Value-Based Payment Model Designs for Behavioral Health Services in Primary Care

Using collaborative depression care management as a case study due to existing evidence, experience, and measures

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2015-2016 Health and Aging Policy Fellow

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Outline

• Background
• Overview of collaborative care management
  – Review of cost-savings from the IMPACT study
• Limitations and effect of existing FFS codes
• Literature to inform new payment models
• Considerations for value-based payment models in ACOs and health homes

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JHF Functions a “A Think, Do, Train, and Give Tank”

Two Non-Profit Operating Arms

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PRHI Provides Transformation and Quality Improvement Support

Across Care Settings

- Collaboration and Integration
- Medication Reconciliation
- Informed, Activated, Discerning Consumers, particularly at End-of-Life
- Screening and Tx
- Hospice/Palliative
- Long-Term Care
- Rehab
- Hospital
- Emergency Services
- Specialty Care
- Primary Care
- Essential Services
- System Requirements
- Care Mgt
- Clinical Pharmacy
- Patient Engagement
- Behavioral Health
- Health IT
- QI Training
- Performance Incentives

Data to Treat, Measure, Evaluate
Perfect Patient Care
Rewards for Collaboration

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PRHI Disseminated Evidence-Based Behavioral Healthcare in Primary Care with Local and National Partners

IMPACT+SBIRT Pilot in SWPA 2009-2010 with UW AIMS Center

Partners in Integrated Care 4-State Dissemination 2010-2013 (AHRQ)

COMPASS 9-State, Implementation Led by ICSI 2012-2015 (CMMI HCIA)

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Collaborative Care Management

Screen and Assess Patients
- Front Desk, Nurse, MA
- Primary Care Physician

Create Treatment Plan
- Primary Care Physician

Track and Support Care
- Care Manager

Systemic Reviews for Treat-to-Target
- Consulting Psychiatrist
- Care Manager
- Primary Care Physician

Create Relapse Prevention Plan
- Care Manager

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1. Primary Care Team Proactively Screens for Depression as Part of the Routine Check-in and Rooming Process
2. Primary Care Provider (PCP) Assesses Depression
3. PCP and Patient Create Treatment Plan and Goals for Both Behavioral and Physical Health
4. PCP Immediately Connects Patients to a Trained Care Manager after a “Warm Handoff”

SWs, LPCs, RNs, MAs, and Psychologists have all been trained in this team and role
5. Care Manager Supports Patient’s Goal-Setting and Self-Care

Motivational Interviewing

Behavioral Activation (Patient-directed goal-setting)  Relapse Prevention

Telephone and in-person
6. Systematic Case Review Team Reviews New Patients and Those Not Improving as Expected, and Sends Recommendations to PCP

*Team Includes:*

- Care Managers
- Consulting Psychiatrist

May also include pharmacists, psychologists, etc.
7. Care Manager (CM) Continues Follow-up Contacts and Monitors Progress with a Tracking System

CM Receives Prompts for routine follow-contacts based on severity

<table>
<thead>
<tr>
<th>NAME</th>
<th>Initial Contact</th>
<th>Follow Up</th>
<th>Referral</th>
<th>Next Appointment</th>
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<tbody>
<tr>
<td>Tester, Test</td>
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<td>24 days overdue</td>
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<tr>
<td>TestLast, Test Test</td>
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<td>22 days overdue</td>
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<td>Patient, Test</td>
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<td>Due today</td>
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CM Tracks Progress at the Patient and Caseload Level

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<tr>
<th>Enrollment Date</th>
<th>Status</th>
<th>PHQ-9</th>
<th>HbA1c</th>
<th>Systolic BP</th>
<th>LDL</th>
<th>I/C</th>
<th>F/U</th>
<th>Hosp/ED</th>
<th>Med</th>
<th>Maint. Plan</th>
<th>Consult Note</th>
<th># Sess</th>
<th>Wks in Tx</th>
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<tr>
<td>2/20/15</td>
<td>T</td>
<td>5</td>
<td>14.0</td>
<td>130</td>
<td>48</td>
<td>2/20/15</td>
<td>2/27/15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>1</td>
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<tr>
<td>12/23/14</td>
<td>T</td>
<td>8</td>
<td>6.9</td>
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<td>12/23/14</td>
<td>2/27/15</td>
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<td></td>
<td></td>
<td>12</td>
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<tr>
<td>6/10/14</td>
<td>T</td>
<td>11</td>
<td>5.1</td>
<td>143</td>
<td>UTD</td>
<td>6/10/14</td>
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<td>2</td>
<td>37</td>
</tr>
<tr>
<td>5/14/14</td>
<td>T</td>
<td>9</td>
<td>8.5</td>
<td>112</td>
<td>168</td>
<td>5/14/14</td>
<td>2/27/15</td>
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<td>19</td>
<td>41</td>
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CM Receives Immediate Feedback on Process and Outcome Measures to Drive QI

<table>
<thead>
<tr>
<th>Initial Contact</th>
<th>Follow Up</th>
<th>Last Available</th>
<th>Decreased 5+ Points</th>
<th># on Meds</th>
<th># w/ Missing Meds</th>
<th># in M/P</th>
<th>Psychiatry Consultation</th>
<th>50% Improved or &lt; 10 after &gt; 10 wks</th>
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<tbody>
<tr>
<td># of Pt.</td>
<td># of Pt.</td>
<td>Mean Phq</td>
<td>Mean # Clinic</td>
<td>Mean # Phone</td>
<td>Mean Phq</td>
<td>PHQ</td>
<td># Req'd</td>
<td># w/ P/N</td>
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<tr>
<td>123</td>
<td>119</td>
<td>115</td>
<td>16.4</td>
<td>1.0</td>
<td>12.5</td>
<td>8.1</td>
<td>44</td>
<td>35</td>
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</table>

(90%) (80%) (90%) (70%) (90%) (90%) (70%) (90%) (70%) (90%) (70%) (90%) (70%)
8. Care Manager Creates Relapse Prevention Plan with Patients once Targets are Sustained

Motivational Interviewing

Behavioral Activation (Patient-directed goal-setting)  Relapse Prevention

Telephone and in-person (typically, the relapse prevention plan visit is in-person)
Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) Randomized Controlled Trial (RCT)

- No savings first year
  - 12-month IMPACT intervention cost of $522 to $597 per patient.
- Second year savings for IMPACT patients with depression and diabetes
  - Healthcare cost-savings of $896 per IMPACT patient with depression and diabetes over 2 years.
- Third and fourth year savings for IMPACT patients
  - 4-year cost-savings of $3,363 per IMPACT patient.

Unützer, JAMA, 2002; Katon, Diabetes Care, 2006; Unützer, J Manag Care, 2008
Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) RCT

The IMPACT study from 1999 to 2003:

Year 1  Year 2  Year 3  Year 4

Invest $522

Net cost savings of $3,363 over 4 years

Adjusted for inflation and taking into account recent cost estimates in MN (2008):
$900 investment per member (PM) in year 1 → $5,200 net cost savings PM over 4 yrs.

Unützer, JAMA, 2002; Unützer, J Manag Care, 2008; Unutzer, Schoenbaum, and Harbin, Brief for CMS meeting 2011.

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Where were savings realized?

Percent of Total 4-Year Cost-Savings: IMPACT vs. Control

- Outpatient Mental Health: 66%
- Pharmacy: 3%
- Other Outpatient: 5%
- Inpatient Medical: 18%
- Inpatient Mental Health and Substance Abuse: 8%

Unützer, J Manag Care, 2008
The Fee-For-Service Dilemma

- Historically, organizations have adapted to the billable codes, not the evidence.
- Different payers have different requirements for which provider types and settings are authorized to bill.
- The G0444 code for depression screening does not cover treatment and follow-up (the other part of the USPSTF Grade B recommendation).
• “findings...support an episode payment adjusted by number of months...and a monthly payment adjusted by ordinal month.”
• “program certification and performance evaluation and reward systems are needed to fully align incentives.”
Community health clinics in the MHIP program in WA received technical assistance, a registry, and a PMPM to implement model.

One year after implementation, 25% of PMPM was tied to performance (in response to variation in performance).
## Depression Measures are Becoming Part of National Measures

<table>
<thead>
<tr>
<th>Depression Measure</th>
<th>Consensus Core Set: ACO &amp; PCMH</th>
<th>HEDIS*</th>
<th>MU 2 &amp; PQRS</th>
<th>Medicare Shared Savings ACOs</th>
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<tbody>
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<td>Depression Remission at 12 Months (MNCM, NQF 0710)</td>
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<td>🔄</td>
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<td>Depression Response at 12 Months (MNCM, NQF 1885)</td>
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<td>Antidepressant Medication Management (NCQA, NQF 0105)</td>
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<td>Depression Screening and Follow-up Plan (CMS, NQF 0418)</td>
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<td></td>
<td>🔄</td>
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</tr>
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</table>

*HEDIS is phasing-in a depression response/remission measure for adults and adolescents*
Considerations for Health Home Payments

• The service delivery model aligns well with a payment model that provides an adjusted monthly payment for each month a patient receives the core components of collaborative care management to assure fidelity

• Tying at least 25% of the payment to depression performance measures (e.g., timely follow-up, systematic case reviews, and reduced symptoms) appears to impact outcomes
Considerations for ACO Shared Savings Payments

• Include both screening and remission measures (and consider the shorter-term outcome measures)

• Start with pay-for-reporting to build capacity to report PHQ-9 scores, then move to pay-for-quality

• Consider up-front payments to create focus and jump start efforts

• Contract design and contextual factors affect ACO’s degree of physical and behavioral health integration (Lewis et al., Health Affairs, 2014)
Will new payment models be sufficient or necessary but not sufficient?