A Look at the Next Frontier: Quality, Value & Integration

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Finding Your "Why": Passion as the Driver of Quality

Today’s Presentation:

- Major Themes:
  - Value & Quality in the context of behavioral health services
  - Opportunities in the process of system reform
  - Collaboration & Communication moving forward
- Topics:
  - Value & Quality: An Intro to Value Based Purchasing, What’s Required, What’s Changing?
  - How do Plans “Manage Care", Drive Quality Outcomes and Stratify Risk?
  - Q&A: Solutions for Collaboration and General Questions

Brokering Quality: What is Changing?

- Fall 2017-Winter 2018: Behavioral Health Service providers (CMHS) undergoing MCO contracting and credentialing
- Summer 2018- Beyond: MCO requirements for value-based purchasing arrangements
- Late Spring? :Baseline quality metrics as contract requirements for MCOs

How do Plans "Manage Care", Drive Quality Outcomes and Stratify Risk?

- **Step 1: Build a quality network**

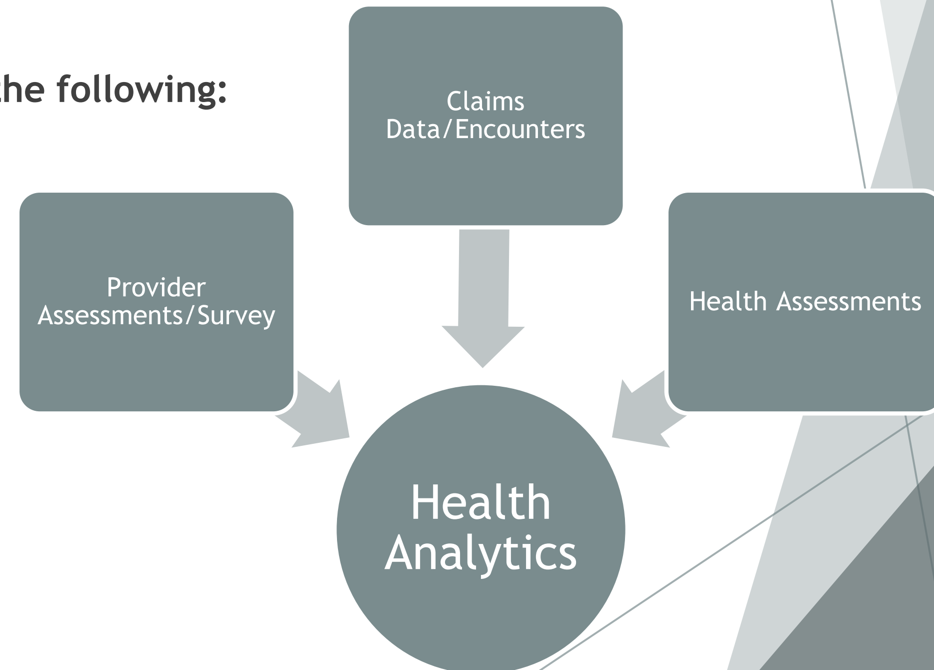
1. **Contracting and Credentialing**
2. **Establishing quality standards**

- **Step 2: Analyze, stratify and build the road map for the POC**

Most MCOs are (or will be) using sophisticated IT solutions for the following:

1. Conduct HRA
2. Analyze MTR and any previous claims data
3. Stratify risk & build **plan of care**

- **Step 3: Care Coordination & Utilization Management**



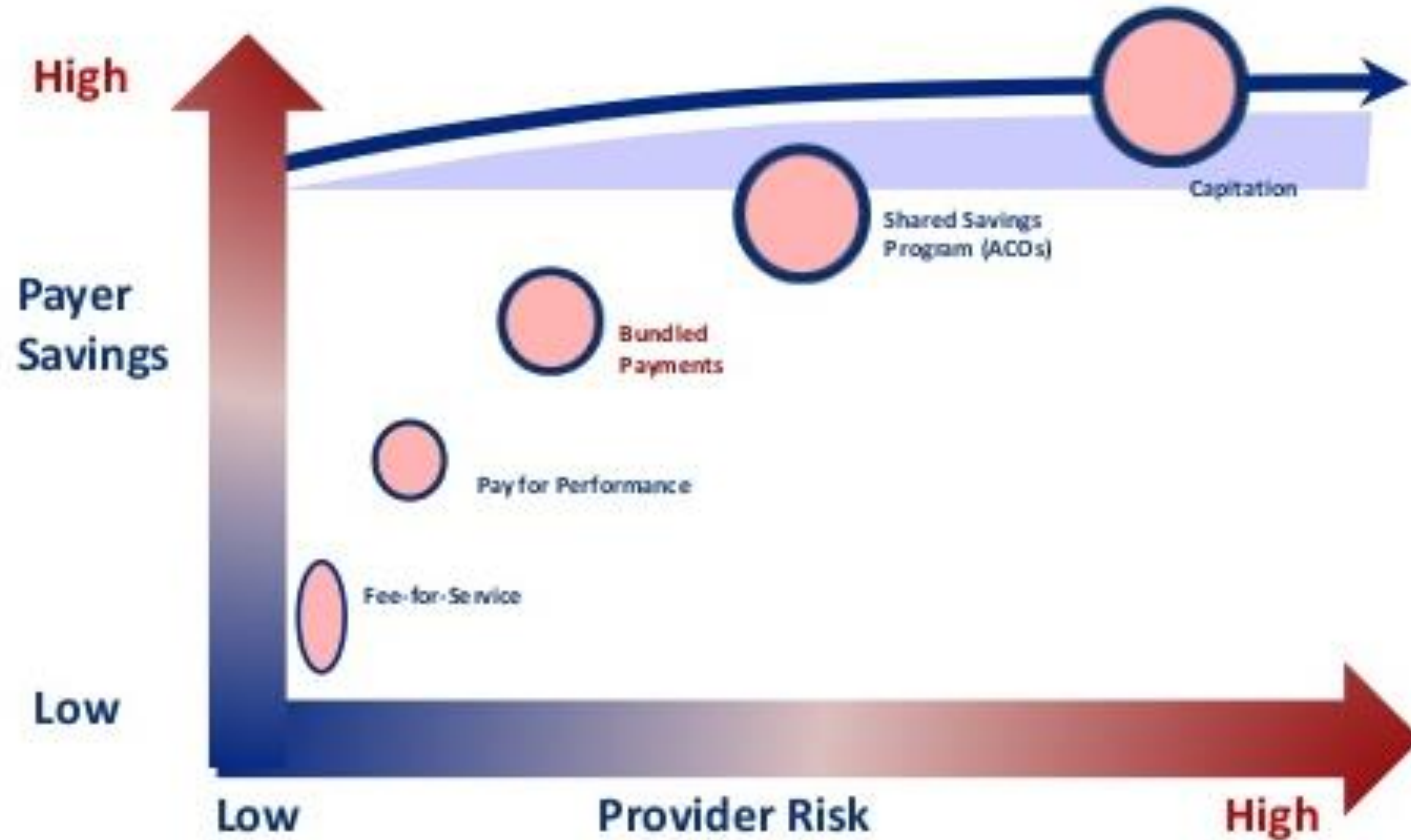
What is DMAS Requiring? What does the Future Hold?

- Required Models: HCP-LAN Stages Future of VBP for CMHS

Category 1	Category 2	Category 3	Category 4
Fee for Service – No Link to Quality & Value	Fee for Service – Link to Quality & Value	APMs Built on Fee-for-Service Architecture	Population-Based Payment
	A Foundational Payments for Infrastructure & Operations	A APMs with Upside Gainsharing	A Condition-Specific Population-Based Payment
	B Pay for Reporting	B APMs with Upside Gainsharing/Downside Risk	B Comprehensive Population-Based Payment
	C Rewards for Performance		
	D Rewards and Penalties for Performance		

- https://hcp-lan.org/workproducts/apm-whitepaper.pdf

Value-Based Purchasing: Many Stages



The Beginning: Foundational Questions for any Value-Based Purchasing Program

- What patient outcomes are we trying to achieve? (quality metrics)
- What populations are we going to focus on? (stratify risk)
- How are we going to measure those outcomes? (IT & integration)
- How are we going to pay differently (P4P, Bundled, Shared Risk etc.)

- What drives value in the CMHS space?
  - Examples:
    - BH integration into Primary Care
    - Reduction of BH related hospital admissions and inpatient stays?
    - Reduction of BH related Emergency Department admits?
    - Increased support in psychotropic medical management?

Keys to Successful Models in Other States: CMHS & VBP

- Data, Data, Data, Data….Real Time, accurate & integrated!****
- A focus on specific disease states and co-morbidities (ex: diabetes and depression)
- A focus on truly integrating acute medical services with behavioral health

- Resources to consider checking out:
  - [Health Affairs: How VBP should Measure Behavioral Health]
  - [Arizona: Model for VBP in Behavioral Health Services]

How are VBP for CMHS actually developed: The ASAM & LOCUS Model

- **Step 1: Level of Care System:** Payers and providers create a level of care system that describes different levels of care with enough specificity that common agreement can be reached.
- **Step 2: Utilization Management Guidelines:** Once the Levels of Care are identified, Utilization Management Guidelines are developed for each Level of Care Description. These include:
  - Admission Criteria
  - Range of Service Hours/Days/Units
  - Continued Stay Criteria
  - Transition Criteria
- **Step 3: Self-Management Rules:** The payer and providers will agree on which levels can be self-authorized (most levels), which levels require pre-authorization (only the highest), and how concurrent review will be managed (less review for providers who follow the rules).

What Efforts Are Underway In Virginia?

Behavioral Health Home partnerships (contractually required in both Medallion and CCC Plus populations)

ARTS & ASAM Criteria: A quality-centric program that employs some VBP strategies and can act as a foundational best practice model for community-based services

Patient Centered Medical Homes (PCMHs)

Some risk-sharing arrangements with FQHCs

About that Data…

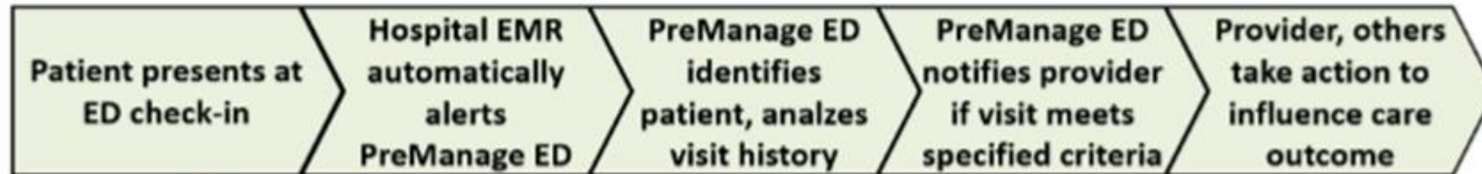
Emergency Department Care Coordination Initiative

REAL TIME DATA IS COMING SOON!!

The bill requires that IT system to be;

1) real-time,
2) integrated with PMP data,
3) capable of delivering ADT (alert, discharge, transfer) feeds in real-time,
4) capable of uploading one plan of care of CCDA,
5) capable of delivering decision support and care recommendations for providers and
6) interoperable with Virginia's Advance Directives Registry

ED Care Coordination Initiative



- Patient checks in with hospital registration
- Hospital records core identification and demographic info

- PreManage ED is directly integrated with the hospital EHR; no addt'l data entry required
- Patient registration data immediately sent to PreManage ED
- PreManage ED will act as a node on the Hiway, send Direct messages via HIway infrastructure for participating hospitals who elect that message type

- PreManage ED identifies patient (even if key information missing from patient's hospital record)
- PreManage ED cross-references patient with all prior ED and In-Patient visit history, independent of location

- If visit triggers a pre-set criterion, PreManage ED notifies the hospital
- Notifications contain visit history, diagnoses, prescriptions, guidelines, and other clinical meta data
- Notifications typically sent to EHR within seconds

- Provider has the information in hand before she sees patient
- Patient-provider information asymmetry is closed; able to make informed care decision
- Via PreManage, health plans, PCPs, others can be notified of visit and outcome for downstream follow-up

ED Care Coordination Initiative

- **Who will have access?**

  - Every provider in the MCO's network, CSBs, Hospitals and the MCOs themselves
  - No cost to the provider
  - MCOs contractually required to participate

-What is the timeline?

-System will be implemented starting in the summer of 2018 through 2019

-How can I learn more and get engaged?

-As a part of the planning process, the EDCCI is establishing clinical consortium groups. Dr. Kate Neuhausen (CMO at DMAS) will be the point of contact for this project and will be ran through the Medicaid Physician Managed Care Liason Committee (MPMCLC).

References