LEARNING COMMUNITY FEATURES

February 21, 2019 10:00 am

Call Instructions:

Please

- Mute your phone, microphone, and speakers on your computer/device
- *Enter your name/organization in the chat box feature for attendance*
- *We encourage active participation via Chat or audio*
    - Submit questions via the chat box feature
        - *Questions will be answered as submitted*
    - *Unmute yourself to ask question and participate in discussions*

Time to ask questions via audio will be offered for those on the phone

*6 - Toggle mute/un-mute

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Alternative Payment Models and Integrated Behavioral Health

Stephanie Gold, MD

SIM/TCPi Webinar
February 2019

With thanks to: Brian J. Park, MD MPH; Andrew Bazemore, MD MPH; Winston Liaw, MD MPH

Objectives

- Define the current major payment models in the United States
- Understand the strengths and limitations of different payment models for primary care and integrated behavioral health
- Describe the evidence for different payment models

What are we trying to pay for?

Key Definitions

- Value-based payment – refers to payment models that incentivize improved quality and decreased costs

- Alternative payment models – non-FFS methods of payment that incentivize cost control and/or quality

- Advanced alternative payment models
  – Quality Payment Program (MACRA) distinction
  – Subset of APMs selected by CMS that meet criteria:
    - Uses certified EHR technology
    - Incentivizes quality similar to MIPS
    - Either (1) medical home model expanded under CMMI or (2) bears downside financial risk
  – If enough patients/payments from advanced APMs, practices are part of advanced APM QPP track exempt from MIPS, receive 5% payment incentive.

HCP-LAN Framework

CATEGORY 1
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE

CATEGORY 2
FEE FOR SERVICE – LINK TO QUALITY & VALUE

A
Foundational Payments for Infrastructure & Operations
(e.g., care coordination fees and payments for HIT investments)

B
Pay for Reporting
(e.g., bonuses for reporting data or penalties for not reporting data)

C
Pay-for-Performance
(e.g., bonuses for quality performance)

CATEGORY 3
APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE

A
APMs with Shared Savings
(e.g., shared savings with upside risk only)

B
APMs with Shared Savings and Downside Risk
(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

3N
Risk Based Payments NOT Linked to Quality

CATEGORY 4
POPULATION – BASED PAYMENT

A
Condition-Specific Population-Based Payment
(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

B
Comprehensive Population-Based Payment
(e.g., global budgets or full/percent of premium payments)

C
Integrated Finance & Delivery Systems
(e.g., global budgets or full/percent of premium payments in integrated systems)

4N
Capitated Payments NOT Linked to Quality

Payment Models

- **Fee for Service**
- Traditional Capitation
- Pay for Performance
- Shared Savings
- Blended FFS and Capitation
- Bundled Payment
- Direct Primary Care
- Comprehensive Primary Care

Fee For Service

- Patient sees provider → provider bills for services → insurance reimburses services rendered*

Positives	Negatives
Role for low-cost, under-utilized services (e.g., vaccines)	Incentivizes volume of services, without regard to what is appropriate
	No incentive to control costs
	No linkage to quality

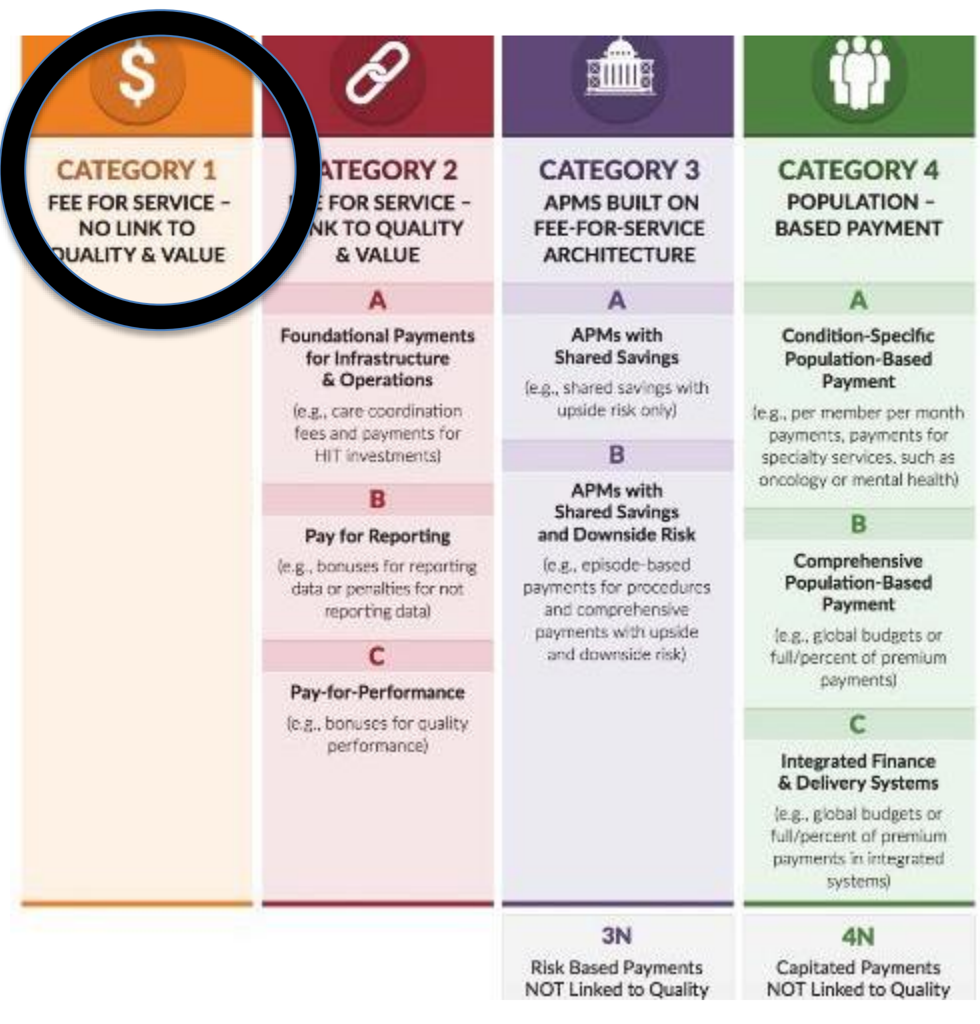
- Who bears risk?
  – Insurers, patients via cost-sharing (copays, deductibles)

*Specialty-dominated RUC largely defines payment for different services

FFS- The Evidence

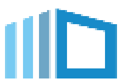
- What we have now: increasing costs, widespread variation in care delivery, poor population health outcomes, primary care workforce shortage and high burnout levels

FFS



Implications for Integrated BH

- Many integrated care services do not have billable codes
- Fee schedule favors procedural care over cognitive care



Payment Models

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Traditional Capitation

- Insurance pays PMPM independent of services to practice → patient sees provider

Positives	Negatives
Allows for proactive care (e.g., invest in primary care infrastructure)	Significant financial risk to practices/clinicians
Incentivizes cost savings	Encourages inappropriate under-delivery of services, “cherry-picking” patients
	No linkage to quality (except to avoid downstream utilization for cost control)

- Who bears risk?
  - Clinicians/practices

Traditional Capitation - The Evidence

- Example: growth under managed care (HMOs) in the 80s and 90s
- Takeaway: Results mixed, some suggest lower costs and lower patient satisfaction. Growth under managed care led to patient and provider backlash concerning gatekeeping/decreased choice and financial risk.

Traditional Capitation

Implications for Integrated BH

- Flexibility of prospective funds can be used more flexibly for a variety of integrated services
- Some concern that if there is no other requirement/incentive for integration, money will be used up for physical health conditions

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Pay for Performance

- FFS/Capitation +/- payment for specific quality targets

Positives	Negatives
Links care to quality	Shortcomings of underlying payment system prevail
May improve targeted metrics	Non-targeted metrics may worsen or not improve
	Quality often measured via disease-oriented, process metrics (vs. patient-centered, true outcomes)
	Significant administrative burden

- Who bears risk?
  – Same as underlying payment model, with some more risk to providers for meeting/not meeting targets

Pay for Performance - The Evidence

- Example: Quality Outcomes Framework (QOF)

- Takeaway: P4P can improve what it pays for; overall results and ROI are modest. May lead to significant administrative burden.

Pay for Performance

Implications for Integrated BH

- Integrated services are incentivized if there are behavioral health metrics selected (or indirectly incentivized if looking at whole health outcomes)

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Shared Savings and ACOs

- Insurance pays risk-adjusted PMPM to organization (ACO) → organization reimburses providers → patient sees provider → savings are shared between insurer and organization*

Positives	Negatives
Incentivizes cost savings	Encourages inappropriate under-delivery of services
Allows for proactive care (e.g., invest in primary care infrastructure)	Lag in receiving savings can limit ability to invest upfront in needed primary care infrastructure
	Payments and cost benchmarks often based on prior years → can reward high spenders

- Who bears risk?
  - Overarching organization (ACO)

*can have one-sided or two-sided risk models

Medicaid Regional Accountable Entities

HCPF
CO
COLORADO
Department of Health Care Policy & Financing

PMPM $
$ Capitated Payment
$ Fee for Service Payments

Regional Accountable Entity (RAE)

PMPM or Other Arrangement $
$ Fee for Service or Other Arrangement

Primary Care Services

Behavioral Health Services

- **Region 1:** Rocky Mountain Health Plans
- **Region 2:** Northeast Health Partners
- **Region 3:** Colorado Access
- **Region 4:** Health Colorado, Inc.
- **Region 5:** Colorado Access
- **Region 6:** Colorado Community Health Alliance
- **Region 7:** Colorado Community Health Alliance

Image credits: Colorado Health Institute

Shared Savings - The Evidence

- Examples:
  - Physician Group Practice
  - Medicare Shared Savings Program
  - Hennepin Health

> Those who have one foot in the canoe, and one foot in the boat, are going to fall into the river.
> Proverbs

- Takeaway: Mixed results. Providers still often paid on FFS basis. May need to focus efforts on high cost, high care beneficiaries and include social services.

Shared Savings

Implications for Integrated BH

- Reinvestment dollars could be used flexibly for integrated care
- Proactive use of funds at the practice level can be limited if the practice is still reimbursed via FFS

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Blended FFS and Capitation

- FFS + PMPM (e.g., payments for: PCMH, care management, etc.)

Positives	Negatives
Partially allows for proactive care	Shortcomings of underlying payment system prevail
Risk-adjustment (if done) mitigates against cherry-picking	No explicit linkage to quality

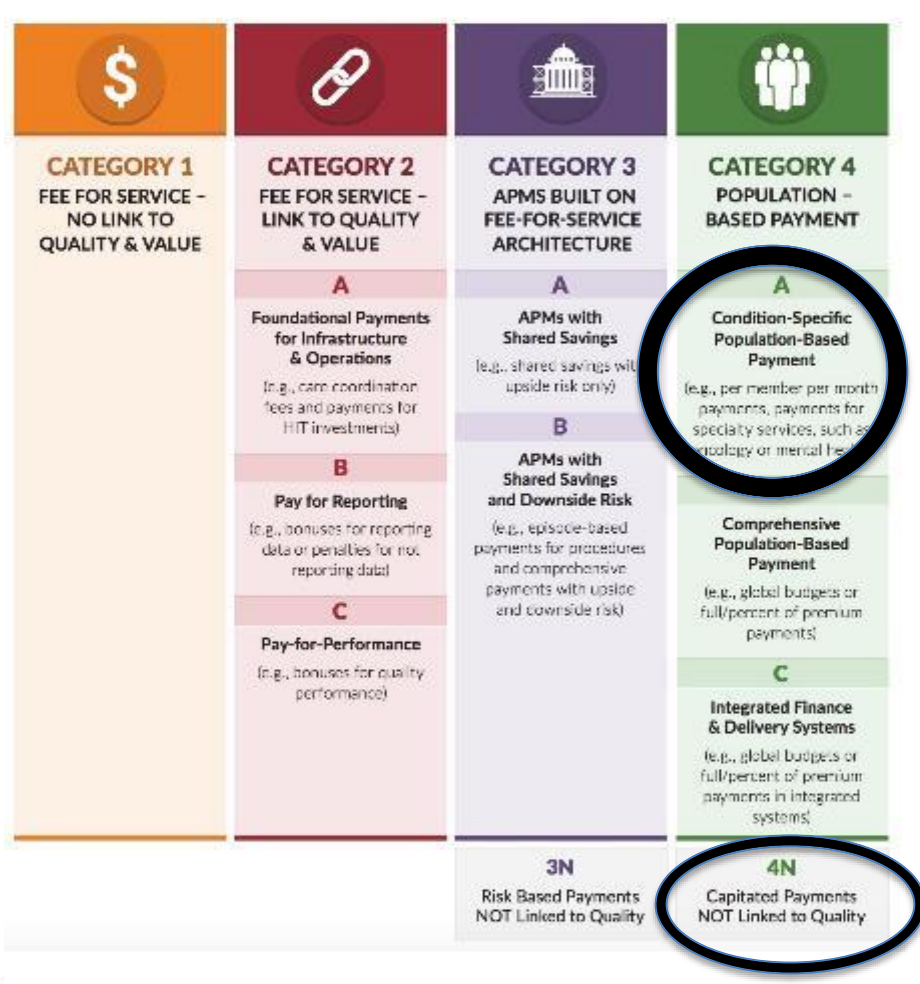
- Who bears risk?
  - Similar to whichever model is predominant

Blended FFS / Capitation - The Evidence

- Examples:
  - Community Care of North Carolina
  - Multi-payer Advanced Primary Care Practice (MAPCP)
  - Comprehensive Primary Care Initiative

- Takeaway: Mixed results. Lessons learned from effective programs: multipayer collaboration, real-time data sharing, targeting high utilizers.

Blended FFS and Capitation



Implications for Integrated BH

- As under traditional capitation, the PMPM amounts could be used flexibly for integrated care, but in many instances of this model there are specifications on use of the PMPM (ie for care coordination)

Payment Models

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Bundled payment

- Patient seeks care for a defined episode → insurance reimburses practice/organization with a global payment

Positives	Negatives
Incentivizes control of costs within the episode	Could incentivize inappropriate under-delivery of services
Global payment allows for flexibility in how money is used	No incentive to decrease number of episodes
	Very difficult to define an "episode" in primary care

- Who bears risk?
  - Practices/organizations

Bundled Payment - The Evidence

- Example:
  - PROMETHEUS (primary care)
  - BCPI (non primary care)
- Takeaway: Defining episodes of care for primary care patients with multimorbidity is near impossible. Bundled payments for acute care show promise but may be faulty when based on historic payments and no downside risk to participants.

Bundled Payment

Implications for Integrated BH

- Bundled payments could be used for conditions such as depression, but difficult to determine what is included or not included in a bundle
- Integrated services may not be diagnosis-specific

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Direct Primary Care

- Patient pays monthly fee directly to practice → sees provider +/- payments for additional services

Positives	Negatives
Allows for flexible, proactive care (e.g., invest in primary care infrastructure)	Risk of higher patient cost-sharing for any non-primary care needs
Incentivizes control of (primary care) costs	Could worsen workforce shortages
	No linkage to quality

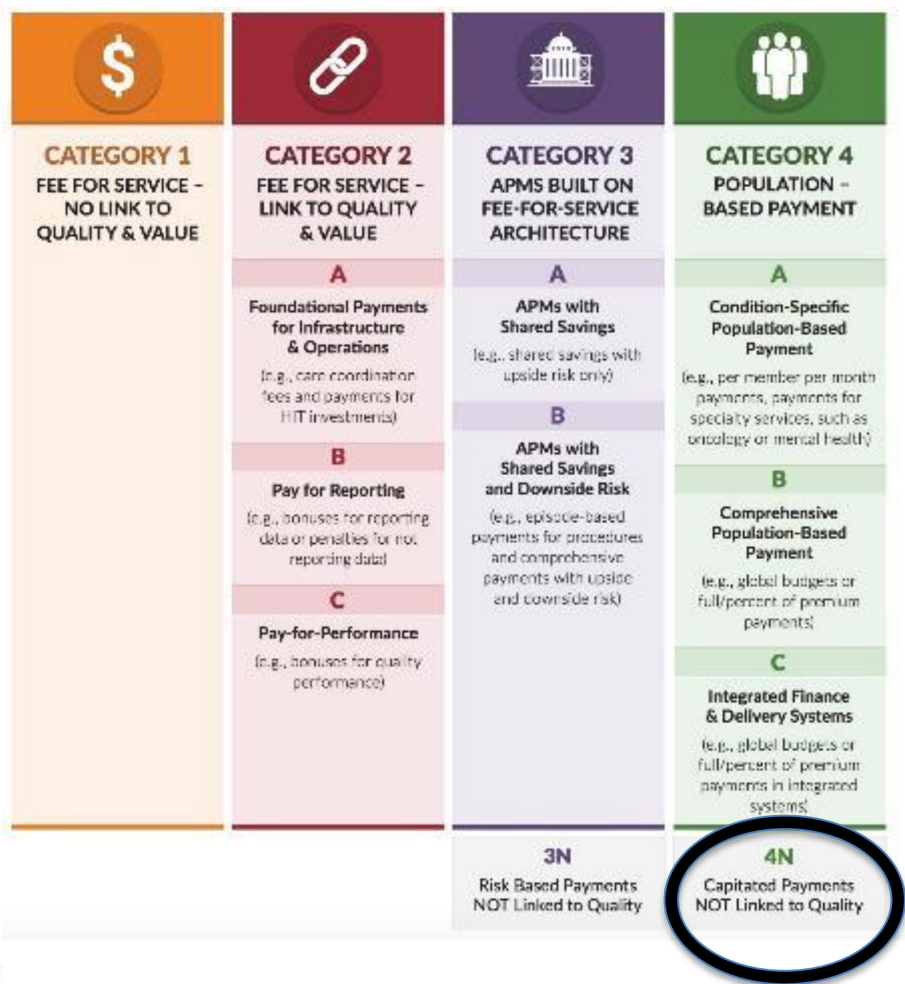
- Who bears the risk?
  - Patients for anything outside of primary care services, practices/clinicians with regard to primary care services

Direct Primary Care - The Evidence

- Example: Qliance

- Takeaway: Improved patient and provider satisfaction. Possible effects on decreased utilization. Some concerns about financial sustainability. More evidence needed.

Direct Primary Care



Implications for Integrated BH

- Similar to capitation, funds can be used flexibly for integration
- Concern that funds could be used up by other needs felt to be more pressing

Payment Models

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- **Comprehensive Primary Care**

Comprehensive Primary Care Payment

- Insurance pays risk-adjusted PMPM to the practice [plus bonuses for meeting quality targets] → patient sees provider

Positives	Negatives
Allows for flexible, proactive care (e.g., invest in primary care infrastructure)	Encourages inappropriate under-delivery of services
Incentivizes control of (primary care) costs	Same limitations on using quality metrics as with P4P
Risk-adjustment mitigates against cherry-picking	
Includes linkage to quality	

- Who bears risk?
  - Clinicians/practices

Comprehensive Primary Care - Evidence

- Example: Iora Health
  - (CPC+ Track 2 close to this)

- Takeaway: Possible improvements in patient satisfaction, health outcomes, decreased costs. More study needed.

Comprehensive Primary Care

Implications for Integrated BH

- Same implications as P4P and capitation
- Risk-adjustment helps ensure there are sufficient funds to meet patient needs

It’s not that simple

- Mixed models (capitation+ FFS +/- shared savings +/- P4P)
- A given practice has multiple contracts with multiple payers
- Blurred lines/definitional confusion (ie “DPC” contracting with insurance)
- Outcomes reflect change in *delivery* model, but change in payment model enables change in delivery
- How the practice is paid is not the same as how the clinicians are paid
- Separated payment streams for behavioral health, social services, public health

Designing an ideal payment model..

1. Base payment for primary care in PMPMs to allow flexibility and a proactive approach

2. Risk adjust at the patient- and community- level

3. Align efforts across payers to decrease administrative burden and increase effectiveness of incentives

4. Include payment for behavioral health, public health, and social services in a primary care global budget

5. Where payment is tied to quality, select patient-oriented measures appropriate for primary care that do not create overly burdensome requirements

Questions?

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SUGGESTIONS FOR FUTURE TOPICS

REGISTER NOW

DENVER METRO SIM CLS
THURSDAY MARCH 7, 2019

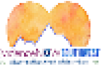
WESTERN SLOPE SIM CLS
FRIDAY MARCH 8, 2019

REGISTRATION LINK OPEN UNTIL FEBRUARY 28;
HTTP://WWW.PRACTICEINNOVATIONCO.ORG/

FUTURE PTO EVENTS

- **2/26 – CO QPP Coalition Webinar; "Kick-Start to 2019" noon- 1 pm**
- **2/27 – SIM PTO Training; Cohort 2 & 3, Introduce BB8, BB9, BB10; Share Tips & Tricks; 9-10 am**
- **2/28 – SPLIT Office Hours: 9 - 10 am**

- **March 2019**
- **3/7 – Virtual Colorado MAT Learning Forum 12:30 – 1:30 pm**
- **3/7 – SIM CLS Denver; 8 am – 4 pm**
- **3/8 – SIM CLS Grand Junction; 9 am – 4 pm**
- **3/12 – TCPi PTO Touchbase; 9-10 am**
- **3/15 – QPP Coalition; MIPS 101 11 am - noon**
- **3/18 – TCPi APM Convening Mtg**
- **3/19 – CHITA Learning Community; 3-4 pm**
- 3/20 -- MGMA Practice Webinar; 12-1 pm
- 3/21 -- Learning Features Call; Value Based Payment/Cost and Utilization 10 -11 am



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