Taking the Leap to Pay for Value:
Stratify Risk, Measure Costs and Analyze Results

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Executive Summary

Digitized data has been a part of healthcare since the first electronic health record (EHR) was created in the 1960s. With over 50 years of collected data, there is a wealth of information available to help drive efficiencies and outcomes, as well as guide us in the reorganization of the value chain of human services. The key to achieving that goal is the ability to turn data into information, information into knowledge and, finally knowledge into wisdom (DIKW).

The DIKW progression is cited in the Workforce Training Program developed under the guidance of the Office of the National Coordinator (ONC). Here is how DIKW is defined in those training materials:

- Digitized data: Symbols, facts, measurements
- Information: Data processed to be useful; provides the “who, what, when, where”
- Knowledge: Application of data and information; provides the “how”
- Wisdom: Evaluated understanding

Today through interoperability and data exchange, it is possible to have a comprehensive view of the individual that includes data from behavioral health and physical health. Automated monitoring of individual data can provide an alert based upon certain events, such as the individual missing or never scheduling an outpatient appointment. With these global comprehensive views of the data we have the ability to “mine” for the information we need to promote patient health, track population health trends, and allocate resources appropriately by applying the right tools to the data that we collect.

This whitepaper will outline how the progression from data to wisdom is critical in helping behavioral health organizations begin the transition to pay-for-value models, such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which supports physicians who choose to adopt new payment and delivery models such as the Merit-Based Incentive Payment System (MIPS), or Certified Community Behavioral Health Clinic’s (CCBHC) pilot program. It will cover a method to stratify risk by:

- Defining the population
- Assessing the health needs of that population
- Stratifying the population
- Engaging the consumer and incorporating evidence-based practices and methods to determine the costs of serving the population effectively and efficiently
- Managing outcomes and cost effectiveness through various tracking mechanisms

Setting DIKW in Motion

The diagram below illustrates digitized data (diagnosis, age, medications, etc.) collected from a client / patient who presented at a hospital and was admitted to the inpatient psychiatry unit. When we process that data, it becomes information that tells us on January 17, 2016, the client had a diagnosis of post-traumatic stress disorder (PTSD) and was discharged from the hospital.

Our knowledge of the PTSD diagnosis shows that if a person diagnosed with PTSD is not seen within seven days from discharge, he or she will represent to a medical facility 60% of the time. This knowledge becomes wisdom when we apply it to this specific client, and create a process that ensures outpatient care will occur within seven days of discharge.
Federal Programming, Shared Risk and Value-based Payment

Recent legislation demonstrates a clear pivot by the federal government toward value-based purchasing. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) has made important changes to how Medicare will pay providers of Medicare beneficiaries. A major component of this legislation is the implementation of the Merit-based Incentive System (MIPS) and Alternative Payment Models (APMs). These programs require providers to be able to nimbly translate data into wisdom.

Not only is the Medicare program changing to encourage the movement from data to wisdom, federal legislation for Medicaid is making similar moves. Section 223 of the Protecting Access to Medicare Act (PAMA), established a demonstration program based on the Excellence in Mental Health Act. CCBHCs were created as part of this act to expand access to mental health and addiction care in community-based settings. CCBHC’s payment model is based on the prospective payment system (PPS) created in the early 2000s by Medicare to drive better efficiencies and involve providers in risk sharing.

Originally launched for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), the PPS model grouped services into bundles and based remuneration on an estimated reasonable cost of providing those services (with some abilities to make adjustments).

One of the ultimate goals of PPS is to drive down costs while improving outcomes. During the two-year CCBHC pilot program, the PPS model will be based on a “cost-related” model. States select a daily or a monthly fee that will be used to reimburse providers. CCBHCs prepare a cost report identifying their costs to provide the mandated services and a reimbursement rate is derived from those costs.

The per-daily-visit or per-month rate is determined up front using the cost report, which puts the CCBHC into a risk-sharing situation with payers. As this paper will illustrate, this places great importance on accurately preparing and modeling the services that will be part of your cost report.

The CCBHC program affects one payer (Medicaid) that is attempting a shift to pay for value in the behavioral health system. MACRA and MIPs will have a broader reach. There are many other payers that will, or are, following this path, and when Medicare and Medicaid head in a direction, more are certain to follow. Each payer will have the ability to make demands upon the services and population that will be covered. Understanding these requests of your payer is the first step in risk stratification.
Stratify Through Population Views to Assess Services, Evidence-based Practices and Costs

Value-based payment models provide a definition of the population that will be covered through a particular model. Once a population is defined, assessing the appropriate services and identifying the best evidence-based practices are frequently done concurrently as organizations refine their final basket of services and the organization can appropriately risk stratify. To accomplish the iterative process, start with a basket of services that will be provided for a population (based on geography or diagnosis, etc.), then categorize the population into risk (i.e., high, medium, low). This process provides insight into the number of people in each of the risk categories to determine the costs for serving the population based on the services required and the responsivity to different treatment modalities. These costs should appear in the cost report and become the basis for the PPS reimbursement rate. The rate applies to all individuals in the entire population.

As organizations work to model cost structure and improve outcomes, interventions must be designed to target each strata of the population to ensure certain populations are not being over- or under-treated. These interventions may include addressing the social determinants of health – housing, transportation, employment, education – as a means of increasing the likelihood the treatment will be successful.

Using Risk Stratification to Drive Clinical Focus for Individuals

To move from knowledge to wisdom, organizations need to know how to serve the high-risk populations and focus on reducing waste and creating financially efficient population health management. This shift calls for a transition from episodic care to a coordinated care model. Coordinated care will require looking at both physical and behavioral health issues as well as the social determinants of health. This process will create a comprehensive care plan that ensures individual needs are met.

In the planning stages for cost reporting and care delivery, organizations will have to make assumptions about what the services will look like. However, it is critical to involve the individual in his/her care as an organization
moves from hypothetical modeling to the reality of service delivery. Planning can anticipate what these preferences might be and the impact they might have on the service offering.

Different providers can be engaged to manage the physical and social aspects of care. Regardless of provider, a comprehensive, cohesive look at the individual is critical to developing an effective treatment plan and ensuring it is carried out. Recent pilot projects that integrate behavioral health and physical care in a collaborative care model show significant decreases in cost and increases in positive outcomes. Care coordination is the backbone of CCBHCs. Targeted case management and patient-centered care planning are mandatory services of CCBHCs that assist in identifying appropriate care and gaps in care – and move from a population view, now to a consumer view.

Predictive Modeling

Risk stratification provides a current view of the population. Knowing which clients in the medium- or low-risk category today are at risk for moving up a category requires predictive modeling. This can be accomplished by understanding factors that are strong indicators of potential health risks, but are not detectable through standard stratification of claims data. Finding access to data such as divorces, drops in income, bankruptcy filings, lost employment and even address changes can be predictors of future risk.

Using New Parameters to Evaluate Care Costs

Transitioning to a pay-per-value model also allows organizations to rethink how care is delivered. Each service provided, whether it’s billable or not, should be evaluated as part of the care delivery framework for the population served. One way to conduct this evaluation is to create a grid that enumerates every task or service related to care and treatment, along with the population served, staff providing the service, modality, cost, outcome success factor and frequency. Using this information, a cost-effectiveness analysis can be performed to identify areas where costs could be reduced without causing a negative effect on outcomes.
Medication adherence checks, for example, could be handled using text messages, which cost about $0.03, to clients as reminders instead of a monthly appointment with a psychiatrist at a cost of $50 per visit. To assist in reducing the number of appointment no-shows, organizations can implement a structured automated reminder process or use behavioral engagement strategies such as motivational interviewing techniques. If considering motivational interviewing, does your staff already have these skills? Will new training programs need to be implemented? How will fidelity to motivational interviewing be measured? To identify areas where costs could be reduced without causing a negative effect on outcomes.

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Managing, Measuring and Repeating Success

Each CCBHC is required to report on nine quality measures, and each state can develop its own quality measures. In the CCBHC model, the Substance Abuse and Mental Health Services Administration (SAMHSA) recommends potential sources of data collection for these quality measures. Some of sources overlap with other quality models, such as meaningful use clinical quality measures (CQMs), Physician Quality Report Systems (PQRS) and/or National Quality Forum (NQF). In the end, the measures focus mostly on process. For example, did an assessment take place and how soon after intake? The next shift is to measure beyond process. Did the action of doing the assessment cause an action that improved an outcome?

To transition successfully to a care delivery model that incorporates shared risk and pay-for-value reimbursement, organizations should consider incorporating key performance indicators (KPIs) for clinical measures to better manage their business and providers. One way to establish KPIs is through evidence-based practices (EBPs).

EBPs are treatments that have been shown through research to be effective. They offer organizations the means to measure the quality of the delivery of services. They provide structure to reproduce successful methods and repeat what works, as well as know when a treatment is not working based on prior evidence.

Without EBPs, organizations can be left with gray areas in evaluating outcomes and few insights into how to improve the effectiveness of the care they deliver. Delivering services outside this framework can make it difficult to know if the success (or lack of success) is due to the provider handling the process or the process itself.

As organizations continue to measure, there is also a need to assess the coverage and process, redefining service delivery and measuring again. Performance measurement analyzes the success of delivery by comparing data on what actually happened to what was planned or intended. This measurement process is meant to identify areas for quality improvement, differences in care/outcomes among populations and to help improve care coordination between providers of care.

Taking the Leap

Traditional payment models, such as fee-for-service, have been all about volume. These types of payment models may not always consider the best path of care for a particular individual. Value-based payment models
and CCBHCs are giant steps toward a new clinical paradigm focused on putting the consumer at the center of care, arriving at the best outcome, while controlling costs at the same time. It is about quality not quantity.

There are many tools that make this possible, including:

- Population health management
- Care coordination
- Consumer-directed care
- Care delivery models (accessibility)
- Evidence-based practices
- Continuous loop of measuring and improving

Having a plan that includes each of these tools provides organizations the toolkit to leap across the divide. Value-based care models, specifically CCBHCs, are presenting the industry a unique opportunity to rethink healthcare delivery at all levels. These models are forcing organizations and providers to look at the whole person knowing that the highest costs come from individuals with multiple chronic conditions, and they are expanding a vision from just a healthcare view – to a true person-centric view that includes the social determinants of health. The health system today is broken, but hang on – that’s about to change.
Carol Reynolds  
Senior Vice President, Client Experience

Carol and her team are responsible for the delivery and support of innovative solutions to Netsmart clients. This includes driving our client health initiatives, as well as other areas that affect the client experience, such as solution support, user groups, client councils and product management.

Carol previously served as our senior vice president of implementations and operations and was a manager, leader, mentor and team builder to our project managers and project executives. In this role, she created a project management office, developed standard processes for requirements capture and reduced average project duration by 32 percent.

Prior to joining Netsmart in 2002, Carol owned Advanced Information Management, Inc., a software applications developer for the senior living industry. She designed and developed healthcare applications for both financial and clinical environments, as well as implementation services. Her experience included company-wide strategic planning; project planning/implementation; production programming and customer service/support and call center operations for 42 applications used by more than 400 long-term care facilities.

Carol earned her bachelor’s degree in business from Marian College and a master’s degree in project management from Boston University, graduating with honors. Carol currently serves as the vice president of Outreach for Project Management Institute (PMI), Long Island Chapter. She received her project management professional (PMP) certification from the Project Management Institute and her product management certification from Pragmatic Marketing.

About Netsmart

Connecting the mind, body and communities

Netsmart is healthcare’s largest human services and integrated care technology provider. Our technology, services and expertise help Netsmart clients deliver services and care to more than 25 million persons nationwide.

We serve over 500,000 users in more than 24,000 organizations across all 50 states in these communities:
- Behavioral health
- Addiction treatment
- Intellectual and developmental disabilities
- Child and family services
- Public health
- Home health, hospice, private duty and palliative care
- Vital records

We’re proud of the role our solutions and services play in delivering outcomes-based care to so many people. But we also recognize the need to do more, which is why Netsmart advocates for policies and legislation that support the communities we serve.

It’s also important to raise awareness of the key roles human services and integrated care play in the healthcare ecosystem. We’re pleased to support the EveryDayMatters® Foundation, which was established for human services organizations to learn from each other and share their causes and stories.

Our goal – through technology, services and advocacy – is to change the face of healthcare today by acknowledging that whole-person care is a reality, with human services and home care playing a pivotal role.