Payment Innovations in Treatment and Recovery Services

Opioid and Other Substance Use Disorders Study Committee

Dept. Of Health Care Policy & Financing

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Value Based Payments Help Us Reach Parity, Address Structural Challenges

Stigma

Criminal Justice & Sentencing

Lack of funding, limiting infrastructure

Complex care, social needs

Value Based Payments are for Everyone!

How we pay for care influences health care delivery

- Fee-for-Service can be easier to track and bill, but also drives administrative burden and total cost of care
  - ➢ Separate, distinct actions don’t always benefit the whole person
- Looking for alternative payment models (APMs) that require less paperwork, allow for flexibility in practice, address social needs, recognize specific populations, coordination
- Managed care BH encourages flexibility in provider contracts from RAEs, integration, whole person health
  - ➢ Administrative funds also allow for ad hoc purchases with Medicaid funds like bus passes

Paying for Outcomes

- Well designed value-based payments save total cost of care by keeping people healthy, connecting providers to stable revenue, not by rationing care
- Value based care pays for the coordinated delivery of quality health care to a population
- VBPs help focus on patient experience & health outcomes
- Physical and behavioral health moving to VBP, now required by RAEs for CMHCs

HCPF (state) → RAEs (region) → Providers (community)

How Do We Measure Success?

Health Delivery, not Health Care

- VBPs does not measure if treatment is effective
- Tests health care delivery models
- Are these policies making a difference?

Examples of Incentives

- Clinical outcomes
- Timely access to care
- Serving specific populations & equity
- Preventing hospitalizations
- Patient experience

National Benchmarks + Some local priorities

- National Quality Forum build, test, and publish metrics
- Using these for RAE incentives, SUD waiver
- Measure some unique local challenges as well

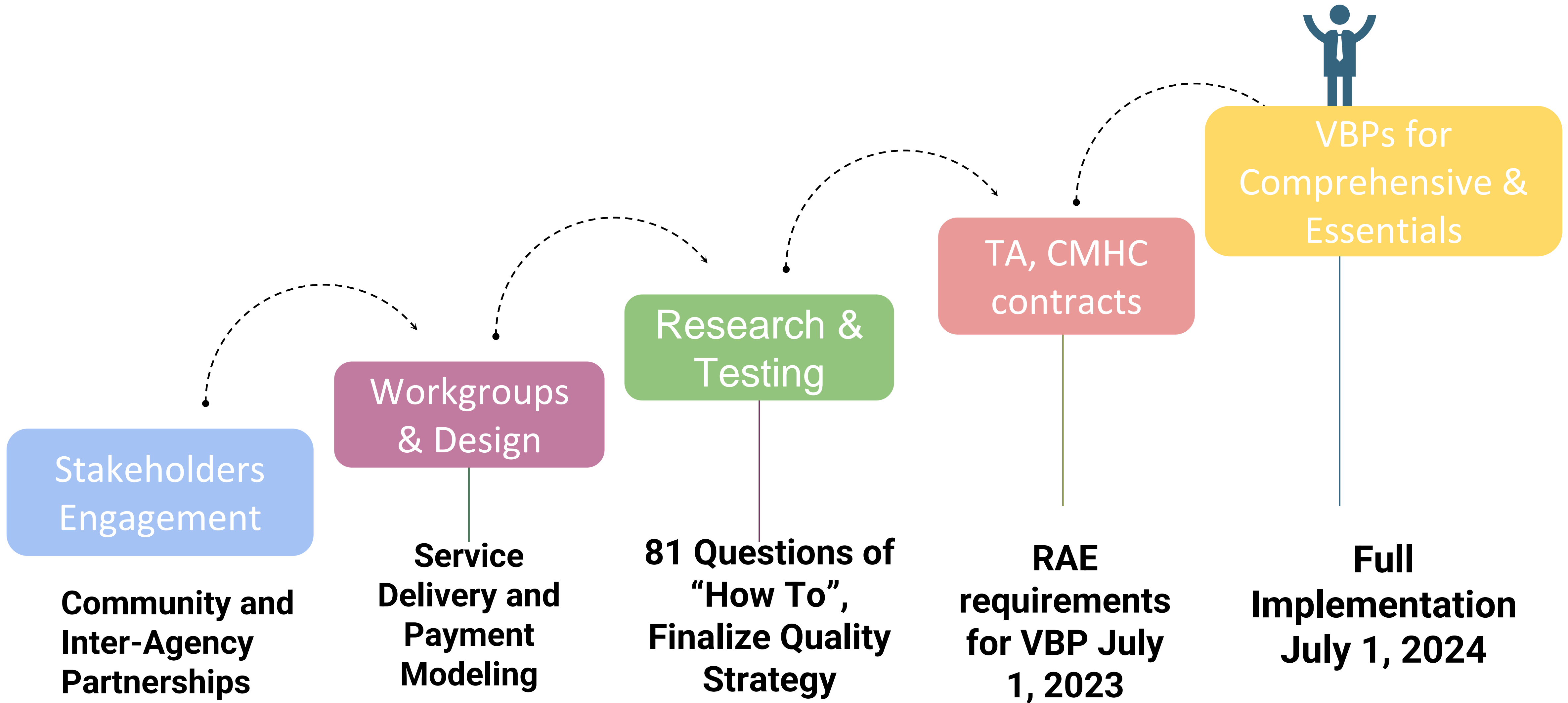
Payment design considerations

- Population variation (rural, urban, social factors)
- Supporting providers is key to success
- Driven by evidence, quality strategy
- Must account for any potential incentives to limit access, provide unnecessary care, cherry-picking
- **Patient, member, and advocate voices make for patient-centered program design**

VBP Plan for BH Safety Net

- Prospective Payment System (PPS) + cost-based reimbursement for Comprehensive Providers
  - ➢ Supports RAE efforts to hold their networks accountable
  - ➢ APM emphasizes value over volume, supports for high-acuity patients requiring complex service needs
  - ➢ Payment in advance provides stable funds, matches federal CCBHC model, incentives to provide comprehensive care
- Enhanced Payments for Essential Providers
  - ➢ Higher payment for those who meet BHA standards
- Implemented with a Universal Provider Contract July 2024

BH PPS Timeline



Spotlight Examples of APMs and VBPs

- Tier payments based on the acuity of a patient for residential care, home care
- Bundled payments for a set of services, like inpatient care, maternity care, MAT
- Primary Care APM 1 & 2
  - APM 1 began in 2018 and most PCMPs in the ACC participate. Goal of increasing investment into primary care will improving quality.
  - APM 2 began in 2022 and provides PCMPs with stable revenue through a partial capitation with a 16% rate increase effective 7/1/23.

Whole Person Care: Integrating Primary and BH Care

- Screening, Brief Intervention, Referral, Treatment
  - Need this for kids, rural/frontier, urban public PCPs
- BH services in a primary care office
  - Full integration, MAT, co-located care, referral only
  - Consulting psychiatrist, addiction specialists
- Primary care for people with ongoing BH needs
  - CMHC/comprehensive providers, OTPs, bi-directional
- How to pay for two services at once?

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