

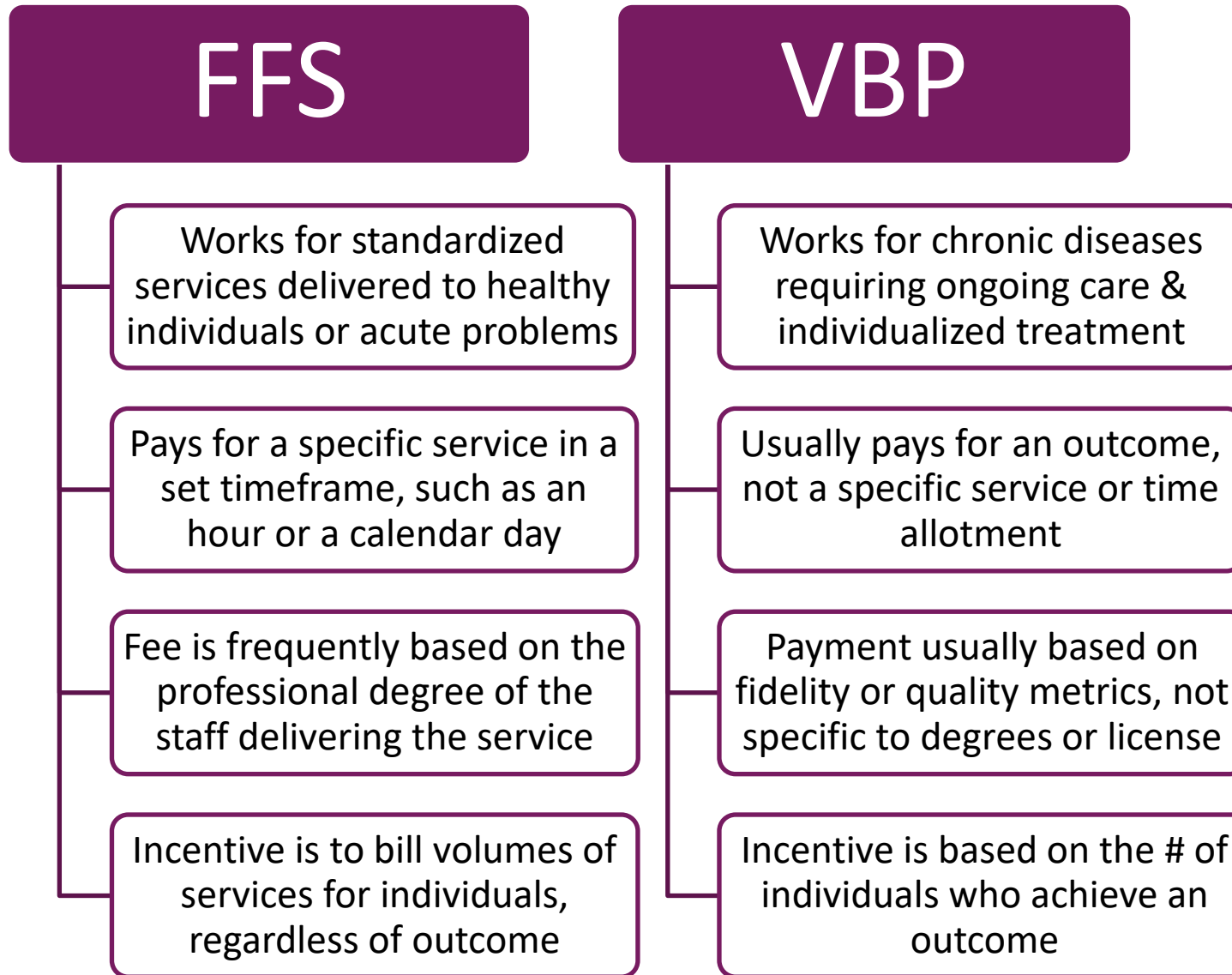
Preparing for a Value-Based Payment (VBP) Future in Substance Use Treatment in PA: Using the Centers of Excellence (COE) Program as an Example

David Loveland, Ph.D.
Senior Program Director
Community Care Behavioral Health

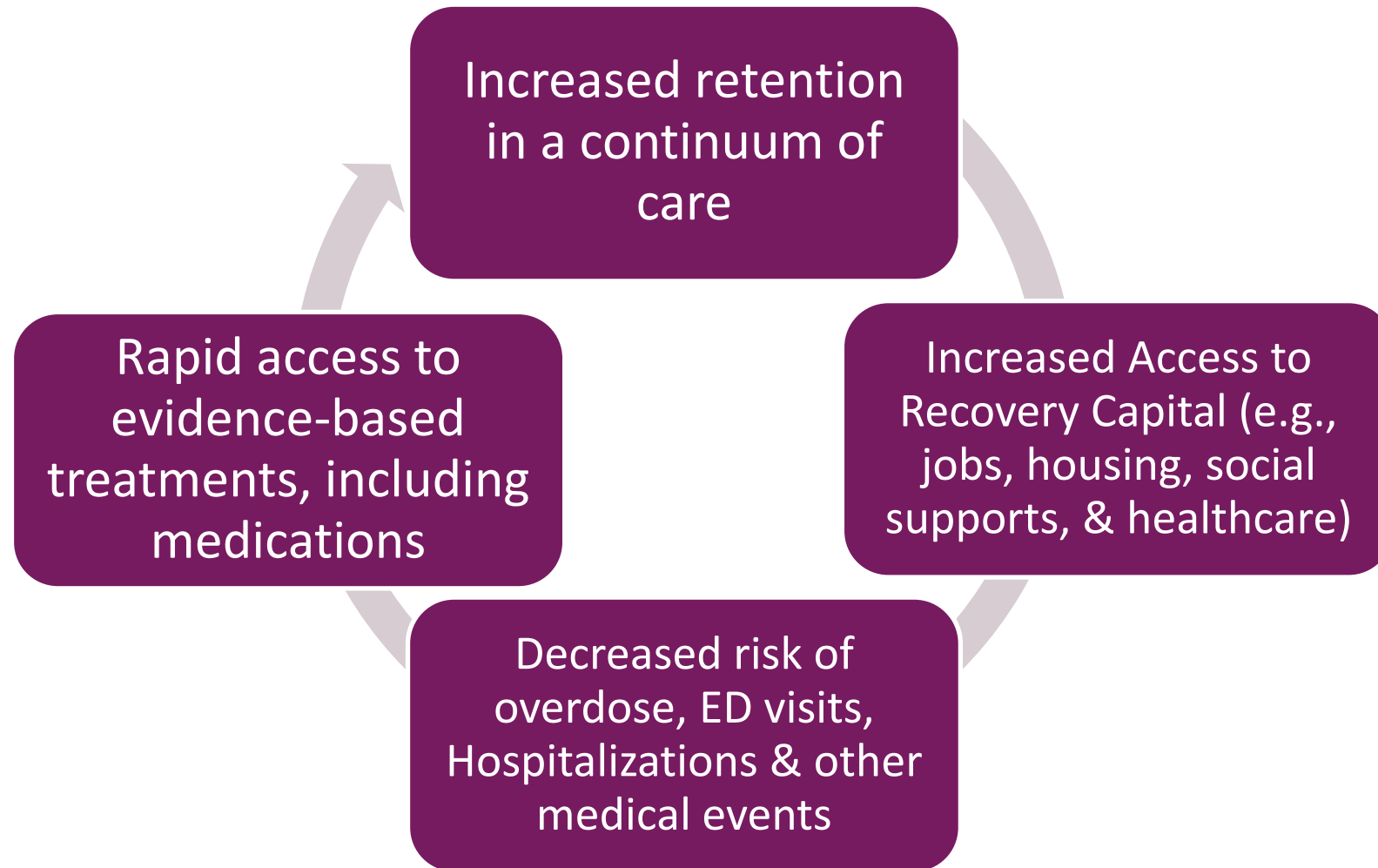
Statement of Vested Interest

- The presenter, David Loveland, has no real or perceived relevant financial relationships to the content of this presentation

Some Notable Differences Between FFS and VBP



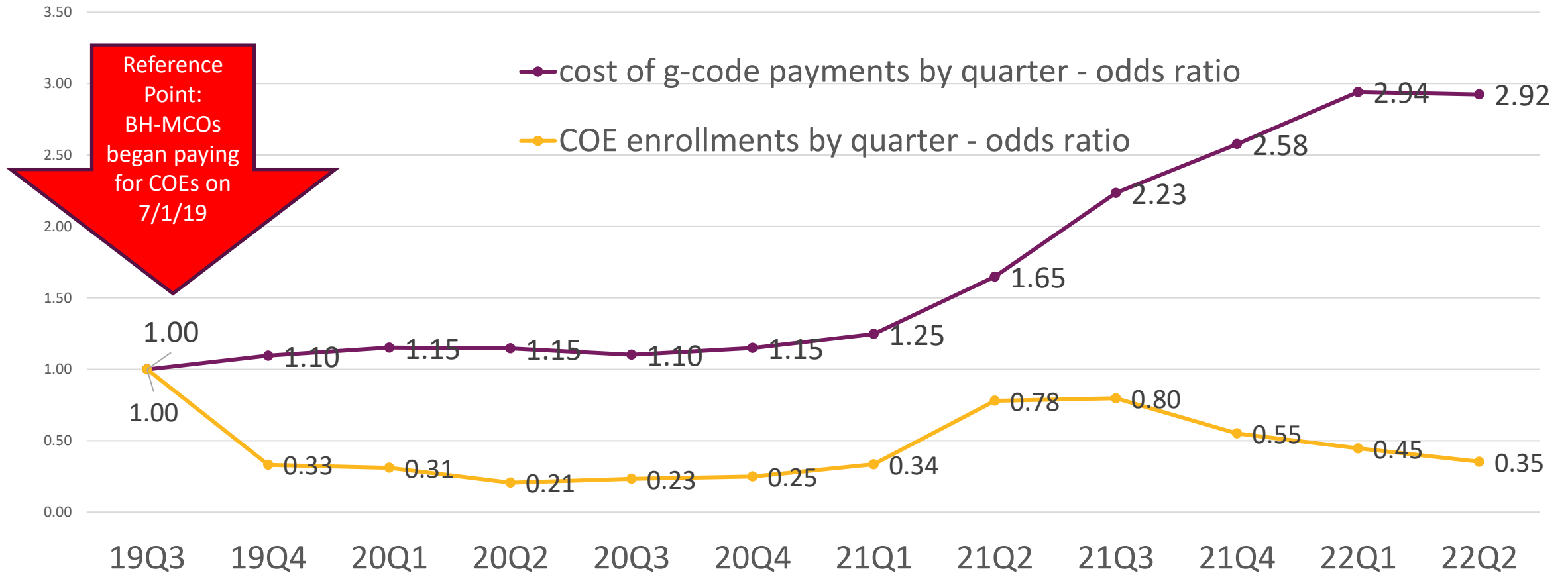
VBP for People with an SUD – Possible Goals



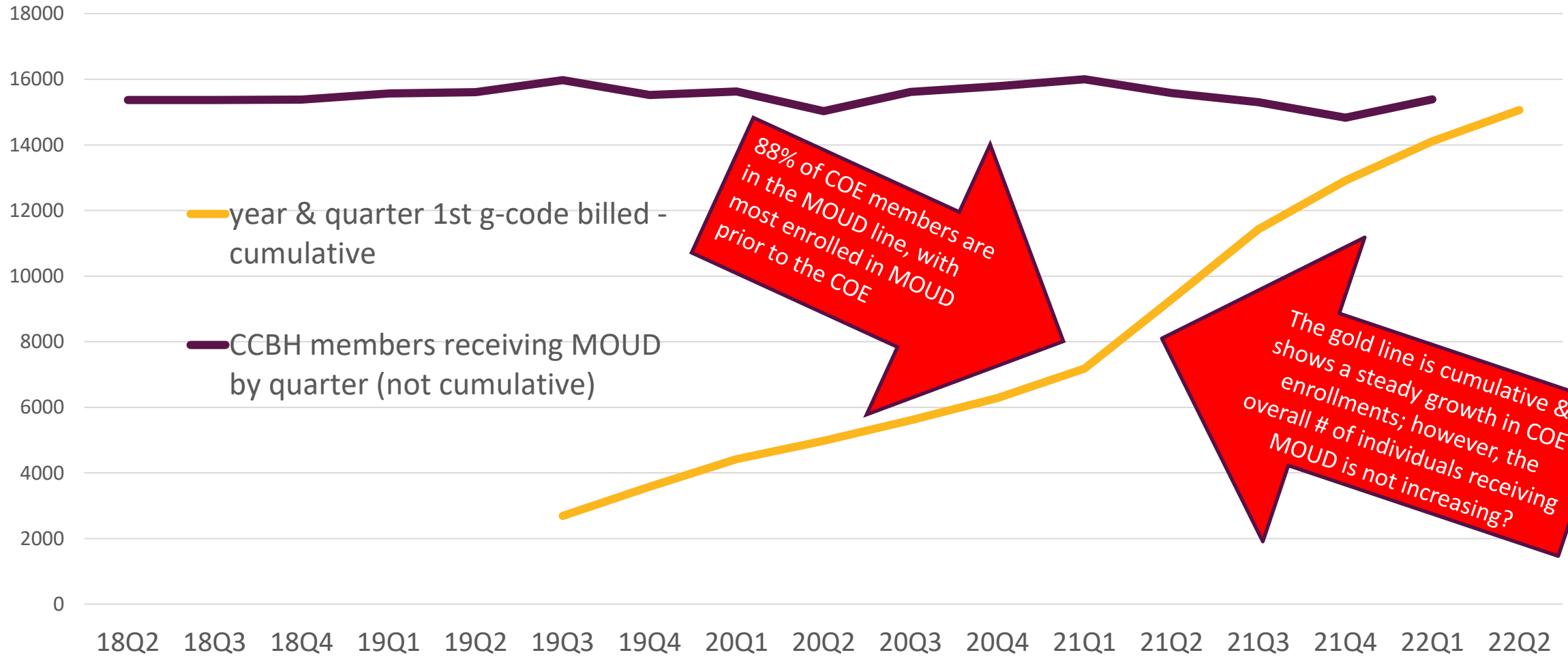
Centers of Excellence (COE) for Individuals with an Opioid Use Disorder (OUD)

- The COE program was launched in 2016 in response to the opioid epidemic, with the goal of engaging individuals with an OUD who were not **accessing** or **benefiting** from behavioral health services
 - Engaging individuals in crisis, providing rapid access to Medications for OUD (MOUD), and retaining them over time are three overlapping goals
 - The COE program was initially funded with grant dollars and transitioned to Medicaid funding in 2019 through a billing code with a fixed payment of \$277.22 per member, per month (PMPM) for care coordination
 - ✓ Beginning on 1/1/23, Medicaid Managed Care Organizations can modify the payment structure, including implementing a VBP

Quarterly Enrollments and Costs of COEs in CCBH Network: Cost includes only the PMPM payment of \$277 for care coordination



Total Unique CCBH Members Receiving MOUD from Behavioral Health Providers and Cumulative Enrollments in COEs



88% of COE members are in the MOUD line, with most enrolled in MOUD prior to the COE

The gold line is cumulative & shows a steady growth in COE enrollments; however, the overall # of individuals receiving MOUD is not increasing?

Cost of Treatment and Cost Effectiveness: Are they the same?

Data on the prior slides shows a nearly threefold increase in COE treatment costs over three years, with most of the increase occurring in the past 18 months

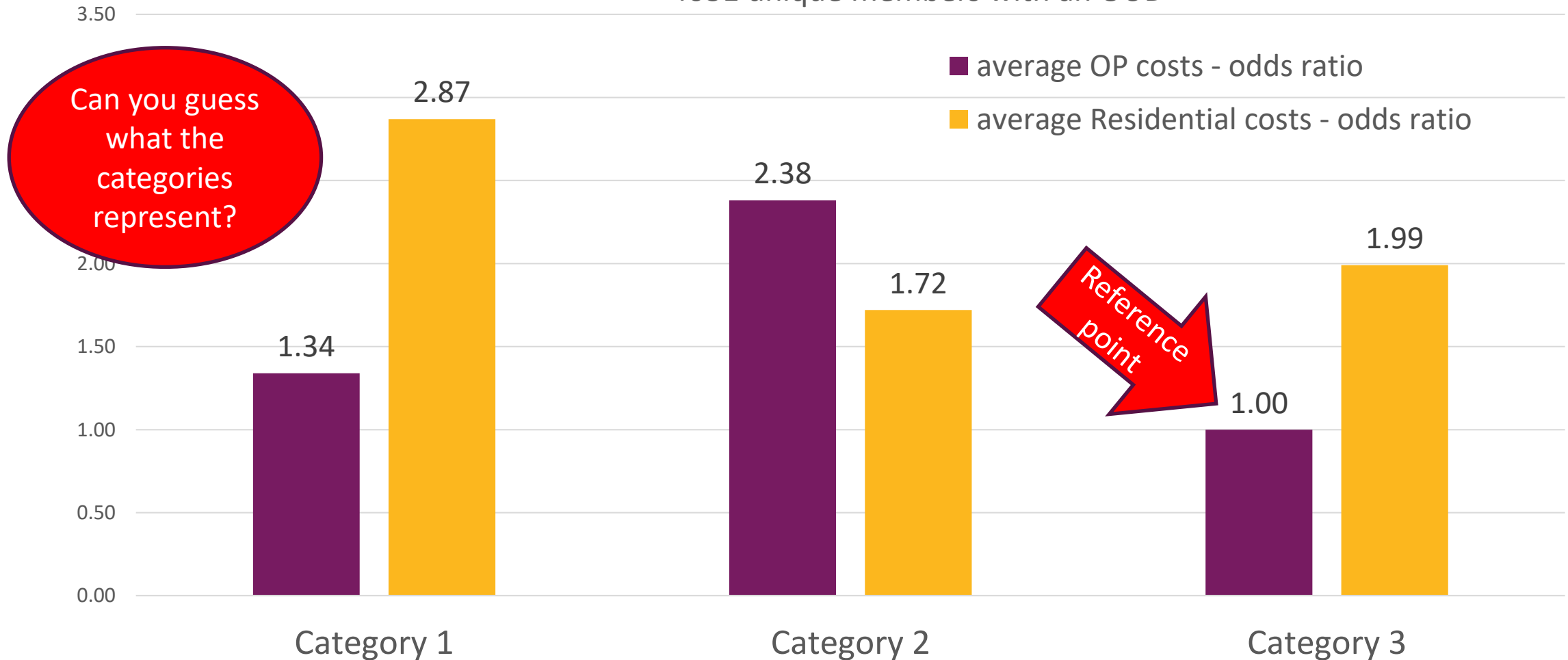
Nearly 9 out of 10 members enrolled in a COE had received MOUD in the recent past or were actively receiving MOUD at the agency prior to being enrolled in a COE program at the same agency

Is the COE program cost effective or cost ineffective, based on the data noted in the prior four slides?



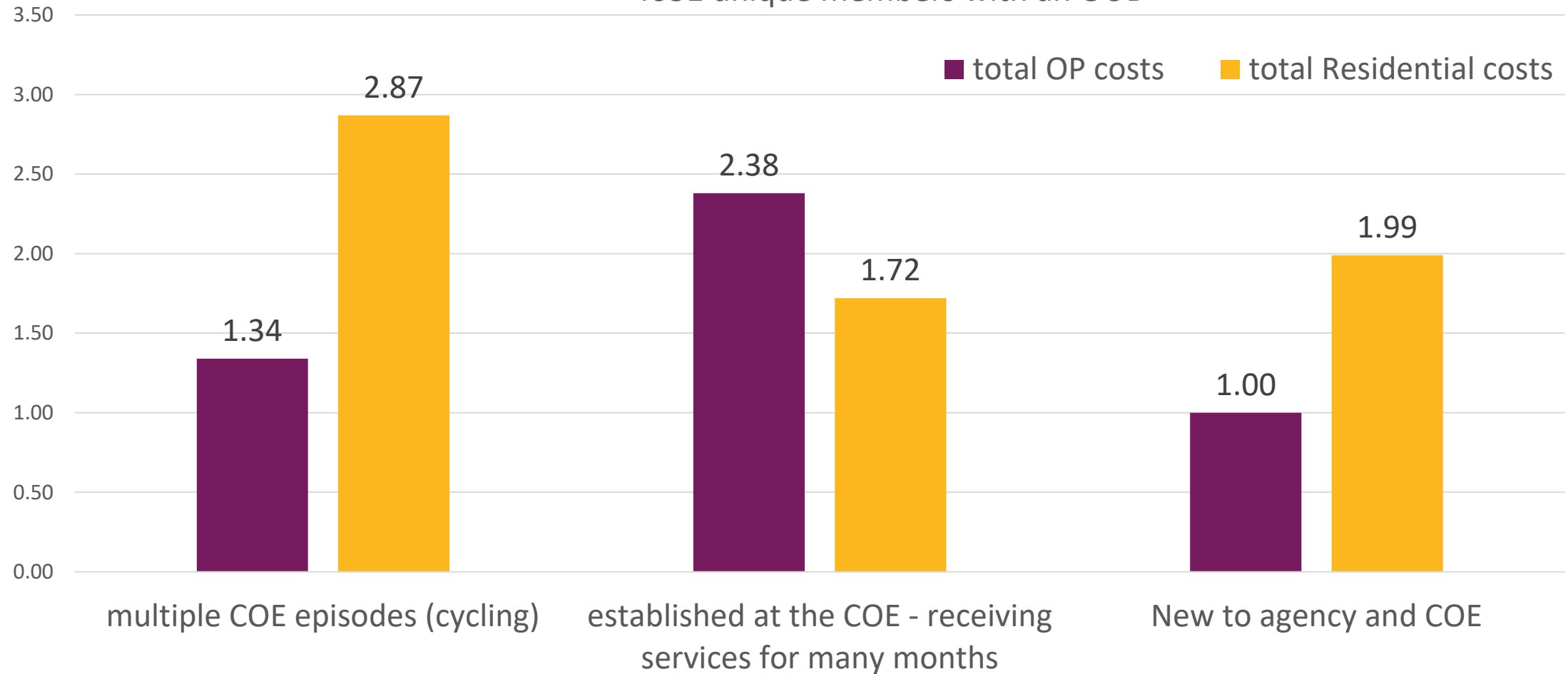
Overall Behavioral Health Expenditures 12 Months Prior to Enrolling in a COE Program

4031 unique members with an OUD



Overall Behavioral Health Expenditures 12 Months Prior to Enrolling in a COE Program

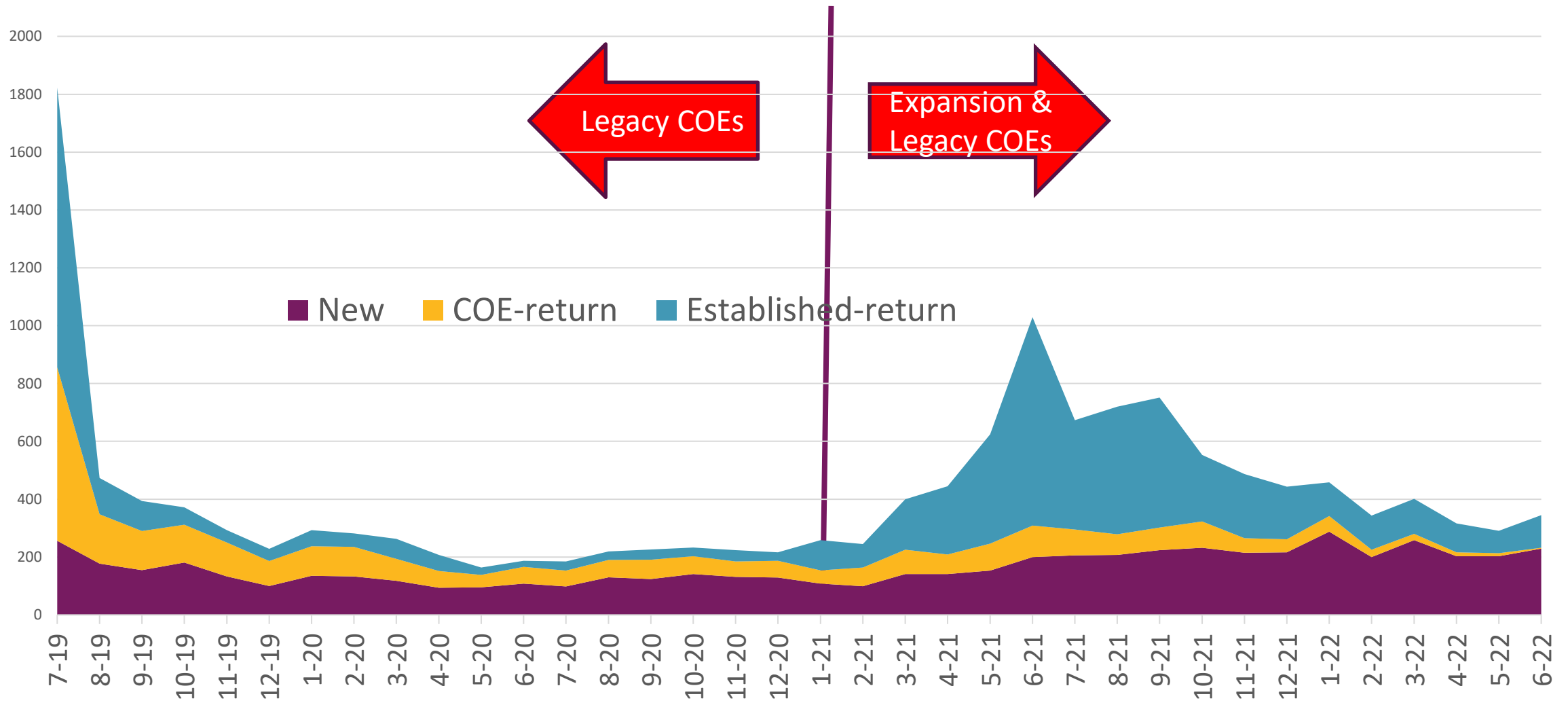
4031 unique members with an OUD



Enrollment Patterns by a Members History with the COE Agency

- Members can be grouped into three exclusive categories of experience with the COE agency
 - ***New members*** have no history with the agency and received their first g-code claim within 30 days of other billing claims submitted by the COE agency
 - ***COE-returning*** members have had one or more prior episodes in the COE program, separated by a break in billing of 61 or more days
 - no billing claims from the COE agency for 61 or more days, including the g-code
 - ***Established – returning members***
 - These members have been receiving continuous services at the agency for more than 30 days before receiving a g-code, with an average retention of 600 days, or have disengaged and returned to the agency one or more times, before enrolling in the COE

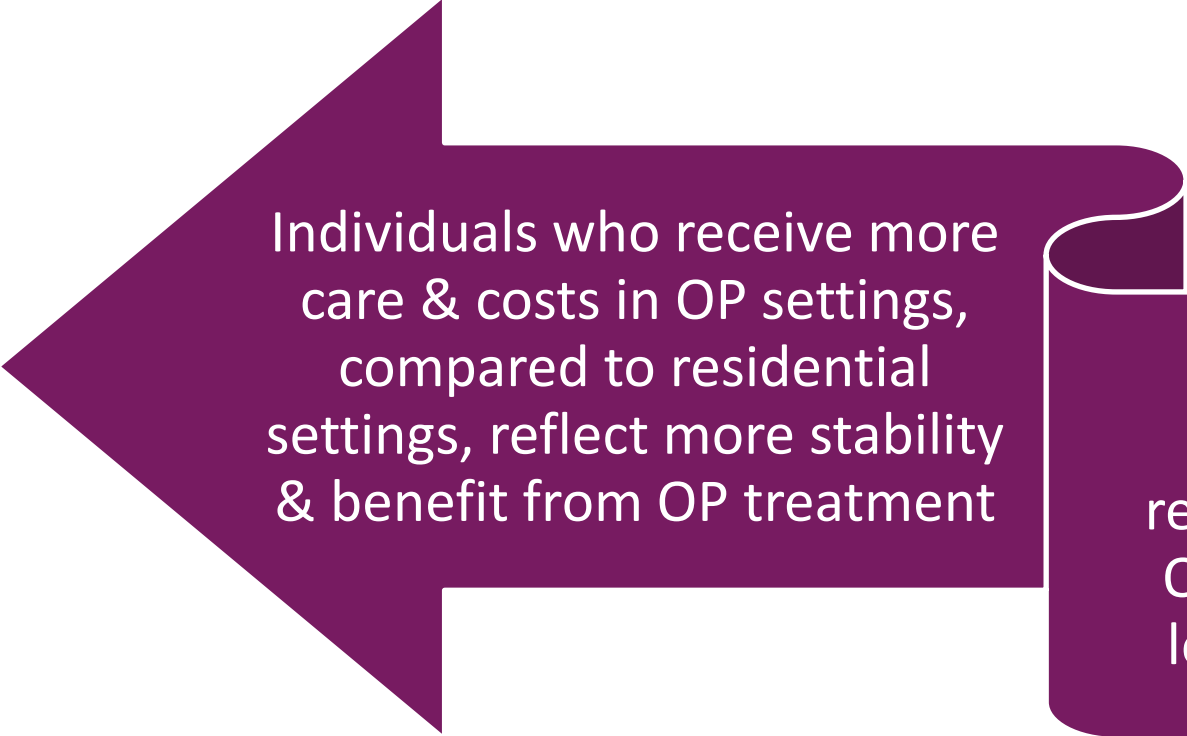
Enrollment by Month & History with the COE – between July 2019 & June 2022



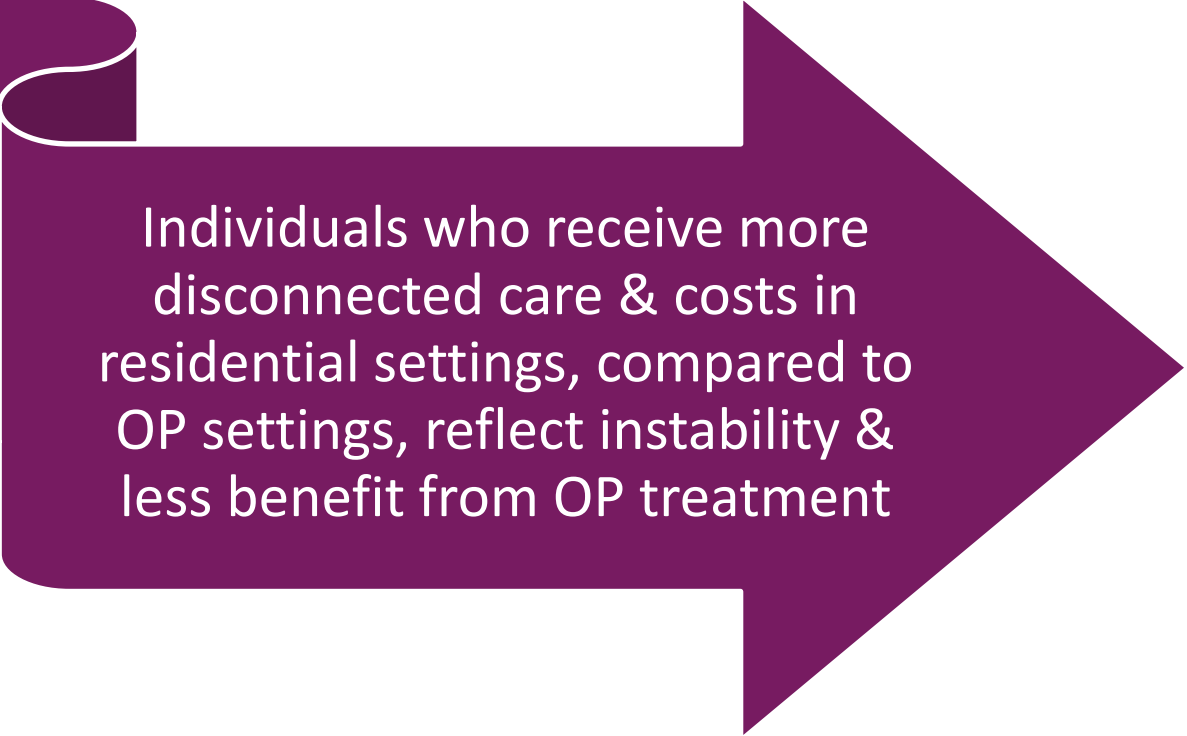
Possible Misalignment with FFS Payments & Incentives with COEs

- Data on the prior slide highlights the growth of members entering the COE program who are either stable or have extensive experience with the agency
 - Individuals actively receiving services at a SUD program are easier to reach in terms of billing the g-code, while engaging new members or those who require community outreach, are more difficult to reach in terms of billing the g-code
 - Engaging stable members is counter to the goals of the COE program, however, the FFS payment provides an incentive to serve active clients or those who return to the agency

BH Costs and Indicators of Stability and Treatment Impact

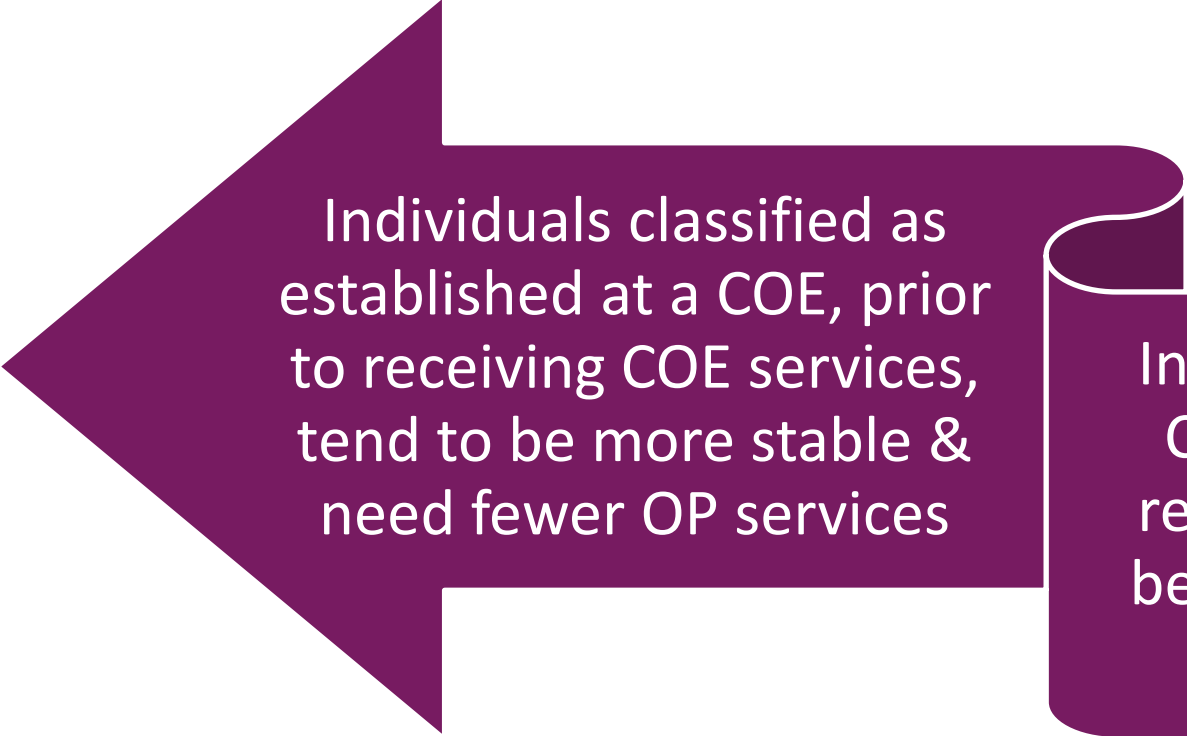


Individuals who receive more care & costs in OP settings, compared to residential settings, reflect more stability & benefit from OP treatment

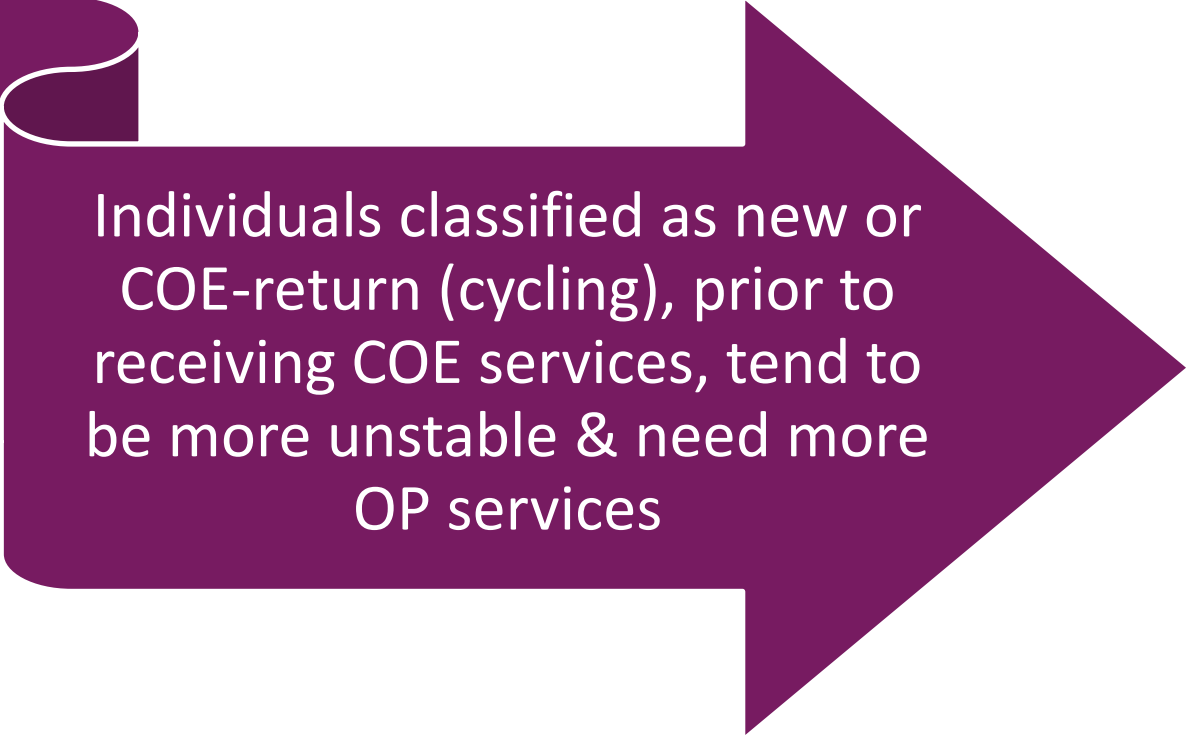


Individuals who receive more disconnected care & costs in residential settings, compared to OP settings, reflect instability & less benefit from OP treatment

BH Costs and Indicators of Stability and COE Treatment Impact



Individuals classified as established at a COE, prior to receiving COE services, tend to be more stable & need fewer OP services

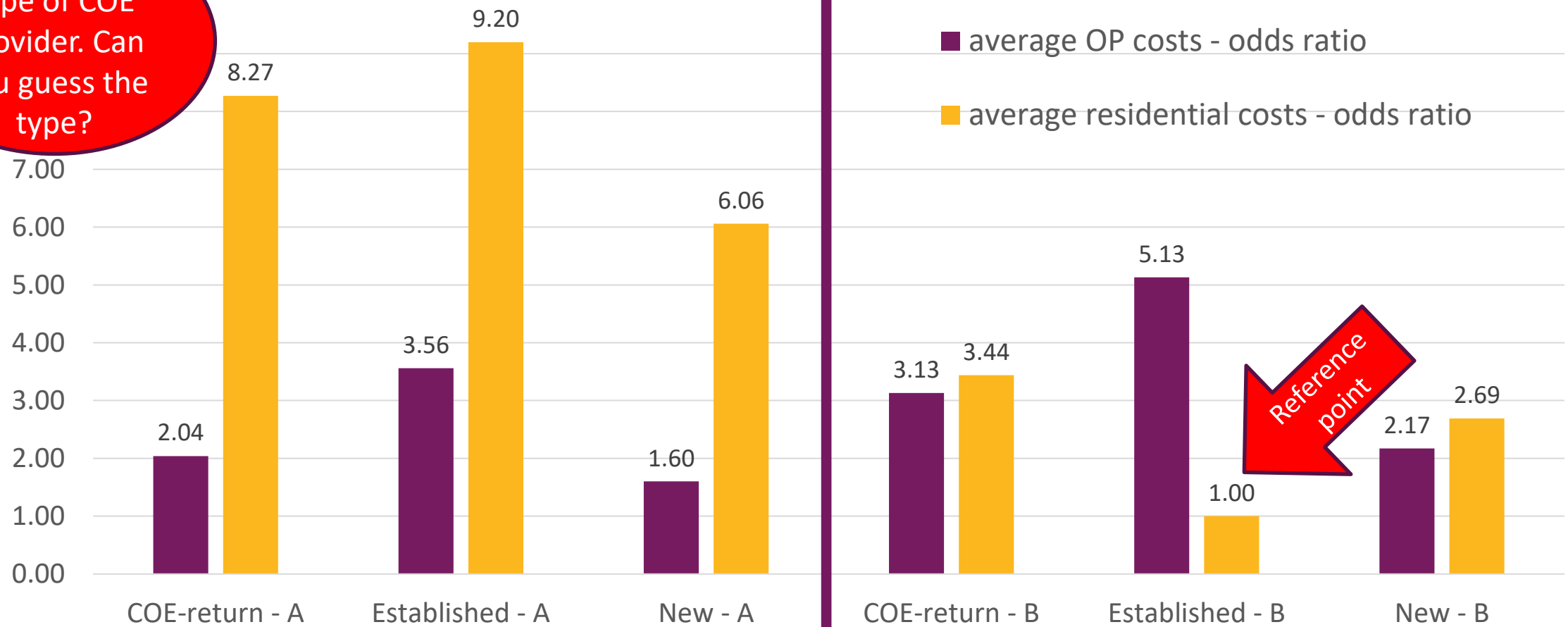


Individuals classified as new or COE-return (cycling), prior to receiving COE services, tend to be more unstable & need more OP services

Overall Behavioral Health Expenditures 12 Months Prior to Enrolling in a COE Program

A & B are a type of COE provider. Can you guess the type?

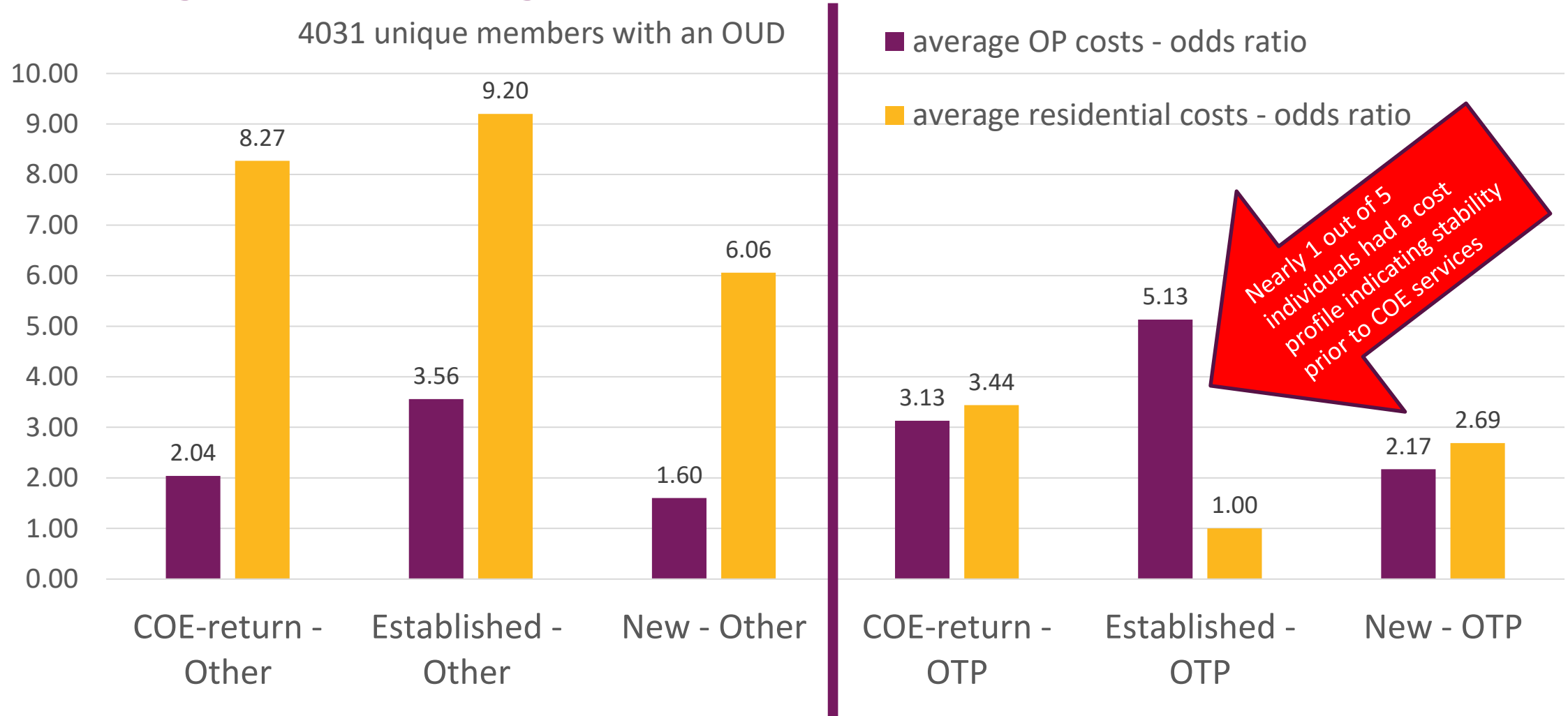
4031 unique members with an OUD



Classifying COEs by Type of SUD Organization

- COEs can be grouped into one of two categories of SUD organizations
 - A. Other (OBOTs)** – this category includes two types of SUD providers
 - **SUD – OP** – the second most common COE is a traditional outpatient SUD provider that offers OBOT services – SCAs are included in this category
 - **Residential & OP** – the third most common COE is an organization that offers both residential and OP services – all COEs that have a residential component are included in this category, even if it also has OTPs and OBOTs
 - B. Opioid Treatment Program (OTP)** – a methadone treatment program, representing approximately 63% of all COEs in the CCBH network

Overall Behavioral Health Expenditures 12 Months Prior to Enrolling in a COE Program



Selection Confounds and COE Front Doors?

Individuals entering an OBOT COE program have prior residential costs that are over 3 times higher than those who are entering an OTP COE.

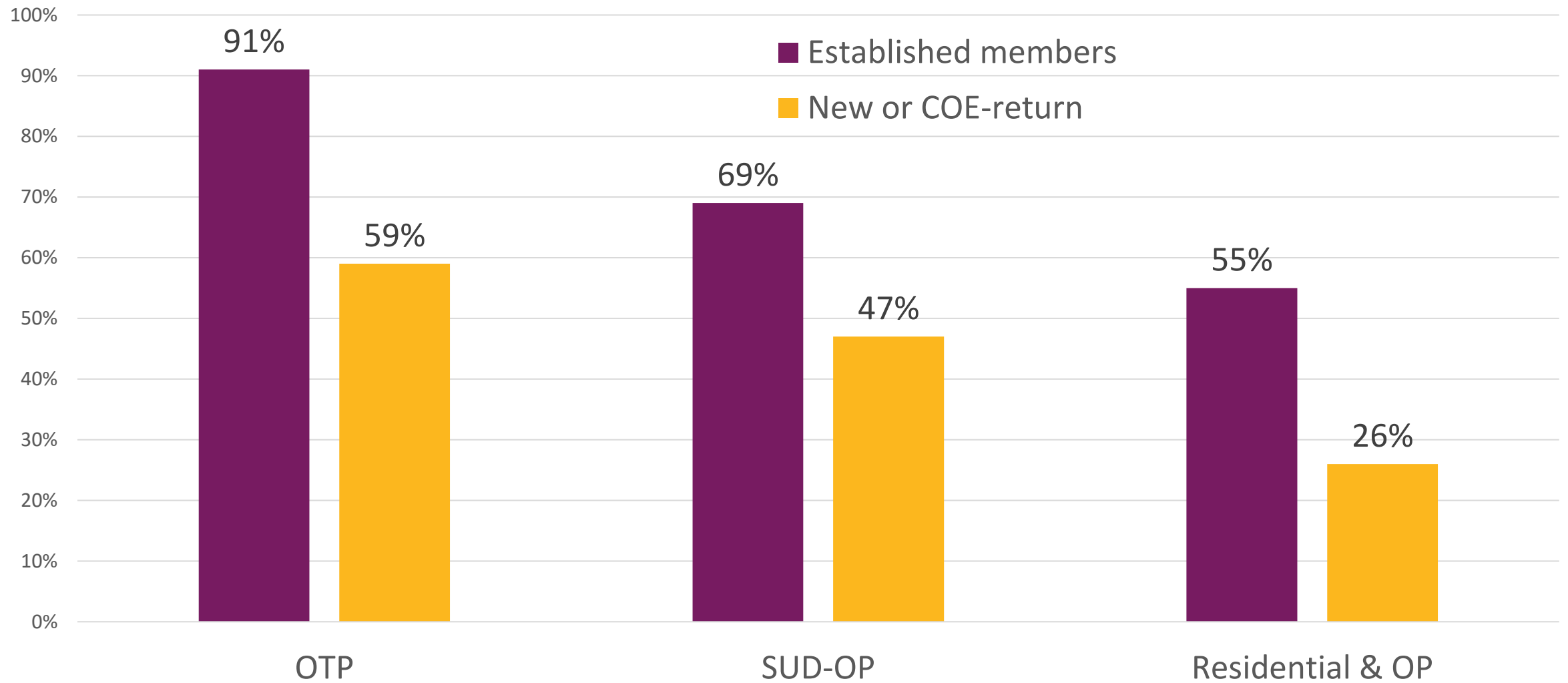
Why are individuals more stable at admission in an OTP, on average, than other types of COEs?



Selection Confounds and FFS Payments – Reactive Treatment

- Individuals with an OUD tend to disengage from none-MOUD treatment at higher rates than individuals with other SUDs
 - On the other hand, individuals who receive methadone have the highest retention rates in all SUD treatment services (buprenorphine is second)
 - Despite the efficacy of MOUD, most SUD providers do not provide rapid access to MOUD nor refer individuals to MOUD providers, which leads to cycling patterns, including high attrition, referred to as AMA rates, from most treatment interventions
 - OTPs tend to have high retention, but low enrollment rates; other SUD providers have lower retention and higher enrollment rates for those with an OUD

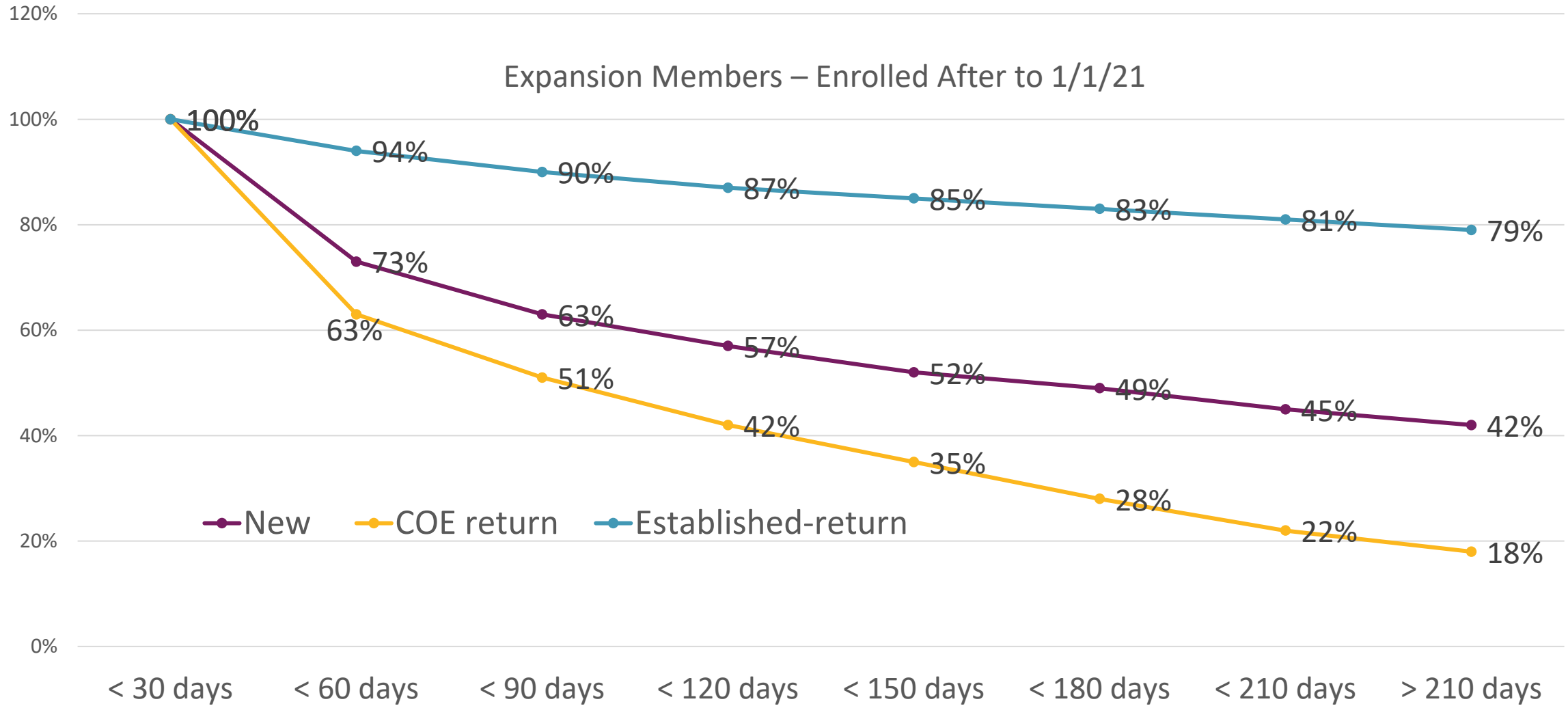
90-day Retention by COE Type and Stability of Members: After 1/1/21



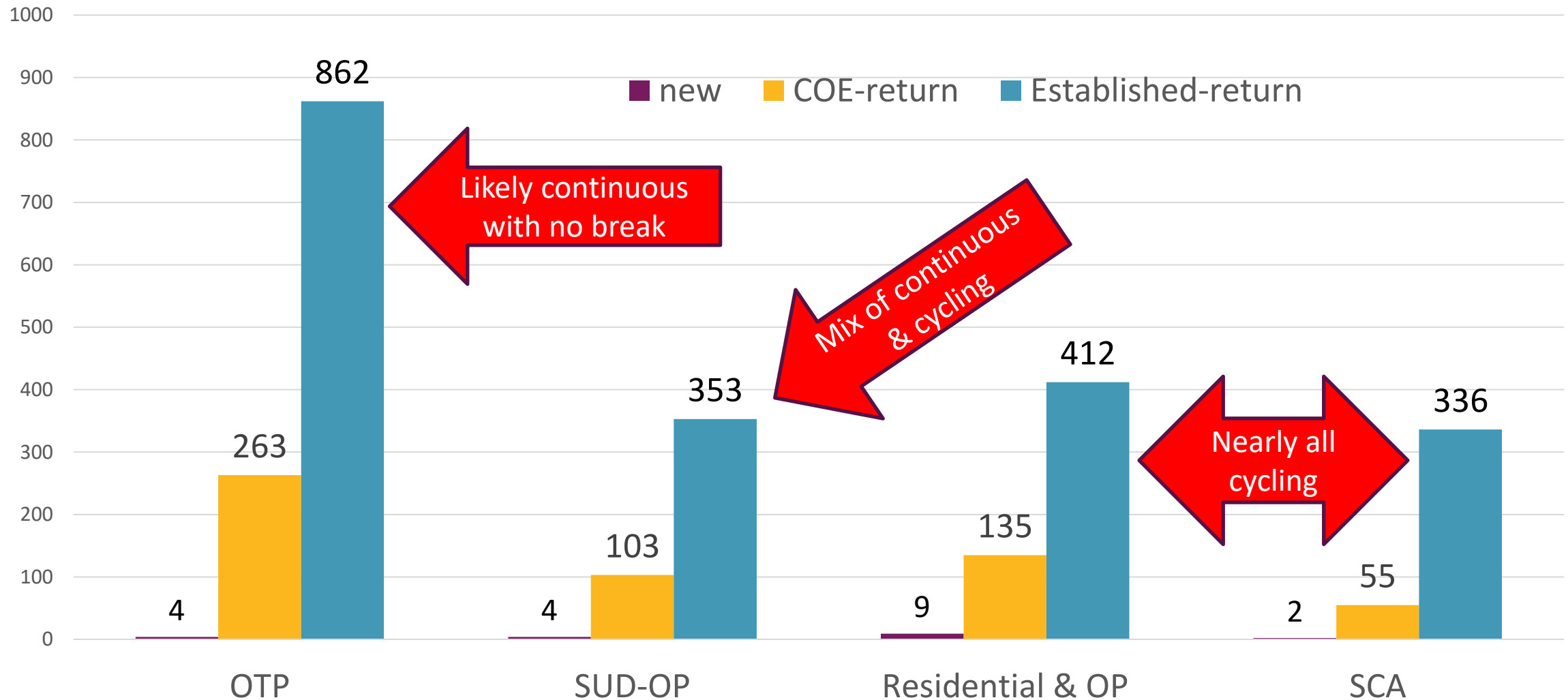
Attrition or Disengagement from the COE by Enrollment Status

- Attrition or disengagement trends are influenced by the status of members at enrollment into the COE
 - Those categorized as either new or COE-return display the highest attrition rate within the first 30 days of the program, with 27% of new and 37% COE-return members disengaging within the first month
 - Less than half of new or COE-return members are retained at six months, while over 80% of those categorized as established are retained for six or more months
 - Attrition rates diverged more after the expansion; retention increased for established members and decreased for COE-return

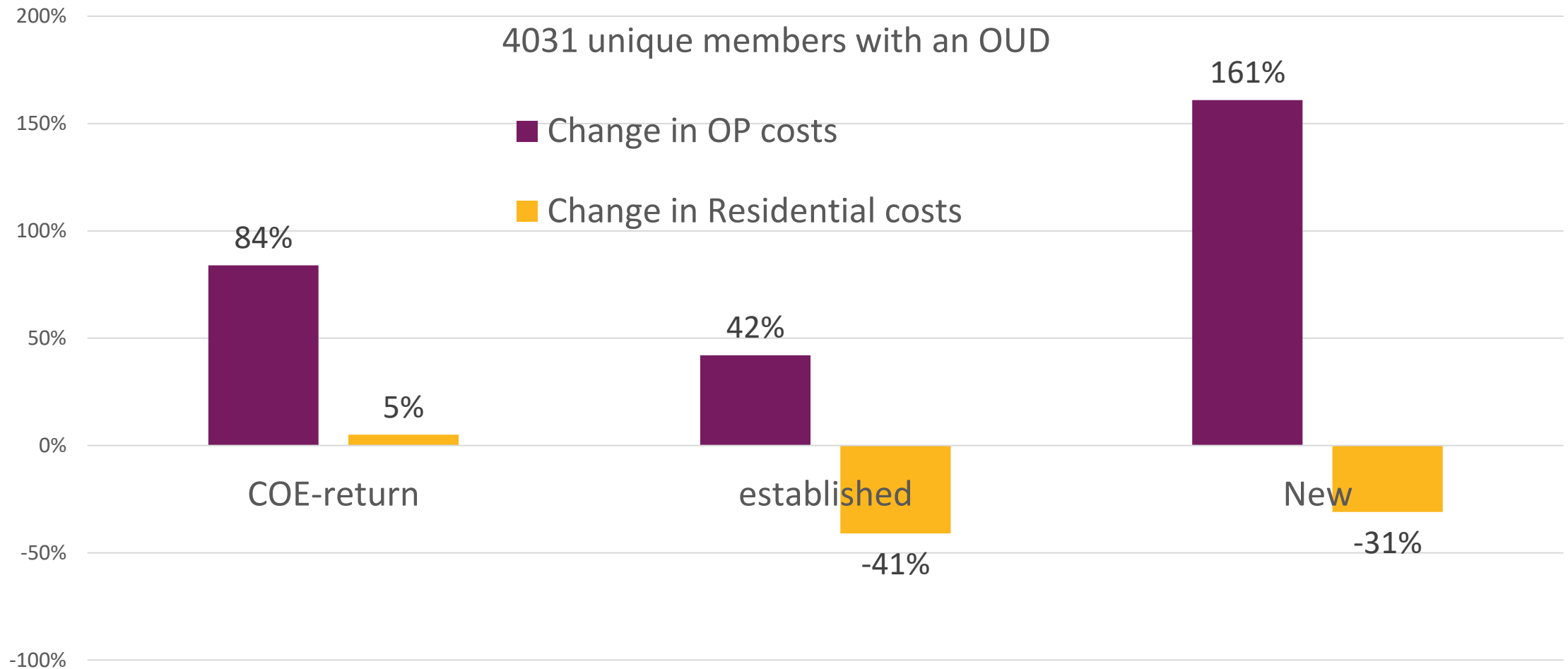
Attrition or Disengagement from the COE by Enrollment Status



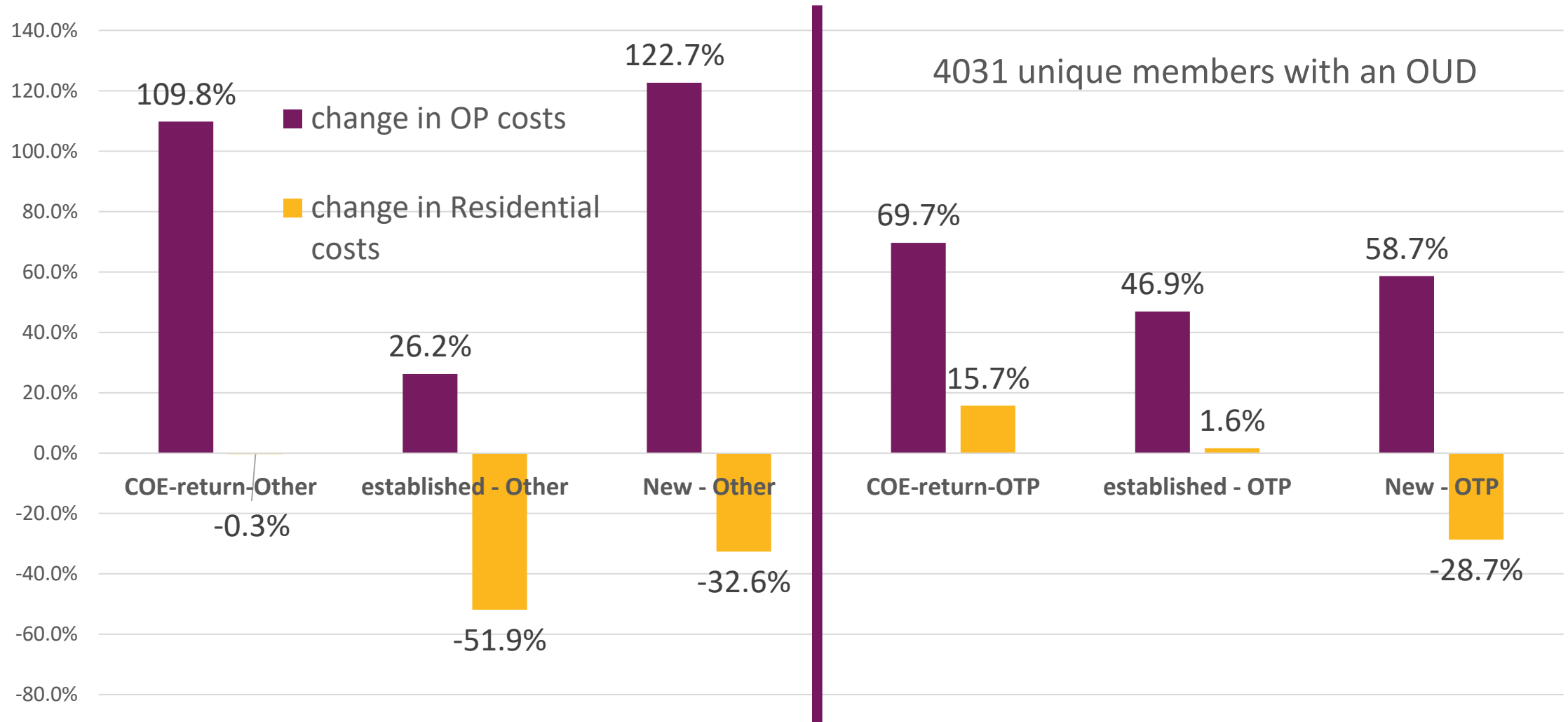
Average # of Days Between Initial Billing at Agency & First G-code Billed



Percentage Change in Behavioral Health Expenditures from 12 Months in Past to 12 Months in the Future After Initiating COE Services



Percentage Change in Behavioral Health Expenditures from 12 Months in Past to 12 Months in the Future After Initiating COE Services

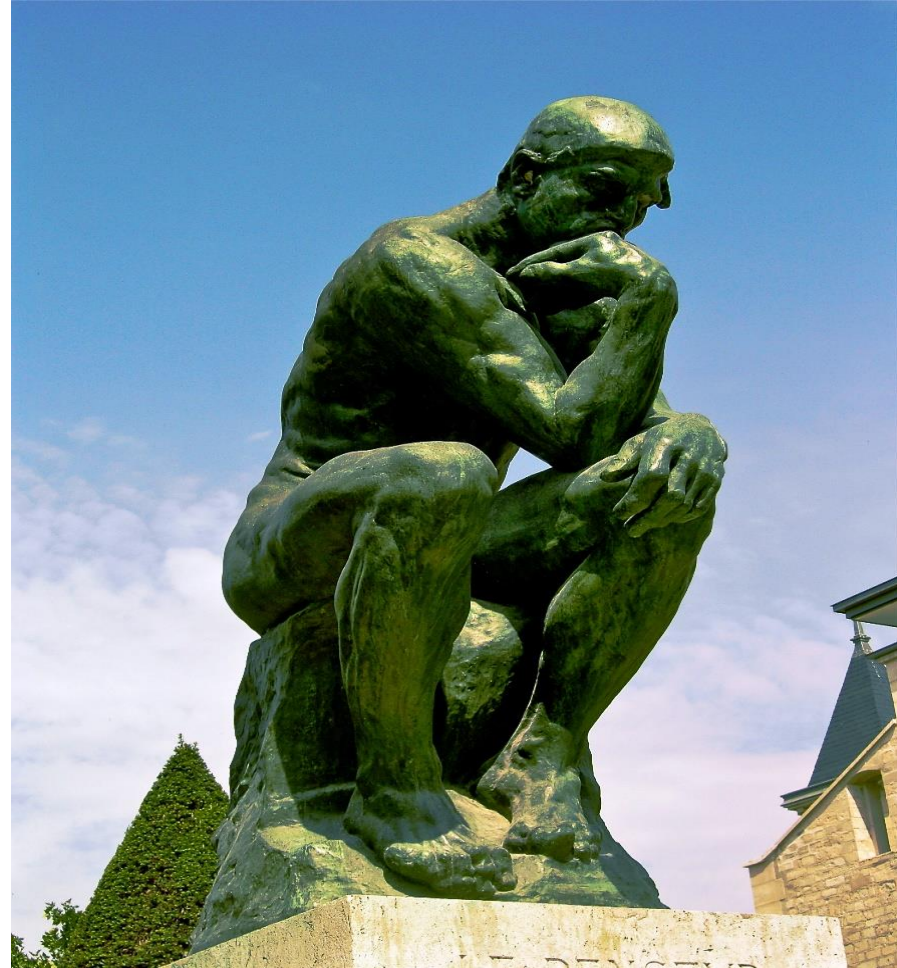


Redesigning the COE Payment Protocol

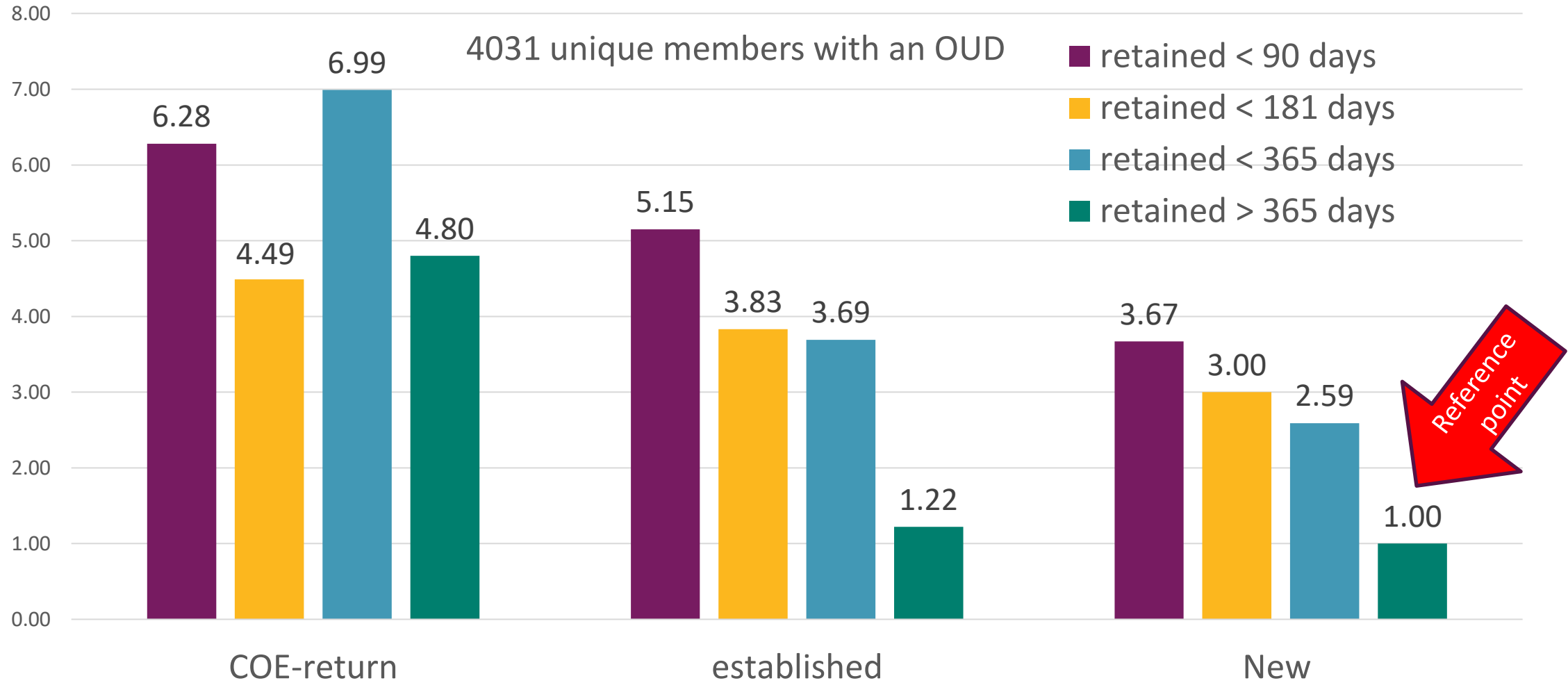
Based on what you have seen in COE cost data, how would you redesign the payment structure?

What type of individual with an OUD needs more COE services and what type needs less or no COE services?

How can you modify the payment for both groups?



Average Retention in COEs and Residential Cost Over 12 Months After Enrollment – Odds ratios



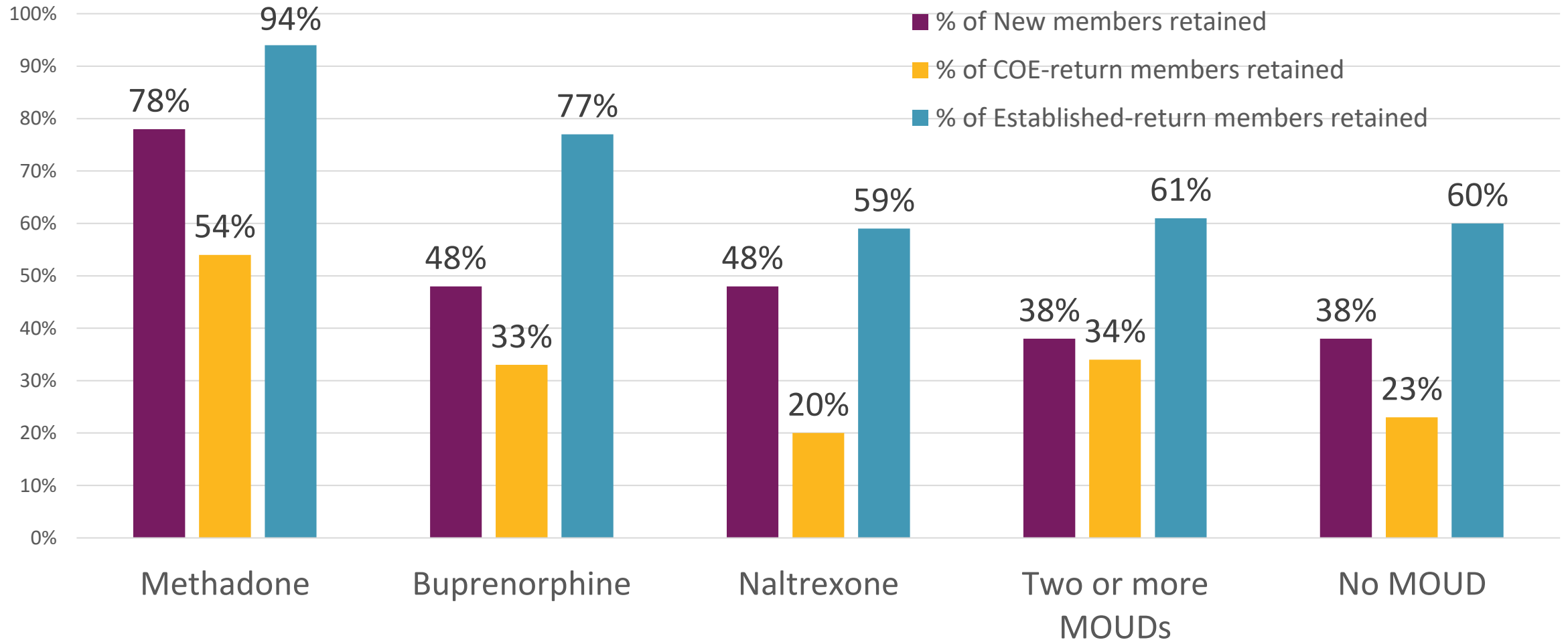
Retention Beyond One Year: Odds of being retained for more than a year in a COE by each month of the first year of enrollment



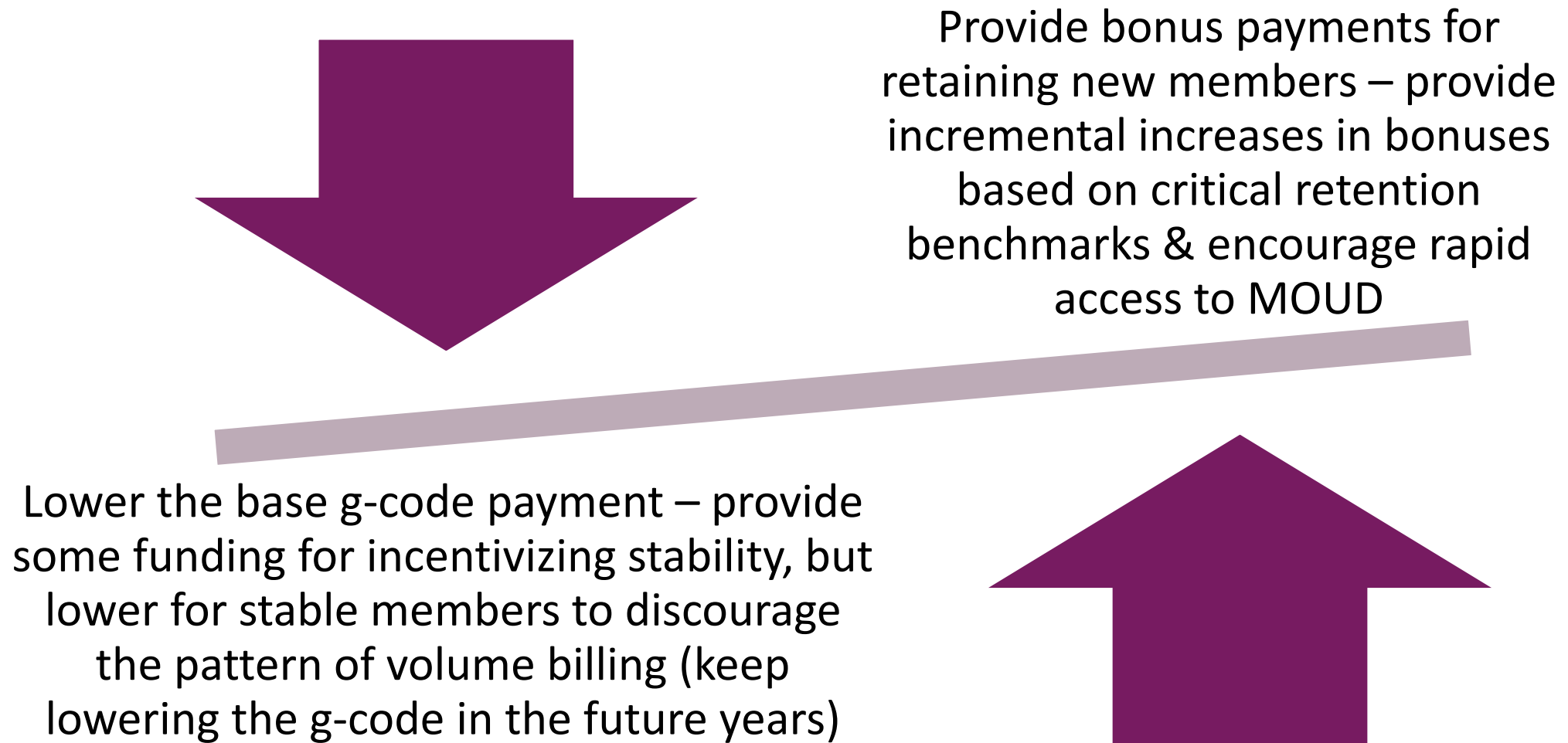
The Odds of Being Retained for 12 Months

- Data on the two prior slides highlights a consistent finding associated with MOUD programs; i.e., ***the longer a person stays active in a MOUD program, the better the outcomes***
 - Data on slide 27 reveals the cost savings over time, for those who are retained in a COE program, with a significant reduction in residential costs achieved at 12 months
 - Data displayed on slide 28 highlights the increase odds of being retained over one year, for each month retained
 - even though the odds of a new member being retained for one year is 31% at enrollment, the odds of hitting the 12-month mark increases with each passing month
 - COEs can improve outcomes by methodically increasing the overall retention, one month at a time,
 - The biggest impact occurs if a COE can hold onto a person for six months

90-day Retention Rates in COE by Medication Type & History with the COE: After 1/1/21



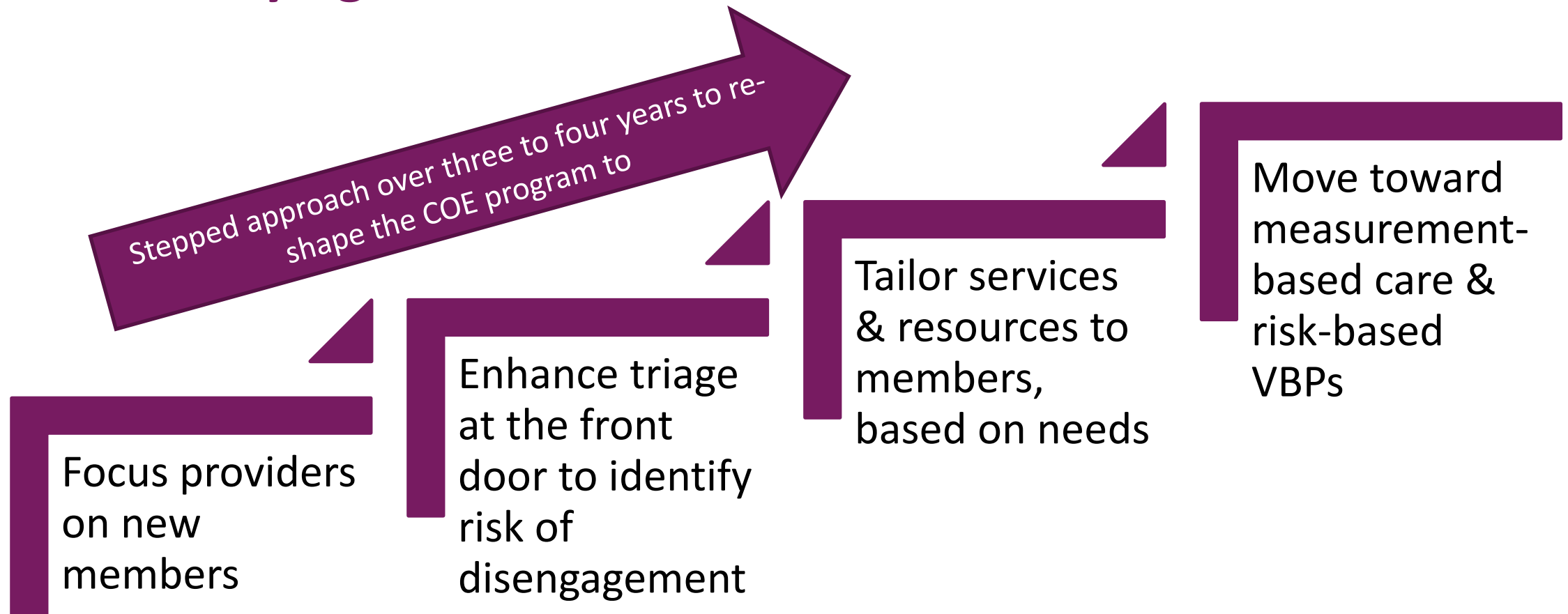
Redesigning the COE Payment Protocol: VBP for CY2023



Detailed Billing Codes & Payments for New COE Members

Month	Billing codes for measurement - billing codes from the COE agency only	Base payment via g-code paid in real time	Bonus earned on the first day after the month, paid at the end of the year	Total payment
1	1 st G9012 code begins the clock	Reduced payment	Small bonus	G-code + bonus
2	G9012	Reduced payment	Moderate-Large bonus	G-code + bonus
3	G9012	Reduced payment	Small bonus	G-code + bonus
4	G9012	Reduced payment	Large bonus	G-code + bonus
5	G9012	Reduced payment	No bonus	G-code
6	G9012	Reduced payment	Large bonus	G-code + bonus
7	G9012	Reduced payment	No bonus	G-code
8	G9012	Reduced payment	No bonus	G-code
9	G9012	Reduced payment	No bonus	G-code
10	G9012	Reduced payment	No bonus	G-code
11	G9012	Reduced payment	No bonus	G-code
12	G9012	Reduced payment	Moderate bonus	G-code + bonus
13 -	G9012	Reduced payment	No bonuses	G-code

COE: Modifying the Model for the Future



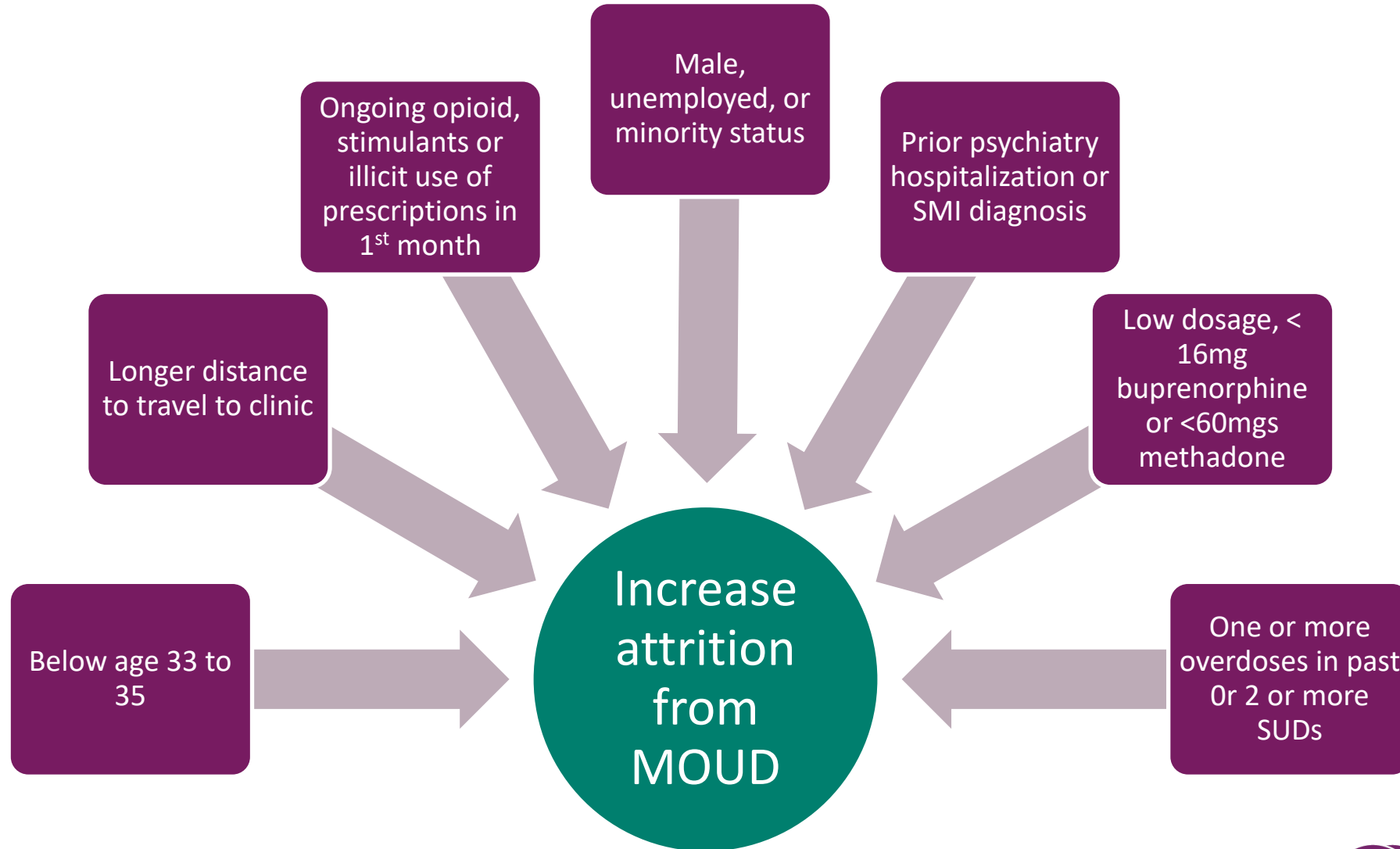
COE: Modifying the Model for the Future

CY2023 –PBC version of VBP to focus on new members – prepare COEs for risk-based VBPs, test PERU risk tool

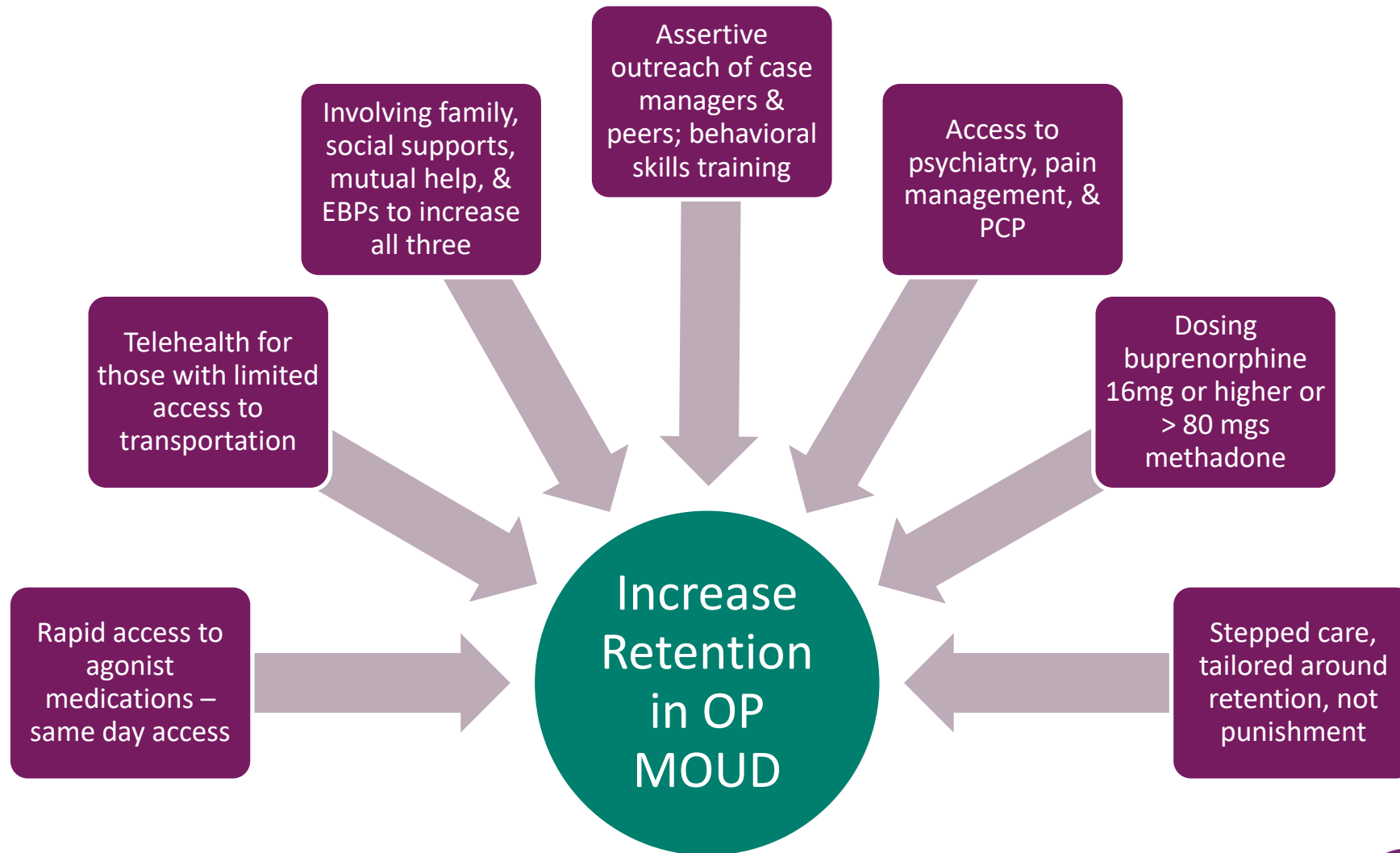
CY2024 – integrate risk assessment of members – tailor payment to risk of disengagement based on PERU risk survey in REDCap, test measurement-based care

CY2024 or CY2025 – move to risk-based VBP based on expanded outcomes (e.g., retention, access to care, BARC-10) & use measurement-based care metrics for fidelity monitoring

Attrition Factors from MOUD



What Works: Strategies to Improve Retention in OP MOUD



Thank You

David Loveland, PhD

Senior Program Director, Recovery Program,
Development and Implementation
Community Care

lovelanddl@ccbh.com | 412.402.7570