Achieving value from behavioral health in ACOs

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Topics for discussion

Agenda

Background and key issues

National examples

Outcome measures

Summary

Achieving value from behavioral health in ACOs.

Background and key issues

BlueCross BlueShield of North Carolina

Foundation: Behavioral health

Terminology

The term "behavioral health" encompasses **both** mental health and substance use (SAMHSA definition).

Behavioral health defined

Mental health (MH) disorders range from mild to severe.

- Examples include: Depression, Anxiety, ADHD, eating disorders, bipolar disorder, schizophrenia.

Substance use disorders (SUD) include all potential substances of abuse, and range from mild to severe.

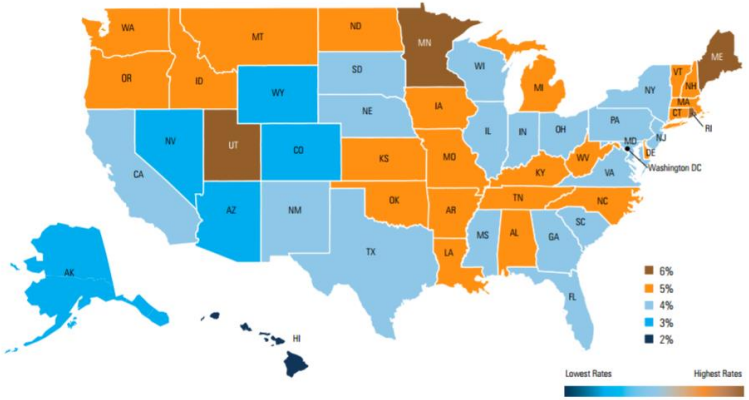
- For specific substance use disorders, the substance is named in the title, i.e. opioid use disorders, alcohol use disorders, etc.

Why terminology matters

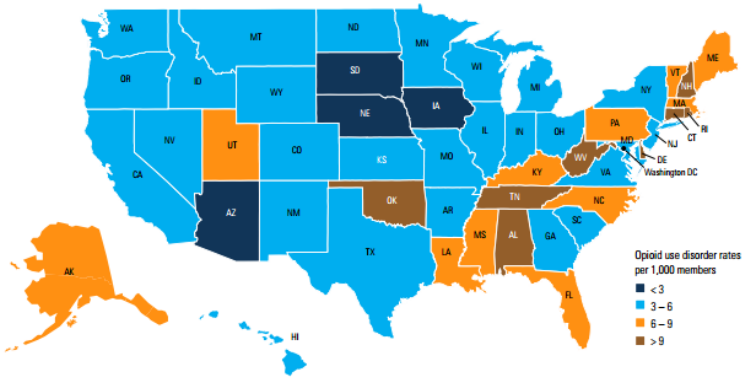
Establishing a common language and understanding of Behavioral Health for the enterprise is critical for communicating effectively internally and externally.

1 Behavioral health disorders are prevalent & 2 negatively impact total health.

Rates of Depression[1]



Opioid Use Disorder Diagnosis[2]



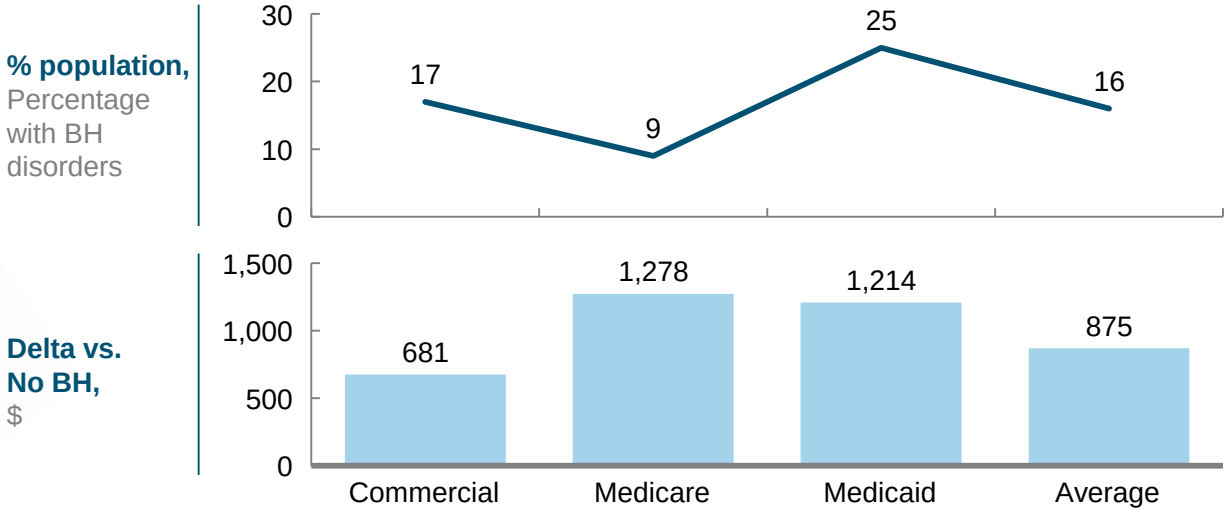
- **1 in 5** Americans will experience a behavioral health disorder in a given year.[3]
- Suicide is the **2nd** leading cause of death in youth aged 10-24 years, and suicide rates for adults and youth are rising.[4]
- Physical health conditions like diabetes, cardiovascular disease, and cancer have worse outcomes and are more expensive to manage when co-occurring with behavioral health disorders.[5]
- Opioid use disorders are rising with opioid related overdose deaths growing by **~20%** year over year.[6]
- Behavioral health disorders account for **4 out of the top 10** national health conditions impacting health.[7]

1. Blue Cross Blue Shield Association, https://www.bcbs.com/sites/default/files/file-attachments/health-of-america-report/HoA_Major_Depression_Report.pdf ; 2. Blue Cross Blue Shield Association, https://www.bcbs.com/sites/default/files/file-attachments/health-of-america-report/HoA_Opioid_Epidemic_Report.pdf ; 3. Kaiser Family Foundation, https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/?_sf_s=mental#item-start ; 4. CDC https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_06.pdf and https://www.cdc.gov/vitalsigns/suicide/infographic.html#graphic ; 5. Katon W. *Dialogues Clin Neurosci*, 2011 and Sotelo JL et al. *Int Rev Psychiatry*, 2014; 6. National Institute of Drug Abuse www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates ; 7. Blue Cross Blue Shield Association, https://www.bcbs.com/the-health-of-america/health-index/national-health-index.

3 Behavioral health disorders drive total healthcare spending.

In the United States, for individuals with behavioral health disorders across all lines of business, total medical expenses are higher by an average of **$875 pmpm** compared to those without behavioral health disorders.

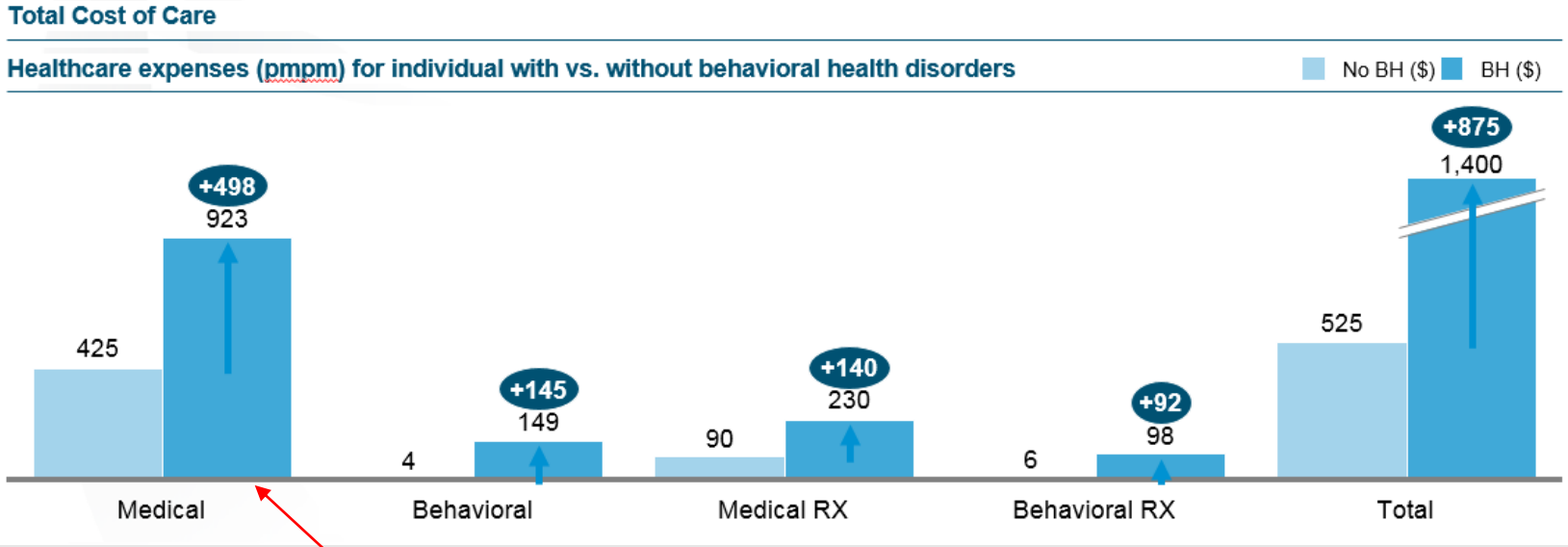
Prevalence and total cost of care by line of business (national estimates)



SOURCE: Melek, Stephen and et al. Potential economic impact of integrated medical-behavioral healthcare. [Online] Jan.2018. http://www.milliman.com/uploadedFiles/insight/2018/Potential-Economic-Impact-Integrated-Healthcare.pdf

3 Behavioral health disorders drive total healthcare spending.

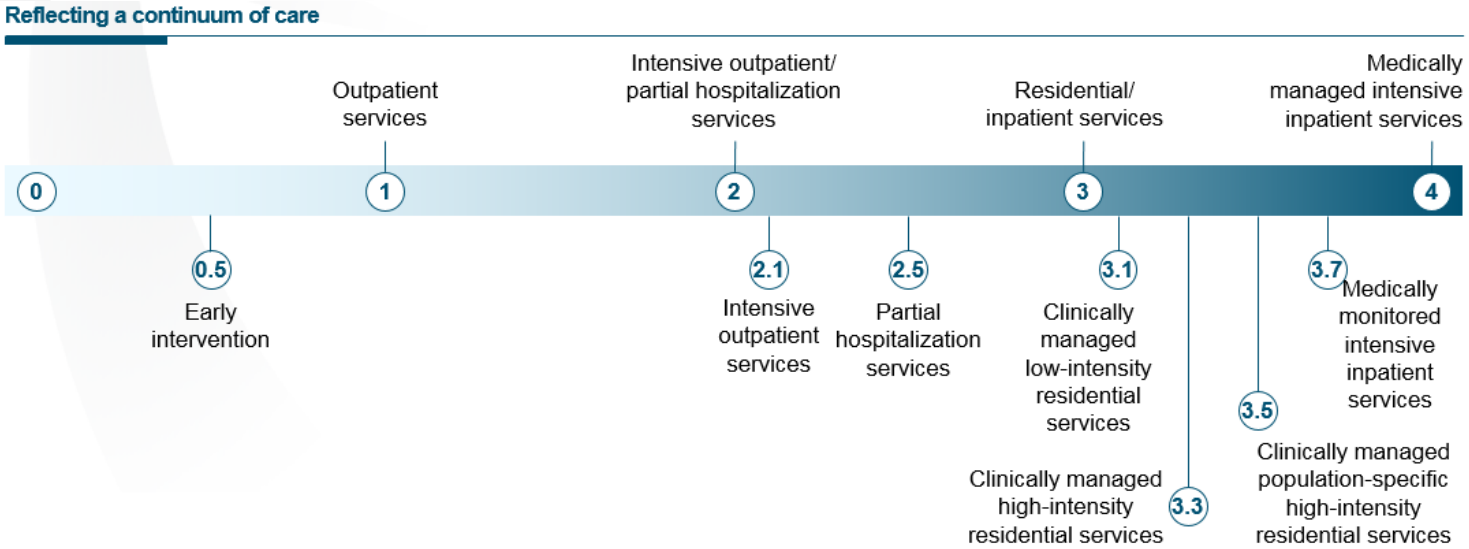
Higher total medical expenses for individuals with behavioral health disorders are driven by spending on physical health conditions.



There is an estimated **9%-17% annual savings** opportunity attainable through integration of physical and behavioral health care.[1]

SOURCE: Melek, Stephen and et al. Potential economic impact of integrated medical-behavioral healthcare. [Online] Jan.2018. http://www.milliman.com/uploadedFiles/insight/2018/Potential-Economic-Impact-Integrated-Healthcare.pdf

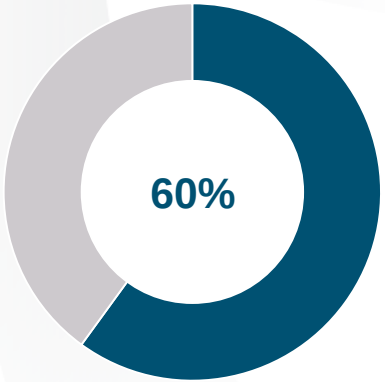
3 Substance use disorders, in particular, drive poor health and high cost.



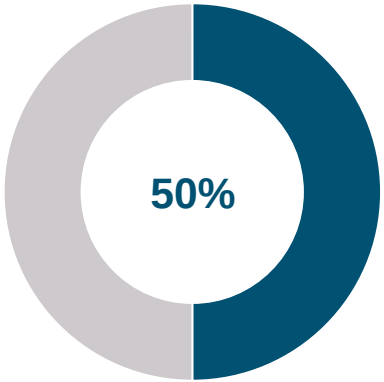
Note: Within the five broad levels of care (0.5,1,2,3,4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represents benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.

4 Behavioral health treatment is effective, but access to care is limited.

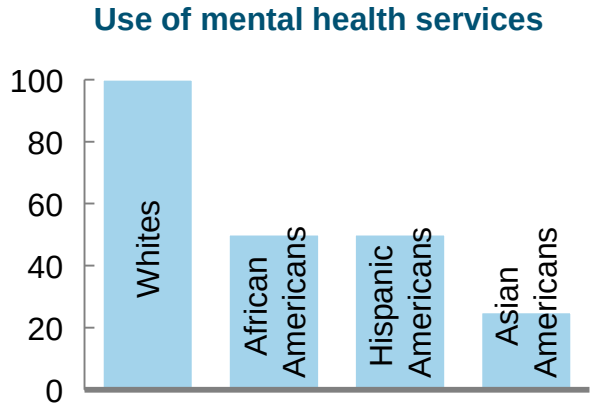
Treatment in America



Nearly 60% of adults with mental health disorders did not receive mental health services in the previous year.[4]



Nearly 50% of youth aged 8-15 years with mental health disorders did not receive mental health services in the previous year.[1]



African American & Hispanic Americans used mental health services at about ½ the rate of Whites in the past year and Asian Americans at about 1/3 the rate.[1]

NAMI mental health facts in America
https://www.nami.org/nami/media/nami-media/infographics/generalmhfacts.pdf

National examples

BlueCross BlueShield of North Carolina

National examples: CMS

BEHAVIORAL HEALTH

By Alisa B. Busch, Haiden A. Huskamp, and J. Michael McWilliams

Early Efforts By Medicare Accountable Care Organizations Have Limited Effect On Mental Illness Care And Management

DOI: 10.1377/hlthaff.2015.1669
HEALTH AFFAIRS 35,
NO. 7 (2016): 1247–1256

National examples: Massachusetts

MENTAL HEALTH

By Colleen L. Barry, Elizabeth A. Stuart, Julie M. Donohue, Shelly F. Greenfield, Elena Kouri, Kenneth Duckworth, Zirui Song, Robert E. Mechanic, Michael E. Chernew, and Haiden A. Huskamp

DOI: 10.1377/hlthaff.2015.0685
HEALTH AFFAIRS 34,
NO. 12 (2015): 2077–2085

The Early Impact Of The 'Alternative Quality Contract' On Mental Health Service Use And Spending In Massachusetts

ADDICTION
SSA SOCIETY FOR THE STUDY OF ADDICTION
RESEARCH REPORT
doi:10.1111/add.13555

Effects of accountable care and payment reform on substance use disorder treatment: evidence from the initial 3 years of the alternative quality contract

Elizabeth A. Stuart[1], Colleen L. Barry[2], Julie M. Donohue[3], Shelly F. Greenfield[4], Kenneth Duckworth[5], Zirui Song[6], Robert Mechanic[8], Elena M. Kouri[7], Cyrus Ebnesajjad[1], Michael E. Chernew[7] & Haiden A. Huskamp[7]

National examples: Intermountain Healthcare

Research

JAMA | Original Investigation | INNOVATIONS IN HEALTH CARE DELIVERY

Association of Integrated Team-Based Care With Health Care Quality, Utilization, and Cost

Brenda Reiss-Brennan, PhD, APRN; Kimberly D. Brunisholz, PhD; Carter Dredge, MHA; Pascal Briot, MBA; Kyle Grazier, PhD; Adam Wilcox, PhD; Lucy Savitz, PhD; Brent James, MD, MStat

Table 3. Outcomes for Quality Measures, Service Utilization, and Payments for Patients and Practices Using TBC and TPM Models

	No. of TBC Events (%) (163 226 Person-Years)[a]	No. of TPM Events (%) (171 915 Person-Years)[a,b]	Odds Ratio (95% CI)[c]	*P* Value[c]
Quality Measures[d]				
Intervention variables[e]				
Depression screening among patients with active depression	21 787 (46.09)	11 407 (24.13)	1.91 (1.75 to 2.08)	<.001
Adherence to diabetes bundle	6646 (24.60)	5275 (19.53)	1.26 (1.11 to 1.42)	<.001
Documented self-care plan	4263 (48.35)	763 (8.65)	5.59 (4.27 to 7.33)	<.001
Nonintervention variables[f]				
Hypertension in control (<140/90 mm Hg)	54 198 (85.00)	62 297 (97.70)	0.87 (0.80 to 0.95)	.002
Documented advanced directives	15 686 (9.61)	16 171 (9.91)	0.97 (0.91 to 1.03)	.28 (NS)
Annual visit with PCP	137 357 (84.15)	126 016 (77.20)	1.09 (1.03 to 1.15)	.002
Service Utilization[d]	**No. TBC Events (Incidence Per 100 Person-Years)**	**No. TPM Events (Incidence Per 100 Person-Years)**	**IRR (95% CI)**	
Hospital admissions	15 427 (9.45)	17 334 (10.62)	0.89 (0.85 to 0.94)	<.001
Emergency department visits	29 555 (18.11)	38 383 (23.52)	0.77 (0.74 to 0.80)	<.001
Ambulatory sensitive visits	5350 (3.28)	6948 (4.26)	0.77 (0.70 to 0.85)	<.001
PCP visits	380 036 (232.83)	408 641 (250.35)	0.93 (0.92 to 0.94)	<.001
Specialty visits	348 507 (213.51)	355 619 (217.87)	0.98 (0.97 to 0.99)	.02 (NS)
Urgent care visits	90 852 (55.66)	91 770 (56.22)	0.99 (0.97 to 1.02)	.74 (NS)
Total Payments[g]	**TBC Rate (95% CI)[a]**	**TPM Rate (95% CI)[a]**	**β (95% CI)**	
Payments received, $	3400.62 (3353.39 to 3447.85)	3515.71 (3468.48 to 3562.94)	−115.09 (−199.64 to −30.54)	.008

Abbreviations: IRR, incidence rate ratio; IQR, interquartile range; NS, nonsignificant; PCP, primary care physician; TBC, team-based care; TPM, traditional practice management.

[a] The dataset was normalized by dividing by the odds ratio for quality measures and IRR for service utilization. This adjusted factors were next multiplied by TBC percentage and events to compute the corresponding TPM values.

[b] The TPM group was the referent.

[c] Generalized estimated equations modeling included adjustment for age, sex, race/ethnicity, Charlson Comorbidity Index, geographical region of care, type of insurance, number of years of routinized MHI prior to the study period (2003-2009), and the previous year of TBC implementation exposure.

[d] For outcomes related to quality measures and service utilization, a *P* value of .008 or less must be achieved to account for multiple interrelated comparisons.

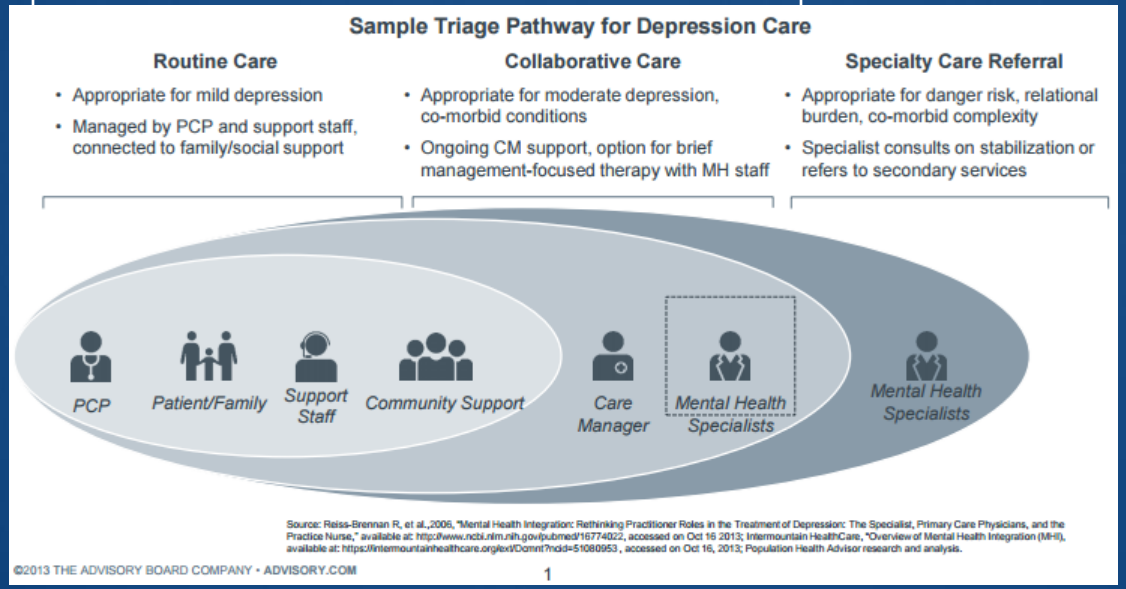
[e] Intervention variables were measures linked specifically to TBC deployment.

[f] Non-intervention variables: measures that were not directly linked to TBC deployment.

[g] Total payment needed to achieve a *P* value of .05 or less to be considered statistical significant. Outcomes not meeting this threshold were designated as nonsignificant.

Key components of behavioral health systems that add value within ACOs.

1. Integrated behavioral health and primary care.



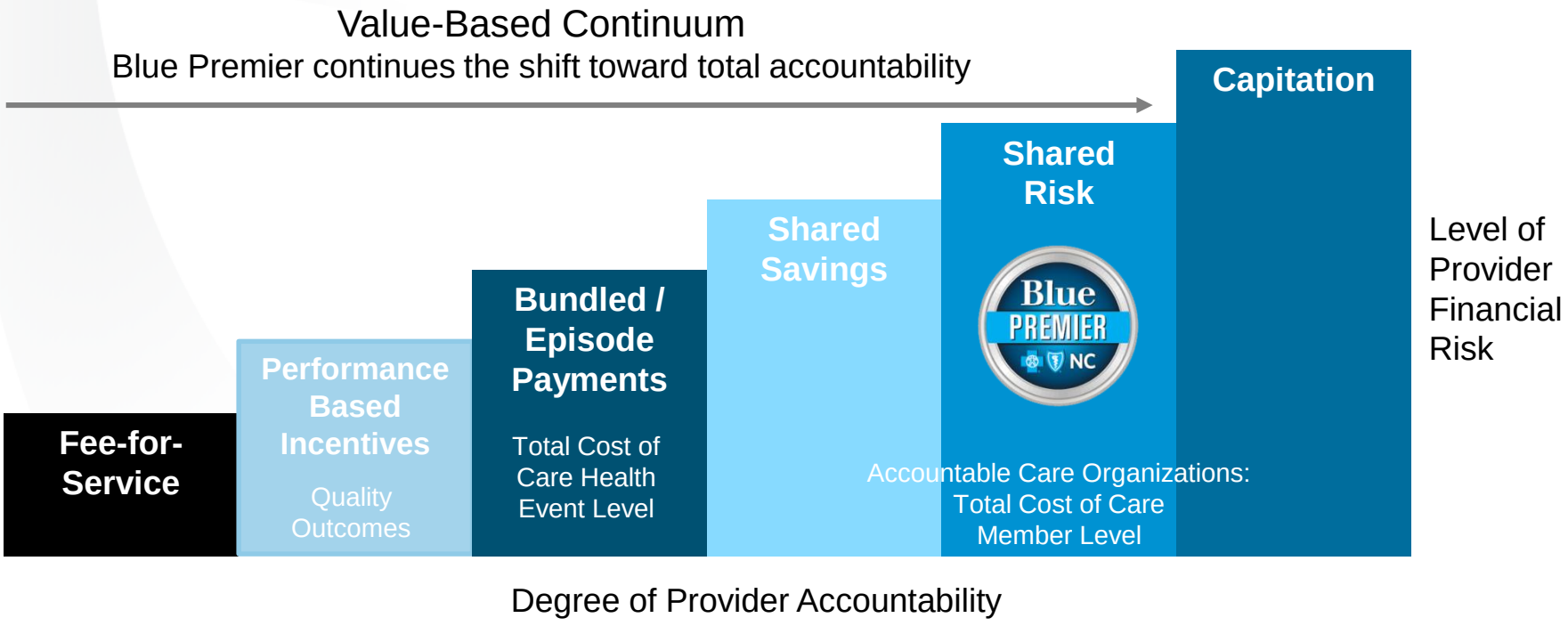
2. High performing behavioral health specialists that a) provide consultation for primary care providers and b) treat individuals with severe mental health and substance use disorders.

3. Case management across the continuum and between levels of care.

4. Accountability for total health and cost outcomes across the continuum.

Blue Premier: Innovations in value-based care and payment models

Blue Premier: Innovations in value-based care and payment models



Blue Premier: ACO/Health System Payment Model

Blue Premier: Multipronged focus

Blue Premier
Outcomes-Based Reimbursement

+ Large Health Care Systems

808,000* MEMBERS

Independent Primary Care

+ Non-system affiliated
+ PCP & multispecialty

70,000–80,000 MEMBERS**

Advanced Primary Care

+ Partnership with vendor(s) to expand primary care base across state

12,000–20,000 MEMBERS**

*The attributed members for Blue Premier consists of the estimated attributed members of the 8 targeted health systems for 1/1/2019
**Estimated attributed membership by 2023

Blue Cross NC behavioral health strategy: Three key components

Blue Cross NC behavioral health strategy: Three key components

Integrated behavioral and physical health

Integrated care improves access and reduces total medical expenses, especially for individuals with co-occurring physical and behavioral health disorders.

Optimized behavioral health network

Redefine payment methods and recruit providers to deliver effective outpatient behavioral health treatment, reducing avoidable use of emergency departments, inpatient units, and RTCs.

Best-in-class solutions

Solve the most pressing issues in behavioral health through innovation.

Strategy is applicable for **all lines of business.**

Blue Cross NC behavioral health strategy: Three key components

Integrated behavioral and physical health

- **Provide practice support for ACOs** and independent providers to integrate behavioral and physical health services.
- **Drive implementation of Quartet** that enables integrated care.
- **Incorporate the HEDIS measure** *Depression screening and follow up for adolescents and adults* into ACO contracts with financial risk by 2022 to incentivize delivery of integrated care.

Optimized behavioral health network

- **Develop an alternative payment model** for Behavioral Health
  - Basic: Higher FFS rates for improved quality and access.
  - Advanced: Prospective payments tied to quality for an attributed population.
- **Recruit (within state and/or nationally) behavioral health specialists** to provide both in-person and telehealth/tech-enabled services.

Best-in-class solutions

- Outpatient treatment for substance use disorders.
- Substance use residential treatment centers (RTCs).
- Integrated care.
- Telehealth and digital Cognitive Behavioral Therapy (CBT).
- Case management for serious mental illness and substance use disorders.

Integrated care supported by Quartet Health

Quartet

Quartet supports delivery of the collaborative care model through four main functions:

- Quartet staff **enroll primary care practices and behavioral health specialists** on the Quartet platform; providers can communicate and coordinate care through the platform.
- Quartet conducts **predictive modeling** to identify BCNC members at risk for behavioral health disorders;
- Quartet attributes at-risk members to primary care practices and supports **screening for behavioral health disorders within primary care**,
- Quartet specialists provide **triage and referral for members with behavioral health disorders** to treatment within primary care, with an in-person behavioral health specialist, and/or through digital/telehealth enabled services.

Evolving and integrating BCNC's behavioral health offering

Leveraging data-driven insights, Quartet will help BCNC improve network adequacy and establish collaboration across physical and mental health providers.

Alignment with Provider-led strategy

Quartet's PCP-focused tool allows BCNC to impact provider workflows by offering a differentiated behavioral health solution for their patient panel.

Driving significant economic value creation

Quartet will create value for BCNC by creating savings, improving risk adjustment factors, and by jointly marketing to health system for differentiated solutions.

Key Transformational Activities: Optimized network

- **Develop a value-based payment model for behavioral health**
  - Basic: New foundation for network providers linking fee-for-service payments to quality.
  - Advanced: Prospective payments tied to quality for an attributed population.
    - Includes payment for team-based care, consultation to primary care, and the case management functions necessary to help members engage in outpatient treatment and reduce avoidable use of ED and inpatient services.
- **Recruit (within state and/or nationally) high-performing behavioral health specialists** to provide both in-person and telehealth/tech-enabled services.

Key Transformational Activities: Best-in-class solutions for behavioral health

Optimize internal capacity for management of behavioral health services.

Identify market opportunities to buy or partner with organizations to develop innovative and more effective approaches to behavioral health.

Ensure solutions are cohesive through oversight and integration.

Areas of interest include:

- Increasing access to effective outpatient treatment for substance use disorders.
- Developing a cost-effective alternative to substance use residential treatment centers (RTCs).
- Integrated care.
- Telehealth and digital Cognitive Behavioral Therapy (CBT).
- Case management support for serious mental illness and substance use disorders.

Outcome measurement

BlueCross BlueShield of North Carolina

Outcome measurement in behavioral health

Structural: resources and organizational components that are necessary for delivering care, example:
- *Behavioral health network adequacy standards.*

Process: provider practices that may influence the outcome of care, examples:
- *HEDIS Depression screening and follow up for adolescents and adults.*
- *Frequency of communication between high-performing network specialists and primary care.*

Health outcomes: the results of healthcare services, examples:
- *Behavioral health Provider- and Member-reported clinical quality and outcome measures for mental health and substance use disorders.*
- *HEDIS Blood Sugar Controlled and Controlling Blood Pressure.*

Economic: the cost of healthcare services, examples:
- *Total cost of care.*
- *HEDIS mental health utilization (includes inpatient, ED, and outpatient).*
- *HEDIS identification of alcohol and other drug services (includes inpatient, RTC, ED, and outpatient).*

Consumer experience: the person's experience participating in healthcare services, examples:
- *Member surveys on experience of care.*

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Examples of person- and provider-reported outcome measures

Depression: Patient Health Questionnaire (PHQ)-2/PHQ-9

Anxiety: Generalized Anxiety Disorder-7 item (GAD-7)

Substance use: National Institute on Drug Abuse ASSIST tool

OCD: Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

Bipolar disorder: Bipolar Disorder Symptoms and Functioning Monitoring Form

Psychosis: Clinician-Rated Dimensions of Psychosis Symptom Severity (from APA)

Shared decision making: principal assumptions

Patients want to be fully informed

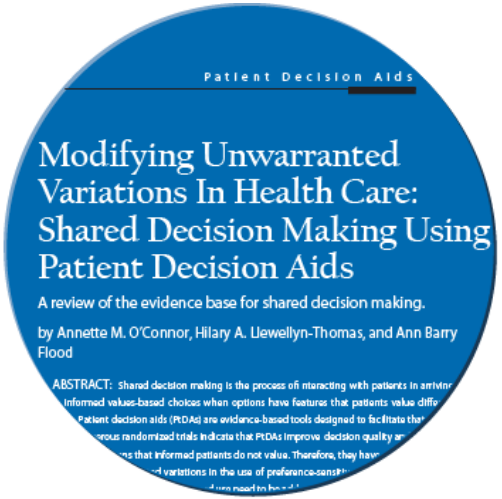
Informed patients will participate in shared decision making

Fully informed physicians will honor patients values and preferences

Patient are more risk averse than are their physicians

Shared decision making: preference-sensitive care

- Care for conditions where treatment options exist
- Where the treatment options involve significant tradeoffs in the patient's quality or length of life
- The choice of treatment should be decided upon by the fully informed patient in partnership with their physician (shared decision making)



A.M. O'Connor et al, "Modifying Unwarranted Variations In Health Care: Shared Decision Making Using Patient Decision Aids" *Health Affairs,* 7 October, 2004

Shared decision making: person-centered outcomes

Papers

Decision aids for patients facing health treatment or screening decisions: systematic review

Annette M O'Connor, Alaa Rostom, Valerie Fiset, Jacqueline Tetroe, Vikki Entwistle, Hilary Llewellyn-Thomas, Margaret Holmes-Rovner, Michael Barry, Jean Jones

Abstract

Objective To conduct a systematic review of randomised trials of patient decision aids in improving decision making and outcomes.
Design We included randomised trials of interventions providing structured, detailed, and specific information on treatment or screening tioners. Their efficacy has been described in general reports and reviews. [1-4] We conducted a systematic overview of the trials of decision aids to determine whether they improved decision making and outcomes for patients facing treatment or screening decisions.

Methods

Summary measure of surgery versus medical management across the eight (8) trials

RR (95% CI) = 0.75 (0.60-0.94)

O' Connor AM., et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database of Systematic Reviews 2001 (updated 2008)

Shared decision making: behavioral health

Evidence that patients and providers want it but….little research to date

Mayo Clinic has developed paper based decision aids for treatment of depression

- Primary focus is ‘which drug’ to choose
  - Efficacy versus side effects
- Does not consider non-pharmacological treatments
- Their results show improvement in decision process without increased visit time but….no change in adherence or symptoms

Summary

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Summary

1. **Behavioral health disorders are prevalent.**

2. **Behavioral health disorders negatively impact total health.**

3. **Behavioral health disorders drive total healthcare spending.**

4. **Behavioral health treatment is effective for improving total health and reducing costs, but access to care is limited.**

Conclusion

- ACOs that are responsible for population health and the total cost of care are uniquely incentivized to address behavioral health disorders.
  - However, behavioral health-specific outcome measures and incentives are needed to drive change in use of services.
- Increasing access to outpatient behavioral health treatment may reduce the total cost of care.
- For ACOs, stepped models with integrated behavioral health treatment within primary care are important.
- Outcome measurement that is aligned across care locations is key.