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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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

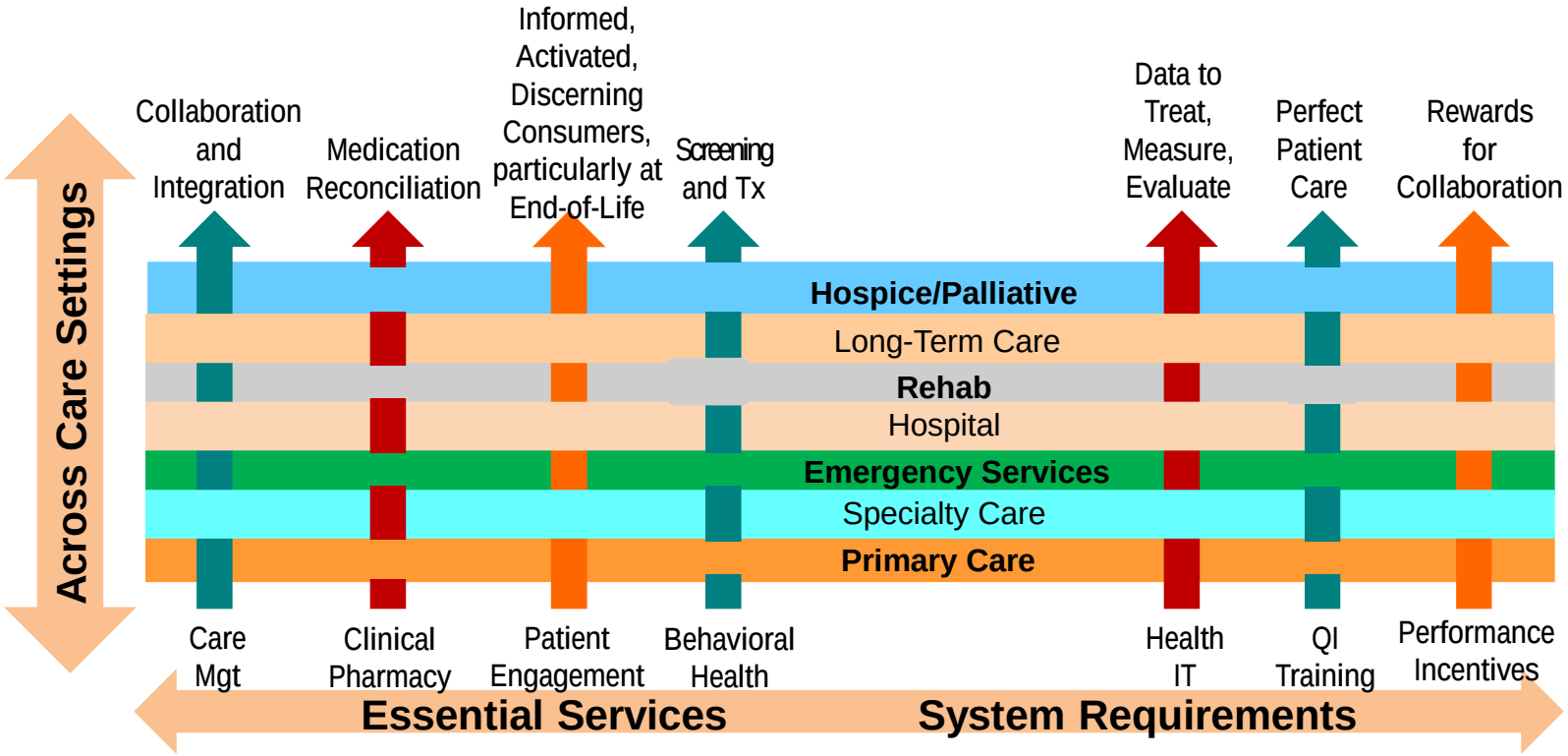
JHF Functions a “A Think, Do, Train, and Give Tank”

A Regional Health Improvement Collaborative (RHIC)

Two Non-Profit Operating Arms

Building the Health Leaders of Tomorrow

PRHI Provides Transformation and Quality Improvement Support

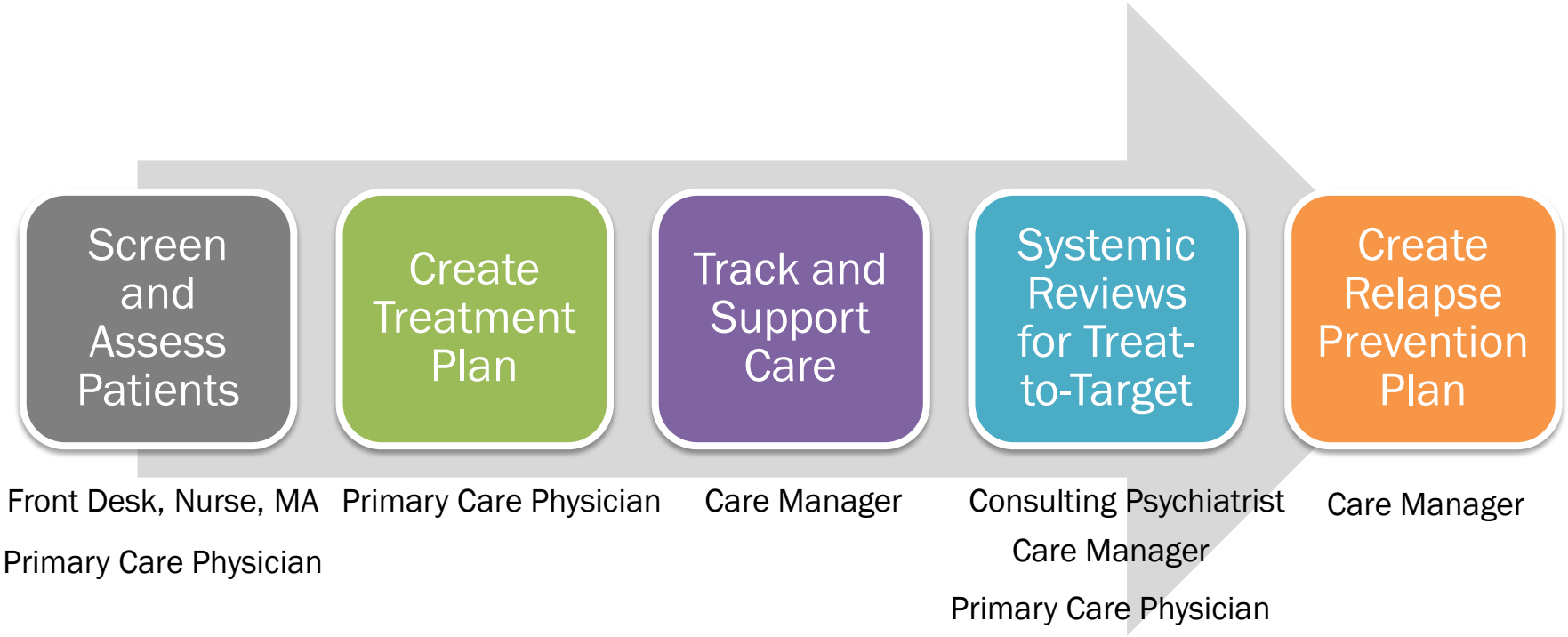


PRHI Disseminated Evidence-Based Behavioral Healthcare in Primary Care with Local and National Partners

- IMPACT+SBIRT Pilot in SWPA 2009-2010 with UW AIMS Center
  (Jewish Healthcare Foundation, The Fine Foundation, and Staunton Farm Foundation)
- Partners in Integrated Care 4-State Dissemination 2010-2013 (AHRQ)
- COMPASS 9-State, Implementation Led by ICSI
  2012-2015
  (CMMI HCIA)

http://jhf.org/publications-videos/list.php?publication=2

Collaborative Care Management



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

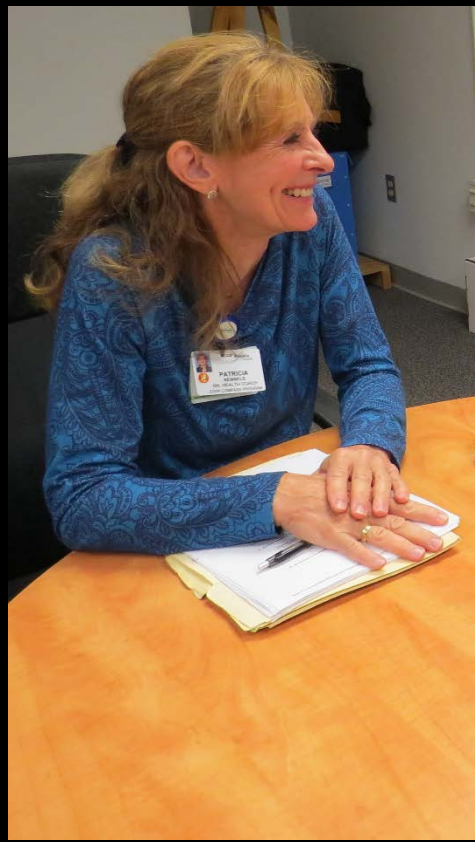
5. Care Manager Supports Patient's Goal-Setting and Self-Care

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

Name	Initial Contact	Follow Up	Referral	Next Appointment
Tester, Test		24 days overdue		
TestLast, Test Test		22 days overdue		
Patient, Test		Due today		9/13/2013 12:00PM

Screenshots from UW AIMS Center's CMTS

CM Tracks Progress at the Patient and Caseload Level

Enrollment Date	Status	PHQ-9		HbA1c		Systolic BP		LDL		Contacts							
		First	Last	First	Last	First	Last	First	Last	I/C	F/U	Hosp/ED	Med	Maint. Plan	Consult Note	# Sess	Wks in Tx
2/20/15	T	5	5	14.0	14.0	130	130	48	48	2/20/15	2/27/15				2/24/15	2	1
12/23/14	T	8	3	6.9	6.9	150	130	42	42	12/23/14	2/27/15				12/30/14	4	9
6/10/14	T	11	13*	5.1	5.7	143	150	UTD	UTD	6/10/14	2/27/15				2/24/15	12	37
5/14/14	T	9	0*	8.5	8.9	112	114	168	159	5/14/14	2/27/15	12/3/14			2/3/15	19	41

CM Receives Immediate Feedback on Process and Outcome Measures to Drive QI

# of Pt.	Initial Contact		Follow Up				Last Available	Decreased 5+ Points	# on Meds	# w/ Missing Meds	# in M/P	Psychiatry Consultation			50% Improved or < 10 after > 10 wks
	#	Mean PHQ	# of Pt.	Mean #	Mean # Clinic	Mean # Phone	Mean PHQ	PHQ				# Req'd	# w/ P/N	Not Improv w/o P/N	PHQ
123	121 (98%)	11.8	119 (98%)	16.4	1.9 (12%)	12.5 (76%)	8.1	44 (38%)	35 (29%)	86 (71%)	0 (0%)	0 (0%)	109 (89%)	23	70 (70%) (n=108)

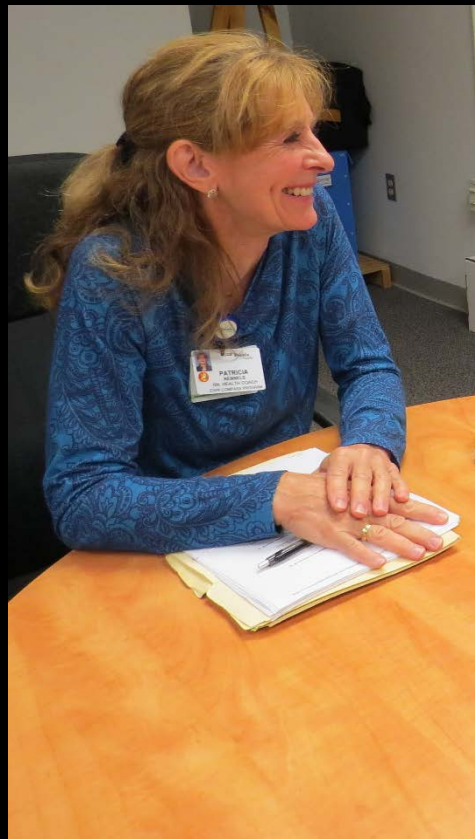
8. Care Manager Creates Relapse Prevention Plan with Patients once Targets are Sustained

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:

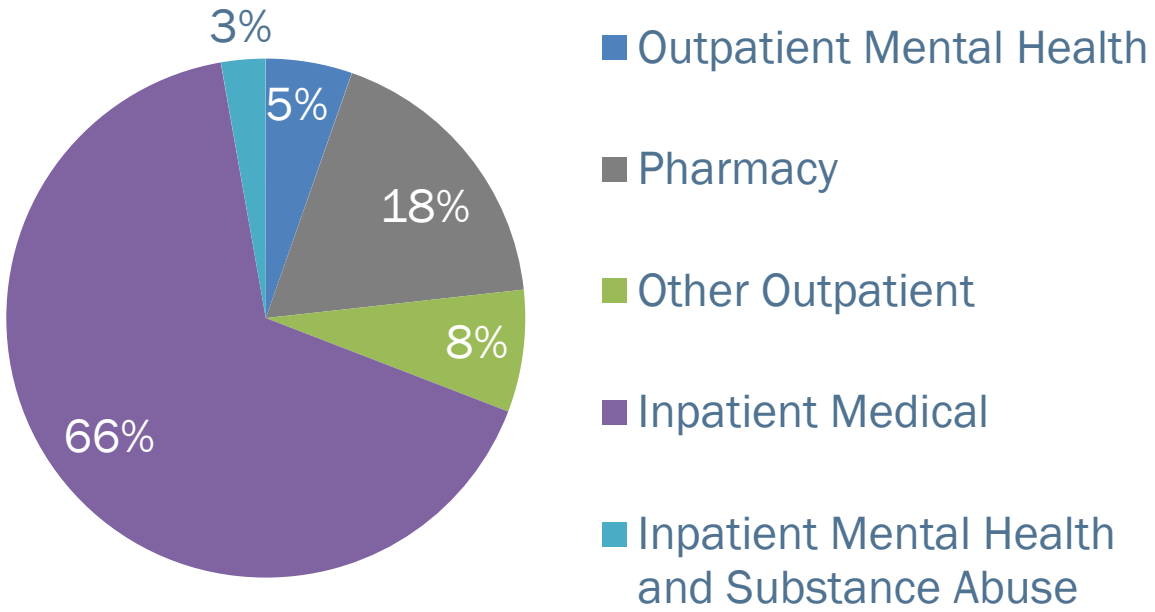
Adjusted for inflation and taking into account recent cost estimates in MN (2008):

$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.

Where were savings realized?

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



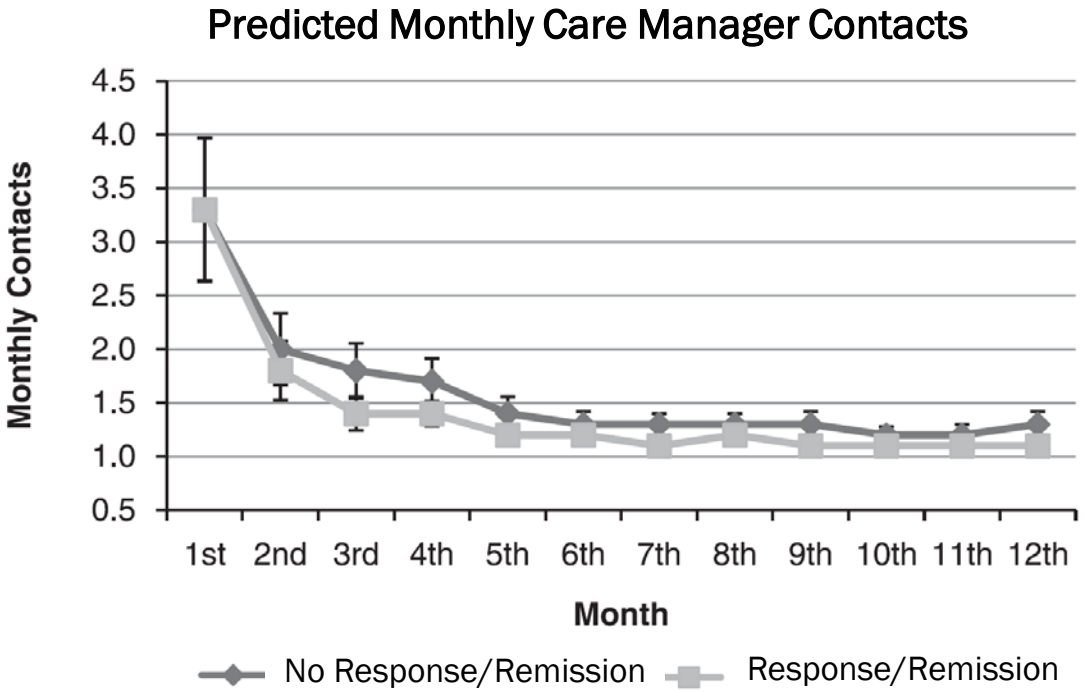
Unützer, J Manag Care, 2008

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)

Modeling for Case Rates

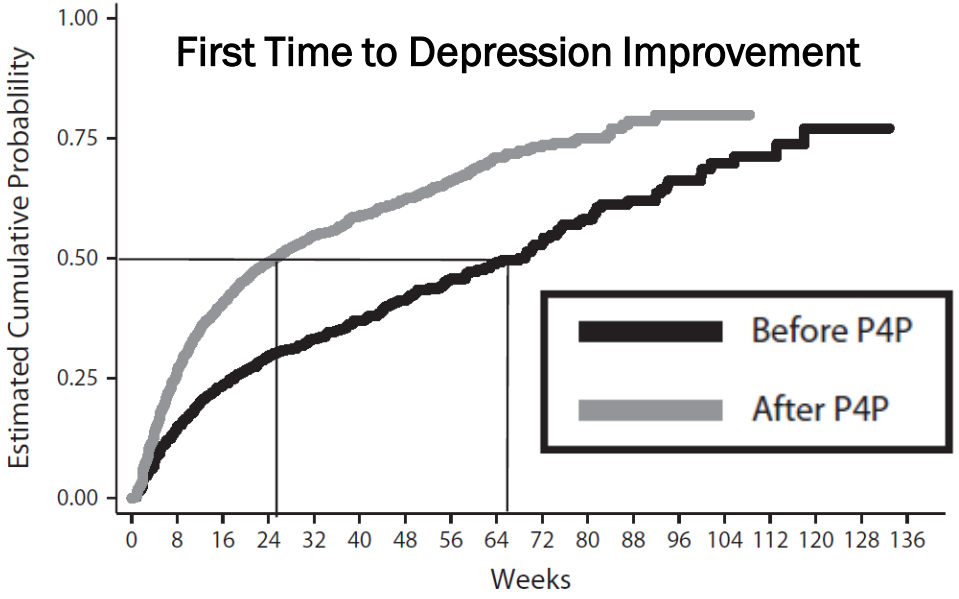
Bao et al. Health Services Research, 2011



- "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."

Pay-for-Performance Effects

Unützer *et al., Am J Public Health, 2012*



Note. P4P = pay-for-performance.

FIGURE 1—Kaplan–Meier survival curve for time to the first improvement in depression before and after P4P-based quality improvement: Washington State Mental Health Integration Program, January 2008–December 2010.

- 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

	Consensus Core Set: ACO & PCMH	HEDIS*	MU 2 & PQRS	Medicare Shared Savings ACOs
Depression Remission at 12 Months (MNCM, NQF 0710)	✓		✓	✓
Depression Response at 12 Months (MNCM, NQF 1885)	✓			
Antidepressant Medication Management (NCQA, NQF 0105)		✓		
Depression Screening and Follow-up Plan (CMS, NQF 0418)			✓	✓

**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?