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Trends in behavioral health payment, coverage and outcomes

Stuart Portman, Senate Finance Committee
Dr. Joe Parks, National Council for Mental Wellbeing
Dr. Christine Bredfeldt, Milliman, Inc

July 26, 2022

Health Policy Executive Summit 2022

Meet the speakers

Stuart Portman
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Stuart Portman

Senate Finance Committee

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Dr. Joe Parks

National Council for Mental Wellbeing

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CCBHC Integration Leadership

3M Health Policy Executive Summit - July 2022

Integrated Care: 15 Years In, But Not There Yet

Many Healthcare organizations have not attempted to implement any of the current integration models

Often implemented as an isolated special project/service instead of a whole organization transformation

Often not sustained or expanded beyond initial grant funding

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Policy and Implementation Barriers

Lack of flexibility in implementation of integrated services

Lack of appropriate bidirectional measures of progress in “integratedness”

Lack of connection of “integratedness” to value

Lack of financing to support either implementation or sustainability

CCBHCs: Supporting the Clinical Model with Effective Financing

Standard definition	→	**Raises the bar for service delivery**
Evidence-based care	→	**Guarantees the most effective clinical care for consumers and families**
Quality reporting	→	**Ensures continuous quality improvement**
Prospective payment system	→	**Covers anticipated CCBHC costs**

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CCBHC Integration Requirements

coordinates care across the spectrum of health services, including access to high-quality physical health

determine any medications prescribed by other providers and provide information to other prescribers

population health management and interoperability

Contact within 24 hours of ER or Hospital discharge

assessment of need for medical care and a physical exam

primary care screening and monitoring of key health indicators and health risk

Staff training in integration

Care Coordination:
The "Linchpin" of CCBHC

Partnerships or care coordination agreements required with:

- FQHCs/rural health clinics
- Inpatient psychiatry and detoxification
- Post-detoxification step-down services
- Residential programs
- Other social services providers, including
  - Schools
  - Child welfare agencies
  - Juvenile and criminal justice agencies and facilities
  - Indian Health Service youth regional treatment centers
  - Child placing agencies for therapeutic foster care service
- Department of Veterans Affairs facilities
- Inpatient acute care hospitals and hospital outpatient clinics

Targeting Population Health

PPS provides resources and incentives to target population health. CCBHCs are:

Hiring **dedicated population health** analysts, clinicians, other staff

Using **data analysis** to understand utilization and risk among client population

Developing **care pathways** to ensure comprehensive, assertive service delivery to high-risk populations

Strengthening **integration with primary care** to help clients manage chronic physical health conditions that are cost drivers

Partnering with hospitals to **streamline care transitions** and prevent readmission

Assessing for **non-health needs** that are determinants of health (e.g. housing, food, etc.)

And much, **much more**!

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How does the CCBHC financial model support these gains?

CCBHC **Prospective Payment System (PPS)** establishes a Medicaid rate reflective of clinics' costs

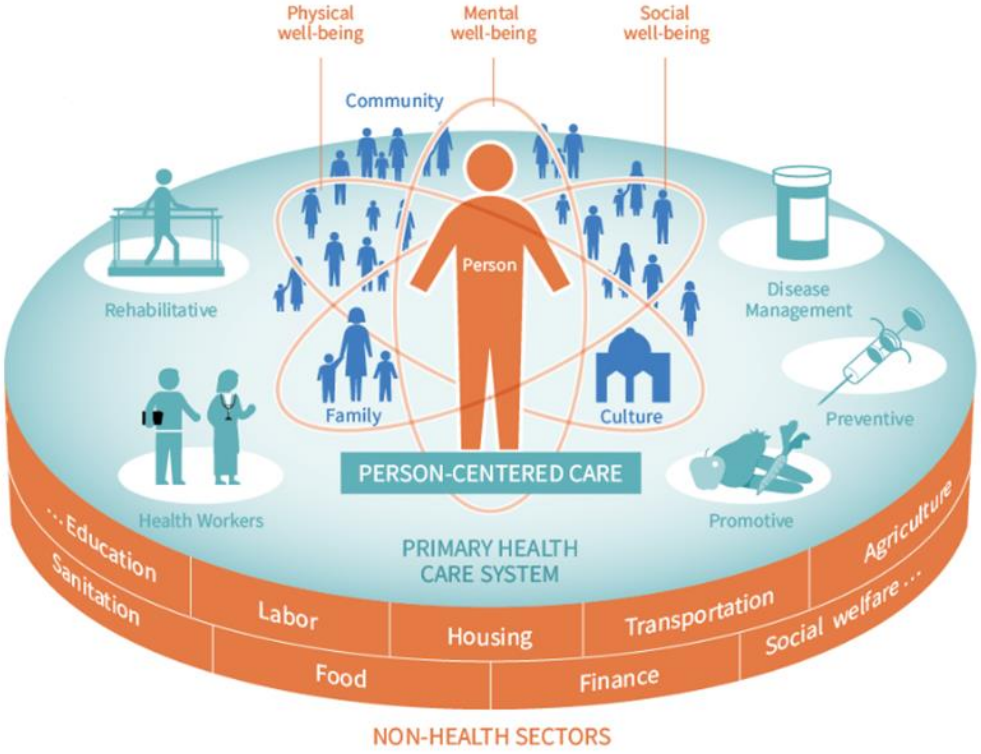
Advantages include the ability to:

- Hire new staff and fill vacancies in competitive markets
- Add new service lines
- Have staff number and mix that reflects level of community need, not historically available reimbursement
- Support non-billable activities (e.g. care coordination, outreach)
- Support technology and data costs
- Build partnerships with hospitals, police, and others

Comprehensive Healthcare Integration (CHI) Framework

The CHI Framework provides guidance on implementing the integration of physical health and behavioral health to help providers, payers and population managers:

- Measure progress in organizing delivery of integrated services (“integratedness”)
- Demonstrate the value produced by progress in integrated service delivery
- Provide initial and sustainable financing for integration



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Characteristics of the CHI Framework

- ✓ Broad application to both PH and BH settings, and adult and child populations
- ✓ Evidence-based domains of integration
- ✓ Measurable standards for integration
- ✓ Self-Assessment Tool
- ✓ Flexibility of achieving successful progress in integration
- ✓ Connection of progress in integration to metrics demonstrating value
- ✓ Integration payment methodologies for improving value by improving and sustaining integration

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Resources:

CCBHC SUCCESS CENTER

https://www.thenationalcouncil.org/ccbhc-success-center/

CENTER OF EXCELLENCE for Integrated Health Solutions

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

https://www.thenationalcouncil.org/program/center-of-excellence/resources/

Comprehensive Healthcare Integration (CHI) Framework

https://www.thenationalcouncil.org/resources/the-comprehensive-healthcare-integration-framework/

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Potentially Preventable Readmissions and Behavioral Health

Lessons from the Mississippi Medicaid Quality Incentive Payment Program

Christine Bredfeldt, Senior Healthcare Consultant

JULY 26, 2022

Roadmap

1 The setting: Mississippi Medicaid's Quality Incentive Payment Program (QIPP)

2 PPR/ED Behavioral Health Considerations

3 Calculating PPR/ED Performance with Behavioral Health Adjustment

4 Additional Considerations for PPR/ED Measurement

5 Questions?

What is the Quality Incentive Payment Program?

- The Quality Incentive Payment Program (QIPP) is designed to link a portion of the Mississippi state-directed payment program to utilization, quality and outcome
- Developed in collaboration between the Mississippi Division of Medicaid and the Conduent Payment Method Development team
- Two of the major components of QIPP are PPR/ED performance and PPC performance
- PPR/ED
  - Started in July 2019
  - Development of a new measure “Potentially Preventable Hospital Returns” (PPHRs) combining inpatient readmissions and return ED visits
  - Performance is based on PPHRs, but PPR and PPED components are reported as well
- PPCs were added in July 2021

Structure of the QIPP PPHR Program

Quarterly Reports

Baseline Year

The first year of each measurement cycle is designed to measure baseline performance

- Baseline performance of each hospital is compared to the statewide average on a casemix adjusted basis
- Statewide averages are calculated separately for general acute and psychiatric hospitals

Improvement Year

In July of the second year of each cycle, hospitals with poor performance scores are required to submit a corrective action plan

Performance Year

Hospitals have one year to improve their performance

Hospitals that submitted corrective action plans need to either:

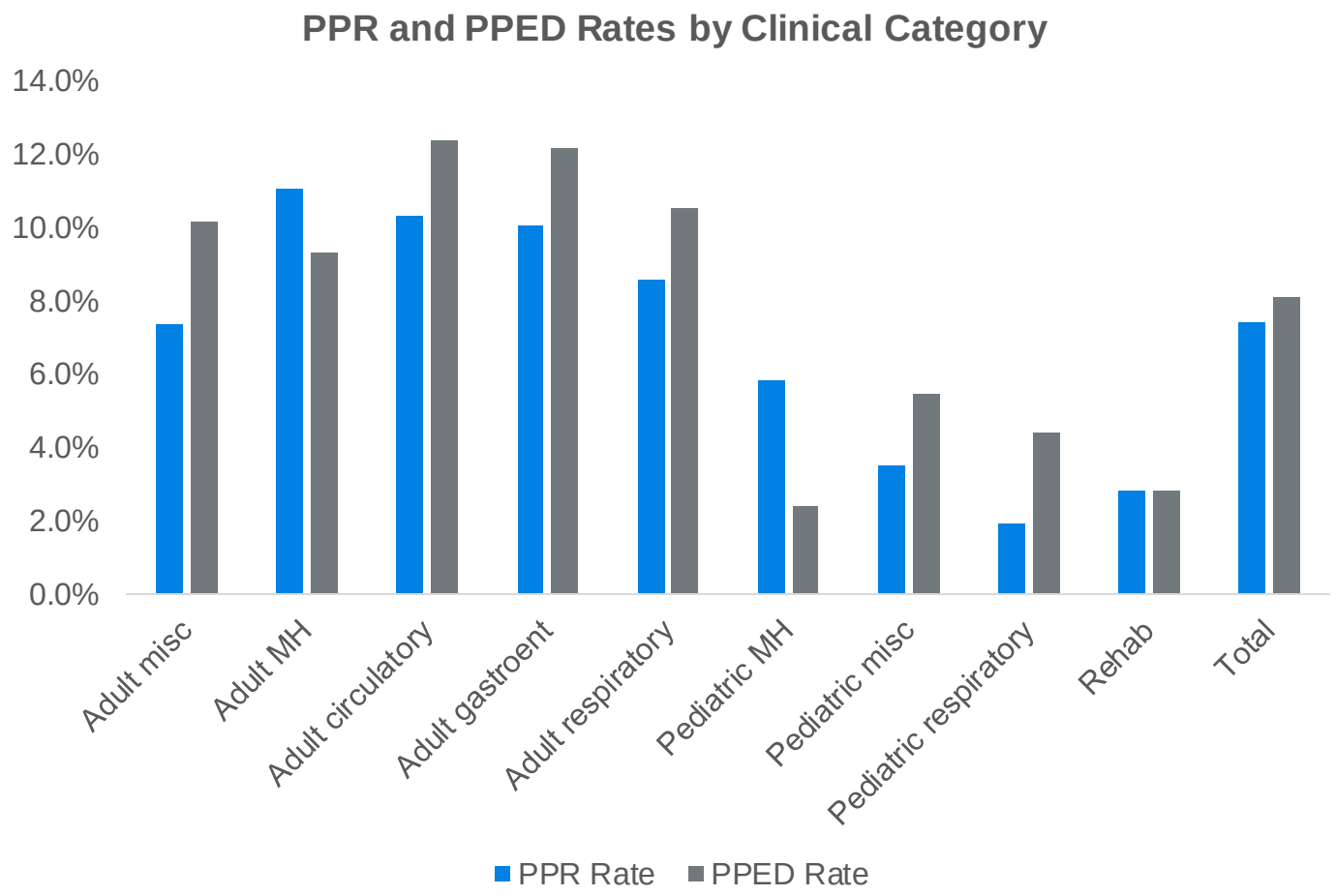
- Perform better than a threshold

  OR

- Improve performance by 1 – 2%

QIPP payments are distributed based on performance

PPR/ED Behavioral Health Considerations



- **Readmissions tend to be higher for stays where behavioral health is the reason for visit than for most other health issues**
  - This is true for both adult and pediatric patients
  - Return ED visits are lower for behavioral health concerns than for other types of visits
- **Readmissions also tend to be higher for patients with mental health or substance abuse (MH/SA) comorbidities**
  - Hospitals with higher rates of patients with MH/SA secondary diagnoses tend to have higher readmission rates
  - QIPP uses a MH/SA adjustor to account for different MH/SA burdens at different hospitals

Calculating Performance with Behavioral Health Adjustment

- **Actual-to-Expected Ratio:** QIPP measures performance by comparing the actual number of PPHRs at a given hospital to the number of expected PPHRs at an "average" hospital with the same mix of APR-DRGs, severity of illness and age category
- **MH/SA Adjustment:** To adjust performance for behavioral health burden, a statewide MH/SA adjustor is calculated based on average PPHR performance for patients with vs. without MH/SA comorbidities

Calculating Performance with Behavioral Health Adjustment

Exhibit 1: Example Calculation of the Actual-to-Expected Ratio for Hospital A								
APR-DRG	Description	Age Category	Mental Health Comorbidities	Statewide Norm	MH/SA Adjustor	At-Risk Stays	Actual PPHRs	Expected PPHRs
139-1	Other Pneumonia	Adult	Yes	7.32%	1.22	25	2	2.23
139-1	Other Pneumonia	Ped	Yes	4.44%	1.77	25	1	1.96
139-1	Other Pneumonia	Adult	No	7.32%	0.93	100	6	6.81
139-1	Other Pneumonia	Ped	No	4.44%	0.97	100	5	4.31
750-1	Schizophrenia	Adult	N/A	17.28%	N/A	50	10	8.64
750-1	Schizophrenia	Ped	N/A	14.29%	N/A	50	6	7.15
Total:						**350**	**30**	**31.10**

This example is illustrative only and does not represent actual data.

$$\frac{\text{Actual}}{\text{Expected}} = \frac{30}{31.10} = 0.96$$

Additional Considerations for PPR/ED Measurement

- The APR-DRG grouping algorithm used for casemix adjustment was developed using data from general acute care hospitals only
- Inpatient psychiatric facilities treat qualitatively different patients and offer different treatment approaches
  - General acute care hospitals treat acute exacerbations of behavioral health conditions
  - May transfer patients to psychiatric units within the hospital or psychiatric hospitals
  - Focus on stabilization rather than remission or resolution[1]
- Psychiatric facilities are more likely to treat chronically ill patients
  - Have longer lengths of stay[2]
  - Likely to treat patients with more chronic disorders
  - Goal is remission or resolution rather than short-term stabilization[1]

Relative performance of Psychiatric and General Acute Hospitals for Pediatrics

PPR

Psychiatric Hospitals: 5.6%
General Acute Hospitals: 6.6%

PPED

Psychiatric Hospitals: 3.0%
General Acute Hospitals: 0.5%

Take Home Point:
It may be necessary to calculate separate expected rates for this hospital class to allow for fair performance measurement and comparison

1. Lipsitt D.R. (2003). Psychiatry and the general hospital in an age of uncertainty. *World Psychiatry, 2(2),* 87-92, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1525083/
2. Lee S., Rothbard A.B., Noll E.L. (2012). Length of Inpatient Stay of Persons with Serious Mental Illness: Effects of Hospital and Regional Characteristics. *Psychiatric Services*, *63(9),* 889-895. https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201100412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Panel Discussion
&
Question and Answer
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