



Integrating Depression Screening and Management with Primary Care in New York City

LESSONS LEARNED FROM THE MULTI-PAYER ONE VOICE INITIATIVE

By Joslyn Levy, BSN, MPH; Jorge R. Petit, MD; Laurel Pickering, MPH; Kathy Sakraida; Michael J. Thompson

ABOUT THE INITIATIVE

Introduction

The One Voice Initiative is a multi-payer demonstration project to implement an evidence-based collaborative depression care model in a limited number of primary care practices in the New York City (NYC) region¹ in order to improve depression screening and management. The initiative was developed by the Northeast Business Group on Health (NEBGH) multi-stakeholder Mental Health Task Force as a public-private partnership with the NYC Department of Health and Mental Hygiene (DOHMH), which included primary care physicians, mental health professionals, commercial health plans, pharmaceutical companies, consultants, employers and consumers.

NEBGH is a not-for-profit coalition representing nearly 200 organizations and more than a million covered lives. Its mission is to empower employers to seek the best quality care at the best price for the overall achievement of greater value. Members include employers, providers, insurers and other organizations committed to improving the quality and reducing the cost of health care in New York, New Jersey, Connecticut and Massachusetts.

Background

The impetus for the initiative came from both the public and private sectors. The NYC DOHMH had begun a series of public mental hygiene initiatives aimed at addressing the startling data from the 2004 NYC Health and Nutrition Exam Survey (NYCHANES)² that showed that 8% of the NYC population had a diagnosis of major depression at the time of the survey but only 37% of those New Yorkers were receiving mental health treatment. NYC DOHMH had a clear aim of making depression screening and disease management a standard practice in all primary care settings in a large, diverse urban metropolis.³

This disparity was further magnified by the mismatch between the very high number of antidepressant medication claims reported by NEBGH's employer members and the very low detection rates of depression reported by health plans in NEBGH's annual eValue8⁴ survey. eValue8 measures health plan performance in areas that are critical to population health management and health system reform. In addition, NEBGH employer members had been expressing concerns about the impact of depression on their employees' health, absenteeism, presenteeism and productivity.

The case for integrated depression care was robust and yet these models were neither the norm in NYC's large and comprehensive hospital and clinic settings, nor the recommended and supported standard of care among the major commercial plans. Since the literature and all available evidence clearly demonstrated

Transforming existing healthcare delivery models is the key to providing higher quality care, resulting in better health outcomes for a larger segment of our population.

In recognition of the need for new models of care, Northeast Business Group on Health (NEBGH) is pleased to share its early experiences in testing a model that integrates depression screening and management with primary care in selected primary care practices in New York City (NYC). This collaborative care model has been successfully implemented elsewhere in the country, and the challenge facing NEBGH's Mental Health Task Force is to design an implementation that works within NYC's complex, distributed, primarily fee-for-service environment. This work is ongoing but has thus far resulted in some early successes as well as key learnings.

Contained in the following pages is a description of the project NEBGH is coordinating, highlighting observations, lessons learned and recommendations for those embarking on a similar quest.



8%

Percentage of NYC population diagnosed as having major depression

37%

Percentage of those diagnosed receiving treatment

that there was value in integrating depression with primary care, the One Voice Initiative sought to formulate multi-stakeholder, regional strategies that would facilitate its widespread adoption.

The model and its application to NYC

The One Voice Initiative is based on the Three Component Model⁵ (Model): a collaborative depression care model that calls for a three-member clinical team comprised of a primary care provider, care manager and consulting psychiatrist to work as an integrated team in order to screen, diagnose and treat depression in primary care.



Various features of individual health plans and of the payer environment in NYC **presented obstacles** to engaging health plans in meaningful collaborative work.

This Model has been implemented and proven to work in other parts of the country where non-profit, regional health plans and large medical groups predominate. NEBGH's Mental Health Task Force sought to design a feasible structure for Model implementation and reimbursement within NYC's more complex, predominantly fee-for-service environment with for-profit national health plans and many small, independent physician practices. While there has been some limited adoption in NYC in select federally-qualified health centers and primary care practices serving Medicaid and low-income populations, its successful, widespread implementation within NYC's commercial environment has not been demonstrated.

Key features of One Voice

Multi-Payer Participation is Crucial

Early in the development of the One Voice Initiative, it was determined that it would be critical to get multiple payers to adopt the Model in order for it to be successful. With the patient panels of almost all of the providers in NYC spread among many payers, no single payer would be substantive enough to change the general practices of the primary care community. Plan support was defined as paying for the services essential to the Model's success. To gain buy-in and provide proof of concept, a pilot was deemed appropriate to demonstrate the higher value associated with this Model

from improved health outcomes and ultimately lower or no greater costs.

Based upon the commitment voiced by several health plans to identify mechanisms to pay for care provided under the Model, NEBGH began working with those plans to identify and recruit a limited number of

small and large primary care practices serving their members. To date, two practices have implemented the Model and have provided positive feedback. Additional provider practices have expressed interest in being included in the pilot, but their participation is on hold pending the final reimbursement solutions from their predominant payers. Several major payers have made substantial progress and commitments to develop non-standard mechanisms to reimburse for the Model pilot. One major payer is exploring an outcomes-based approach to reimbursement.

Meet Needs of Small Practices and Compensate All Team Members

In order to adapt the Model to the NYC provider community, a significant modification was made. Licensed clinicians would be used to fulfill the

care manager role and may not be members of the primary care practice team, may be physically remote and providing services telephonically in most instances. This modification was made since these clinicians were in health plan networks and eligible to bill directly for their services. This approach provided the flexibility required for an individual clinician to support multiple practices.

NEBGH Commitment to Physicians

NEBGH's commitment to the physician practices was to:

- Identify care managers and a consulting psychiatrist to work with the practice.
- Deliver training in depression screening and management.
- Provide technical assistance for Model implementation.
- Provide a registry for supporting care management for those practices that do not have an electronic health record (EHR) or for those whose EHRs do not support this function.
- Support ongoing measurement of the pilot impact on patient outcomes.
- Work with health plans to examine the return on investment.

ANALYSIS AND RECOMMENDATIONS

Lessons learned—NEBGH experience informs others

Throughout the pilot design process and initial implementation, NEBGH has encountered challenges and opportunities, some particular to NYC, that may inform others considering similar multi-stakeholder efforts. A recent publication on barriers to adoption of the integration

of depression within primary care highlighted many of the areas that we have encountered thus far, including provider attitudes about integrated care, increased out-of-pocket co-pays, implementation challenges in primary care practices, medical providers' lack of access to psychiatrists and lack of financial incentives, to name a few.⁶ The purpose of this brief paper is to detail the lessons learned from this process and to offer recommendations for enhancing the likelihood of the success of other similar local initiatives to integrate depression screening and management within primary care settings.

1. Define and Build the Business Case for Change

While there is clear evidence that this Model has been implemented and proven to work in other parts of the country where non-profit, regional health plans and large medical groups predominate, there is no precedent for implementing the Model in a complex and less integrated delivery

clients is significantly different from that of self-insured clients, and there are significant differences within each of these categories depending on the services provided and how policies are structured. Savings come back to the plan on fully-insured clients, whereas savings go back to the employers on self-insured clients.

2. Engage Stakeholders to Understand the Root Cause Issues and Resistance to Change

NEBGH's Mental Health Task Force is made up of stakeholders across the health care community, including four national plans and one local plan, primary care physicians, mental health professionals and employer representatives.

A consensus was reasonably achieved on the clinical process and algorithm, however, the reimbursement methodology did not fit the traditional fee-for-service model used by health plans. From the provider perspective, key concerns are the need to have a

"safe" process for the primary care practice to engage patients about mental illness and to refer for appropriate treatment if any issues are identified. Another is their capacity to

adequately treat the volume of patients that might be identified as a result of Model implementation. Practitioners are skeptical about the efficiency of accessing consultation support when needed, a key feature of the model.

From the payer perspective, additional issues were raised. They were concerned that One Voice could initially drive up the cost of care since previously untreated depressed patients would now be treated. And, with members

constantly shuttling between plans, will the investment pay off for them in the next year? Payers also expressed the importance of minimizing provider fraud and abuse. Finally, there was residual resistance to investing in mental health services due to a largely outdated impression that these services do not have an endpoint. Changing perceptions like these are essential to successfully introducing initiatives like One Voice.

As with any change initiative, it is critical to identify the issues and work through them. A very transparent process of stakeholder engagement was critical to understand these characteristics of the NYC health care market that impede stakeholders' clinical improvement efforts. It was also critical to start the process of addressing the very real challenges inherent in changing clinical and insurance reimbursement practices to improve diagnosis and treatment of depression.

3. Balance Multi-payer Collaboration with More Intensive Engagement of Each Health Plan

Payer collaboration is now viewed as an essential component of quality improvement and cost-saving initiatives. NEBGH is in a unique position to convene a forum of health plans: the health plans are NEBGH members and many of their large customers are NEBGH members. The payers also participate in NEBGH's annual eValue8 survey, which compares health plan performance. The payers have consistently attended Mental Health Task Force meetings over a period of several years, and they were active participants in discussions pertaining to novel reimbursement approaches to cover "atypical" (e.g., the use of a licensed clinician as the care manager) services. Some have even contributed financially to the development of the One Voice Initiative.

However, collaboration is not easy. Payers are driven to develop a competitive edge in the value



Key concerns are the need to have a "safe" process for the primary care practice to engage patients

about mental illness and to refer for appropriate treatment if any issues are identified.

system like NYC. While it is expected that One Voice will result in eventual savings in health care costs associated with improved management of co-morbid chronic diseases and increased productivity, savings in expenditures are just one factor that health plans consider when deciding on what services are covered under a plan.

Furthermore, plan considerations vary substantially based on their customer mix. The business case for fully-insured

and provision of services to achieve comparative advantage over their competitors in attracting new purchasers/employers.

In addition, various features of each health plan and the environment in NYC presented obstacles to engaging health plans in meaningful collaborative work. Described by the United Hospital Fund (UHF) as “impediments to multi-payer actions,”⁷ these features have slowed the development of the One Voice Initiative. One example is that plan representatives who participate in meetings or discussions may not have the full authority or the full knowledge of the broader implications of potential solutions to commit the plan to specific reimbursement mechanisms. By necessity, this poses significant challenges to finalizing solution development and causes delays in the decision-making and implementation process.

Also, the dominance of national health plans in the NYC insurance market presents a challenge. Local carriers serve a concentrated market, rendering them receptive to local demands and flexible in their ability to develop tailored programs and services. National health plans, however, have members spread throughout the country, a system infrastructure that supports multiple markets and a leadership that must look at priorities nationwide. Piloting changes associated with One Voice proved difficult. Plans indicated that making changes to complex electronic claims processing systems was a significant barrier. In addition, national plans may be implementing similar pilot initiatives in other markets and be reticent to undertake multiple approaches to the same issue in different markets. Furthermore, given the corporate structure of the national carriers, even senior level plan representatives on the local level may need to engage corporate level resources and decision-makers to make the necessary decisions to bring the project to life.

Implementing the project across multiple health plans, each with its own administrative structure is challenging. Ultimately, the Mental Health Task Force decided to move forward with NYC’s large regional health plan, EmblemHealth, while working to get the participating national plans on board at a later date. The lessons learned in this initial launch will refine the blueprint for the broader launch as the final payment issues are resolved with the national plans.

4. Be Flexible on Reimbursement and Network Management Issues

Initially, health plans were concerned about the legality of pursuing a goal of common reimbursement structures because of valid anti-trust concerns related to disclosing the specifics of their payment rates. Over time, the group clarified the boundaries of these restrictions and engaged in more open conversation.

However, developing an effective, efficient, common reimbursement model has proven to be a major challenge. While fee-for-service CTP/E&M or HCPC codes describing the services to be provided under the Model were identified as possible reimbursement mechanisms for care management and specialty consultation services, the commercial insurers have not been receptive to reimbursement using those codes because Medicare does not accept them.

Some other key concerns raised:

- Patient attribution: Determining how to bill and pay for inter-professional consultation about a patient when the consultation takes place in the context of a review of a group of patients is unclear.

- Verification of out-of-office services: Paying for services provided over the phone, by email or in other forms (e.g., review of patient data by psychiatrists who consult only with care managers, not with patients directly) raised concerns related to fraud and how to document that these services have taken place.
- Distribution of costs across Medical and Behavioral Benefits: Determining which costs should be covered under the medical benefit and which under the behavioral benefit is open to interpretation and the implications of these decisions pertaining to service caps and carve-outs are significant.



- Variation in plan authority to pilot modified benefits within and across plans: Differences in how plans manage their fully-insured business vs. self-insured business impacts the ability of plans to pilot changes in products or benefits. In some cases, self-insured employer customers need to approve a plan’s participation in a pilot if the employer will be asked to pay significantly more than expected under the current contract.
- Deductibles and co-pays: There was also a potential need to resolve issues related to billing plan members for deductibles and co-pays for services not directly experienced by the patient. Some of the plans indicated that they could forgive the co-pay and deductible, but not all believed that they were in a position to do so given their contractual arrangements with employers.

Eventually, each plan that engaged in the discussions did offer proposals for how to cover the essential services.

However, plan differences in payment mechanisms and administrative practices rendered a single approach unfeasible.

Network challenges can also be an issue. A suggestion that behavioral health providers be credentialed by all of the participating health plans was met with some resistance. One Voice envisioned developing a model of shared resources, with one Licensed Clinical Social Worker (LCSW) serving as care manager for multiple health plans at a single practice, but in order to introduce this model, LCSWs had to be credentialed by every plan serving the practice. Health plans expressed a preference for using the providers that were already on their panels and had concerns about their ability to enter into an expedited credentialing process to achieve this goal.

In addition, the health plans have internal care managers and/or disease management programs in place, and expressed a preference for relying on their own internal clinical resources for consultation and care management. The plans acknowledged that providers rarely access these services, however, some were more eager to increase the demand for services, which they already offer, rather than developing a new structure to reimburse independent clinicians.

The Impact of a Shifting Health Care Environment

Interestingly, in the course of implementing the One Voice Initiative, the health care environment has shifted at an unprecedented rate. The planning phase of this initiative was launched in 2009, with initial implementation launched in 2012. This time horizon coincided with a period of major upheaval in the broader health care arena. It has caused many of the proposed payment solutions to be revisited as some of the fundamental assumptions on which they were based also shifted.

Health Care Reform

The introduction of new health care reform legislation, new models of care delivery and new technology has created an opportunity for greater care coordination and focus on outcomes and improved health. Hence, plans are increasingly moving toward shifting reimbursement away from pure fee-for-service to approaches that reward better outcomes and further support primary care. This affords One Voice the opportunity and challenge to leverage and conform to that new point of view. Conversely, some Affordable Care Act (ACA) provisions pertaining to health plans may have produced unintended consequences. For instance, the ACA lowered the percent that health plans can attribute to administrative costs; as a result, plans are less receptive to making any payments outside of the claims system as a means of piloting new services in a very limited capacity. This inability to use alternative mechanisms to pay for pilot projects did introduce an additional impediment to innovation.

New Care/Payment Models

The anticipated widespread adoption of the Patient-Centered Medical Home (PCMH) and movement towards outcomes-based payment have impacted the way health plans think about paying for services, including care management. Ultimately, it is highly likely that practices will be compensated for providing care management.

Pilot projects like One Voice offer practices an opportunity to begin testing and developing workflows

to integrate these services and offer health plans an opportunity to test and develop new payment models.

Meaningful Use

For the short term, Meaningful Use (MU) has introduced yet another area of uncertainty and required redirection of practice resources away from other key initiatives. With the financial pressure to adopt EHRs, health plans have seen that some practices in the process of integrating the new technology may not have the capacity to focus on pilot projects related to new systems of care delivery simultaneously.

The Provider Perspective

At the provider level, primary care practitioners have been eager to engage in One Voice: Providers understand the impact of depression, and they realize that adopting the Model to manage depression in primary care would help them to best support their patients. Behavioral health practitioners embraced the concept as well. There is strong support for NEBGH to help facilitate overcoming a range of challenges in attempting to put the Model into practice. These can be characterized below:

Uncovered and Unfamiliar Services

Without payment structures to cover care management services through One Voice, providers are reluctant to enroll in the pilot project. Similarly, e-visits and telephone visits – the mechanisms that are fundamental to the delivery of behavioral health and care management services in the Model – are not yet



Providers understand the impact of depression and they realize that adopting the Model to **manage depression in primary care would help them to best support their patients.**

widely accepted in primary care practices in NYC given the absence of routine insurance coverage for these services.

The financial barriers to adopting the Model have played out differently in different practices and in some unexpected ways. For example, it was assumed that the Model would be easier to implement in practices that received capitated payment for both medical and behavioral health services. However, an unanticipated layer of complexity emerged that impacted payments for care management services. In the absence of fee-for-service reimbursement, one of the practices recruited would be responsible for covering the cost of any external care management services. Although the practice has some internal care management capacity, it is not sufficient to meet potential demand. While the practice acknowledges the clinical value of the pilot, it is hesitant about over-committing financial resources as it is not clear how any potential savings from improved care (decreased inpatient utilization, decreased pharmacy expenses, etc.) would accrue to the practice to compensate for dollars expended.

Redefining Roles

Most typically, care managers under the collaborative model are not trained behavioral health professionals, and as such, their role is limited to patient education, self-management support and coordination of services, including referrals to behavioral health professionals for therapy. Identifying LCSWs as the appropriate professionals to function in the care manager role – a decision that was largely based on New York City’s predominantly fee-for-service model – introduced opportunities to enhance services to be offered under the Model, but it also introduced complexity around defining and delimiting the care manager role.

LCSWs indicated that they felt well prepared to fill the care manager role

and believed that they added value to primary care service delivery through their involvement in One Voice. However, questions arose regarding the scope of services for LCSWs such as: Does it make sense to send a patient to a therapist when the LCSW Care Manager could provide those services? The LCSWs seem to have straddled the issue by providing a type of brief intervention that is more than the typical care management, but less intensive than therapy. Determining where the line for referrals should be drawn continues to be a question and challenge. In one of the pilot practices the designated care manager is a psychiatric nurse, which introduces similar clinical opportunities and challenges.

Leveraging and Managing Data

Patient data is difficult for practices to track, access and analyze. Even where EHRs are present, providers typically cannot run reports to support population management or assess impact. When practitioners use paper records, they are even more compromised when creating reports or analyzing data. Effective care management and improvement of care requires that the care team use data to support decision-making and inform improvement efforts. Furthermore, there are some structural barriers to sharing behavioral health data with PCPs due to health system guidelines and patient concerns about confidentiality.

Behavioral Health Capacity

Psychiatrist participation in health plan networks in NYC is limited. Primary care providers frequently voice the concern that if they routinely screen for depression, they will identify depression and not have anyone to refer the patient to for treatment. This is despite the fact that LCSWs and other behavioral health professionals are available through health plans for consultation. These professionals have the requisite

skills to assess and treat, with the exception of prescribing, and also leverage their own referral networks. Broadening PCPs’ understanding of behavioral health services and that staff is essential to the success of depression screening and management in primary care. PCPs should be encouraged to utilize these resources, whether within or outside of the scope of a pilot project like One Voice.

Recommendations

Based on the lessons learned from NEBGH’s experience so far, NEBGH has developed nine (9) recommendations for future projects that endeavor to integrate depression screening and treatment into primary care:

1. Find the objectives that are common to all stakeholders in the project by identifying the motivators for each subgroup (e.g., health plans, physicians, employers, etc.) that will solidify their commitment to designing, implementing and evaluating the project.
2. While difficult to achieve, try to include health plan representatives on the steering committee that have the power and commitment to bring the project to life within their organizations or are clearly serving as direct representatives of those individuals that do. Clarify these criteria at the beginning of the project, and introduce an administrative process for assessing and potentially removing members, and for inviting replacement members to join the project. At a minimum, have at least a clear understanding of who the decision makers are and what the representative needs to do to get their approval.
3. Ensure that each health plan is committed to testing new reimbursement schema; a commitment to supporting and

advocating for a change in clinical practice is not sufficient. Also acknowledge that building this commitment is likely to be a long-term endeavor.

4. Address legal issues and anti-trust concerns up front.
5. Address reimbursement for all members of the care team including:
 - a. Specific billing codes to be used for reimbursement if using a fee-for-service model.
 - b. Issues related to capitated practices. Who pays for services? What is included in the capitation, and what is not?
 - c. Specific plans for how to handle co-pays and deductibles.
 - d. Mechanisms for paying for panel management services (review and discussion of multiple patients) that either fall outside of the individual claims process or include methods of individual patient attribution.
 - e. Medical home models and other reforms. Seek areas of concurrence between the project goals and reimbursement opportunities.
6. Engage health plans in substantive discussions of business drivers. Address the many different functions that health plans fulfill, the variation in plan structure and business models both among multiple plans and across their multiple products.
7. Review provisions of the ACA and other healthcare legislation at regular junctures and address areas of concern and any new opportunities with payers. Work with payers and providers to develop intermediary mechanisms that can fulfill the obligations of

PCMH and other new models over time.

8. Encourage employers and other health care purchasers, like unions, to request that health plans work together to facilitate better ways for physicians to screen and manage depression.
9. Encourage PCPs to refer to non-physician behavioral health professionals when behavioral health services are indicated, and to only refer to psychiatrists when their services are specifically indicated.

Conclusions

At the time of this publication, One Voice is still a work in progress. The national health plans are reevaluating how they will pay for collaborative care services. Additionally, the focus of New York's State Health Innovation Plan is to ensure that in the next five years, 80% of NY State population receives health care services through integrated care-delivery models.⁸ One of the models will integrate behavioral health services into the primary care setting. NEBGH's efforts to date will serve as a learning opportunity for others embarking on this important work.

It is critical that we address mental health needs and in particular, depression. Depression impacts physical health and reduces productivity. Peter Drucker said, "The most valuable assets of a 20th century company were its production equipment. The most valuable asset of a 21st century institution, whether business or non-business, will be its knowledge workers and their productivity." In NYC, we have a preponderance of "knowledge workers" and the mental capacity of those workers is the most important asset of our employer community.

Coordinating improvement initiatives and payment reforms among multiple payers is crucial. Multi-payer

initiatives are critical to support the economics and coordination of system transformation as well as reduce the fragmentation of competing and proliferating quality initiatives.

We know collaborative care works, and we believe we can make it work in an environment as challenging as NYC. As importantly, when we can make it work here, we know we can make it work anywhere!



NEBGH thanks the following organizations for their critical financial support: Astra Zeneca, National Business Coalition on Health, Cigna, Anthem and EmblemHealth.

References

1. Khan I, Levy J., One Voice: An employer-led initiative for depression screening and treatment in primary care in New York City. Mental Health Works. 2010 Oct - Dec; 16 -19.
2. New York City Department of Health and Mental Hygiene (2004). Health and Nutrition Exam Survey (HANES).
3. Changing the Landscape: Depression Screening and Management in Primary Care. NYC DOHMH December 2005 <http://www.nyc.gov/html/doh/downloads/pdf/dmh/dmh-depression-paper.pdf>.
4. eValue8™. Offered in cooperation with the National Business Coalition on Health, eValue8™ is the nation's leading, evidence-based tool for assessing and managing the quality of health care plans. eValue8 enables NEBGH members to assess the performance of health plans in New York, New Jersey, Connecticut, and Massachusetts, and make informed purchasing and benefits decisions.
5. Oxman TE, Deitrich AJ, Williams JW Jr, Kroenke K., A three-component model for reengineering systems for the treatment of depression in primary care. Psychosomatics. 2002 Nov-Dec; 43(6):441-50.
6. Grazier KL, Smith JE, Song J, et al. Integration of Depression and Primary Care: Barriers to Adoption. J Primary Care & Comm Health. June 2013.
7. Cavanaugh S., Burke G. A multipayer approach to health care reform. United Hospital Fund. 2010.
8. New York State Health Innovation Plan. NY State Department of Health, Executive Summary December 2013 https://www.health.ny.gov/technology/innovation_plan_initiative/.



NEBGH works with employers in:

- **NEW YORK**
- **NEW JERSEY**
- **CONNECTICUT**
- **MASSACHUSETTS**

Northeast Business Group on Health

61 Broadway, Suite 2705

New York, NY 10006

Phone: 212-252-7440 x223

Fax: 212-252-7448

www.nebgh.org

© 2014 Northeast Business Group on Health.
All Rights Reserved.