Value Based Payments / Value Based Care for Behavioral Health Organizations: An MCO Perspective

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Why VBP (VBC)?

HCA Directive that both PH and BH move to value based payments with providers with timelines for % of contracted providers that need a VBP methodology.

Goal is to drive system change related to care/service delivery with a focus on quality improvement and outcomes.

Improve processes

Data – to measure change/improvement (continuous improvement)
Providers working toward quality improvement

What data are you collecting or can you collect?

Examples…

✓ Initial Access to Care
✓ Return Access to Care
✓ Engagement in Treatment
✓ Treatment Retention
✓ Volume of Services

State Measures have been selected (not all are HEDIS measures)

2019 – Increased focus on BH and VBP/VBC
Measures of Focus for BH

HEDIS
- AMM
- Mental Health Penetration
- SUD Initiation and Engagement

STATE
- Alcohol and Drug Penetration
- Mental Health Penetration
- Substance Use disorder Initiation
- Substance Use disorder Engagement
Molina VBC’s Under Construction…
We will only enter Behavioral Health VBCs in 2019 for regions we have data and experience (Southwest and/or North Central)

Agreements will consider past performance and will be oriented toward enhanced performance

Providers must have good performance submitting claims or encounters to enter into VBC
Moving to VBC’s…

Working the last two years to determine

• How attribute members for BH? (Familiar with this for PH)

• Focus on *simple* incentive models to achieve targets for identified measures

• Down the line "*whole person care*" including BH, PH and Molina with more specific and targeted outcomes

• Will evolve like VBC’s with PH

• Our goal is to meet the HCA requirements and to incentivize the right outcomes
Process Expectations

- Routine screening for BH and PH conditions
- Use of standardized screening instruments
- Tracking of health conditions
- MOU’s/BAA’s with key PH and other BH provider(s) if needed services not onsite

Outcomes - Data

- Realistic attainable goals with some stretch
## Model of Care Spectrum

**Shorter Term**
- Increased Screening for all Service Types
- Increased Follow up for all service types in all care settings
- Increase in timely care for referrals

**Longer Term**
- Increased in Collaboration of different Disciplines
- Co-Location and high level of collaboration of providers of different disciplines

### Mental Health
- Complete routine physical health screening or validate its been done within annual timeframe
- Referral and/or connection to Primary Care provider based on screening
- **Near Term:**
  - Ideal – complete screening including BP and A1C

### SUD
- Same as above
- **Same as above**
- **Follow ups scheduled minimum of weekly Release of info (42CFR) to coordinate with referring entity. (Take money away if they cannot meet.)**

### Physical Health
- **Screening for depression (PHQ3 recommended + NIAAA+Opiod+Drug)**
- **Referrals (as appropriate) to internal behaviorist or external (if not available internally) and consent for referral to treatment**
- **Secondary option-provider who identified risk conducts follow up visit with in 2 weeks.**
- **Evaluate need for meds and patient interest to adhere**
- **Medications prescribed- need to adhere to AMM including follow up on meds and adjustments to meds**
- **Referral to SUD Provider based on screening**
Key Concepts

Attribution of Members
Measurement (what can we count?)
Baseline Performance
Targets
Actual Performance
Reward ($) for improvement!
Next Steps at Molina

Review Data (Target Completion 4/31)
• Review SWWA BH visit data to help isolate the BH VBC payment model

Develop VBC Elements (Target Completion 5/15)
• Identify the specific activities we want to contract with providers

Develop reporting capability (Target Completion 5/31)
• Determine how we will monitor activities and performance