BCG

Accelerating to Value
LAN SUMMIT
Health Care Payment Learning & Action Network

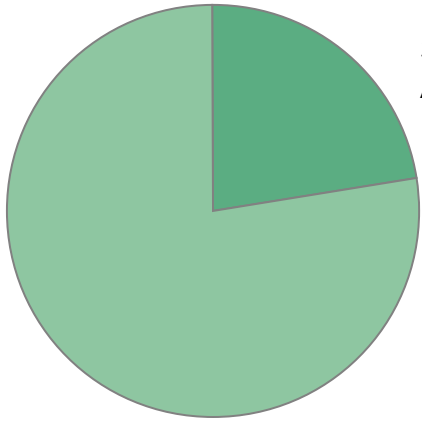
Behavioral Health and Alternative Payment: A (Non-Scientific) Progress Report

Stephanie Jordan Brown
April 26, 2016

The Boston Consulting Group

The prevalence and under-treatment of behavioral health disorders is well documented...

43.6 Million Adults with AMI in the Past Year (18.1% of All Adults)

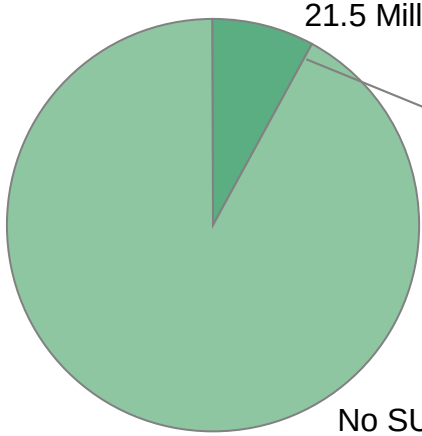


SMI: 9.8 Million (4.1% of All Adults and 22.6% of Adults with AMI)

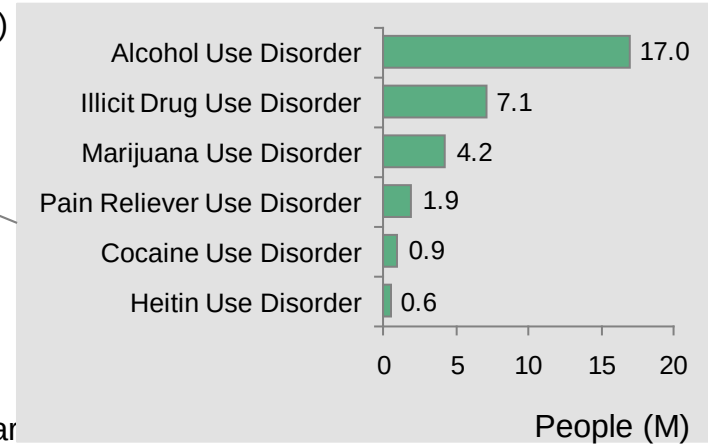
AMI Excluding SMI: 33.7 Million (14.0% of All Adults and 77.4% of Adults with AMI)

45% received receive treatment

SUD in the Past Year
21.5 Million People (8.1%)



No SUD in the Past Year (91.9%)

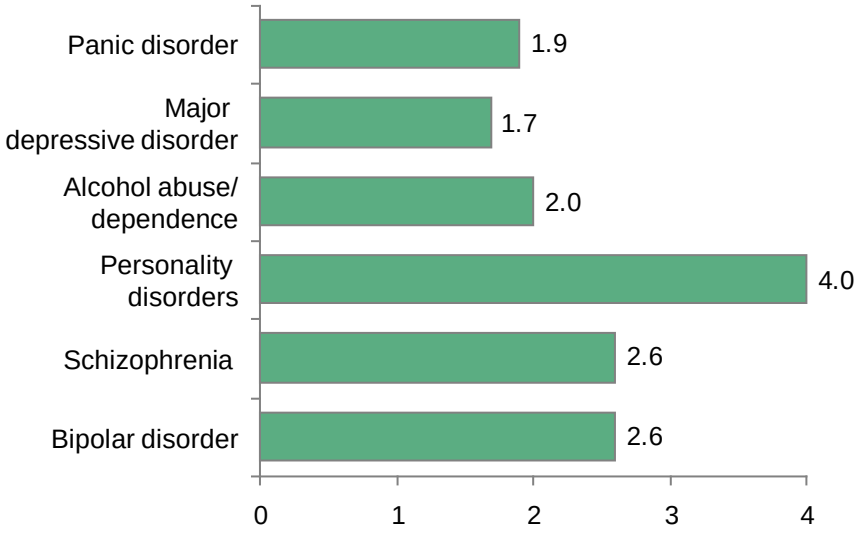


10 % receive treatment

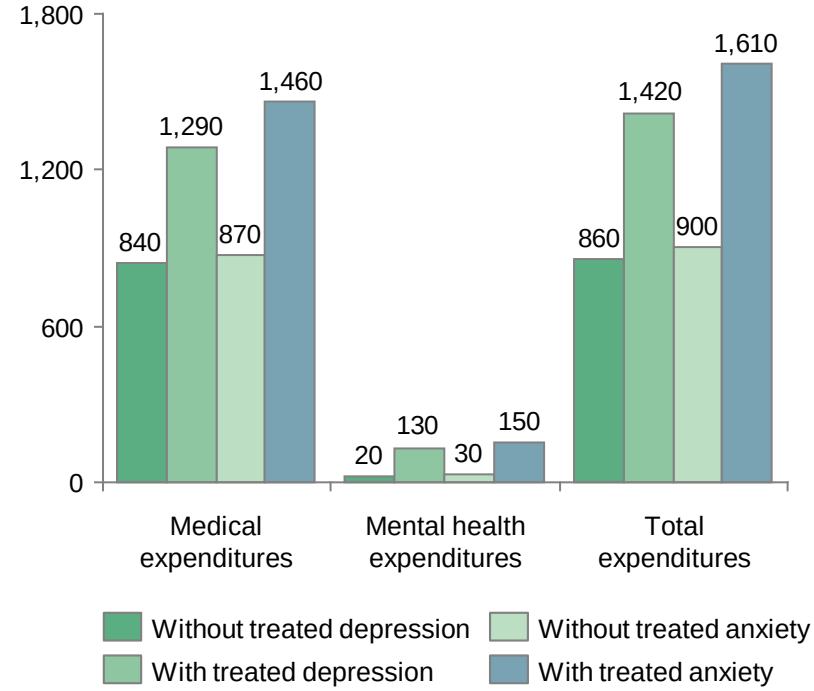
Source: SAMSHA 2014 National Survey of Drug Use and Health; http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014/NSDUH-DR-FRR3-2014.pdf

Studies show BH co-morbidities are tied to both poorer health outcomes and higher costs

Relative risk of all cause premature mortality associated with mental disorders compared with the general population



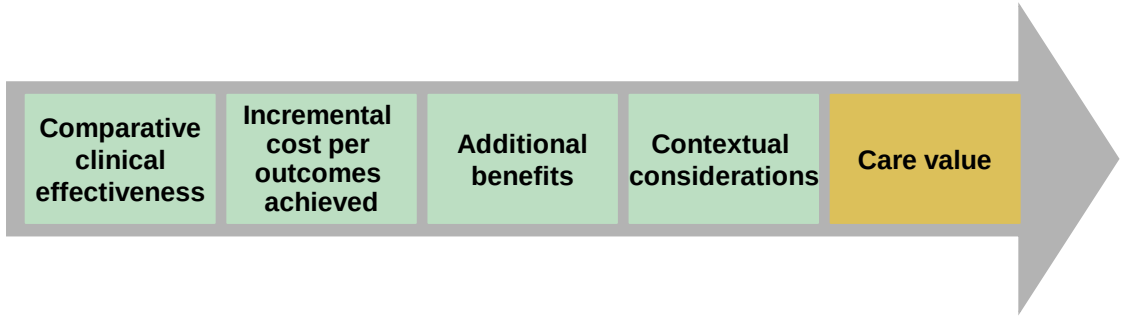
Comparison of monthly healthcare expenditures for chronic conditions and comorbid depression or anxiety, 2005

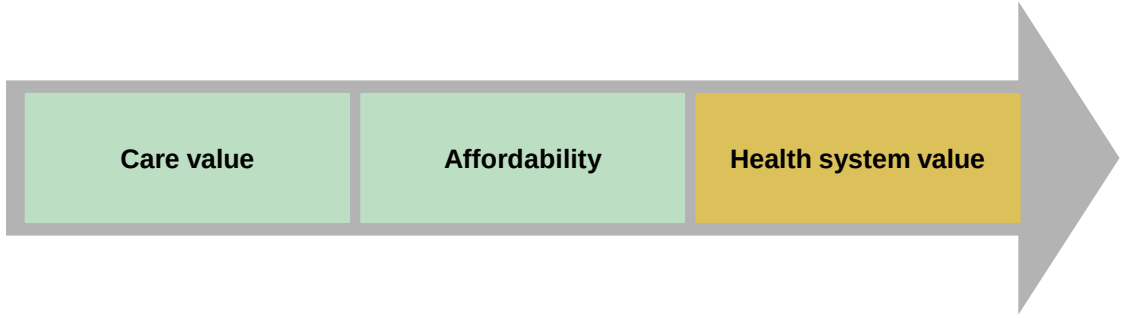


Policy makers, providers, and payers are beginning to respond with efforts to improve care coordination and clinical integration across the continuum

Source: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438

The chronic care model of integration has been shown to be both clinically and cost-effective





Institute for Clinical and Economic Review: Study of Comparative Effectiveness

"Findings from multiple evaluations across a variety of integration models and populations suggest that BHI falls within generally-acceptable thresholds for cost-effectiveness ($15,000 - $80,000 per QALY gained vs. usual care)."

"Economic studies have shown with consistency that BHI increases organizational costs, at least in the short term... while there are not currently consistent data with which to estimate potential cost offsets from BHI, fairly conservative estimates of reductions in health care costs could offset these initial investments considerably. "

Additional study of the embedded Behavioral Health Consultant model is also needed to establish its comparative effectiveness

Source: http://icer-review.org/wp-content/uploads/2016/01/BHI_Final_Report_0602151.pdf

Nevertheless, integration efforts are still largely being financed through a patch-work quilt of funding sources

Level of Integration (AHRQ Lexicon levels of integration measurable with IPAT)	FFS Codes Currently Covered (billable today by contracted providers)	Additional FFS Billing Opportunities (could be made available to qualifying practices)	Additional Care Management/Medical Home Allocations (typically program specific)	Additional Infrastructure Dollars for HIT, eHealth, overhead etc.
Collaborative Referral to Outpatient BH Provider	• Case Consult (adult & youth) • Family Consult (youth) • Collateral Contact	• **New codes that could be made reimburseable:** • **Telehealth codes**	• E.g., Practice-Based Care Management Payment/Incentive	• Grant Funding (SAMHSA, other)
Co-Located Outpatient BH Provider in Primary Care Clinic	• Case Consult (adult & youth), • Family Consult (youth), • Collateral Contact • Diagnostic Evaluation • OP Therapy Codes (as per specs and DPH regs) • Medication Mgmt Codes (as per specs and DPH regs)	• **New codes that could be made reimburseable:** • **Telehealth codes** • **Health & Behavioral Assessment and Intervention Codes** • **SBIRT Codes** • **Transition of Care Codes**	• E.g., Practice-Based Care Management Payment/Incentive	• Grant Funding (SAMHSA, other) • Contractual arrangements with partner Primary Care Sites to share medical home dollars, other incremental financing, or gain share
Fully Integrated Outpatient BH Provider on Primary Care Team	• Case Consult (adult & youth), • Family Consult (youth), • Collateral Contact • Diagnostic Evaluation • OP Therapy Codes (as per specs and DPH regs) • Medication Mgmt Codes (as per specs and DPH regs)		• E.g., Practice-Based Care Management Payment/Incentive	• Grant Funding (SAMHSA, other) • Contractual arrangements with partner Primary Care Sites to share medical home dollars, other incremental financing , or gain share

Alternative payment models promise to change how care is financed and, by extension, how it is delivered...

APM Framework (At-A –Glance)

Category 1
Fee for service—No link to quality & value

Category 2
Fee for service—link to quality & value

- A — Foundational Payments for Infrastructure and Operations
- B — Pay for Reporting
- C — Rewards for Performance
- D — Rewards arid Penalties for Performance

Category 3
APMS Built on Fee-for-Service architecture

- A — APMs with Upside Gainsharing
- B — APMs with Upside Gainsharing/Downside Risk

Category 4
Population-based payment

- A — Condition-Specific Population-Based Payment
- B — Comprehensive Population-Based Payment

A spectrum of different designs across public and private payers are starting to incorporate behavioral health.

APM Framework (At-A –Glance)

Category 2
Fee for service—link to quality & value

Category 3
APMS Built on Fee-for-Service architecture

Category 4
Population-based payment

OPTUM®

OPTUM®

COLORADO
Department of Health Care Policy & Financing

MassHealth
PCC Plan

MASSACHUSETTS

MBHP
Massachusetts Behavioral Health Partnership
a Beacon Health Options company

health reform
MINNESOTA
A Better State of Health

Intermountain Healthcare

Health Care Payment Improvement Initiative
Building a healthier future for all Arkansans

- Pay for Performance on Quality Metrics
- Rate Increases Tied to Quality Measures
- Bundled Payment for ADHD and ODD
- MAT Episode payment (DRG)
- Integrated Medical Home PMPMs
- Global Budget Inclusive of BH with gain/loss tied to quality
- Primary Care Prospective Capitation inclusive of BH w/ Shared savings tied to quality
- Prospective Global capitation

We are still in the very early stages of shifting incentives and the system from fragmentation to integration …

In a national survey of 257 ACOs

- 11% percent of all ACOs and 20% percent of ACOs with commercial-payer contracts had conflicting ACO contracts, with responsibility for behavioral health care costs in one ACO contract and not in another
- 42% of ACOs surveyed include behavior health provider groups under their umbrella; (53% among ACOs who consider themselves integrated delivery systems)
- 21% reported having an agreement with a specialty behavioral health provider outside of their organization
- 15% of ACOs report fully integrating BH into primary care

In a national survey of 635 Substance Use Treatment organizations

- Only 15% of these organizations had signed agreements with ACOs
- Another 6.5% were planning to sign such an agreement and 4% were in discussions

"There is much opportunity to advance the integration of behavioral health care into ACOs"

Source: 10.1377/hlthaff.2014.0353 Health Aff October 2014 vol. 33 no. 10 1808-1816; J Health Polit Policy Law. 2015 Aug; 40(4): 797–819.

And we have much yet to learn from those demonstrations that are currently underway

Results from study of the BCBSMA Alternative Quality Contract at the 2 year mark

- Enrollees in AQC organizations were slightly less likely to use mental health services
- Among mental health services users, small declines were detected in total health care spending, but no change was found in mental health spending
- Declines in probability of use of mental health services and in total health spending among mental health service users were concentrated in the AQC organizations that accepted financial risk for behavioral health

- From interviews with leaders in participating AQC organizations:

"The overarching view was that little progress had been made with regard to mental health care integration during the contract's initial years, and delivery system changes that would facilitate behavioral health integration were viewed as a longer-term objective."

Source: Doi: 10.1377/hlthaff.2015.0685 Health Aff December 2015 vol. 34 no. 12 2077-2085;

Some key challenges before us on the path towards integration of behavioral health in payment reforms

INFORMATION EXCHANGE AND PRIVACY PROTECTIONS

RIGHT SIZING PAYMENT TO ENSURE ADEQUATE FINANCING OF CURRENT AND NEW SERVICES

GOVERNANCE OF PARTNERSHIPS AND FUNDS FLOWS

SAFEGUARDING CONSUMER CHOICE

Disclaimer

The services and materials provided by The Boston Consulting Group (BCG) are subject to BCG's Standard Terms (a copy of which is available upon request) or such other agreement as may have been previously executed by BCG. BCG does not provide legal, accounting, or tax advice. The Client is responsible for obtaining independent advice concerning these matters. This advice may affect the guidance given by BCG. Further, BCG has made no undertaking to update these materials after the date hereof, notwithstanding that such information may become outdated or inaccurate.

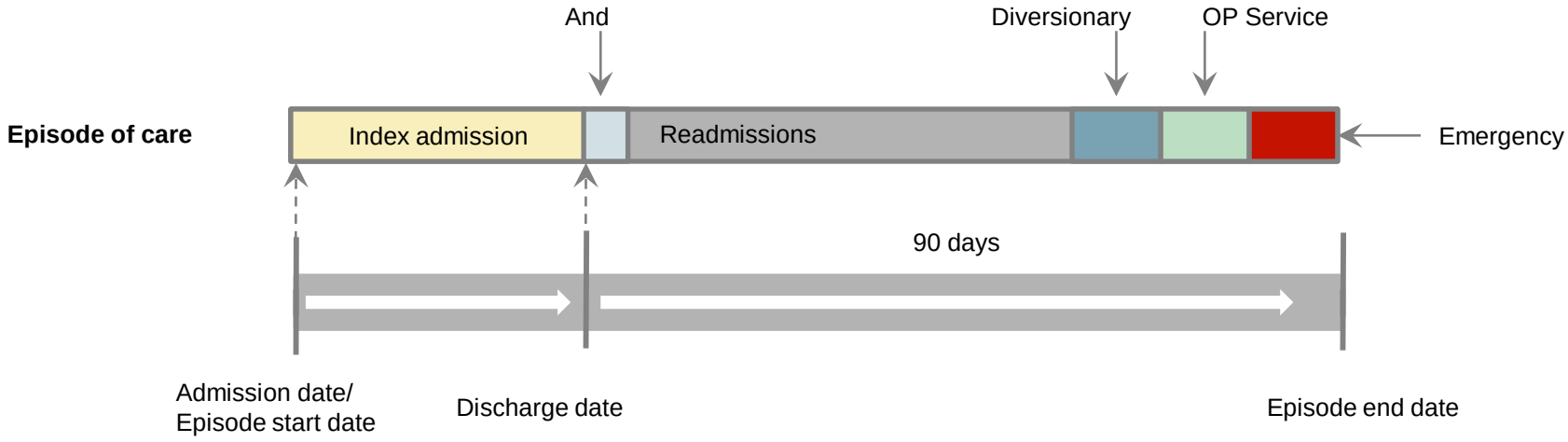
The materials contained in this presentation are designed for the sole use by the board of directors or senior management of the Client and solely for the limited purposes described in the presentation. The materials shall not be copied or given to any person or entity other than the Client ("Third Party") without the prior written consent of BCG. These materials serve only as the focus for discussion; they are incomplete without the accompanying oral commentary and may not be relied on as a stand-alone document. Further, Third Parties may not, and it is unreasonable for any Third Party to, rely on these materials for any purpose whatsoever. To the fullest extent permitted by law (and except to the extent otherwise agreed in a signed writing by BCG), BCG shall have no liability whatsoever to any Third Party, and any Third Party hereby waives any rights and claims it may have at any time against BCG with regard to the services, this presentation, or other materials, including the accuracy or completeness thereof. Receipt and review of this document shall be deemed agreement with and consideration for the foregoing.

BCG does not provide fairness opinions or valuations of market transactions, and these materials should not be relied on or construed as such. Further, the financial evaluations, projected market and financial information, and conclusions contained in these materials are based upon standard valuation methodologies, are not definitive forecasts, and are not guaranteed by BCG. BCG has used public and/or confidential data and assumptions provided to BCG by the Client. BCG has not independently verified the data and assumptions used in these analyses. Changes in the underlying data or operating assumptions will clearly impact the analyses and conclusions.

Thank you

bcg.com | bcgperspectives.com

Analysis of acute episodes reveals ample opportunity to improve continuity of specialty care as well



Mean Bundle Cost by Bundle Length, Adults, 2011-2013

Bundle Length	Cases	Total	Anchor		AND		Readmission		Outpatient		24 hr Diversionary		Non 24 hr Diversionary		Emergency		Financial Incentives		Anchor LOS
		$	$	%	$	%	$	%	$	%	$	%	$	%	$	%	$	%	Days
0	18373	6,867	6,282	91	555	8	0	0	5	0	10	0	6	0	9	0	1	0	9.65
7	17078	7,462	6,240	84	603	8	188	3	53	1	212	3	61	1	86	1	17	0	9.53
30	14971	9,282	6,150	66	690	7	1,370	15	202	2	418	5	191	2	226	2	35	0	9.4
90	12666	12,190	6,111	50	813	7	3,170	26	523	4	692	6	393	3	442	4	46	0	9.3
365	9736	17,401	5,972	34	968	6	5,953	34	1,433	8	1,231	7	873	5	899	5	73	0	9