Alternative Payment Methodology & Measurement-Based Care
November 17, 2021
2:00 pm – 3:00 pm
Co-Chairs: Eric Schwartz, Tim Marshall, Jeff Vanderploeg

Meeting Minutes:

1. **Welcome & Introductions (:03)**
   Tim Marshall opened the meeting and reviewed the workgroup goals. Jeff Vanderploeg was out.

   Marshall reiterated to the group that it was not intended to put forth a CT Alterative Payment Model but to identify best practices and key components that would need to be included in a future model for Connecticut. He noted that today the workgroup would be hearing from two states in regard to their APM experience.

2. **Overview of Workgroup Goals, Anticipated Deliverables, and Timeline (:02)**
   Aleece Kelly welcomed the presenters from Pennsylvania and Oregon to share their experience with implementing alternative payment models in their states for Behavioral Health Services.

3. **Presentation and Q&A: Pennsylvania and Oregon Value-Based Payments (VBPs) (:40)**
   Pennsylvania:
   Amanda Roth, Director - Bureau of Quality Management & Data Review, Office of Mental Health & Substance Abuse Services, Department of Human Services, Commonwealth of PA
   Lori Fertall, Director of Value-Based Programs, Community Care Behavioral Health
   Amy Marten-Shanafelt, Executive Director, Blair County HealthChoices
   Brett Miller, CSBBH Program Director, Blair Family Solutions

   Oregon:
   Laura Sisulak, Children's Health Policy Analyst, Oregon Health Authority
   Lisa Krois, Oregon Health Authority

   Please give an overview of the model and discuss goals and target population:

   Pennsylvania: Pennsylvania highlighted their community and school-based shared risk arrangement as a mature program, developed in 2008 with county, school, family and provider input. It had been implemented in rural, suburban and urban parts of PA with slight modifications based on the location. It is inclusive of treatments including partial hospitalization, in-home services, others. A lot of work was done up front such has meeting with stakeholders and getting their buy-in. Shifting from a fee-for-service arrangement to a bundled payment allowed providers more flexibility of providing more non-billable services to support the youth and family further along in recovery. Provider collaboration to improve our understanding day to day operation has been very helpful for developing the models.

   Oregon: Laura Sisulak, OR, shared that the state had decided to not move forward with the InCK grant, but was still using the work on the APM design. The overarching goals of the model were to reduce out-of-home placement, improve health outcomes and costs associating with unnecessary ER visits. In OR the approach to the effort was focused on using cross-sector data to identify children and youth who have complex medical, behavioral and social needs to target

for intervention. They were implementing it in two regions, serving about 100,000 children and youth including 17,000 who would meet the criteria for complex needs. The second tier was based within the medical home model/primary care in effort to support integrated behavioral health within those practices. Third level was looking at intensive care coordination for children and youth that had a higher level of need and had dual system needs.

Please discuss the incentives strategies or structure that is allowable under each model.

Pennsylvania: They wanted to ensure there was flexibility around service delivery. Under the community and school-based model they are paid monthly but there is a withholding. Providers have to meet certain measures to earn back the withholding but they also have the chance to earn bonuses. The three cohorts of measures that are collected are related to fidelity to the model, cost effectiveness, and outcome measures.

A participant asked about the underlying Medicaid payment structure.

Pennsylvania: All of the VBP programs are developed in partnership with the subcontracted managed care company. Certain parameters are set up with the contract to the state for how much of the medical spending is to be from the VBP arrangement. In PA the counties have the first right of opportunity, the state contracts with the county and the county contracts with the managed care organization. Going into year 5 of the state's VBP program. 30% of total medical spending must be tied to the VBP, and of the 30%, half must be in high/medium risk payment strategies.

Oregon: OR implements managed care through coordinated care organizations (CCOs), regional MCO's. There are very concrete VBP requirements associated with the 1115 waiver. The specific payment model under InCK program is aligned with the VBP road map. It's a 5 year contract started in 2020, annual targets that the MCOs need to reach with their contracted providers. OR uses the LAN framework, which classifies different VBP models and associated risk. OR has a requirement that 20% has to be at least category 2C (pay for performance). Each year it is required to increase, starting with 20%, then 35% and then 50% and ending in 75% in 2024. Beginning with year 3 and 4 there are risk requirements. The model allows for a lot of flexibility within the contract to develop models that make sense to the specific areas and needs. The state has delayed some of the requirements due to the COVID-19 pandemic.

Discuss on the provider side what benefits have been seen and how the state engages providers.

Pennsylvania: Blair Health Choices reported they had been working within the VBP for the last 8 years. Some successes seen are the flexibility; they are able to provide multiple levels of service to clients without having to refer them or send to another provider. Able to provide services in all settings, home, school, community, etc. When looking at VBP opportunities it's important to talk about quality of care and how it's measured. Develop measurements that are meaningful for youth and families to receive high quality care. Staff satisfaction and retention are also important. When developing an APM be careful with what level of burden it could cost the providers actually doing the work. They need to know the outcomes and costs, tracking system and reporting that get in the way of the clinicians doing the work. PA created an organizational self-assessment for providers. It's a tool that has a variety of questions with key areas of

readiness. This gave concrete information for whether a provider was ready or not ready for the VBP implementation.

Oregon: The CCO met frequently with the providers to make sure the providers had the structure that they needed. They really engaged with them to gain their perspectives, and identify measures that would be tied to quality/process. A constant issue for CCOs is the capacity in an environment with a shortage of providers. That reality has to be addressed; being able to increase support for kids and families with health complexity when providers are having a hard time staffing is a challenge.

Discuss further the workforce challenges and working with the providers.

Oregon: The model is being implemented at the regional level between CCO and providers. From a policy standpoint the department is constantly looking at and addressing the challenges. The issue is getting more attention at the legislative level. The CCO is supporting it by trying to focus on targeted help to increase work capacity. They are engaged with providers one on one to identify what will be helpful given the lack of clinicians. Providers weren't able to staff for Wraparound and put that agreement on pause while they look at other ways to support the capacity growth. OR is having a moment of crisis with workforce; it's a large of focus for the Washington Health Authority with a lot of work to try to support the BH providers financially and through workgroups.

What were the consideration for design of the VBP for adults vs children?

Oregon: OR has a lot of family practice providers and fewer pediatric providers. There needs to be a shift of focus to child-centered care coordination resources. It has to be intentional or required to include kids in design.

Pennsylvania: Across all populations there are key things to consider and things that can be solved by value-based payment structures. The VBP is not targeting adults vs. children; it's everything that's brought up through quality-based measures. There is a consumer and family satisfaction survey, volunteers with lived-experience to support those currently going through the programs.

The OR presenter added in the chat that those issues and challenges do cross populations, and at a state level, that is how OHA has approached expectations across the population. That said, what was learned while implementing InCK on the ground is that in some places, that attention to children and youth gets shortchanged when there is a focus on ROI.

Do the panelists have any advice on how to move from pay for reporting/process to outcomes? Any lessons learned to share?

Oregon: Having a glide path is essential, largest lesson learned is progression down the path requires a lot of support for meeting the outcomes and transitioning to pay for outcomes. A lot of providers need "at the elbow" support to be successful.

Have either of the states figured out how to incentivize around flex funding?

Oregon: The 1115 waiver has been very intentional in supporting health-related services and dollars to address social determents of health. It's an evolving program that is being developed over time. There's a recent report out the covers the program; a couple of great overview documents to share.

4. **Wrap-Up, Next Steps and Adjournment (:10)**
   Tim Marshall ended the meeting and informed the participants that an additional meeting in December meeting has been scheduled and will be the final meeting.

5. **Chat box**
   Note that comments from the chat box were included in the minutes above.

Next Meeting Date:
December 15, 9:00-10:00 am.