REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

Assessing Providers Experience With VBP Arrangements
RCPA Provider Member Survey Brief
Feb. 21, 2023

Executive Summary

In January 2023, RCPA developed a survey to assess whether RCPA provider members have in place the foundational components necessary for value-based payment (VBP) arrangements and to gauge members' level of experience with VBP. Executive leaders were asked to complete one survey for their entire organization. When the survey closed, RCPA VBP Work Group Co-Chairs Claire Ryder, Director of Business Development, Resources for Human Development, and Pattie Hillis-Clark, PsyD, Executive Director, Devereux Advanced Behavioral Health, Pennsylvania Children's Services, along with RCPA Mental Health Policy Director Jim Sharp and RCPA SUD Treatment Services Policy Director Jason Snyder met to review the findings. Then, on Feb. 14, the RCPA VBP Work Group met as a whole to discuss the results, deepen the work groups' collective understanding of providers' experience in these areas, and set a course for helping to address and meet the most pressing needs providers are facing relative to VBP.

The intention of this brief is to highlight key survey responses as well as key takeaways from the survey using supporting quantitative and qualitative data.

- Thirty-two organizations completed the survey during the two-week period the survey was open. The majority of individual respondents (44 percent) were considered to be CEO, president or executive director level, followed by clinical services leadership (25 percent). Given the significant financial implications of VBP, the absence of finance executives among those completing the survey was noted.
- The majority of respondents (77 percent) indicated they provided community-based mental health services. Sixty-nine percent indicated they provided mental health outpatient, and 69 percent also indicated they provide substance use disorder (SUD) outpatient treatment, followed by an array of other behavioral health services.
- All respondents indicated they have some form of VBP program in place, with 69 percent indicating they have some type of performance-based contract/quality incentive payment. Despite this, a majority of respondents lacked several critical components of VBP arrangements for many reasons, some of which are outside the direct control of the providers. Discussion among the VBP Work Group identified a need for further investigation into several areas to clarify respondents' answers and to more accurately assess VBP readiness.

Review of and discussion about the results also revealed four key takeaways.

1. The variability in Pennsylvania's five behavioral health managed care organizations' (BHMCOs) priorities and processes makes the development of comprehensive, organization-wide VBP strategies challenging.
2. Despite some VBP arrangements being reported, BHMCOs have not engaged with providers to create individualized VBPs.
3. Providers lack the necessary formalized data, processes and technology platforms that can equip them with real-time information to better manage high-risk populations and improve health outcomes.
4. Further investigation is required in several areas where respondent interpretation or the lack of specificity of the question made an accurate analysis of the response difficult.

The tenor of the discussion of the results as they pertained to both providers and BHMCOs was not one of negativity about the system but rather how the system can be improved through provider, primary contractor and BHMCO collaboration.

Findings

For this brief, examples of survey responses and subsequent discussion are described below to support each of the four key takeaways. However, not all supporting questions and corresponding responses are included in the description below.

Key Takeaway No. 1

The variability in Pennsylvania's five behavioral health managed care organizations' (BHMCOs) priorities and processes makes the development of comprehensive, organization-wide VBP strategies challenging.

With a lack of consensus among Pennsylvania's five BHMCOs as to what is prioritized in a VBP arrangement, a majority of respondents (55 percent) have not made VBP a part of their overall strategic plan (Q5). The mix of VBP arrangements in which providers are currently engaged also points to the variability among BHMCO priorities, with 69 percent of provider respondents indicating they have some type of performance-based contract/quality incentive payment, 22 percent of respondents engaged in episodic/bundled payments with quality metrics, 38 percent in shared savings and 34 percent in other alternative payment arrangements (Q17). Because of these variables, some provider organizations have indicated an intentional focus on basic process outcomes or Healthcare Effectiveness Data and Information Set (HEDIS) measures – seven-day follow-up and avoidance of readmissions, as examples – over health outcomes at this point. Seventy-two percent of respondents indicated they track process or health outcomes as part of their VBP arrangements (Q20). More investigation is required here to determine exactly what outcomes are being tracked.

Key Takeaway No. 2

Despite some VBP arrangements being reported, BHMCOs have not engaged with providers to create individualized VBPs.

Based on survey results, providers have not been an asked to be an active partner in the development of VBP arrangements despite the fact that 30 percent of a BHMCO's medical expenses must be expended through VBP payment strategies per the Pennsylvania Department of Human Services (DHS) HealthChoices Behavioral Health Program Standards and Requirements, Appendix U, of January 1, 2022. Fifty-six percent of respondents said they have not been able to negotiate with a county or BHMCO to establish a VBP arrangement individualized to their organization (Q16), and 75 percent did not have input on the selection of quality metrics/outcomes (Q19).

In discussion, providers suggested that BHMCOs were unwilling to individualize VBPs unless the provider had the ability to scale its VBP arrangement across a large swath of BHMCO members, which would increase the likelihood of meaningful cost savings and operational efficiencies for the BHMCO. The operational challenges for BHMCOs associated with managing multiple different VBPs for individual providers makes individualized plans less likely. Providers also suggested that DHS's Office of Mental Health and Substance Abuse Services, as the behavioral health HealthChoices contract holder, can and should direct BHMCOs to convene along with providers to establish cross-BHMCO VBPs, perhaps initially starting with one level of care as a pilot.

Key Takeaway No. 3

Providers lack the necessary formalized data, processes and technology platforms that can equip them with real-time information to better manage high-risk populations and improve health outcomes.

For a variety of reasons, including barriers to data access and sharing (e.g., lack of formalized sharing processes, privacy laws), limitations on electronic health records, manual or internal processes, and cost, providers often lack critical data to go beyond process measurement to health and cost outcomes. Eighty-four percent of respondents indicated they are not using a health information exchange (Q26), 66 percent said their leadership team does not have access to a performance management dashboard that enables it to monitor and respond to critical organizational indicators in real time (Q22), and 56 percent said they have not established referral and data-sharing relationships with primary care and other physical health specialty providers in the community (Q27).

Although there are systems available that address many of these needs, they are cost prohibitive, even with group purchasing models. This is another area for discussion with the primary contractors and BHMCOs.

Key Takeaway No. 4

Further investigation is required in several areas where respondent interpretation or the lack of specificity of the question made fair accurate analysis of the response difficult.

In some instances, provider responses were counter to providers' discussed experiences, warranting deeper investigation and discussion with individual survey respondents. Several questions may have

been interpreted differently by different respondents. In addition, after further analysis and discussion, some questions were found to be too general or warranted a follow-up question, which was not asked in the survey, to produce more details. For example, when asked what types of outcomes providers measure as part of their VBP arrangements, "Client Outcomes" was provided as an option, but inclusive in that choice was "Health or Process" outcomes (Q20). Understanding whether providers are tracking basic HEDIS process outcomes versus health outcomes is critical to setting the future agenda of this work group. Similarly, when asked whether agencies have good relationships and processes in place for routine communications and handoffs with hospitals (Q10), 84 percent of respondents said yes, but qualitative experience as shared by work group meeting participants contradicts the reported response. Better defining "good relationships and processes" is necessary to better understand the discrepancy and any gaps in these processes.

Next Steps

In many instances, the answers to survey questions yielded more questions. In those instances, RCPA will continue to work with the providers in the VBP Work Group to clarify and deepen our understanding of the answers. As we continue to set an agenda for this work group, many of those areas will become focus areas for upcoming meetings from which we may produce additional papers and insight. In addition, our ongoing work will include other partners and members, including DHS, OMHSAS, primary contractors, and BHMCOs.

Specifically, based on work group participant feedback, upcoming meetings will include presentations by providers with specific expertise in various components of VBP arrangements, focusing on:

- Financial architecture;
- Technology, including dashboards and other VBP-supporting software;
- Staff compensation;
- Workflows and processes to enhance provider ability to react to and intervene with high-risk patients; and
- Data-sharing agreements with BHMCOs.

Ultimately, one of our main goals for this group is to identify VBP-related policy areas where RCPA can use its resources to impact and enhance the environment in which our providers serve their clients in a way that providers are incentivized and reimbursed in meaningful ways that improve patient health outcomes.