

Value-Based Payment and Measurement-Based Care

June 30, 2021

2:00 pm – 3:00 pm

Co-Chairs: Tim Marshall & Jeff Vanderploeg

Proposed Workgroup Goals:

1. Review approaches toward value-based purchasing in behavioral health
2. Review current and planned state initiatives in value-based purchasing (e.g., 1115 Waiver, Integrated Care for Kids (InCK), evidence-based treatment performance incentives, CCBHC provider grants)
3. Make recommendations to Children’s Behavioral Health Plan Implementation Advisory Board and the 12 state Department Commissioners for further follow-up and implementation

Anticipated Workgroup Duration

Monthly; up to 6 meetings

Materials:

1. *Behavioral Health Provider Participation in Medicaid Value-Based Payment Models*
Center for Healthcare Strategies & National Council for Behavioral Health
2. *Moving Toward Value-Based Payment for Medicaid Behavioral Health Services*
Issue Brief, Center for Healthcare Strategies
3. Future materials may include information from 1115 substance abuse waiver, Integrated Care for Kids, CCBHC, others

Meeting Objectives:

1. Review existing work in value-based care and payments
2. Plan out future workgroup meetings agendas, objectives, topics, materials
3. Identify workgroup co-chairs

Agenda:

1. Welcome & Introductions

Jeff Vanderploeg began by welcoming participants and asking them to introduce themselves using the chat function.

2. Overview of Workgroup Goals, Anticipated Deliverables, and Timeline

Tim Marshall provided additional context regarding this group, and noted that there was a desire to ensure that this workgroup does not silo other discussions occurring around the state concerning value-based payment (VBP).

3. Presentation: Overview of Principles and Current State Efforts in Value-Based Care **Bill Halsey, Department of Social Services** **Bert Plant, Beacon Health Options**

Bill Halsey indicated that DSS and other state agencies were committed to standing up a statewide VBP model, for children and adults, for mental health and substance use disorders and indicated that some initiatives were already underway. Bill indicated that a phased or “glide

path” approach makes the most sense for Connecticut, given that some providers still need infrastructure to be able to fully participate in VBP arrangements. Bill also indicated that a clear articulation of quality, outcome, and cost metrics were needed to support VBP. He specifically pointed to a desire to reduce emergency department and inpatient visits and re-admissions, and that other metrics should also be considered. Bill further explained the DSS perspective on payment approaches, indicating that the state was not ready to put downside risk on BH providers. He did say that provider downside risk would be the desire eventually, but that would be done gradually, carefully, and with input. Bill suggested that a payment model that incentivizes better outcomes is the ultimate desire; however, the methodology to get there is still under discussion, and many details are yet to be worked out. Tim further acknowledged that he has heard from many providers that are concerned about the transition to VBP and the particular approach that is ultimately selected.

A participant asked about the structure, governance, and mechanisms of decision-making for this workgroup. Tim indicated that VBP goes beyond the child-serving system and that 12 state agencies have signed on to the Children’s Behavioral Health Plan and affirmed through the recent Behavioral Health Summit an agreement to move forward with VBP, with consideration of the input from this workgroup. He acknowledged that ultimately decisions regarding VBP are likely to fall to Commissioners, OPM, and others at high levels of state government.

Bert Plant provided an overview of the options and decisions that this group may need to consider in determining recommendations to make in the area of VBP. He talked about the critical importance of identifying and aligning the multiple factors in a VBP system such as: goals, strategies, metrics, reporting, provider technical assistance, and payments. Other components he noted were a glide path approach, attribution methods, case mix adjustment, and collaborative process (e.g., a Learning Collaborative model). Additional detail in each area include but are not limited to the following:

- Goals: Examples include improved processes, improved quality, improved outcomes, reduced costs.
- Strategies: Examples included better identification and outreach, restructured delivery systems (e.g., integrated care), changing care processes, improving screening, implementing evidence-based treatments, and introducing measurement-based care.
- Metrics: Metrics frequently are grouped into process, quality, and outcome domains. Cost metrics are also typical of VBP approaches.
- Reports: Dashboards that display data on each of the selected metrics are commonly used to provide feedback to providers, inform data-driven decision-making, and to track performance of the VBP system over time.
- Payment Structure: Common options include rate adjustments, lump sum payments, withhold returns, population-based approaches, capitation and risk sharing, penalties, and other incentives.

Bert further indicated that the current SUD Waiver and Integrated Care for Kids (InCK) initiatives were in their early stages, but both are attempting to implement VBP using many elements of the above guidelines. In addition, Bert shared an example in New Hampshire that Beacon is involved with. The VBP approach there involves 10 regionally-based mental health providers, uses a capitated per member per month rate with pay-for-performance bonus opportunities,

and relies on 8 quality metrics to calculate incentive payments. A result of their approach has been a 12% increase in performance targets met.

4. Responses and Additional information on Associated Initiatives in Value-Based Purchasing

A participant commented that an open-ended approach to model design at this stage was important. He noted that Connecticut should consider not only individual-level metrics among populations attributed to providers, but also metrics that indicate whether the *system* is functioning well as a whole.

A participant indicated that we do not have a “vertically integrated” system in CT, which may limit the adoption of some existing measure sets. A couple of participants noted that some measures have been retired over time because they were not working, and Connecticut should not recreate those mistakes. Further, a participant recalled a report led by Beacon (approximately 2015) that recommended funding to providers to support practice improvements that would result in better uptake of VBP. Bert indicated that glide path incentives or assistance to providers should be considered as part of Connecticut’s approach, and Bill indicated that the approach selected did not necessarily have to be cost neutral to providers. He further noted that this group could learn from “practice transformation specialists” that have been used on the medical side.

A participant asked how consumers might participate in VBP. Bill responded that “member experience” has been used in methodologies and could be considered in CT as well, including in early phases of the glide path. Another participant noted that the adult-based VBP approaches are frequently not applicable to child-serving systems. Bill responded that Tim has been helpful in ensuring these differences are considered in CT’s approach. Participants further noted that determining “whose value” is driving the process is important, as is ensuring that the selected VBP approach results in diversifying the provider pool. Finally, a participant indicated that selected metrics must be free from racial/ethnic bias, which has been an issue in some national approaches.

5. Identify agenda for subsequent meetings: Data, best practices, resources, or presentations

Tim indicated that he and Jeff would meet to cull these meeting notes and identify future agenda topics and presentations, and that they would also let the group know about the next meeting date.

6. Co-chair Volunteers

Tim invited co-chairs to help facilitate these meetings, with support from DCF and CHDI. There were no volunteers at this time, however, individuals should reach out to Tim and/or Jeff if they are interested.

7. Adjourn

The meeting was adjourned at 3:00 p.m.