# Present and Future Payment Strategies to Incentivize Clinic and System Integration

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PacificSource

# Topical Outline

- Overview & Background to PacificSource's Approach
- Clinical Delivery Models
- Payment Approach
- Moving Towards System Integration

# Overview and Background

- Overview of PacificSource
- Behavioral Health Integration
- PacificSource Strategy
- Current VBP Program for BHI

# Overview of PacificSource Health Plans

- Regional, non-profit health plan with multiple lines of business in Oregon, Idaho, Washington and Montana
  - 1/1/2020 will have approx. 450,000 members
- Coordinated Care Organizations (CCO) in Central Oregon and the Columbia Gorge regions
- Expanding CCOs to include Marion/Polk and Lane Counites starting in 2020
- Fully integrated health plan; no carve-out for BH benefits

# Overview of PacificSource Health Plans

## In Central Oregon:

- Medicaid CCO, Medicare Advantage, Commercial Lines of Business

- Approximately 40% of market share (all covered lives) in Central Oregon

- Over 90% of Medicaid members now receiving care in a fidelity integrated primary care clinic
  - Also serve our Medicare Advantage and Commercial members
  - Also serve other payers' members accepted at those clinics

# Advanced Primary Care: The Integrated Patient-Centered Primary Care Home

Primary Care Clinician Shortage

+

Behavioral Health Clinician Shortage

+

No Shortage of BH Patients

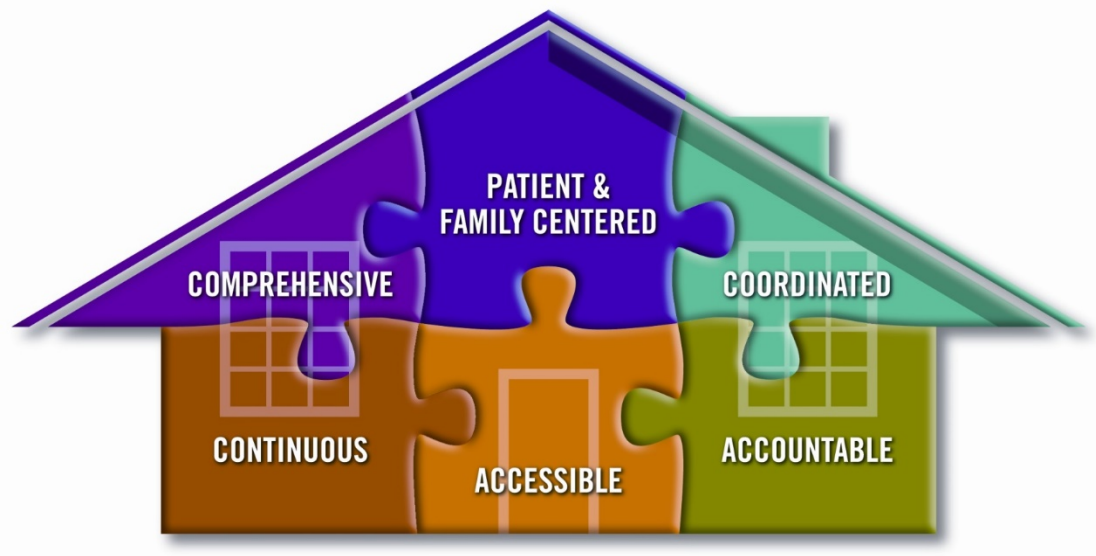
+

Business Case for Medical Cost Offsets

=

**Need a new delivery model:**

**Fidelity Integration of BH in PCPCHs**



# PacificSource Health Plans Integrated Care Vision & Strategy

- Internal transformation ⇨ Break down siloes between physical & behavioral health (e.g. combining care management departments)
- Align policies across all lines of business
- Remove barriers to integrated behavioral health care
- Expand access (BH assessments, brief treatment in PCPCH) & patient choice (e.g. open the Medicaid BH specialty panel)
- Align with local, state and federal policies (e.g. IBHA, PCPCH standards, CPC+)
- Invest in technical assistance to help clinics be successful
- Link payment to provider accountability & move toward VBPs

# PacificSource's Progression & Strategy to Support Integrated Care

| 2015 | 2016 | 2017 | 2018 | 2019 | 2020 + |
|---|---|---|---|---|---|
| ✓ Grant from the state to pilot BHI payment & align across all lines of business<br>✓ Developed policy for fidelity integrated care; Creates clear distinction between co-located specialty BH vs. integrated care | ✓ Use of AG modifier when coding for integrated BH services<br>✓ Expand FFS codes including psychotherapy codes<br>✓ Remove pre-authorization requirements for integrated BH<br>✓ Yearly site visits to verify clinics meet IBHA standards & provide TA | ✓ Align with IBHA standards and Oregon PCPCH recognition criteria<br>✓ Site visits and TA continue<br>✓ Add policy for specialty medical clinics (e.g. women's clinics)<br>✓ CoCM codes pay all LOBs | ✓ Medicaid QIM grant $ for fidelity integrated primary care clinics<br>✓ Quarterly reporting on 3 metrics<br>✓ For full $, clinics must meet population reach metric benchmark<br>✓ Advancing Integrated Care in Central Oregon (AIC) project begins (payer-blind technical assistance) | ✓ Increase metric benchmark to qualify for QIM grant $<br>✓ Develop Medicaid VBP (PMPM) for sustainable support for integrated primary care<br>✓ Removed all pre-auth requirements for BH outpatient services<br>✓ Expand licensed BH provider types for Medicare Advantage plan | ✓ Launch Medicaid VBP program w/ PMPM $<br>✓ New CCO requirements with intense focus on BH and integrated care<br>✓ Create VBP option for Psychiatric Collaborative Care model (CoCM)<br>✓ Expand to other LOB |

# Fee For Service Reimbursement

- Medicaid presents a special challenge as we pay BH outpatient services out of a *different contract* with our BH providers than we do for primary care… so...
  - Developed an “AG-modifier” that we attach to BH codes when delivered in a fidelity BH-integrated PCPCH.
  - Bypasses the PA requirement
  - Buckets the payment to our primary care contracts
  - Broad list of service codes available, including brief psych testing
- FFS pays in primary care for Commercial and Medicare
  - Looking at waiving co-pay for same day BH visits, avoid double co-pay
  - Expanded Medicare BH provider type to include LPCs (not just LCSW)
- Even if FFS optimized, does not sustainably reimburse costs

# Current Value-Based Payment Program Elements

- ✓ Must meet IBHA/PCPCH standards
  - Complete self-assessment form annually
  - 1:6 BHC-PCP staffing ratio at each site
- ✓ Site visits and/or documentation review annually
- ✓ Report 3 metrics quarterly
- ✓ Meet **population reach** metric benchmarks

**Population Reach Metric**

**Numerator:** # of unique patients seen by integrated BHC

**Denominator:** # of unique patients seen in primary care clinic

**Pop Reach =** 5% first year, 10% second year, will increase % and/or tie to outcome metrics going forward

**PMPMs intended to cover high-value services not easily reimbursed through FFS:**

- Prevention and early intervention for common behavioral health concerns
- Same-day brief consultations, assessments & interventions
- Warm-hand offs between the primary care team and BHC(s)
- BHC participation in pre-visit planning, team meetings, and huddles
- Consultations between the primary care team and BHC(s)
- BH care management and care coordination
- Augment FFS reimbursement for BHC services rendered in primary care
- Augment FFS CoCM payments

# BHI Metrics Reported Quarterly

**Metric #1: Population Reach of Integrated Behavioral Health Care**

- Percentage of unique patients seen by a BHC during the reporting period

**Metric #2: Fidelity to the IBHA Standards: Access to Same-Day Behavioral Health Services**

- Percentage of same-day BHC encounters during the reporting period

**Metric #3: Identification & Intervention with a Target Subpopulation**

- Percentage of a target subpopulation of patients who could benefit from BHC involvement and had a BHC encounter during the reporting period
  - Positive depression or substance use screening; failed developmental screening
  - Tobacco use, diabetes, chronic pain, ADHD

# Clinic Accountability & TA Support

**Integrated primary care clinics complete annual self-assessment form attesting to their level of integration**

Based on Integrated Behavioral Health Alliance (IBHA) & state PCPCH standards

**Consultant conducts annual ½ day site visits to integrated primary care clinics to verify level of integration and identify technical assistance (TA) needs**

Key part of justifying financial commitment to transformed care models

After a few years of site visits, documentation review may become sufficient

**Clinics not meeting required level of integration must participate in free TA from consultant to help them move toward full integration**

TA & consultation also available to any primary care clinics to support BHI

# Clinical Delivery Models

- Overview
- PacificSource Hybrid Model
- Ensuring Fidelity
- Technical Assistance

# Summary of Behavioral Health Integration Models In Primary Care

| Co-Located Model | Integrated Care Models | |
|---|---|---|
| **Co-located specialty mental health/substance use/developmental** | **Psychiatric Collaborative Care/TEAM Care** | **Integrated Care Based on IBHA Standards (a.k.a. Primary Care Behavioral Health)** |
| Interventions targeted to a small subset of higher needs patients by referral from the PCP | Adds a BH care manager and psychiatric consultant to primary care team | Integrated BH is a ROUTINE part of primary care; BHC is part of the primary care team and works side-by-side with PCP to manage patients |
| Via referral from PCPs, BHC treats patients with mental health and/or substance use disorders | Utilizes a registry to focus on more intensive and active treatment for a subset of patients; strong "treat to target" approach (condition-focused) | BHC provides a wide range of brief, short-term interventions for mental health, substance use, health behaviors, stress, lifestyle issues, developmental concerns, care plan adherence, etc. |
| Reduced barriers & stigma; increased coordination | Reduced barriers & stigma + increased coordination + outcome focused | Reduced barriers & stigma + increased coordination + increased prevention & early intervention + increased PCP capacity |
| 6-8 45-60 minute appointments/ day | Systematic follow-up; highly protocolized approach; more intensive management via in-person and phone contacts | 8-14 30 minute visits a day; at least 50% of BHC schedule open for same-day access & PCP consultation |
| Not population health focused; focused on highest need patients | Shown to be effective for a wide range of common disorders like depression, chronic medical conditions like diabetes and lowers total costs of care | Focused on improving population health (all patients at the PCPCH) |
| Limited access & capacity (caseloads of 60-100 patients); appointments scheduled and may have a long wait to be seen | BH care manager has limited capacity; caseload may become full | Immediate access to BHC for all patients when needs are identified |

- There are pros and cons to each model
- Models are not mutually exclusive

# PacificSource's Hybrid Model: Integrated Behavioral Health Alliance (IBHA) Consensus Minimum Standards

| |
|---|
| Integrated behavioral health services are provided as part of routine care at the PCPCH including licensed Behavioral Health Clinicians (BHCs) delivering an array of services on-site. BHC as defined in ORS 414.025. |
| Integrated BHC provides a broad array of comprehensive evidence-based behavioral health services. 1:6 BHC to PCP ratio. |
| Integrated BHC provides same-day open access behavioral health services. |
| Primary care clinicians, staff, and BHC utilize shared medical records and have a mechanism in place for collaborative care planning and co-management of patients. |
| BHC is an integrated part of the primary care team. |
| PCPCH utilizes a population-based approach to delivering and coordinating integrated behavioral health services. |
| The integrated team includes psychiatric consultative resources (e.g. Collaborative Care Model, eCounsults, Psychiatric Access Lines, Telepsych services, ECHO Projects). |

Integrated Behavioral Health Alliance: Recommended Minimum Standards for Patient-Centered Primary Care Homes (PCPCH) Providing Integrated Health Care (2015)

IBHA INTEGRATED BEHAVIORAL HEALTH ALLIANCE

# Ensuring Fidelity to the Model

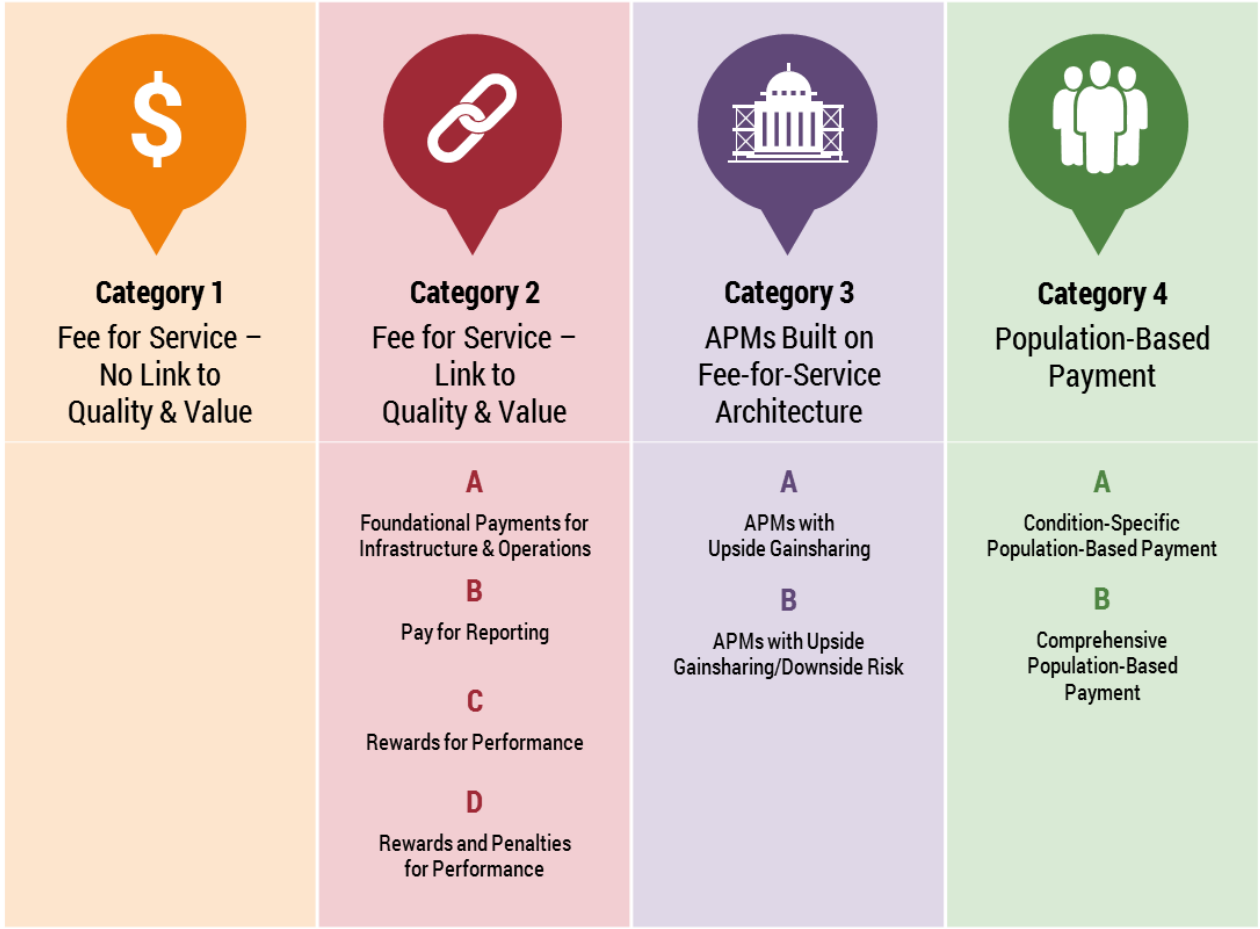
- PacificSource's Integrated Care Expert Consultant provides technical assistance (TA) to our provider partners in support of fidelity BH integration
  - Learning collaboratives
  - TA specific to clinic-identified needs
- Consultant conducts site reviews annually using the IBHA/PCPCH assessment tool
  - Documentation review may be sufficient after 2-3 years
- Clinics that do not pass site reviews are given opportunity to address lack of fidelity, including more TA
- Consultant also provides consultation & support with payment program development

# CCO 2.0 and Moving Towards System Integration

- LAN VBP Framework
- VBP Progression
- Moving Towards System Integration

# OHA VBP Framework: Health Care Payment Learning Action Network (LAN)

**Figure 1. APM Framework (At-A-Glance)**




Health Care Learning & Action Network https://hcp-lan.org/

# CCO 2.0 5 Year Roadmap to VBPs

**VBP Progression using LAN model**

- 2020 = 20% of payments
- 2021 = 35% of payments
- 2022 = 50% of payments
- 2023 = 60% of payments
- 2024 = 70% of payments

**VBPs must cover:**

- Hospital
- Children’s Health
- Maternity Care
- Behavioral Health

# Integrating Across Contracts and Delivery Systems

- For 2020, OHA mandate (welcomed) that CCOs must fully integrate the BH and Medical benefit
  - Example in Central Oregon:  We are negotiating the entire global CCO budget with CMHPs, COIPA and St Charles Health system at the table
  - All financials transparently disclosed
  - Must together decide how to spend the $ to support an integrated health delivery system
  - Increasingly adding quality performance metrics that include BH services that impact total outcomes and total costs of care
    - MAT in EDs, Proactive Consultation, BHC reach for diabetes registries
    - Pilot to improve PCPCH <–> BH Specialty Clinic Coordination of care

# What else is out there on the horizon?

- Needing to move from process metrics to health outcome and total cost of care metrics
  - So many variables…..
  - How do we do this?
- Case rates for CATS (peds psych ED diversion) and Collaborative Care Model?
- Reimbursing BHI in medical settings – more clinical models
  - Delirium  prevention on med-surg units and ICUs
  - Med-Psych Complexity inpatient units
  - PACUs

# Questions