "engagement" work
- Peer Recovery Specialists
- HEDIS Rates

ACCESS – treatment capacity in genuinely under-served areas

More emphasis on "PAYMENT" than "VALUE"

- **Value** is defined as **outcomes relative** to the **real costs**
- **Outcome improvement** without understanding the **true cost of care** is unsustainable and does not help effective allocation of limited resources
- **Cost reduction / revenue increase** without regard to **outcomes** is not value

$$\text{VALUE} = \frac{\text{HEALTH OUTCOMES}}{\text{COST}}$$

- Negotiations are overly **focused on the financial envelope** (bottom half of the value equation)
- VBPs without changing outcomes is a very **expensive way to lower cost**
- Too often in healthcare organizations, the **clinical leads are not well coordinated with the contracting leads** (both payers and providers)
  - Leads to an organizational disconnect: Price changed, but things aren't really going to be that different

Be specific and realistic about “risk”

- In real-life negotiations, provider **confidence in taking on financial risk is notably low**
  - Data quality, balance sheet, systems, population size, geography, lack of control
  - May be overly conservative, but conservative is better than the alternative
- Helpful distinction between **“insurance risk”** and **“performance risk”**
  - Higher confidence around performance risk on things you know how to do
- Be realistic about the trade-offs between **risk** and **administrative flexibility or simplification**
  - A deal predicated mostly on “performance risk” is less likely to yield administrative simplification than a deal predicated on “financial risk”
- Sets up a natural **partnership opportunity between MBHOs and CMHCs**
  - Beacon takes population/insurance risk and CMHC takes performance risk

The amount of required change is consequential – for both payers and providers

It's complicated; there are a lot of systemic and practice level changes that need to happen

- **Requirements around timely patient access, outcome accountability, process measures**, etc., may be tied to financial payments
- **Financial reconciliation** function is big: thresholds, leakage, maintenance of effort
- **Cash management** becomes critical: VBPs cut both ways on receivables
- **Utilization management moves from payer-led to provider-led,** forcing a re-think of how the provider organizes clinical practice to stay within financial allowances
- **IT and reporting infrastructure is different:** providers need to generate and monitor patient utilization reports and financial utilization reports in a way they have likely not done
- **Payer / Provider interaction goes up, not down** – quality reviews, case rounding, complex case management, transitions to/from higher levels of care
- In addition to the new requirements, **still have to submit claims accurately,** even if they are not paid and instead counted as encounters

Administrative costs will INCREASE, for both the payer and provider

- Bolstered finance functions
- Accurate **eligibility** maintenance. Critical to understand that payers struggle constantly with eligibility.
- **Encounters, encounters, encounters, encounters**
  - States, CMS are not changing the way they **build rates and do risk adjustment**
  - **Traditional billing and claims infrastructure is still required** (timely filing, accurate provider files, accurate coding, accurate diagnosis)
  - **Increased difficulty:** "Flexible supports" still need to be converted into procedure codes: activity tracking
- **Audits increase**. Consequence of new emphasis on "controls" and "vendor oversight"
- Do not underestimate time frames and investment required for **proper implementation.** Know your own organization, but also **know your payer**

Negotiate A Key Role; Rise to the Occasion

- Do not let the FFS challenge distract from the next challenge – Managed Care. **Work starts now**
- Be really clear about a few **specific BH problems** that are currently unaddressed:
  - Primary Care for SMI; Access to care with a clear definition; Crisis stabilization and response
- Pick things that exemplify the value of a strong, defined community mental health system that is based on recovery principles. **Define a role for the MH safety net**
- Clearly identify the **definition of SMI** and quantify the **total cost of care for the SMI**
- Create a **"Maintenance of Effort" framework** with re-investment requirements
- Create structures to bring **scale and operating leverage** where there is none today
- **Don't get divided**. Your unified voice is much more powerful than your individual deal skills