Panel Conversation: Partnering with Medicaid Managed Care

Delta Center State Learning & Action Collaborative Convening #3

February 11, 2019

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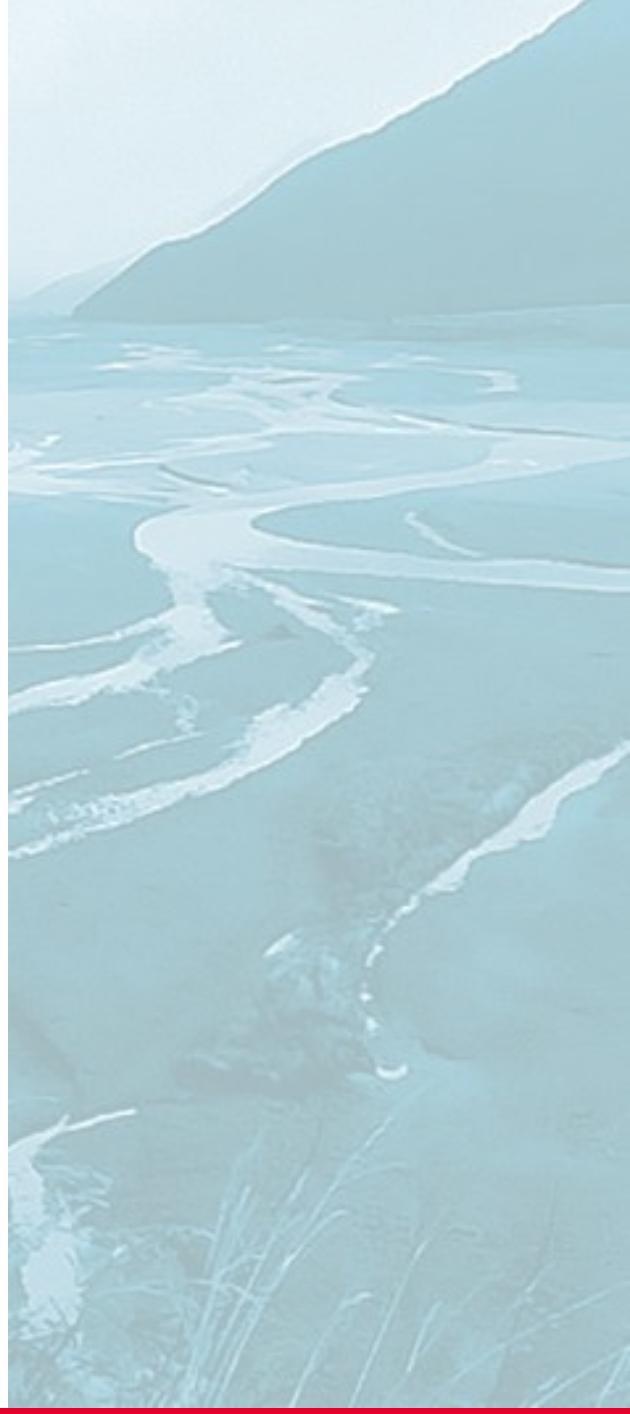

KEVIN CAMPBELL

Greater Oregon Behavioral Health

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Background/Introduction

What are the key pieces of advice you would give to BHSAs and PCAs on how they (as state associations) might best partner or interact with MCOs?

- Recognize that all care is local and when you have seen one CCO, you have seen one CCO
- Participate in Local Advisory Committees and Provider Advisory Panels
- Recognize that CCO's are charged with focusing on healthcare, not just medical care
- Recognize the balance between physical health and emotional health and well-being

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What advice would you give to BHSAs and PCAs on what they should be doing to best support their members (organizations participating in the state association) in partnering with managed care?

- Recognize that the quintuple aim will never be achieved if we focus only on payment methodologies and ignore the collaborative relationships needed for multigenerational person centered and community based care
- Every service delivery system is perfectly designed to conform with the requirements of its payment system(s)

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KIM COX - OPTUM

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Value-based Medical and Behavioral Integrated Care

Rethinking Behavioral Health

Kim Cox

Vice President, Specialty Networks

February 11, 2019

OPTUM®

rethinking **behavioral health**

Our Mission

To help people live healthier lives and to help make the health system work better for everyone.

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Value-based purchasing

our approach to the reimbursement continuum

Lower Financial Accountability

- P4P/Shared **savings contracts with qualified facilities** and outpatient providers: **15%** to **20%** reduction in readmit rates
- Ambulatory follow-up rate improved from **3%** to **10%**
- Bundled payments: **5%** better performance on **90-day** re-admission rate

Moderate Financial Accountability

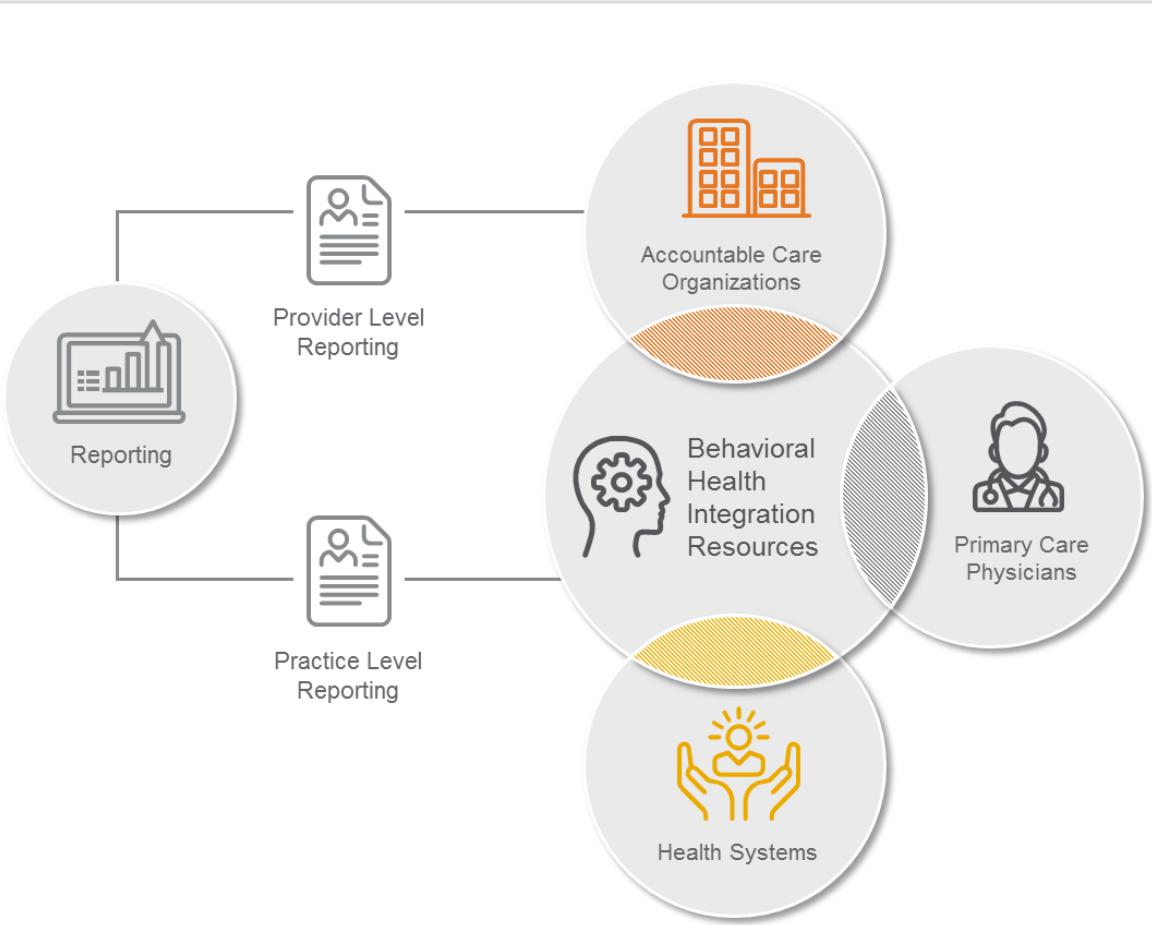
- SUDS **medication-assisted therapy (MAT)** providers
- Reduced readmissions
- Improved **community tenure**

Maximum Financial Accountability

- ACOs, **medical-behavioral integration** in health homes
- Improved care coordination
  - **9%** increase in adherence to quarterly PCP visits
  - **4% increase in primary caregiver or peer support linkages**

behavioral integration with **primary care**

Behavioral health experts provide **broad-based interventions** across the network to improve the delivery of evidence-based behavioral health care and facilitation of **deeper connections** and behavioral health collaboration



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Contracting models to **promote integration**

Accountable Care Organizations

Integrated ACO

- Add Behavioral Metrics to ACO program
- Confirm data sharing guidelines based on federal and state regulatory requirements
- Prioritize locations based on pre-determined criteria
- Determine how clinical transformation is managed

GlidePath

- A behavioral health incentive approach with key components to support providers and members to accomplish improvements in quality and outcomes

•Targeted provider network

•Clinical model

•Financial incentives

Health Systems

Collaborative Care Model (CoCM)

- Use new CMS codes to reimburse PCP who is part of interdisciplinary team comprised of psychiatric consult (F2F or virtual) and care manager

•Similar model in place today for a major NYS health system

•Opportunity to be first out of the gate with wide-spread use of new codes in support of Collaborative Care/Medical Behavioral Integration

Primary Care Physicians

PCP Incentives

- Leverage PCP incentive programs in place today as another means of promoting PCP integration and care coordination
- Apply BH metrics to current programs

Whole person care **network/clinical integration examples**

Kansas CMHC Glidepath

- Capitated arrangement with earned incentive
- Targeted SPMI population with co-morbid medical conditions
- Metrics include seven-day HEDIS follow-up, member engagement in clinic appointment every 30 days, diabetes screening and reduction in adverse events

New York Collaborative Care

- Embedded behavioral health specialists in a Collaborative Care Center promotes identification and services to individuals with comorbid conditions
- Telemental health supports
- Care coordination payments

Oregon

- Integration specialist supporting PCP clinics
- Educating practitioners on best practices, connecting to BH specialists and resources, facilitating access to psychiatric consultations, tracking referrals/consultations on the delivery of BH screening assessments.

Missouri CMHC System

- Large CMHC with 15 locations
- Shared risk, value-based contact aimed at reducing inpatient admissions and maintaining members in community-based care

New York, Ohio, Iowa Health Home

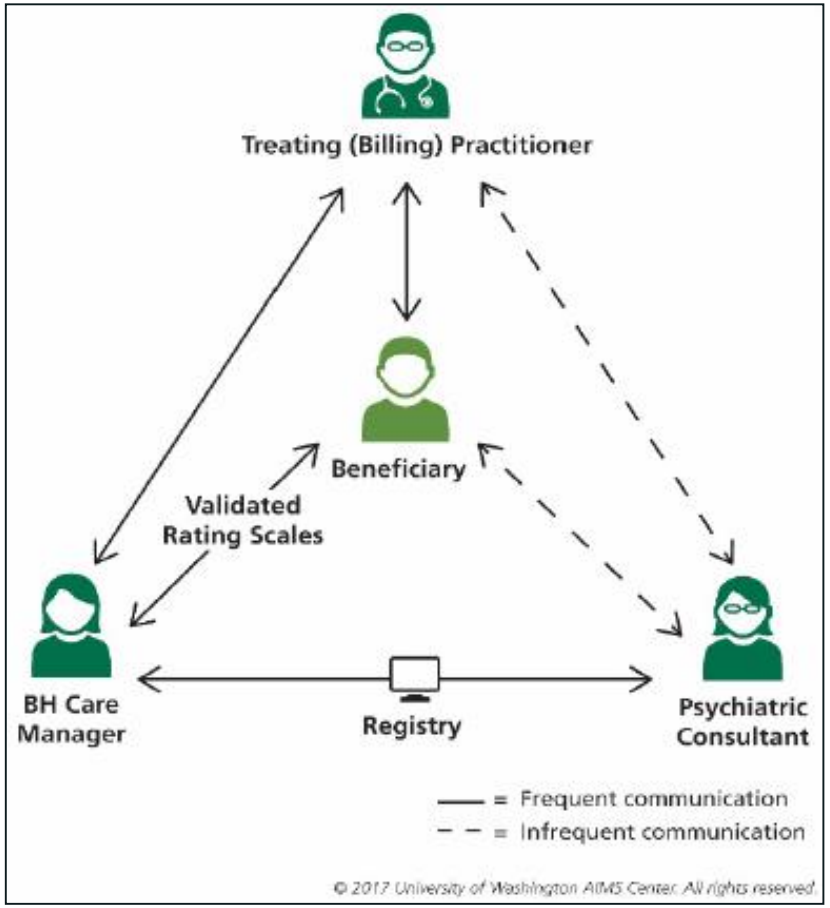
- Capitated arrangement to support care coordination for health home population
- Measures 8 metrics across 6 domains
- Early results show improvement in PCP visits and peer support linkages

Utah

- Integrated agreement to support health plan partner's Employer, Individual, and Medicare channels
- Health Plan partner amending medical facility and group agreement to include BH provisions

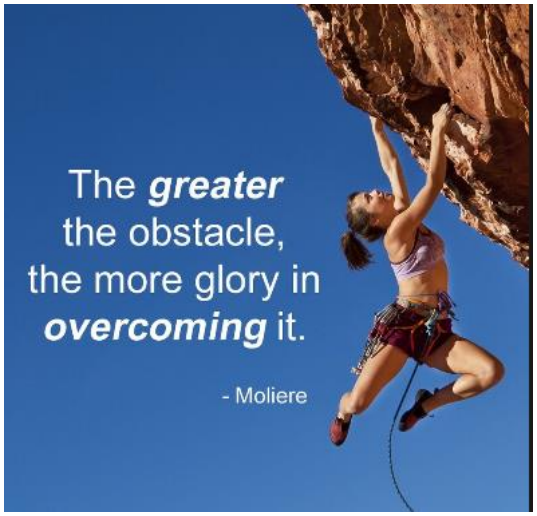
Clinical Integration BH Provider Considerations

- Define expected program outcomes and measurement targets
- Establish data sharing protocols with PCP and Payer
- Establish consistent care coordination process
- Understanding value-based contract expectations and reimbursement model



Headwinds

1. Lack of an industry-standard outcome tool
   - Optum working with ABHW (Association for Behavioral Health and Wellness) to encourage standardization
2. Low number of patients/admits; many low-volume providers
3. Lack of assignment of members challenges use of capitation
4. Provider readiness to manage risk and challenges to achieve metrics
5. Trust
6. Collaborative Partners
7. Openness on all sides
8. Willingness to try something new



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PATRICK GORDON

ROCKY MOUNTAIN HEALTH PLANS

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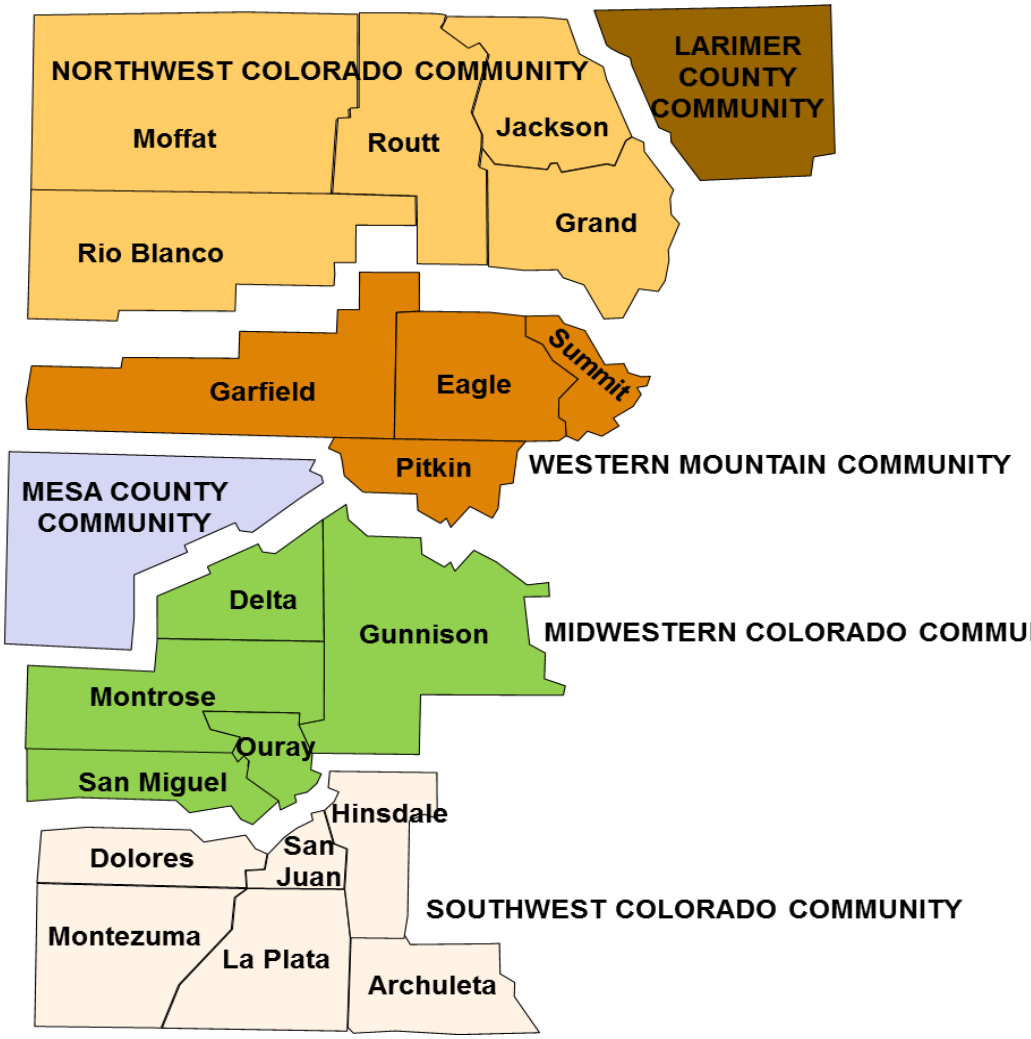
Background/Introduction
Rocky Mountain Health Plans – Colorado Region 1



- 6 distinct "Health Communities"
- Population
  - 144,000 "PCCM" Members
  - 180,000 BH Benefit Members
  - 36,500 "Prime" MCO Members
  - 11,500 CHP+ Kids
- Community-based oversight & health alliances partnerships
- Aligned initiatives – CPC+, AHCM, SIM

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RMHP's role as a partner

- To create an economic basis for whole person care.
- To maximize flexibility in public programs – not spending.
- To create a durable program founded on local leadership.
- To share data for transparent analysis and goal setting.
- To prioritize resources and focus on goals.
- To share burdens and benefits – equitably and timely.
- To improve community capacity and health trends.

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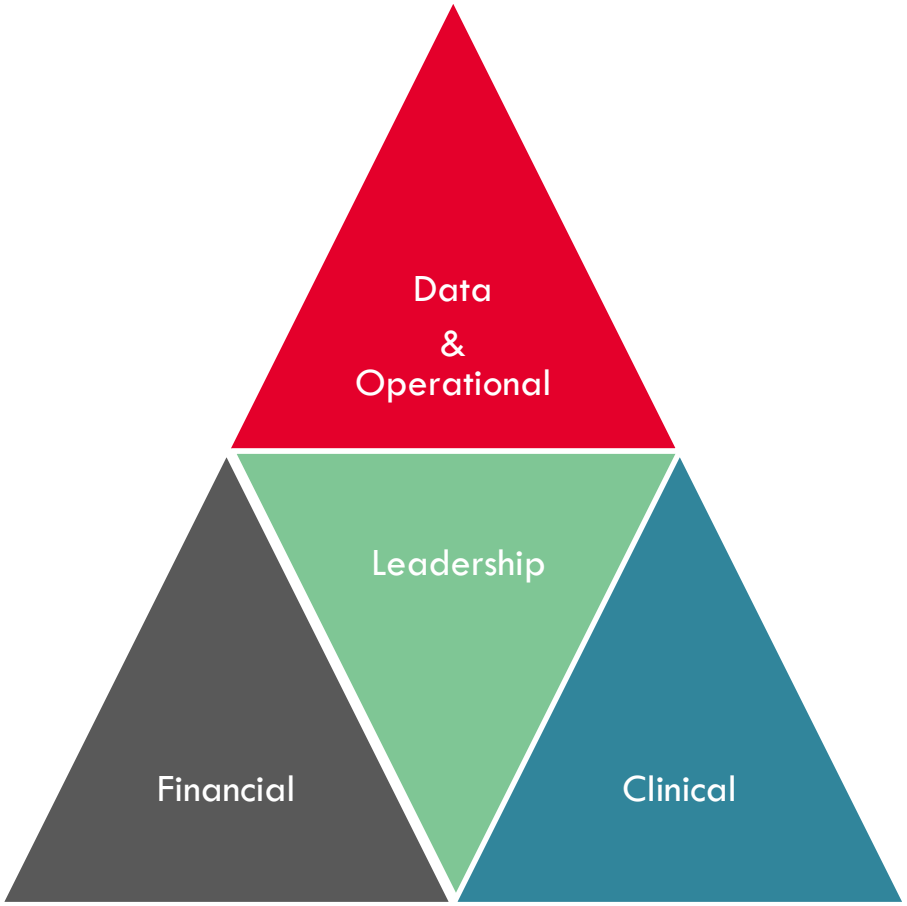
We must drive all facets of integration



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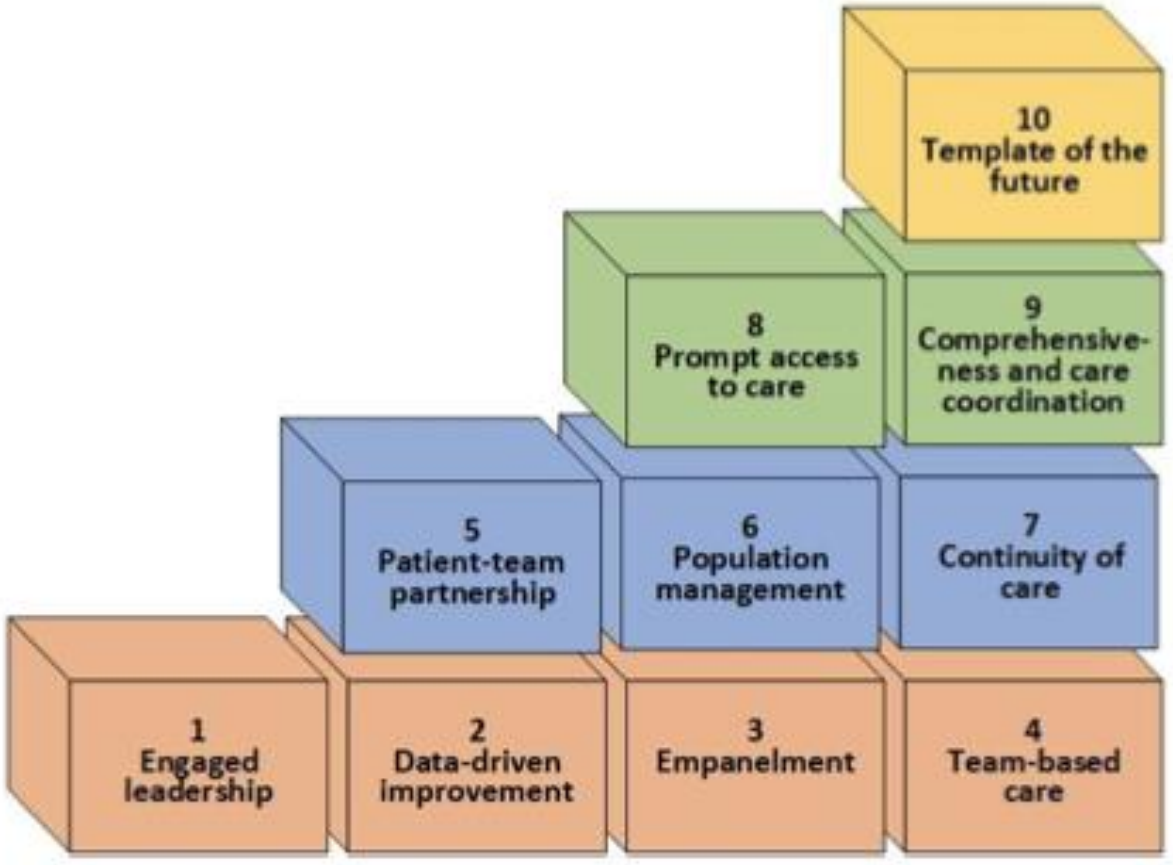
RMHP Practice Tiering Program



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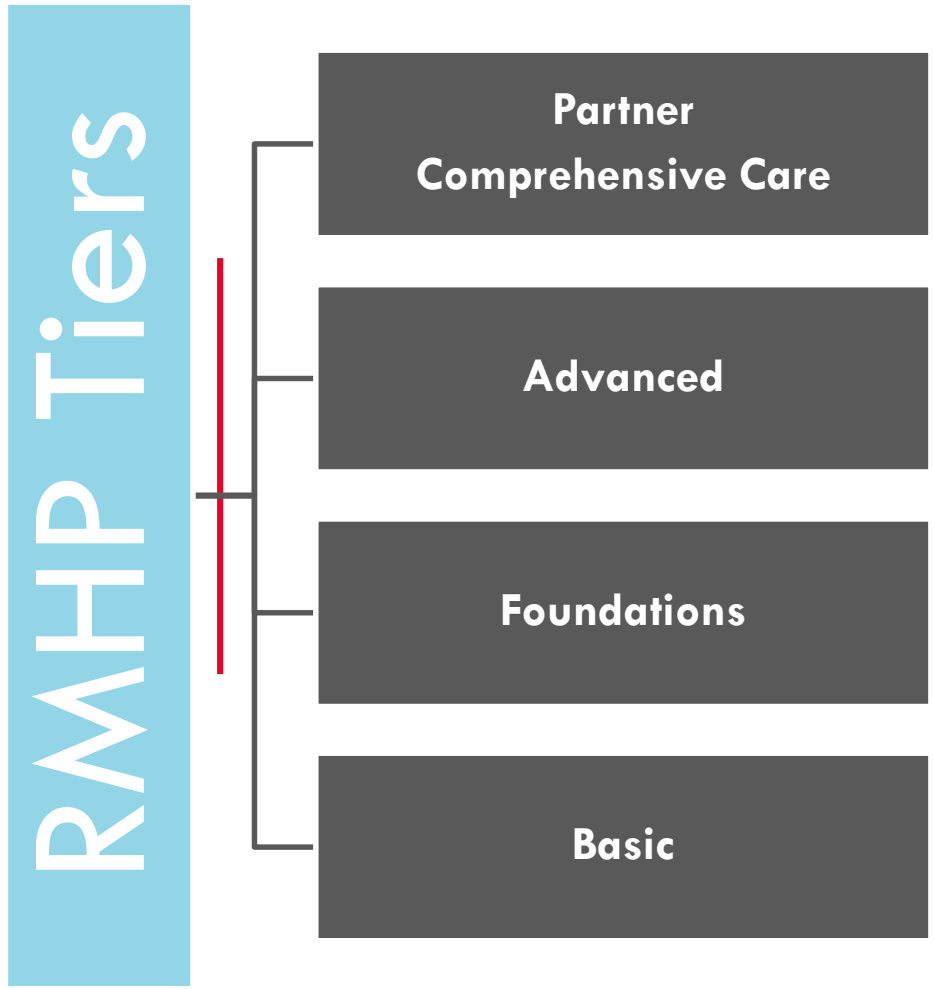
It's not who you are – it's what you do.



*See pages 21-23 of RMHP *Orientation Guide* for detail

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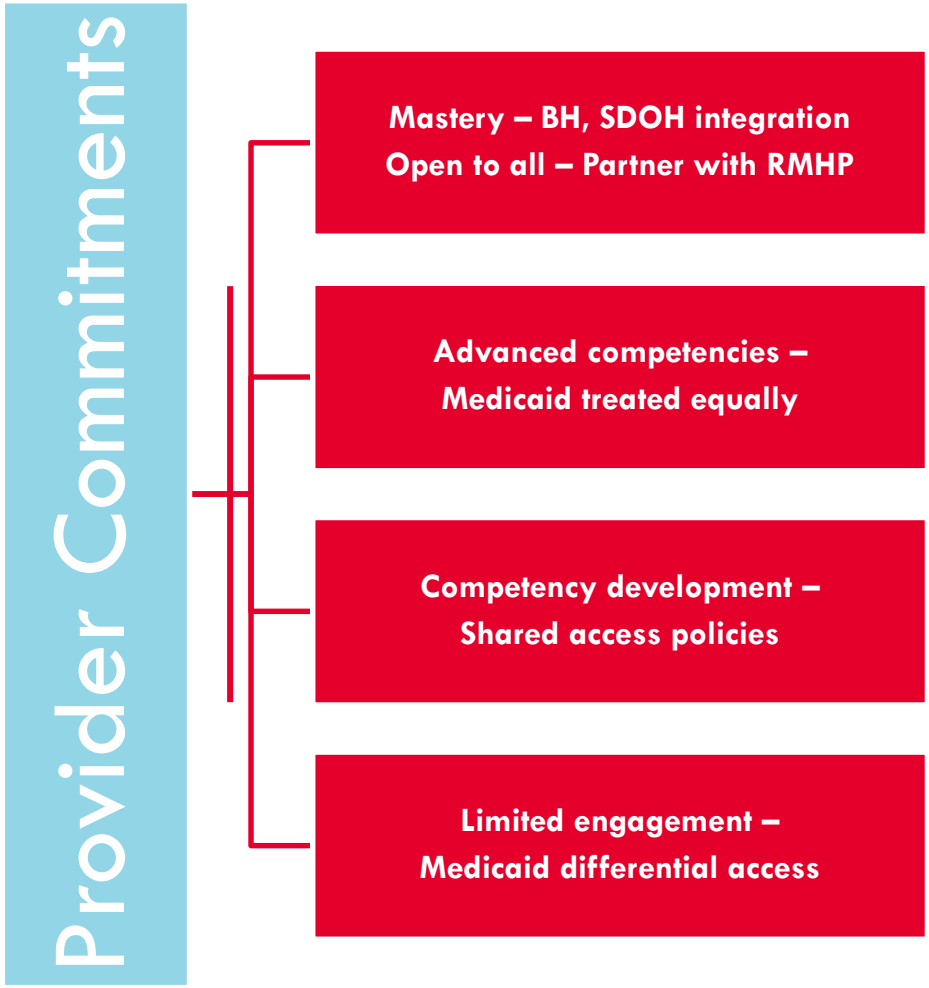

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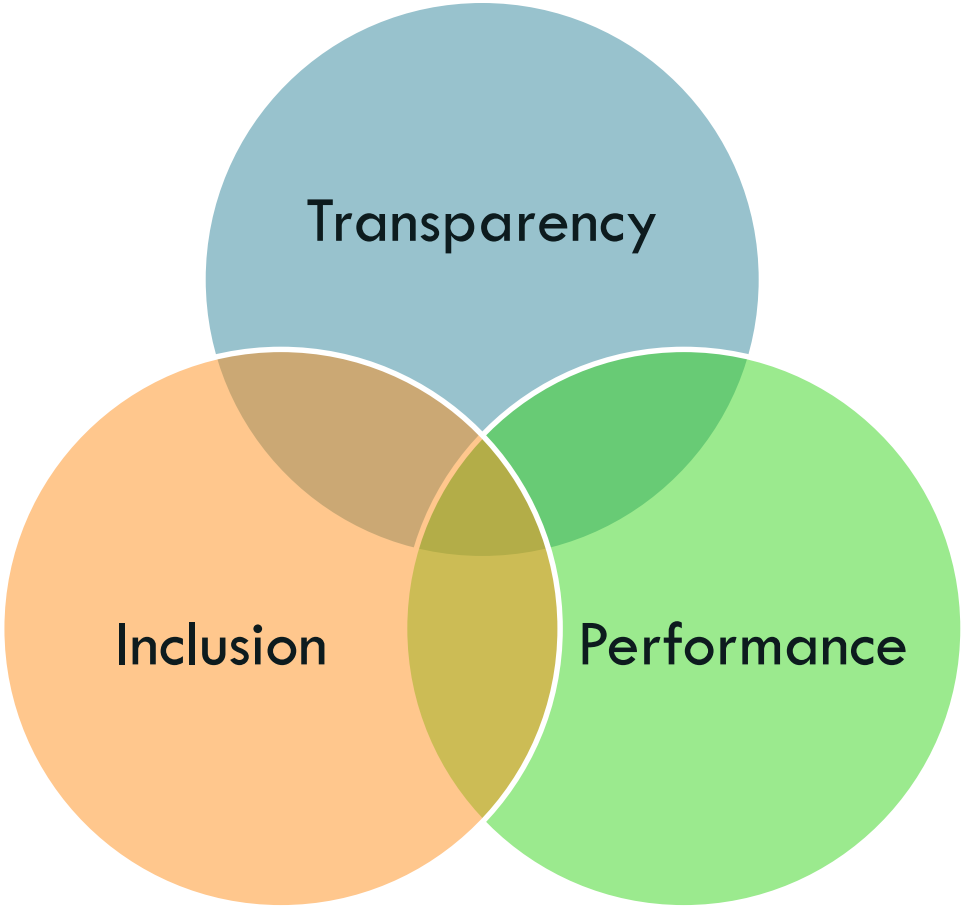
First Principles

It's not who you are – It's what you do



"Joint Operating Agreement" – JOA

Regional Accountable Entity for the Accountable Care Collaborative

Technical Proposal Solicitation # 2017000265

Colorado Department of Health Care Policy and Financing

ROCKY MOUNTAIN HEALTH PLANS®

Reunion Health

July 28, 2017

Reunion Health in Partnership with Rocky Mountain Health Plans

- MH providers get **a pathway out of the carve out**, opportunity to participate in health system design and savings;
- 10 FQHCS + 3 Mental Health Centers formed "Reunion Health, LLC" to navigate program change;
- Contractual agreement w. 'first principles': **"It's not who you are, it's what you do"….**plus, transparency + responsibility for community;
- **Checks & balances**: RMHP a minority "vote" on care model design and related issues – but can act unilaterally when necessary to manage risk;
- Independent providers, health and human services stakeholders get both **"a voice and a vote".**
- Explicit commitment **to practice transformation and network tiering for PH and BH.**

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Transparent program oversight

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What advice would you give to BHSAs and PCAs on what they should be doing to best support their members (organizations participating in the state association) in partnering with managed care?

1. Payment model – Basic FFS, enhanced pmpms, risk-adjusted capitation, incentives & shared savings – designed and executed from the "ground-up".

PAYER PARTNER ASK: Support value-based alternatives to FFS and cost-based reimbursement – with *and without* state action.

2. Clinical transformation – boots on the ground, human intelligence, regular quarterl meetings. eCQM, HIE and advanced measures collection and state reporting.

PAYER PARTNER ASK: Support rigorous, transparent, objectively-measured practice transformation and network tiering models. Differentiation matters.

3. Community Integration – Leadership network development must be prioritized, resourced and continually strengthened. Regional alignment in key areas –APM, BH, SDoH.

PAYER PARTER ASK: Promote regional initiatives, partnership when Statewide is too big or slow. Variation is good.