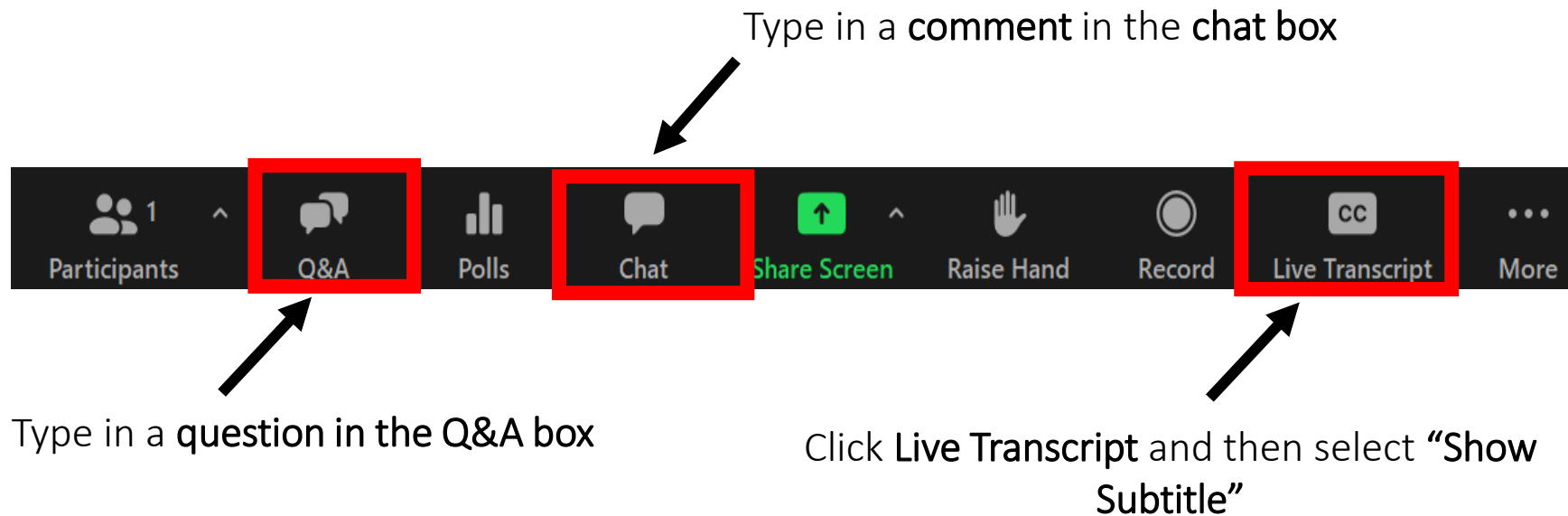# Comprehensive Health Integration Part 4: Payment Models for Comprehensive Health Integration

July 27, 2022
2-3pm EST

Questions, Comments & Closed Captioning

Type in a **comment** in the **chat box**

Type in a **question in the Q&A box**

Click **Live Transcript** and then select **"Show Subtitle"**

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Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services (HHS).

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Substance Abuse and Mental Health
Services Administration

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Poll #1: What best describes your role?

- Clinician

- Administrator

- Policy Maker

- Payer

- Other (specify in chat box)

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Poll #2: What best describes your organization? (check all that apply)

- Primary Care Provider

- Mental Health Provider

- Substance Use Treatment Provider

- Other (specify in chat box)

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Poll #3: Where is your organization in the process of integration?

- Learning/Exploring

- Beginning Implementation

- Advanced/Full Implementation

- Ongoing Quality Improvement

- Other (specify in chat box)

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Introductions

Joe Parks, MD
National Council for Mental Wellbeing
Medical Director, discloses consulting with Merck, Otsuka, Boehringer-Ingelheim

Andy K. Kelly, MBA
Vice President, Provider Enablement at Optum

Patrick Runnels, MD, MBA
Chief Medical Officer, Population Health – Behavioral Health
University Hospitals
Vice Chair, Psychiatry
Case Western Reserve School of Medicine

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Learning Objectives

- Discuss how different payment methodologies can support the "integratedness" of a particular program.

- Identify three CPT (Current Procedural Terminology) codes that support integration that your organization should consider utilizing.

- List at least three payment methodologies specific to making integration operational and visible within your organization.

- Identify at least one new payment methodology to support integration within your organization.

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Expert Panel and Editors

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National Council for Mental Wellbeing

Henry Chung, MD
Co-editor
Montefiore Care Management Organization/
Albert Einstein College of Medicine

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Jeff Reiter, PhD, ABPP
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Intellectual disAbility Services

Jared Skillings, PhD, ABPP
American Psychological Association

Tim Swinfard, MS, LPC
Compass Health Network

Rachel Talley, MD
University of Pennsylvania

Todd Wahrenberger, MD
Pittsburgh Mercy Health System

CENTER OF EXCELLENCE
for Integrated Health Solutions

Funded by Substance Abuse and Mental Health Services Administration
and operated by the National Council for Mental Wellbeing

Advancing Integrated Care Through Training and Technical Assistance

To advance the implementation of **high quality, evidence-based treatment** for individuals with co-occurring physical and mental health conditions, including substance use disorders.

Provide training, resources, and technical assistance to health practitioners and other stakeholders addressing the needs of individuals with co-occurring physical and mental health conditions, including substance use disorders.

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Current State of Implementation of Integration

Disappointing Uptake after 15 Years of Work

- Many Healthcare organizations have not attempted to implement any of the current models

- Often implemented as an isolated special project/service instead of a whole organization transformation

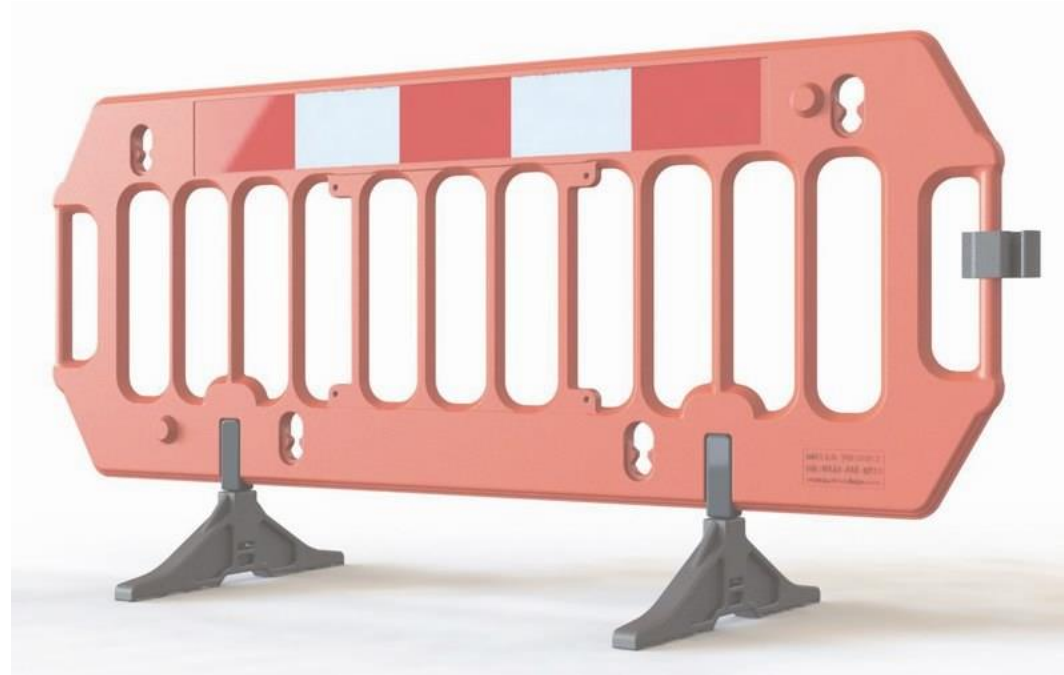- Often not sustained or expanded beyond initial grant funding

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Policy and Implementation Barriers

⚠ **Lack of flexibility in implementation of integrated services**

⚠ **Lack of connection of "integratedness" to value**

⚠ **Lack of appropriate bi-directional measures of progress in "integratedness"**

⚠ **Lack of financing to support either implementation or sustainability**

Comprehensive Healthcare Integration (CHI) Framework

What is the CHI Framework?

The CHI Framework provides guidance on implementing the integration of physical health and behavioral health to help providers, payers and population managers:

- Measure progress in organizing delivery of integrated services ("integratedness")

- Demonstrate the value produced by progress in integrated service delivery

- Provide initial and sustainable financing for integration
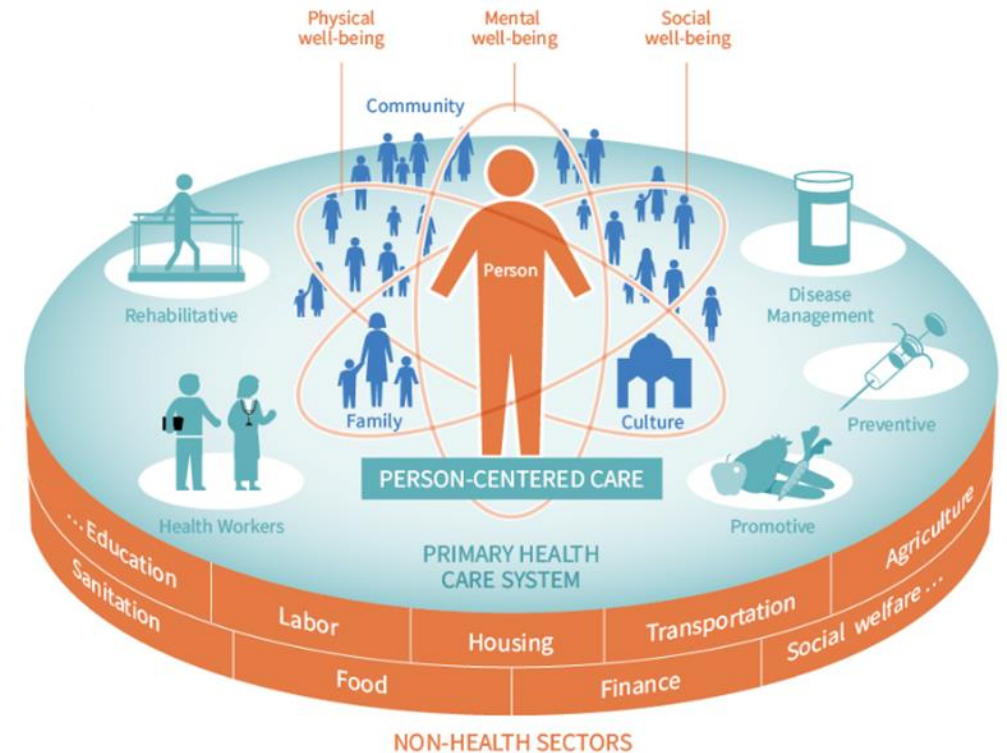
Components of the CHI Framework

- **Eight Domains** – Care processes related specifically to addressing physical health and behavioral health issues in an integrated manner.

- **Three Constructs** - Each Integration Construct describes an organized approach that has several evidence-based or consensus supported core service elements for "integratedness" tied to the indicators on the Eight Domains, each of which can be implemented flexibly depending on the capabilities of a provider organization and the priority needs of the population served.

- **Integration Metrics** – Measuring the degree of integratedness in care delivery and the improvement in outcomes from implementing integration that ties each Integration Construct to Value.

- **Integration Payment Methods** – Demonstrating how to cover costs of implementing and sustaining integration for each Integration Construct, incentivizing creating value through financing integration

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Eight Domains of Integration

Screening, Referral, and Follow-up

Prevention and Treatment of Common Conditions

Continuing Care Management

Self-Management Support

Multi-Disciplinary Teamwork

Systematic Measurement and Quality Improvement

Linkage with Community and Social Services

Sustainability

Three Integration Constructs: Core Components

- Describes an approach that has several evidence based or expert consensus supported core service elements drawn from the eight domains for "integratedness"

- Can be implemented flexibly depending on the mission, resources, incentives and capabilities of a provider organization.

- Are adaptable with some degree of consistency by organizations whose initial targets may range more basic to more advanced integratedness based on available resources.

- The names of the Constructs are driven by the Domains' primary integratedness workflows implemented to either measurably improve health outcomes or measurable processes that have been shown to directly result in improved health outcomes.

The Three Integration Constructs

Integration Construct 1:
Screening and Enhanced Referral

- Optimizes screening and "enhanced" referral processes
- Does not require significant investment
- Best practice for smaller practices/programs with fewer resources

Integration Construct 2:
Care Management and Consultation

- Includes robust program commitment to a set of screening and tracking processes with associated on-site care coordination and management

Integration Construct 3:
Comprehensive Treatment and Population Management

- Typically requires comprehensive PH and BH staffing in a single organization (hospital, independent clinical practice, FQHC, etc.)
- Measures improved health outcomes along the Domains

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Demonstrating Value Using CHI

Definition of Value: Measurable improvement in individual or population health, BH or PH outcome measures and/or increased equity and quality in relation to expenditure.

Identify one or more co-occurring conditions and/or populations to address through integrated service delivery.

Implementation of measurable indicators of integratedness and relevant outcome metrics for those conditions

Financing Goals

Financing implementation

- Initial implementation of an Integrated Construct: *example-staffing, care processes and infrastructure needed to provide Integration Construct 1 (Screening and Enhanced Referral).*

- Strengthening an existing Construct: *by adding more types of conditions or interventions, expanding access of those interventions to a higher percentage of the population served and/or increasing the outcome targets for the interventions provided.*

- Incentivizing progress from one Construct to the next: *supporting investment in necessary staffing, technology, infrastructure and change management to make progress in the relevant CHI Framework Domains.*

Financing sustainability

- Provide continued support for maintaining an existing level of integratedness via current provision of a specific Construct for a particular set of issues in a defined population.

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Types of Payment Methodologies for Integration

Current Procedural Terminology (CPT) Service Code Payments (usually fee-for-service).

- Single Service payment codes: (e.g., screening, individual care coordination, etc.)
- Bundled service payment codes: (e.g., COCM, Medication treatment for opioid use disorder, etc.)

Care Enhancement Payments (usually Per Member Per Month or Prospective Payment System): a bundled payment for provision of specific service structures and processes, for the entire population served or (for per member per month) for a defined population.

Value-based payments (VBPs): usually a supplemental payment for achieving a prospectively determined value target. Provides reward (and sometimes penalty) linked to achieving clinical quality process or outcome goals and/or cost savings goals. For entities engaged in population management, this approach usually also involves capitation payments with some level of risk sharing.

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Examples of Currently Available CPT Codes Relevant to Integration

- HBAI codes – CPT 96156- 96171
- SBIRT CPT - codes 99406-99409
- Preventive Medicine (99401-99412)
- BH screens and repeat measures (96127)
- Developmental/Behavioral screens (96127)
- Adaptive Behavior Services (97151-97158)
- General Behavioral Health Integration Care
- Management – CPT 99484
- CPT codes for specialist consultation (99241-99245)
- CPT codes for health education, wellness coaching
- Collaborative Care codes
- Bundled payment for MAT
- Medicare – Chronic Care Management, Complex CCM, Principal CM, Transitional Care Management TCM
- Interprofessional Telephone/ Internet/Electronic Health Record Consultations codes 99446, 99447, 99448, 99449, 99451 to report interprofessional telephone/ Internet/electronic health record consultations

Currently Available Examples of Care Enhancement Payments May Include:

- Per-member, per-month (PMPM) payments
  - Person Centered Medical Home (PCMH)
  - Medicaid Primary Care Management (PCCM)
  - Section 2703 health home for chronic conditions (behavioral health and physical health as well as SUD and child and adolescent populations)

- Prospective Payment System (PPS)
  - Certified Community Behavioral Health Center (CCBHC)
  - FQHC in some states
  - Primary Care First (Medicare)

- Grant funding methodologies

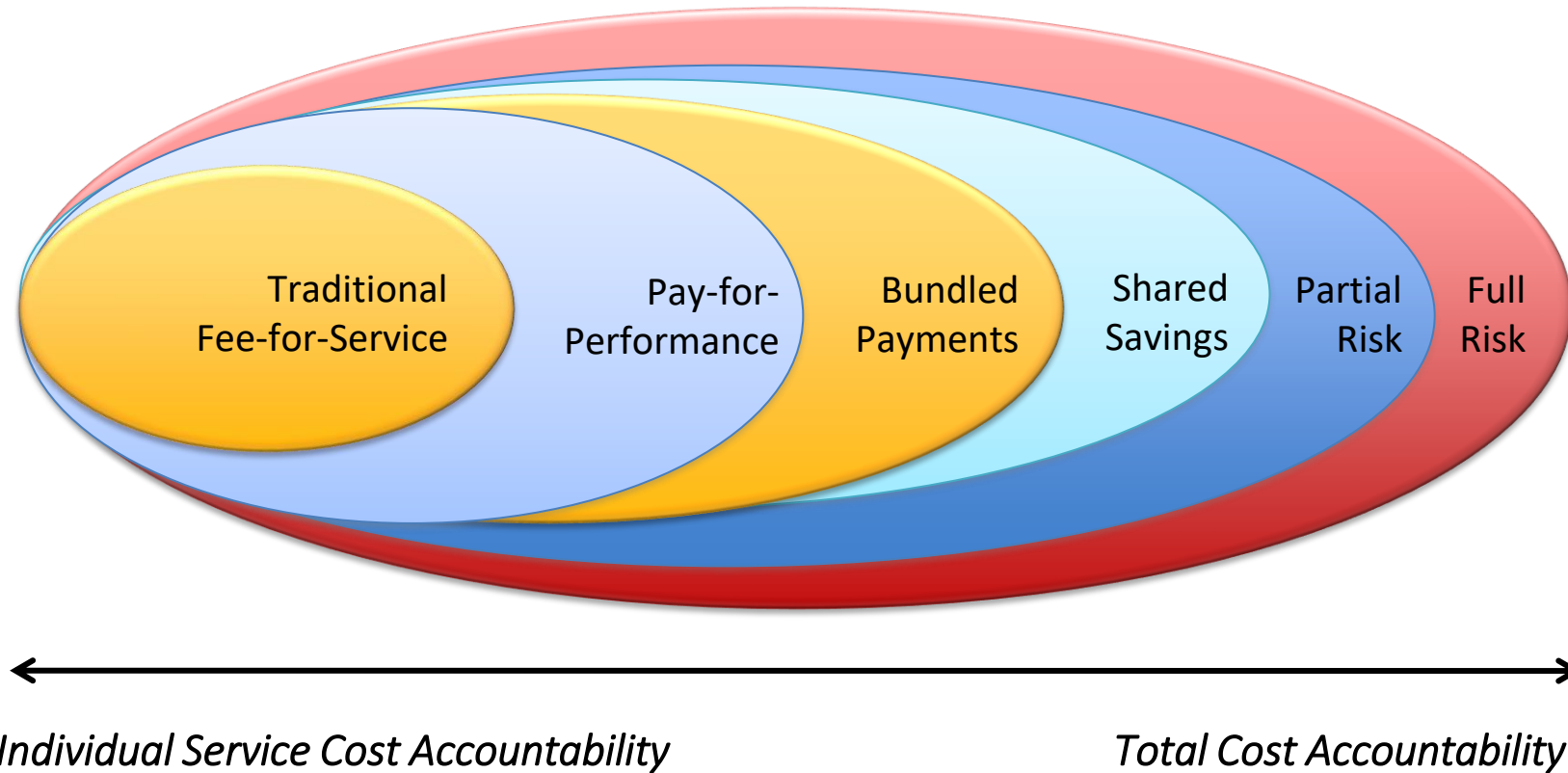NATIONAL COUNCIL *for* Mental Wellbeing

Currently Available Payment Methodologies That Include a Value-Based Component:

- Accountable Care Organizations (ACO) including sub-capitation

- Medicare Shared Savings Plan (MSSP)

- State-based Medicaid Savings Initiatives

- Merit-based Incentive Payment System (MIPS)

- Bundled or Episode-based Payments

- Performance-based Incentive Payments (PBIP), which are frequently included in the following programs:
  - Person-Centered Medical Home (PCMH) PMPM
  - Medicaid Primary Care Case Management (PCCM) PMPM
  - Certified Community Behavioral Health Center (CCBHC) PPS
  - FQHC
  - Section 2703 health home for chronic conditions – PMPM

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Types of Payment Methodology

Traditional Fee-for-Service · Pay-for-Performance · Bundled Payments · Shared Savings · Partial Risk · Full Risk

Individual Service Cost Accountability → *Total Cost Accountability*

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Payment Methodologies to Facilitate Implementation of Integrated Constructs

- **Implementation Grants** - Initial costs of planning, consultants, new staff recruitment, training, IT costs, technical assistance

- **CPT Code Payments** - Useful to incentivize implementation and utilization of selected specific interventions (developmental screening- 96127). Setting the rate above breakeven is often necessary to adequately incentivize the investments in staffing and infrastructure to implement

- **Care Process Bundled Payments** - Useful to incentivize multidisciplinary care processes that are applied across multiple specific treatments such as care coordination and disease management. Usually requires reporting on staffing and processes for accountability.

- **Value-based Payments -** Versatile, can be applied to either implementation goals (Structure or Process) or outcome goals. This is easy to change over time, as initial goals are met and new goals are chosen.

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Example - Combining Incentive Payment Methodologies for integrating care for Substance Use Disorder

- Care process bundled payment for implementing a standard section 2703 health home with the staffing requirements that include substance abuse counseling in the final bundled payment set at a rate more than bare minimum to cover the costs.

- CPT code billing allowed in addition to the health home bundled Payment for SBIRT screening incentivizes implementation and ongoing substantial utilization of SBIRT screening

- Value-based payment for meeting or exceeding target of percentage of people newly diagnosed with SUD who are subsequently engaged in treatment within 30 days incentivizes following through to get person screening positive for SUD engaged in treatment

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Matching Payment Methodology to Sustainability of Each Integration Construct (1/3)

Integration Construct 1 – Screening and Enhanced Referral

- A time-limited start up grant to cover initial implementation costs

- CPT code services that specifically support integration with rates set to adequately cover costs and incentivize uptake.

- Value-based incentive payment for timely implementation of the necessary screening and referral structures or performance measures related to screening and referral

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Matching Payment Methodology to Sustainability of Each Integration Construct (2/3)

Integration Construct 2 – Care Management and Consultation

- A time-limited grant to cover implementation costs of evidence-based integration programs

- Bundled Care Enhancement Payments with rates set to adequately reflect costs of the specified staffing and integration processes

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Matching Payment Methodology to Sustainability of Each Integration Construct (3/3)

Integration Construct 3 – Comprehensive Treatment and Population Management

- Substantial access to Care Enhancement payment or risk-based capitation payment

- Value-based incentive payments for integration processes and outcomes

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Payer and Provider Case Studies

Andy K. Kelly, MBA
Vice President, Provider Enablement
at Optum

Patrick Runnels, MD, MBA
Chief Medical Officer, Population
Health – Behavioral Health
University Hospitals
Vice Chair, Psychiatry
Case Western Reserve School of
Medicine

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Provider Enablement Supports - Optum

A comprehensive, integrated, value-based program capability, designed to support providers in improving member and population outcomes, delivering person-centered care.

Provider alignment

- Engagement in cost and quality goals
- Provider-specific performance measurement
- Provider-tailored training, support and connectivity

Population health management

- Population identification and stratification
- Total cost of care management
- Contract-specific performance tracking

Proactive patient care

- Care gap identification and reporting
- Actionable, timely reporting and analytics

Payer partnership

- Patient benefit and digital tool availability
- Single point of contact for troubleshooting, provider engagement
- Partnership, not transactional engagements
- Alternative payment methods

Elements for success

Aligned incentives, case rates, shared savings, bundles

Quality metric alignment process, nationwide best practice distribution

Innovative solutioning with providers and stakeholders

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Integrated Behavioral Health Home Model

Optum

- Attribute members
- Pop health data management
- Actionable data
- Gaps in care data
- Performance reporting
- Consultant support and oversight

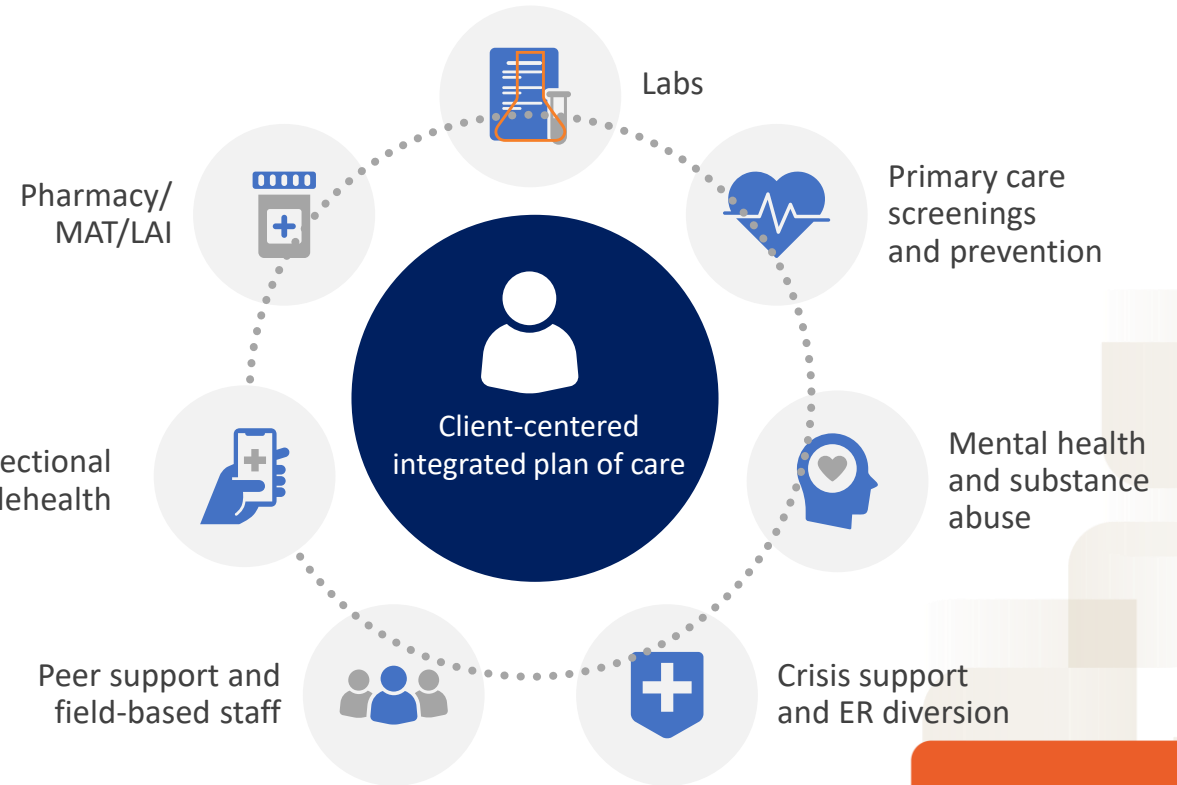**APM:** shared savings through total cost of care reduction

Quadruple Aim
Improved member and provider satisfaction, better health care outcomes, and lower costs

- Electronic interface: portal, shared CM platform
- Data integration/HIE
- Collaborative partnership
- Aligned incentives

SMI Health Home

Labs

Primary care screenings and prevention

Pharmacy/ MAT/LAI

Client-centered integrated plan of care

Mental health and substance abuse

Bidirectional telehealth

Peer support and field-based staff

Crisis support and ER diversion

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Optum Member Story

- **39-year-old female**
- **Medical diagnosis: Epilepsy, diabetes, asthma and pregnancy**
- **Behavioral health diagnosis: Major depressive disorder, possible schizoaffective disorder**
- **IBHH eligibility criteria met: BH diagnosis and ED utilization (14 visits)**

1 OBH **attributed the member** to the IBHH provider and provided the **monthly Population Health Report** that provides utilization and cost data for high-cost-/high-need members.

2 The IBHH **identified and prioritized the member for outreach** because of high ED utilization and **matched her to an IBHH CM** in her geographic area. The **IBHH CM outreached** the member about the program and initiated the intake process.

3 **Member opted into the program** and shared she was **using the ED at least monthly** in order to refill her psychiatric and physical health medications, plus she has seizures that are not well managed. She also stated she's **had trouble finding a PCP,** and in the last month learned **she is pregnant.**

4 **IBHH multidisciplinary team:**
- **Reviewed** the case
- **Secured releases of information**
- Collaborated with healthcare specialists
- Located a **psychiatrist** and scheduled her Intake appointment
- Followed up with the member after the appointment
- Confirmed her **enrollment in OP BH** services and that **prescriptions were received/filled**
- The team is working to **help locate a PCP, an OB/GYN and plans to coordinate with member's neurologist**

5 The OBH **PEC helped create connections between the IBHH and UHC's Healthy First Steps Program** so that timely outreach/assessment occurs, given that this likely qualifies as a high-risk pregnancy.

6 Over the next two weeks the **IBHH will complete any additional assessments/ screenings** and complete the member's **Health Action Plan** that will serve as a single plan of care that can be shared across the member's multiple providers.

Expected outcomes:
- Improved medication adherence
- Reduced ER Utilization
- Increased PCP engagement
- Improved pregnancy outcome

Key steps: OBHS PEC → IBHH Provider → Successful outcome for the member

IBHH reports the member is actively engaged, is in frequent contact with her IBHH CM, and is very appreciative to have the additional support.

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Early Indicators of Success

Behavioral IP admission rate

Acute inpatient

ED utilization

22%
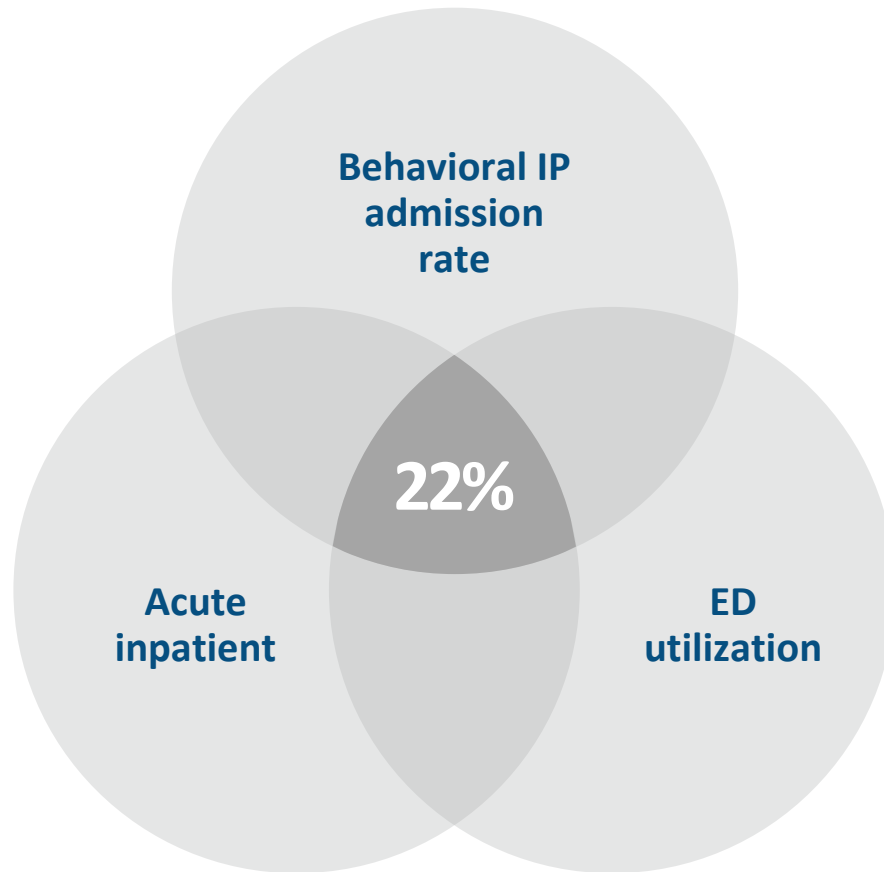
22% enrollment rate
Represents percentage of members opting into the program

25% reduction in acute IP
Based on frequency of medical admissions to IP facility

32% reduction in ED utilization
Based on frequency of visits to an ED

54% reduction in BH IP rate
Based on frequency of admission events to a BH IP facility

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Case Study #2: University Hospitals Health System – Cleveland OH

- 1.5 million unique patients served annually

- 600,000 individuals in value-based payment arrangements across all payer types

- ~400 primary care physicians (Primary Care Institute)

- ~60 Psychiatrists across the whole system

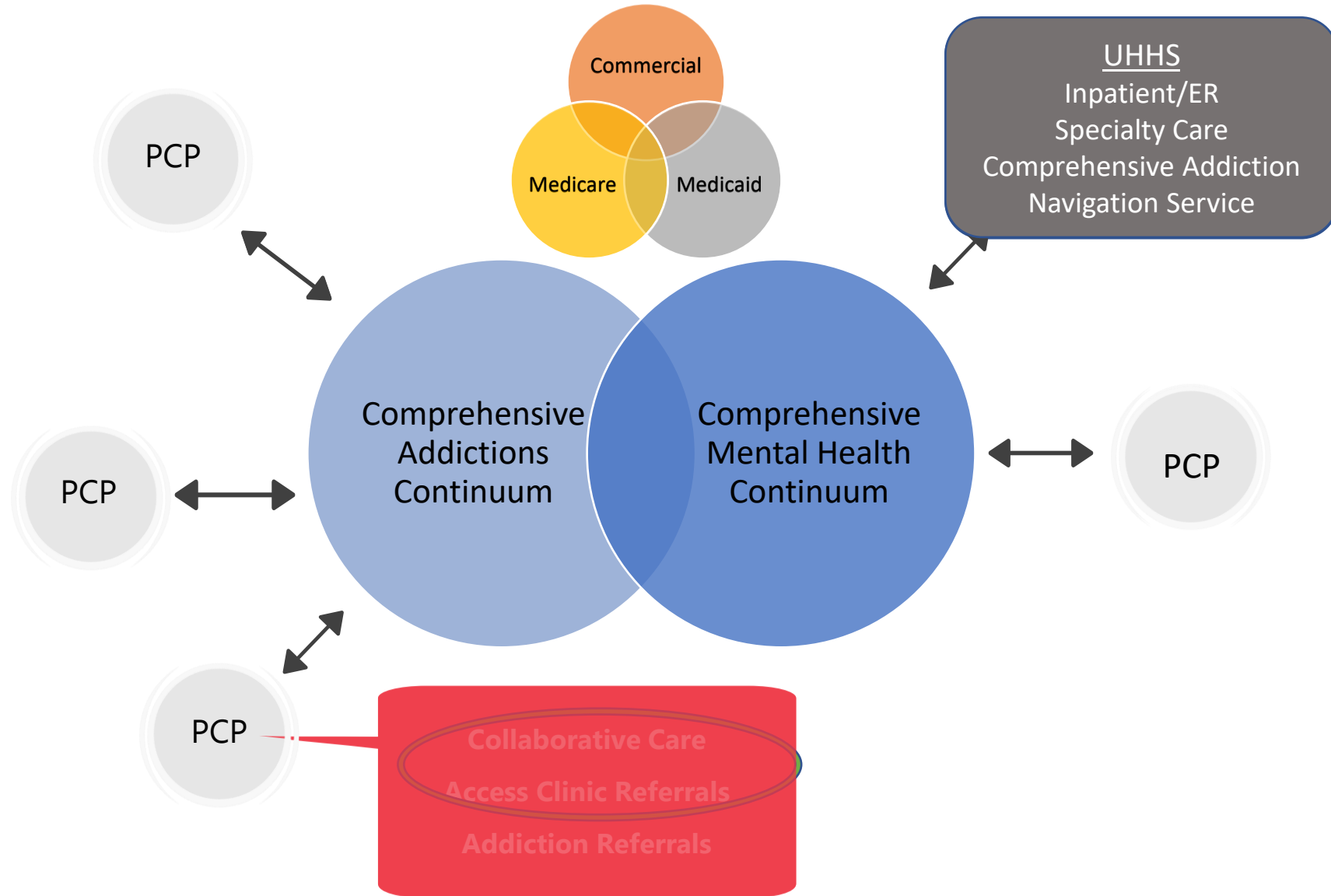*University Hospitals Health System data collected from EHR*

Behavioral Health Integration Strategy

1. Collaborative Care Model(CoCM) within PCI

2. Short-term Consultation to Psychiatry across entire system

3. Special Focus on Highly Complex Patients

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Case Study #1 Optum Behavioral Health Hub Overview

Commercial

Medicare

Medicaid

UHHS
Inpatient/ER
Specialty Care
Comprehensive Addiction
Navigation Service

PCP

PCP

PCP

PCP

Comprehensive Addictions Continuum

Comprehensive Mental Health Continuum

Collaborative Care
Access Clinic Referrals
Addiction Referrals

Optum Data collected as Care Management CQI initiative

Collaborative Care

- Phase 1: Prototype (1 practice, 2 years)

- Phase 2: Piloting (7 practices, 1 year)

- Phase 3: Expansion (Distribute across all practices, 3 years)

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Collaborative Care Model - Financing

- Goal: "near" sustainability through CoCM codes

- Hurdles:
  - Real World execution rarely mirror AIMS Center model
  - Turnover
  - Culture Change
    - Primary Care Teams
    - Behavioral Health Managers (BHMs)
    - Psychiatrists
  - Who owns:
    - Billing
    - Behavioral Health Managers (BHMs)

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Our Experience

- Expected BHMs to see 65 unique patients per month

- Reality was closer to 45 for high-functioning BHM/PCP pairings

- Result: Billing well below expectations

- But...a few BHMs came close to budget with fewer cases

Lesson: this model is a REALLY big culture change for all, takes longer than expected for individuals to behave differently

University Hospitals Health System data collected from EHR

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Short-Term Psychiatric Consultation – Access Clinic

- Access to psychiatry consultation in 7 days

- Virtual or Live

- Time limited Consultation → 1-4 visits, then send back to PCP (80%) or through to long-term psychiatry (20%)

- Active communication with PCP through Task List

- Open Notes – visible so that PCP can see plan directly

University Hospitals Health System data collected from EHR

Access Clinic Results

- Average wait time = 4 days

- Average number of visits = 1.5

- Modal number of visits = 1

- Provider satisfaction:

  1. Increased for PCPs
  2. Same for Psychiatric providers
  3. Increased for Patients --> they LOVED rapid access and having PCP being able to follow up

University Hospitals Health System data collected from EHR

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Access Clinic Financing

- Short Term Consultations → fewer, longer visits per provider → decreased revenue (follow codes better than evaluation codes)

- Total FTEs to fully meet 400 physician need of PCI → 3-4

- Total shortfall → $250K annual reduction in billing for same provider time (Against $40 million psychiatry budget)

Bottom line: WELL WORTH IT!

University Hospitals Health System data collected from EHR

Complex Care – Transactional Solutions Don't Work

SPECIAL ARTICLE

Health Care Hotspotting — A Randomized, Controlled Trial

Amy Finkelstein, Ph.D., Annetta Zhou, Ph.D., Sarah Taubman, Sc.D., and Joseph Doyle, Ph.D.

CONCLUSIONS

In this randomized, controlled trial involving patients with very high use of health care services, readmission rates were not lower among patients randomly assigned to the Coalition's program than among those who received usual care. (Funded by the

Finkelstein, A., Zhou, A., Taubman, S., & Doyle, J. (2020). Health Care Hotspotting – A Randomized, Controlled Trial. *N Engl J Med*, 382, 152-162. https://doi.org/10.1056/NEJMsa1906848

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Internal Barriers

Trust

Self Esteem

Complexity

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Clinical Case Management

Professional = LSW/RN

Longitudinal

Proactive

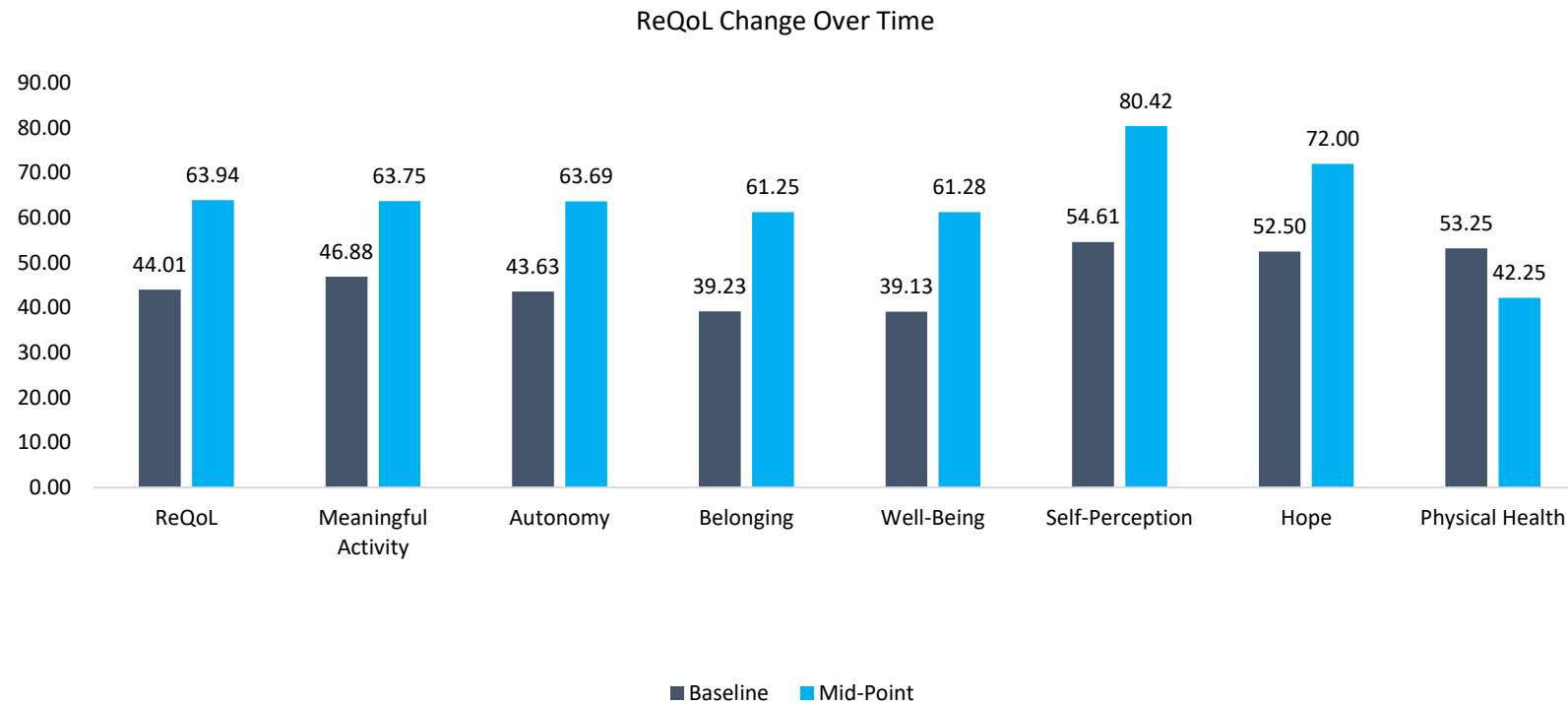*Relationship* → *Trust* → *Self Esteem*

Caseload Ratio = 30:1
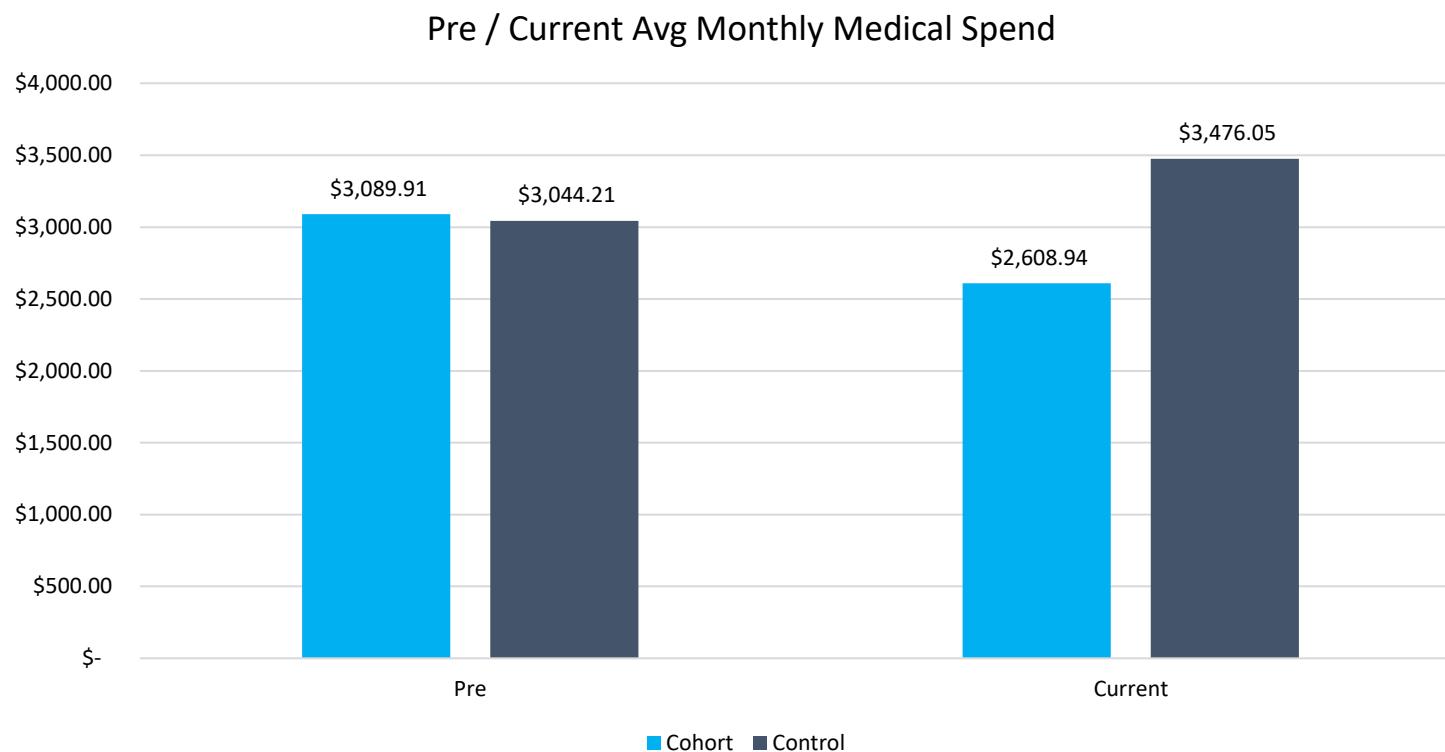
Quality of Life

ReQoL Change Over Time

University Hospitals Health System data collected from EHR

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Recommendations

Collaboration among multiple payers to reimburse implementation and sustaining integration

Utilize payment methodologies that cover integration start-up costs.

Utilize payment methodologies that provide sustainability of integration. Set care management and/or bundled rates that are adequate to cover costs.

Match payment methodology to the Integration Construct.

Eliminate or reduce patient co-pays that obstruct integration.

Providers - Improve proficiency in using the available billing and coding procedures and visit types.

Provide equity for BH provider eligibility for integration payments.

Payers - educate providers on billing codes available to support integration.

Recommendations for Policymakers

- Eliminate all prohibitions on billing for a primary care and BH service on the same day.

- Improve coverage and rates for CPT code payments that support integration.

- Expand and incentivize CCBHCs and FQHCs to provide integrated care services and measures according to the CHI Framework and Constructs.

- Adopt all-payer integration initiatives using the CHI Framework to improve evaluation of processes and outcomes and reduce variability across payers.

These recommendations are from the CHI authors and expert panel members.

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CHI Framework Learning Opportunities

Available to download now: https://www.thenationalcouncil.org/resources/the-comprehensive-healthcare-integration-framework/

- Spring 2022 CoE Webinars:
  - Part 1: Introducing a New Framework, April 27 (View the recording here)
  - Part 2: Domains and Constructs, May 25 (View the recording here)
  - Part 3: Measuring Integration and Choosing Metrics, June 28 (View the recording here)
  - Part 4: Payment Models for Comprehensive Health Integration, July 27 (View the recording here)

  Visit the Events Page, on the COE-IHS to access future events!

  https://www.thenationalcouncil.org/program/center-of-excellence/

- Winter 2022 ECHO - Learning Community

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Questions & Comments?

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Tools & Resources

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- [CoE-IHS Webinar: Comprehensive Health Integration Part 1: Introducing a New Framework Recording](#)
- [CoE-IHS Webinar: Comprehensive Health Integration Part 2: Domains & Constructs Recording](#)
- CHI Framework - https://www.thenationalcouncil.org/resources/the-comprehensive-healthcare-integration-framework/
- Center of Excellence for Integrated Health Solutions – [Resource Home Page](#)
- [CIHS Standard Framework for Levels of Integrated Care](#)
- [CIHS Essential Elements of Effective Integrated Primary Care & Behavioral Health Teams](#)
- [General Health Integration Framework](#) – Advancing Integration of General Health in BH Settings
  - [Utilizing an Evidence-based Framework to Advance Integration of General Health in Mental Health and Substance Use Treatment Settings](#) – Blog post
- [Medical Director Institute – Home Page](#)
- [High-Functioning Team-Based Care Toolkit](#)
- [Organizational Assessment Toolkit for Primary & Behavioral Health Care Integration (OATI)](#)
- [Quick Start Guide to Behavioral Health Integration for Safety-Net Primary Care Providers](#)

Other

- Agency for Healthcare Research & Quality – [Implementing a Team-Based Model in Primary Care Learning Guide](#)
- Health & Medicine Policy Research Group – [Behavioral Health Primary Care Integration](#)

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Upcoming CoE Events:

CoE-IHS Office Hour: Providing Integrated Care Services & Advancing Health Equity for Individuals with Intellectual Developmental Disabilities (IDD)

Register for the Office Hour on Tuesday, August 16th, from 3-4pm EST

CoE-IHS Office Hour: Perinatal Health Post-Series Office Hour

Register for the Office Hour on Thursday, August 25th, from 3-4pm EST

Interested in an individual consultation with the CoE experts on integrated care?

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Questions?

Email integration@thenationalcouncil.org

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