



Brief 8, June 2020

Primary Care PMPMs and Behavioral Health Integration Brief

Prepared for the Bipartisan Policy Center

Stephanie Gold, MD, Perry Dickinson, MD, Larry Green, MD

The need for risk-adjusted PMPMs: Fee-for-service creates complexity in billing for practices, incentivizes increased volume of services, and ties payment to delivery of specific covered services. Prospective payments, most often in the form of a PMPM, grant flexibility to practices in designing care to best meet patient needs. Risk adjustment matches payment to patient need. Without risk adjustment, prospective payments will be insufficient for patients with higher needs.

What are key features of successful risk-adjusted PMPMs?

- **Total amount:** The current amount invested in primary care is inadequate. To advance primary care, change is needed not only in the type of payment but also the overall amount. Current spending estimates on primary care in the U.S. range from 2.12%-7.7% of the total cost of care,¹² depending on the population studied and definitions used. Evidence from other countries³ and across states⁴ suggests better outcomes with a higher proportion of the total cost of care directed toward primary care; based on this evidence, experts recommend 10-12% of the total cost of care be invested into primary care.⁵
- **Proportion of PMPM vs FFS:** Simulations suggest that more than 63% of practice payment would need to be capitated to enable care transformation.⁶ Moving slowly to this target may feel more manageable to some practices but will delay the ability to make significant changes.
- **Level of risk:** Capitated payments for primary care services (as compared to all outpatient services or the total cost of care) keep the financial risk to clinicians more manageable than prior iterations of capitation.
- **Social risk adjustment:** Studies show that including individual and community-level measures of social risk improve the predictions of risk models.^{7 89} Most currently used methods of risk adjustment do not capture this.
- **Change in payment at the level of the practice:** Many managed care organizations or accountable care organizations receive a PMPM but continue to pay primary care practices via FFS, limiting change potential and creating conflicting incentives.

Where have global payments for integrated behavioral health been implemented successfully in the past?

- CPC+ includes a risk-adjusted care management PMPM – both Track 1 and Track 2 practices (though it was not a requirement for Track 1) made progress in the first year of the program integrating behavioral health.¹⁰



- In a Colorado pilot comparing 3 primary care practices with usual care to 3 matched primary care practices receiving a lump sum prospective payment to finance integrated care, public payers observed \$1 million net savings (covering 9,042 patients) through reductions in downstream utilization.¹¹
- South Central Foundation in Anchorage has been cited as an exemplary primary care medical home with integrated behavioral health. They are financed through a variety of sources but have been able to use funds flexibly primarily through Indian Health Services annual block grants which cover approximately 45% of their expenses.¹²

What are key considerations related to BHI in the design of primary care PMPMs?

- Some experts have voiced concerns that behavioral health funding could be “crowded out” by physical health needs in a global primary care PMPM - but specific incentives for BHI and care coordination can help prevent this. Linking payment to outcomes also creates an inherent incentive for integrated care. Funding to address the social determinants of health similarly should be addressed in a global primary care PMPM with considerations for specific incentives or requirements.
- One Colorado study of 11 practices found that ongoing expenses for integrated care average \$4.58 PMPM (\$40 PMPM when repurposed existing resources were taken into account) and start up expenses average \$20,788 (\$44,076 if repurposed existing resources taken into account).¹³
 - There should be caution in using an average amount as the expected funding necessary: there was a large range of expenses observed, varying based on the practice’s prior work in practice transformation (e.g. if they already had team-based care, a well functioning EHR in place) and the length of time it took to integrate (in addition to extent of prior practice transformation work, this was also significantly impacted by staff turnover of integrated care champions or behavioral health providers).

What are key considerations around the use of pay for performance and measurement in designing primary care and integrated behavioral health alternative payment models?

- General points
 - Most evidence on P4P suggests increased administrative burden (to both providers and payers) with only modest return on investment and some concerns about other unintended consequences on patient care (e.g., use of access measures leading to decreases in continuity).^{14 15 16} Applying financial incentives for external motivation can also compromise providers’ intrinsic motivation.¹⁷
 - It is important to keep in mind what the goal of care transformation is and how that applies to measurement. The aim of integrated care is to provide fundamentally better care for people. Measuring the desired outcomes of better care implies the need for different kinds of measures that examine care



more broadly, such as through assessing comprehensiveness of care (including behavioral health care), what proportion of the target population is reached by a tool or intervention, and collecting patient perspectives on their care and health as a whole (see below for examples).

- There is a need for further measure development related to prevention, pediatric behavioral health, and patient goal-directed metrics.
- When examining return on investment of behavioral health integration, the impacts in pediatrics occur much farther downstream and thus can be difficult to capture without having a longer time frame.
- Outside of depression measures, most behavioral health clinical quality measures are not well integrated into EHRs and lack adequate reporting mechanisms.
- Measures to consider
 - Measurement of the key pillars of primary care (comprehensiveness, continuity, coordination, and first contact). Examples: claims based measures of comprehensiveness^{18 19} and continuity.²⁰
 - Practice level measures of advanced primary care capabilities and infrastructure and processes for integrating behavioral health. Example: Practice Integration Profile.^{21 22}
 - Measures of access. Example: CAHPS questions- In the last 12 months, when you needed counseling or treatment right away, how often did you see someone as soon as you wanted? (As above, would keep in mind that incentivizing access has the potential to negatively impact continuity of care).
 - Patient reported measures of overall functioning. Example: Outcomes Rating Scale, health-related quality of life
 - Patient reported measures of the therapeutic relationship with clinicians and practices. Example: Session Rating Scale, Green Center patient-reported primary care measure.²³ (Note that the patient-reported primary care measure is in the process of becoming an NQF approved measure).
 - REACH - this measures to what extent an intervention or tool reaches the target population. (Level 1 REACH, what proportion of the target population was screened; Level 2 REACH, what proportion of the positive screens had a full assessment; Level 3, what proportion of positive full assessments received appropriate services). REACH will be highly variable based on practice selection of the target population to screen (which could vary from patients with a specific comorbidity to whole clinic)²⁴; as such, it is not a measure that lends itself to comparisons across practices. Instead, percentage improvement in REACH to a threshold rather than a specific target could be examined, or it could be recognized if a practice is measuring and monitoring REACH and incorporating this into their QI work.



- Clinical quality measures. While they have some utility, these have been overemphasized in programs and tend to be disease-oriented rather than whole person oriented. Metrics related to weight management, unhealthy alcohol use, smoking, and exercise counseling can tie measurement to prevention. When using disease-oriented measures, a focus on validated measures for the most common chronic diseases (diabetes, hypertension, depression, and anxiety) is reasonable though does not capture the work of primary care comprehensively.

How can multipayer alignment be encouraged?

- General points
 - For alternative payment models to be successful, multipayer alignment is necessary. This implies participation of governmental, commercial, and employer-based payers.
 - State-led efforts to align payers for demonstration projects have had some success but continue to encounter barriers, including issues with antitrust and commercial plans not having the flexibility to vary from guidance or programs set by their national leadership.
 - Even within demonstration projects that have had some success with alignment, there is significant variation between payers in terms of what is provided as a PMPM.
- Possible policy levers
 - Consider government (state and federal) convening of payers with assurance of antitrust protections.²⁵
 - Consider how congressional action might better enable regulatory levers through Divisions of Insurance.

Should global payments for the integration of primary care into specialty mental health settings similar to the certified community behavioral health clinics (CCBHCs) program be scaled?

- Outcome evaluations of the CCBHC model are pending, but preliminary data suggests clinics have improved access and done significant care transformation – enabled by prospective payment.²⁶
- Expansion of this model to other behavioral health clinics that meet (or commit to meeting) similar requirements for provision of comprehensive, accessible, and coordinated services would be appropriate.



References

- ¹ Reid R, Damberg C, Friedberg MW. Primary care spending in the fee-for-service Medicare population. *JAMA Internal Medicine*. 2019; E1-E4.
- ² Spending for Primary Care. Patient-Centered Primary Care Collaborative Fact Sheet. <https://www.pcpcc.org/sites/default/files/resources/PCPCC%20Fact%20Sheet%20PC%20Spend%202019.pdf>
- ³ Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005;83:457–502.
- ⁴ Jabbarpour Y, Greiner A, Jetty A et al. Investing in Primary Care: A State-Level Analysis. The Patient-Centered Primary Care Collaborative and the Robert Graham Center. July 2019.
- ⁵ Phillips RL, Bazemore AW. Primary care and why it matters for U.S. health system reform. *Health Affairs*;2010;29(5):806-810.
- ⁶ Basu S, Phillips RS, Song Z, Bitton A, Landon BE. High levels of capitation payments needed to shift primary care toward proactive team and nonvisit care. *Health Affairs*. 2017;36(9):1599-1605.
- ⁷ Ash AS, Mick EO, Ellis RP, et al. Social determinants of health in managed care payment formulas. *JAMA Internal Medicine*. 2017;177(10):1424-1430.
- ⁸ Hu J, Kind AJH, Nerenz D. Area Deprivation Index predicts readmission risk at an urban teaching hospital. *Am J Medical Quality*. 2018:1-9.
- ⁹ Hu J, Schreiber M, Jordan J, George DL, Nerenz D. Associations between community sociodemographics and performance in HEDIS quality measures: A study of 22 medical centers in a primary care network. *Am J Medical Quality*. 2017;33(1):5-13.
- ¹⁰ CPC+ First Annual Report. Mathematica. April 2019.
- ¹¹ Ross KM, Gilchrist GC, Melek SP, Gordon PD, Ruland SL, Miller BF. Cost savings associated with an alternative payment model for integrating behavioral health in primary care. *Translational Behavioral Medicine*. 2018.
- ¹² Alaska Southcentral Foundation – Nuka System of Care. Primary Care Collaborative. <https://www.pcpcc.org/initiative/alaska-southcentral-foundation-nuka-system-care>
- ¹³ Wallace NT, Cohen DJ, Gunn R, et al. Start-up and ongoing practice expenses of behavioral health and primary care integration interventions in the Advancing Care Together (ACT) program. *The Journal of the American Board of Family Medicine*. 2015;28(Supplement 1):S86-S97.
- ¹⁴ Gillam SJ, Siriwardena AN, Steel N. Pay-for-performance in the United Kingdom: impact of the Quality and Outcomes Framework—a systematic review. *Ann Fam Med*. 2012;10:461-468.
- ¹⁵ Roland M, Olesen F. Can pay for performance improve the quality of primary care? *BMJ*. 2016; 354:i4058.
- ¹⁶ Roland M, Guthrie B. Quality and Outcomes Framework: what have we learnt? *BMJ*. 2016;354:i4060.
- ¹⁷ Hartzband P, Groopman J. Physician burnout, interrupted. *New England Journal of Medicine*. 2020.
- ¹⁸ Bazemore A, Petterson S, Peterson LE, Phillips RL. More comprehensive care among family physicians is associated with lower costs and fewer hospitalizations. *Ann Fam Med*. 2015;13:206-213.
- ¹⁹ O'Malley A, Rich EC, Shang L, et al. New approaches to measuring the comprehensiveness of primary care physicians. *Health Serv Res*. 2019;54:356-366.
- ²⁰ Bazemore A, Petterson S, Peterson LE, Bruno R, Chung Y, Phillips RL. Higher primary care physician continuity is associated with lower costs and hospitalizations. *Ann Fam Med*. 2018;16:492-497.
- ²¹ Macchi CR, Kessler R, Auxier A, et al. The Practice Integration Profile: Rationale, development, method, and research. *Families, Systems, & Health* 2016;34(4):334-41.
- ²² Practice Integration Profile. PIP 1.0. Secondary Practice Integration Profile. PIP 1.0. <http://www.uvm.edu/~pip/PIPitems2016.pdf>.
- ²³ Etz RS, Zyzanski SJ, Gonzalez MM, Revers SR, O'Neal JP, Stange KC. A new comprehensive measure of high-value aspects of primary care. *Ann Fam Med*. 2019;17:221-230.
- ²⁴ Balasubramanian BA, Fernald D, Dickinson LM, et al. REACH of interventions integrating primary care and behavioral health. *J Am Board Fam Med*. 2015;28:S73-85.
- ²⁵ Wirth B, Takach M. State strategies to avoid antitrust concerns in multipayer medical home initiatives. *Commonwealth Fund Issue Brief*. July 2013.
- ²⁶ U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation. Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2018. <https://aspe.hhs.gov/system/files/pdf/262266/CCBHRptCong.pdf>