Aligning for Action

LAN SUMMIT

Health Care Payment Learning & Action Network

2C Supporting Integrated Physical and Behavioral Health through APMs

Welcome

Brie Reimann
(SAMHSA-HRSA)
Deputy Director for the National Council's Center for Integrated health Solutions, (CIHS)

Today's Panel

Greg Bowman

Staff VP of Provider Collaboration and Payment Innovation, Anthem

Kate Neuhausen

Board-Certified Family Physician

Chief Medical Officer of Virginia Medicaid

Sowmya Viswanathan

Population Health at Dartmouth Hitchcock Health System

Mishka Terplan

Professor in Obstetrics and Gynecology and Psychiatry

Associate Director of Addiction Medicine at Virginia Commonwealth University

Addiction Medicine Consultant for the Virginia Department of Medicaid Services

PAYMENT INNOVATION TO SUPPORT INTEGRATED BEHAVIORAL HEALTH AND ENHANCE OPIOID TREATMENT

Katherine Neuhausen, MD, MPH
Chief Medical Officer
Virginia Department of Medical Assistance Services

Virginia Medicaid Key Facts

1 Million +

Virginians covered by Medicaid/CHIP

1 in 8

Virginians rely on Medicaid

50%

Medicaid beneficiaries are children

1 in 3

Births covered in Virginia

2 in 3

Residents in nursing facilities supported by Medicaid - Primary payer for LTSS

62%

Long-Term Services & Supports spending is in the community

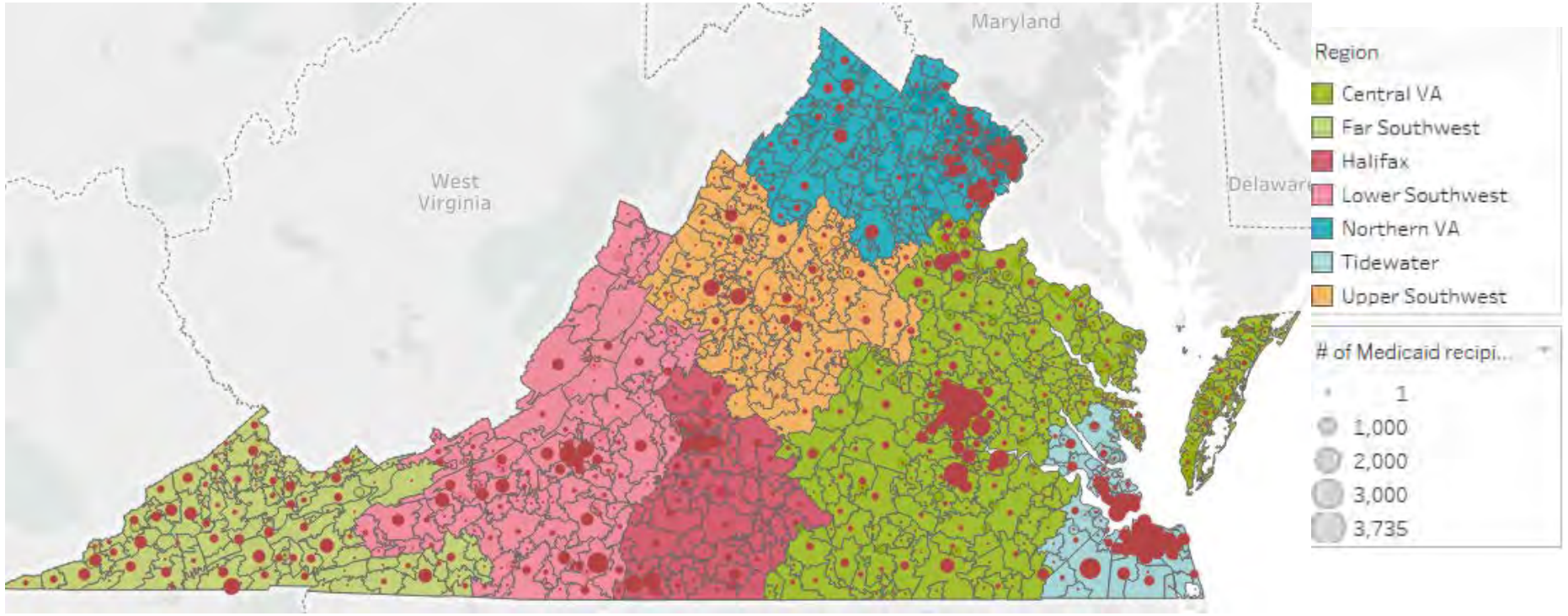
Behavioral Health

Medicaid is primary payer for services

ARTS Addiction and Recovery Treatment Services

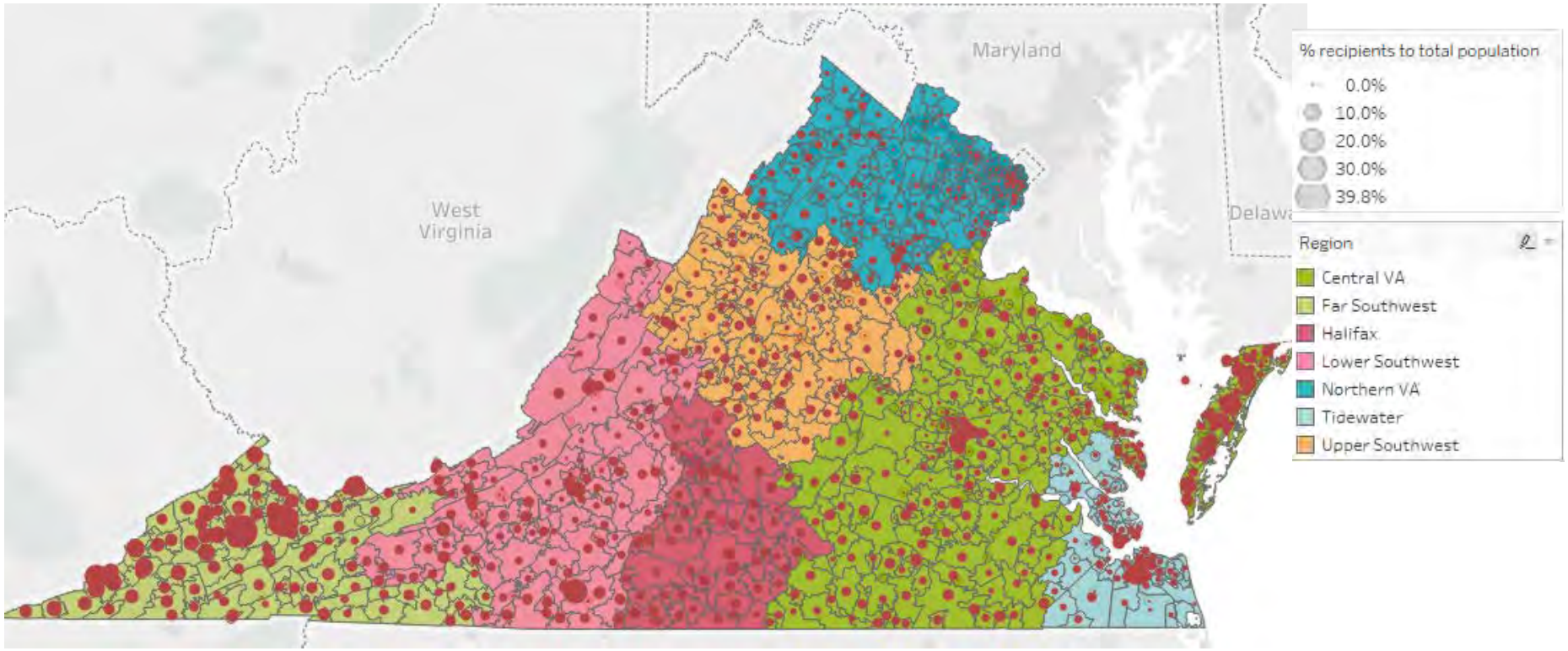
DMAS Virginia's Medicaid Program

Medicaid Members with Substance Use Disorder Diagnosis



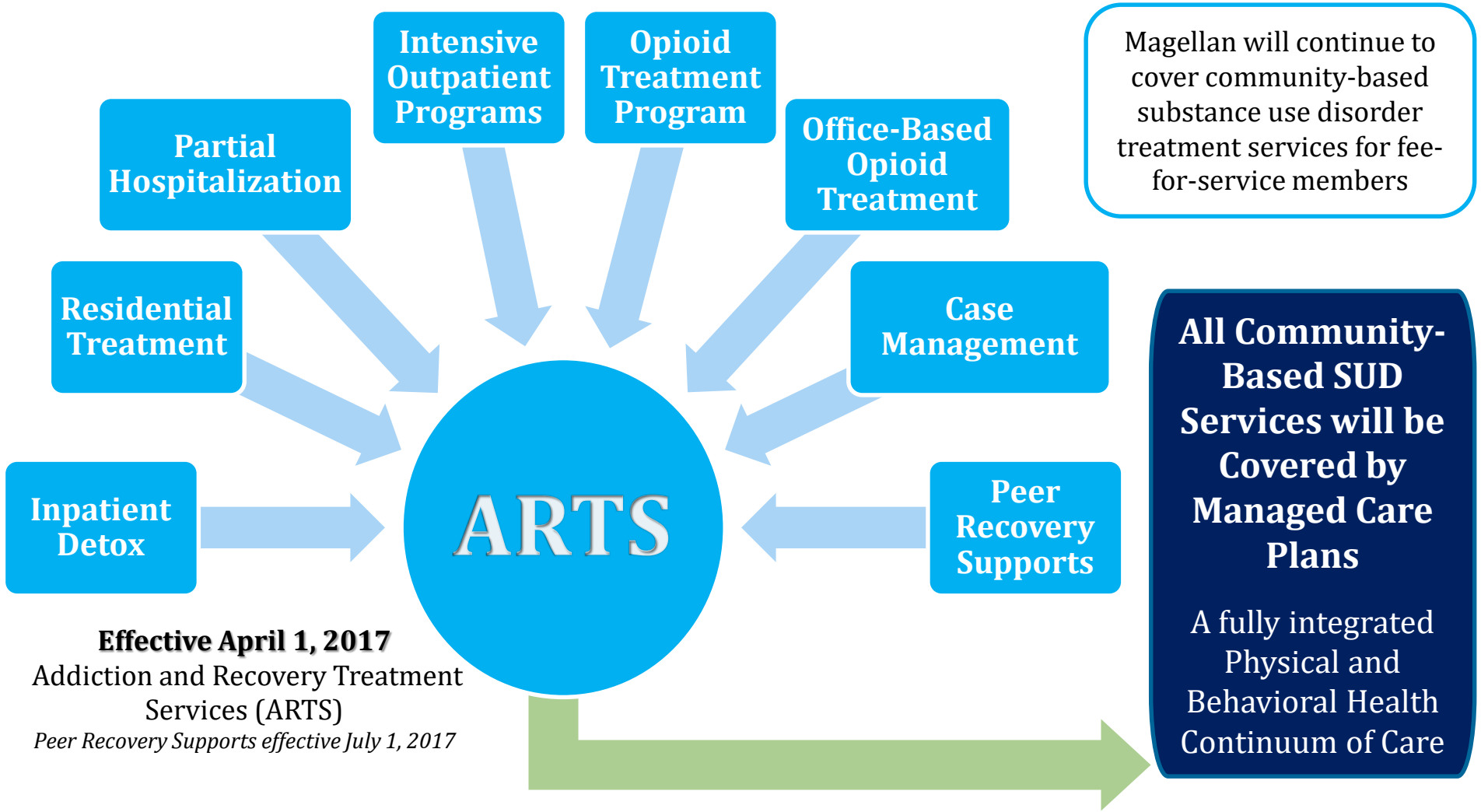
Source: Department of Medical Assistance Services – claims/encounter data (November 3, 2016).
Circles # of Medicaid recipients whose claims/encounter data included an addiction related diagnosis.

Communities Impacted by Addiction



Source: Department of Medical Assistance Services – claims/encounter data (November 3, 2016) and 2010 U.S. Census Bureau Population.
Circles % of Medicaid recipients whose claims/encounter data included an addiction related diagnosis respective to the total population in that zip code.

Transforming the Delivery System for Community-Based SUD Services



Magellan will continue to cover community-based substance use disorder treatment services for fee-for-service members

All Community-Based SUD Services will be Covered by Managed Care Plans

A fully integrated Physical and Behavioral Health Continuum of Care

Effective April 1, 2017
Addiction and Recovery Treatment Services (ARTS)
Peer Recovery Supports effective July 1, 2017

ARTS Addiction and Recovery Treatment Services

DMAS Virginia's Medicaid Program Innovation + Quality + Value

Preferred Office-Based Opioid Treatment

Settings and Care Model

- CSBs, FQHCs, outpatient clinics psychiatry practices, primary care clinics
- Provide Medication Assisted Treatment (MAT) - use of medications in combination with counseling and behavioral therapies that results in successful recovery rates of 40-60% for opioid use disorder compared to 5-20% with abstinence-only models
- Supports integrated behavioral health - buprenorphine waivered practitioner with on site behavioral health provider (e.g., psychologist, LCSW, LPC, psych NP, etc.) providing counseling to patients receiving MAT

Payment Incentives

- Buprenorphine-waivered practitioner in the OBOT can bill all Medicaid health plans for **substance use care coordination** for members with moderate to severe opioid use disorder receiving MAT
- Can bill **higher rates for individual and group opioid counseling**
- Can bill for Certified Peer Recovery Support specialists

Preferred OBOT Providers Recognized by DMAS and Credentialed by Health Plans

Care Team Requirements

- Buprenorphine-waivered practitioner (physician, NP, or PA who has completed 8 hour SAMHSA training) may practice in settings such as CSBs, FQHCs, primary care clinics, outpatient psychiatry clinics
- Co-located credentialed addiction treatment professional (licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed psychiatric clinical nurse specialist, licensed psychiatric NP) providing counseling on-site

MAT Requirements

- Buprenorphine monoproduct prescribed only to pregnant women..
- Maximum daily buprenorphine dose 16 mg unless documentation of ongoing compelling clinical rationale for higher dose up to max of 24 mg.
- No tolerance to other opioids, soma, sedative hypnotics, or benzodiazepines except for patients already on benzos for 3 months during a tapering plan

Preferred OBOT Providers Recognized by DMAS and Credentialed by Health Plans

Risk Management and Adherence Monitoring

- Random urine drug screens, a minimum of 8 times per year.
- Virginia Prescription Monitoring Program checked at least quarterly.
- Opioid overdose prevention education including the prescribing of naloxone.
- Patients seen at least weekly when initiating treatment.
- Utilization of unused medication and opened medication wrapper counts

Benefits to Preferred OBOT Providers

- No Prior Authorizations required for buprenorphine products.
- Can bill all Medicaid health plans for substance use care coordination for members with moderate to severe opioid use disorder receiving MAT.
- Can bill higher rates for individual and group opioid counseling.
- Can bill for Certified Peer Recovery Support specialists.

Rate Structure for Preferred OBOTs: New Codes

Code	Service	Description	Unit	Rate/ Unit
H0014	Medication Assisted Treatment (MAT) induction	Ambulatory detoxification Withdrawal Management-Induction	Per encounter	$140
H0004	Opioid Treatment Services	Opioid Treatment – individual and family therapy	1 unit= 15 min	$24
H0005	Opioid Treatment Services	Opioid Treatment – group therapy	1 unit = 15 min (per patient)	$7.25
G9012	Substance Use Care Coordination	Substance Use Care Coordination	1 unit = 1 month	$243
T1012	Peer Support	Peer Recovery Support Specialist	1 unit = 15 minutes	$6.50

ARTS Addiction and Recovery Treatment Services

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION + QUALITY + VALUE

Rate Structure for OBOTs: Existing Codes

Code	Service	Description
CPT E/M Code	Established Patient Visit	Follow-Up Visits by Physician/NP after Induction
80305-80307	Urine Drug Screens	Urine Drug Screen for Opioids and Illicit Drugs
CPT Codes for Labs	Labs	Examples: Hepatitis B Test (86704), Hepatitis C test (86803), HIV Test (86703), Syphilis Test (86593), Treponema Pallidum (86780), Syphilis Test Non-Treponema (86592), Pregnancy Test (81025), Skin Test-Tuberculin (86585), EKG (93000, 93005, 93010), Alcohol-Breathalyzer (82075)

Higher Rates for Opioid Counseling

Service Description

- Psychosocial Treatment for Opioid Use Disorder that includes at a minimum the following components:
  - Assessment of psychosocial needs
  - Supportive individual and/or group counseling
  - Linkages to existing family support systems
  - Referrals to community-based services
  - Care coordination, medical/prescription monitoring, and coordination of on-site and off-site treatment services

Provider Requirements

- Credentialed Addiction Treatment Professionals

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Substance Use Care Coordination APM

Service Description

- **Integrates behavioral health** into primary care and specialty medical settings through interdisciplinary care planning and monitoring patient progress and tracking patient outcomes.
- Supports **interdisciplinary team meetings** with medical and behavioral health staff to develop and monitor individualized treatment plans.
- Links patients community resources (including NA, AA, peer recovery supports, etc.) to facilitate referrals and respond to social service needs.
- Tracks and supports patients when they obtain medical, behavioral health, or social services outside the practice.

Provider Requirements

- At least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and at least one year of substance abuse related clinical experience; or
- An individual with certification as a substance abuse counselor (CSAC)

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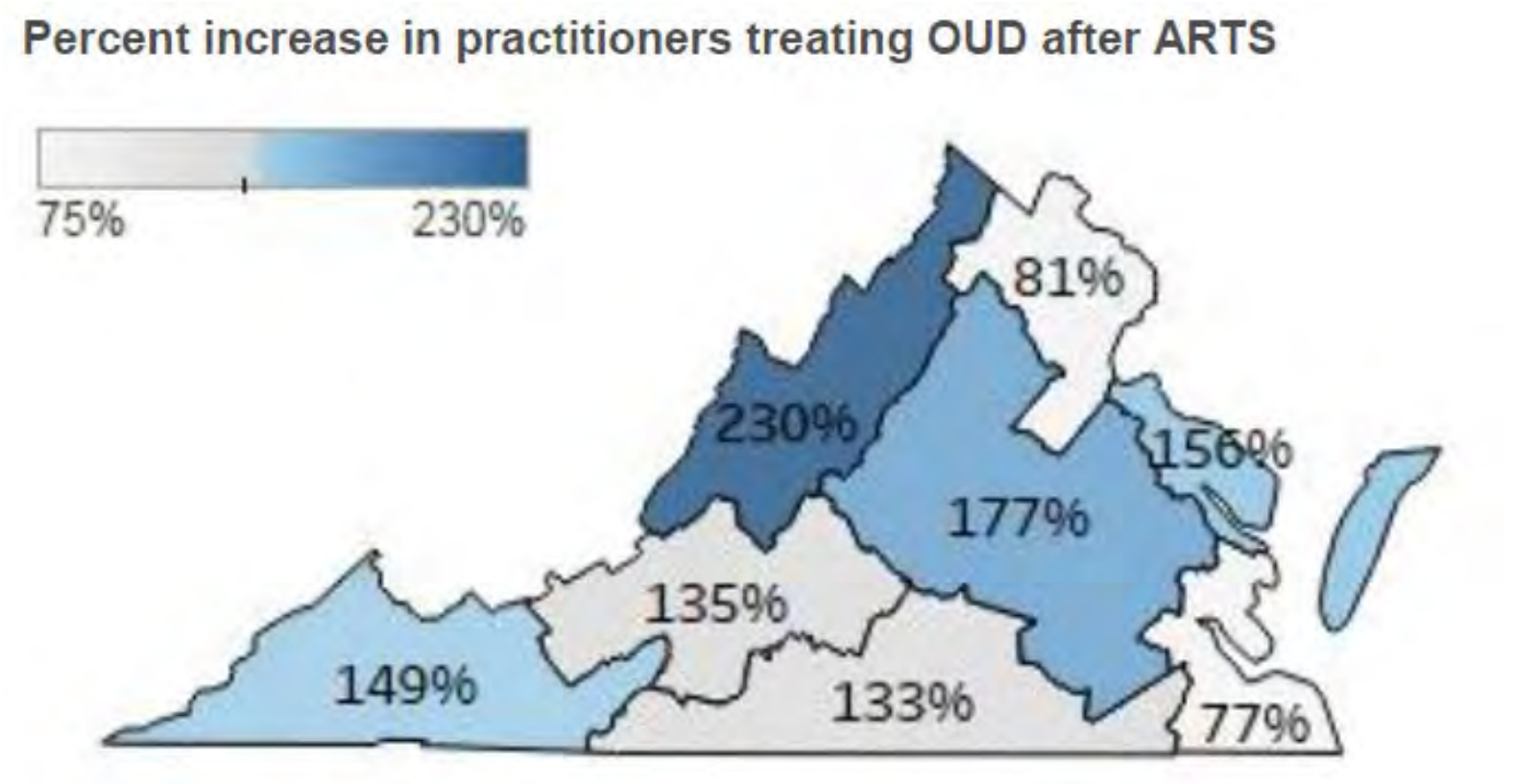
OBOT Quality Measures for Substance Use Care Coordination APM

1. Urine Drug Screening
2. Appropriate Prescribing of Buprenorphine Mono Product to Pregnant Women only
3. Buprenorphine Dosage Monitoring
4. No Tolerance to Benzodiazepine Co-prescribing
5. Screening for HIV, Hepatitis B & C at Treatment Initiation
6. Opioid Overdose Prevention – Naloxone Co-prescribing
7. Monitoring of Patients at Initiation

Preliminary Findings from VCU Evaluation
First Quarter of ARTS Implementation

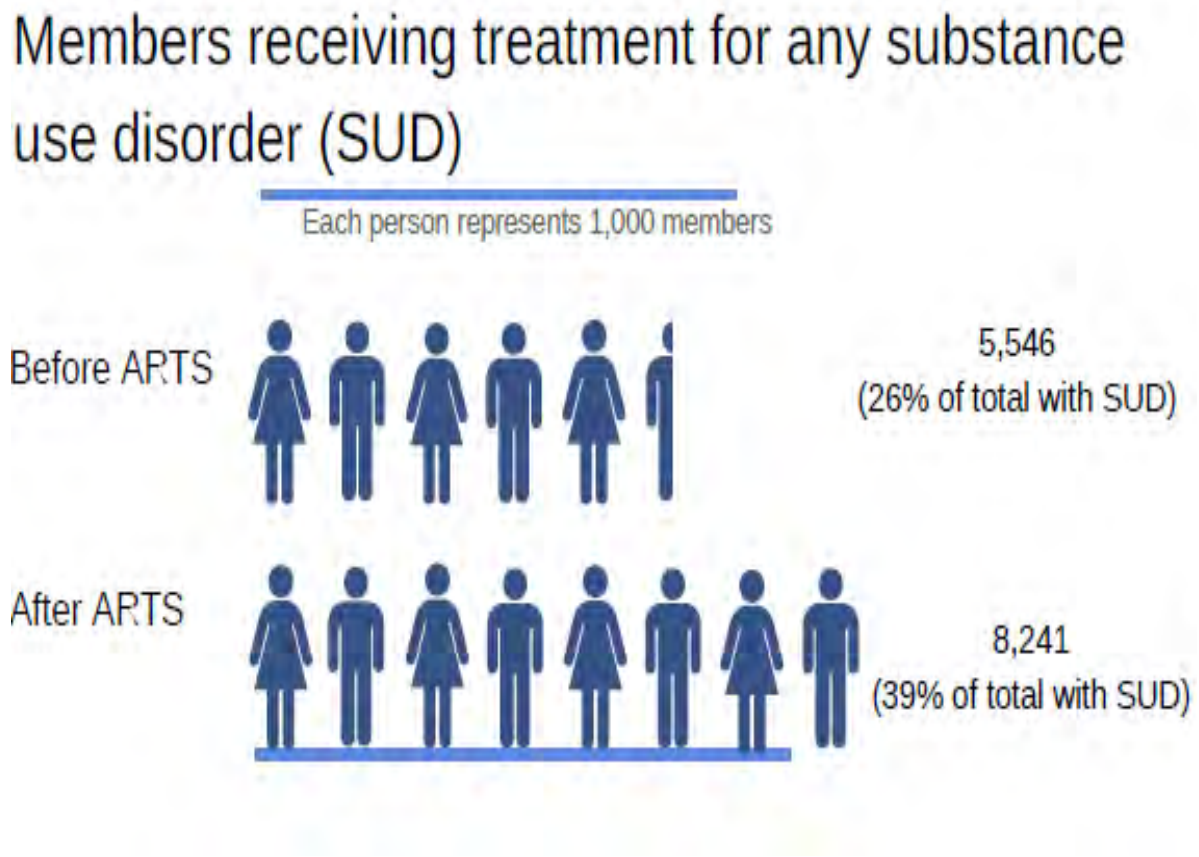
- **Treatment rates** among Medicaid members with substance use disorders (SUD) **increased by 50%**
- The **number of practitioners providing outpatient psychotherapy or counseling** to Medicaid members **more than doubled**:
  - Treating Opioid Use Disorder (OUD) - **300 to 641 practitioners**
  - Treating SUD - **667 to 1,603 practitioners**

Number of Outpatient Providers Treating OUD More than Doubled



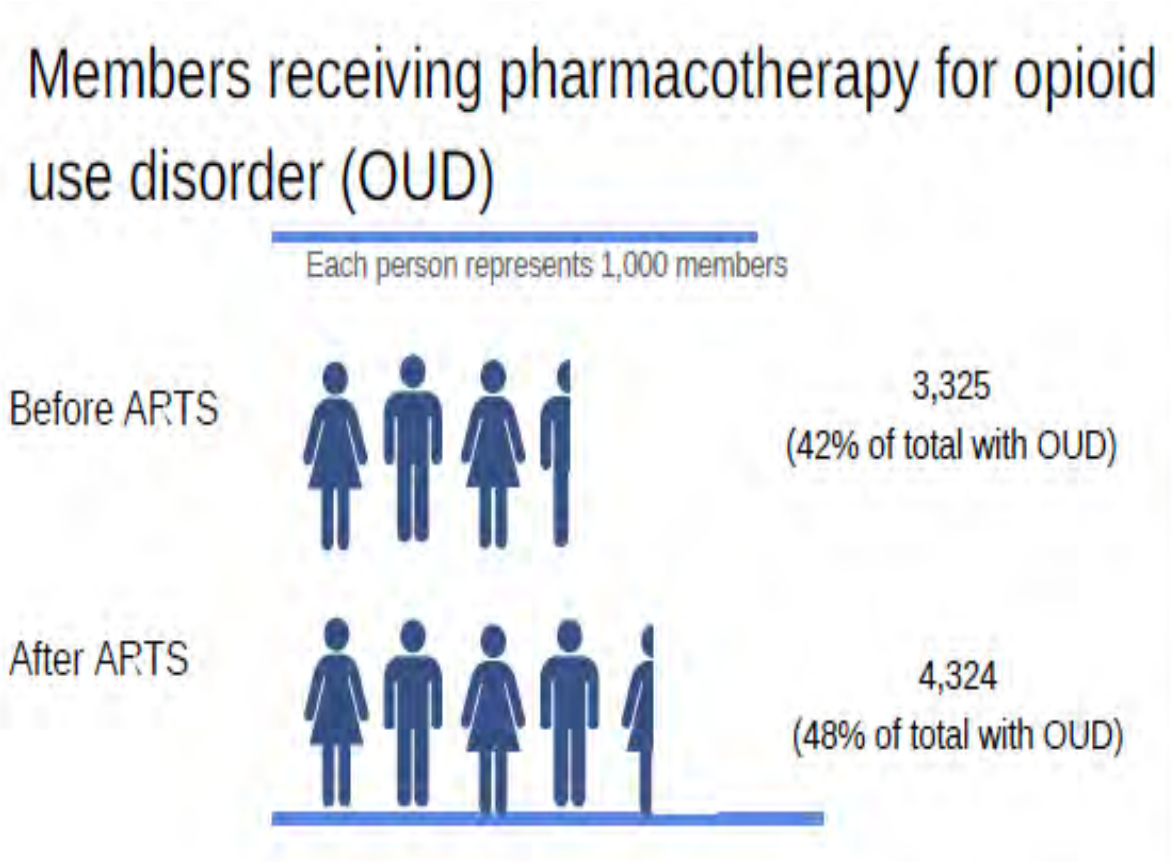
During the first three months, **ARTS has reduced the treatment gap** for SUD by **increasing the number of practitioners** providing services for SUD **across all regions** in Virginia

ARTS Narrows the Treatment Gap



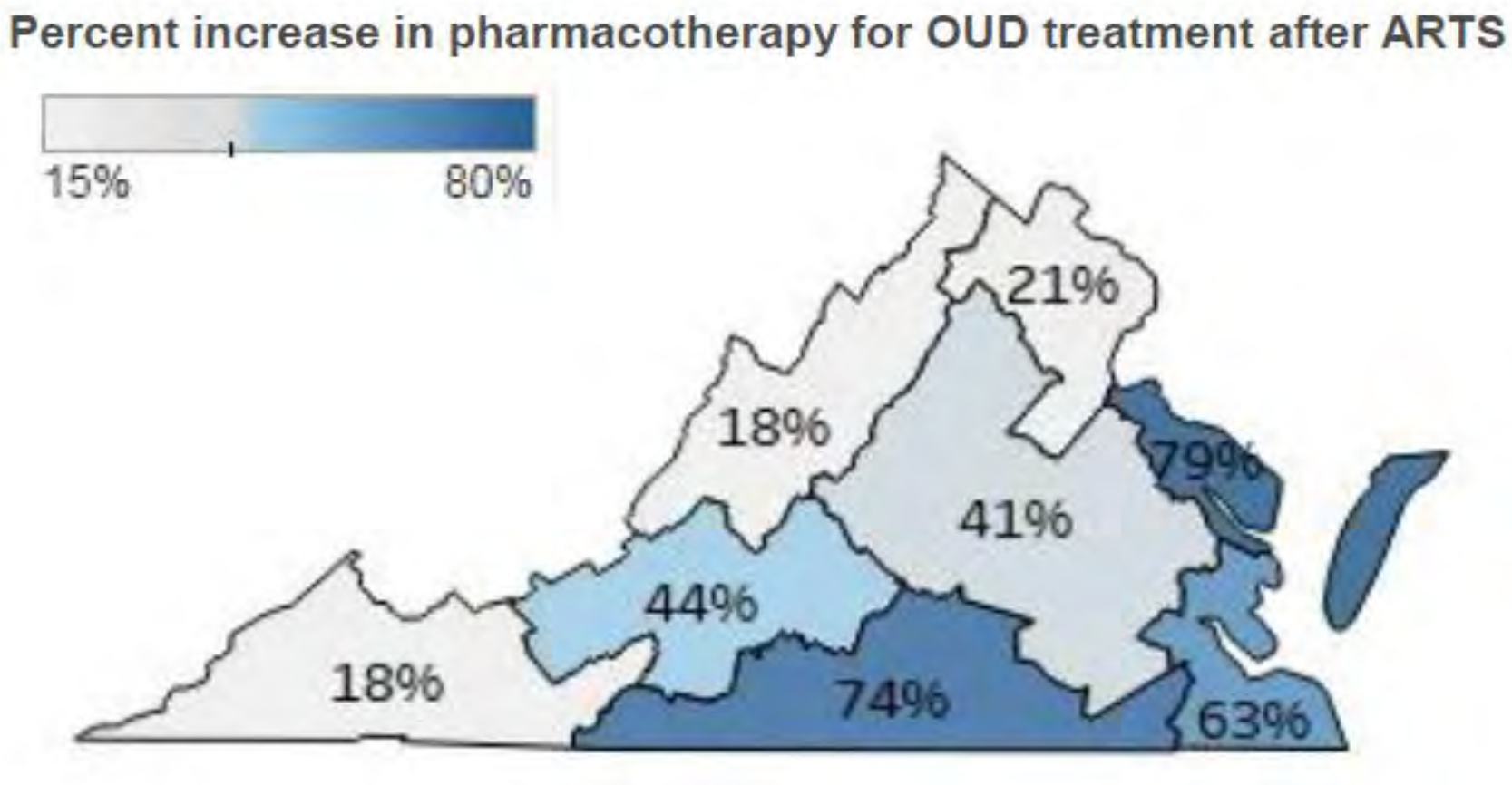
Prevalence of members with SUD is likely higher than the estimates in this report because they include only those who have been diagnosed or treated for SUD.

ARTS Narrows the Treatment Gap



Prevalence of members with SUD is likely higher than the estimates in this report because they include only those who have been diagnosed or treated for SUD.

Pharmacotherapy for OUD Increasing



ARTS **significantly increased** the number of Medicaid members receiving **pharmacotherapy for OUD** in all regions in Virginia.

CLINICIAN'S PERSPECTIVE ON INTEGRATING BEHAVIORAL HEALTH INTO OPIOID TREATMENT

Mishka Terplan, MD, MPH
Associate Director, Addiction Medicine
Virginia Commonwealth University

QUESTIONS

For more information, please contact:

SUD@dmas.virginia.gov

http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx

Dartmouth-Hitchcock Health strategy to integrate physical and behavioral health

LAN summit 2017

Sowmya Viswanathan MD MBA MHCM

Dartmouth-Hitchcock
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Dartmouth-Hitchcock

Dartmouth-Hitchcock Health (D-HH) is a nonprofit academic health system that serves a patient population
of 1.4 million in northern New England.

Mission

- We advance health through research, education, clinical practice and community partnerships, providing each person the best care, in the right place, at the right time, every time.

Vision

- Achieve the healthiest population possible, leading the transformation of health care in our region and setting the standard for our nation

Values

- A Culture of Caring, Transparency, Trust, integrity, Respect, Teamwork, Stewardship, Community & Commitment

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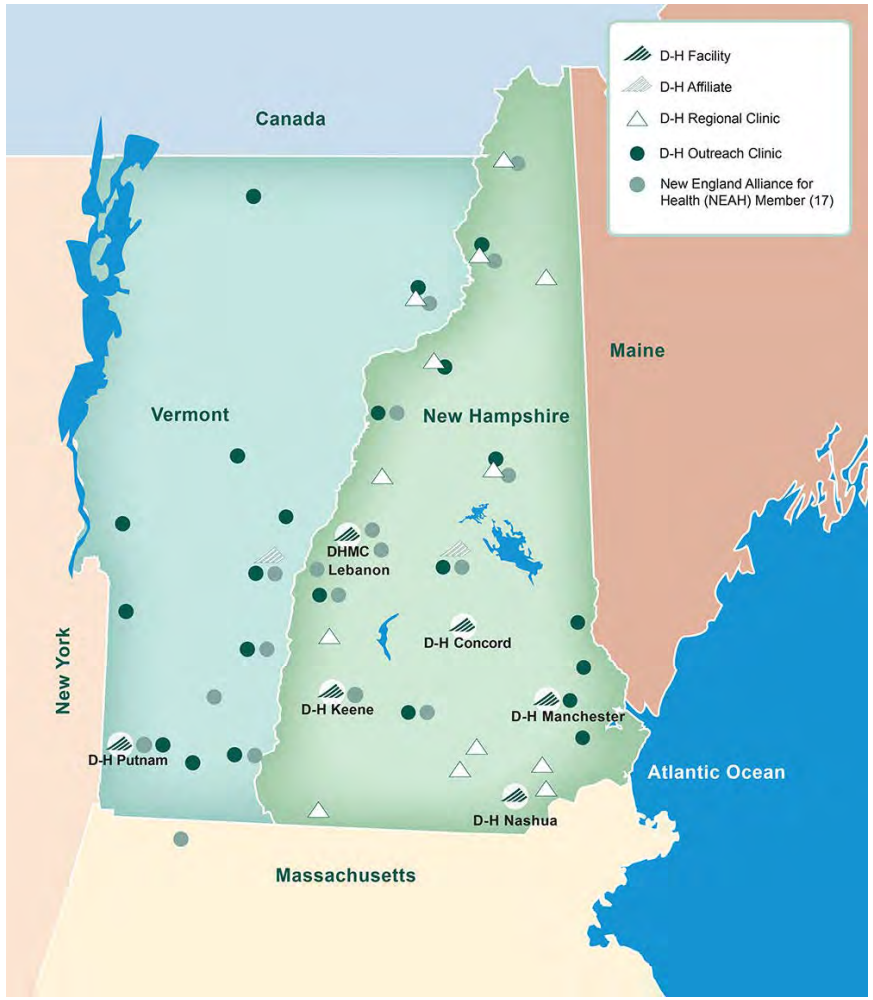
Dartmouth-Hitchcock

Affiliate hospitals:

- New London Hospital, NH
- Mount Ascutney Hospital, VT
- Alice Peck Day Memorial Hospital, NH
- Cheshire Medical Center, NH

24 Dartmouth-Hitchcock Clinics that provide ambulatory services across New Hampshire and Vermont



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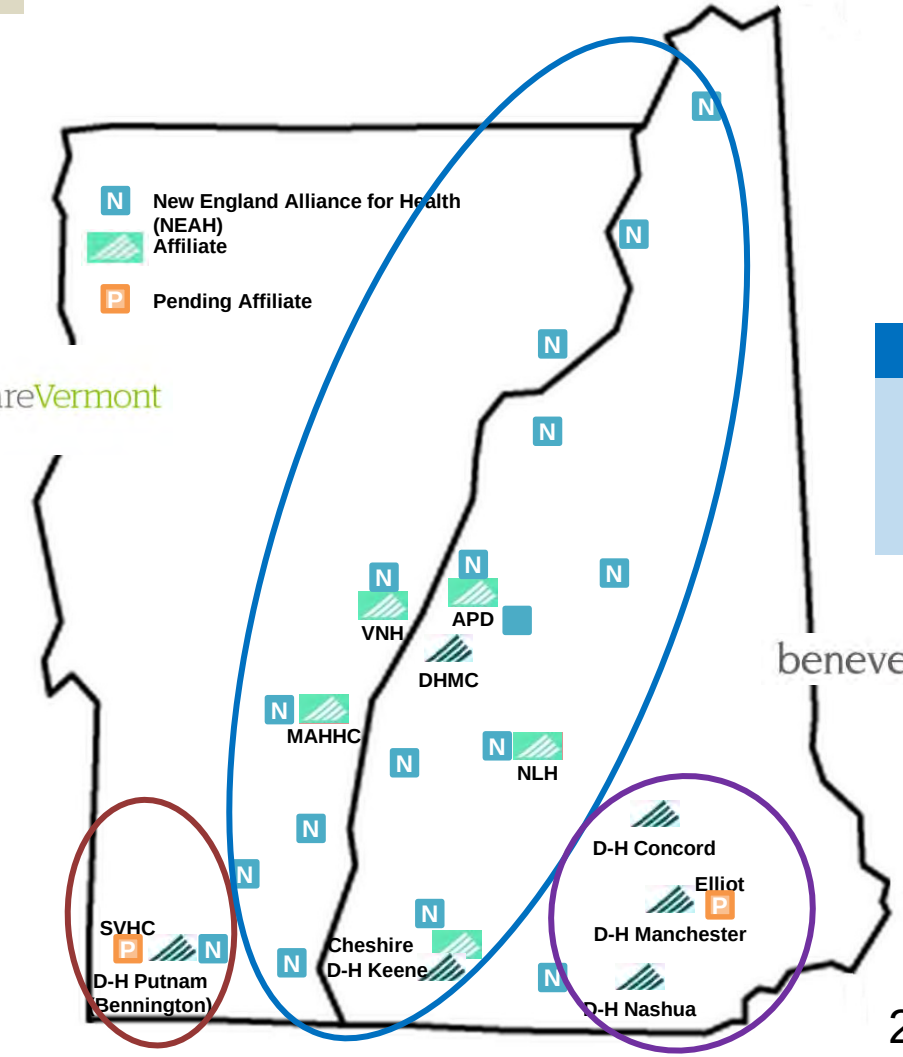
Creating a Sustainable Health System for NH and VT



OneCareVermont

VT Population: 640,000
Payers:
- Commercial 50%
- Medicaid 23%
- Medicare 18%
- Other Gov't 5%
- Uninsured 4%

Southwestern VT

Population:
~ 60,000
Older than median
Trend – Declining

NH Population: 1,330,000
Payers:
- Commercial 65%
- Medicaid 12%
- Medicare 15%
- Uninsured 7%

DHMC Primary Service Area

Population:
~ 400,000
Older than median
Trend – Flat/Declining

benevera health

Southern NH

Population:
~ 800,000
Younger than median
Trend – Growing

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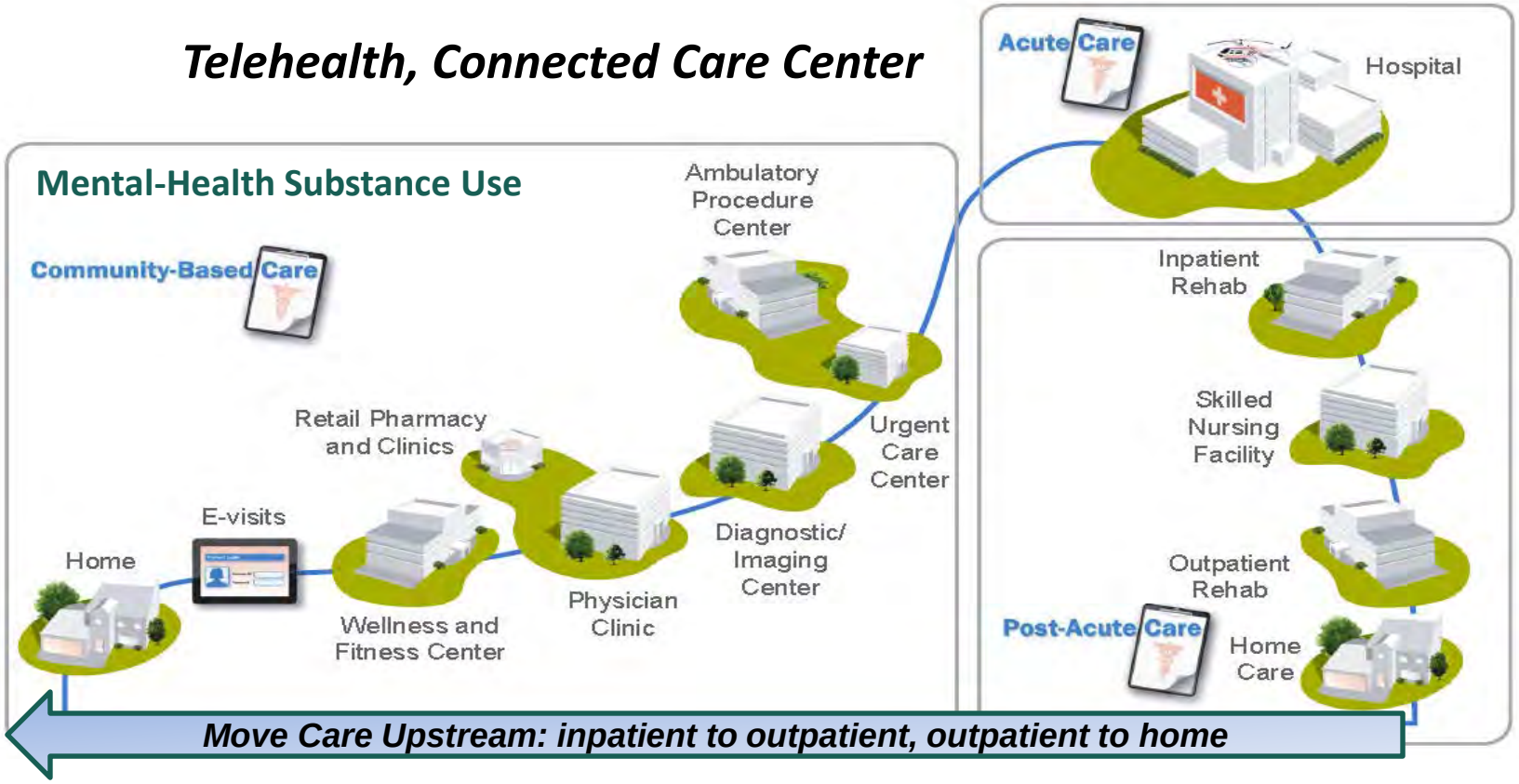
D-H NGACO Key Strategy – Moving Care Upstream

Telehealth, Connected Care Center



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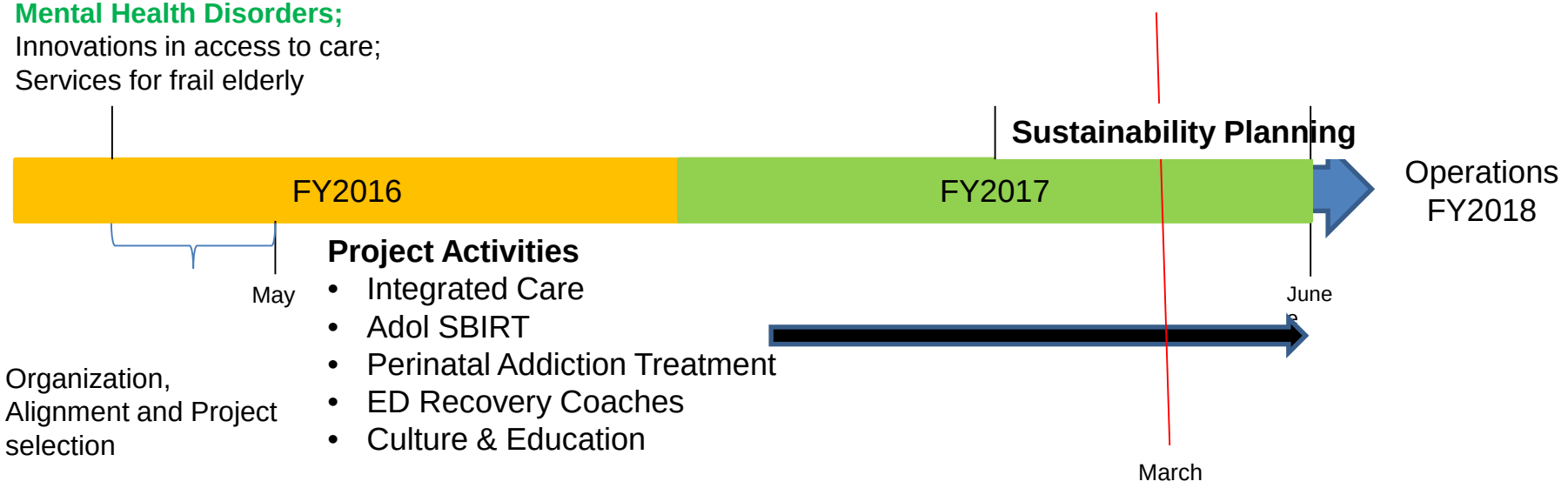
Timeline

Population Health Management Council reviewed Community Health Needs Assessments and identified 4 key population health improvement foci

- **Substance Use Disorders;**
- **Mental Health Disorders;**
- Innovations in access to care;
- Services for frail elderly



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- Integrated Care
- Perinatal Addiction
- SBIRT
- ED Recovery Coach
- Culture Change

BEHAVIORAL HEALTH PROJECTS IN DARTMOUTH-HITCHCOCK

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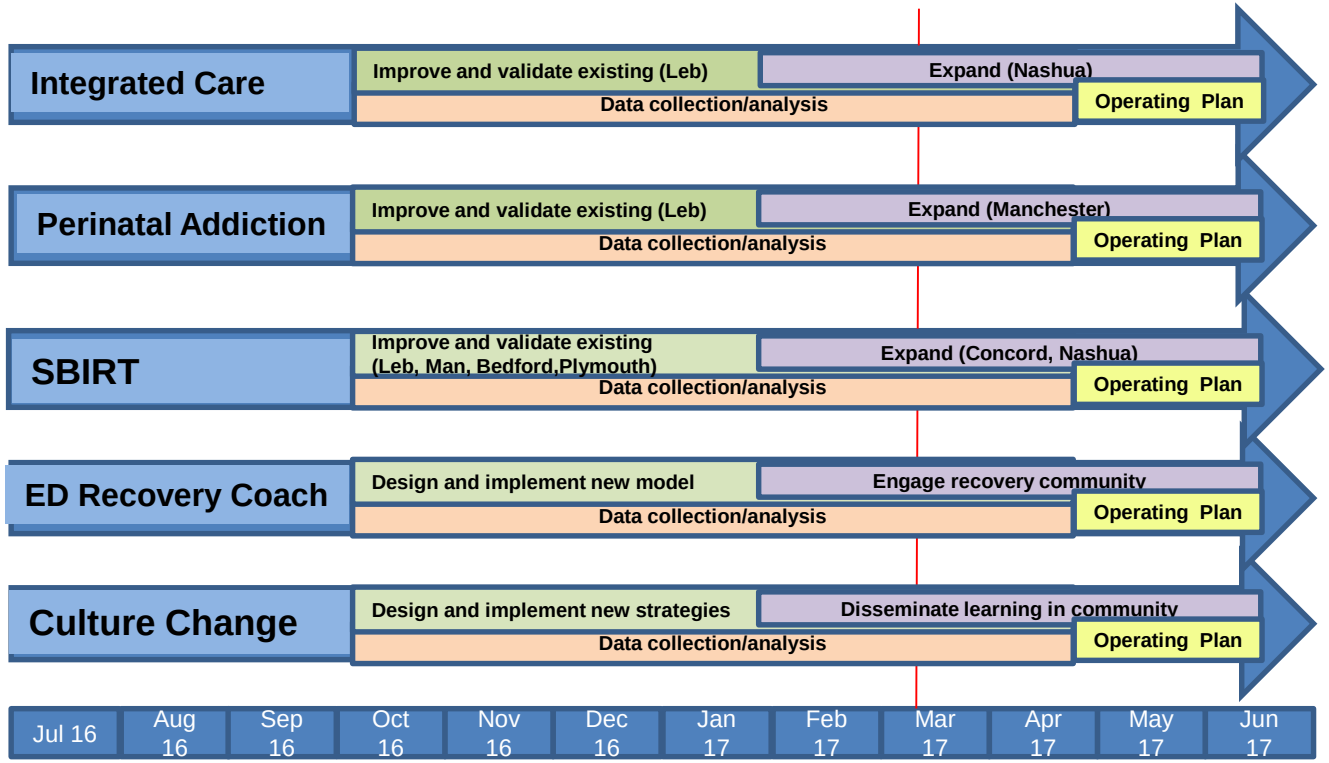
IMPROVEMENT PROJECTS → PRACTICE TRANSFORMATION → **POPULATION HEALTH IMPACT**



27,000 Adults seen in Nashua per year

4,300 births per year (estimate - 344 Opiate Use Disorder)

8,400 Adolescents per year

30,000 ED visits, estimated 3% present with primary SUD (900 ED visits) D-H Employees and Community

150+ D-H employees representing 7 departments are involved on Project Teams

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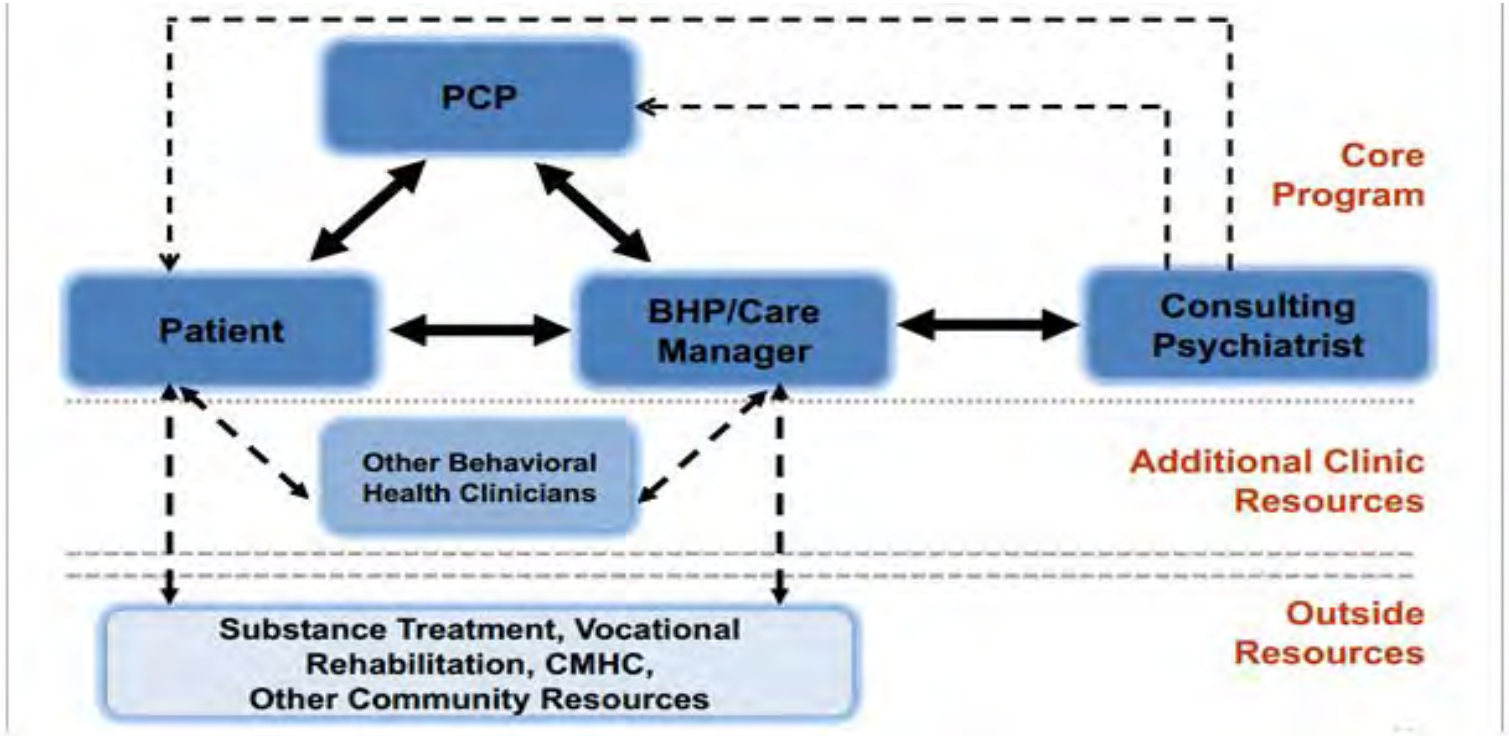
Collaborative care approach works



Integrated Care

Public Health Challenge

- The co-occurring complexities of mental health, physical health, and substance use in our patient populations continue to grow and best practice recommendations continue to evolve.
- Mental health and substance use disorder services, including behavioral health treatment, are a primary focus of local and national discussion; fragmented care does not achieve optimal outcomes of wellbeing or population cost of care.

Accomplishments

- Standardized Screening Tools (MH, SUD, SDoH)
- Clinical Practice Guidelines finalized (MH & SUD)
- Approval of BHC resource in Nashua
- Nashua implementation plan established

Learning

- Practice transformation effectiveness requires leadership and resources
- Data and population health measurement is difficult
- Revenue sources and use of codes need proper evaluation before implementation
- Clinic flow is impacted differently in each location by implementation of new standards of care
- Behavioral health resource additions are important to overall care team effectiveness

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PATP	**Public Health Challenge** - *Perinatal substance use disorders affect an estimated 10-20% of pregnancies in the United States; 8-10% NH; 7-8% D-H deliveries; Opioid use disorders are on the rise.* - *Untreated, perinatal substance use is associated with significant morbidity and mortality for women and their infants, including infectious disease, prematurity, poor fetal growth, and neonatal withdrawal*

Accomplishments

- Program enhancements
  - Social worker
  - Pediatrics
  - Food shelf (Haven)
  - Play group
- Program expansion through SBIRT screening and MAT in OB practices
- State of NH collaboration

Learning

- Practice transformation effectiveness requires leadership and resources
- Data and population health measurement is difficult
- Revenue sources and use of codes need proper evaluation before implementation
- Effectiveness is dependent upon three key functions (clinical care, case mgmt., patient education & counseling)
- Recovery activities are critical for effective relapse prevention
- DH operations are not often conducive to collaborative care with external community organizations

Sustainability

Program serving 40 women at a time (60-80 women/year)

- Integrated addiction services
- Psychiatric care
- Obstetrical care
- Structure for Well-Child visits
- Case management

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SBIRT

Public Health Challenge

- One out of six primary care patients are challenged by a substance use condition, however only 1/4 ever discuss it with a health care professional

- Use of alcohol and other drugs remains a leading cause of morbidity and mortality for young people in the United States

- Evidence and tools for screening and intervention strategies are available, but not consistently being implemented within the primary care settings

Accomplishments

- SBIRT implemented at 5 out of 6 adolescent pc sites
- >80 screening rate
- 4-6 % positive findings
- 100% follow-up to positive findings

Learning

- Practice transformation effectiveness requires leadership and resources
- Data and population health measurement is difficult
- Revenue sources and use of codes need proper evaluation before implementation
- Clinic flow is impacted differently in each location by implementation of new standards of care
- Behavioral health resource additions are important to overall care team effectiveness

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ED Recovery Coaches

Public Health Challenge

- *A substance use disorder is a primary, chronic, and relapsing disease that affects body and brain.*
- *Recovery and recovery support are key components of effective treatment. Varied treatment options, availability of immediate help, recurring opportunities for help, and access to ongoing supports are essential to sustained recovery from addiction.*

Accomplishments

- Pilot up and running at D-H ED
- Activation of Recovery Coaches 3 to 4 time per week
- 210 patients served

Learning

- DH operations are not often conducive to collaborative care with external community organizations
- Initial numbers of eligible participants is lower than estimated
- Effective practice transformation requires leadership and resources
- Measurement of meaningful population health outcomes is difficult
- Behavioral health resource additions may be important to overall care team effectiveness

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Education and Culture

Public Health Challenge

- *A community culture of stigma persists against persons with behavioral health challenges, including persons with substance use, mental health, intellectual disability, and other conditions.*
- *Studies have shown that knowledge, culture, and social networks can influence the relationship between stigma and access to care and people not seeking the care they may need*

Accomplishments

- Stigma Conference (160 participants)
- Six topic focus trainings or seminars
- Nine meetings (D-H departments, state, community)
- Outward facing website with comprehensive resources

Learning

- Practice transformation effectiveness requires professional development and training
- Culture change is difficult to measure; it's a natural evolution of comprehensive education and multi-disciplinary engagement
- Confidence of care teams is improved with a "safety net" of accessible consultation and guidance
- Undefined or lack of cross-departmental leadership and decision-making slows progress

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What is next?

- The behavioral health needs are intense across our services system and especially in the south where D-H offers little to no behavioral health service.
- D-H strategy in this region is increasingly focused on population health, risk-based contracts.
-
- A population health strategy requires a systematic approach to behavioral health care.
- With the learning from the SUMHI, D-H is ready.
- Moving forward will require an operational investment.

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Anthem's Physical Health and Behavioral Health Value-Based Provider Payment Programs

Physical Health 

- Total Cost of Care for Primary Care Provider and Accountable Care Organization :
  - Shared Savings APMs
  - Shared Risk APMs
- Obstetrics Pay-for-Performance Program
- Inpatient Facility Pay-for-Performance Program

Behavioral Health 

- Outpatient Behavioral Health Provider Pay-for-Performance Program
- Behavioral Health Inpatient Facility Pay-for-Performance Program
- Bundled Payment Models

Physical Health: Shared Savings and Shared Risk APMs

- Current integrated measures include:
  - Physical Health providers are held accountable for Behavioral Health costs (OP, IP, Rx) in Total Cost Of Care models
  - Quality measures in models include some BH measures (e.g., ADHD medication HEDIS measure)

- Potential future integration opportunity:
  - Incentives for physical co-location of BH providers with PH providers
  - Screening rates (depression, substance abuse, etc.) included in quality measure sets

- Integration challenges:
  - In these models, PCPs and ACOs are held accountable for their attributed members. We cannot hold another provider or subset of providers accountable for the same attributed members.
  - Behavioral Health providers usually are reluctant to be accountable for the total cost of care of a set of attributed members
  - Member attribution differences between PCP-based models and Behavioral Health provider models are difficult to reconcile
  - In many cases, Primary Care Providers and Behavioral Health providers both can and do deliver services tracked for quality metrics, including those measures involving prescribing anti-depression medications, ADHD medications, etc. , and credit is given either way

Physical Health: Obstetric Pay-for-Performance Programs

- Current integrated measures include:
  - Substance Abuse Disorder Screening
- Potential future integration opportunity:
  - Incentive for physical co-location of Behavioral Health providers with Physical Health providers
- Integration challenges:
  - Obstetric providers don't feel qualified or have enough resources to be held accountable for many traditional Behavioral Health measures

Behavioral Health: Outpatient Pay-for-Performance Programs

- Current integrated measures include:
  - Overall ER utilization rate
  - Annual PCP visit
  - Follow up care for children prescribed ADHD medication
  - Anti-depressant Medication – Initiation and Continuation
  - Diabetic Screening – Schizophrenia / Bi-Polar on Antipsychotics
  - Diabetic HgA1c Screening

- Potential future integration opportunity:
  - Incentives for physical co-location of PH providers with BH providers
  - Screening rates (depression, SUD, etc.) included in quality measure sets
  - FUM: Follow up after ER visit for Mental Illness
  - FUA: Follow up after ER visit for Alcohol and Other Drug Dependence

- Integration challenges:
  - Behavioral Health providers don't feel in control or connected enough to be held accountable for many traditional Physical Health measures