RESTRUCTURING PAYMENT TO OPTIMIZE BEHAVIORAL HEALTH ACCESS: A CCO CASE STUDY

Advanced Health walks back from capitation to incentivize outpatient visits while maintaining an overall value-based framework with community providers

A switch to pay-for-performance leads to a desired uptick in outpatient visits but stresses community providers

Oregon faces challenges in delivering behavioral health care services. The state regularly ranks poorly in national assessments of mental health care access and unmet need,[1,2] and all but two counties are within designated mental health Health Professional Shortage Areas.[3]

Recently, the state addressed the behavioral health workforce crisis through House Bill 4004, which funded direct payments for providers, and House Bill 2949, which allocated $80 million for behavioral health workforce development. In November 2022, Oregon also received federal approval to increase fee-for-service behavioral health rates by an average of 30%.[4]

A recent assessment of national Medicaid mental health reimbursement, however, showed Oregon payment rates above the average for common mental-health services.[5] Additionally, a 2022 Oregon workforce report identified non-wage issues, including barriers to career advancement and workforce burnout caused by high client acuity, large caseloads, and administrative burdens, as important sources of provider shortages, particularly in community-based facilities.[6] Together, these findings suggest that reimbursement may be one among multiple systemic challenges that coordinated care organizations (CCOs) face when working with providers to support behavioral health access for members.

This brief explores the experience of Advanced Health, a CCO covering two rural counties on the southern Oregon coast, in working with community providers to implement changes to a long-time payment model with the goal of improving outpatient access for members.

KEY TAKEAWAYS

- **CCOs need to ensure appropriate access to services under capitated arrangements.** Benchmarking against statewide data can reveal areas where access is lacking.
- **Pay-for-performance can promote and establish appropriate service volumes for members** while still maintaining ties to quality. Pay-for-performance can also incentivize particular services within larger capitated agreements.
- **Payment models that address both performance and provider sustainability** are important to ensure continuity and stability of services.

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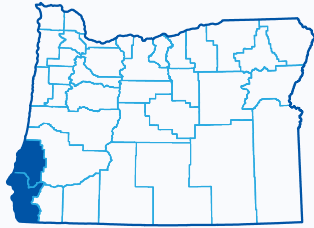
AT A GLANCE

ADVANCED HEALTH MENTAL HEALTH CARE CONTRACTING



Who's involved: Coos Health & Wellness, the Coos County Community Mental Health Program

HCP-LAN Category:[8] 4A (condition-specific population-based payment) overall, with a fee-for-service component for outpatient visits

Members included: 23,947 (all Coos County members)

Annual dollar value: $9.4M

Financial risk: Provider completely at risk for capitated services

Quality component: Emergency Department Utilization among members with mental illness (NCQA)

Social determinants of health and equity component: The model aims to improve mental-health service access for at-risk members.

An evolving behavioral health care delivery landscape in Oregon

Since the advent of CCOs in 2012, behavioral health contracting in Oregon has gone through several shifts. The CCO model brought behavioral health services into the global Medicaid budget, but many CCOs initially delegated services to the behavioral health organizations that had administered them prior to CCO formation.

Starting in 2020, the CCO 2.0 model prohibited delegation of behavioral health services[7] and required CCOs to administer benefits, aiming to promote integration with other care. In 2022, CCOs reported a mixture of payment models for behavioral health. Some providers were in capitated arrangements with population-based payment and quality targets. Others were in value-based payment (VBP) models, such as pay-for-performance and shared-savings, that retained a fee-for-service architecture while incentivizing quality and promoting cost effectiveness.

Providers operate in a variety of settings, ranging from county-based Community Mental Health Programs (CMHPs) and other agencies to individual practices, which may be difficult to engage in VBP. This varied service landscape leads to questions about optimal models for supporting access to services in different local environments and for different member needs.

Impetus for a new model at Advanced Health

Capitation had been the payment method of choice for behavioral health care on the southern Oregon coast for decades, dating back to the pre-CCO era of regional behavioral health organizations. When Western Oregon Advanced Health CCO was formed in 2012, it continued this arrangement, delegating mental health service delivery to its two county CMHPs, Coos Health & Wellness and Curry Community Health. The CCO also maintained separate capitated contracts with a regional provider, Adapt Integrated Health Care, for substance-abuse disorder (SUD) services in each county.

With CCO 2.0, Western Oregon Advanced Health (newly renamed "Advanced Health") took over the administration of behavioral health benefits but continued its capitated agreements with all three agencies.

Converting these contracts to VBP arrangements to fulfill OHA's VBP Roadmap meant adding quality measures. While this seemed a relatively straightforward task, the CCO uncovered concerns as it dug into measures of member access.

Challenges with outpatient access

"When we were reviewing our behavioral health access — our production relative to other CCOs — [we] became concerned that our members were not getting the access they need," said Chris Hogan, chief financial officer

at Advanced Health. Problems centered around access to outpatient services, including psychotherapy. Initially, the CCO thought the low numbers might reflect a reporting issue, but further investigation suggested a true shortage in services. The CCO hypothesized that shifting to a fee-based, pay-for-performance model for these services might incentivize the CMHPs to offer more visits.

"That's where our minds were: 'How can we design a new contracting structure that will maintain capitation, but provide a significant financial incentive to improve access for our members?'" Hogan said. As CCO 2.0 approached, the CCO created a VBP arrangement that blends capitation (with a quality measure) for some specialized programs with pay-for-performance for outpatient services.

How it works

The CCO pays for some programs through capitation, including "fidelity" programs, such as Assertive Community Treatment and Intensive In-Home Behavioral Health Treatment, that require special staffing models or include non-claims-based services. Individual outpatient visits are paid on a per-service basis to incentivize volume and address the CCO's concerns about promoting access. As the arrangement's quality component (and another means of incentivizing outpatient access), providers receive payments for hitting targets for reducing emergency department visits for behavioral health.

"If you are in a system where access is already a problem, then capitation can be counterproductive."

—Chris Hogan, Chief Financial Officer, Advanced Health CCO

While the new contracts shift some behavioral health payments from higher to lower categories in the HCP-LAN framework, Hogan considered the move appropriate.

"The aim of capitation, in terms of the financial incentives, is to incentivize providers to reduce unnecessary utilization. We want them to be efficient," he said. "However, if you are in a system where access is already a problem, then capitation can be counterproductive."

The CCO's approach is, in fact, supported by the HCP-LAN, which notes that fee-based payment with appropriate quality indicators may be ideal for high-value services (such as vaccinations and colonoscopies) that payers want to incentivize.[8]

How providers responded

While Advanced Health knew the model would put new pressures on providers, some of the responses might have been hard to predict.

Challenges in Coos County

Coos Health & Wellness transitioned to the new model in 2020, but is still grappling with its financial impact. David Geels, mental health director at the program and a 20-year veteran of care delivery in the region, said that what makes the new model challenging is not that fee-based rates for outpatient therapy visits are low — they're not, he says — but that the CMHP's complex patient load makes generating visits difficult.

"Community mental health programs — we're the safety net, so we tend to serve the folks that are the most challenging, the ones that maybe struggle to show up for appointments, that are hard to track down," Geels said.

If a patient misses a scheduled visit, Geels noted, the service cannot be billed. Transit time is also unbillable if a provider travels to see a patient who cannot come to the clinic. Consequently, while pay-for-perfomance might work well for low-acuity patients, the CMHP found it hard to generate enough revenue with high-acuity patients who have serious mental illness or complex social needs.

"Our system basically treats everyone the same. It ignores the complexity of treating the patient and instead focuses only on the duration of any face-to-face visit. This is not the reality of treating many of our patients," Geels said.

The shift in outpatient payment was especially challenging for the CMHP's psychiatric providers. For psychiatric outpatient visits, the program bills through the evaluation and management codes used by medical providers, which pay less on average than the codes for outpatient psychotherapy. Under the new pay-for-perfomance agreement, the CMHP ramped up the pace of psychiatric visits to maintain the level of revenue it had in the previous capitated arrangement. The increased pressure for productivity led psychiatric providers to leave the program.

The providers decided, Geels said, they would be "better off going into a private practice where they could choose the

patients they wanted to see, they could see them for how long they wanted, and the reimbursement would be more along the commercial end of rates."

The CMHP covered the gap through greater reliance on telehealth and locum tenens providers (those who work temporarily in practices other than their own). A group of psychiatric nurse practitioners set up practice and helped supplant the CMHP's lost capacity. However, according to Geels, community providers and even some telehealth providers have balked at taking on higher-complexity patients, leaving them to be managed by the CMHP.

"Community mental health programs — we're the safety net, so we tend to serve the folks that are the most challenging... Our system doesn't encounter complexity in those situations very well."

—David Geels, Mental Health Director, Coos Health & Wellness

Closure in Curry County

As the new payment model approached, Curry Community Health, the smaller CMHP, struggled to gear up to bill visits in the new pay-for-performance model. The CCO delayed implementation of the new model for three months, then seven. At the same time, the sparsely populated county was struggling to fulfill its public health functions amidst the COVID-19 Public Health Emergency, relinquishing its public health authority to the state in early 2021.[9] Ultimately, Curry Community Health elected to close its doors in 2021 while still under capitation.

The closure precipitated a crisis for mental health access in the area. Advanced Health was able to convince Adapt, its SUD provider in both counties, to take on the CMHP role for Curry County with support from AllCare CCO, which also has members in Curry. Adapt insisted upon a capitated arrangement for Medicaid members, at least initially, as a condition for expanding services.

Supporting capacity for rural service delivery

Greg Brigham is the chief executive officer of Adapt, which took over the CMHP role in Curry County. Capitation, he said, was crucial for Adapt to expand into a new area and set up shop before establishing a client base to support itself through fee-based billing. In the past, Adapt has made things work under pay-for-performance models like the one Advanced Health implemented if rates were carefully selected. Adapt does, however, view some form of capitation or cost-based payment enhancement as essential to maintaining a full range of services in sparsely populated rural communities.

Advanced Health recognized the disruption that changes to payment models can create for providers – for example, the increased financial risk and administrative burden that its change in outpatient visit reimbursement entailed for the CMHPs. The CCO, Hogan said, aims to support providers through adequate rates, regular meetings to discuss challenges, and updates to agreements as needed. For now, however, the CCO wants to stay focused on member access.

As hoped, visit volumes increase

Claims reporting indicates that outpatient therapy visits have gone up for CCO members since the pay-for-performance model went into effect. Visits increased by 51% between the last quarters of 2019 and 2020 (an interval when visits were dropping across the state). Visits have increased an additional 7% since then. While improved reporting under the new arrangement may contribute to the increase, the CCO is also seeing services from a wider group of clinicians, suggesting the new payment strategy is broadening its provider network. Rates of emergency department visits associated with behavioral health codes, the model's quality measure, decreased from 86.9 per thousand members in 2021 to 84.3 in 2022.

Eventually, Hogan said, Advanced Health may return to capitation for all behavioral health services. Service levels under the current pay-for-performance arrangement will help establish appropriate new baselines for volume and access.

Implications

As Oregon works to improve access to behavioral health care, VBP offers payers financial levers to address shortages or imbalances in services. However, changed expectations may stress providers, particularly when they serve patients living in adverse social circumstances.

In areas with long-entrenched delivery models, statewide benchmarking data may provide useful indicators of where service volumes or costs are inconsistent with those of other CCOs, facilitating conversation about appropriate service levels. Payment model discussions that address both performance and provider sustainability are important to ensure continuity and stability of services, particularly in rural areas with fewer resources. Implemented carefully, VBP can lead to arrangements that are sustainable for participating providers and improve member care.

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www.ohsu.edu/chse | **CHSE-info@ohsu.edu** | **@OHSU_CHSE**