Value Based Payment: Opportunities for SUD Providers

From Science to Practice to VBP: SUD Services as Healthcare

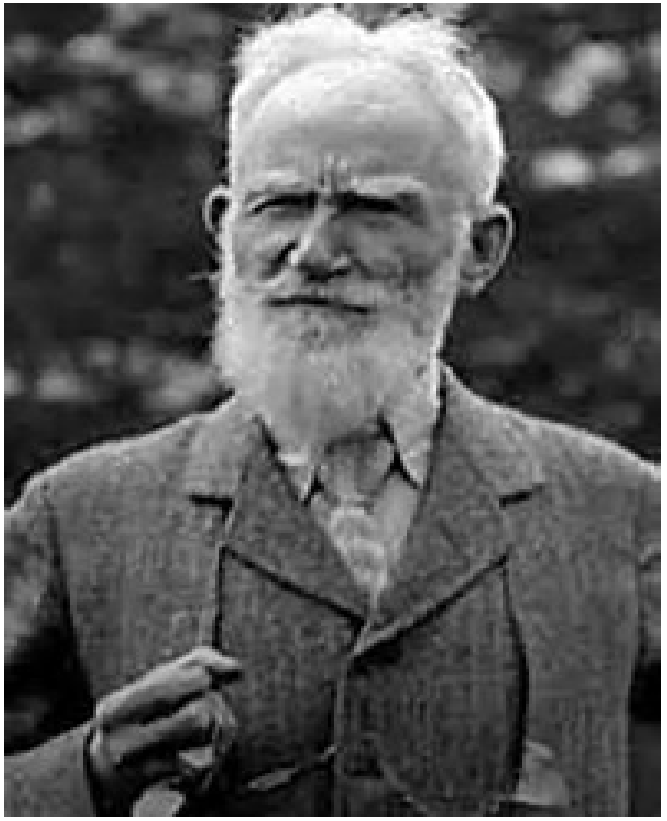
Tami L. Mark, PhD, MBA
Senior Director, Behavioral Health Financing

Agenda

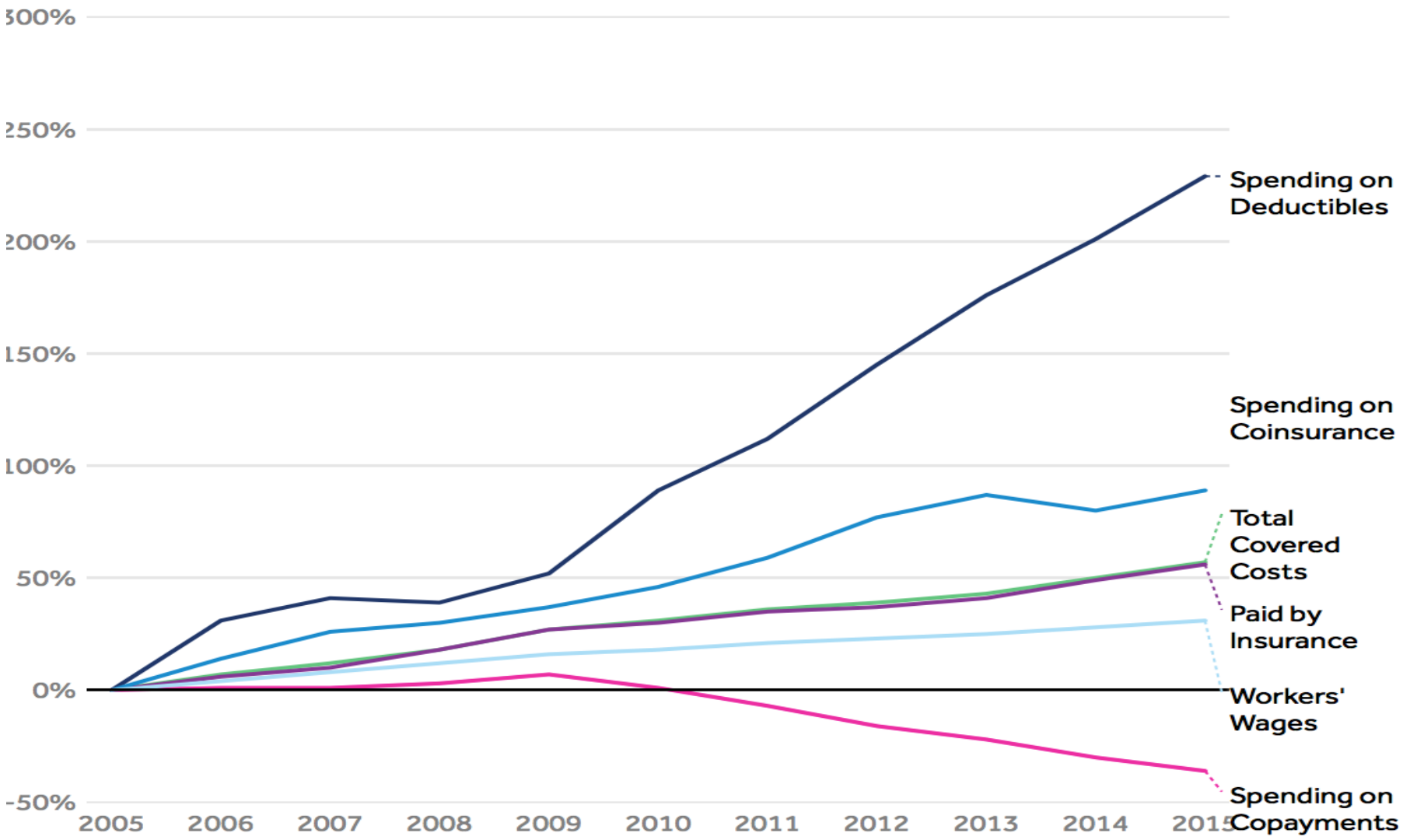
1. Big Picture
2. VBPs and APMs
3. Opportunities for SUD field
4. Discussion

George Bernard Shaw's Thoughts on FFS

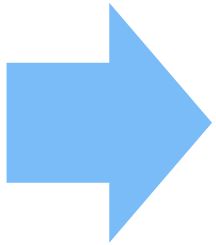
That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity.



Cost Shifting to Consumers Reaching Tipping Point



Kaiser Family Foundation analysis of Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2005-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2005-2015 (April to April)

VOLUME  VALUE

National Context: VBPS and APMs

National Context

- **Value Based Purchasing (VBP)** refers to this general idea that we want to stop paying for services using fee-for-service to paying for “health” or if not health than at least the quality of care.

- **An Alternative Payment Model (APM**) is a payment arrangement used to drive VBP by linking provider payments to both quality and total cost of care.

DHHS Goal is to Move from Category 1 to Category 4

Category 1

Fee for Service – No Link to Quality & Value

Category 2

Fee for Service – Link to Quality & Value

- **A** Foundational Payments for Infrastructure & Operations
- **B** Pay for Reporting
- **C** Rewards for Performance
- **D** Rewards and Penalties for Performance

Category 3

APMs Built on Fee-for-Service Architecture

- **A** APMs with Upside Gainsharing
- **B** APMs with Upside Gainsharing/Downside Risk

Category 4

Population-Based Payment

- **A** Condition-Specific Population-Based Payment
- **B** Comprehensive Population-Based Payment

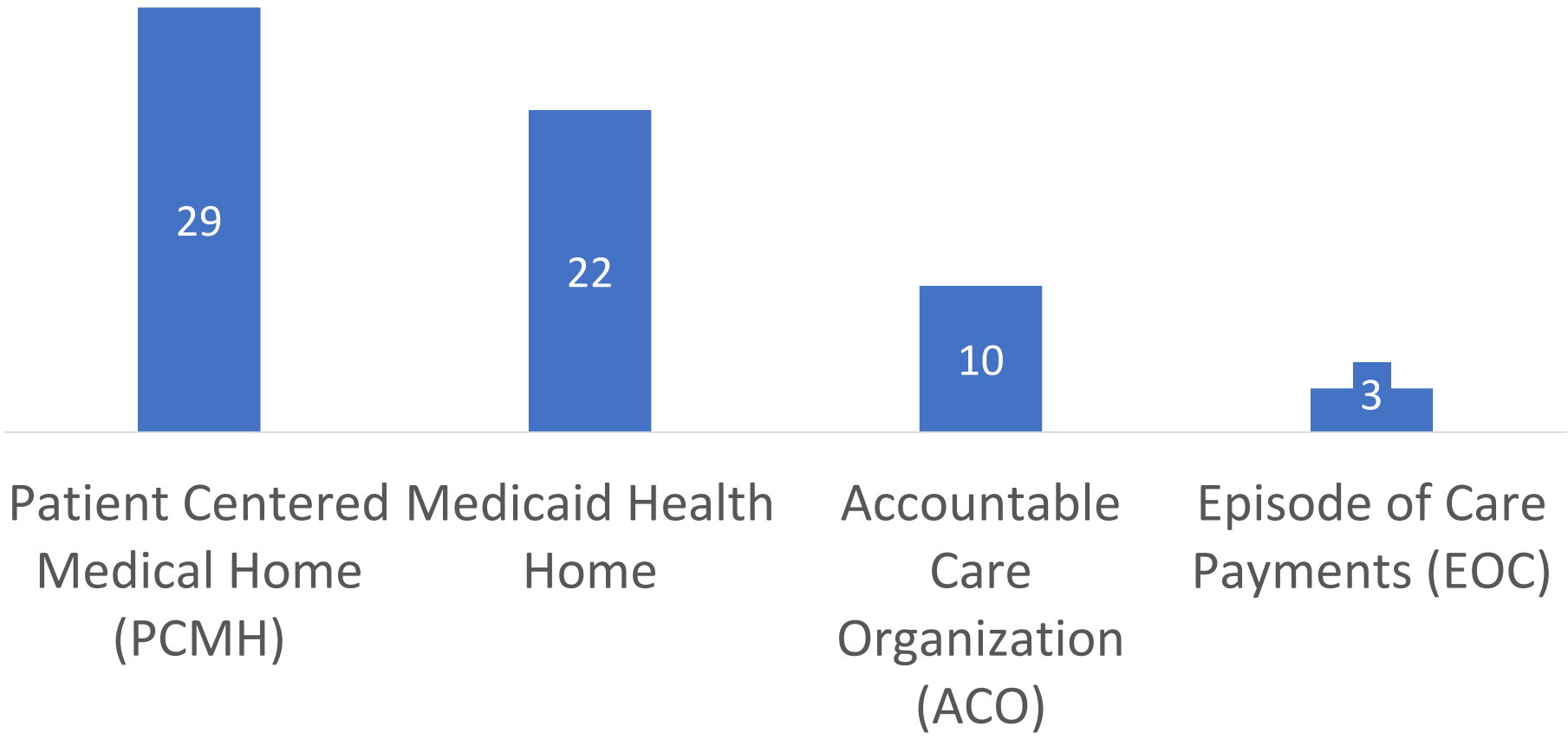
MACRA and Medicare Quality Payment Program

The Merit-based Incentive Payment System (MIPS)

Advanced Alternative Payment Models (aAPMs)

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2, 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement Payment Model

Number of States Reporting APM Initiatives, by Type



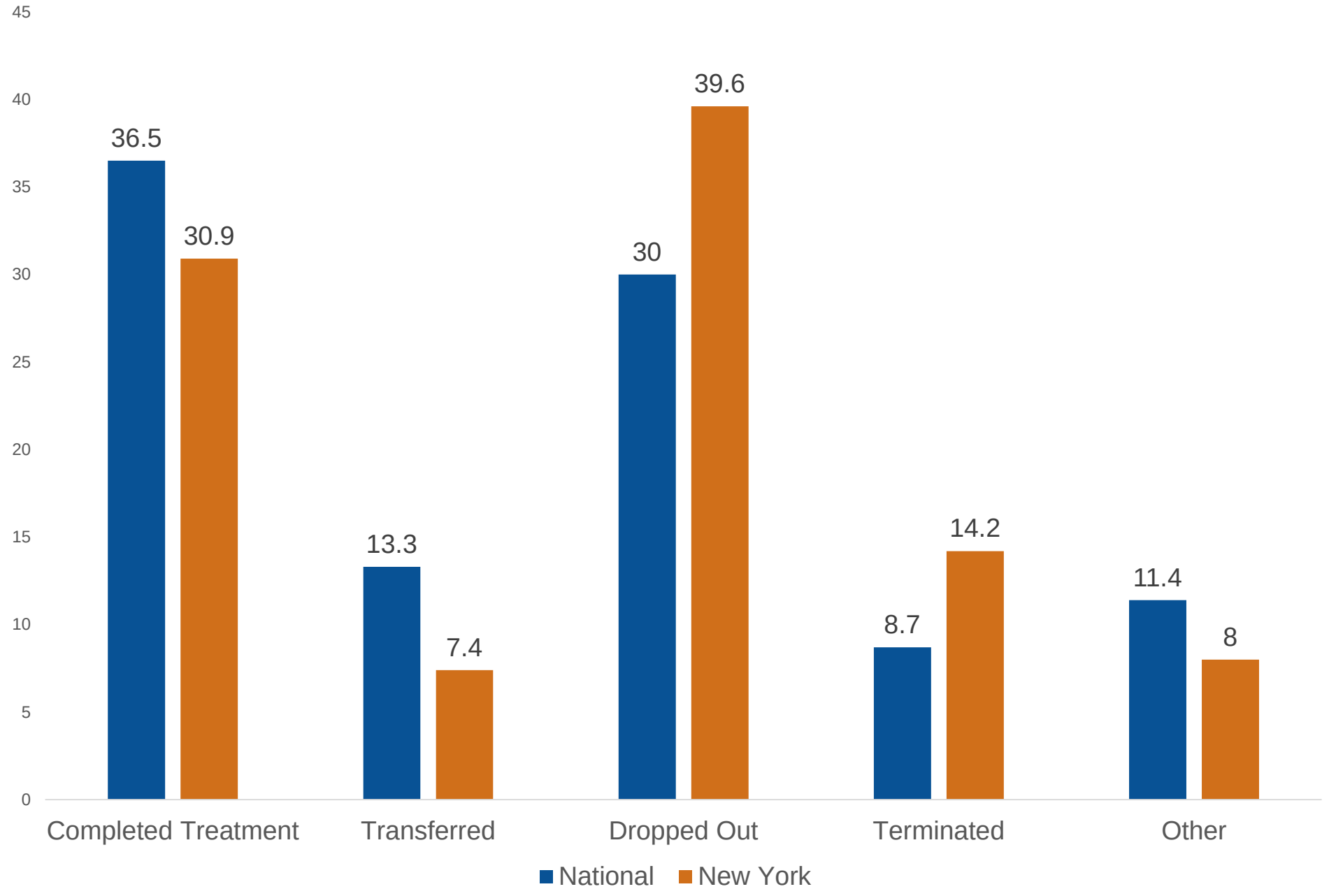
Source: Sources: KFF 50-state Medicaid Budget Survey for FY16 and FY17; CMS list of approved Medicaid Health Home SPAs (May 2017); CHCS Medicaid ACO Fact Sheet (June 2017) as compiled in Deloitte. Health Policy Brief, Alternative Payment Models in Medicaid.

CMS Administrator Seema Verma

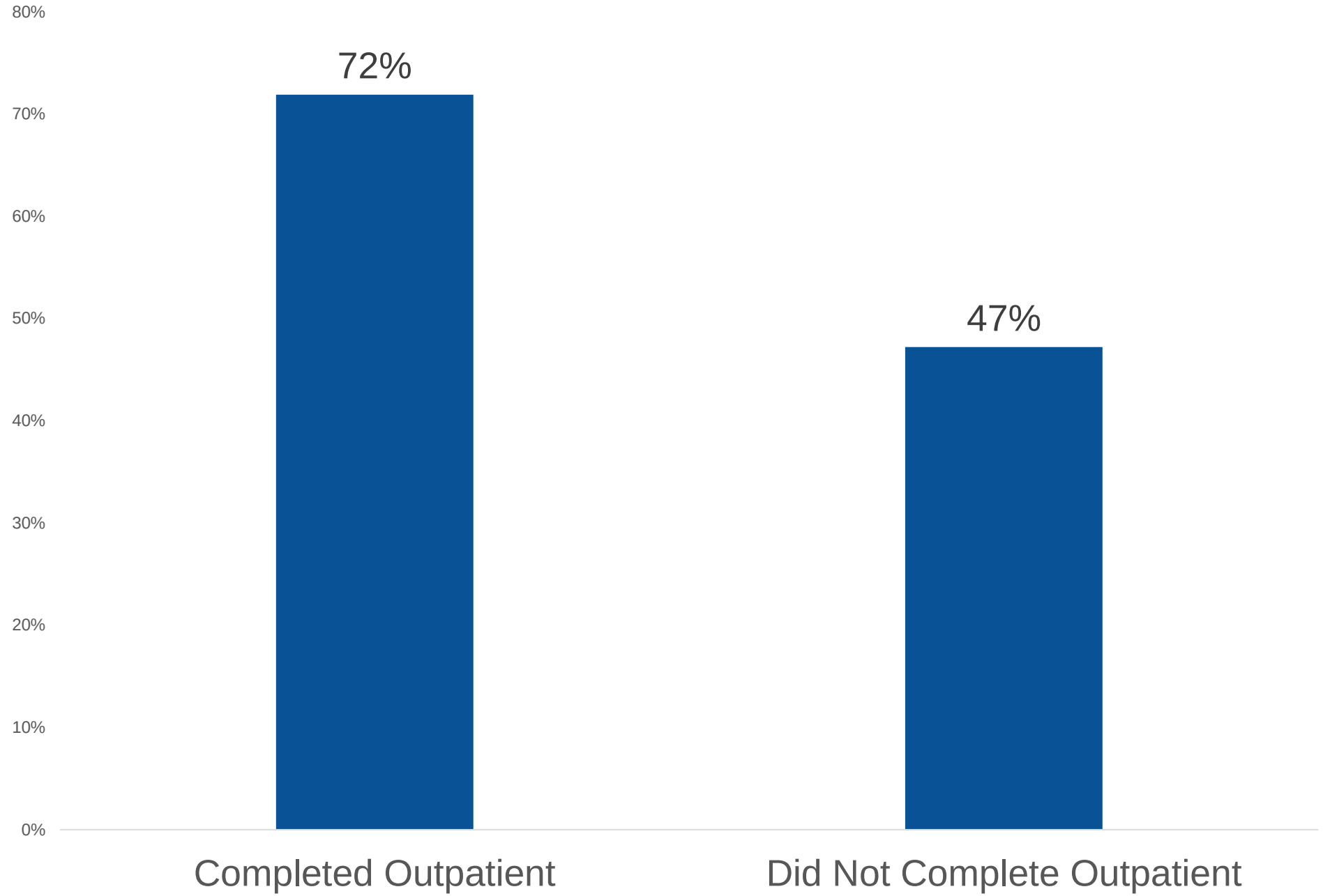
- We want accountability for Outcomes Not Process
- Be more flexible about “how” but tighter on the “what” outcome

Opportunities and Risks for SUD Providers

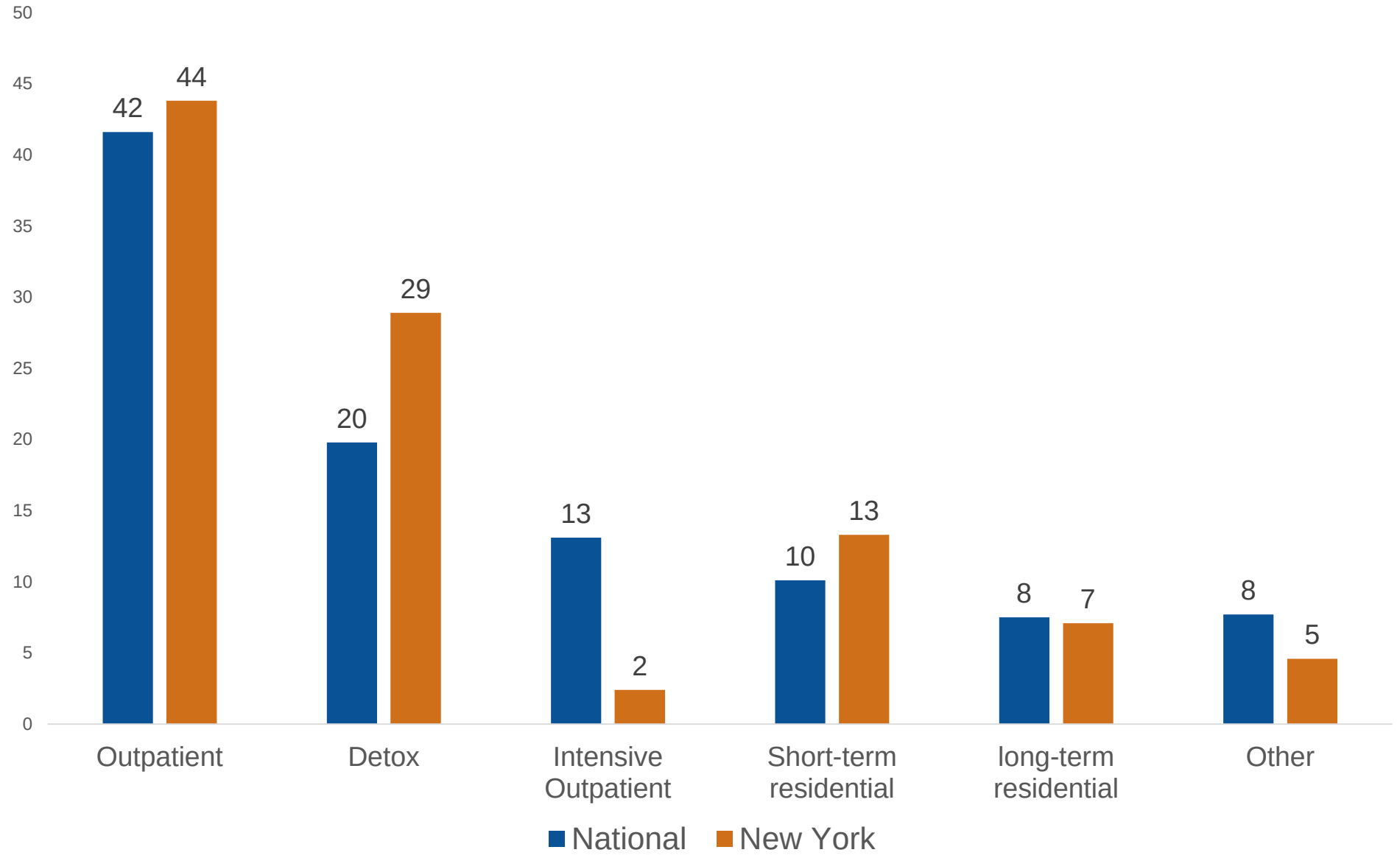
Outpatient Treatment Completion Rates



Outpatient Treatment Abstinence Rates at Discharge



Opportunities for Improvement? Mix of Services



Opportunities

1. Focus on outcomes
2. Obtain information to support continuous quality improvement
3. Gain flexibility to use whatever services and staff necessary to achieve outcomes
4. Access to information to support care coordination

1. Focus on Outcomes not Inputs

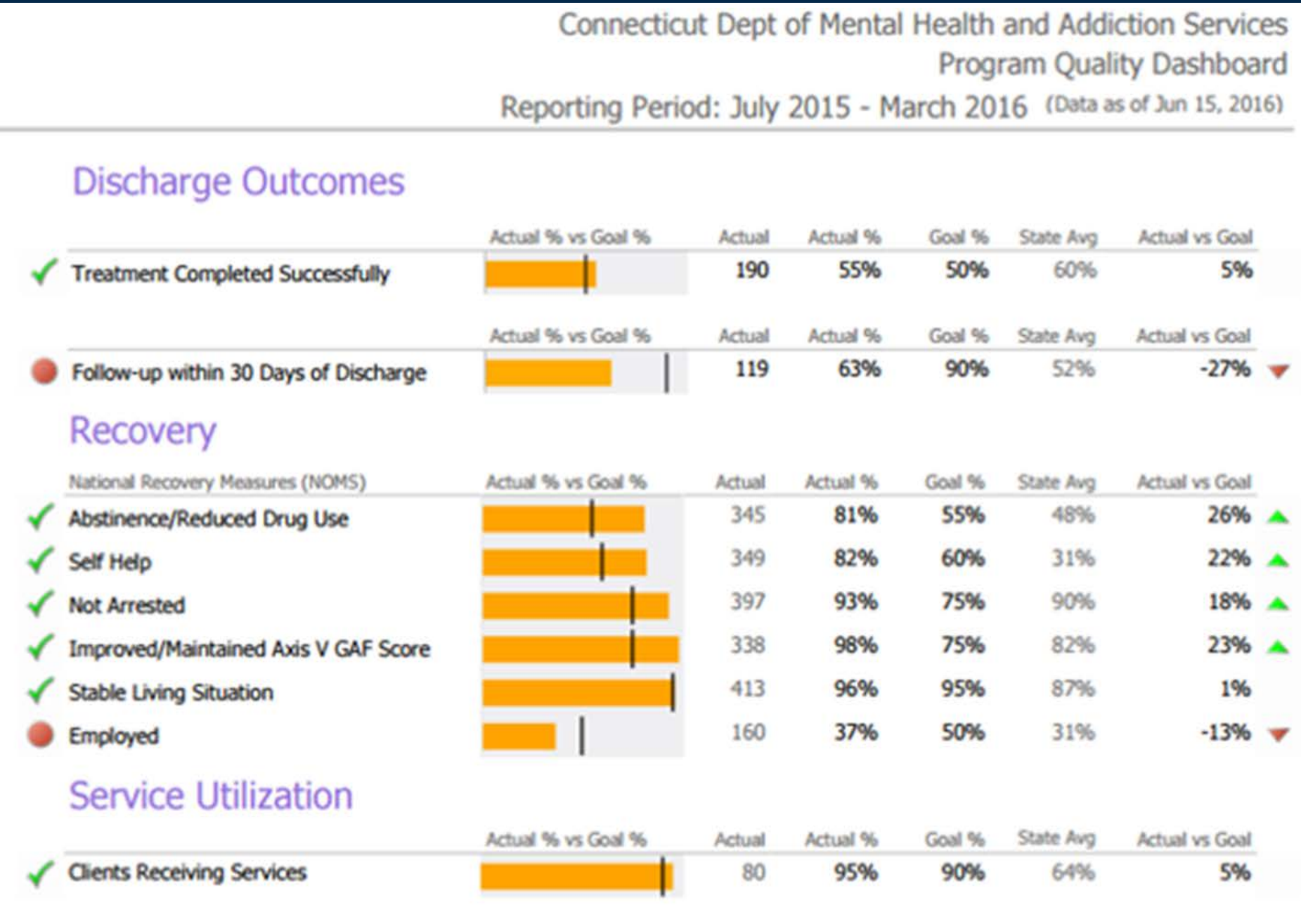
3. In the past 30 days (or 7 days if Follow-up), how many days have you felt depressed, anxious, angry or very upset throughout most of the day?

Intake (last 30d)		FU (last 7d)	Wk 1	Wk 2	Wk3	Wk4	Wk5	Wk6	Wk 7	Wk8
0	O	0 days	O	O	O	O	O	O	O	O
1-3	O	1 day	O	O	O	O	O	O	O	O
4-8	O	2 days	O	O	O	O	O	O	O	O
9-15	O	3 days	O	O	O	O	O	O	O	O
16-30	O	4 or more days	O	O	O	O	O	O	O	O

4. In the past 30 days (or 7 days if Follow-up), how many days did you drink ANY alcohol?

Intake (last 30d)		FU (last 7d)	Wk 1	Wk 2	Wk3	Wk4	Wk5	Wk6	Wk 7	Wk8
0	O	0 days (Skip to #6)	O	O	O	O	O	O	O	O
1-3	O	1 day	O	O	O	O	O	O	O	O
4-8	O	2 days	O	O	O	O	O	O	O	O
9-15	O	3 days	O	O	O	O	O	O	O	O
16-30	O	4 or more days	O	O	O	O	O	O	O	O

2. Data to Support Continuous Quality Improvement



Connecticut Dept of Mental Health and Addiction Services
Program Quality Dashboard
Reporting Period: July 2015 - March 2016 (Data as of Jun 15, 2016)

Discharge Outcomes

	Actual % vs Goal %	Actual	Actual %	Goal %	State Avg	Actual vs Goal
✓ Treatment Completed Successfully		190	55%	50%	60%	5%

	Actual % vs Goal %	Actual	Actual %	Goal %	State Avg	Actual vs Goal
● Follow-up within 30 Days of Discharge		119	63%	90%	52%	-27% ▼

Recovery

National Recovery Measures (NOMS)	Actual % vs Goal %	Actual	Actual %	Goal %	State Avg	Actual vs Goal
✓ Abstinence/Reduced Drug Use		345	81%	55%	48%	26% ▲
✓ Self Help		349	82%	60%	31%	22% ▲
✓ Not Arrested		397	93%	75%	90%	18% ▲
✓ Improved/Maintained Axis V GAF Score		338	98%	75%	82%	23% ▲
✓ Stable Living Situation		413	96%	95%	87%	1%
● Employed		160	37%	50%	31%	-13% ▼

Service Utilization

	Actual % vs Goal %	Actual	Actual %	Goal %	State Avg	Actual vs Goal
✓ Clients Receiving Services		80	95%	90%	64%	5%

3. Flexibility in Services Delivered

- Health Homes
- Certified Community Behavioral Health Centers

Shifting reimbursement from fee-for-service to capitated payment gave providers flexibility to provide the services their patients need

4. Access to Data and Information Technology to Support Coordination of Care

Risks

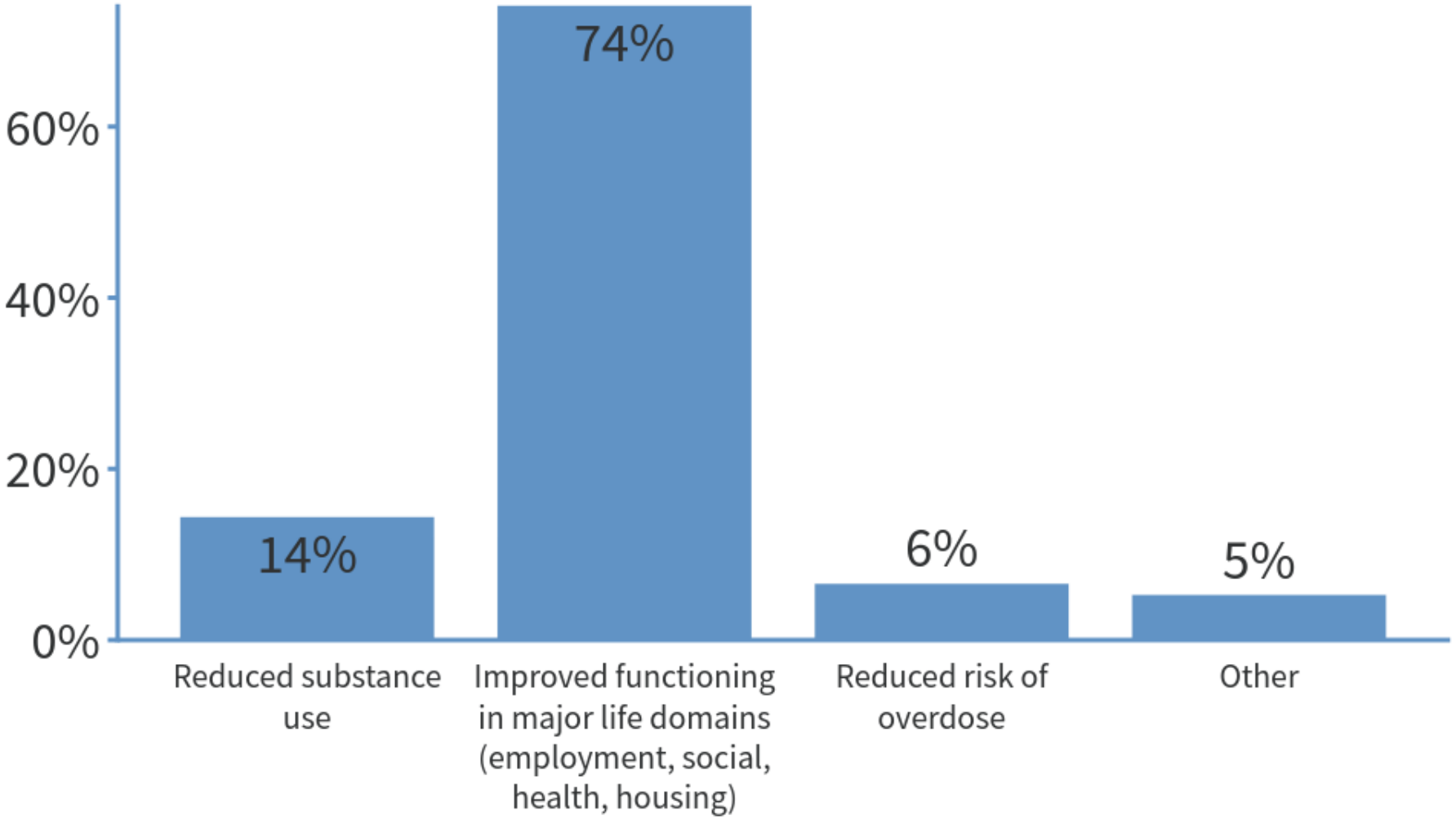
- Merging of “protected funding”
- Quality metrics irrelevant to your patients
- Maintaining data systems (TEDS/NOMS)
- Financial risk

Do you have your personal device?

To participate fully today, please text the word SUDVBP to 22333 or go to PollEv.com/sudvbp from your web browser.

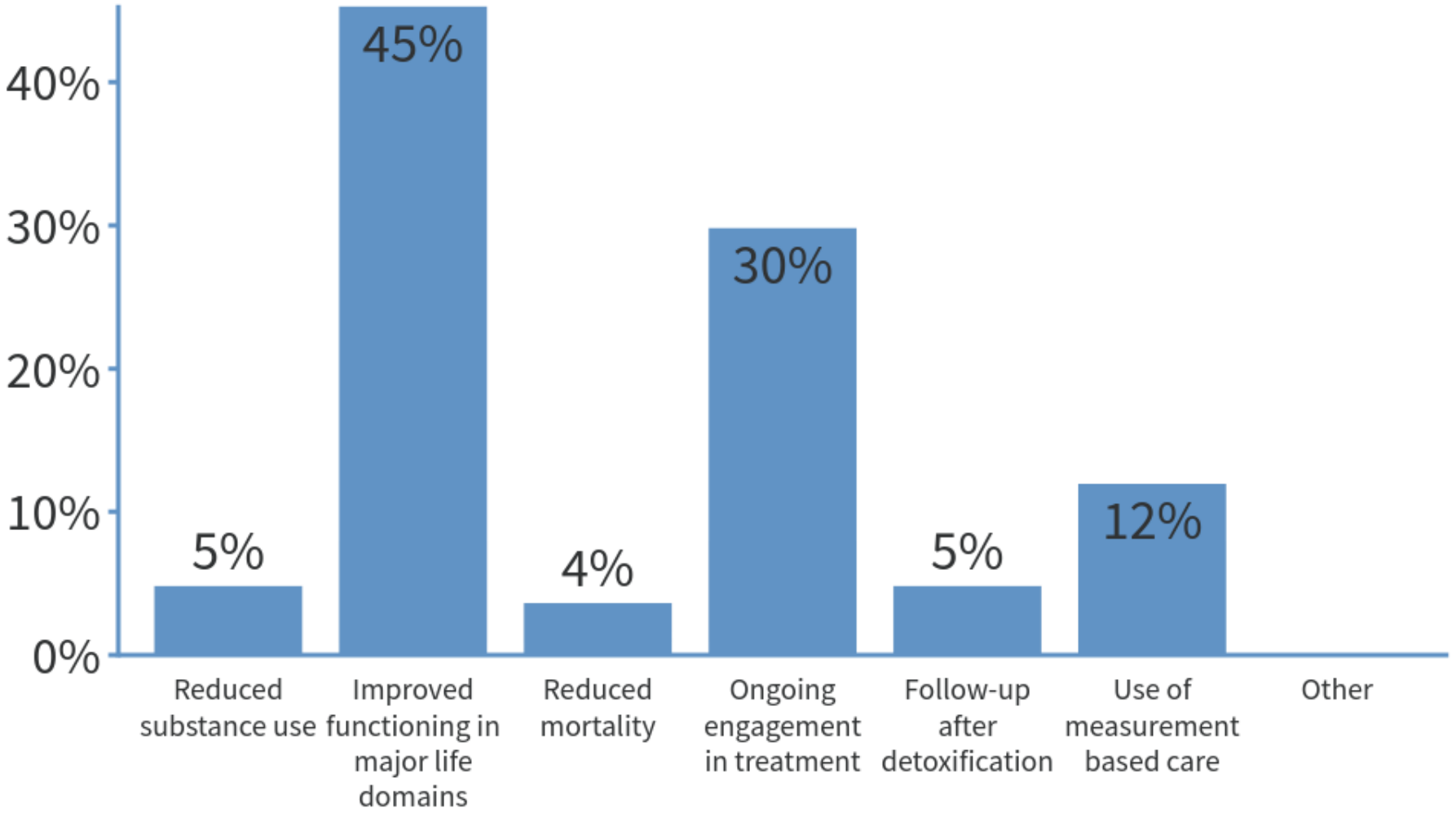
What is the most important outcome from addiction treatment to patients?

Poll locked. Responses not accepted.



What outcomes is most important to hold addiction providers accountable for?

Poll locked. Responses not accepted.



More Information

Tami L. Mark, PhD, MBA

Senior Director, Behavioral Health

RTI International

301.816.4612

Tmark@rti.org

Comments? Questions?