Present and Future Payment Strategies to Incentivize Clinic and System Integration

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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 Counties 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
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

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

<table>
<thead>
<tr>
<th>Co-Located Model</th>
<th>Integrated Care Models</th>
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<tr>
<td><strong>Co-located specialty mental health/substance use/developmental</strong></td>
<td><strong>Psychiatric Collaborative Care/TEAM Care</strong></td>
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<tr>
<td>Interventions targeted to a small subset of higher needs patients by referral from the PCP</td>
<td>Adds a BH care manager and psychiatric consultant to primary care team</td>
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<td>Via referral from PCPs, BHC treats patients with mental health and/or substance use disorders</td>
<td>Utilizes a registry to focus on more intensive and active treatment for a subset of patients; strong “treat to target” approach (condition-focused)</td>
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<td>Reduced barriers &amp; stigma; increased coordination</td>
<td>Reduced barriers &amp; stigma + increased coordination + outcome focused</td>
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<tr>
<td>6-8 45-60 minute appointments/day</td>
<td>Systematic follow-up; highly protocolized approach; more intensive management via in-person and phone contacts</td>
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<td>Not population health focused; focused on highest need patients</td>
<td>Shown to be effective for a wide range of common disorders like depression, chronic medical conditions like diabetes and lowers total costs of care</td>
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<td>Limited access &amp; capacity (caseloads of 60-100 patients); appointments scheduled and may have a long wait to be seen</td>
<td>BH care manager has limited capacity; caseload may become full</td>
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- 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

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<tr>
<th>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.</th>
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<tr>
<td>Integrated BHC provides a broad array of comprehensive evidence-based behavioral health services. 1:6 BHC to PCP ratio.</td>
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<td>Integrated BHC provides same-day open access behavioral health services.</td>
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<td>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.</td>
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<td>BHC is an integrated part of the primary care team.</td>
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<td>PCPCH utilizes a population-based approach to delivering and coordinating integrated behavioral health services.</td>
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<td>The integrated team includes psychiatric consultative resources (e.g. Collaborative Care Model, eCounsults, Psychiatric Access Lines, Telepsych services, ECHO Projects).</td>
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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)

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<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
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<td>Fee for Service</td>
<td>Fee for Service</td>
<td>APMs Built on</td>
<td>Population-Based</td>
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<tr>
<td>– No Link to</td>
<td>– Link to</td>
<td>Fee-for-Service Architecture</td>
<td>Payment</td>
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<td>Quality &amp; Value</td>
<td>Quality &amp; Value</td>
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<td>APMs with Upside Gainsharing</td>
<td>Condition-Specific</td>
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<td>Population-Based Payment</td>
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<td>APMs with Upside Gainsharing/Downside Risk</td>
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<td>Comprehensive Population-Based Payment</td>
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<td>Rewards for Performance</td>
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<td>Rewards and Penalties for</td>
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<td>Performance</td>
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[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