



Addressing Behavioral HEALTH Inequities **Part 2**

Business advice from the edge of the emerging future of health care

Issue 2: How to Ensure Success with Value-based Reimbursement

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Traditionally, healthcare providers, especially behavioral healthcare providers, have been paid based on a fee-for-service (FFS) model, receiving reimbursement for each service performed regardless of quality of care or outcomes. This model focused on *quantity*; more services meant more pay.

But with the advent of healthcare reform and the universal goals of better consumer and family experience, improved outcomes, and reduced costs, payment models have shifted to a focus on the *quality* of services delivered and the *outcomes* those services produce for people. To be fair, there have been exceptions to the FFS model of payment for decades. There were the “capitation” payments health maintenance organizations (HMOs) were paid as far back as the late 1970s and 1980s, as well as the array of pay-for-performance (P4P) models that have been in place since the 1990s trying to make up for the shortcomings of the HMO payment model.

Value-based reimbursement (VBR) is a payment model that is dependent on clinical outcomes, appropriateness of services, and proper use of resources. This is a dramatic change in the way providers are accustomed to being paid for their work. VBR rewards innovation and collaboration across health and behavioral health that leads to better outcomes and more comprehensive, high-quality care for patients.

This document is the second in a two-part series entitled *Addressing Behavioral Health Inequities*. It is intended to help you understand what VBR is all about, how data collection and reporting are tied to success, and how you can reengineer processes and services in order to maximize revenue and outcomes in this new environment.

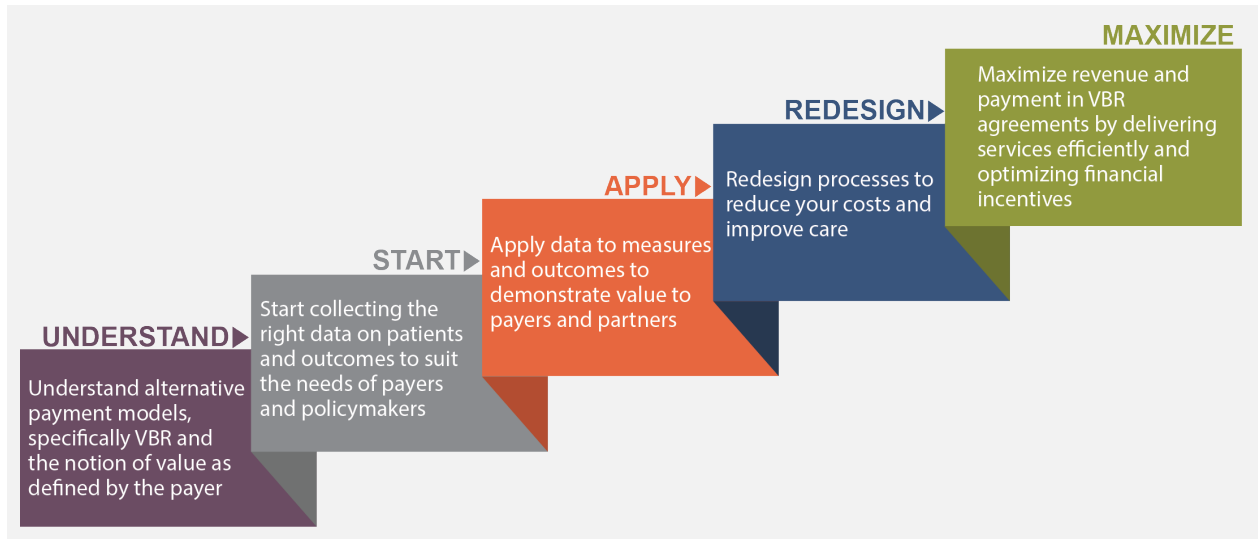
Read on to learn more.

Alignment with SAMHSA Strategic Goals:

VBR is closely aligned with achieving SAMHSA’s goal to reduce the impact of SMI [serious mental illness] and serious emotional disturbance [SED] and improve treatment and recovery support services ... through developing finance strategies to increase availability and affordability of care.

*Substance Abuse and Mental Health Services Administration (SAMHSA)
Strategic Plan FY2019 2023*

This issue will teach you how to . . .



The Basics of Value-based Reimbursement

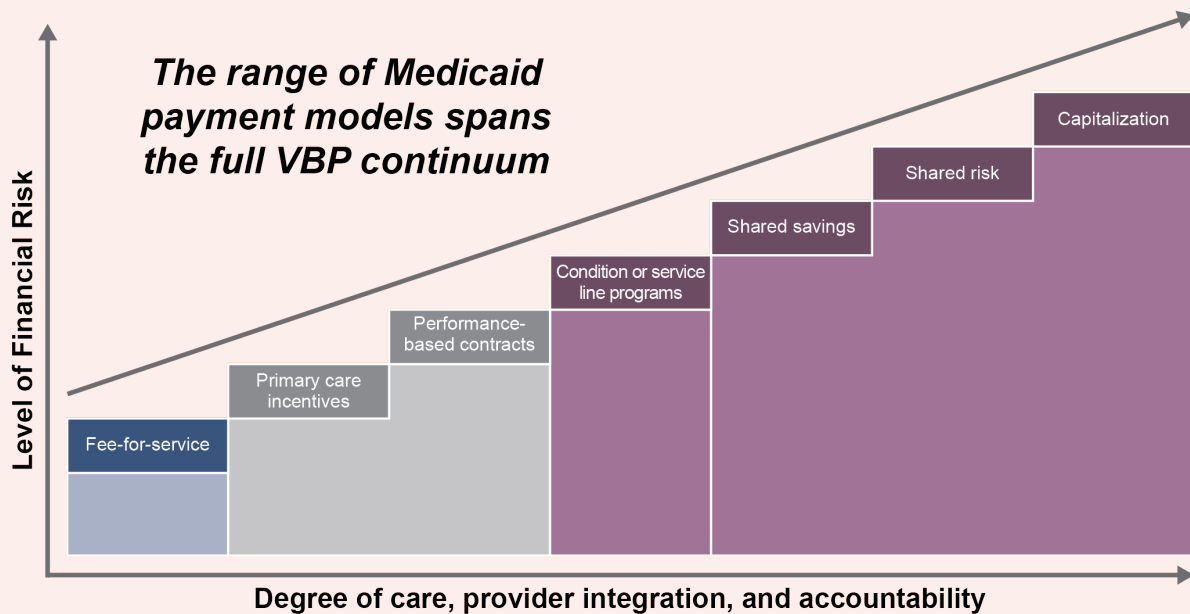
There have been many efforts over the last few years to reduce costs in the healthcare system, from reshaping healthcare entities (e.g., creation of accountable care organizations [ACOs] and health home models) to developing provider networks. One such strategy has been the shift from paying for volume to paying for value.

Value-based reimbursement (VBR) is a form of contracting for services based in part on performance and is becoming increasingly common for many health and behavioral health care providers.

VBR is what is known as an **alternative payment model/mechanism (APM)**. APMs tie payments to the delivery of high-quality, cost-effective care. APMs enable payers and providers to align along a spectrum of risk, reward, and accountability. Put simply, the greater the risk and accountability for the provider, the greater their financial consequences (upside and, in some cases, downside) will be.

APMs with lower levels of risk and reward may include pay-for-performance (P4P) models, which compensate providers for achieving or exceeding specified benchmarks including structure, process, outcome, or patient experience measures. More complicated, but increasingly familiar, are the shared savings models used in ACOs and their commercial sector counterparts. Traditional capitation and newer episode and bundled models, as well as Delivery System Reform Incentive Payment (DSRIP) Program initiatives, are at the higher end of the risk spectrum.

The Value-Based Payment Continuum



Source: Adapted from UnitedHealth Group

IAP Medicaid Innovation Accelerator Program

Source: Medicaid Innovation Accelerator Program (IAP). (2017, October 5). *Medicaid Value-Based Payment Approaches and Key Design Considerations National Learning Webinar*. <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/vbp-learning-webinar.pdf>

Refining and evolving these models and constructing the place for behavioral health within them will become a focus for the foreseeable future.

Key Takeaways

- VBR payment models exist over a spectrum of risk and reward. This requires an evolving relationship with payers and increasing collaboration and communication.
- VBR has been implemented within the primary healthcare sector and has begun within the behavioral healthcare sector
- VBR has a focus on preventive care, maintaining health, and making clinical decisions based on data and outcomes.

What Data Can Do for You

To succeed with value-based reimbursement (VBR), you must be able to collect, analyze, and report data. It is not an overstatement to say that the future of healthcare delivery will be almost entirely dependent on data. Data will

- Inform payment contracts
- Drive clinical decision-making
- Make or break a provider's reputation with patients, partners, and peers regarding outcomes and quality of care

Negotiating VBR contracts with your payers is dependent on your ability to demonstrate you are delivering value in your services and outcomes.

The way to do that? Data.

Data management and analytics are essential to VBR. The shift from fee-for-service (FFS) payment to VBR depends on an organization having access to reliable data reflecting the quality of their services and the outcomes consumers and families experience.

Behavioral healthcare providers may collect and analyze their data on their own, or they may form partnerships with medical care providers to offer integrated physical and behavioral healthcare and thereby merge their data and systems.

How to Get There

Behavioral healthcare providers will need to decide what information they want or need to collect and what data tools are necessary for collection, analysis, and reporting to demonstrate fidelity with aims like outcomes, quality, and cost controls and produce meaningful information to guide decision-making.

This decision process will likely fall into four main categories:

1. Understand Your Data Requirements.

You will need to identify what metrics you are required to report and what data you need to collect in order to do so. These may vary by state and payer but include state and federally mandated outcome measures and key performance indicators, as well as those required or preferred by certain insurers and managed care plans.

Key Considerations in VBR

The following are all important pieces of the pie that is VBR. You should have at least a basic knowledge of all these factors and how they may inform your contracts, payments, and programmatic decisions.

Population health analytics

What insight can you draw from local and national population health data to better understand the people you serve or those who need your services? (Learn more about population health in Issue 1 of *Addressing Behavioral Health Inequities* (note to self put in website citation))

Clinician incentive programs

What are the available compensation arrangements, and how do they drive quality improvement?

Social determinants of health

How do factors such as education, employment, access to care, and housing affect your clients or potential clients?

IT and business intelligence

What tools and expertise do you need in order to collect, filter, analyze, and distribute data in real time?

Utilization of services

How can you contribute to increasing preventive care and decreasing inappropriate use of high cost services?

Evolving relationships with payers

How can you increase collaboration and communication with your payers?

Continuous quality improvement

What strategies do you have in place to identify problems and implement solutions?

2. Create or Acquire a Data Warehouse or Data Analysis Solution.

Unless you have a very robust and informed information technology (IT) or data department, this step will likely best be achieved with some outside help. This is a complex process that involves

- Determining all the different types of data that will need to go into the data warehouse (e.g., electronic health record [EHR] data, claims data, clinical decision support system, clinical notification system)
- How the data will be cleaned, sorted, and organized once in the warehouse
- In what form, how often, and with what information the data will be reported out

There are many data warehouse software solutions on the market today.

3. Train Staff on How to Use Data Warehouse and Business Intelligence Tools.

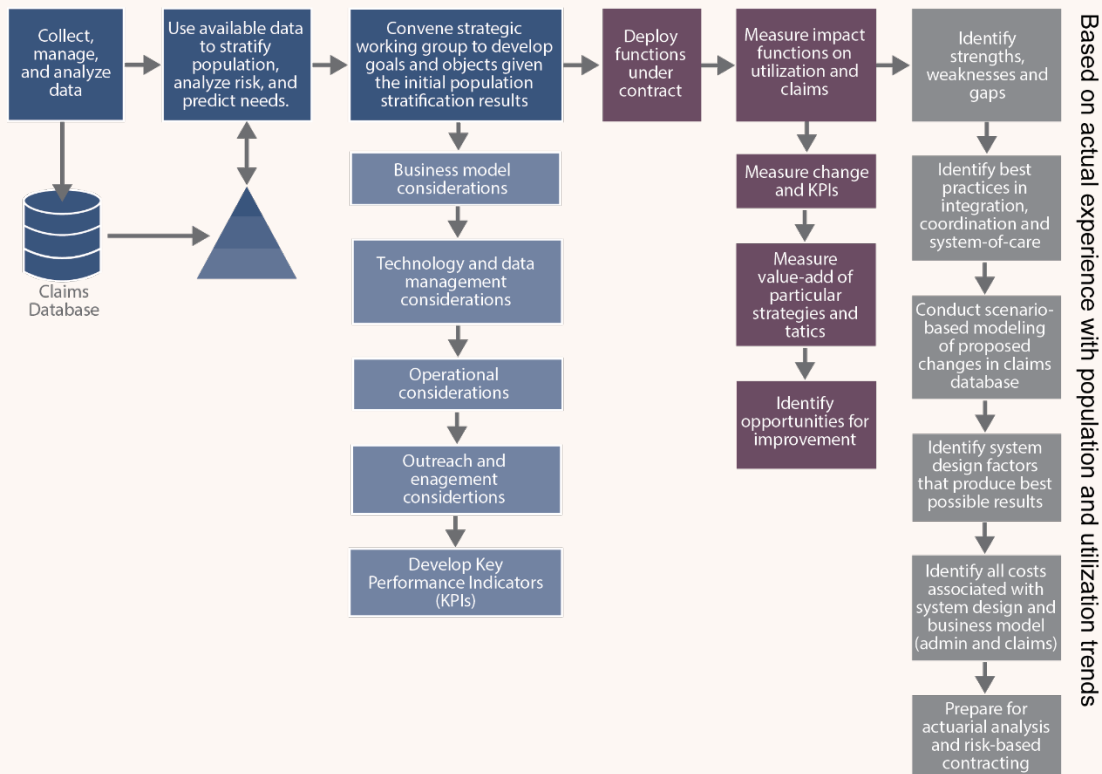
Providing clinical outcomes data and using such data to make decisions is going to be very new to many of your staff. Investing time and money to educate staff is crucial to ensuring success in this area.

4. Use Data Reports and Dashboards to Make Informed Decisions.

A data warehouse will provide you with insight through reports, dashboards/scorecards, and other analytics. This is what you will need for your required reporting and for your internal purposes to drive clinical decisions for the best results for your patients.

VBR Readiness: An Evolving Context

What an organization does today to lay the foundation for a future that entails financial risk in the form of Value-Based Reimbursement and/or capitation is mission-critical. The following graphic illustrates the progressive path forward.



The Data Privacy Challenge for Behavioral Health Providers

Reliable and comprehensive behavioral health data reflecting outcomes, quality, access, cost, and consumer satisfaction are difficult to harness and leverage as they are transferred between the organizations that provide services (e.g., inpatient hospital, emergency room, community mental health provider).

This is especially true for substance use disorder treatment data. Substance use disorder information is subject to Confidentiality of Substance Use Disorder Patient Records, 42 Code of Federal Regulations (CFR) 2, which contains stricter prohibitions than the Health Information Portability and Accountability Act (HIPAA) on sharing, exchanging, or reporting information.

However, this should get easier. In March 2020, the Department of Health and Human Services' (HHS) Office of the National Coordinator for Health IT (ONC) released the Cures Act Final Rule, which will have a significant impact on some of the challenges of interoperability and data-sharing within the healthcare system. The act is focused on giving patients easier access to their medical information, supporting providers' data needs, and addressing industry-wide information sharing practices. The Act calls on the healthcare industry to adopt standardized application programming interfaces (APIs) to allow consumers to securely and easily access their electronic health information (EHI).

The final rule “adopts the U.S. Core Data for Interoperability (USCDI), which sets a new baseline for interoperability,” according to ONC. “The USCDI will help to improve the flow of EHI and help ensure that the information can be effectively understood when it is received. Over time, it will be updated to expand the baseline set of interoperable data available nationwide.” This rule will help reduce many of the data-sharing challenges that health system partners are currently experiencing. Learn more about this at <https://www.healthit.gov/buzz-blog/21st-century-cures-act/the-cures-final-rule>

Reengineering Processes to Maximize Revenue

Behavioral healthcare and social services providers have long worked at the fragmented margins of the healthcare system in this country. Stigma, disparities, separate silos of funding, and other factors have stunted the capability of most behavioral healthcare and social services providers to participate fully in managed care and new accountable care and coordinated care enterprises. Many providers are still working with a mix of paper and electronic records, disconnected workflows, and a hodgepodge of hardware and software.

Healthcare reform and the transition to VBR present an opportunity for behavioral healthcare providers to more fully integrate into the healthcare system through data-informed process redesign and relationships or partnerships with healthcare providers.

There are some simple steps you can take to redesign your business processes to improve efficiency, reduce errors and waste, and meet regulatory standards that govern treatment, payment, and operations.

How to Get Started

The following is a simplified list of approaches for analyzing, adapting, and improving your processes to help your organization succeed in a VBR environment through improving the quality and outcomes of the services you provide.

Some of these processes may be performed with your existing staff and resources. Others may be better left to outside consultants or contractors with expertise in these areas.



Step 1: Document and Assess Your Current State.

This is the time put in writing the way you do things now so you can analyze and compare these processes to how you need or wish to do them in the future. This includes the following:

1. Articulating existing core business processes
2. Reviewing current policies and procedures, as well as the requirements of payers and accreditation
3. Mapping, documenting, and validating workflows
4. Measuring time and value-add
5. Defining roles, rules, and relationships
6. Establishing the baseline of current performance

To complete this step accurately, you will need to do an exercise called process mapping: diagramming, or “mapping” each step, contributor, and barrier to your processes in order to identify where there may be errors or poor outcomes that erode your quality and ultimately would affect your bottom line when it comes to VBR. For the best results, you may want to engage an outside expert in process mapping or quality improvement to help you with this step.

Ultimately, process mapping includes creating a detailed diagram of every core process and identifying

- Volume constraints or bottlenecks
- Types and sources of delay
- Workarounds or corrective actions
- Confused roles and responsibilities
- Duplicated or redundant efforts
- Unnecessary activities
- Outdated methods based on habit or lack of training
- Potential for automation
- Scalability
- Quality assurances or quality gaps
- Specifications and requirements

Step 2: Design Your Desired Future State.

Now, think about how you need or would like your business operations to look. In what areas are you required to collect and report data to maximize your revenue? What outcomes do you hope to achieve for consumers, families and your organization? What type of new services might you need in order to do so?

This process should include (1) creating goals and objectives for performance, (2) designing a future state that complies with all rules, and (3) making a plan to implement changes thoroughly (see step 3).

Step 3: Identify Gaps and Barriers and Implement New Processes.

You know where you are as an organization or provider (your current state) and where you want to be (your future state). Now is the time to make some changes to help you get from point A to point B. Look at the processes you mapped and the errors and inefficiencies you found that are keeping you from your desired or required future state.

Some of fixes will be easy and fast, while others may require some more intensive restructuring, changes in policies or procedures, or more buy-in and education for staff. Remember, you want to focus most on the processes that are tied to quality or achievement in certain metrics and measures and that may affect your revenue and your patient or client outcomes.

Step 4: Analyze and Monitor Your Progress and Adjust as Needed.

For any change process to truly succeed, you need to monitor your progress and make adjustments when it makes sense to do so. It is critical to make continuous quality improvement (CQI) part of your process redesign. This involves ongoing monitoring, swift review and revision, and improvement of processes toward achieving your organization's goals. For every process that is redesigned, ask yourself:

1. Are our staff properly trained in the new process?
2. Have we fully implemented the new process?
3. Does the new process perform to the levels we expected?
4. Do our customers and contracts have evolving or emerging requirements and standards we need to comply with?
5. How does the process need to be reengineered to meet those standards and perform to the levels we expect?

From Process Redesign to Business Redesign: Functional Adaptation and Restructuring

Beyond the steps outlined previously, behavioral healthcare providers should consider how else their basic business functions, staff roles, and operational norms may create barriers to VBR and how adapting or restructuring can lead to success.

Many behavioral health businesses are organized around traditional programs and fragment roles across functions. This undermines the organization's ability to tie performance and outcomes data to VBR. There are two ways to address this: functional *adaptation* and functional *restructuring*.

Functional adaptation—revamping departments, reporting hierarchies, operations, and processes—is an important element of adjusting to payment reform. Areas that may need to adapt include

- Managed care contracting
- Payer relations
- Revenue cycle management
- Utilization review and appeals
- Quality assurance
- New financial models/reimbursement methods
- Marketing
- Innovation
- Strategic partnerships and joint ventures

Functional restructuring takes functional adaptation one-step further. Restructuring your business functions can help you improve operations in the healthcare marketplace and align your workforce in the areas you need to focus on. Functional restructuring efforts should focus on

- Establishing objective staffing models and labor-related budgets
- Reassigning people to roles they are best suited for in terms of skill, knowledge, and attitude
- Managing to strategic aims, as well as those aims required to make the most of VBR contracts
- Setting revenue benchmarks to support the infrastructure investment
- Redesigning performance improvement initiatives

With these steps, you should be well on your way to redesigning and revamping your business processes and operations to improve your outcomes and prove the quality of your services.

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