Convene.
Strategize.
Activate.

TRANSFORMATION
TODAY & TOMORROW

Alternative Payment Methods and the Value Proposition

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Objectives

Define Alternative Payment Methods (APMs) and Value Based Contracting Principles

Understand the federal and state government expectations for APMs in Medicaid

Identify the key areas of an organization that are changed by using APMs and roles of the provider and payer

Discuss the types of risks associated with APMs and how to manage that risk.

Shared Goals and Better Outcomes

PROVIDERS

Showing Value

Knowing people are getting better but can't prove it, no data

Available data doesn't tell the real story

Can't afford the requirements

PAYERS

Paying for Value

Have lots of data and don't know if people are getting better

Available data doesn't tell the story

Can't afford the cost

Shared Goals and Better Outcomes

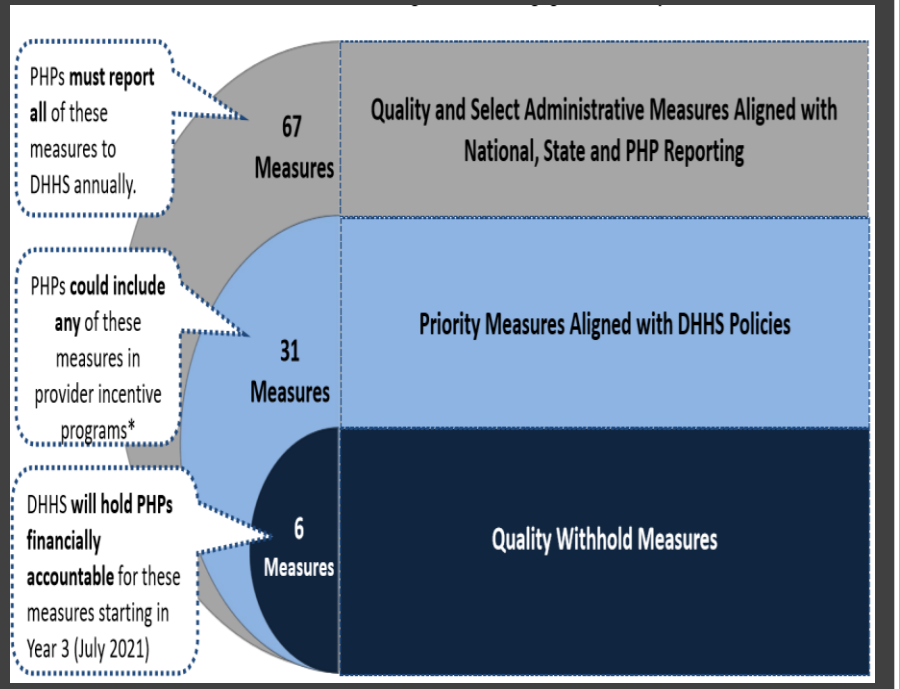
DHHS quality vision

DHHS seeks to develop a data-driven, outcomes-based continuous quality improvement process that rewards PHPs for advancing quality outcomes in targeted areas that support three central Aims:

1. Better Care Delivery
2. Healthier People, Healthier Communities
3. Smarter Spending

North Carolina Department of Health and Human Services. (March 20, 2018). *Provider Health Plan Quality Performance and Accountability.*

DHHS tools to incentivize quality



DHHS will set goals for PHP quality improvement efforts through the establishment of quality measure sets including establishing a subset of measures which will be priority measures for DHHS

DHHS will establish a quality withhold program which will launch in year 3 of managed care

DHHS has established requirements for PHP deployment of Value-based Payments (VBP) as a tool to incentivize quality improvement among contracting providers (based on priority measures)

PHPs will submit an annual Quality Assessment and Performance Improvement (QAPI) plan (based on priority measures)

PHPs will engage national accrediting bodies to improve quality and a External Quality Review Organization (EQRO) to validate quality performance and provide feedback

North Carolina Department of Health and Human Services. (March 20, 2018). *Provider Health Plan Quality Performance and Accountability.*

PHP Implications: The Stakes are High – The Expectation is the Same for TPs

Financial penalties starting in contract year 3[1]

DHHS will use PHP quality scores in the PHP auto-assignment algorithm, allowing PHPs with higher quality scores to disproportionally be assigned new beneficiaries[1]

If quality performance is unacceptably low over a continued period, the Department may decline to renew or terminate a PHP contract [1]

Health Plan performance will be publicly reported on an annual basis. [2]

[1] North Carolina Department of Health and Human Services. (March 20, 2018). *Provider Health Plan Quality Performance and Accountability.*

[2] North Carolina Department of Health and Human Services. (April 25, 2019). https://files.nc.gov/ncdma/documents/Quality-and-VBP-Webinar_Final.pdf

Yesterday We Heard

- The Tailored Plan measures – in discussion BUT
  - Experience says these in some form will continue.
  - Maybe not all but the Department has put the vision out there for reaction and discussion.

Measure Set Structure

Based on current recommendations, Tailored Plans will be required to report 67 measures (standard plan) plus additional measures for the TP set.

Confirmed/Required Measures for TP Reporting

67
Measures from SP Set
Includes the 38 measures required for NCQA Health Plan Accreditation, and adult and child core set measures.
*Note, if all SP measures are included, TPs would be required to report 94+ measures

+

27
Additional Measures Required for SUD Monitoring Protocol
There are 27 total SUD protocol measures; 1 is required for Health Plan Accreditation

+

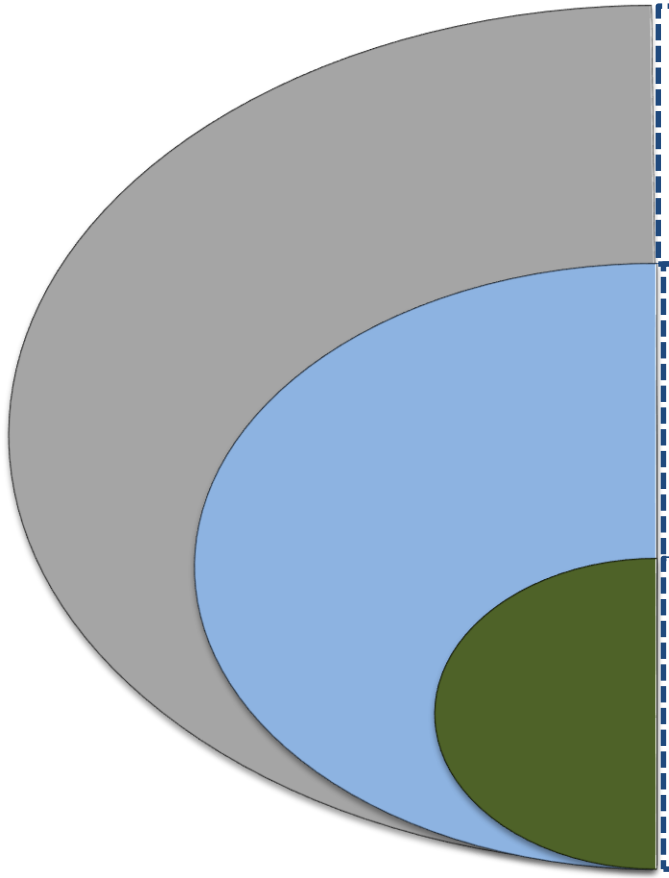
10
CMS Health Home Measures
10 total measures, 4 of which are required for Health Plan Accreditation

Additional Measures Under Consideration

- Chronic Condition Management
- Utilization Measures
- Post-Utilization Follow-up Measures
- Screening Measures
- Satisfaction with Care and Waiver Measures
- Survey Measures: Quality of life, consumer experience and functional status surveys to meet block grant reporting requirements and assess treatment outcomes

Measure Subsets

The TP measure set will include priority, AMH+/CMA and withhold measures.



Quality Measures Aligned with National, State and PHP Reporting & Select Administrative Measures

- *Quality measures are used by the DHHS to baseline PHP performance and set priorities in future years; DHHS may also elect to report on these measures publicly*
- *PHPs must report on all quality measures*

***Vision*: Report on quality measures broadly in initial years, and streamline the measure set over time to priority areas**

Priority Measures Aligned with DHHS Policies

- *Priority measures are aligned with the Quality Strategy and reflect NCIOM stakeholder input*
- ***DHHS will select AMH measures and quality withhold measures from the priority set***
- *PHPs must select measures from priority set to use in non-AMH performance improvement projects and value-based contracting arrangements*
- *Priority measures will be the minimum set of measures used for public reporting*

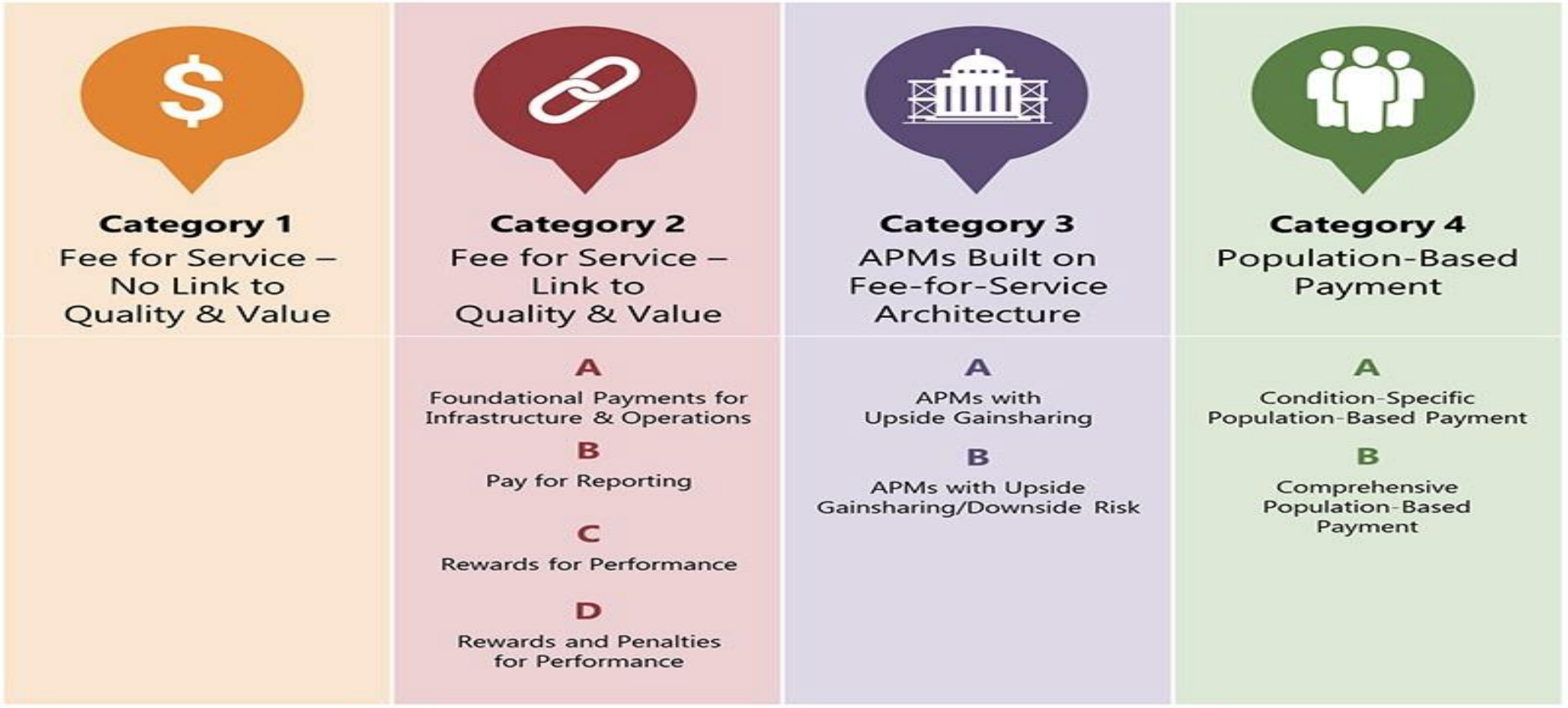
***Vision*: Leverage Priority Measures to Promote DHHS' Key Quality Areas**

Quality Withhold Measures

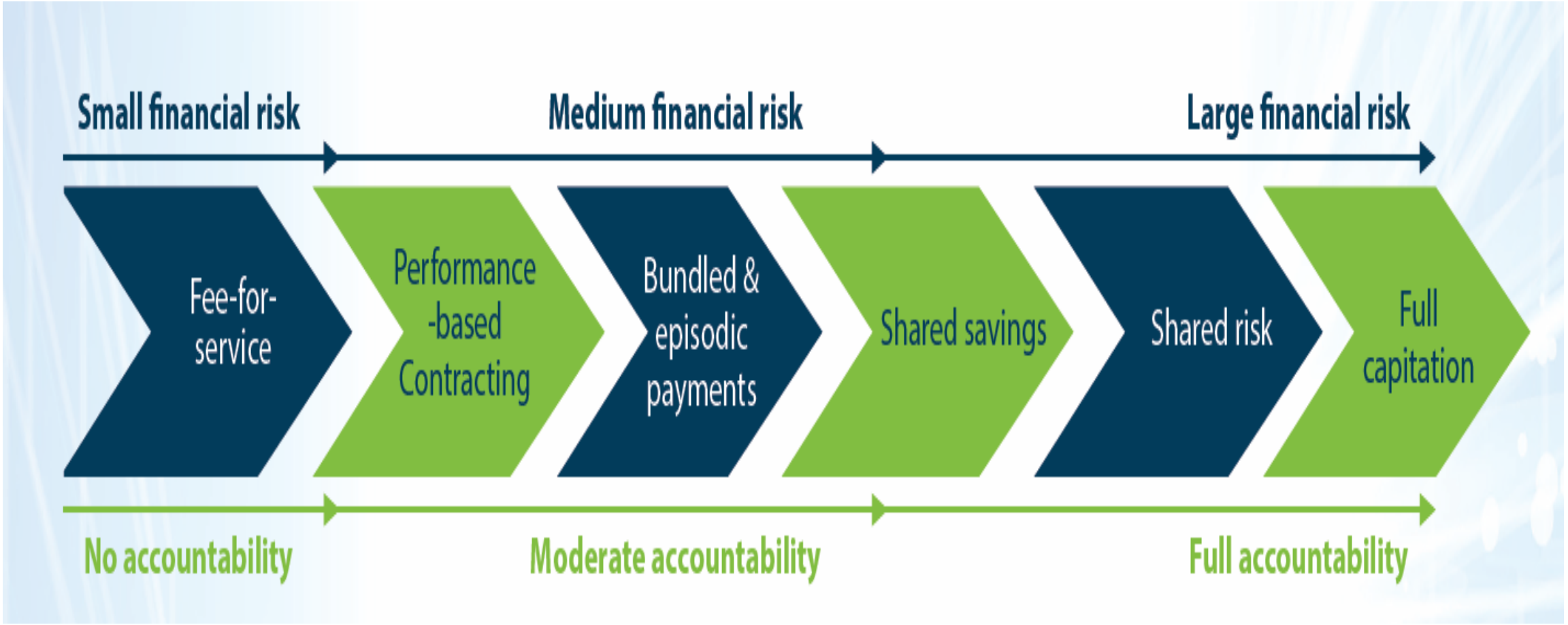
- *Quality withhold measures are used to financially reward and hold PHPs accountable against a sub-set of measures included in the* ***priority measure set***
- *Quality measures are the only component of the measure universe where performance (as opposed to reporting) is tied to PHP financial outcomes.*

***Vision*: Make annual updates and changes to Quality Withholds Measures based on assessment of PHP readiness to move from process measures to outcome and population health measures**

Alternative Payment Model Framework



Models of Value Based Contracting



Being a Provider of Value

We know who the payer is. We know who our clients are.
Now how do we position ourselves as the provider of choice?

Social Drivers of Health

Not Just about Behavioral Health or IDD Services

Social Drivers of Health

Incorporate in risk stratification/risk adjustment

Potential to develop SDOH gap closure payments

Critical when moving to total cost of care arrangements

Let’s Hear From Our Panel Members About Their Activities Here in NC and in Other Markets

Alliance Health

Expanding Alternative Payments

Alliance Value Based Payment Path

- Early Experience
  - Multisystemic Therapy (MST) - Episode Payment
  - Family Centered Treatment/Intercept - Episode Payment
  - Therapeutic Foster Care (TFC) – Pay for Reporting
  - Intensive Alternative Family Treatment and Enhanced TFC – Bundled Payment
  - Fostering Solutions – P4P with shared risk
  - Transition Management Support – P4P
  - Outpatient Plus – Bundled Payment
  - ACTT Community Inclusion – Pay for Reporting/P4P

Alliance Value Based Payment Path

- Considerations for Continued Implementation
  - Quality first strategy
  - Improve data sharing
  - Support provider infrastructure
  - Ensure all existing models incentivize both quality and cost
  - Focus on areas with highest impact
  - Increase use of shared savings models
  - Scalability

PRTF Value-Based Payment Project

- Align work of Alliance, Psychiatric Residential Treatment Facility (PRTF) and community-based treatment provider
- Implement family treatment before residential care
- Category 3B shared savings with upside
- Support concurrent family and residential treatment
- **Goals**
  - Reduce Average Length of Stay (ALOS) in residential care
  - Improve post-discharge community tenure
  - Increase number of children returning home from residential care
  - Improve parental self-efficacy measured by the Child and Adolescent Needs and Strengths (CANS) checklist

UnitedHealthcare and Their Partner Optum

OBH - VBP Implementation Overview

Model	Overview	Comments
CMHC w/ Genoa Shared Savings	This model for outpatient providers (CMHCs and other groups) offers a shared savings opportunity based on a reduction to inpatient costs and achievement of one or more quality metrics (5 metrics in all)	• Model is being piloted in FL, TX, LA, OH, KS, NE, AZ and RI.
CMHC w/o Genoa Shared Savings	This model for outpatient providers (CMHCs and other groups) offers a shared savings opportunity based on a reduction to inpatient costs and achievement of one or more quality metrics (3 metrics in all)	• Model is planned for pilots in OH, LA, PA, KS, RI, FL and AZ,
Clinical Excellence	Facilities can earn shared savings if they reduce to 30 day episode cost of care and meet one or more quality metrics (3 metrics in all)	• Model is not in place in any states yet
Health Homes	This model is the Optum Behavioral National Model developed to drive total cost of care value and improved health outcomes through a managed health home model paired with a monthly case rate and potential shared savings opportunity.	• Model is not in place in any states yet

OBH - VBP - Metric Overview

Model	Metrics
CMHC w/ Genoa Shared Savings	• BH IP PMPM • Medication Adherence (3) • 7/30 Day FUH
CMHC w/o Genoa Shared Savings	• BH IP PMPM • BH IP Readmit Rate • 7/30 Day FUH
Clinical Excellence	• 30-day Episode Cost • LOS Outlier Rate • BH IP Readmission Rate • 7-Day FUH
Health Homes	• TCOC • Follow-Up After Hospitalization for Mental Illness (HEDIS - FUH): 7-day • Comprehensive Diabetes Care - Composite 1 (HEDIS - CDC): Eye exam • EPSDT Adolescent Well-Care Visits (HEDIS - AWC) • Plan All-Cause Readmissions (HEDIS -PCR) • Ambulatory Care (HEDIS - AMB) - ED Visits • Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS - SSD) • Inpatient Utilization (HEDIS IPU) • Rate of inpatient psychiatric admissions • Med Adherence - Mood Stabilizers • Med Adherence - Anti-Psychotics • Med Adherence - Anti-Depressants

Questions for Our Panelist

Payers and Providers Share Responsibilities and Roles in APM arrangements. Please discuss the shared and individual roles and responsibilities of the Provider and the Payer.

What are Some of the Challenges Faced by Providers of BH or IDD Services? How is Your Agency Addressing those Challenges with Providers In Order to Move Forward with APM or VBP arrangements?

More Questions

Opportunities

Key Takeaways

- A new day of quality measurement, i.e.; APM or VBP is upon us
- Providers should become familiar with HEDIS measures and CAHPS
- SPs and TPs will be expected to perform against a subset of quality measures or they will be subject to withholds/penalties
- The proportion of Medicaid payments to providers tied to Value Based Payment Arrangements will increase in the coming years
- PHPs will be required to submit Quality Assessment and Performance Improvement (QAPI) plans based on HEDIS and CAHPS outcomes to DHHS
- DHHS has indicated they plan for the Tailored Plan design to follow closely with the Standard Plan design so expect similarities
- Providers must begin to make necessary shifts in operations to assure their existence in the new environment

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