Behavioral Health and Payment Reform

MASSACHUSETTS HEALTH COUNCIL “INTEGRATION OF BEHAVIORAL HEALTH CONFERENCE”

April 3rd, 2014
Founded in 1996, Beacon coordinates the MH/SA benefit for approximately 1 million Massachusetts residents.

DIVERSE GEOGRAPHY AND EXPERIENCE

- **Health Plan Customers**
  - Neighborhood Health Plan
  - Fallon Community Health Plan
  - Boston Medical Center HealthNet Plan
  - Senior Whole Health
  - Group Insurance Commission

- **Massachusetts Populations Served**
  - Employers
  - TANF
  - Medicare Advantage
  - Medicaid/ Long-Term Disabled
  - Foster children
  - Homeless populations
  - Dually eligible
  - Children and adults with autism
  - PACE Program
  - Seriously Mentally Ill/ SED

- Headquartered in *Boston with major service center in Woburn and 8 field locations serving some 11 million members nationwide.*
- Statewide network of providers
1. BH conditions affect approximately 26% (58 million) of US adults Archive of General Psychiatry 2005; 62(6) 617-627

2. ACA will likely add 3.7 million individuals with SMI and many more with less severe conditions into the insurance system American Journal of Psychiatry 2011; 168(5) 486-494
National Payment Reform Models Have Been Largely Silent on Incorporating Behavioral Health

<table>
<thead>
<tr>
<th>Patient Centered Medical Home</th>
<th>Health Homes</th>
<th>Accountable Care Organizations</th>
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<tbody>
<tr>
<td>• An model of care whereby primary care is the cornerstone for a member’s total healthcare needs</td>
<td>• 90% Federal match on care mgmt/care coordination</td>
<td>• Provider-led organization managing full continuum of care</td>
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<td>• Population-based interventions designed to meet the needs of mild BH conditions</td>
<td>• Eligibility includes 2 or more chronic conditions, 1 chronic condition and at-risk for another chronic issue or serious MH condition</td>
<td>• Accountable for overall costs and quality for a defined patient population</td>
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<td>• Technological enhancements (EMRs); data sharing</td>
<td>• Emphasis on linkage to natural community supports</td>
<td>• Shared savings models based on spending target encourages coordination of BH care</td>
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<td>• National quality standards (e.g. NCQA)</td>
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<td>• Partial or full capitation models</td>
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<td>• State Innovation Model Grants</td>
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Of the 33 quality measures CMS included to hold ACOs accountable to quality, only 1 (screening for depression) is directly related to Behavioral Health.
Essential Tools for BH Providers to Succeed in Payment Reform

1. Nimble and robust IT platform
   a) EMR with behavioral health functionality
   b) Ability to share care planning information
   c) Ability to track patient experience inside and outside of primary delivery site
   d) Ability to identify member’s PC/specialty providers and to track and act upon bi-directional communications

2. Strong analytic infrastructure
   a) Ability to track and quantify utilization of services
   b) ROI analysis capability

3. Service delivery flexibility
   a) Development of new programming to contain utilization in the least restrictive, most clinically appropriate setting
BH Payment Reform Requires a System-wide Paradigm Shift

FFS payment accounts for >85% of BH provider payments in Massachusetts (both acute and ambulatory.) Payment Reform and Cost Containment will not succeed without a system-wide paradigm shift in how payers pay, and how providers accept compensation. Shifting from volume payments to value-based payments.

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<tr>
<th>Payment Method</th>
<th>Key Elements</th>
<th>Pros</th>
<th>Cons</th>
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<tr>
<td>Fee-for-Service</td>
<td>Provider compensated a set fee for each service provided</td>
<td>Fixed revenue per unit of service</td>
<td>FFS perpetuates overutilization</td>
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<td>Sub-Capitation</td>
<td>Provider receives a set amount “capitation” per member/per month to cover all services</td>
<td>Encourages internal utilization management of all services</td>
<td>Very nature of BH makes predictability of capitation challenging for smaller providers</td>
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<td>Shared Savings/Risk Adjustment</td>
<td>Payer and provider agree to a risk-adjusted comprehensive payment for a defined membership, i.e., all of a payer’s members in a PCP panel, often with an opportunity for a quality add-on based on outcomes</td>
<td>Discourages overutilization Risk adjustment accounts for BH complexity Aligns payment with desired outcomes</td>
<td>Provider must have a sophisticated infrastructure (Actuarially sound and operationally strong) to track and coordinate care</td>
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The BH Delivery System has Inherent Challenges to Achieving Payment Reform

1. Broad continuum of care not offered by all providers

2. Member choice – “leakage consideration”

3. Access to specialty services limited in certain areas

4. Risk involves ability to handle losses – providers often do not have the financial infrastructure to absorb losses

5. Provider and payers need alignment on outcomes/value that matters

6. Provider infrastructure to self-monitor performance, change from FFS or bed-days to care episodes
Systemic Barriers can be Overcome

1. Solidify definitions of quality and value with payers.

2. Conduct internal self-assessments to inform gap analysis: are other services needed to complement our work?

3. Providers can join/create an IPA. Through contractual alignment with payers, provide necessary access, reduce cost and share in savings.

4. Enhance and diversify service continuum to provide community-based interventions required under the Health Home specifications.

5. Consider acquisitions/consolidations to enhance purchasing power and to mitigate exposure to financial losses.
Nationally, Beacon Has Evolved its Contracting Beyond FFS

1. **Case Rate Contracting**: Beacon is seeing positive outcomes by contracting with diversionary providers at a bundled rate for all components of a service, covering a defined group of procedures and services. Beacon’s **Case Rate** contracting follows a member post-treatment and emphasizes community tenure.

2. **Quality Withholds/Incentives**: Beacon is contracting with community providers thorough an enhanced payment above their FFS rates based on meeting agreed-upon **quality metrics** such as: reduced readmission, PCP coordination, peer engagement, medication adherence and adherence to evidenced-based treatment protocols.