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PERSPECTIVE

Has Value-Based Reimbursement Arrived for Behavioral Health?A Payer Perspective

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Abstract

Background: Value-based reimbursement (VBR) has become increasingly common among medical practitioners but mental health practitioners (MHPs) have largely remained in fee-for-service (FFS) arrangements. Aligning payment incentives to clinical outcomes rather than volume of services, VBR aspires to achieve health care's quadruple aim, namely improved patient experience, improved population health, reduced costs, and improved work life of health care providers.
Aims of the Study: (i) Describe both the historical challenges to implementing VBR for mental health care within the United States, along with the shifting healthcare landscape which now enables VBR arrangements between payers and MHPs; (ii) Highlight considerations for defining quality care and establishing VBR contracting.
Results, Discussion and Implications: Historically, VBR has been challenging to implement due to a shortage of MHPs in payer networks. Technological challenges such as the absence of electronic medical records required for efficient data analysis and immature data-sharing capabilities, have hindered VBR, as has a culture of clinical practice that relies on clinical intuition as opposed to measured outcomes. VBR is now gaining traction based on overwhelming evidence for measurement-based care, a prerequisite for outcome reporting that larger practices have begun to achieve. Multiple stakeholder organizations have been advocating for measurement-based care. Payers and MHPs can and should collaboratively structure VBR contracts to align greater reimbursements with achievable increases in quality across multiple domains. Contracts can focus on numerous process metrics, such as time to care, treatment adherence, and appropriate avoidance of emergency care, along with clinical and functional outcomes. In some instances, case rates for episodes of care can meanwhile help payer and MHPs transition from FFS to VBR.

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Background

The psychiatric profession has experienced several paradigm-shifting breakthroughs in recent decades: the rise of several novel psychotherapies, deinstitutionalization of severely mentally ill patients, new classes of pharmacological agents, neuromodulation (e.g. transcranial magnetic stimulation), the rapid acceptance of virtual treatment, and the increasing acceptance of measurement-based care and evidence-based tools. What is next on the horizon?

We believe the next frontier is likely value-based reimbursement (VBR). VBR is a payment model in which payers provide agreed upon monetary incentives for specified outcomes. Accordingly, it aligns reimbursement with presumably better care of individuals and populations at a time of increasing scrutiny on cost, quality and outcomes. An example would be a predetermined bonus payment for achieving some combination of reduced time to care, a minimum number of visits (suggestive of therapeutic alliance), improved scores on clinical rating scales, more efficient treatment, patient satisfaction with mental health practitioners (MHPs), and/or reduced utilization of the emergency room or higher levels of care for a specific time period. Successful VBR can improve both provider and patient experiences of treatment and enable commercial payers for treatment to assume greater accountability to their clients, namely small and large employer groups who select health insurance products on behalf of their employees. As such, VBR aspires to achieve health care's quadruple aim, namely improved patient experience, improved population health, reduced costs, and improved work life of health care providers.[1] While cost and quality improvements across Centers for Medicare and Medicaid Services Center for Innovation were variable with VBR arrangements in non-behavioral Medicare settings,[2] we believe the behavioral landscape, which has yet to be evaluated with the same rigor, presents both unique challenges but also significant opportunities for success.

VBR represents a substantial pivot from current payment models in which MHPs been reimbursed by commercial in-

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surers or government insurers for professional services on a fee-for-service (FFS) basis for either units of time or procedures. While MHPs strive to provide the highest possible quality of care, a FFS model does not align financial incentives to quality of care. From the perspective of a large payer organization, we explore the challenges and opportunities of this model for behavioral providers specifically.

Current Challenges to Value-Based Reimbursement (VBR)

Mental Health Practitioners (MHP) Shortages in Payer Networks

A pre-requisite for the value-based partnerships between payers and MHPs is payer network participation. However, compared to non-psychiatric medical colleagues, psychiatrists have disproportionately established cash-only practices. In one study, the percentage of psychiatrists who accepted private FFS insurance was 55.3% (with lower-than-desired rates and administrative hassles commonly cited as reasons in other studies) compared to 88.7% of physicians in other specialties.[3] While many MHPs prepare invoices so that their patients with commercial insurance can obtain reimbursement using typically less generous out-of-network benefits, these MHPs do not maintain any contractual obligation with payers to provide care and receive remuneration, let alone structure revenues based on outcomes.

Payers have been reluctant to antagonize their network's MHPs by insisting on VBR. Payers need to maintain robust networks despite nationwide shortages of psychiatrists, and particularly child psychiatrists. With 10,500 child psychiatrists practicing in the United States, the number of practitioners per 100,000 children range by state from 4 to 65, with a national average of just 14.[4] Meanwhile, in one recent study of adult psychiatrists using simulated patients, only 18.5% of psychiatrists were available to see new patients, with median wait times of 67 days for in-person appointments and 43 days for telepsychiatry appointments.[5] Thus, payers have accepted MHPs into their networks on the FFS basis that most of them have historically preferred.

Practice Patterns

Perhaps the most significant hurdle is a cultural one. While MHPs may be adaptable, changing fundamental practice patterns can take time, persuasion, and a personal commitment to achieve. While the Covid-19 pandemic abruptly catalyzed a tectonic shift to and acceptance of virtual treatment, in part because the care of patients and providers' livelihoods required it, incorporating measurements and tracking outcomes can feel robotic, impersonal, cumbersome, and distracting from the work of forging a therapeutic alliance as envisioned by MHPs for over a century. Only 20% of MHPs use measurements in their practice despite ample tools.[6]

Lagging Technology

For MHPs who already work with payers and are willing to both treat patients and accept VBR, technology poses an additional challenge. In 2009, the Health Information Technology for Economic and Clinical Health (HiTECH) Act allocated funding to hospitals and health systems to upgrade and digitize their medical records in order to improve the quality, safety and efficiency of care.[7] This process has allowed for more robust screening and better integration of care among providers. However, mental health outpatient and inpatient practice settings were not targeted for these funds, and the shift from paper charts has been slow and incomplete. The costs associated with certified electronic health record (EHR) technology and the unique needs of MHPs represent significant barriers to adoption with only 6 percent of mental health facilities and 29 percent of substance use treatment centers using an EHR, compared to more than 80 percent of hospitals.[8] The ability to collect, aggregate and analyze data efficiently depends upon their existence electronically. Manual data extraction from paper charts is possible but time consuming and inefficient. We believe critical to the success of VBR adoption is the integration of evidence-based tools at the point of care, not adding administrative burden to the provider. Of note, solo- or small group practices with limited time or resources to transition to EHR technology may face greater challenges in moving to VBR than larger behavioral healthcare systems whose economies of scale more easily enable the requisite investments.

Auspicious Signs for Implementing Value-Based Reimbursement (VBR)

Measurement-Based Care Evidence and Increasing Stakeholder Support

Despite the challenges, overwhelming evidence shows that when we measure care and treat towards outcomes, the outcomes are better, and achieved more quickly.[9] Published studies of measurement-based care can help persuade MHPs to change their practices, and the data clearly show increased remission rates, lower risk of relapse, improved medication adherence, and even a *strengthening* of the therapeutic alliance.[10] The long-standing management tenet, "what gets measured gets managed" is likely influenced by the Hawthorne effect; individuals modify their behavior when aware of being monitored.[11]

Moreover, quality-oriented stakeholders have taken note. For example, the American Psychiatric Association's Council on Quality Care has strongly endorsed the use of measurement-based practice due to better quality of care, improved practice efficiency, and enhanced reimbursement opportunities.[12] Both the Joint Commission and Utilization Review Accreditation Commission (URAC) have incorporated proof of routine use of standardized rating scales in their accreditation standards. Policy advocacy organizations such as The Kennedy Forum have also advocated strongly for measurement based treatment.[13] Shatterproof's Atlas, a navigation tool for substance use disorder patients, is developing relevant outcome measures that will help patients choose high quality, appropriate treatment. Additionally the National Council for Quality Assurance (NCQA) has published a roadmap, albeit not specific to mental health, on how to implement a measure-based care model that emphasizes the role of the pro-

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vider, payer, and patient in successful implementation.[14] Meanwhile, the National Quality Forum vets and disseminates quality metrics across medical disciplines, although it must be acknowledged that among the 25 endorsed behavioral health measures, the focus is primarily on emergency department avoidance, inpatient follow-up and readmission, or selected medication regimens for attention deficit hyperactivity Disorder or schizophrenia. These endorsed measures comprise a very small subset of over 500 behavioral quality measures currently available, albeit with varying degrees of validity, feasibility, and uniqueness.[15]

The healthcare ecosystem has also changed rapidly this past decade. As with other branches of medicine, private equity backed companies have purchased and consolidated inpatient facilities and outpatient clinics, which gives them greater collective bargaining power with payers. These integrated behavioral health systems allow for multiple efficiencies across sites, such as uniformity of electronic medical records, greater data aggregation and analysis, and reporting of clinical outcomes. Many of these entities realize that, beyond rapid access to services, achieving and marketing better outcomes is good business, and they have approached payers seeking higher levels of reimbursement for such outcomes.

Collaborative Approaches to Value-Based Reimbursement (VBR)

We believe that progress toward VBR must be based on collaborative goal and standard setting involving both payers and MHPs to achieve a common interest: better patient care. When the financial incentives are aligned as well, VBR can potentially be more attractive than a FFS model.

Determining What to Measure

Among the many questions to be mutually determined, the first is what variables are worth measuring that define quality care. Despite a variable landscape on adoption of behavioral health measures, in an era of persistently insufficient access to care we believe that access, i.e. the time to first appointment, matters. Our internal data suggests that the shorter the time to a first appointment, the more likely a patient is to continue in treatment, and the more likely clinical improvement will be. Even before the advent of value-based care, our company historically paid a premium to MHPs who availed themselves to patients who needed appointments urgently, e.g. within twelve to twenty-four hours. We found that at least one outpatient visit with a MHP was associated with reduced total medical costs, and that a MHP's ability to connect with a patient through follow-up appointments, a proxy for therapeutic alliance, drives further cost savings in total medical spend.[16] VBR could also incentivize MHPs to track and improve patients' treatment adherence not only with follow-up appointments but also with relevant laboratory testing (e.g. urine toxicology screens). Also, payers who also administer pharmacy benefits can track prescription fills.

Other process variables include coordination of care with medical care providers, reduction of avoidable emergency department utilization and psychiatric inpatient readmission, and more rapid integration with lower levels of care for patients discharging from inpatient or residential settings. A codified VBR relationship between MHPs and payers allows for greater information exchange to achieve these goals.

Symptom reduction is important and measurable and begs the questions of which measures should qualify, and who decides. For depression and anxiety, the Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder-7 (GAD-7) respectively are widely used. Payers may understandably wish to pick a few measures, perhaps one for each of the most common diagnoses, to compare outcomes achieved across provider groups. However, they must be cautious to not dictate treatment. That said, in our experience, MHPs have agreed to specific requests for measurement, so long as they are easy enough to operationalize. A payer-approved menu of acceptable scales for each diagnosis could balance MHP autonomy with payers' potential interest in comparing MHP practices. In any case, scales should demonstrate adequate evidence for validity and accuracy, ideally be in the public domain for ease of implementation and comparison, and for structure and process measures, have a direct bearing on steps that are associated with improved clinical outcomes.[17] Once the measures are chosen, other questions remain: do we measure absolute change on a scale or relative change from a baseline? Should the amount of change vary based on the initial baseline? Do we expect sicker patients to improve relatively more because there is more room for improvement? Or do we expect them to improve less because they are sicker? How do we define "sicker patients?" Should we consider average improvement for patients of all races and ethnicities, or within these categories? Finally, should we consider primarily individuals' outcomes, or should the results be considered in aggregate?

In addition to symptom reduction many MHPs and patients value functional improvement. For example, has a patient been able to make amends with family, locate housing, find employment or improve productivity resolve legal or penal issues, or return to school? Related to functional improvement are social determinants of health (SDOH). A newly emerging area in mental health VBR is the extent to which providers can identify and mitigate them so that they impede access to and improvement from treatment to a lesser extent such that health equity is achieved across patient populations.[18] MHPs, whose education and training focuses on a biopsychosocial model of individuals, should theoretically be able to empathically inquire about gaps in nutrition, education, transportation, housing or other necessities that would impede good health and access to treatment. That said, these discussions, as well as follow-up remedial steps, require time and additional expertise, perhaps from other colleagues. In a VBR framework, MHPs would need to believe they have both agency to mitigate SDOH and appropriate reimbursement to justify the undertaking.

The Importance of Data Sharing

The ability to share data quickly and bidirectionally underlies the success of any value-based contracting arrangement. A temporary measure for payers and MHPs is data extraction and analysis by one party to then hand over to the other. For

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example, MHPs might summarize their symptom reduction efforts or time to first appointment to share with a payer. A payer might tabulate total costs of care (including medical care) for the reduction in emergency department utilization for a group of patients in treatment or the improvement in total cost of care. This kind of data preparation and sharing is time-consuming, however, and the feedback is delayed. The destination state involves both parties being able to visualize, by means of data automated dashboards and other visualization techniques, the data that they need in real time. For example, a patient's lack of follow-through with an initial or second appointment could trigger outreach from a payer's coaching and care management program to assess the clinical needs of the patient or the goodness of fit with the provider. An emergency visit for panic symptoms or parasuicidal behavior would be useful information for an MHP to obtain from a payer to review at their next scheduled appointment with the patient. This type of data exchange takes a significant amount of technological investment, with particular attention to privacy and security. Ideally, patients would participate in data sharing for improved health literacy and participation in treatment. In fact, as reported recently in this journal, decreased patient cost-shares for treatment that is more effective could also lead to patient selection of higher value care.[19]

Reimbursing for Value

Finally, how do we construct contracts for payment? A relatively easy transition from FFS contracting to VBR is a case rate for an episode of care. While a case rate is not the same as VBR, its use can help providers develop comfort with a payment model that does not offer a set fee for an appointment or specific procedure, hopefully encouraging a more holistic view of the overall needs of the patient and the course of care. Meanwhile, case rates ensure a predictable amount of cash flow per treated patient, and for facility-based care reduce staff time and resources devoted to utilization management activities. Similarly for payers, case rates allow for predictability of costs and reduced staff time for claims and utilization management. Case rates work best when a course of care is relatively predictable, e.g. an uncomplicated detoxification for alcohol use disorder, and when guard rails are in place for outliers, e.g. for patients discharged prematurely against medical advice, or whose care becomes much more complicated than could have been reasonably predicted at the outset. Case rates also allow MHPs to include otherwise non-billable services in the cost of care that they nevertheless believe to be valuable. So long as these services do not comprise an excessive amount of time and resources, they can successfully be budgeted into a case rate. Bonuses for better outcomes can be built into case rate contracts. However, it must be noted that case rates confer some risk to MHPs. If the cost of services is below the case rate, they pocket the difference, but if the cost of services is above the case rate, they bear a financial loss.

Ultimately, we believe that an increasing number of practices and facilities will have an increasing number of patients in VBR arrangements, dependent upon candid conversations about how incentives will be paid. Some bonuses may be based on improvement over a baseline, while others may be based on industry standards of care (as government programs do). Some accountable care organizations are already incentivized for screening for psychiatric conditions (e.g. depression, alcohol use disorder) along with establishing a plan of care. Initial VBR contracts, primarily with no downside risk to behavioral providers and facilities, may have various incentives for meeting several process and outcome variables, either wholly or in part. How partners choose to structure these contracts may depend on specific outcomes important to payers and their clients or the clinical strengths of MHPs. Data transparency and good communication among partners are critical dependencies.

At our company, we have structured our initial contracts with a small number of collaborating MHP provider groups to focus on faster time to care, better engagement (e.g. at least three visits within a specified time period as a proxy for therapeutic alliance), and improvement on clinical rating scales, with contractual incentives paid for metrics met. Meanwhile, we are aware of a collaboration between another payer and health technology company (Blue Cross of North Carolina and Quartet Health respectively) that have partnered to facilitate VBR with both small and large MHP practices.[17] Anecdotally, our own provider partners have told us they are discussing or have created VBR arrangements with other payers. While we believe both payers and MHPs are in the early stages of creating these contracts, the willingness of MHPs to partner with payers in the mutual pursuit of higher value care leaves us optimistic about VBR's future.

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