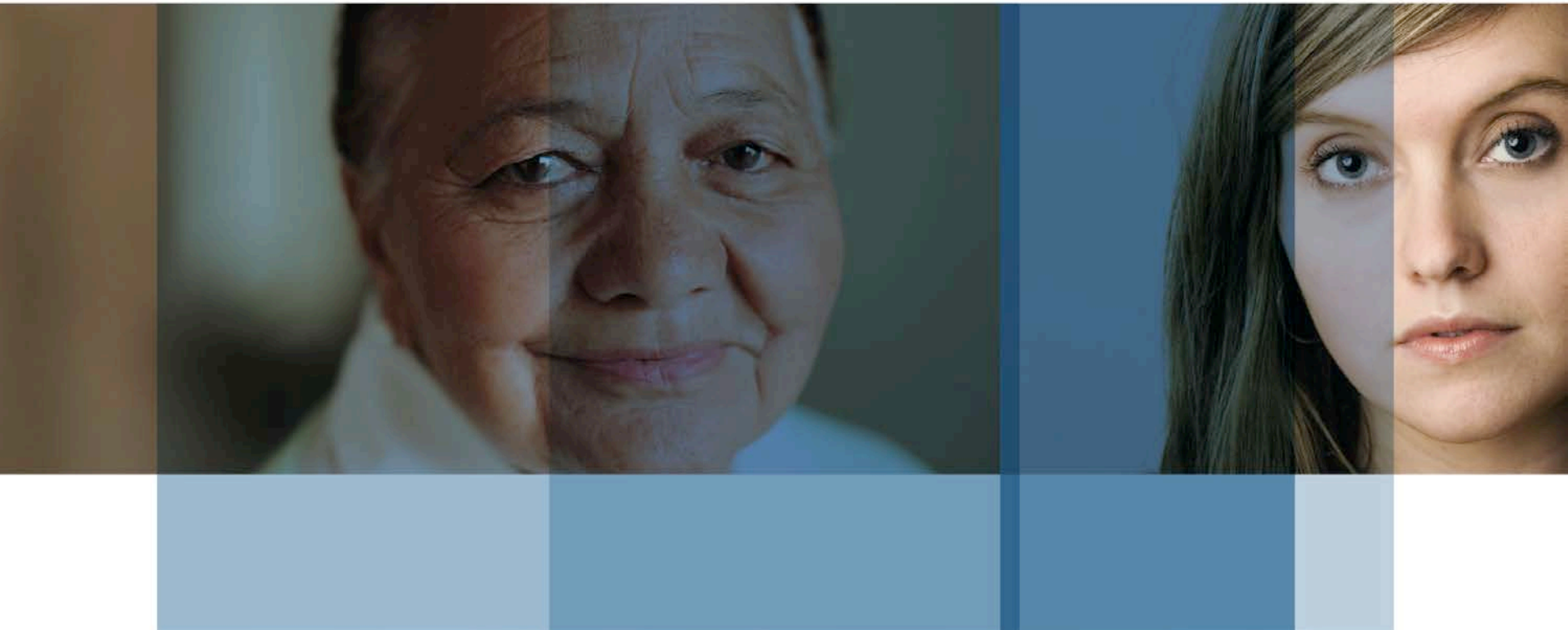
Behavioral Health and Payment Reform

MASSACHUSETTS HEALTH COUNCIL *"INTEGRATION OF BEHAVIORAL HEALTH CONFERENCE"*

April 3rd, 2014



Founded in 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

- Headquartered in **Boston with major service center in Woburn and 8 field locations serving some 11 million members nationwide**
- Statewide network of providers

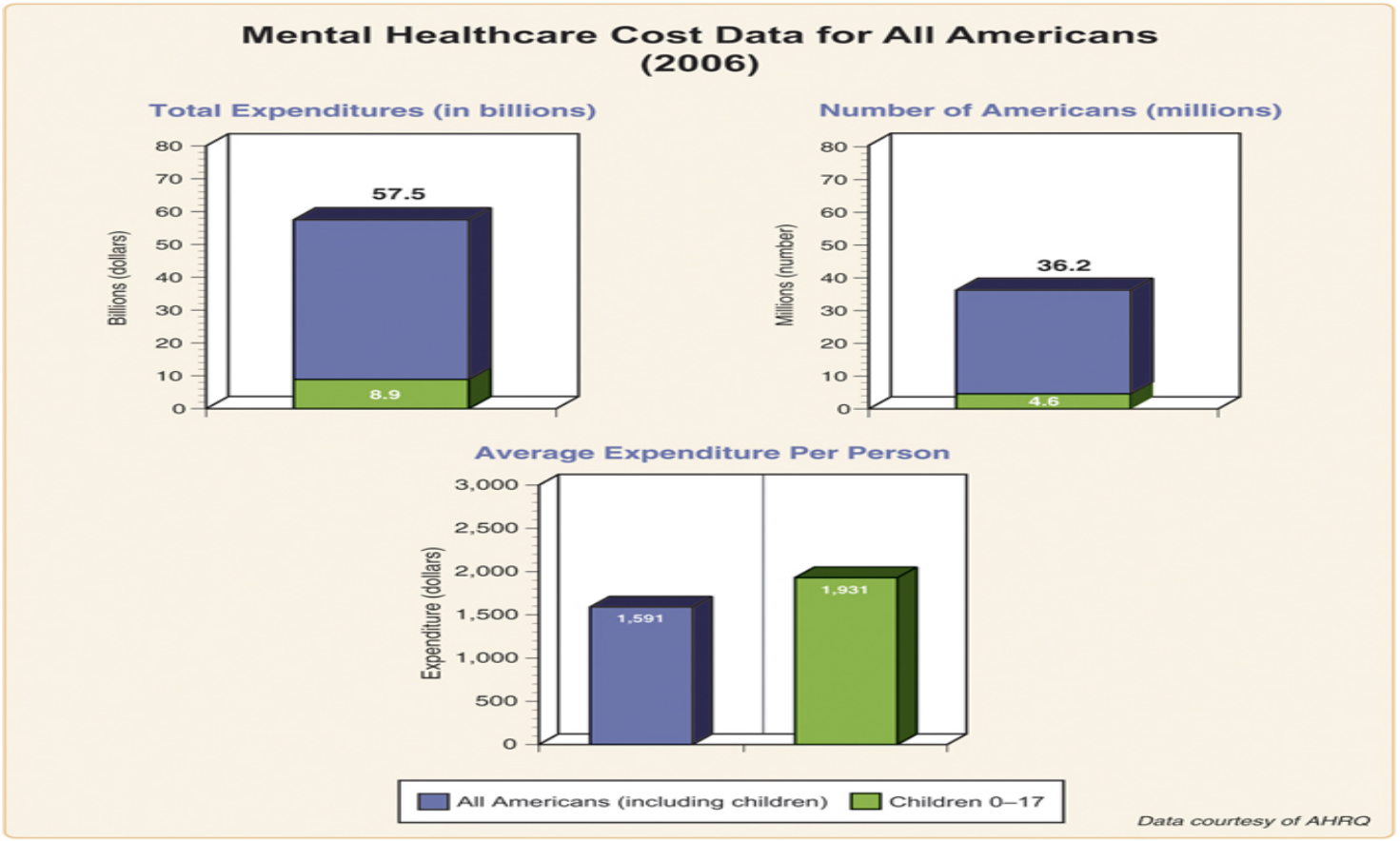
Massachusetts Populations Served

- 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

Prevalence and Cost Demand Reform to BH Payment Models

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 sever 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

Patient Centered Medical Home	Health Homes	Accountable Care Organizations
• An model of care whereby primary care is the cornerstone for a member's total healthcare needs • Population-based interventions designed to meet the needs of mild BH conditions • Technological enhancements (EMRs); data sharing • National quality standards (e.g. NCQA) • State Innovation Model Grants	• 90% Federal match on care mgmt/care coordination • Eligibility includes 2 or more chronic conditions, 1 chronic condition and at-risk for another chronic issue or **serious MH condition** • Emphasis on linkage to natural community supports	• Provider-led organization managing full continuum of care • Accountable for overall costs and quality for a defined patient population • Shared savings models based on spending target encourages coordination of BH care • Partial or full capitation models

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.

Payment Method	Key Elements	Pros	Cons
Fee-for-Service	Provider compensated a set fee for each service provided	Fixed revenue per unit of service	FFS perpetuates overutilization
Sub-Capitation	Provider receives a set amount "capitation" per member/per month to cover all services	Encourages internal utilization management of all services	Very nature of BH makes predictability of capitation challenging for smaller providers
Shared Savings/Risk Adjustment	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	Discourages overutilization Risk adjustment accounts for BH complexity Aligns payment with desired outcomes	Provider must have a sophisticated infrastructure (Actuarially sound and operationally strong) to track and coordinate care

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.*