If Behavioral Health Is So Important Why Aren't ACOs Doing More About It?

NAACOS Fall Conference 2023

Joshua Israel, M.D. Senior Medical Director
Lelin Chao, M.D. Senior Medical Director
Jeffrey Mandel, M.D. Market President, Aledade Pennsylvania & Kentucky
Michele Fronckiewicz Executive Director, Aledade New Jersey

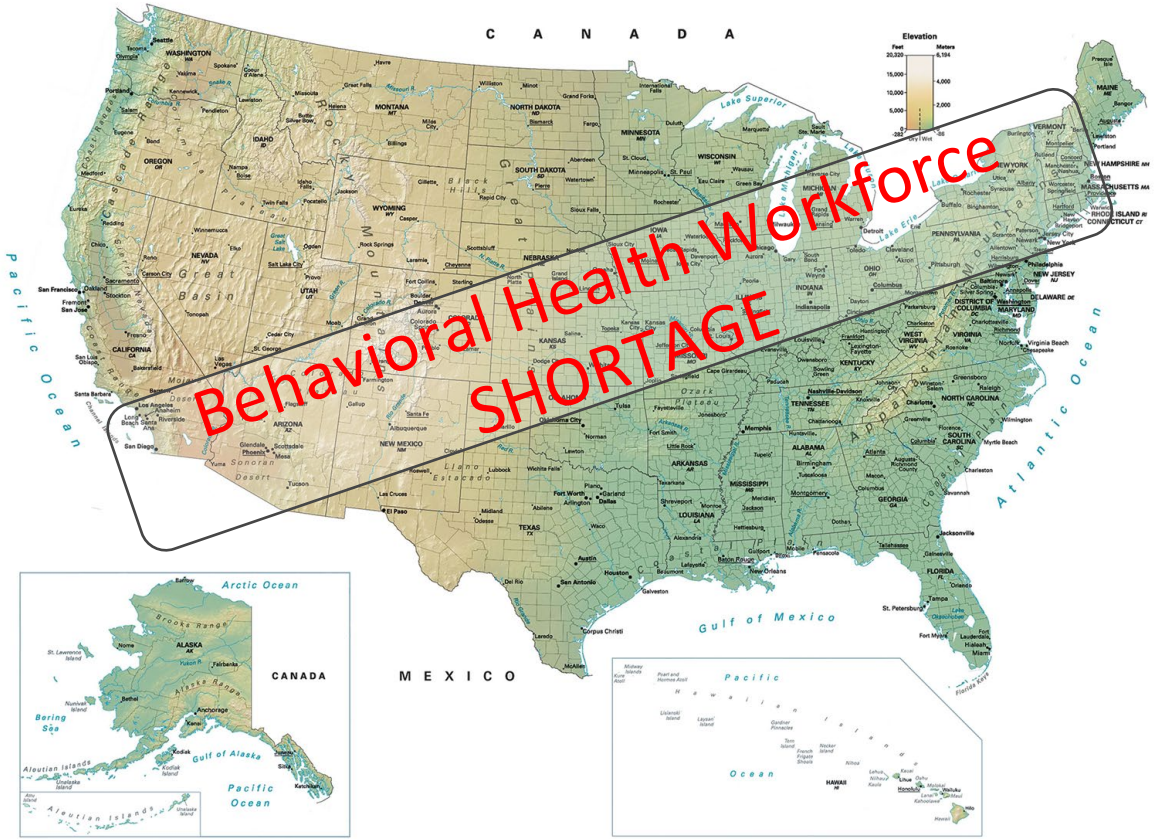
Aledade

Annual U.S. Prevalence of 10 DSM Behavioral Health Disorders

Disorder	Prevalence (%)
Current depression	10.4
Generalized anxiety disorder	7.9
Harmful use of alcohol	3.3
Alcohol dependence	2.7
Somatization disorder	2.7
Panic disorder	1.1
Agoraphobia with panic	1.0
Hypochondriasis	0.8
Agoraphobia without panic	0.5
Any disorder	24.0
Two or more mental disorders	9.5

Composite International Diagnostic Interview (CIDI)

Referral Challenges



The Numbers

A Health Professional Shortage Area (HPSA): A federal designation to identify areas in the U.S. with a shortage of health professionals

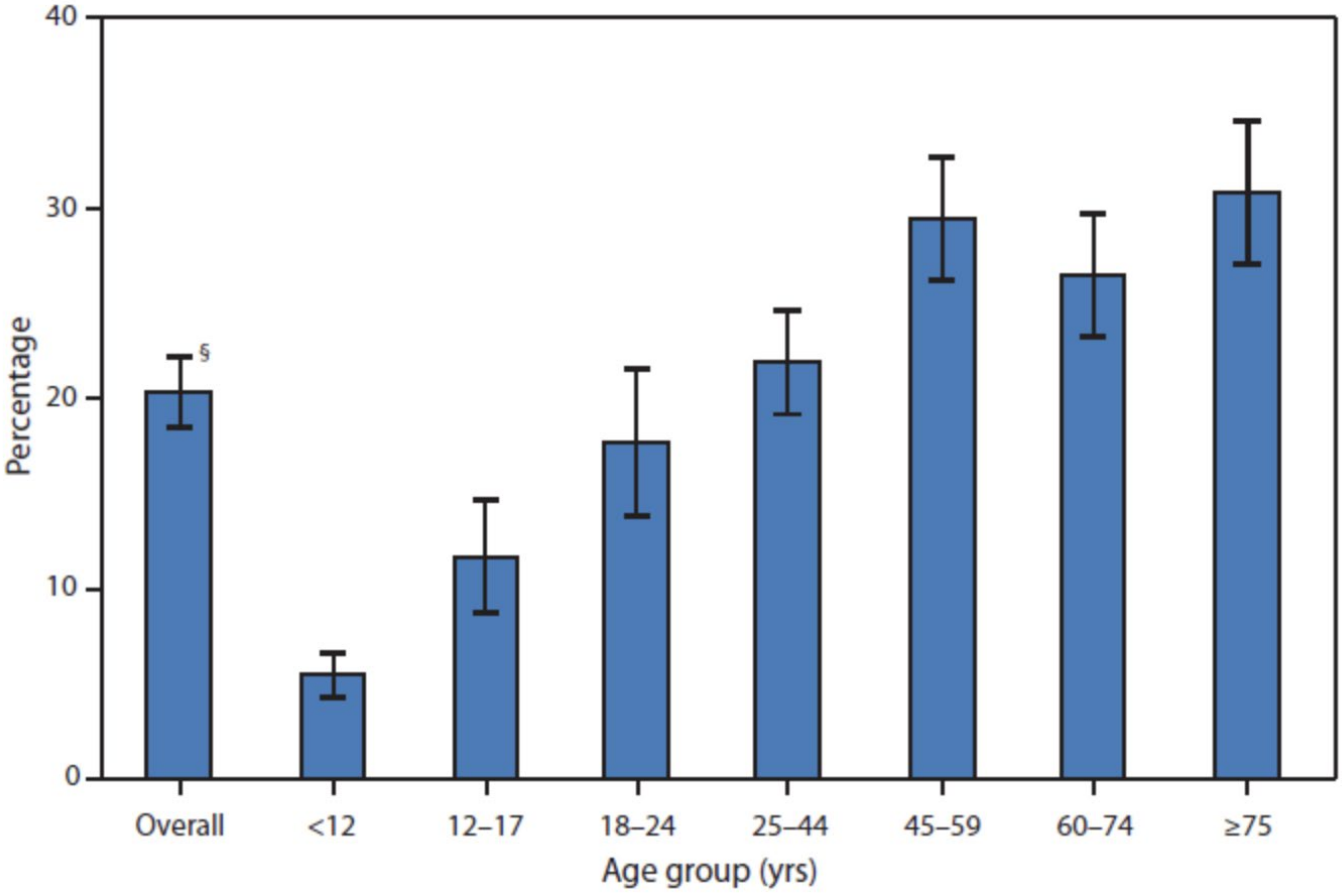
U.S. Population Living in a **Mental Health** HPSA	Percent of U.S. Counties without any psychiatric clinicians	Percent of Total Need Met
157,000,000	56%	28%

The Numbers

- Current Number of Psychiatrists: ~39,000
- Number of Psychiatric NPs: ~23,000
  - To Compare, there are ~210,000 Primary Care Physicians and 86,000 NPs and PAs
- Estimated Number of Behavioral Health Providers to solve the shortage: 15,000-30,000
- Number of New Psychiatry Residents in 2022: 1,640

40% of Americans think that finding a local psychiatrist who accepts their insurance is more gruelling than filing taxes

Percentage of PCP Office Visits, involving mental health counseling, diagnosis or medica



60% of Behavioral Health treatment is provided in primary care practices.

This includes 70-80% of antidepressant prescriptions

Opioid Use Disorder

- Only 1 in 4 Americans with opioid dependence receives evidence-based medication treatment
  - 52% of ACOs in 2022 offered *some* form of MAT/Opioid Use Disorder treatment.
- **Buprenorphine:** 80% reduction in substance abuse, higher rates of employment, decreased rates of HIV and Hepatitis C, reduced criminal behavior
  - When the X-Waiver was in place only ~8% of Primary Care Physicians had ever prescribed it.
  - As of 2023: there is no special waiver required to prescribe it and rates of buprenorphine prescribing have been increasing
    - But: 80% of the increase is from Nurse Practitioners and Physician Assistants prescribing.

Consequences of the Lack of Behavioral Health Treatment Acces

- $193 Billion in lost productivity due to impaired work performance
- Only ~50% of patients with a mental illness received care in 2022
  - 30% of patients with depression never receive any treatment.
- 15% of U.S. adults had a substance use disorder in the past year.
  - ~94% did not receive any form of treatment.

Models of Care

20% of PCPs work with a BH provider on -site

Co-location

The BH provider shares a space, but may still be doing siloed treatment

Telemedicine

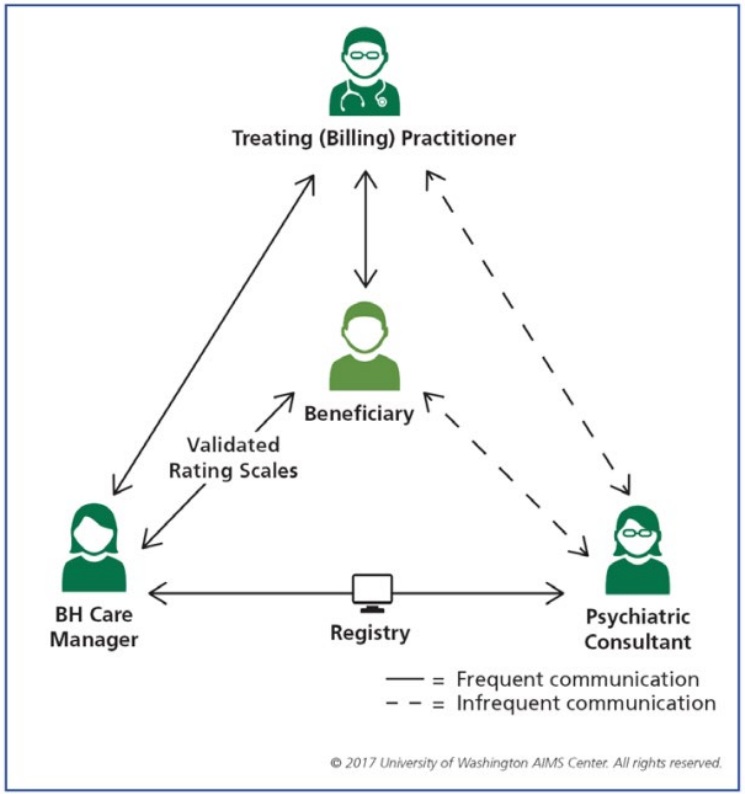
Can provide care to regions with no physical provider.

Redistributes the shortage.

Primary Care Behavioral Health

The BH provider is co-located and provides care specifically directed towards supporting the PCP. Typically does not develop a long term panel of patients so that their panel does not fill up and make them unable to be of additional service

Integrated Care: The Collaborative Care Model (CoCM)



CoCM: Behavioral health integration that enhances usual primary care by adding two specific services to the primary care team, intended primarily for patients whose conditions aren't improving:

1. Care management support for patients receiving behavioral health treatment
2. Psychiatric inter-specialty consultation

A team of 3 individuals deliver CoCM:

- Behavioral Health Care Manager
- Psychiatric Consultant
- PCP: The Treating (Billing) Practitioner

CoCM Benefits

- Physicians report that integrated care:
  - Directly improves patient care (94%)
  - Is a needed service (90%)
  - Helps provide better care to patients (81%)
  - Reduces personal stress level (90%)
- 90+ RCTs and meta-analyses: reduces PHQ and GAD scores, lowers total cost of care

So why are these billing codes not utilized widely?

CoCM Challenges

Clinical Challenges	"Agency Problem"	Not Payer Agnostic	Patient Engagement	Contracting
Some BH patients are hard to care for: emotionally challenging and time-consuming. CoCM brings PCPs deeper into these challenges than referring out.	Caring for BH patients is of most financial benefit to health plans, then to ACOs and PCPs. CoCM asks PCPs to be the ones to to take on the challenge.	Not every health plan covers CoCM. Many health plans to do cover it pay even less than Medicare.	Patients need to agree to the service, and most plans require co-pays. Some of the patients who would benefit from the service do not want to pay for it.	Independent PCPs need to arrange a contract with BH providers on their own or review contracts provided to them.

Billing Complexities

- There can be Stark law (anti-kickback) challenges unless the contract is arranged carefully.
- The billing is especially complex, requiring PCPs to submit bills for work they did not perform or supervise.
  - Confusing claims claims denials
  - "Loss Aversion" – writing checks to the outside BH team.
- CoCM can't be billed unless the full set of benefits is delivered
  - Flexible payment practice may be beneficial.

The model may be best supported by clinically integrated networks or fully outside of a fee for service model, such as bundled payments.

Approaches taken by other ACOs

A clinically integrated network ACO. In 2023:

- **LCSWs provided ~7,500 billed psychotherapy services to adults and children.**
  - A brief therapy model and bridge for those with complex needs.
  - The majority of clinicians are embedded within the medical home and offer face-to-face and virtual services.
    - This model helps reduce the stigma associated with behavioral health needs.
    - Currently employ only fully licensed LCSWs, but exploring how to add LCSW-Associates to meet the growing demand for services while meeting near-budget neutral fiscal expectations.

- **~4,000 Collaborative Care Management encounters for 156 unique adult patients.**
  - CoCM is provided virtually, follows the University of Washington AIMs Center model for Psychiatrist and LCSW staffing ratios and workflows.
    - Anxiety response rates of 56%
    - Depression response rates 41%
    - The issues facing further scale are:
      - Payer reimbursement
      - Maintenance of caseloads
        - CoCM time accrues monthly, with waves of first-of-the-month graduations, creating peaks and valleys in caseloads. Plan is to set targets weekly enrollments to get to steady state.

Approaches taken by other ACOs

A network of ~75+ community providers and ~900 academic physicians with ~17,000 patients

- Having behavioral health providers in their multi-specialty academic group in the ACO has helped improve access.
- They try to prioritize referrals from ACO PCPs over outside referrals when possible.
- ACO nurse care managers and community health workers outreach patients can make direct referrals to the behavioral health providers.

Approaches taken by other ACOs

A multi-speciality, physician-owned medical practice and ACO

"We have struggled on how best to address the behavioral health needs of our patients. We perform depression screens, but there have been so few resources in our rural setting that management has been one more thing for our primary care providers."

- Will be adding a GAD screening tool to PCP visits.
- Launching a Collaborative Care Model using virtual therapists and providers from outside the area.
- Using shared savings, have hired a psychiatrist and physician assistant to launch a new psychiatry department for medication management when the providers wish to refer.
- Access to the new department will be limited to established patients of the group.

"If all goes according to plan we will have both services live by the end of the year."

Approaches taken by other ACOs

A large health system with 200+ primary care clinics in 5 states and an ACO.

Follows the University of Washington AIMs Center model

The program was developed over a four -year period and continues to expand across the system, mostly telephonic with the availability to meet with patients in primary care offices as needed. They contracted with psychiatrists to ensure all members of the BHI team utilized the same EHR.

BHI is available in 15 primary care clinics. 850 referrals, and 570 were screened to be appropriate for the program. Some patients have been enrolled in BHI more than once; therefore, we have had 614 total episodes in BHI.

Overall PHQ-9 improvement for patients is 19.7% and overall GAD7 improvement is 11.65%.

Revenue has increased.

<u>Barriers include:</u>

- Lack of payer reimbursement for managed Medicaid plans
- Limited use of the general BHI CPT codes
- Inability to expand due to limited Psychiatrist time
- Ensuring that correct codes are placed on claims for accurate billing.
- Not yet expanded to pediatric populations.

Approaches taken by other ACOs

One ACO in an “exploratory phase”:

“We have explored using a tele -behavioral health vendor to do some initial assessments on our chronic patients… have talked with a few vendors, and we do believe that there is a benefit to offering this to our sickest patients for free.”

Any patient enrolled in their Chronic Care Management program will be eligible for the service.

“Additionally, we are considering that all patients will be given an online assessment for us to help identify any challenges or conditions that would not normally be revealed in an Annual Wellness Visit. hope to explore this further in 2024”

“All In”

A Case Study of an Integrated Behavioral Health Home

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Lelin Chao, M.D.

Prescribing Buprenorphine: A Catalyst for Integrated Care at an Urban FQHC

- Multi-site, urban FQHC founded in 1970, Baltimore, MD
- All physicians received X-Waiver for Buprenorphine prescribing by 2004
- Worked with BH and SUD specialists to develop a “no wrong door” comprehensive program for patients with opioid use disorder
- With the University of Maryland School of Pharmacy faculty, became the first health center to develop a collaborative care protocol
- 2008 operationalized “stack visits” for BH specialists to be integrated in primary care visits

Helping Up Mission™

NOW IT'S UP TO US

Ce Location

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Michele Fronckiewicz

Aledade

“A Match Made in Heaven”
(New Jersey Co-Location - Primary Care Behavioral Health)

Primary Care Practice + Partner (Forge)

Goal to improve self management for both mental and physical wellness

Effective and Accessible

93% satisfaction with therapist and treatment plan
97% of referred patient intake completed within 1 business day

Improved Outcomes

- 36% reduction in depression &PTSD symptoms
- 34% reduction in anxiety symptoms
- 47% reduction in suicidal thoughts, feeling, behaviors
- 20% increase in primary care visits
- 62% reduction in ED utilization

Collaborative Care Update

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Jeff Mandel, M.D.

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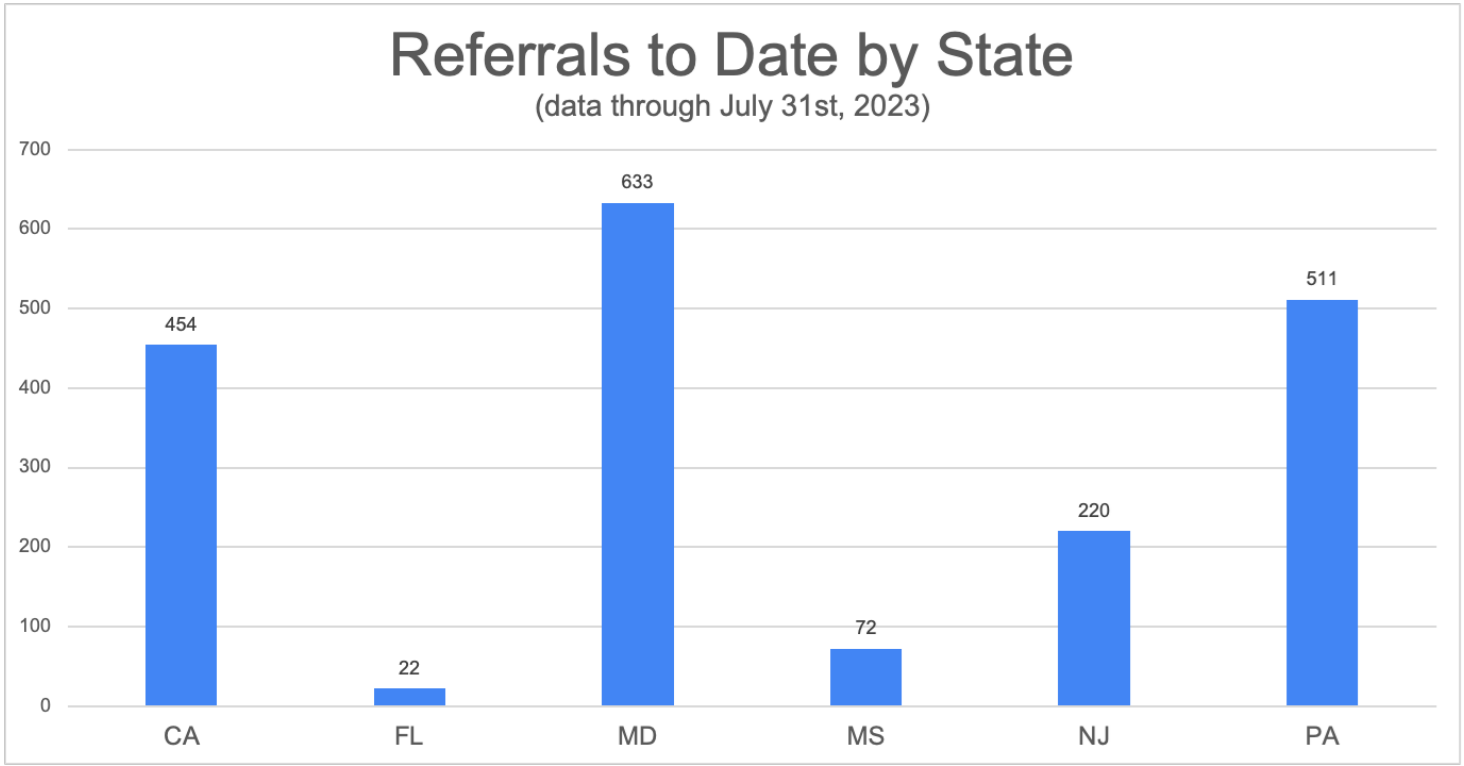
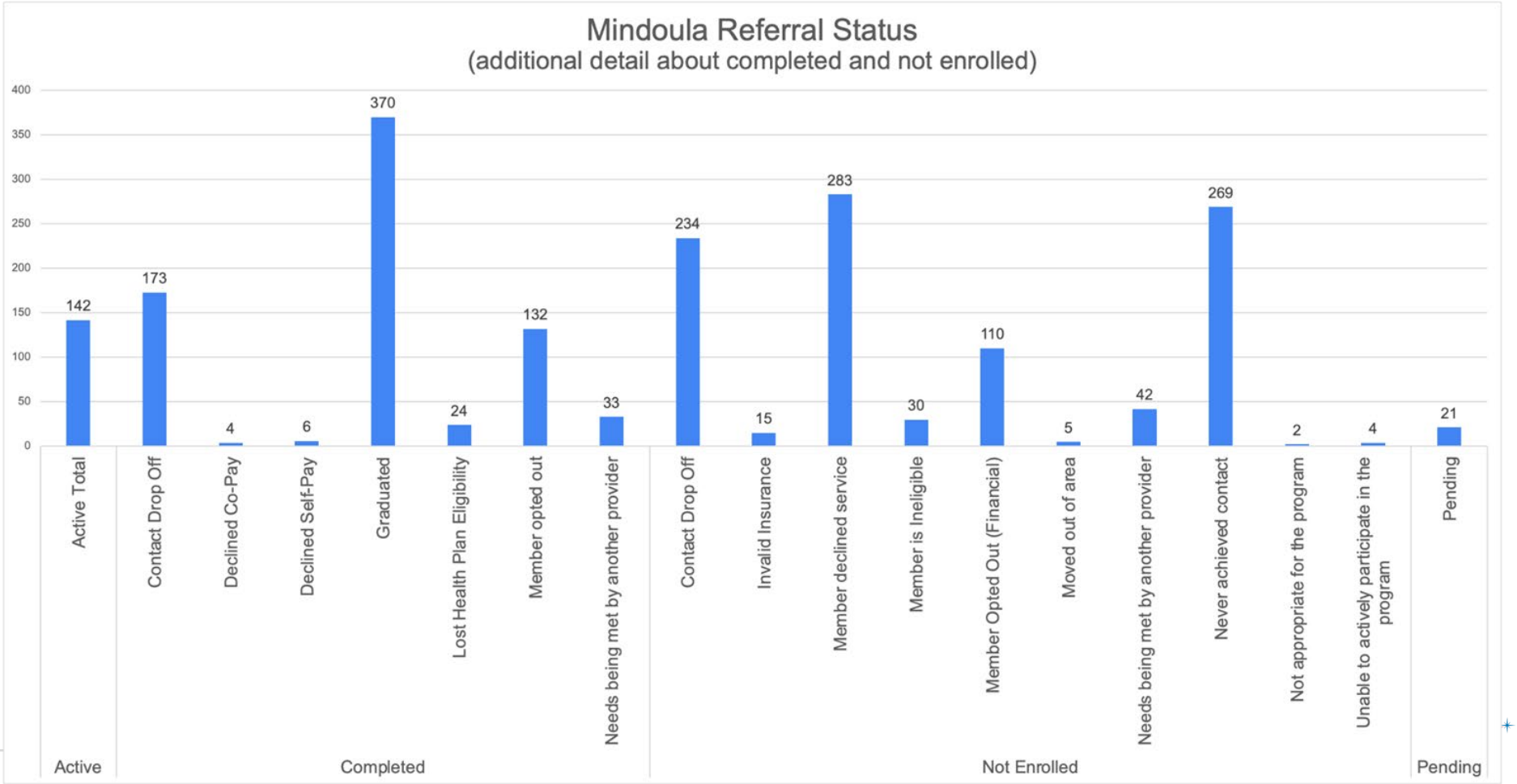
Mindoula Total Referrals by ACO/CTO

As of July 31, 2023



Mindoula Referrals: Patient Status



Mindoula Total Referrals by Practice

Specific Clinic	Referrals	State
-	220	NJ
-	216	PA
Graham Medical Clinic	**215**	**PA**
-	170	CA
-	142	CA
-	72	MS
-	67	CA
-	61	PA
-	42	CA
-	33	CA
-	16	FL
-	6	FL

Interview with Graham Medical

1. How hard is it for your patients to access counseling or psychiatry?
   It is often challenging. Our patients have difficulty with finances and access to behavioral health.

1. What type of patients do you refer to Mindoula?
   Anxiety, panic disorder, depression, PTSD

1. What type of patients does Mindoula seem most able to help with?
   Depression, anxiety. Not with bipolar, schizophrenia or suicidal.

1. Please describe your workflow for referring patients to Mindoula .
   It is a regular referral. The provider makes a referral and then Mindoula calls the patient.

Interview with Graham Medical

4. In what ways has Mindoula helped your practice?

It has reduced our clinical burden and time spent. There is additional revenue but it is not remarkable.

5. Are most patients accepting of Mindoula's Collaborative Care treatment model?

Yes

6. How do you explain it to patients when they are being referred?

"Since in person care is hard to access, we have a psychiatric practice that we pay to help us make medication decisions by phone for our patients. They will assess you over the phone and send us a letter with their recommendations."

Interview with Graham Medical

7. Do you think the billing and payment system with Mindoula is a good one?

Yes

8. What unmet needs for Behavioral Health treatment remain for your practice and your patients?

Bipolar disorder, pediatric psychiatry