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Payment Reform and Opportunities for Behavioral Health: Alternative Payment Model Examples

September 2017

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Dear Reader,

Payment reform is at the center of discussions concerning health care reform. It is one recommended approach to address the dual problems of climbing U.S. health care costs and poor patient outcomes. Reformers propose switching from volume-based payment systems to value-oriented, alternative payment models to improve care quality and reduce costs. Unfortunately, alternative payment reform proposals rarely have considered behavioral health care.

Alternative payment arrangements can contribute to the expansion of many evidence-based behavioral health treatments, such as medication-assisted treatment of addiction, collaborative care, tele-mental health, and early intervention to promote recovery after an initial psychotic episode. These payment models may be diverse in their financing structures and cover a range of interventions, yet they should share four core values: measurement-based care, clinically appropriate technology for monitoring, value-based payments, and flexibility in care delivery.

As funders, the Thomas Scattergood Behavioral Health Foundation and Peg's Foundation initiated a project to collect and further develop behavioral health alternative payment models. The project drew upon the experience of collaborators in academic institutions, advocacy organizations, medical and behavioral providers and payers. This preliminary report introduces alternative payment models under development. To be released in fall 2017, the final report will include detailed descriptions of models adaptable by both public and private payers.

All treatments included in the report have a substantial clinical evidence base supporting their ability to improve patient outcomes and reduce costs. The report focuses on innovative funding structures and how they might increase the widespread dissemination of proven therapies.

Through these tangible solutions, we believe that collectively we will begin to improve quality and reduce the cost of U.S. health care.

Sincerely,

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Please e-mail paymentreform@scattergoodfoundation.org with your comments.

*The views expressed in this work are those of the authors, and not necessarily of the National Institute of Mental Health, the National Institute of Health, or the federal government

The U.S. healthcare system is undergoing immense transformation as public and private payers test and implement strategies to improve care quality and patient outcomes and reduce costs. This movement could not come at a more appropriate time, as U.S. healthcare expenditures approach three trillion dollars annually, accounting for nearly 18% of gross domestic product.[1] Several factors contribute to the rising cost of healthcare. These include, but are not limited to, the aging population, changing disease prevalence, inadequate investment in social services, and emphasis on expensive medical interventions.[2] Furthermore, the general difficulties associated with measuring health care outcomes limit the influence of natural market forces that typically drive purchasing behaviors and competition.

Another driver of elevated health care spending in the U.S. is clinician fees, which are substantially higher than those in peer nations.[3] Throughout the modern history of this country, health care payment has largely consisted of various fee-for-service (FFS) arrangements in which clinicians submit billing codes for each unit of service delivered and receive retrospective payments. While FFS has the potential to incentivize work productivity and efficiency, it also inherently compels clinicians to focus on volume instead of outcomes.[4] Unfortunately, when providers attempt to redesign care delivery to provide higher-quality services, they often face the barriers of inadequate payment for services not traditionally covered by payers or financial penalties for performing fewer or lower-cost services.

Payment reform provides an opportunity to address the rising cost of U.S. healthcare. Shifting from volume-driven systems to value-oriented alternative payment models (APMs) can improve care quality and reduce cost. APMs align reimbursement with cost-efficient, high-quality care by increasing provider flexibility and incorporating measurement-based payment. Examples of APMs include accountable care organizations (ACOs), bundled payments, and provider capitation.

Despite the copious discussions on health care payment reform in recent years, there has been little focus on behavioral health.[5, 6, 7] A recent survey of 257 ACOs found that "most ACOs have done little to move beyond the traditional model of fragmented primary and behavioral health care." More than one-third of these ACOs did not maintain relationships with behavioral health provider groups, and only 14% fully integrated primary and behavioral healthcare.[8] Another recent survey found that ACOs commonly excluded substance use providers, with only 15% of surveyed specialty organizations reporting a formal agreement with an ACO.[9]

Behavioral health is also often absent from the standardized and quantifiable screening and outcomes measures that are essential to payment reform and measurement-based care. Many Medicaid and commercial ACOs do not require depression screening, United States Preventive Services Task Force (USPTF)-recommended services, or non-process outcomes reporting. Furthermore, the only non-process measures related to behavioral health within the Centers for Medicare and Medicaid Services (CMS) Core Quality Measure Collaborative (CQMC) measure set governing Medicare ACOs focus on depression screening and remission.[10] While the 2017 Medicare Shared Savings Program and Next Generation ACO Model's performance measures include metrics related to the general patient/caregiver experience (i.e., shared decision making, provider communication and physician ratings), these are not specifically focused on mental health outcomes. There are two metrics focused on depression screening and remission, but effective measurement-based practice should cover a fuller range of outcomes for mental health and substance use disorders and services.[11, 12, 13] The overall lack of representation of behavioral health metrics in Medicare ACOs is particularly unfortunate given the significant number of validated measurement-based care instruments, such as Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Disorder-7 (GAD-7), and Altman Scale, that are ready for immediate adoption.

Behavioral health's virtual absence from APMs is also concerning given the substantial financial costs associated with mental illness and addiction. Whether present as the primary diagnosis or as a comorbid condition to physical illness, behavioral health disorders are a principle driver of overall health care costs. The reasons for this are multifold and range from the propensities of mental illness and substance use disorders to cause significant functional impairment to the noteworthy prevalence of these conditions in the U.S. population, which has been estimated to be as high as twenty-six percent.[14, 15] Furthermore, behavioral health conditions are associated with premature mortality and higher overall utilization of health services, including those for primarily physical illness.[16, 17] For instance, the per member per month costs for management of patients with arthritis, asthma, diabetes, and hypertension increase when the patient has a co-morbid behavioral health condition.[18, 19] A report completed by Milliman using data from Medicare, Medicaid, and commercial insurance found that the total cost of care for patients with comorbid behavioral health conditions was 2.5 to 3.5 times that of their peers with only physical illness.[20, 21] Given the expected increase in older adults with mental illness from under eight million in 2010 to fifteen million in 2030, the economic impact of behavioral health conditions appears to be trending upward.[22]

As noted earlier, alternative payment structures in the U.S. have rarely focused on behavioral health, leaving most of this care reimbursed in FFS models.[23] To be most effective, payment reform should incentivize the incorporation of evidence-based behavioral health treatments into health systems. It is noteworthy than the U.S. health care system will continue to utilize FFS, even as APMs are increasingly designed and implemented. Indeed, many APMs are deliberately organized to supplement or complement FFS. Several evidence-based services, such as tele-mental health; medication assisted treatment; coordinated specialty care programs for first episode psychosis; Screening, Brief Intervention, and Referral to Treatment (SBIRT); and collaborative care, have established FFS reimbursement mechanisms that remain underutilized by all payers. All payer use of existing FFS codes would substantially improve patient and financial outcomes with these services. This paper recommends a number of approaches to expand the use of APMs both to supplement existing FFS codes and as standalone reimbursement models.

While the expansion or full implementation of established FFS codes for evidence-based services should be a priority, payment reform will increase the use of many effective interventions and, ultimately, decrease costs. Given the variation in health care delivery across the country, APM recommendations should be diverse in their payment structure and cover a range of topics, but share the following **core values:**

Core Values of All Alternative Payment Models

1 / Measurement Based Care

2 / Technology for Monitoring, Improvement, and Coordination

3 / Value Based Payment

4 / Flexibility in Care Delivery

- **Measurement-based care (MBC):** MBC is the process of systematically measuring symptom severity and modifying treatment dependent based on patient outcomes. Numerous randomized controlled trials confirm the value of MBC for patient outcomes, including a meta-analysis of six studies that demonstrated that MBC substantially improved patient outcomes compared with usual care.[24] The efficacy of MBC for patients with behavioral health disorders is also well established.[25, 26]

- **Technology for symptom monitoring, care improvement, and treatment coordination that is clinically appropriate for MBC:** Technology is capable of supporting clinical decision making, empowering consumers, and promoting innovation. It is particularly useful in APMs, because MBC and value-based payment arrangements require continuous tracking and improvement of patient outcomes. Furthermore, many alternative payment arrangements, including ACOs, accountable health communities,[27] and collaborative care relationships, rely on care coordination between all providers interacting with the patient. Electronic medical records support data sharing and should be considered when implementing an APM. Limitations to technology implementation, including expense, provider productivity, and privacy, must be weighed against the potential benefits.

- **Value-based payments (VBP):** VBP arrangements reward providers with incentive payments for delivering high-quality and cost-effective care. Generally, providers report on a predetermined set of core and optional measures and receive additional payments on top of care reimbursement for meeting quality and cost goals. For example, shared savings—most commonly associated with ACOs—is a type of VBP arrangement that offers clinicians working together a percentage of any healthcare savings resulting from their efforts. Common metrics used for VBP include initiation and engagement in substance use treatment, depression screening, depression remission, and utilization of emergency department and inpatient hospital services. Although these common measures employed by both public and private payers cover a fairly narrow segment of the care spectrum, metrics used within a VBP arrangement should reflect the target population and capabilities of the provider system.

- **Flexibility in care delivery:** FFS incentivizes clinicians to deliver a high volume of services while limiting flexibility in care options to services with billing codes. FFS also traditionally excludes coverage of critical behavioral health services. APMs, such as global payment, capitation, and bundled payment, predetermine a fixed amount of money per time period, patient, or health episode, respectively, offering providers flexibility in determining the appropriate services. Research has shown that bundled payment arrangements are cost saving.[28] However, because of FFS underpinnings, these arrangements may fail to incorporate behavioral healthcare within a bundle for a common comorbid condition. Capitated payments, which have been a part of the healthcare landscape since the 1990s, are also not without limitations. Practices and health systems have found themselves unable to manage the risk associated with capitation because of inadequate risk adjustment and resource intensity.[29, 30] In developing APMs for behavioral health, the strengths and limitations of all models should be weighed against provider flexibility.

Using these core values, the Thomas Scattergood Behavioral Health Foundation and Peg's Foundation, with contributions from academic institutions, advocacy organizations, health systems, foundations, payers, and providers, has compiled information about several APMs for behavioral health interventions known to improve patient outcomes and reduce costs. Most of these services are being reimbursed in part by all payers via traditional FFS codes, and some are reimbursed via APMs. This paper aims to assist all payers, including CMS, commercial insurers, and ACOs, expand evidence-based services, and enhance monitoring of patient outcomes.

Payment reform is needed to improve service delivery in all treatment settings. Evidence demonstrates the importance of behavioral health interventions across the treatment spectrum. The benefits of early intervention and prevention in the treatment of behavioral health conditions for children and adults are well established. Patients with behavioral health problems more commonly present in the primary care setting.[31, 32] Following disease onset, specific behavioral health interventions are extremely powerful in improving patient outcomes and reducing associated costs. The models presented aim to increase access to evidence-based services delivered in all treatment settings, including early intervention and prevention, primary care, and specialty care. All models would likely improve patient outcomes significantly if implemented. The examples are organized by their readiness for immediate adoption.

11 Alternative Payment Models Currently Under Development

Case Rate for Substance Use Disorders / Specialized Case Rate for Serious Mental Illness / Value-Based Collaborative Care / Multi-Payer Collaborative Care / Patient-Centered Opioid Addiction Treatment Payment (P-COAT) / Coordinated Specialty Care for First-Episode Psychosis / Telehealth / Transitional Care Bundled Payments / CPC+ Behavioral Health-Add On / Accountable Communities for Health for Children and Families / ACO at Risk for Behavioral Health Care

Alternative Payment Models

Case Rate for Substance Use Disorders

Pinnacle Treatment Centers has a case rate agreement with a large insurance company in New Jersey. Case rates are used to pay for each level of care (detoxification, rehabilitation, partial hospitalization, and intensive outpatient). For case rate eligibility, the initial admission must be authorized and the standard criteria (American Society of Addiction Medicine or insurer-determined medical necessity criteria) must be met. Once the admission is pre-certified, concurrent reviews to obtain additional days at the level of care upon admission and authorizations for additional levels of care are eliminated. Pinnacle Treatment Centers needs only to advise the insurer when the patient has been stepped down. With the case rate approach, providers no longer need to submit documentation for frequent reviews and authorizations, increasing the amount of time spent on actual patient care. The approach also helps patients receive the level of care that is best suited to their needs, not what insurance protocols dictate. (Example provided by Pinnacle Treatment Centers.)

Specialized Case Rate for Serious Mental Illness

For the past 20 years, Baltimore City has operated a specialized case rate program for 350 individuals with serious mental illness who are not well served by the public system. The criteria for program admission are that the individual must have a serious and persistent mental illness and have been in a state psychiatric hospital for six months or longer or have had four psychiatric hospitalizations and/or seven psychiatric emergency department visits over a two-year period. There are two providers who receive a single rate, inclusive of state general funds and Medicaid, that covers all mental health services, and the provider is at financial risk for up to 30 days of psychiatric inpatient care. Providers cannot bill Medicaid for any Medicaid-covered psychiatric service, but they can bill Medicare and other third-party payers. The bundled funding structure allows services to be delivered in an individualized flexible manner. There is a single billing code for reimbursement. In addition to the bundled rate, a portion of the participant's income (SSI or SSDI in most cases) is used to pay for housing and other non-Medicaid services. The providers are held to outcomes that target a number of areas, including housing, employment, client satisfaction, homelessness, incarceration, and connection to a primary care provider, and an annual evaluation determines the awarding of incentive funds. Medicaid and all third-party insurers are billed for non-behavioral health services. (Example provided by Maryland Behavioral Health Network.)

Value-Based Collaborative Care

Beginning in 2017, Medicare reimburses monthly collaborative care, including codes G0502, G0503, and G0504, for collaborative care services provided by a treating practitioner, a behavioral healthcare manager, and a consulting psychiatrist. Prior to this billing policy, providers were unable to bill for these services even though they are supported by over 70 randomized controlled trials. However, as with other healthcare services, the outcomes of these evidence-based services may vary when they are translated into different practices and contexts. This may be due to differences in how well the core components of the model, such as systematic follow-up, are implemented.[33, 34] To help control for this variation, payment models that tie a portion of monthly payments to performance measures have improved depression outcomes.[35, 36] A multi-payer value-based payment model demonstration could be piloted to tie 25% of the payment to quality measures, such as percentage of enrolled patients with a PHQ-9 score greater than nine who had at least one follow-up contact with the care manager in the patient-month, percentage of enrolled patients with a PHQ-9 score greater than nine who had at least one psychiatric consultation in the patient-month, and percentage of enrolled patients who have a PHQ-9 score under ten or who achieved at least a 50% reduction in the PHQ-9. (Example provided by Jewish Healthcare Foundation.)[37]

Multi-Payer Collaborative Care

With the advent of Medicare payments for collaborative care, primary care practices are able to deliver this essential service to a large part of the U.S. population. Supplementing these Medicare payments, several state Medicaid agencies are also reimbursing for collaborative care, as well as the Veterans Affairs and Department of Defense (VA/DoD) and several integrated health systems like Kaiser and Inter Mountain. However, full adoption of collaborative care will be greatly enhanced if all payers reimburse for this evidenced-based intervention. To increase multi-payer reimbursement for collaborative care, we recommend a large-scale demonstration in several regions of the country in which state Medicaid agencies and all commercial insurers provide payment for collaborative care using the established codes.

We also recommend considering the benefits of a bundled payment approach developed in Minnesota known as the DIAMOND Program. Among the first to create a multi-payer system for collaborative care, this project was spearheaded by a unique partnership that included the state's six largest commercial health plans, the Minnesota Department of Human Services, and medical provider groups in the state.[38] Together, these groups and organizations agreed that improving depression care was a priority and that the FFS reimbursement system available at the time was inadequate for primary care practices to support effective depression care management.[39] Under DIAMOND, primary care providers implemented collaborative care for depression and could bill for a negotiated bundled monthly payment rate, which was designed to cover associated clinical costs. Honored by all the major commercial insurance companies in the state, the availability of this bundled payment mechanism was enough for about 80 diverse primary care practices to accept the burden of collaborative care startup costs (such as hiring care managers and registry development), because of the promise of at least breaking even if they enrolled enough patients from different payers in their collaborative care program.[40] (Example provided by the AIMS Center.)

Patient-Centered Opioid Addiction Treatment Payment (P-COAT)

There is a growing epidemic in the United States of death due to opioids. Substantial medical literature demonstrates the effectiveness of MAT to treat opioid use disorder. Yet MAT remains substantially underutilized. The current payment system contributes to this underutilization by not reimbursing for many of the services needed to successfully treat a patient with opioid use disorder. P-COAT is an alternative payment model designed to improve outcomes and reduce spending for opioid addiction. The model creates a bundled payment structure representing three phases of care. Bundles can be used in collaboration or separately depending on patient needs. The Patient Assessment and Treatment Planning payment is a one-time payment to support evaluation, diagnosis, and treatment planning. The Initiation of MAT bundle is also a one-time payment but covers services related to the initiation of outpatient MAT, including supervised induction of buprenorphine therapy, appropriate psychological and/or counseling therapy, and care management and coordination services. The Maintenance of MAT bundle is a monthly payment covering all services related to ongoing medication, psychological treatment, and coordination of social services necessary to remain in treatment following initiation. (Example provided by the American Society of Addiction Medicine.)

Coordinated Specialty Care for First-Episode Psychosis

Coordinated specialty care (CSC) produces positive outcomes for youth and young adults experiencing first-episode psychosis, is cost effective, and results in young people getting better—including staying in school, working, and experiencing improved quality of life.[41, 42] Importantly, CSC is most effective in producing positive outcomes containing costs for individuals who are identified early and are provided CSC treatment soon after the initial onset of psychosis. Some of the CSC components are covered in standard health insurance plans. These include prescription drug costs, medication and medication management, psychotherapy, and, often but not always, family support and education. Components that are typically not covered in standard insurance and Medicaid plans are care coordination, supported employment, education, and outreach. This APM model for CSC programs would use a case rate or bundled rate that covers the full array of services and supports delivered in evidence-based CSC programs. In developing APMs for CSC programs, case and/or bundled rates should be available for the first two years of intensive treatment, with adjusted rates that support young people in maintaining gains as they transition to less intensive follow-up care. APMs should support continuity of care and ongoing positive treatment outcomes for individuals experiencing psychosis associated with schizophrenia. (Example provided by National Alliance on Mental Illness.)

Telehealth

As technology for telehealth has become increasingly available and easy to use, it has progressively been cited as a potential solution for treatment disparities and long-recognized obstacles to care in the United States. At present, at least 20% of Americans live in areas where shortages of physicians and healthcare specialists exist, and many others experience structural barriers to initiating or continuing care.[43, 44] Telehealth services offer a potential solution to improving access to care, especially in rural and otherwise underserved areas (including urban settings). Given the shortage of specialty behavioral clinicians both in rural and urban areas, tele-mental health—if expanded to all geographic areas—can significantly improve access to mental healthcare. The Veterans Health Administration (VHA) has been a national leader in this area for years. This is partly due to the multiple unique characteristics that make the VHA a well-suited organization for tele-healthcare: a uniform electronic medical record, a lack of state-specific provider licensure regulation, and a relatively tech-savvy patient subpopulation (from recent experience serving in the military).[45] This APM facilitates the expansion of telehealth services by incentivizing the use of existing payment codes. (Example provided by the AIMS Center.)

Transitional Care Bundled Payments

Reimbursing healthcare services via a bundled payment is intended to reduce unnecessary spending, incentivize value-based care, and encourage care coordination. The application of bundled reimbursement models has lagged in mental health compared with other specialties, although some notable examples and theories have been described.[46, 47, 48, 49, 50] Bundled payments could compel systems and payers to focus on well-described critical time windows for behavioral health patients, such as transition of care from inpatient to outpatient settings or vice versa.[51, 52] Overdoses and suicides disproportionately present in the emergency department, demonstrating the necessity of care transitions to adequate and proactive follow-up. One potential setting for a pilot bundled payment could be in the emergency department; for the first time, the 2017 HEDIS measures included "Follow-Up After Emergency Department Visit for Mental Illness" and "Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence."[53] The 2018 HEDIS document has expanded and clarified these measures.[54] Given the well-described hospital practice changes surrounding transition of care in response to bundled payments for other diagnoses, an initiative in behavioral health could conceivably move the needle toward reducing the large number of preventable hospital readmissions. (Example provided by the AIMS Center.)

CPC+ Behavioral Health-Add On

Patients needing behavioral health treatment most commonly present in the primary care setting, yet these patients struggle to receive effective mental health and addiction care via their primary care providers because of provider shortages and poor care transitions. The model described here modifies the existing Center for Medicare and Medicaid Innovation demonstration project, CPC+, to address inadequate access to behavioral healthcare in the primary care setting. CPC+ is a multi-payer model aimed at improving primary care through an innovative payment structure that includes risk adjustment, performance-based incentives, and partial capitation. The CPC+ Behavioral Health-Add On facilitates behavioral health integration by modifying the payment model so that risk adjustment and performance-based incentives are tied to use of mental and substance use disorder screening tools. It also requires full capitation of behavioral health services to address care shortages and promote provider flexibility in care delivery. (Example provided by Mental Health America.)

Accountable Communities for Health for Children and Families

Social factors during childhood have a profound impact on health, especially behavioral health. However, healthcare approaches all too often focus on medical interventions for adults, with less emphasis on how social determinants affect a child's health and development over time. Structured collaboration among multi-sector partners with shared goals and resources have the potential to improve the health trajectories of children and their families. One such model, Accountable Communities for Health, is a place-based collaboration among healthcare and social sectors in which partners are held financially accountable and jointly responsible for meeting predetermined metrics and goals. Building on the Center for Medicare and Medicaid Service's Innovation demonstration, Accountable Health Community Model Track 3, the Accountable Communities for Health for Children and Families would test the use of an integrator organization aligning clinical and community efforts to address family risk and protective factors and connect families with needed social services in order to optimize the health of the family and child. (Example provided by Nemours Children's Health System and Mental Health America.)

ACO at Risk for Behavioral Health Care

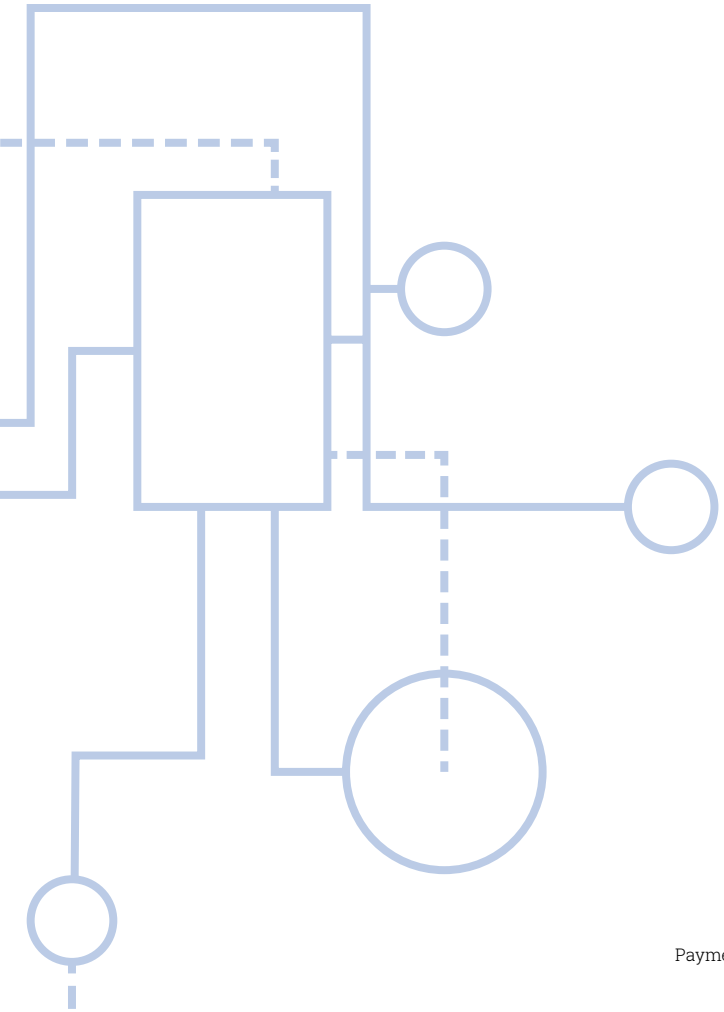
To date, some Accountable Care Organizations (ACOs) have focused on depression screening and depression remission metrics with only Medicare ACOs required to implement these measures.[55] Most ACOs do not screen for or track non-process outcomes measures for other common mental health or substance use disorders. Many authors have viewed this lack of ACO quality measurements incentivizing evidenced-based behavioral healthcare as a missed opportunity for payers, health systems, and patients.[56] Given demonstrated higher healthcare costs and reduced work productivity associated with patients who have mental and/or substance use disorders, it is a logical choice for ACO contracts to couple behavioral health financial risk with corresponding robust and specific performance markers.[57,58]

Medicare, Medicaid, and commercial ACOs are all well positioned to lead the field in this direction. Several ACOs that are partnerships between healthcare systems and large employers (such as the initiative between Boeing and the University of Washington) have brought behavioral health into the forefront by including in their contracts substantial financial risk related to behavioral health quality and outcome indicators.[59] A demonstration project with one or more ACOs in which they screen for all common mental and substance use disorders, including depression, anxiety disorders, psychoses, bipolar, and addictions is needed and highly recommended. In addition, the ACO would track outcomes for all these conditions by using a quantifiable and standardized symptom rating scale. The ACO would carry some risk for these outcomes and could also use many of the other APMs outlined in this paper. (Example provided by the AIMS Center.)

Conclusions

Payment reform in the United States is at the center of discussions concerning rising healthcare costs and poor patient outcomes. These conversations have largely been silent on behavioral health. As we develop APMs focused on mental health and substance use disorders, it is important to consider existing alternative payment approaches as well as innovative ideas yet to be disseminated. The strengths and weaknesses of APMs currently used in general medical care can inform models specific to behavioral healthcare.

As we move forward with the project, we are interested in receiving comments on payment reform and additional recommendations. Please e-mail paymentreform@scattergoodfoundation.org with your comments.



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