BUILDING BLOCKS OF MANAGED CARE, PART 2:

PLANNING FOR CHANGE TO SUPPORT MANAGED CARE FOR BEHAVIORAL HEALTH

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INTEGRATED CARE DC
A learning community for District of Columbia Medicaid providers

PRESENTED BY:
Dr. Art Jones, HMA

Tuesday,
May 9, 2023
11:00 am – 12:00 pm ET

Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the U.S. Department of Health and Human Services (HHS). A total of $3,500,365, or 81 percent, of the project is financed with federal funds, and $810,022, or 19 percent, is funded by non-federal sources. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, HHS or the U.S. Government.

DHCF Department of Health Care Finance

HMA

SECTION TOPICS

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- Managing the Health of a Population
- Measuring Behavioral Health Quality
- The Move to Value-Based Payments
- Clinically Integrated Networks and the Role of Behavioral Health
- Questions and Answers

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MANAGING THE HEALTH OF A POPULATION

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Population (Health)care

Dealing with symptoms and disease treatment. Focus on prevention **proactively**.

Population (Sick)care

Dealing with symptoms and disease treatment **reactively**.

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POPULATION HEALTH: DEFINITIONS AND CONCEPTS

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"The health outcomes of a group of individuals, including the distribution of such outcomes within the group; It has been described as consisting of three components. These are **health outcomes**, **patterns of health determinants**, and **policies and interventions**."

Population Health Science	Population Health Action
Identification and measurement of outcomes	Programs developed and implemented to effectively and efficiently provide care for members of a population in a way that is consistent with the community's cultural, and health resource values (adapted from IHI and AMA).

Source: Kindig D, Stoddard G (March 2003) American Journal of Public Health, 93 (3): 380-3

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3 ELEMENTS OF POPULATION HEALTH

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Physical Health	Behavioral and Emotional Health	Social Health
• State of preventive care • Risk for a disease • Presence of a disease/ condition • Multiple conditions	• Base emotional health • Behavioral risk factors • Behavioral conditions	• Food • Housing • Economic stability • Transportation • Education • Employment • Safety/Violence • Caregiver access • Etc.

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POPULATION HEALTH FOCUS AREAS

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STEPS TOWARDS ACHIEVING POPULATION HEALTH

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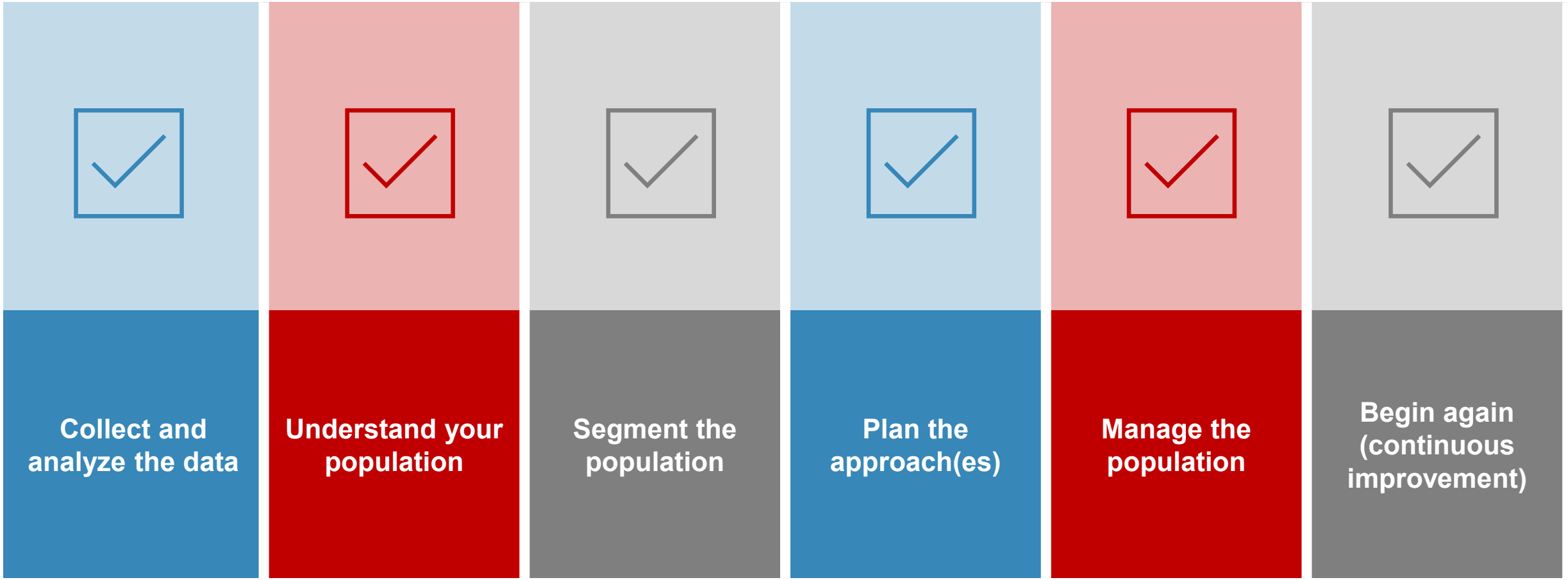

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POPULATION HEALTH ATTRIBUTES

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Member-centric: *Population-based*	**Data-Driven:** *always*	**Evidence-Based:** *including innovative approaches*	**Comprehensive**
Addressing Health Equity	**Working with Providers/Plans:** *enabling involving the populations that they serve*	**Incenting Providers:** *using true Value-Based Contracting; this aligns interests*	**Measuring Outcomes and the Tasks that Drive Those Outcomes**

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POPULATION HEALTH DATA COMPONENTS

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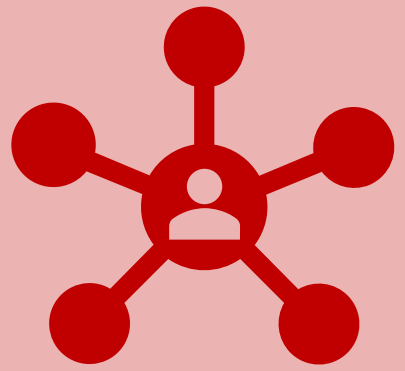
General Population



Attribution: Your Population of Focus

Individual Members of the Population of Focus

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DATA FOR THE GENERAL POPULATION

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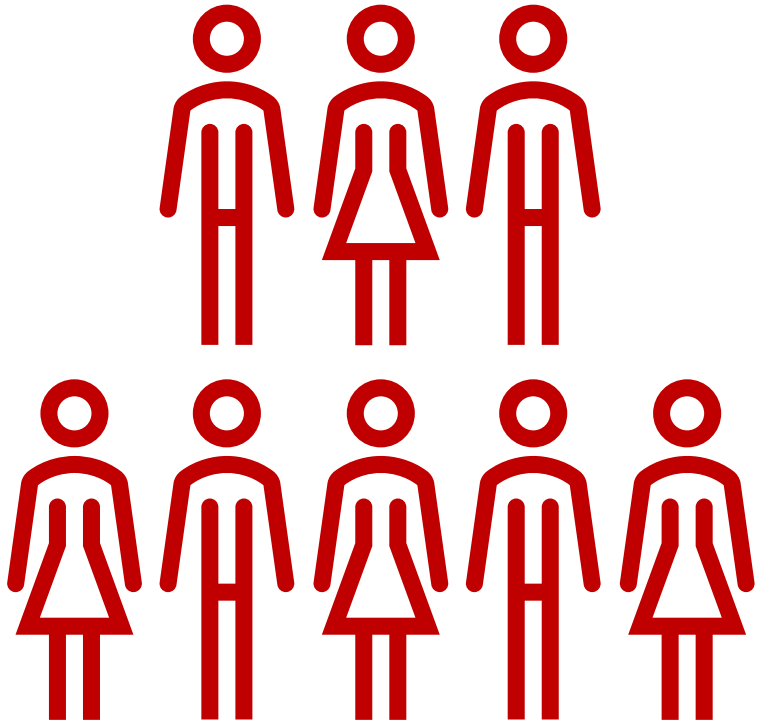
1. Census Data
2. Public Health Data
3. Personal Social Data
4. Accumulated Claims Data



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DATA FOR INDIVIDUAL MEMBERS OF THE POPULATION OF FOCUS

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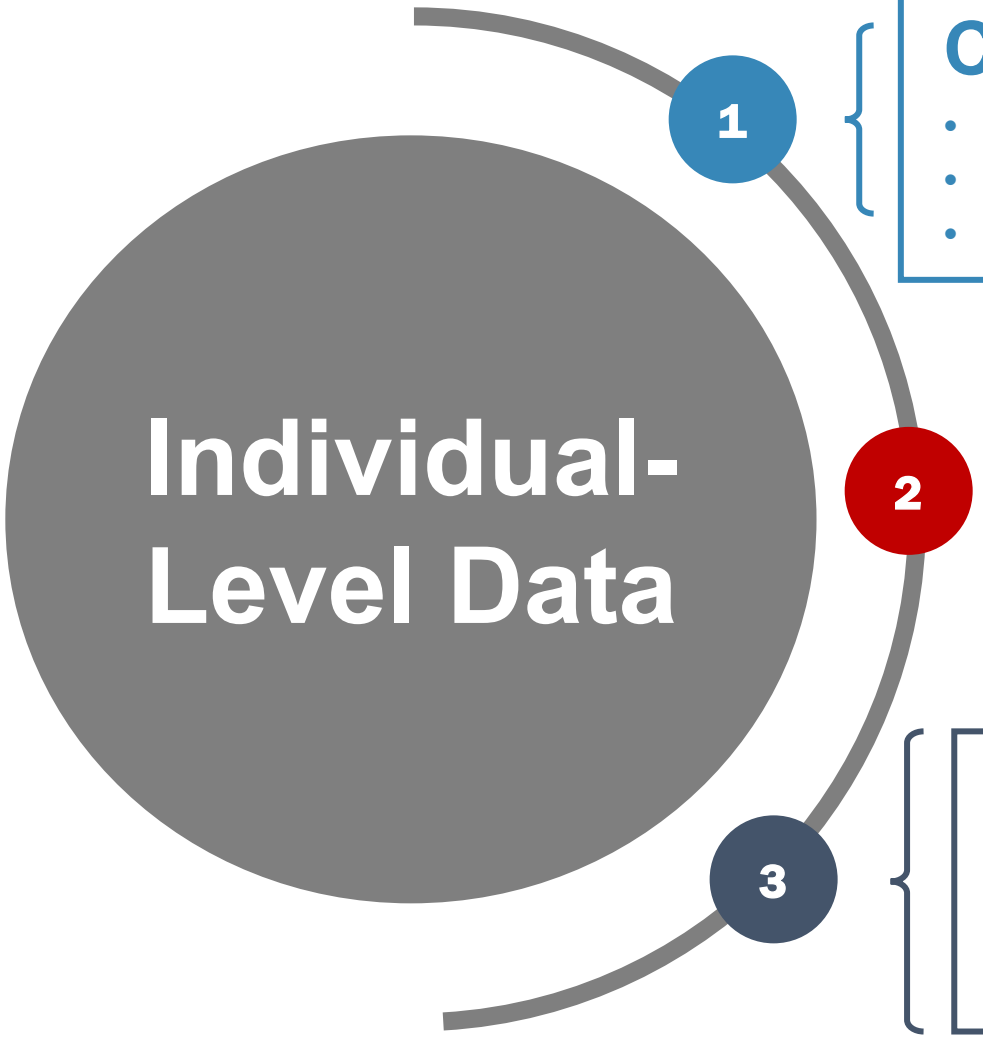

Claims Data:

- Not timely
- Not precise
- Still the **mainstay**

Clinical Data:

- EMR
- HIE and ADT
- Pharmacy

Member-Reported Data:

- Critical (especially for SDoH)
- The Health Risk Assessment

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KEEPING MEMBERS HEALTHY

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1. Prevention
2. Acute Episodic Care
3. Health Risks
4. Stable Physical Condition Management Programs
5. Stable Behavioral Health
6. Stable Social Health

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Source: Photo by Alexis Brown on Unsplash

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BARRIERS TO A SUCCESSFUL POPULATION HEALTH PROGRAM

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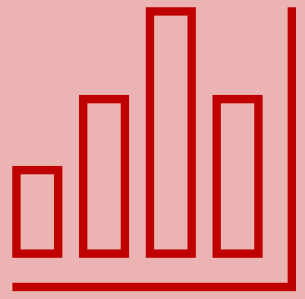
Lack of Data



Lack of Data tools/decision support

Lack of incentive alignment

Provider Culture

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THE CURRENT STATE OF THE DC HIE

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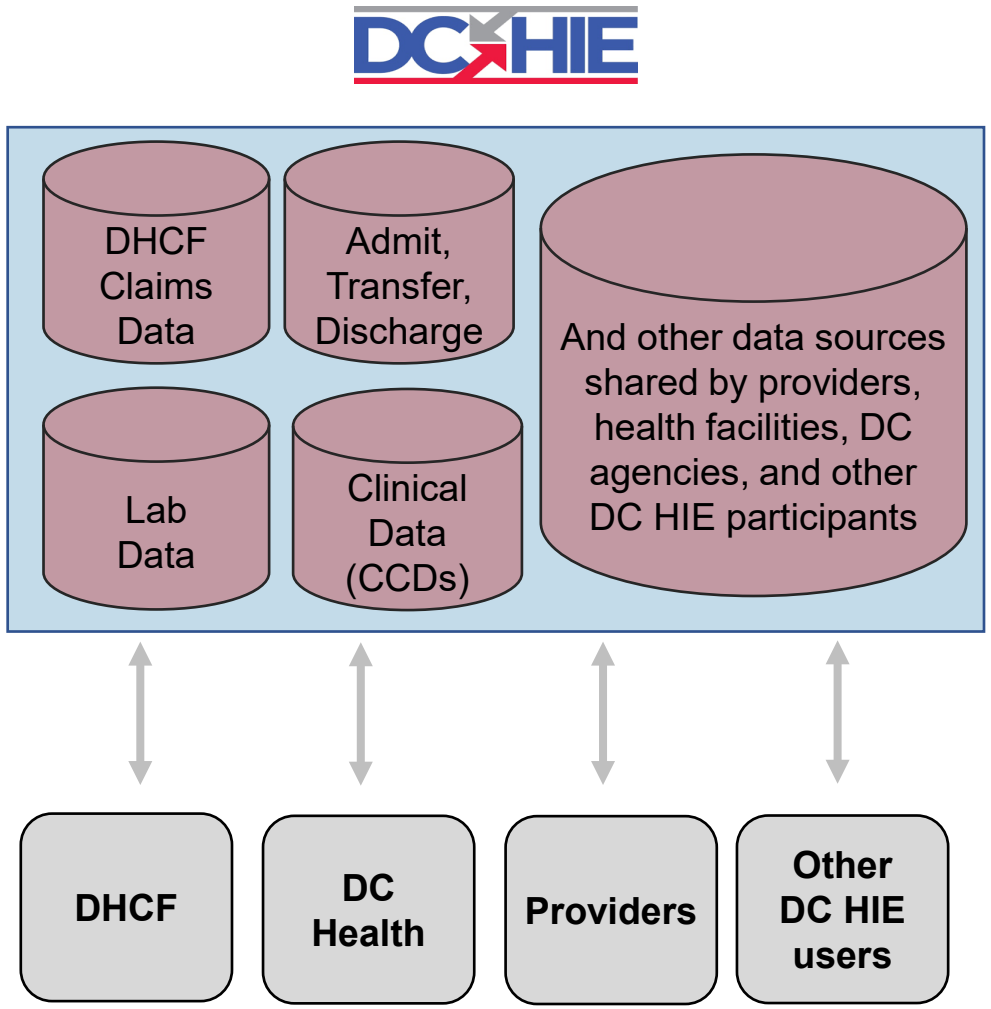
- The **DC Health Information Exchange (DC HIE)** is a health data utility that enables the secure, electronic exchange of health information among participating organizations. DHCF designated CRISP DC to serve as the District's HIE.
- DC HIE users can:
  - View the same content via the same interface, but for different panels – depending on which population they serve
  - View data at the individual-level, panel-level, and in the aggregate from disparate sources
  - Have greater transparency across entities involved in an individual's care delivery



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MEMBER DATA SOURCES- IDEAL STATE

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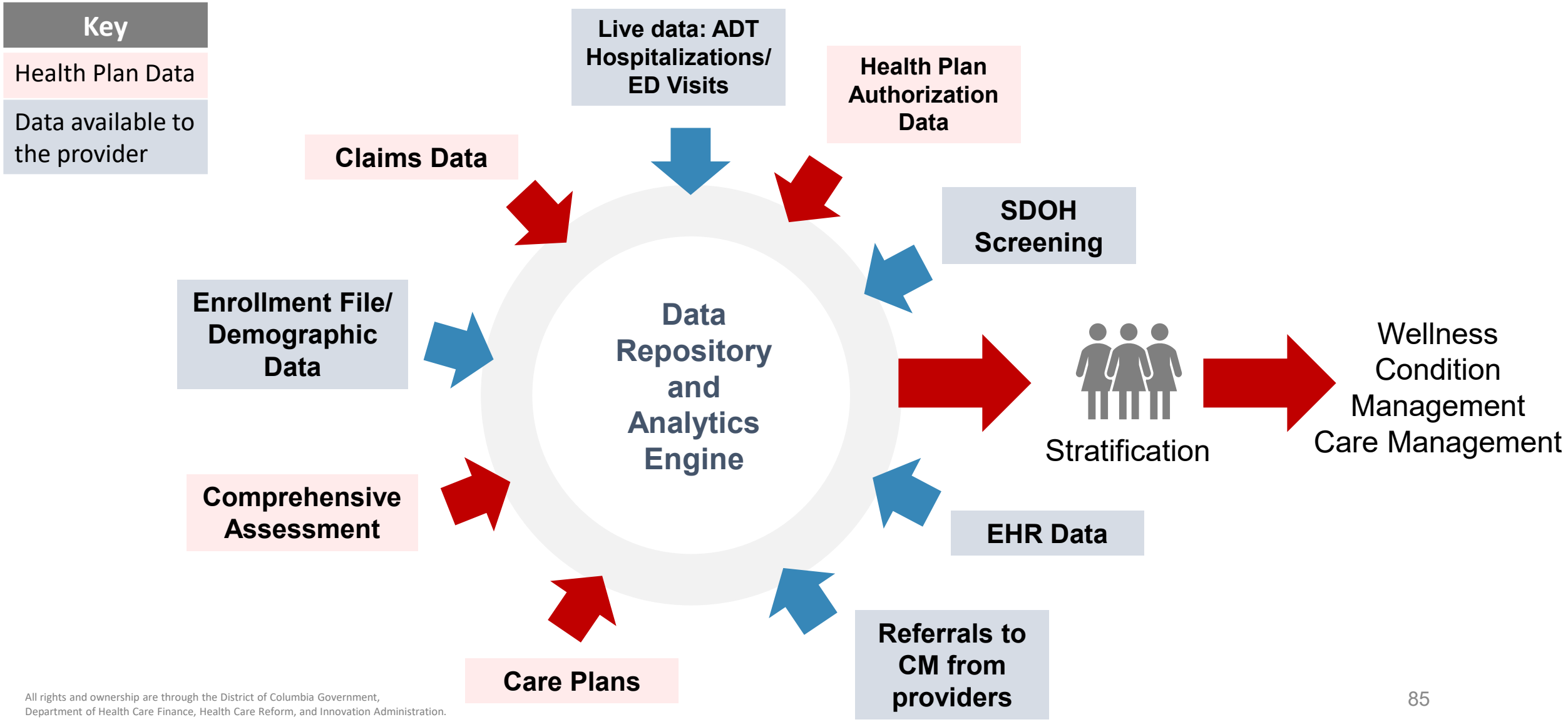

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EMERGING RISK

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Physical	Behavioral	Social
• One or two conditions that are not stable • Condition management programs • ER and hospital utilization	• Unstable condition • ER and hospital utilization • Low adherence to prescribed medications	• Unstable life situation coupled with PH or BH issues

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DYNAMIC RISK STRATIFICATION

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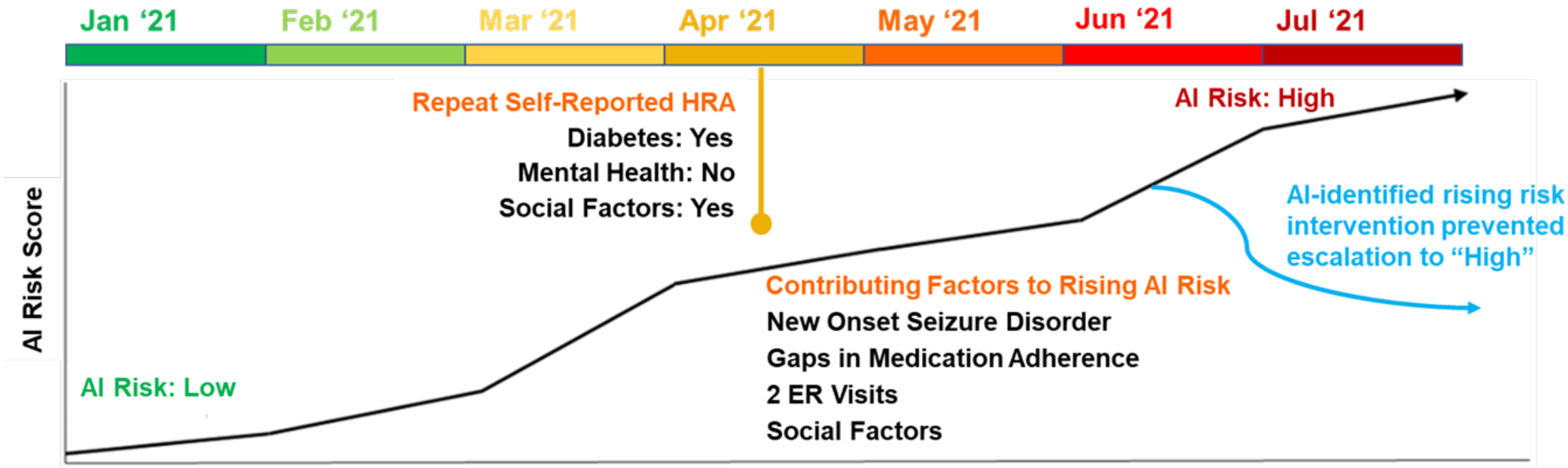

Source: Medical Home Network, 2021.

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MEASURING BEHAVIORAL HEALTH QUALITY

STATES' COLLECTION AND USE OF MEDICAID BH PERFORMANCE MEASURES: 2022

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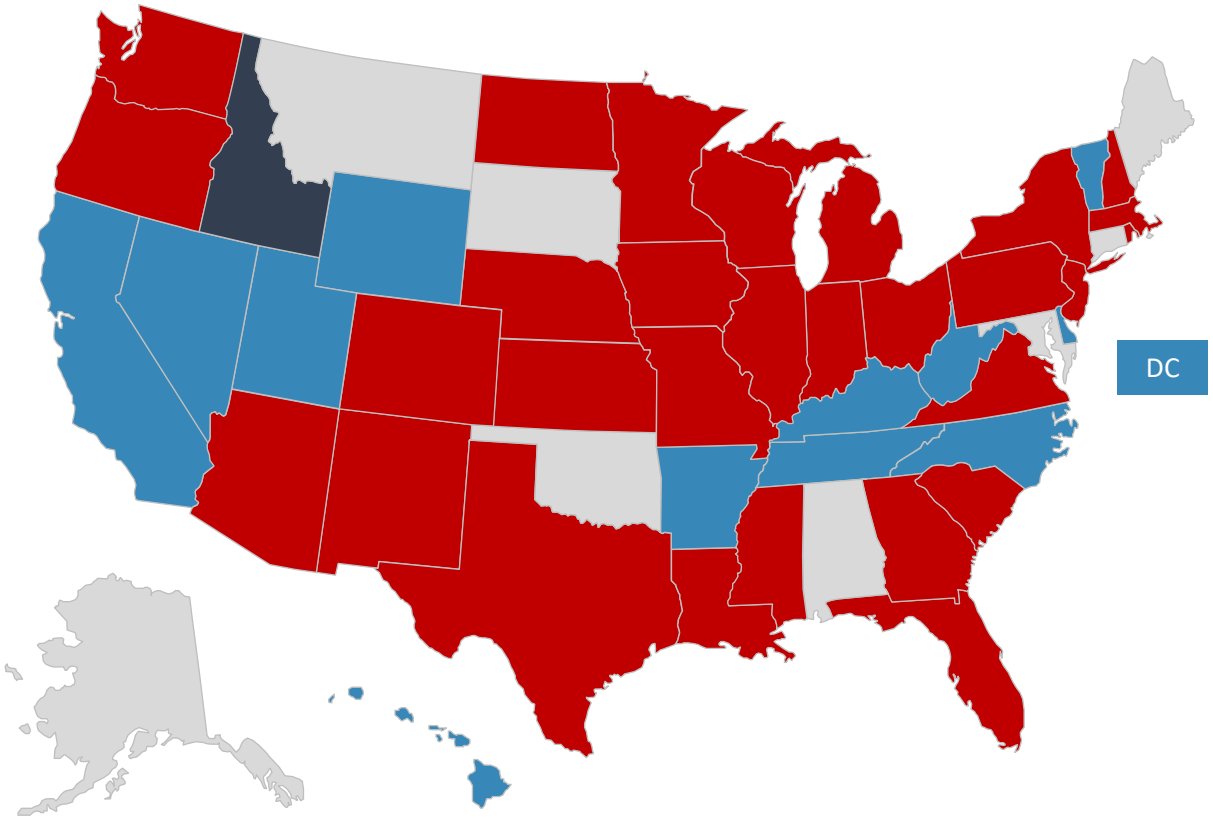
Collects Metrics

Uses Metrics in Payment

Does Not Collect Metrics

Does Not Manage BH



Source: National Academy for State Health Policy: State Use of Behavioral Health Performance Measures in Medicaid Managed Care Contracting. April 2023

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IMPROVING POPULATION HEALTH OUTCOMES

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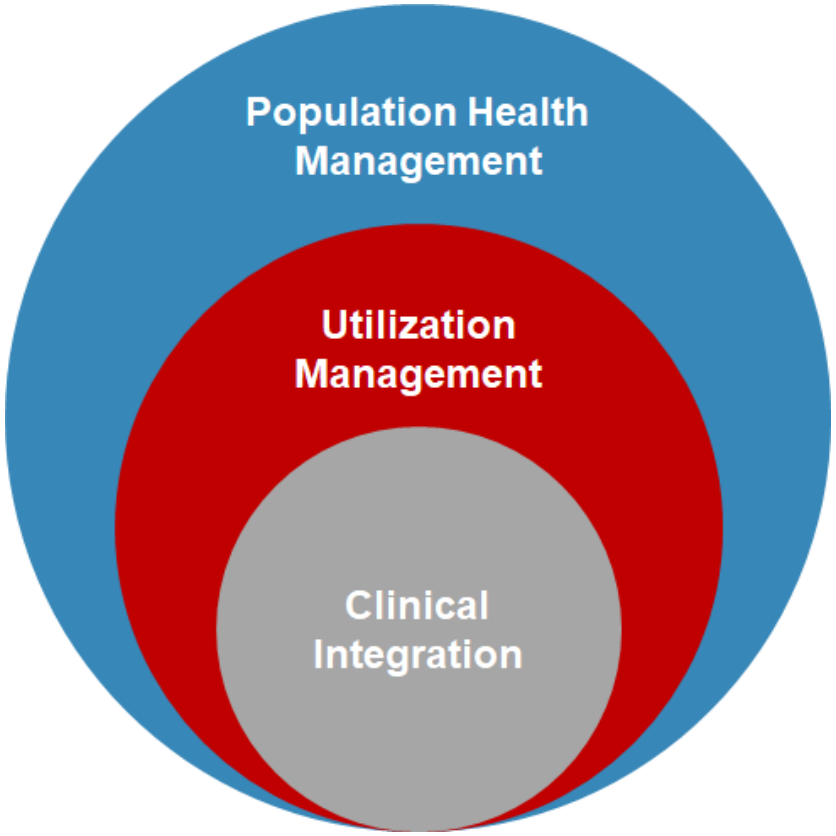

Population Health Management: Provider and plan activities

- Data aggregator and analytics
- Stratify population by health risk
- Individualize care plans
- Care management
- Promote patient engagement

Data-driven quality of care

Utilization Management: Provider and plan activities

- Standardize utilization of resources
- Cost containment
- Managing risk and outcomes

Accountable care

Clinical Integration: Primarily provider-driven activities

- Provider integration
- Patient-centered medical home
- Referral management
- Patient access
- Team-based care

Coordinated care

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DHCF BEHAVIORAL HEALTH HEDIS METRICS FOR MCOS

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Screening for Depression and Follow-Up Plan

Follow-Up After Hospitalization for Mental Illness

Follow-Up After Emergency Department Visit for Mental Illness

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Screening for Depression and Follow-Up Plan

- The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and,
  - if screened positive, received follow-up care within 30 days of a positive depression screen finding.

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Follow-Up After Hospitalization for Mental Illness

- The percentage of discharges for members ages 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Follow-up visits that occur on the same day as the IP discharge do *not* count. Follow-up is reported:
  - within 30 days after discharge
  - within 7 days after discharge.

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Follow-Up After Emergency Department Visit for Mental Illness

- The percentage of emergency department (ED) visits for members ages 6 and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness. Follow-up visits *can* occur the same day as the ED discharge. Follow-up is reported:
  - within 30 days of the ED visit (31 total days)
  - within 7 days of the ED visit (8 total days)

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OTHER NCQA HEDIS BEHAVIORAL HEALTH METRICS

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- Follow-Up Care for Children Prescribed ADHD Medication
- Antidepressant Medication Management
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia

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OTHER NCQA HEDIS BEHAVIORAL HEALTH METRICS (CONTINUED)

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- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications
- Follow-Up After Emergency Department Visit for Substance Use
- Follow-Up After High-Intensity Care for Substance Use Disorder
- Initiation and Engagement of Substance Use Disorder Treatment

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VALUE-BASED CARE

DEFINING VALUE-BASED CARE (VBC) AND ALTERNATIVE PAYMENT METHODOLOGIES (APMS)

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- Under VBC arrangements, providers are reimbursed based on their ability to improve quality of care in a cost-effective manner, or to lower costs while maintaining standards of care, rather than the volume of care they provide.[1]
- Alternative payment methodologies (APMs) refer to payment approaches that incentivize providers for delivering high-quality, cost-efficient care, such as bonuses for achieving specified quality and cost benchmarks, or shared savings for delivering services at a lower cost.[1,2]
  - APMs can apply to a provider type, clinical condition, care episode, or population
  - APMs vary by complexity and risk[1,2]

[1] Centers for Medicare & Medicaid Services. Fact Sheet. Value-based Care State Medicaid Directors Letter (September 15, 2020). https://www.cms.gov/newsroom/fact-sheets/value-based-care-state-medicaid-directors-letter.
[2] Health Care Payment Learning & Action Network (HCPLAN or LAN). Updated APM Framework. https://hcp-lan.org/apm-framework.

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VBP SPREAD IN MEDICAID

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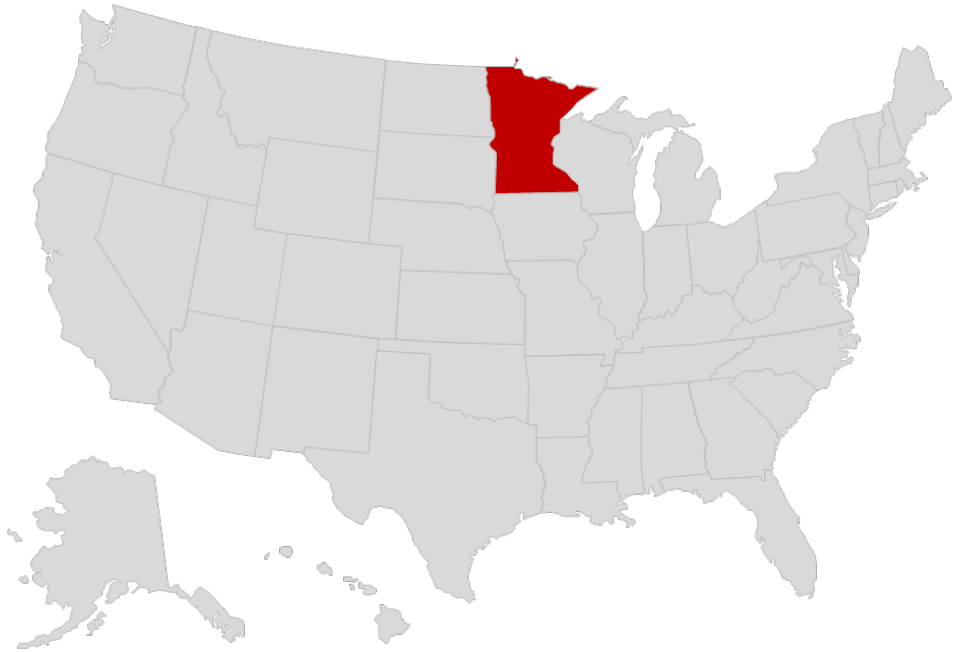
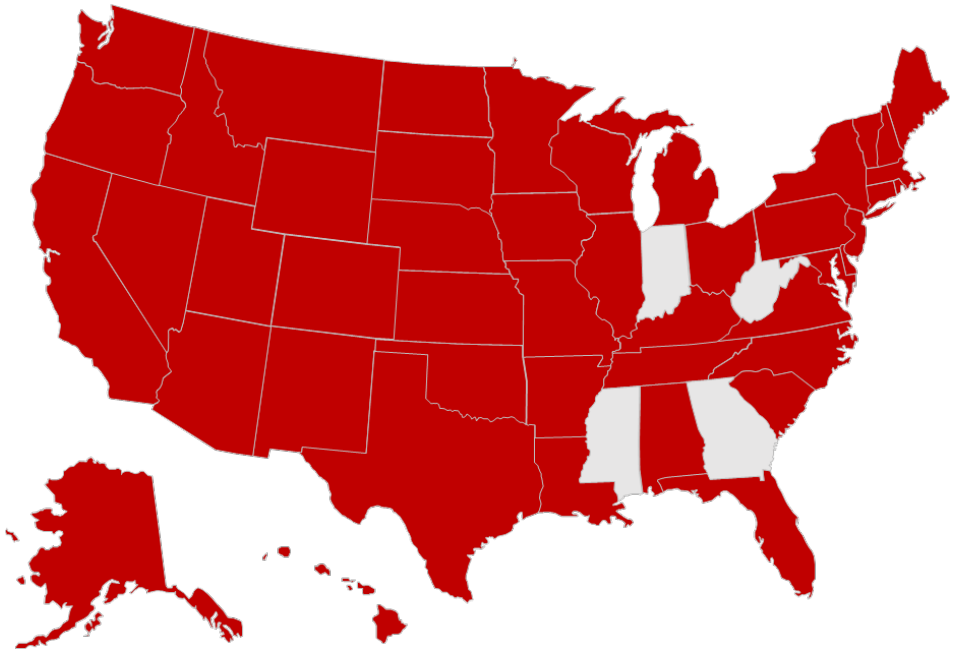
2008



2019



Value-Based Reimbursement State-By-State: A 50-State Matrix Review of Value-Based Payment Innovation. Change Healthcare, 2019.

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THE GLIDEPATH TO MORE ADVANCED ALTERNATIVE PAYMENT MODELS (APMS)

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Pay for Performance	Upside	Upside and Downside	Bundled Care	Capitation
» Usually, quality-gap based	» No risk for provider	» Begins risk for providers	» Provider risk is specific but high in cases	» Typically, as a percent of premium for full capitation
» Was around for decades	» Can be with or without "quality gates"	» Real financial alignment	» Alignment of finances	» Partial arrangements also exist
» Does not really align finances in a meaningful way	» Begins alignment of finances	» Requires two-way data connections for success	» Almost always procedure based	» High financial alignment
» No risk for provider			» Some interesting disease-based arrangements exist	» *"Bill Aboves"* may exist

Less Complex → More Complex

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PROVIDER ENGAGEMENT

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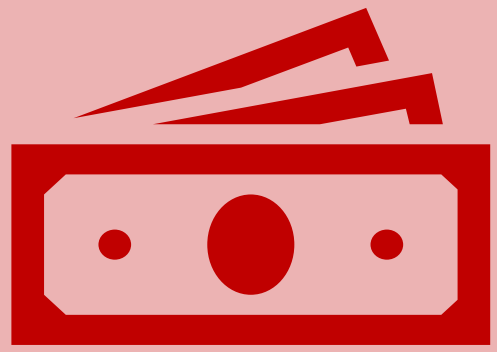
The best population health management is provider-driven, or at least *heavily* provider involved.



Value-based contracting is critical to success.

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HCP LAN FRAMEWORK: ACCOUNTABILITY, INTEGRATION, AND RISK GO TOGETHER

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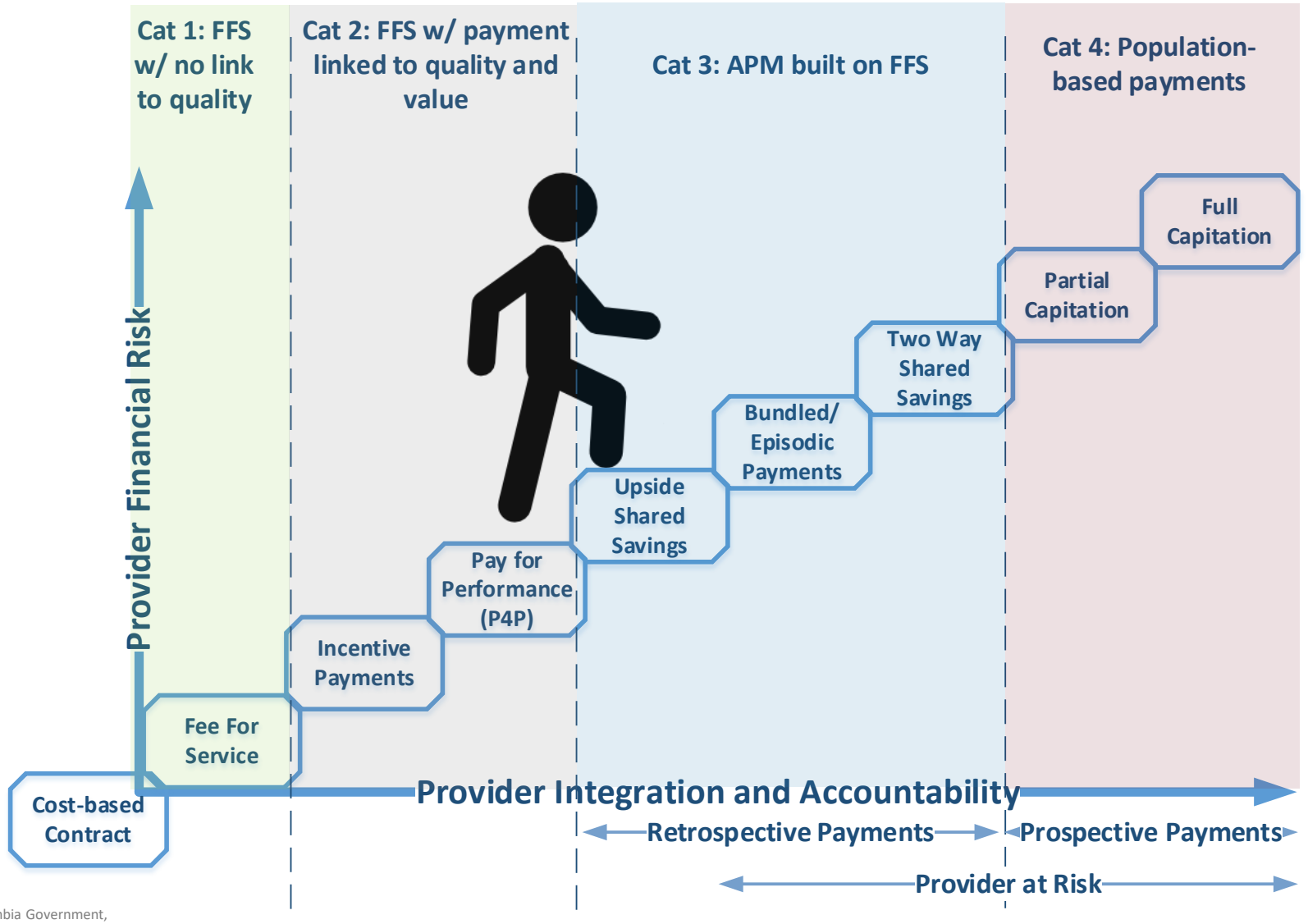

Source: The MITRE Corporation. (2017). *Alternative payment model (APM) framework - HCPLAN*. Health Care Payent Learning & Action Network. Retrieved May 5, 2023, from https://hcp-lan.org/workproducts/apm-whitepaper.pdf

HCP LAN Framework

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CLINICALLY INTEGRATED NETWORKS AND THE ROLE OF BH

VBP ADVANTAGES PROVIDERS WITH CERTAIN CHARACTERISTICS

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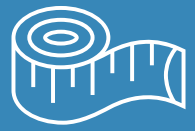
Size



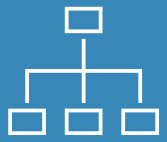
Sophistication

Data Capture and Analysis Capacity

Risk-Readiness

Strong, Strategic Leadership

Administrative Depth



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THE ROLE OF CLINICALLY INTEGRATED NETWORKS (CINS)

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- Enable providers to participate in sophisticated value-based payment arrangements beyond what they might be able to do on their own
- Leverage both size and geographic coverage that the network brings to the payer
- Secure data and the means of analysis to support it
- Facilitate improvement in provider operations, patient satisfaction, and clinical performance for all participants
- Insulate providers from financial risk under VBP arrangements by contracting with MCOs at the network level
- Enable providers to expand their current offerings to their patients and expand their capacity to treat patients in their community

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CIN GOVERNANCE AND COMMITTEE STRUCTURE

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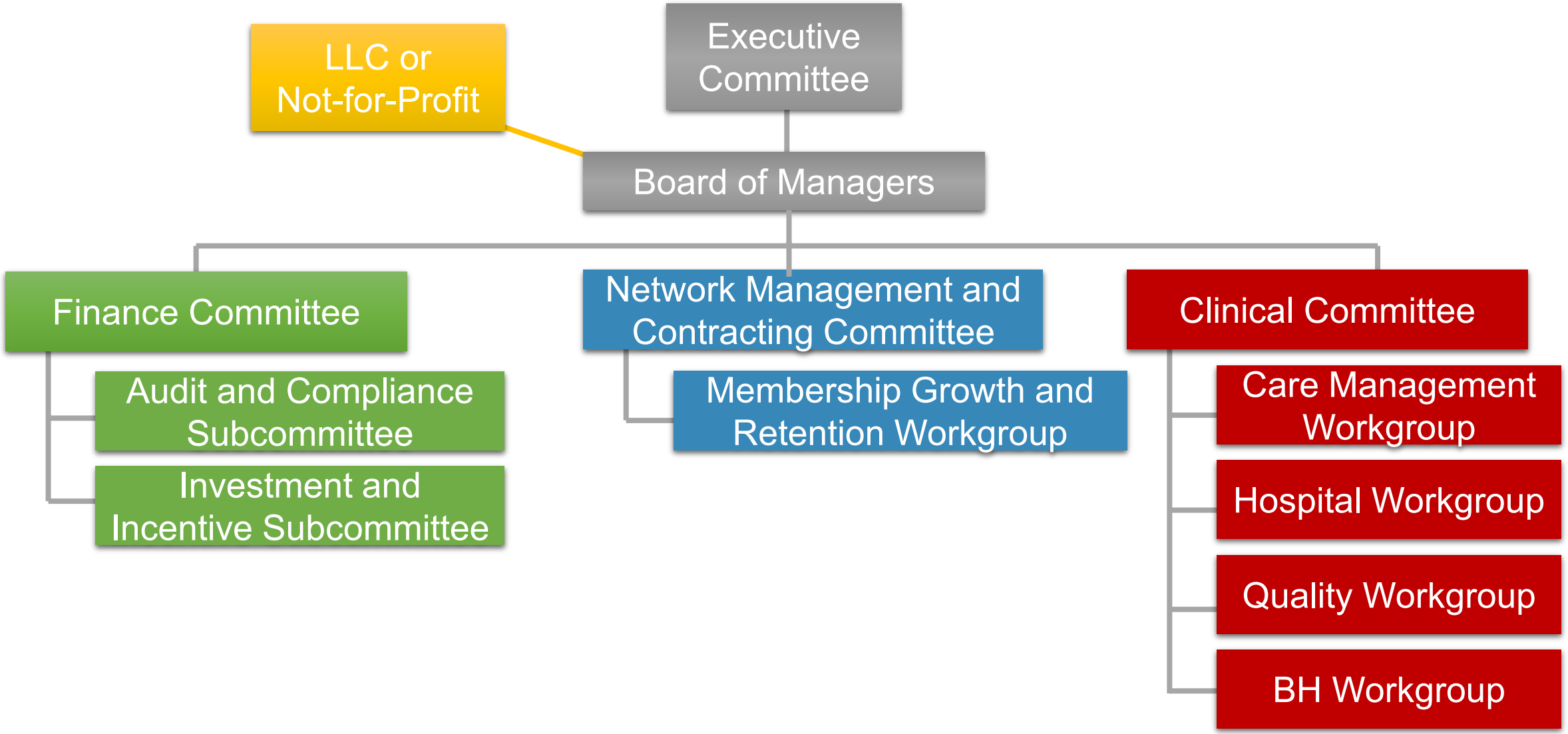

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CONTRACTING AS PART OF CINS UNDER VALUE-BASED PAYMENT

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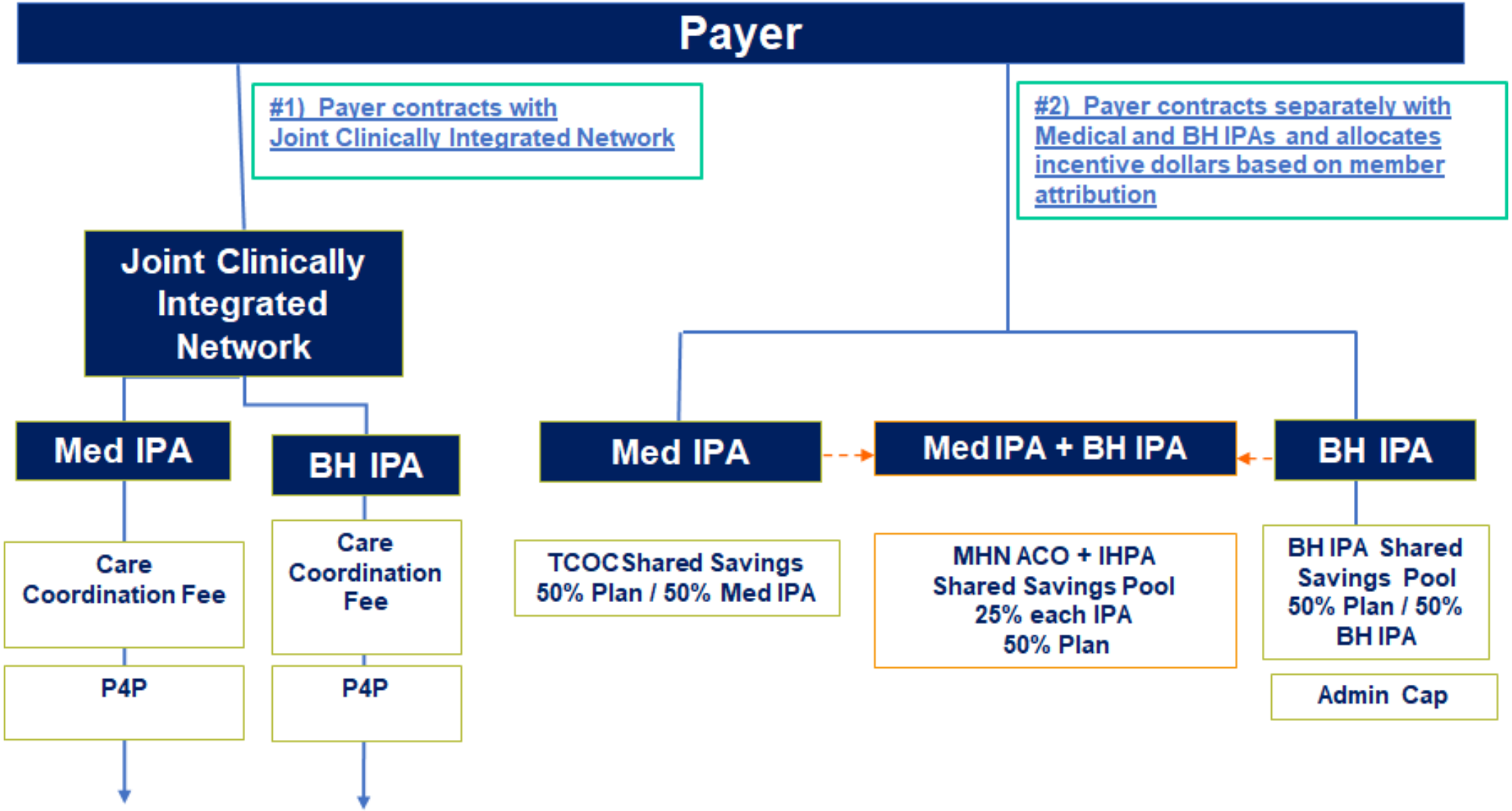

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QUESTIONS

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