Session #4:

Value-based payment for behavioral health providers:

How do we keep from being left out?

June 2, 2021

WEBINAR SERIES OVERVIEW

- This is the fourth of a 5-part series focused on Value-Based Payment (VBP) for Providers.
- The objectives of this series include:
  - Provide an overview of VBP models as they apply to the Oregon landscape.
  - How VBP can support providers to improve patient outcomes through more comprehensive and flexible approaches to delivering healthcare services.
  - Enhance primary care, behavioral health and maternity care providers' readiness for VBP adoption.
- Sponsored by the Oregon Health Authority's Transformation Center in collaboration with Health Management Associates.
- 1.0 hour of CME is available through the American Academy of Family Practice, equivalent to AMA PRA Category 1 Credit™ toward the AMA Physician's Recognition Award. To receive the credit, you must complete the evaluation following-the session.

2021 Webinar Series, 12 – 1pm on:

- **March 17 (Recording available)**
- **April 21 (Recording available)**
- **May 19 (Recording available)**
- **June 2**
- **June 16**

SPEAKERS AND DISCLOSURES

Faculty	Nature of Commercial Interest
 Janet Meyer Presenter	Ms. Meyer discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.
 Art Jones MD Presenter	Dr. Jones discloses that he is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. He is also employed as Chief Medical Officer of Medical Home Network, a non-profit that supports Medical Home Network ACO and other safety net clinically integrated networks to transform care are under advanced alternative payment models.
 Jeanene Smith MD, MPH Presenter and Curriculum Adviser	Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. As a member of the American Academy of Family Practice (AAFP), she ensured the content met the AAFP CME requirements.

TODAY'S AGENDA & LEARNING OBJECTIVES

Agenda:
Welcome and Introductions

Overview of unique aspects behavioral health providers face when considering attribution and discuss some potential approaches for value-based payment.

Discussion of potential bundled payments in behavioral health.

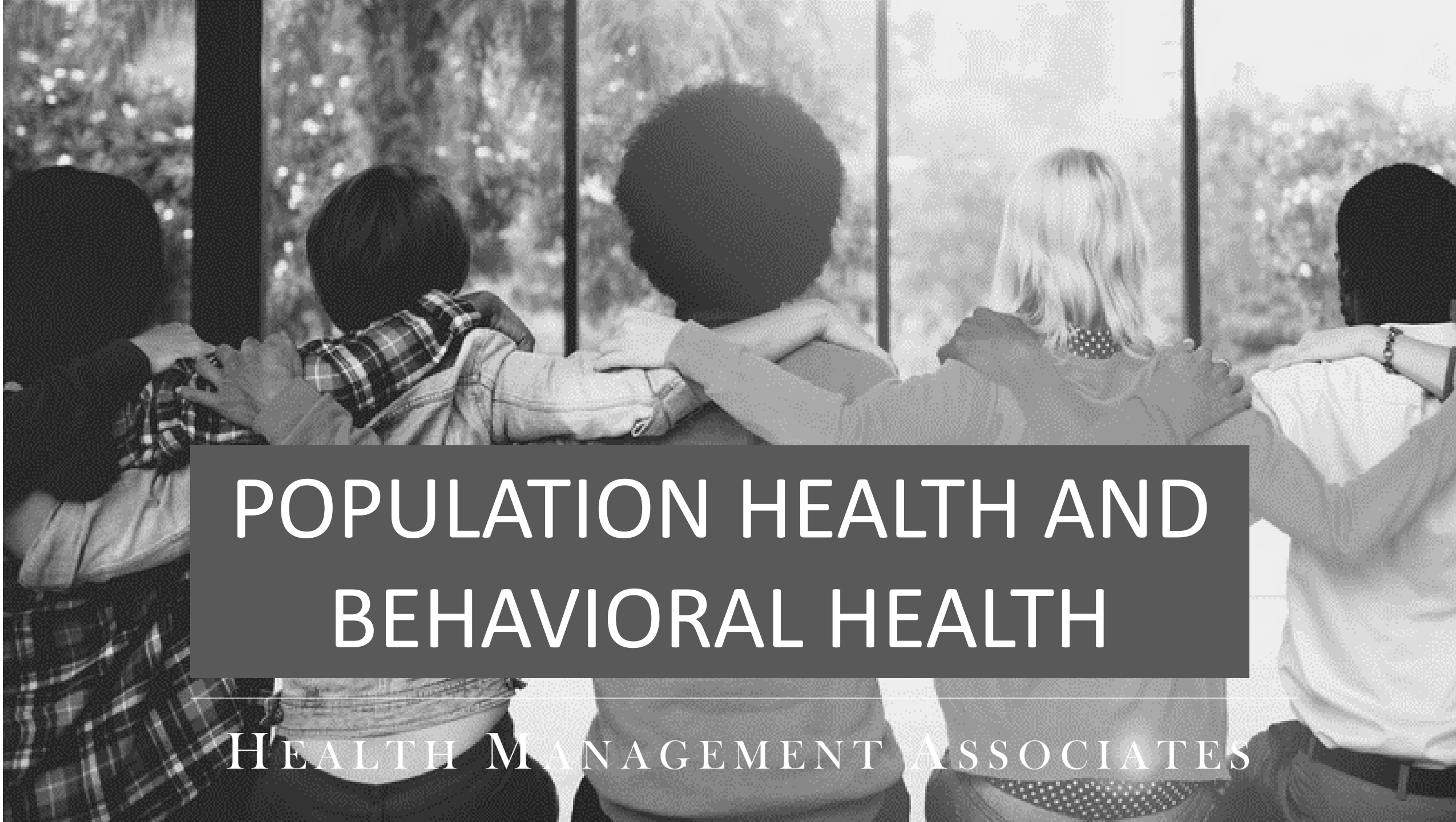
Case examples from a clinically integrated network using VBP.

Q&A

Learning Objectives:

After this webinar, participants will be able to:

- List the top key challenges of patient attribution for VBP in behavioral health.
- Identify 2-3 approaches for behavioral health attribution in VBP.
- Compare the two meanings of bundled payment in the context of behavioral health.
- Describe the role of clinically integrated networks for behavioral health providers in their pursuit of VBP.



POPULATION HEALTH AND BEHAVIORAL HEALTH

HEALTH MANAGEMENT ASSOCIATES

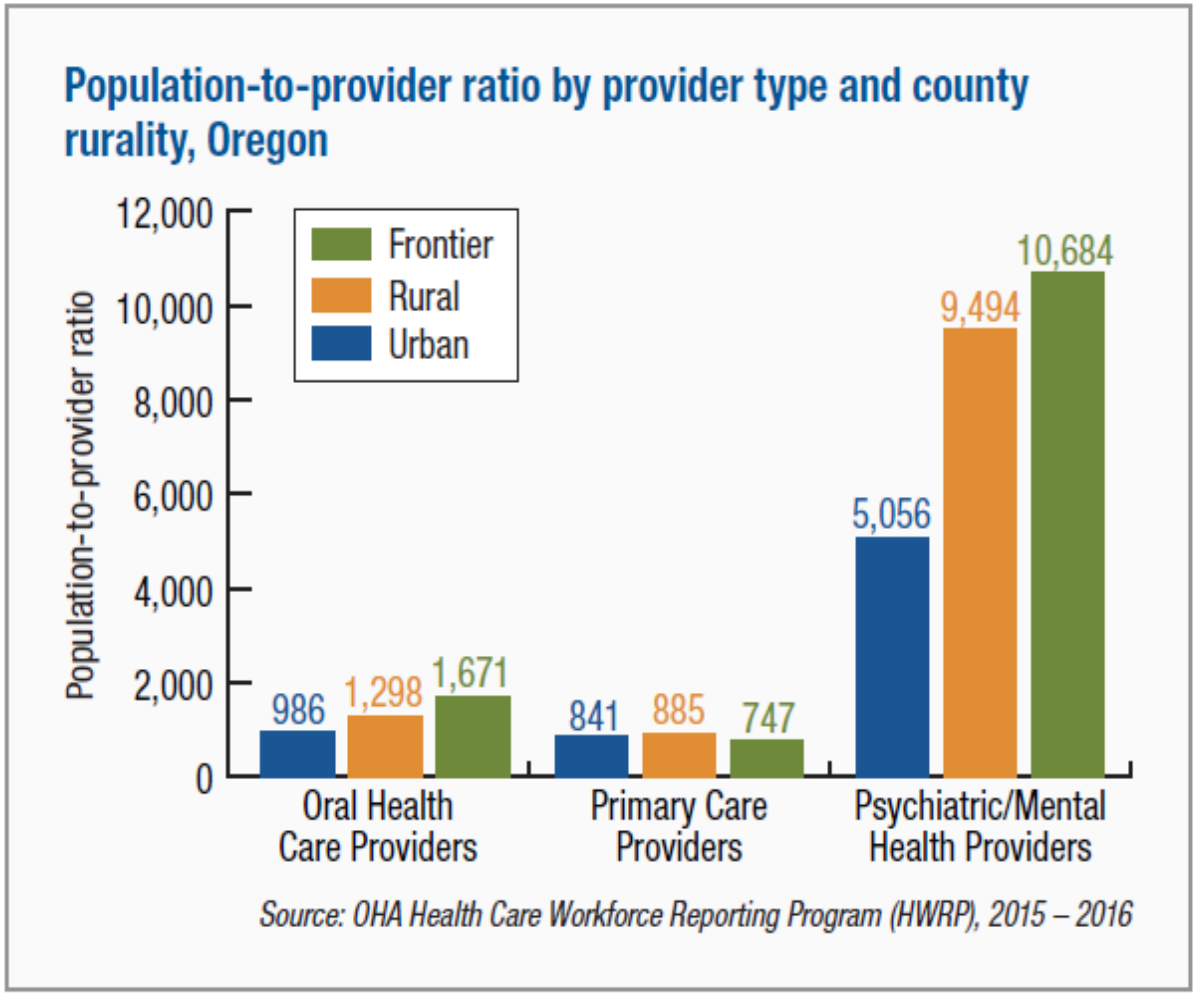
We cannot ignore the historical realities that have shaped today's system:

- People with Serious Mental Illness die 25 years younger than the general population, (1)
- Stigma of behavioral health disorders,
- Historical underfunding of behavioral healthcare,
- Historical underfunding of social services,
- Silos impeding integration,
- Power dynamics impacting our conversations, and
- Cultural impediments to health equity.

(1) Source: National Association of State Mental Health Program Directors Council. (2006). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: Parks, J., et al.

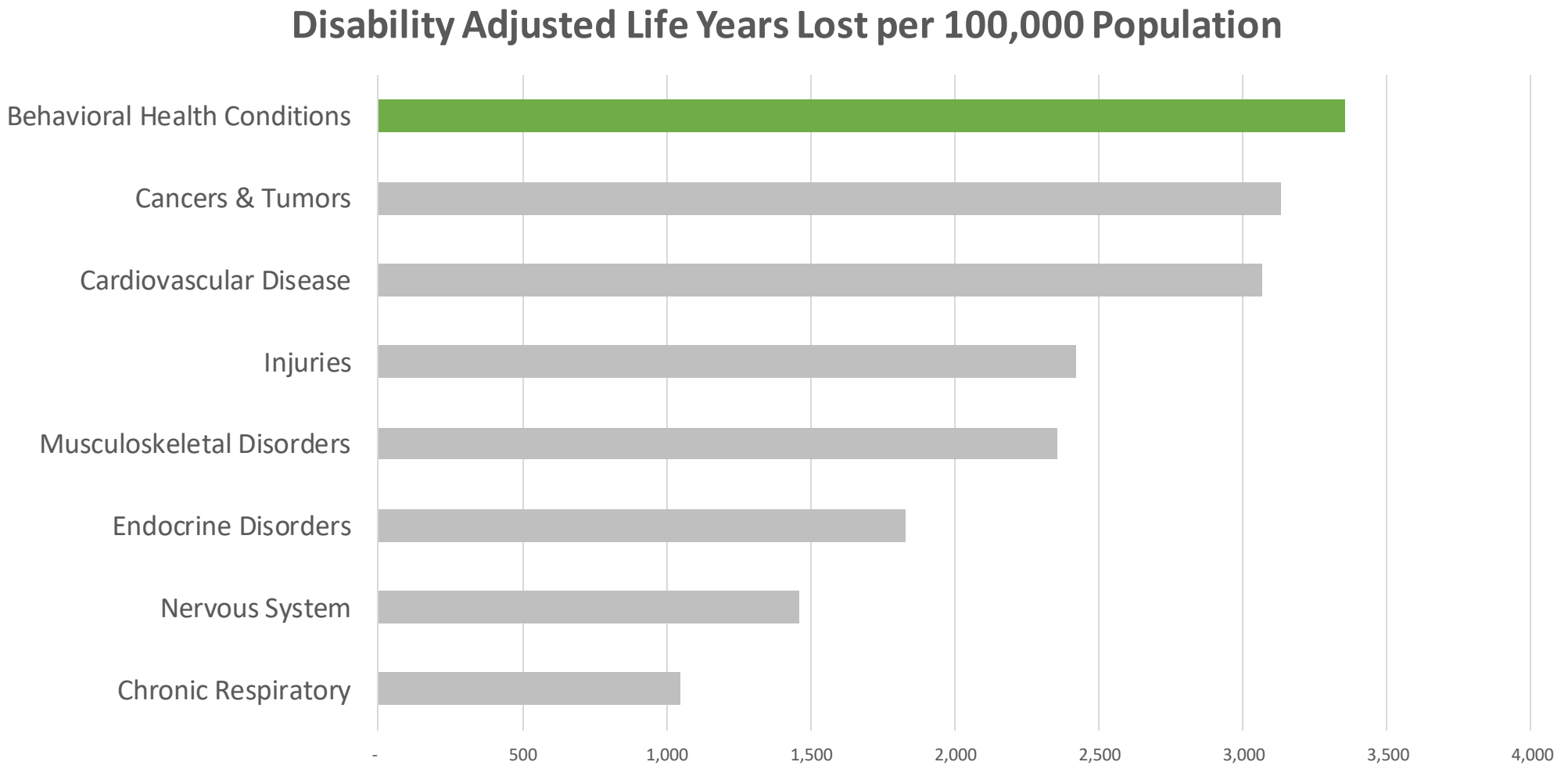
OREGON AND BEHAVIORAL HEALTH DISORDERS

- Oregon has one of the highest rates of mental illness in the country.
- Ranked 9th in the country for suicides.
- Tobacco and substance use are the first and third leading causes of death, respectively.
- There are significant disparities in population to provider ratios by geographic region within the state.



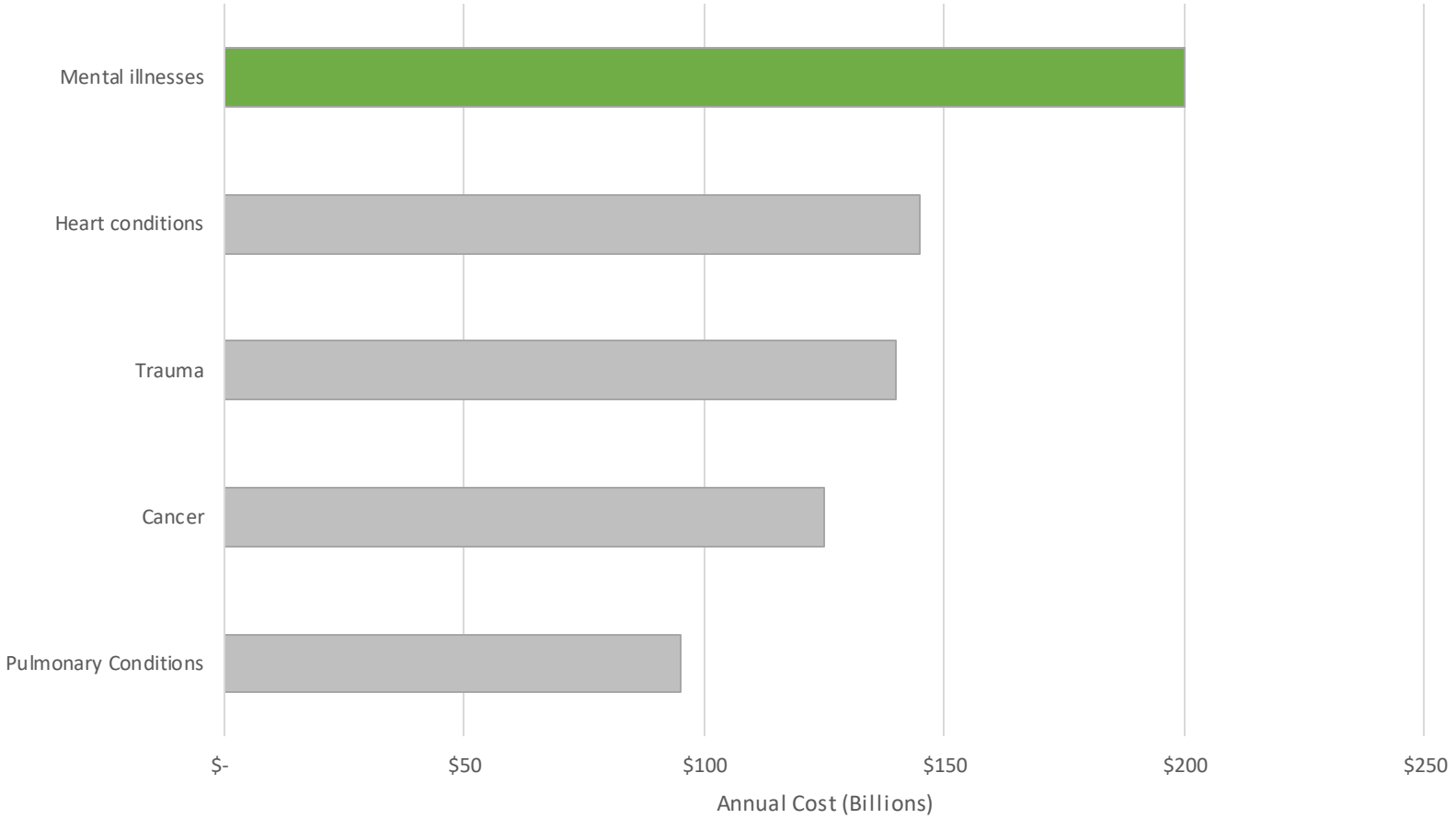
2020-2024 State Health Assessment/State Health Improvement Plan - Oregon Health Authority

BEHAVIORAL HEALTH DISORDERS ARE THE LARGEST CAUSE OF DISEASE BURDEN IN THE US



Source: Kamal R, Cox C, Rousseau D, et al. Costs and Outcomes of Mental Health and Substance Use Disorders in the US. JAMA 2017;318(5): 415.

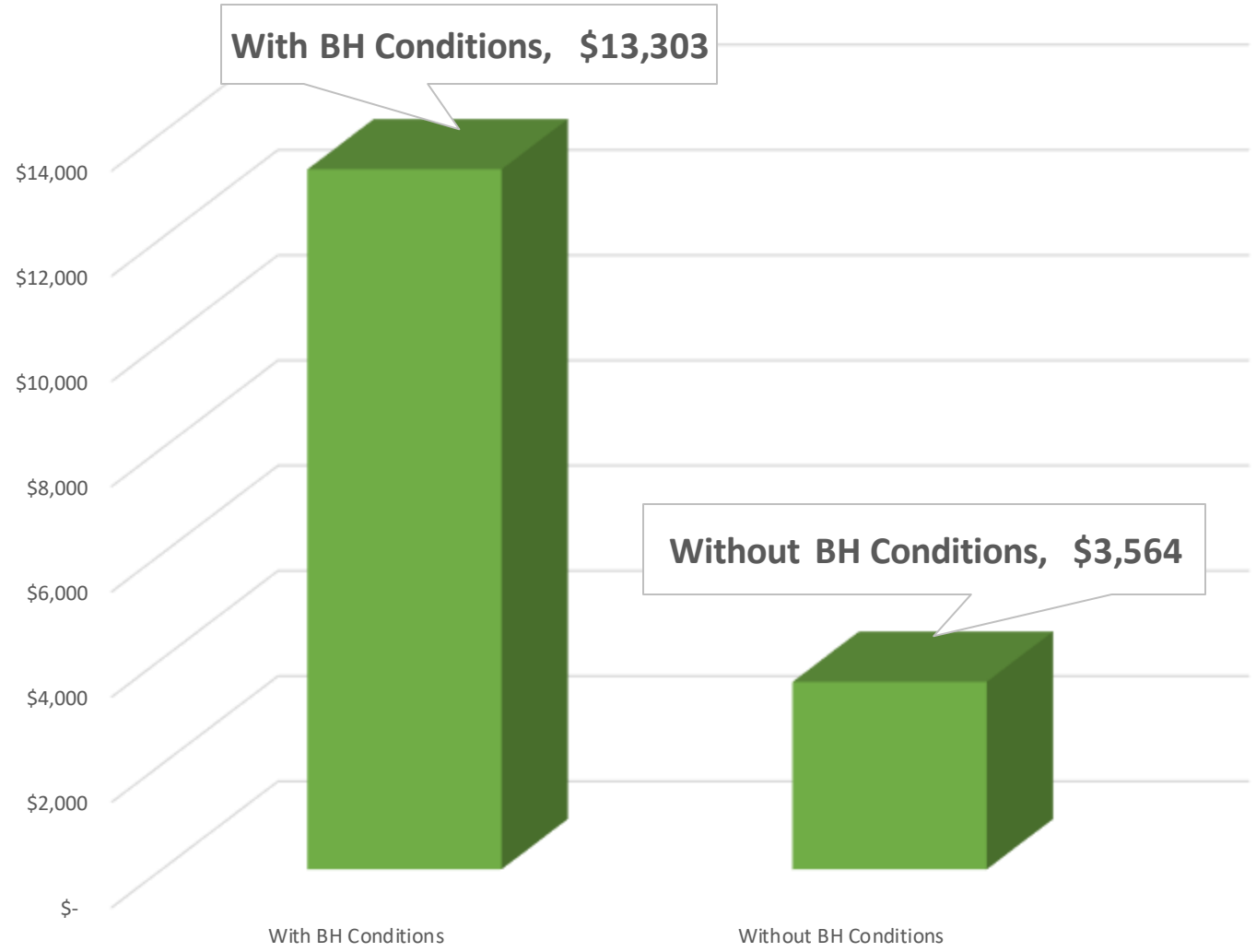
BEHAVIORAL HEALTH DISORDERS ARE THE COSTLIEST CONDITIONS IN THE U.S.



Source: Roehrig C, Mental Disorders Top The List Of The Most Costly Conditions In The United States: $201 Billion. Health Affairs 35, no. 6 (2016) 1130 – 1135.

FOLLOW THE MEDICAID MONEY

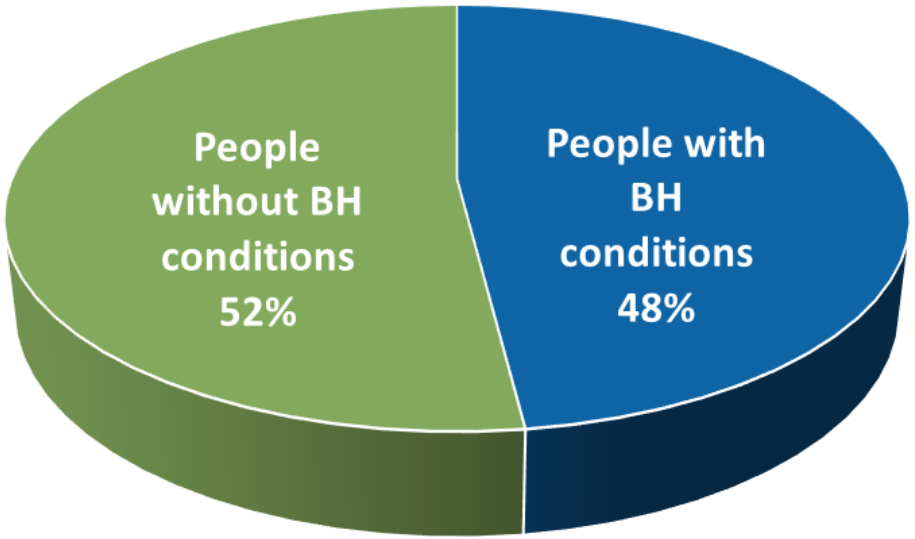
Medicaid Spending on people with mental health conditions is nearly **Four Times** as much as for other enrollees.



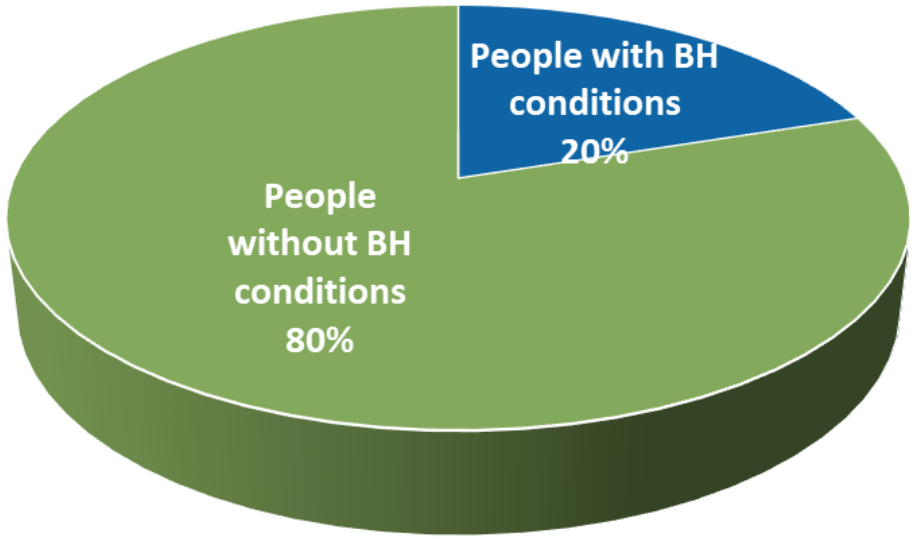
Source: Medicaid's Role in Behavioral Health, Henry J. Kaiser Family Foundation, May, 2017.

FOLLOW THE MEDICAID MONEY

Nearly **half** of Medicaid spending is for enrollees with BH conditions…



…but only 20% of Medicaid enrollees have BH conditions.



Source: Kamal R, Cox C, Rousseau D, et al. Costs and Outcomes of Mental Health and Substance Use Disorders in the US. JAMA 2017;318(5): 415.

COVID-19: MASSIVE BEHAVIORAL HEALTH IMPACT

Nearly half (45 percent) of adults reported that their mental health has been negatively impacted.[1]

- Roughly one-third of Americans say they felt nervous, depressed, lonely or hopeless in the past seven days.[2]
- Layered effect:
  - Compound nature and complexity
  - Death/Loss, illness, fear for self and loved ones
  - Social isolation
  - Economic Downturn/unemployment
  - Political upheaval and racial tension
- Newness of THIS disaster and unknowable-ness of what comes next…

1: https://www.kff.org/health-reform/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/
2: https://www.vox.com/science-and-health/2020/5/29/21274495/pandemic-cdc-mental-health

QUALIFIED AND QUALITY STAFF WILL BE EVEN HARDER TO FIND

+ **COVID-19 has seriously impacted the mental health of America's healthcare workforce.**
  - Yale healthcare worker survey in May 2020:[2]
    - 14.0% had probable major depression
    - 15.8% probable generalized anxiety disorder
    - 23.1% probable post-traumatic stress disorder
    - 42.6% probable alcohol use disorder
  - Meta-analysis of 29 studies of healthcare workers' mental health in June 2020:[3]
    - Average anxiety rate 25.8%
    - Average depression rate 24.3%
    - Average stress rate 45.0%

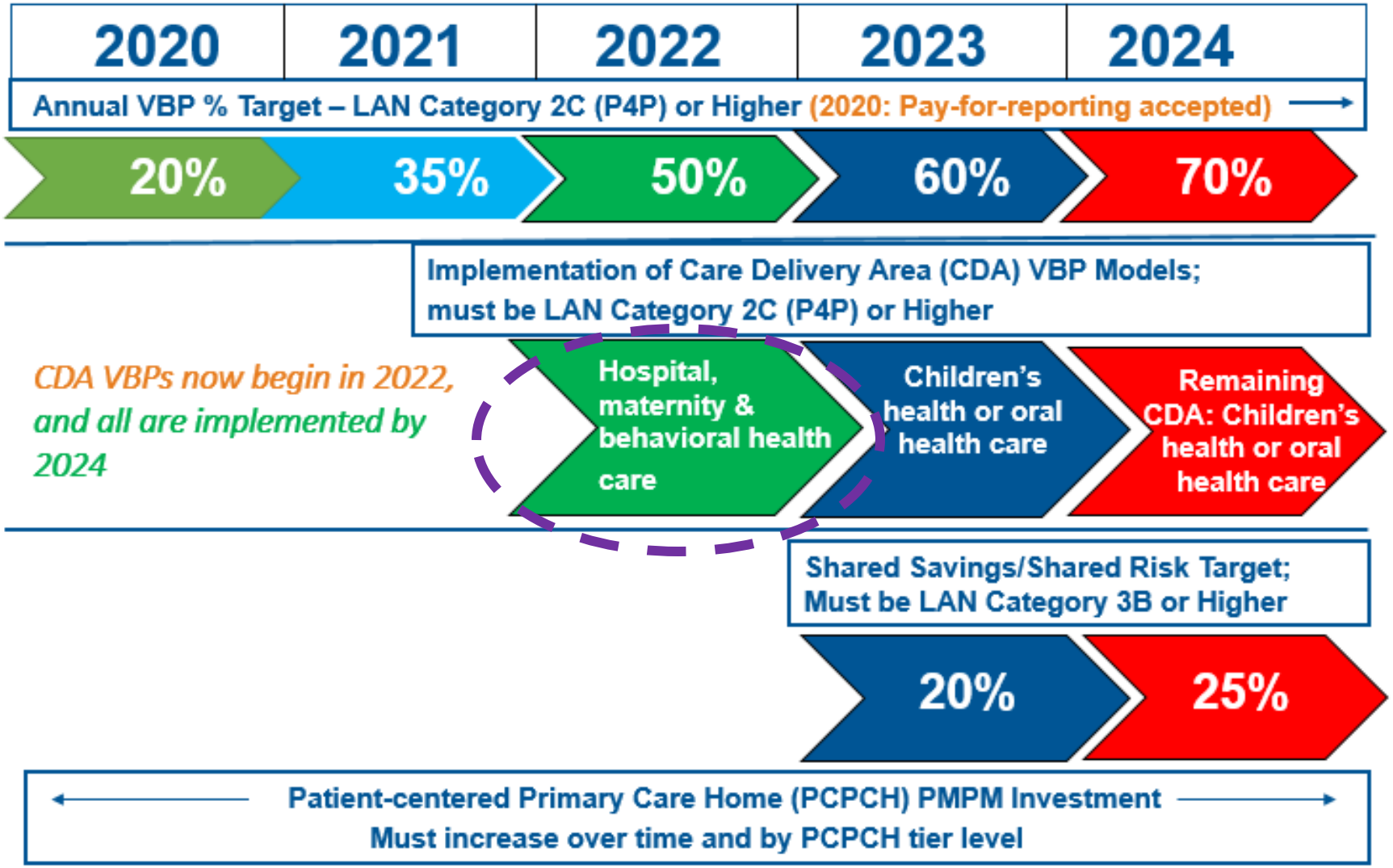
Even before COVID HRSA was projecting a nationwide BH practitioner shortage of between 27,000 and 250,000 FTE by 2025.[1]

1: https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf
2: A hybrid inductive-abductive analysis of health workers' experiences and wellbeing during the COVID-19 pandemic in the United States Rachel Hennein , Sarah Lowe Published: October 26, 2020, PLOS one https://doi.org/10.1371/journal.pone.0240646
3: The prevalence of stress, anxiety and depression within front-line healthcare workers caring for COVID-19 patients: a systematic review and meta-regression. Nader Salari et al. Hum Resour Health. 2020 Dec 17;18(1):100. doi: 10.1186/s12960-020-00544-1.

CCO VBP REQUIREMENTS AND KEY CONSIDERATIONS

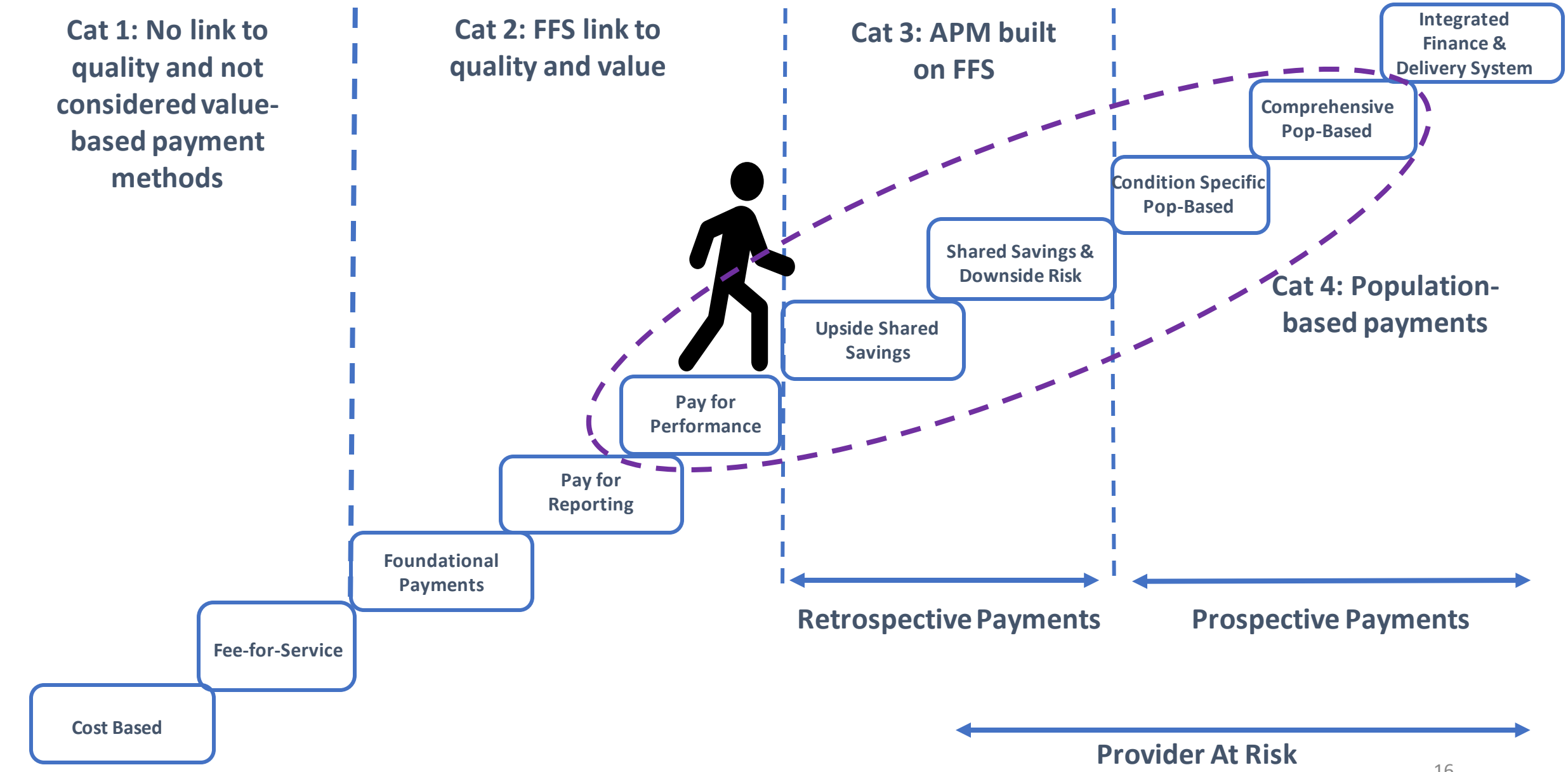
HEALTH MANAGEMENT ASSOCIATES

CCO 2.0 VBP REQUIREMENTS



Timeline Reflects COVID-19 Revisions

PROGRESS IN PURSUIT OF VALUE-BASED PAYMENT: LAN VBP CATEGORIES



OREGON – KNOWN & UNKNOWN

- We know that VBP requirements are measured according to the percent of payments to providers.
- We know that In 2022, 50% of CCOs' payments to providers need to be LAN 2C (P4P) or higher and they must pilot VBPs in hospital, maternity and behavioral health care delivery areas.
- In 2023, 20% must also be in LAN 3B (shared risk) or higher with additional pediatric or oral health care delivery VBP pilot.
- We don’t know what type of strategies the CCOs might develop, for example:
  - The VBP could be a mixture of MH or SUD services delivered in a specialty setting or MH/SUD services integrated into primary care.
  - They may combine areas such as maternity and SUD VBP into pilots
  - The CCO strategy may focus on MH/SUD services in institutional or facility settings and reduce or delay prioritizing outpatient or professional services.
  - For the priority Care Delivery Areas, CCOs are required to implement new or expanded VBP arrangements. Note that expanded arrangements could cover either more populations or more types of services.

VBPs IN BEHAVIORAL HEALTH ARE MORE COMPLEX

The Challenges are varied

SERVICE DELIVERY TRANSFORMATION
Population health management

DEFINING QUALITY
What are the metrics unique to us?

INFRASTRUCTURE
Significantly more complex than historically necessary

SIZE MATTERS
Leverage and cash reserves are critical to success

Patient Attribution:

Identifies a patient-provider health care relationship and is a foundational component of population based and value-based payment models because it designates:

- the population for whom a provider will accept accountability, and
- forms the basis for performance measurement, reporting, and payment.

Health Care Payment Learning Action Network (HCP/LAN) Work Group:

Their attribution recommendation starts with a method to identify a patient-clinician dyad and uses this information to attribute the patient to a provider group or delivery system.

- This recognizes that a provider group or delivery system, not the individual clinician, is accountable for the total cost of care, quality, and outcomes for a patient population.
- The Work Group recommendations are intended for use in payment models that assume primary care providers are the principle starting point for managing a population across the entire continuum of care.

The BH Challenge:

- CCOs assign enrollees to primary care providers (either individuals or clinics).
- Primary care providers have relationships with many BH providers and "exclusive" 1:1 relationships are not common. This is partly a reflection of the structures and silos in our current system but also to allow for patient choice.
- Basing BH attribution on primary care relationships works best with clinically integrated BH networks, the modern day "IPA".
- Other options are available but not common:
  - In some states, populations with SMI are assigned to a BH provider, including CCBHCs, through a type of registry system.
  - Some managed care organizations use an authorization-type process when a client engages with a BH provider; due to MH parity laws this cannot be a service authorization and it can be experienced as administratively burdensome, but it can help to assign accountability for the client's BH services.

ATTRIBUTION FOR VALUE-BASED PAYMENT MODELS FOR BEHAVIORAL HEALTH

- Collaborative Care Model for individuals with depression:
  - attribution based on diagnosis, and
  - payment via fee-for-service, fee-for-service bundled payment, pay-for-performance, shared savings.
- Subset of the general population with behavioral health conditions:
  - attribution based on portion of ambulatory services, and
  - payment via care coordination fee or shared savings.
- Individuals hospitalized for a severe mental illness or substance use disorder related diagnosis:
  - attribution based on a triggering event (hospitalization), and
  - payment via care coordination fee and episode (bundled) payment on total cost of care.

RISK ADJUSTMENT CHALLENGES - FINANCIAL

- Capitated contracts may increase the risk for disenrollment or adverse outcomes among high- cost clients with severe mental illness. Risk-adjusted payments to providers are likely to reduce providers' incentives to avoid or under-treat those populations.
- Options for BH-specific risk adjustment methods are limited, however, most common risk adjustment tools include basic behavioral health disorders in their calculations.
- Hierarchical Condition Category Coding
  - A system implemented by CMS in 2004 as a way for medical groups to estimate a patient's future health care costs in value-based payment models.
  - The model assigns a risk adjustment factor to each Medicare patient which is then used to adjust capitation payments for patients enrolled in Medicare Advantage plans.
- Chronic Illness & Disability Payment System+Rx
  - A diagnosis-based risk adjustment model that uses diagnosis codes as well as NDC codes to assess risk. Commonly used by state Medicaid agencies to adjust capitation payments to managed care organizations, such as CCOs.

RISK ADJUSTMENT CONSIDERATIONS

- The ability to risk adjust your assigned population will help you with monitoring and measuring improvements in performance metrics.
- It is especially important if your practice is being benchmarked across other practices that may have a different patient mix based on diagnosis or specialty areas for select populations.
- Risk adjustment for social needs is not currently in widespread use and has not demonstrated success in supporting efforts to eliminate disparities. There is also concern that emerging “social needs” adjustment tools could exacerbate disparities.
- Risk-adjusted payments to providers should reduce providers' incentives to avoid or under-treat clients with severe mental illness.
- All of these factors further support the concept of “clinically integrated networks” that can help to spread risk across a larger population.
- Accurate diagnosis coding is critical for accurate risk adjustments.

VBP PERFORMANCE METRICS INCLUSIVE OF BH CONDITIONS IS INCREASING

OREGON HEALTH PLAN 2021 MEASURE SET

- Childhood Immunization Status
- Immunization for Adolescents
- Kindergarten Readiness
- Postpartum Care
- **Screening for Depression and Follow-Up Plan**
- **Cigarette Smoking Prevalence**
- **Alcohol and Drug Misuse SBIRT)**
- Preventive Dental
- Oral Evaluation for Adults with Diabetes
- **Mental** and Physical and Oral Health Assessment for Children in DHS Custody
- Comprehensive Diabetes Care
- **Initiation and Engagement of Alcohol/Drug Abuse or Dependence Treatment**
- **ED Utilization among Members with Mental Illness**
- Meaningful Language Access to Culturally Responsive Health Care Services

- The Certified Community Behavioral Health Center (CCBHC) models and quality measures provide an example that could be expanded across the behavioral health system and could inform ongoing VBP design efforts. They include a range of measures:
  - Access - time to initial evaluation
  - Process - documentation of current medications in medical records
  - Outcome measures – improvement in depression, death by suicide
  - And measures addressing social determinants of health such as housing status

- Additionally, the CCBHC measure set includes measures relevant to adult and pediatric populations and incorporates behavioral and physical health measures for behavioral health providers.

NATIONAL EXAMPLES: BEHAVIORAL HEALTH VBP

HEALTH MANAGEMENT ASSOCIATES

Tennessee – Health Link

- Developed a Medicaid care coordination program called Health Link based largely on CMS's health home model for individuals with SMI and substance use disorder (SUD) diagnoses.
- Payments for care coordination and care management activities are monthly case rates.
- Providers are also eligible for outcomes payments based on quality/efficiency metric performance.
- While community mental health centers (CMHCs), federally qualified health centers (FQHCs) and other mental health agencies are eligible to participate in Health Links, the majority of participating providers are CMHCs.

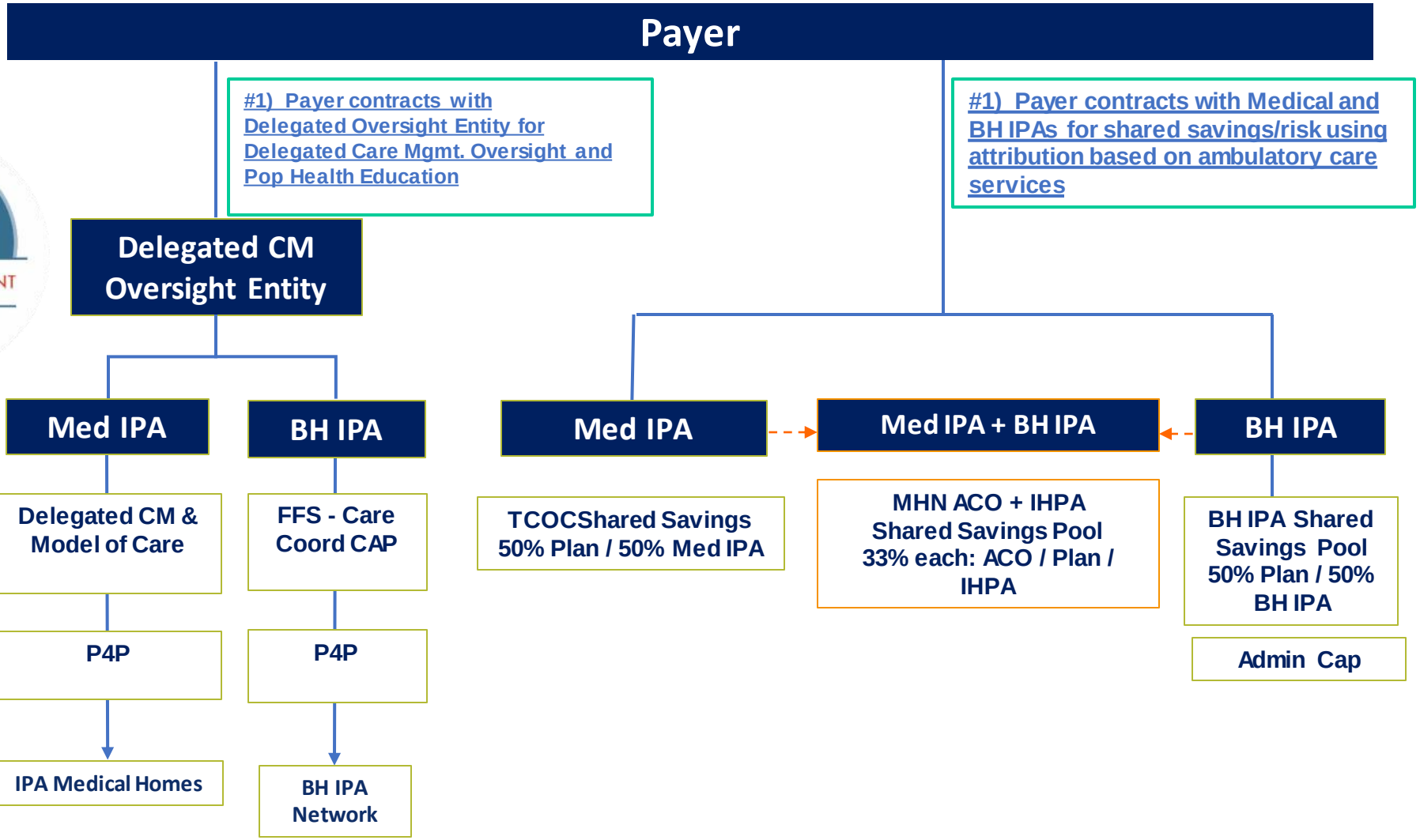
- TennCare is the state's Medicaid program
- Medical and behavioral health are integrated and provided via three managed care plans offered statewide
- Health Link was developed by TennCare working closely with providers and the 3 health plans

Total Cost of Care Contract with MVP* Health Plans

- CBH Care provides community-based behavioral health services in Northern New Jersey at multiple sites, serving over 4,000 people per year
- Seven medical performance indicators (i.e. adolescent well-care visit, colorectal cancer screening)
- PMPM Care Management Fee
- Portion of gross premium as a Shared Savings Payment
- Detailed information sharing by the plan
- Developed a managed services organization (MSO) in collaboration with another Behavioral Health IPA (CBC) called IMSNY

*Note: MVP has Medicaid, Medicare and Commercial lines of business

LAN CATEGORY 2 AND 3 EXAMPLE



MEDICAL HOME NETWORK

Massachusetts – Total Cost of Care

- MassHealth (Medicaid) contracts with ACOs to deliver physical health care, mental health care and SUD treatment to a defined group of MassHealth members.
- Attribution is based on the patient's primary care provider.
- ACOs must also work with state-contracted community partners for care management of members with significant behavioral health or long-term services and supports needs.
- ACOs are paid either a prospective capitated rate or achieve shared savings/shared loss against a Total Cost of Care (TCOC) benchmark, depending which of the three state-defined ACO models they participate in.
- MassHealth pays community partners directly, via PMPM payments for months in which they provide outreach and care coordination supports. In the future, community partner payment will include a quality performance withhold.

- MassHealth is the state's Medicaid plan that contracts with Managed Care Organizations, Accountable Care Organizations (ACOs) and Primary Care Plans.
- Behavioral Health is carved out of some of the contracts, integrated in others.

New York: Bundles/Total Cost of Care

- NY's "VBP Roadmap" outlines the state's vision for VBP in its Medicaid program.
- Two VBP options are specifically related to behavioral health:
  - **The Integrated Primary Care Bundle**, which includes care for the most prevalent physical and behavioral chronic conditions in New York Medicaid, including but not limited to asthma, hyper-tension, bi-polar disorder, depression and anxiety, substance use and trauma; and
  - **Total Care for Special Needs Populations**, which implements Total Cost of Care (TCOC) VBP arrangements with providers who work with a subset of eligible subpopulations, including individuals with significant behavioral health needs who are covered under New York's Health and Recovery Plans (HARPs).
- State guidelines recommend patient attribution based on Medicaid MCO-assigned PCP for the former and Medicaid MCO-assigned health home for the latter model, though MCOs and VBP contractors may develop alternate methodologies.

- New York Medicaid services are provided primarily through managed care plans.
- Behavioral Health services are integrated with physical health.
- Their "VBP Roadmap" is an evolving document with a variety of VBP options and levels of financial responsibility

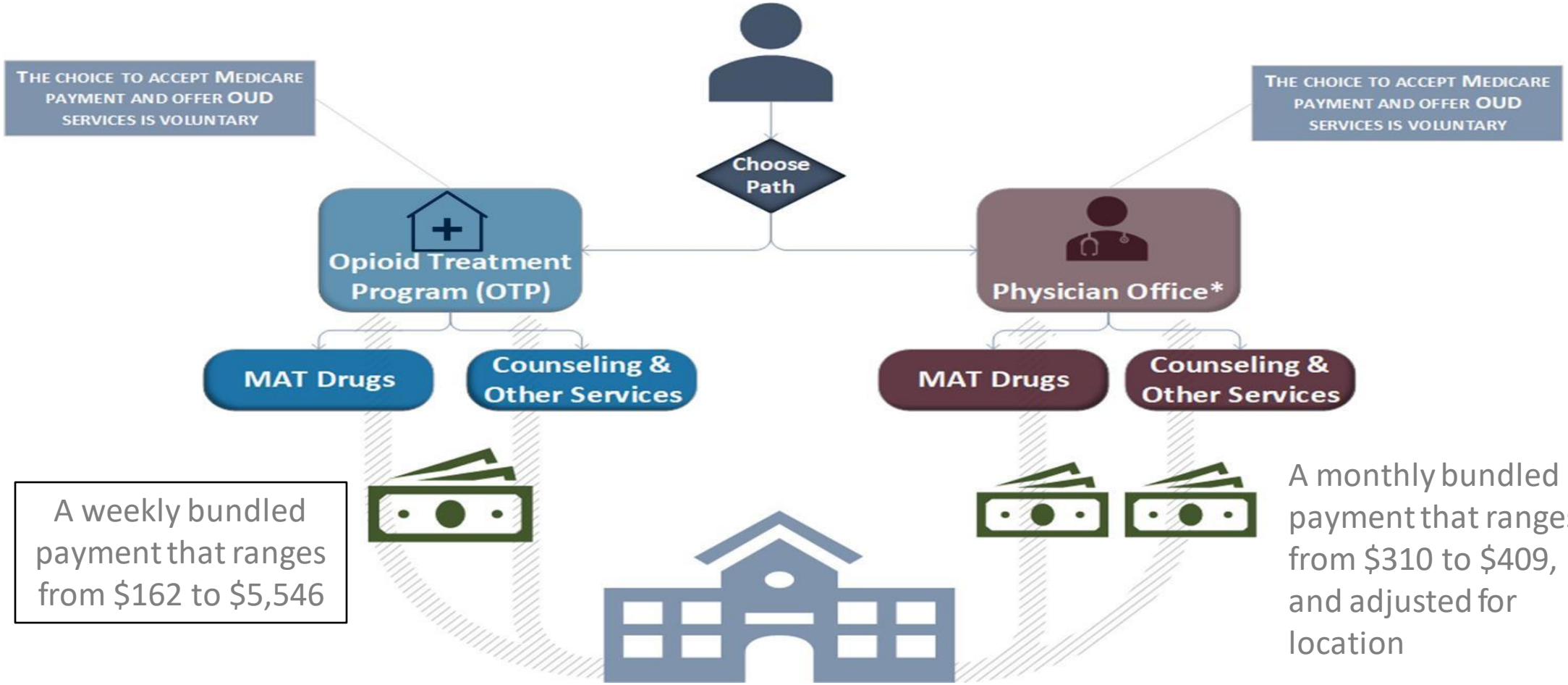
LAN 4:
NEW MEDICARE BENEFIT: OPIOID USE DISORDER TREATMENT BUNDLES

- **Opportunity:** Beginning January 1, 2020, Medicare beneficiaries may receive—and providers can be paid for— opioid use disorder (OUD) treatment that includes counseling, as well as medication-assisted treatment (MAT) and related items and services.

- **Key Summary Points:**
  - Medicare beneficiaries, including those dually eligible for Medicare & Medicaid, are the fastest growing group of OUD patients.
  - Services will be covered by a bundled payment, either weekly or monthly depending on type of provider, that can repeat as long as a patient needs treatment.
  - The bundled payment model refers to payment for all services provided for a patient within an episode of care, and CMS is encouraging use of telehealth in the bundle
  - Episode of care refers to the care delivery process for a certain condition or within a certain time frame
  - CMS has taken the lead in using the bundled payment model

NEW OPIOID USE DISORDER BUNDLED PAYMENTS – TO IMPROVE ACCESS TO MAT

- CMS designed the new OUD benefit so that Medicare beneficiaries who seek treatment may elect one of two treatment pathways.
- CMS is encouraging use of telehealth as part of the bundled services.



A weekly bundled payment that ranges from $162 to $5,546

A monthly bundled payment that ranges from $310 to $409, and adjusted for location

MODELS OF CARE FOR VALUE- BASED PAYMENTS AND OUTCOMES

HEALTH MANAGEMENT ASSOCIATES

VALUE-BASED PAYMENT MODELS CREATE OPPORTUNITIES, NOT RESULTS

Payment Reform *without*
Practice Transformation
doesn't
change outcomes.

Delivery System Transformation

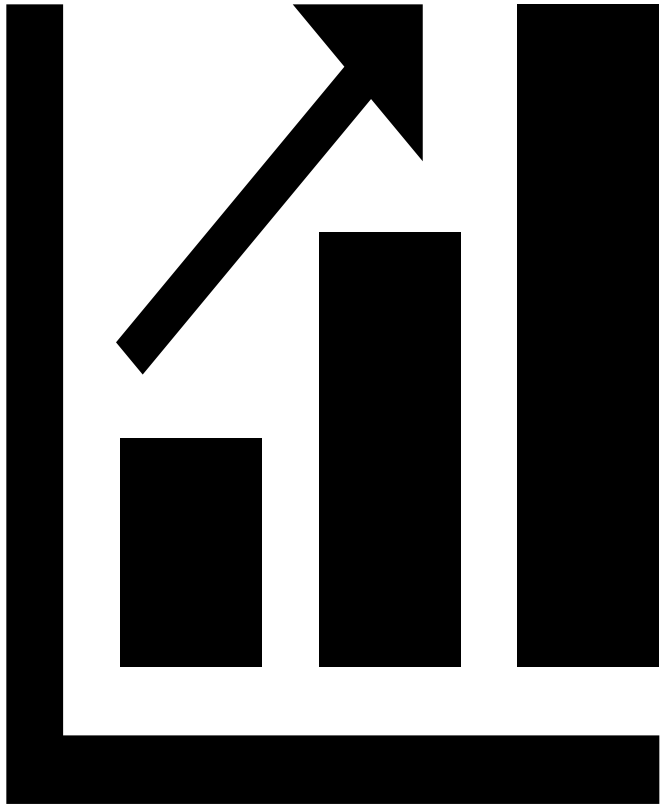
Payment System Transformation

Practice transformation
without a
financial model
is not
sustainable.

Technology is transforming the way care should be provided

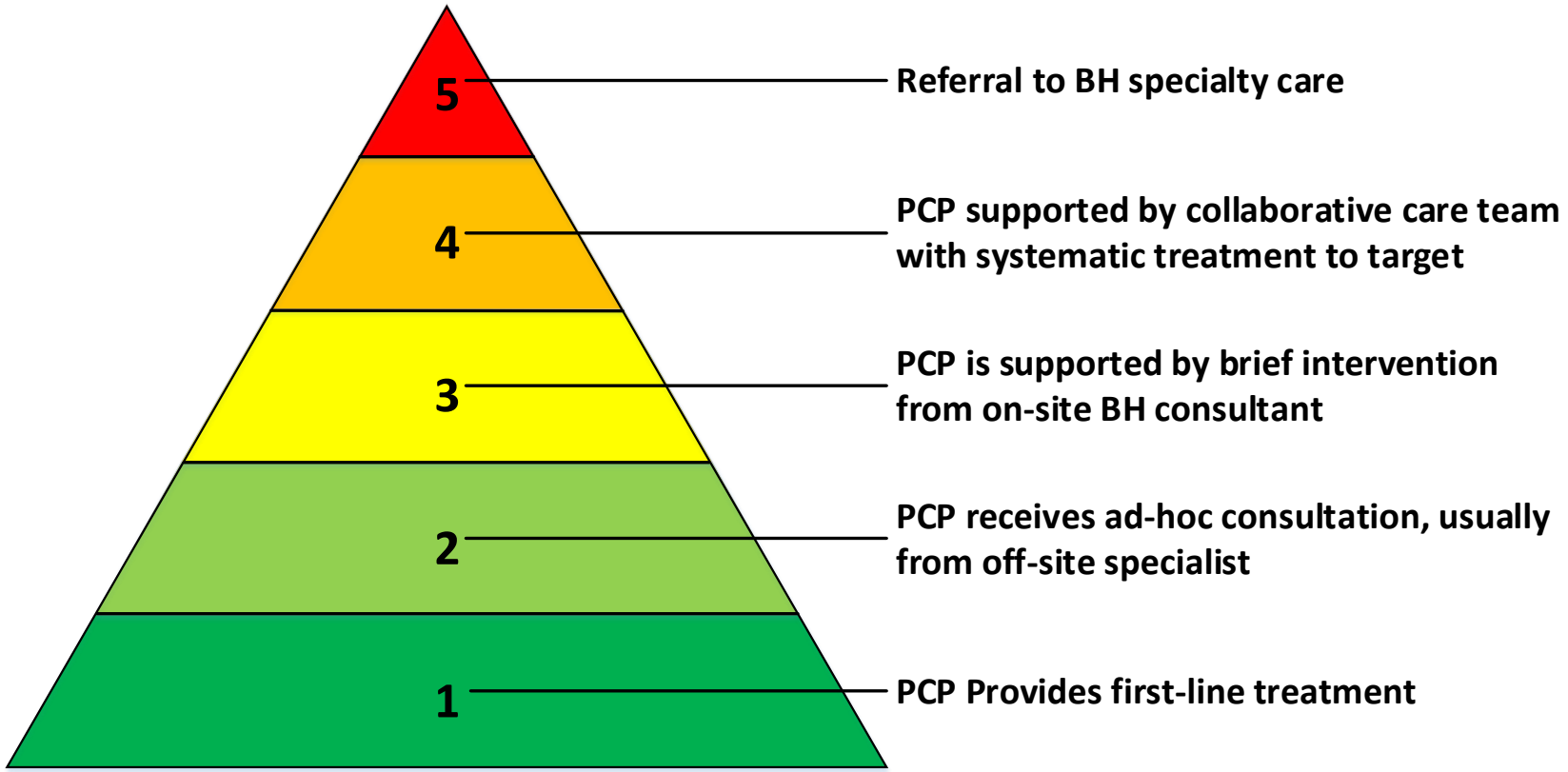
- How are you using data to provide measurement-based care? Population-based care?
- How are you using technology to improve access?
  - Telemedicine
  - iCBT (Internet Cognitive Behavioral Therapy)
- How are you using technology to maintain connection with your clients?
  - What data are you passively collecting?
- How are you using technology to communicate with your colleagues?

MEASUREMENT-BASED CARE – BECOMING THE EXPECTATION, NOT THE EXCEPTION



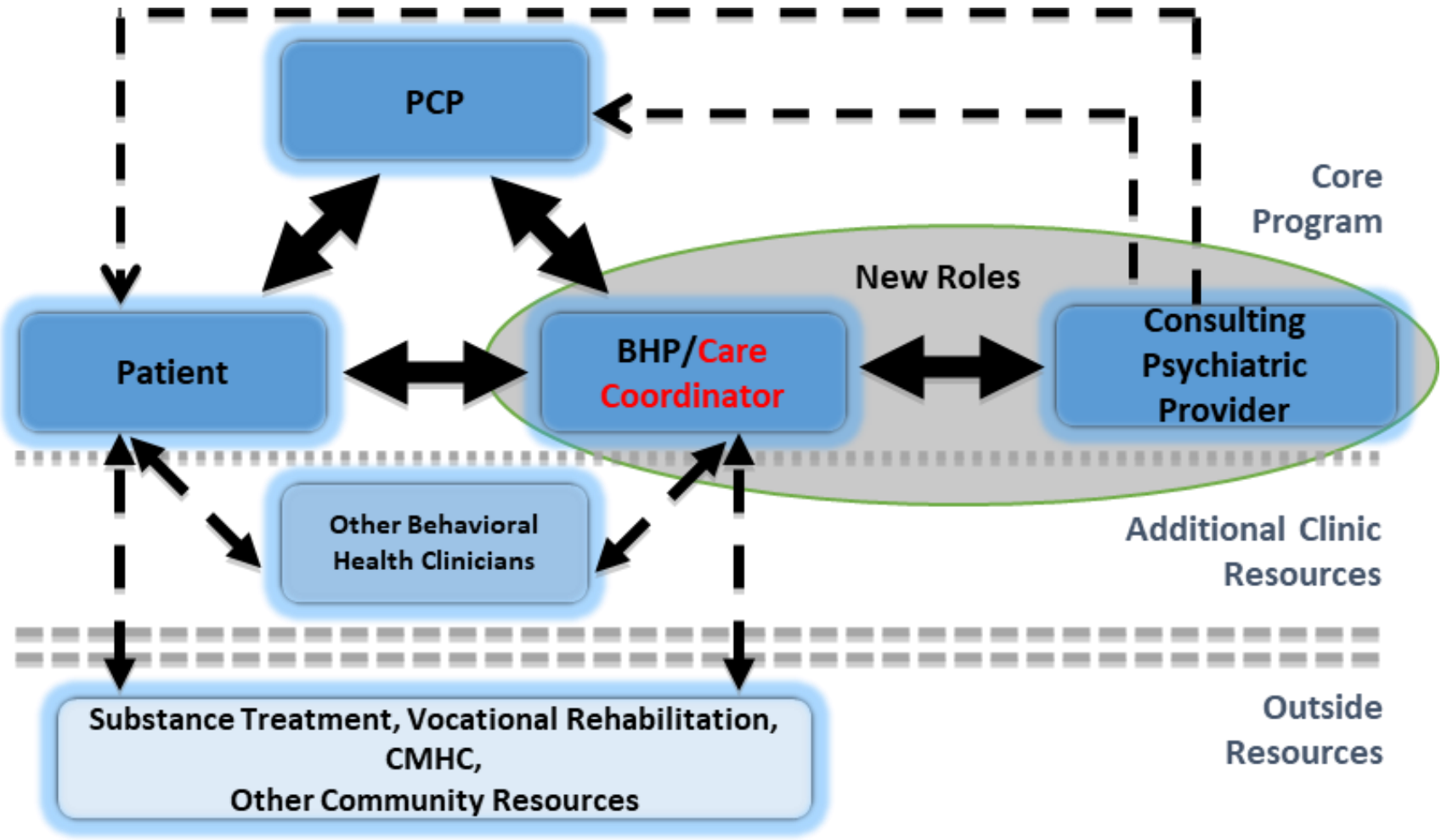
- **Measurement-based care (MBC): the practice of basing clinical care on client data collected throughout treatment:**
  - Research shows that BH providers only detect 19% of patients who are worsening using judgement and standard practice.
  - Detection is even lower for those whose symptoms are not improving as expected. We don't know that people aren't improving.
- **Systematic administration of symptom rating scales – use huddle or registry:**
  - Measurement Based Care is NOT a substitute for clinical judgement.
- **Use of the results to drive clinical decision making at the patient level – overcome clinical inertia.**
- **Patient rated scales are equivalent to clinician rated scales.**
- **You have to be all-in because one-time screening or infrequent assessments aren't sufficient.**

STEPPED MODEL OF INTEGRATED BEHAVIORAL HEALTHCARE



Source: aims.uw.edu

COLLABORATIVE CARE MODEL FOR MANAGING CHRONIC CONDITIONS



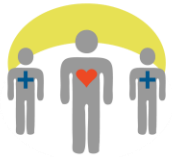
TRANSITIONS OF CARE WORKFLOWS

Real-Time Connect Alerts & Communication

MHN CONNECT

AI / Machine Learning

Hospital Relationships



Patient Engagement

Warm Handoffs

Ambulatory Visits

MEDICAL HOME NETWORK

PRIMARY CARE INTEGRATION IS NO LONGER OPTIONAL

- ROI of $6.50 for every $1 spent.
- 70+ randomized controlled trials demonstrate it is both more effective and more cost-effective:
  - Across practice settings,
  - Across patient populations,
  - For a wide range of the most common BH disorders.
- Better medical outcomes for common chronic medical diseases.
- Greater provider satisfaction.

COLLABORATIVE CARE MODEL – INTEGRATING PRIMARY CARE AND BEHAVIORAL HEALTH

- Medical Home Network (MHN) in Illinois recognized the need to integrate physical and behavioral health in the primary care setting, while also reducing strain on, and improving access to, psychiatry services.
- MHN used shared savings to self-fund an evidence-based approach to enhancing behavioral health access for our population.
- Initially paid a capitation for each member enrolled in the program but transitioned to a bundled payment triggered by at least one qualifying service in the month
- 3,659 patients have been enrolled in the Collaborative Care Program. **54%** of patients actively engaged in the program demonstrated a **50% reduction** in depression symptoms and **34% reached full remission from depression.**

54%
Reduction in symptoms

34%
In Remission

MEDICAL HOME NETWORK

NEW MODELS OF CARE: CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS (CCBHC)

- An emerging model for delivering whole-person care focused on mental health and substance use care especially for individuals who have the most complex needs.

Protecting Access to Medicare Act (PAMA) of 2014

- 2015 – Planning Grants to 24 States: $24M
- Demonstration Program Authorized in 8 States: 15% Enhanced FMAP

Excellence in Mental Health Act of 2017

- Expanded Demonstration Program to 2 Additional States
- Expansion Grants
  - 2018: $50M
  - 2019: $150M
  - 2020: $200M

CARES Act

- Expansion Grant
  - 2020: $250M

American Rescue Plan

- Expansion Grant
  - 2021: $420M

Currently, in Oregon there are CCBHCs in Columbia, Deschutes, Grant, Harney, Hood River, Josephine, Klamath, Lane, Multnomah, Wallowa, Wasco, Washington, and Yamhill counties.

CCBHCS ARE DEMONSTRATING SAVINGS

Case Study: Missouri

- Hospitalizations declined by 83% after first year.
- Net savings of $127.7M statewide with integrated care.
- ED services decreased by 75% after first year.
- 20% decrease in cholesterol and a 1.48 point decrease in hemoglobin A1c for CCBHC recipients.
- Criminal justice services decreased 55% in one year.

Case Study: New York

- All-cause readmission dropped 55% after first year.
- BH inpatient services show a 27% decrease in monthly cost.
- BH ED services show a 26% decrease in monthly cost.
- Inpatient health services decreased 20% in monthly cost.
- ED health services decreased 30% in monthly cost.

CLINICALLY INTEGRATED NETWORKS AND VBP

HEALTH MANAGEMENT ASSOCIATES

CHALLENGE: BH PROVIDERS AND CLINICALLY INTEGRATED NETWORK GOVERNANCE

13 FQHCs & 3 Hospital Systems

- Alivio Medical Center
- Asian Human Services Family Health Center *(New)*
- Aunt Martha's Health & Wellness
- Chicago Family Health Center
- Christian Community Health Center
- Erie Family Health Centers
- Esperanza Health Centers
- Friend Health
- Heartland Health Centers
- La Rabida Children's Hospital
- Lawndale Christian Health Center
- Near North Health Service Corp
- PrimeCareHealth
- PCC Community Wellness
- Rush University Medical Center + RUMG
- Sinai Chicago + SMG

VALUE NETWORK IPA

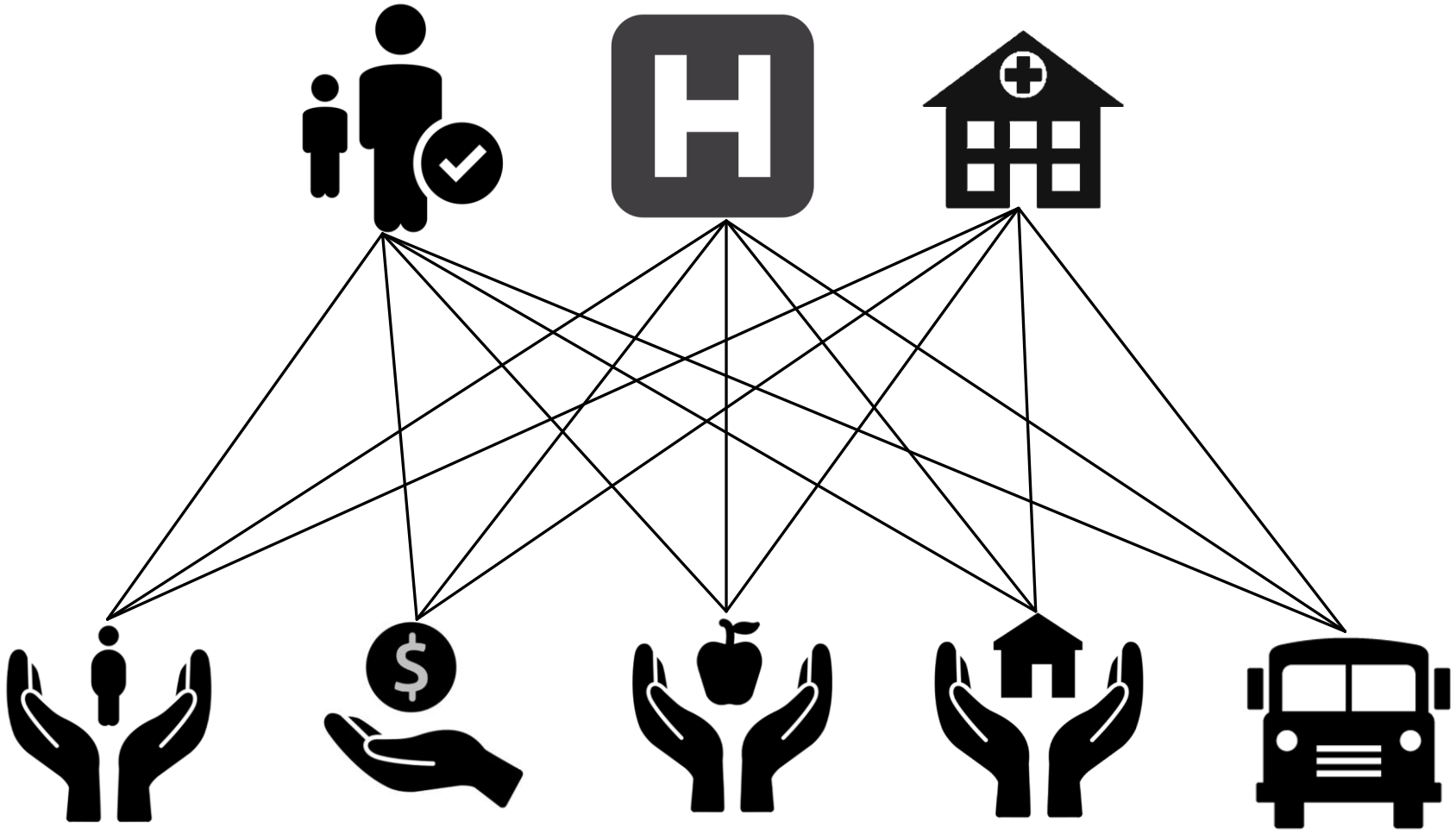
- VBP contract in 2020 with BCBS of Western New York focusing on seven HEDIS quality metrics and two HEDIS utilization metrics.
  - 25% improvement in initiation and engagement of alcohol or other drug dependence treatment
  - 3% improvement in antidepressant medication adherence (acute phase).

ILLINOIS HEALTH PRACTICE ALLIANCE

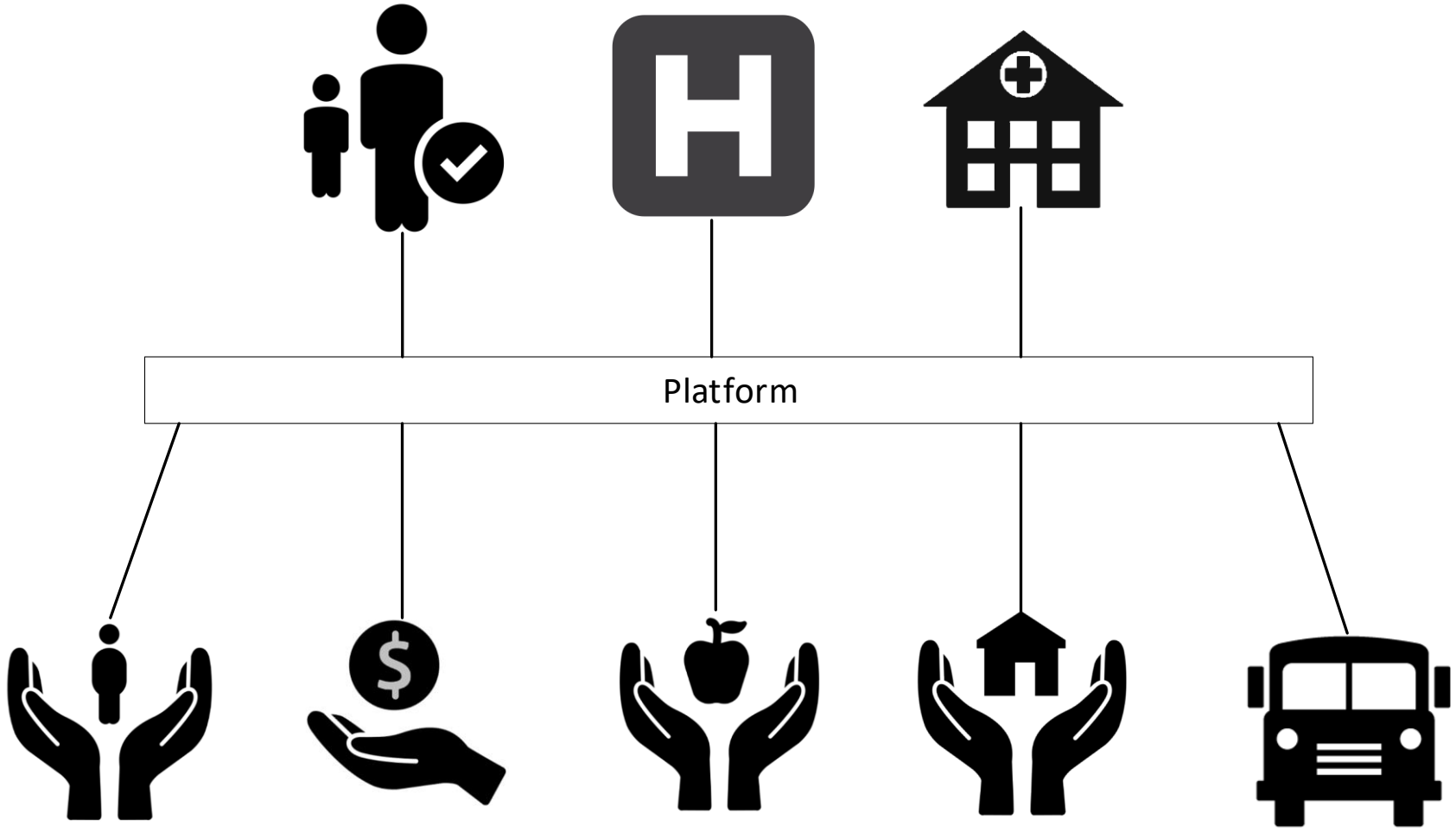
- 105 BH providers
- Utilize a common (HealthEC) platform for care management
- Contracts with Centene Health Plan

METRIC	Month 1 Results	Month 12 Results	Percent Improved
Care Transitions	68%	100%	32%
Health Risk Screenings	30%	48%	18%
Health Risk Assessment	44%	89%	45%
Care Plan Completion	36%	75%	39%

THE WEB OF RELATIONSHIPS CAN GET COMPLICATED WITHOUT A CLINICALLY INTEGRATED NETWORK



A PLATFORM SIMPLIFIES THINGS FOR EVERYONE



CONCLUSION: THE PANDEMIC AND POLITICAL REALITIES ARE PUSHING YOU TO CHALLENGE EVERYTHING

+ Your strategy
+ Your program model
+ Your partners
+ Your role in the delivery system
+ Your quality program
+ Your level of integration

Q & A

Send your questions to the host via the Question function.

RESOURCES

- 2020-2024 State Health Improvement Plan (SHIP) – Priority Behavioral Health https://www.oregon.gov/oha/PH/ABOUT/Pages/Behavioral-Health
- National Association of State Mental Health Program Directors Council. (2006). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: Parks, J., et al.
- Health Care Payment and Action Network (LAN) APM Framework: https://hcp-lan.org/apm-refresh-white-paper/
- Center for Health Care Strategies: "Behavioral Health Provider Participation in Medicaid Value-Based Payment Models: An Environmental Scan and Policy Considerations" (2019) available at: https://www.chcs.org/media/behavioral-health-provider-participation-in-medicaid-value-based-payment-models-an-environmental-scan-and-policy-considerations.pdf
- Center for Health Care Strategies: "Moving toward Value-Based Payment for Medicaid Behavioral Health Services" (2017) https://www.chcs.org/media/VBP-BH-Brief-061917.pdf
- Unützer J, Harbin H, Schoenbaum M, Druss B. The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes, Health Home Information Resource Center Brief, May 2013.
- Hwang W, Chang J, LaClair M, Paz H (2013), Effects of Integrated Delivery System on Cost and Quality. Am J Manag Care. 2013;19(5):e175-e184.
- Katon WJ, Russo JE, Von Korff M, Lin EH, Ludman E, Ciechanowski PS. "Long-term Effects on Medical Costs of Improving Depression Outcomes in Patients with Depression and Diabetes." Diabetes Care. June 2008;31(6):1155-1159.

RESOURCES

COVID-19 and Workforce:

- From Kaiser Family Foundation: https://www.kff.org/health-reform/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

- From the Centers for Disease Control: https://www.vox.com/science-and health/2020/5/29/21274495/pandemic-cdc-mental-health

- From HRSA: https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf

- A hybrid inductive-abductive analysis of health workers' experiences and wellbeing during the COVID-19 pandemic in the United States Rachel Hennein , Sarah Lowe Published: October 26, 2020, PLOS one https://doi.org/10.1371/journal.pone.0240646

- The prevalence of stress, anxiety and depression within front-line healthcare workers caring for COVID-19 patients: a systematic review and meta-regression. Nader Salari et al. Hum Resour Health. 2020 Dec 17;18(1):100. doi: 10.1186/s12960-020-00544-1.

RESOURCES CONTINUED

Payment models:

- The Patient-Centered Opioid Addiction Treatment (P-COAT) (American Society of Addiction Medicine)
- The Addiction Recovery Medical Home Alternative Payment Model (Alliance for Addiction Payment Reform)
- The Clinical Pathways and Payment Bundles for Medication Assisted Treatment (CMS)
- The Case Rate Toolkit: Preparing for Bundled Payments, Case Rates, and the Triple Aim (National Council for Behavioral Health)
    - Case Rate Toolkit Presentation (National Council for Behavioral Health)
    - Companion Paper: An Update on Behavioral Healthcare Payment Reform (National Council for Behavioral Health)
- Center for Health Care Strategies: New York's VBP Roadmap: https://www.chcs.org/resource/navigating-new-york-state-value-based-payment-roadmap/
- National Council for Behavioral Health's Summary of NY's Care Transitions Network Initiatives available at: https://www.thenationalcouncil.org/value-based-care/overview/

UPCOMING FROM THE OHA TRANSFORMATION CENTER

- Please complete the evaluation that will be sent out after the webinar.
- CME credit will be emailed to participants completing the evaluation.
- Slides, webinar recording will be available at: **https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Value-Based-Payment.aspx**
- Next session: **June 16, 2021, Noon to 1pm**

  Topic: Value-based payment and maternity care: What have we learned so far?
- Follow-up questions?

  Contact: **OHAVBPQuestions@healthmanagement.com**