Next Generation Models for Health Plan Behavioral Health Service

OPEN MINDS Executive Retreat
Sept. 19, 2018
Managing people with multiple chronic conditions has become more prevalent and a challenge for clinicians and health plans. People with mental health conditions may not receive the care needed for their medical conditions.
Agenda

• National Trends
• Florida Potentially Preventable Events
• Health Home Models
• Value Based Purchasing Continuum
• Business Model Transformation for Behavioral Health Services
National Trends – Our Challenge

Health Spend

88% Medical Services | 4% Healthy Behavior | 8% Other

5% of patients account for 50% of total healthcare expenses

Key cost driver: Behavioral disorders — 68% of adults with BH conditions also have PH conditions.

Sources: Bipartisan Policy Center, “F” as in Fat: How Obesity Threatens America’s Future (TFAH/RWJF, Aug. 2013)
National Trends – Our Challenge

• Healthcare spending grew from 13.3 % of GDP in 2000 to **17.8%** in 2015.

• Per capita spend on healthcare was $2,657 in 1990. Jumped to **$9,508** in 2015.

• State and local Medicaid per capita spend grew from $296 in 2000 to **$626** in 2015.

Super Utilizers

• 5% of Americans consume **half of all** healthcare resources.

• **Frequent and preventable use** of expensive healthcare settings often to blame.

• This group, often referred to as “**super-utilizers**,” is individuals with multiple illnesses whose care is uncoordinated and fragmented, resulting in high resource use.

More than 80% of Medicaid Super-Utilizers have a comorbid mental illness.

In 44% of Medicaid Super-Utilizers, mental illness is in the form of a Serious Mental Illness.
Florida Potentially Preventable Events

The state of Florida calculated Potentially Preventable Events (PPE) for all Medicaid recipients for the period of July 2015 to June 2016:

- **44%** of PPEs for admissions were for conditions that could be managed with outpatient care.
  - Rate: 1.87 per 1,000 enrollee months

- **49%** of PPEs for readmissions were due to a continuation or recurrence of a condition from the initial admission.
  - Rate: 87.95 per 1,000 hospital admissions

- **Over 75%** of all ER visits were considered a PPE; of those 57% were due to conditions that might be treated in a primary care setting.
  - Rate: 24.13 per 1,000 enrollee months

There was a slight increase in PPEs for readmissions and ER visits from the previous year.
Florida Potentially Preventable Events

Top 5 reasons for a PPE for an admission:
• COPD
• Congestive Heart Failure
• Other pneumonia
• Seizure
• Kidney and UTI

Top 5 reasons for a PPE for an ER visit:
• Upper respiratory infections
• Abdominal pain
• Gastro/vomiting
• Muscle/connective tissue
• Chest pain

Top 5 reasons for a PPE for a readmission:
• Schizophrenia (23.7% of top 10)
• Bipolar disorders (15.5% of top 10)
• Sickle cell anemia
• Major depression (10.2% of top 10)
• COPD

These 3 BH conditions accounted for almost half of the top ten PPEs for readmissions. (Bipolar disorders and major depression are the most common for children.)
Plan Specific Driving Diagnoses

Top 5 Med/Surg and BH admits by ETGs:
1. Mental diseases and disorders (16%)
2. Diseases of respiratory system
3. Diseases of circulatory system
4. Infectious and parasitic diseases
5. Diseases of digestive system

Top 5 Med/Surg and BH readmits by ETGs:
1. Mental diseases (21%)
2. Diseases of circulatory system
3. Diseases of respiratory system
4. Infectious and parasitic diseases
5. Diseases of digestive system

Many readmissions are within 5 days of discharge.
Social Determinants

A social determinant score is calculated for each member as part of the population stratification. Information obtained from health risk assessments, claims data (Z codes) and census data from American Community Survey.

- Census data used: single parent household, income, years of school completed, households with public assistance income, individuals without insurance and crime rate.

<table>
<thead>
<tr>
<th>Category</th>
<th>Elements Included</th>
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<tbody>
<tr>
<td>BH Risk</td>
<td>Depression, substance use/abuse, tobacco use</td>
</tr>
<tr>
<td>Housing</td>
<td>Stable housing, homelessness, transportation needs</td>
</tr>
<tr>
<td>Poor Economic status</td>
<td>Education, health literacy, employment, food, finances</td>
</tr>
<tr>
<td>Safety</td>
<td>Member feels safe in home/community, abuse or neglect, ability to navigate in home</td>
</tr>
<tr>
<td>Social Supports</td>
<td>Availability of community resources, help in home, language or cultural issues, communication needs</td>
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# Social Determinant Drivers

<table>
<thead>
<tr>
<th>Known information</th>
<th>Ranking</th>
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<tbody>
<tr>
<td>HRS and claims</td>
<td>1) BH risks, 2) poor economic status, 3) social supports, 4) housing, and 5) safety</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Census information</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public information</td>
<td>1) housing, 2) safety, 3) social supports, 4) poor economic status and 5) BH risks</td>
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Approach to address:

1) Work with the resources in the community to link members with needed services
2) Identify partnerships to help address at a broader community level.
Integration Value

A model that integrates physical and behavioral healthcare is essential to optimizing outcomes.

Consumers with behavioral disorders are often ‘super-utilizers’ of healthcare resources.

Undiagnosed and/or untreated behavioral health conditions hinder medical treatment.

Consumers with comorbid behavioral and chronic medical conditions have higher average costs.

Lack of integrated care results in poorer outcomes and higher costs per consumer.
Health Home Models
Health Home

A health home defined as a designated provider (including a provider that operates in coordination with a team of healthcare professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.

Health home services include:

• Comprehensive care management
• Care coordination and health promotion
• Comprehensive traditional care, including appropriate follow-up from inpatient to other settings
• Patient and family support
• Referral to community and social support services
• Use of health information technology to link services
Patient Centered Medical Home

The National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home Recognition program describes PCMH as a model of care that emphasizes care coordination and communication to transform primary care into “what patients want it to be.” Patients in medical homes receive the right care, in the right amount, at the right time.

Provide whole person/comprehensive care and self management support across the spectrum of care needs, including:

• Preventive care
• Routine and urgent care
• Mental health
• Advice, assistance, and support for making changes in health habits and making healthcare decisions
Non PCP Medical Home

NCQA’s Patient-Centered Connected Care™ Recognition program supports clinical integration and communication, creates a roadmap for delivering intermittent or outpatient treatment, does not act as the primary care provider for a majority of its patients, and can effectively communicate and connect with primary care and fit into the medical home “neighborhood.” The recognition program:

• Supports the use of evidence-based guidelines in treating patients.
• Provides a consensus-driven framework for how non-PCMH and non-specialty sites fit within the medical home neighborhood and how they connect to primary care.
• Helps providers become a part of the medical home neighborhood, resulting in better outcomes and improved patient experience.
• Improves trust among providers.
• Helps reduce waste in the healthcare system, such as duplication of procedures and unnecessary readmissions or hospitalizations.
Integrated Model

• Substance Abuse and Mental Health Services Administration’s (SAMSHA) nationally-recognized definition of whole-person health care is a systematic and bi-directional integration that includes the continuous communication and coordination of physical health (PH), behavioral health (BH), and/or substance use disorder (SUD) treatment.

• Integrated care exists in different forms including but not limited to coordinated integrated care (in which care is referral triggered with periodic exchanges between BH and PH staff), co-location (in which BH and PH services are available within the same building), and integrated (in which a patient-centered care model exists and integrates treatment plans developed by BH and PH staff).
SAMSHA’s Integrated Model

• Patient-centered care team providing evidence-based treatments.

• Behavioral health generalist as part of the medical team.

• Finding the right person, setting the right expectations, and providing the right support.

• PCPs building new knowledge and skills related to psychiatric medication.

• Screening all patients for other health conditions (including behavioral health) in addition to the presenting problem.

• Measuring the quality and outcomes of care.

• Providing care coordination that supports information sharing across providers, patients, types and levels of services, sites, and timeframes.

• Using clinical pathways as one of the main decision-support and quality management tools.

• Population-based care, instead of focusing on individual patient outcomes.

• Medical records for communicating findings and treatment recommendations.
Integration Challenges

• Current models are heavily Primary Care Physician based

• Inconsistent physical/behavioral health communications and sharing of treatment plans for common patients

• Members may see multiple behavioral health providers

• Lack of member attribution model for behavioral health providers

• What information can be shared with a behavioral health provider, outside the care they provide

• Minimal financial incentives for behavioral health providers
Financial Models
Summary of Financial Models

• Existing models have focused on primary care providers
• Some pay for performance for specialists and hospitals
• Bundled payments for some services, many follow CMS program
• More complex financial models must attribute membership to a particular practice and allocate all cost of care to that population
• Practices must be able to financially and clinically manage a population for risk models and have the IT and/or electronic medical records to support monitoring
Framework for Value Based Purchasing

• Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) continuum is a well known framework. It was launched in March 2015.

• This framework establishes a continuum of clinical and financial risk for provider organizations, which moves providers toward payments not solely based on cost but improvement in quality and health outcomes.

• Value Based Purchasing models must evolve with provider capabilities over time and provide support for the increased accountability.
# APM Framework

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<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
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<tbody>
<tr>
<td>FFS – No link to quality and value</td>
<td>FFS – with link to quality and value</td>
<td>APMs built upon FFS</td>
<td>Population-based payment</td>
</tr>
<tr>
<td>FFS payments only</td>
<td>Foundational payments for infrastructure and operations (e.g. care coordination fee)</td>
<td>APMs with shared savings (e.g. upside risk only)</td>
<td>Condition-specific population-based payment (e.g. pmpm for oncology or SPMI patients)</td>
</tr>
<tr>
<td></td>
<td>Pay for reporting (e.g. additional payment for reporting data, such as blood pressures)</td>
<td>APMs with shared savings and downside risk (e.g. episode-based payments for procedures and upside and downside risk)</td>
<td>Comprehensive population-based payment (e.g. global budgets or full/percent of premium payments)</td>
</tr>
<tr>
<td></td>
<td>Pay-for-performance (bonuses for reaching targeted rates for specific measures)</td>
<td>Risk based payments not linked to quality</td>
<td>Integrated finance and delivery systems (e.g. global budgets or full/percent of premium payments in integrated systems)</td>
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<tr>
<td></td>
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<td></td>
<td>Capitated payments not linked to quality</td>
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Value Based Purchasing Continuum
Sunshine Health Incentive Framework

Provider Transition Journey

- Activity Based Payments
- Pay for Performance (P4P)
- HBR Upside
- Enhanced Primary Care Program
- Population Health – Total Cost of Care
- Preferred Provider Partnerships

We align providers to appropriate models based on their readiness to an outcomes based model.

HCP-LAN APM Framework, Category on Continuum of Increasing Risk

- Upside only models
- Up and Downside models

Provider Capabilities Being Assessed

- Location & Physician Types
- Assigned Members
- Additional Services
- VBP Experience
- EHR Use / Meaningful Use Achieved
- PCMH Certification
- HEDIS Scores / System Knowledge
BH VBP Continuum Examples

Paying for activities or pay for performance, such as HEDIS measures for:

- Adherence to antipsychotic medications in those with schizophrenia
- Diabetes monitoring for those with diabetes and schizophrenia
- Cholesterol and blood sugar testing for youth on antipsychotic medications
- Visit in 7 days post BH inpatient discharge

Behavioral Health Homes who provide integrated BH and PCP services:

- FFS per service plus shared savings
- Capitation payment plus shared savings

Population Health:

- Health home for those with SMI
  - Responsible for total cost of care and a risk model

- BH IPA model
BH IPA Overview
What is a BH IPA?

An Independent Practice Association (IPA) is a network of providers who agree to participate in an association to contract with managed care plans. Providers maintain ownership of their practices and administer their own offices; the IPA serves as a corporate structure for negotiating and administering managed care contracts for its members.

Why an IPA?

Innovative care delivery models are needed to impact the health of consumers. Behavioral health needs have a significant impact on the total cost of care. Centene is interested in developing and supporting models of care that improve access and outcomes for individuals with behavioral health needs and believes that doing this in partnership with behavioral health providers creates a model that is effective and sustainable.
BH IPA Value

Mission: Create a statewide network to provide culturally appropriate behavioral health services that is integrated with physical health services and meets the needs of differing communities, individuals, families with a focus on excellent customer service objectively measured through metrics that demonstrate improved health outcomes.

Structure: A BH IPA services as a structure for negotiating and administering managed care contracts for its members. The BH IPA determines quality expectations, shared infrastructure, and how to invest revenue. The BH IPA accepts capitation payment from managed care plans and distributes the revenues to participating providers.

Goals:

<table>
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<tr>
<th>• Align providers</th>
<th>• Leverage scale and efficiencies</th>
<th>• Transform practices for success</th>
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<tr>
<td>• Speak with one voice</td>
<td>• Leverage plan and provider expertise</td>
<td>• Develop strategies for integrated health homes</td>
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Transition to BH IPA Model

**Current**

- Fragmented with limited recognition for value created
- MCOs
- BHOs
- FFS based contracts

**Near term**

- Streamlined operations with predictable cash flow
- Capitated Outpatient Contracts, gain sharing on inpatient services
- IPA
- Outpatient encounter/capitation

**Long term**

- Delivery system reform tied to value-based payments
- Capitated BH services, coordination with physical health
- IPA
- Outpatient and/or Global Capitation
- Hospital Services
- FQHC
IPA’s as a Catalyst to Enable Value-Based Care

<table>
<thead>
<tr>
<th>Current</th>
<th>IPA</th>
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<tr>
<td>MCO Contracting</td>
<td>Efficient: Single contract with minimal administrative overhead; leveraging scale of providers.</td>
</tr>
<tr>
<td>Payment Models</td>
<td>Value-Based: FFS + incentives; Pay for performance; predictable cash flow; shared savings.</td>
</tr>
<tr>
<td>Decision-Making</td>
<td>Self-directed: Provider defined; client focused; less onerous.</td>
</tr>
<tr>
<td>Technology/Data</td>
<td>Accessible: Claims and performance data; care management platform; real time updates; predictive risk stratification modeling; BH/physical health visibility.</td>
</tr>
<tr>
<td>Care Management</td>
<td>Provider Managed: Embedded care managers; shared assessment and care plan capability.</td>
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**Complex:** Multiple MCOs, multiple and varied requirements necessitating high administrative overhead.

**Outdated:** FFS based only; unpredictable cash flow; onerous reconciliation.

**Imposed:** Mandated MCO utilization management and rules; high administrative overhead.

**Siloed:** Systems not integrated with MCO or other providers; data limited to individual provider services.

**MCO Centralized:** Telephonic outreach to clients; limited coordination with providers; screening, assessment, and care plan duplication.
BH IPA Value to Providers

• Predictable and reliable cash flow.
• Risk of shifting to VBP will be mitigated through shared practices and learning.
• Empowers providers to have more ownership and ability to influence the BH system of care.
• A data-driven culture will be promoted by sharing and the utilization of actionable data that is benchmarked by provider organization and across providers.
• Partnership and integration between BH and PH providers will be incentivized and supported.
• BH and Integrated Health Home systems of care and positive outcomes will be enhanced through evidence-based and evidence informed practices with managed care plan investment/partnership.
• Forum to speak with one voice to the managed care plans.
Questions

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