NOW is the time for Action

WHAT THE RESEARCH SHOWS

Payment Reform Edition
SUCCESS REQUIRES CONTINUOUS DISRUPTION
SOMEBEWHERE IN OUR JOURNEY WE LOST OUR WAY
RISE IN SUICIDE IN AMERICA

“U.S. Suicide Rate Surges to a 30-Year High”

Rise in suicide rate for middle-aged men and women (45-64)

Findings from National Center for Health Statistics found increase in suicide in every age group except for older adults

Overall suicide rate rose 24% between 1999 and 2014.
Many individuals who die by suicide have recently had a primary care visit

45% 1 Month

20% 24 Hours

73% Elderly – 1 Month

Luoma, Martin, & Person, 2002; Pirkis & Burgess, 1998; Juurlink et al., 2004
In 2013, mental health was estimated to be the most costly condition.

- Pulmonary Conditions: $\text{X}$
- Cancer: $\text{X}$
- Trauma: $\text{X}$
- Heart Conditions: $\text{X}$
- Mental Health: $201$ Billion

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Treatment Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>49%</td>
<td>Primary Care Only</td>
</tr>
<tr>
<td>18%</td>
<td>No Visit</td>
</tr>
<tr>
<td>14%</td>
<td>Primary Care + Mental Health</td>
</tr>
<tr>
<td>14%</td>
<td>Other Combo</td>
</tr>
<tr>
<td>5%</td>
<td>Mental Health Only</td>
</tr>
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</table>

Findings from 109,593 respondents to the 2002-2009 Medical Expenditure Panel Surveys (MEPS)

Inmates meeting criteria for mental health problem within previous year

State Prison: 56.2%
Federal Prison: 44.8%
Local Prison: 64.2%

Approximately
- State
- Federal
- Local

Received mental health treatment since admission

How Yelp Reviews Can Help Improve Patient Care

Aaron E. Carroll
THE NEW HEALTH CARE
SEPT. 12, 2016
A CASE FOR INTEGRATING BEHAVIORAL HEALTH AND PRIMARY CARE

66% of primary care providers report they are unable to connect patients with outpatient behavioral health providers due to a shortage of mental health providers and health insurance barriers.

20% of primary care office visits are mental health related.

46% of adults will experience mental health illness or a substance abuse disorder at some point in their lifetime.

67% of adults with a behavioral health disorder do not get behavioral health treatment.

35% of children receiving outpatient care for mental health conditions only saw their primary care providers.

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2/3 of Americans believe mental health has a negative impact on the nation's economy.

75% believe mental health reform is important for reducing suicide and increasing access to care.

5% believe mental health is a priority for Congress.

50% of those surveyed did not know or were not sure how to access mental health for themselves or a loved one.

psychiatry.org/newsroom/news-releases/apa-mental-health-care-survey
Define or be defined

What is integrated behavioral health and primary care?

The care that results from a **practice team** of primary care and behavioral health clinicians, **working together with patients and families**, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), **life stressors and crises**, stress-related physical symptoms, ineffective patterns of health care utilization.

UPSTREAM
Behavioral health

• Institutionalization (mid 1800s - 1950/1960)
  – Inpatient care model - patients lived in hospitals and were treated by professional staff (used to be considered most effective way to care). Institutionalization welcomed by families and communities (e.g. Uncle Johnny)

• Deinstitutionalization (1950s on)
  – A push for deinstitutionalization and outpatient treatment began (in part due to living conditions and development of antipsychotic drugs). It was believed that community-oriented care could help patients have a higher quality of life if treated in their communities
  – In 1963, Congress passed the Mental Retardation Facilities and Community Health Centers Construction Act, which provided federal funding for the development of community-based mental health services.
The “two pots” of money
## Model mastery

<table>
<thead>
<tr>
<th>Payment model</th>
<th>Description</th>
<th>Pros</th>
<th>Cons</th>
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<tr>
<td>Fee for Service (FFS)</td>
<td>FFS system uses a retrospective payment where each item of service provided is reimbursed based on certain billing codes that are submitted as a claim to the health insurance company; behavioral health payments primarily come from a separate entity within an insurance company</td>
<td>Behavioral health services can receive compensation for their mental health services</td>
<td>Relegates behavioral health clinicians to deliver more traditional mental health interventions often independent of the team</td>
</tr>
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# Model mastery

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<td><strong>Modified Fee for Service</strong></td>
<td>Oftentimes a hybrid of FFS and non-FFS payments. For example, pay for</td>
<td>Increases the ability of PCMH to engage in some value-based rather</td>
<td>Still makes behavioral health its own service line and intervention</td>
</tr>
<tr>
<td></td>
<td>performance (see below) and partial capitation.</td>
<td>than solely volume-based care.</td>
<td>rather than a part of the team</td>
</tr>
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<td></td>
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<td><strong>Pay for Performance (P4P)</strong></td>
<td>P4P holds clinicians accountable for the outcomes their care delivers. Such initiatives aim to incentivize processes and outcomes of care</td>
<td>Increases the likelihood that certain behavioral health conditions are addressed (e.g., depression)</td>
<td>Payment may not be sufficient to support the behavioral health member of the primary care team</td>
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Model mastery

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<td><strong>Bundled Payments</strong></td>
<td>Bundled payments reimburse for a discrete course of treatment rather than paying for each discrete clinical interaction and procedure</td>
<td>Supports more of the team approach to specific conditions</td>
<td>Behavioral health often not considered as a part of the payment bundle</td>
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<td>Global Payments</td>
<td>A global payment system, or a capitated system, pays a predetermined per person rate to healthcare organizations, regardless of the delivered services</td>
<td>When behavioral health is a part of the service expectations through the global payment, there can be seamless and unfettered access to behavioral health; behavioral health becomes natural extension of primary care team</td>
<td>Challenge associated with assuming risk for patients with behavioral health; practice change and transformation</td>
</tr>
</tbody>
</table>
Spending Pattern – Conventional FFS

- Emergency: 3.7%
- Inpatient: 22.6%
- Outpatient: 18.3%
- Specialists: 20.8%
- Pharmacy: 17.5%
- Primary Care: 4.6%
- Ancillary: 12.5%
Spending Pattern – Value Based

- Emergency: 3.4%
- Inpatient: 20.9%
- Outpatient: 16.9%
- Behavioral: 0.5%
- Primary Care: 9.1%
- Specialists: 19.3%
- Ancillary: 11.5%
- Pharmacy: 18.4%
Isn’t the second pie bigger? No.

<table>
<thead>
<tr>
<th>Advanced Practices</th>
<th>$479.30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Payments</td>
<td>$4.35</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$482.85</strong></td>
</tr>
<tr>
<td>Conventional Network Average</td>
<td><strong>$505.83</strong></td>
</tr>
<tr>
<td>Risk Normalized Difference</td>
<td><strong>-4.54%</strong></td>
</tr>
</tbody>
</table>
• Comprehensive primary care is a “high leverage” investment

• Integrated BH is just another (important) aspect of comprehensive primary care

• Small part of the total health care budget

• Exemplars are performing very well; the question is how to scale this model through accelerated transformation.
An example of payment reform

SUSTAINING HEALTHCARE ACROSS INTEGRATED PRIMARY CARE EFFORTS (SHAPE)
• Sustaining Healthcare Across integrated Primary care Efforts
  – A partnership between Collaborative Family Healthcare Association, Rocky Mountain Health Plans, Colorado Health Foundation, and University of Colorado School of Medicine Department of Family Medicine
  – To test an alternative payment model to sustain behavioral health in primary care
The set up

• To test a different payment method to financially support and sustain behavioral health in primary care;
• To better understand the costs associated with integration and a global payment methodology for behavioral health and primary care;
• To test the real world application of a novel payment methodologies on novel primary care practices who have integrated behavioral health with the end goal to inform policy.

• The SHAPE project deployed a mixed methods evaluation collecting both qualitative (interviews and monthly calls with providers and staff and site visit notes) and quantitative (clinical and claims) data.
• The evaluation team assessed the value of integration and payment reform on overall healthcare cost and outcome trends in integrated practices with the main focus of understanding if a new model of payment changed the sustainability of integrating behavioral health into primary care.
Experimental
- Foresight
- Mountain Family
- Primary Care Partners

Intervention
- MidValley
- Axis
- Sunrise
Defining the “intervention”

• Sufficient, non-encounter, non-volume based reimbursement to afford primary care providers the time and capacity required to perform evidence-based clinical interventions, as well as the “asynchronous” planning, panel management and coordination activities entailed in effective integrated care;

• Accountability for the total cost of care incurred by patients, supported by internal and external feedback reporting, with proportionate and progressive exposure to losses and bonuses for achieving prospective budget and quality targets;

• A material bonus opportunity for measured quality, independent of financial budget targets, for the purpose of continuous improvement, innovations and the development of stronger external connections with community resources.
# A Tale of Two Approaches

<table>
<thead>
<tr>
<th>Component of Care</th>
<th>Traditional</th>
<th>Integrated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>Referral</td>
<td>Point of Primary Care</td>
</tr>
<tr>
<td>Scope of Service</td>
<td>Mental Health Diagnoses</td>
<td>Overall Health Function</td>
</tr>
<tr>
<td>Scheduling</td>
<td>Separate</td>
<td>Shared</td>
</tr>
<tr>
<td>Collaboration of Care</td>
<td>Individual Provider</td>
<td>Team Based</td>
</tr>
<tr>
<td>Health Record</td>
<td>Separate</td>
<td>Shared</td>
</tr>
<tr>
<td>Administrative Operations</td>
<td>Separate</td>
<td>Shared</td>
</tr>
<tr>
<td>Payment</td>
<td>Separate</td>
<td>Global</td>
</tr>
<tr>
<td>Communication</td>
<td>Minimal</td>
<td>Frequent &amp; Timely</td>
</tr>
<tr>
<td>Focus of Care</td>
<td>Provider-Centric</td>
<td>Patient-Centric</td>
</tr>
<tr>
<td>Approach to Care</td>
<td>Case by Case</td>
<td>Population-Based</td>
</tr>
<tr>
<td>Efficiency of Delivery Structure</td>
<td>Fragmented &amp; Inconsistent</td>
<td>Coordinated and Aligned</td>
</tr>
</tbody>
</table>
Payment recommendations

• This is not about changing the way we pay for behavioral health; this is about changing the way pay for primary care that includes behavioral health

• Make sure the delivery setting is getting paid by keeping the patient healthy, not per patient visit (e.g. move as quickly as possible away from fee for service)

• Make sure there are incentives in place to encourage primary care clinicians to work with behavioral health (e.g. hold them accountable for certain behavioral health conditions)
Key steps

1) Consistently define your effort
   How can you pay for or measure what you have not defined? What is and what is not integration?

2) Calculate a baseline cost of your program (expenditure analysis)

3) Create global payments based upon defined practice budgets (see #2) for personnel, interventions and related infrastructure – to create team-based, whole-person care (e.g. CoACH)
   Change payments to allow for behavioral health providers to not be trapped in a workflow designed to maximize volume-based payments, or pigeon holed into distinct “physical” and “mental health” coding categories

4) Consider at what level you intent to measure your effort
   Access? Cost? Improvement?

5) Tell your story (often)
Additional considerations

• How can the population be stratified by severity (e.g. SPMI vs mild/moderate)?
• How do payment models limit your ability to practice prevention?
• Measurement (e.g. how many more people were seen, at what cost, and where?)
• How is care financed to support model? How do payment models limit what can done in practice?
• What are the minimal training requirements/competencies based upon setting?
• How are social determinants factored in?
• How is information shared across the community?
UNIVERSAL HEALTH POLICY QUESTIONS
OF EQUITY AND EFFICIENCY

**WHO** is covered?

**WHAT** is covered?
What is the **LEVEL OF PAYMENT**?
What is the **FORM OF PAYMENT**?
THOSE WHO SAY IT CAN’T BE DONE ARE USUALLY INTERRUPTED BY OTHERS DOING IT

James Baldwin
One stop
integrationacademy.ahrq.gov

Policy
farleyhealthpolicycenter.org

Case study
advancingcaretogether.org

State example
coloradosim.org

National organization
cfha.net

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