

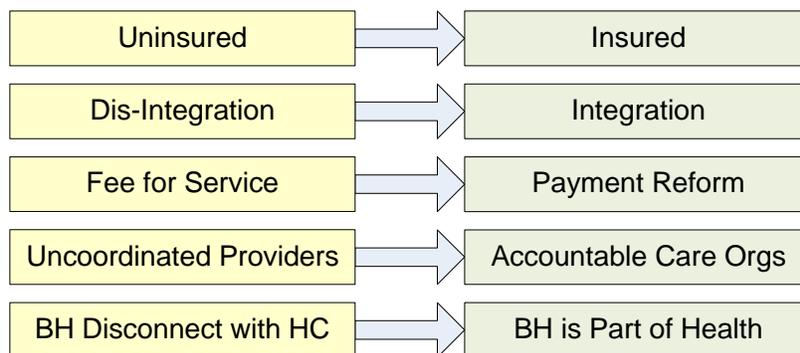
How Are We Going to Get Paid Tomorrow? Emerging Models for Health and Behavioral Healthcare Working Draft

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Overview

There is clear consensus that health reform efforts at the Federal and State levels will not succeed unless quality is improved and costs are contained. To accomplish these objectives healthcare reform must include simultaneous reengineering of the payment and delivery systems.

Within this context, passage of comprehensive federal healthcare reform legislation will usher in an era of unprecedented change in the health and behavioral care systems. We will almost certainly see most uninsured persons with moderate to severe mental health and/or substance use disorders obtaining coverage through Medicaid or the Exchanges. Payment reform and service delivery redesign will trigger dramatic changes in how health and behavioral health services are funded and managed in order to bend the cost curve. Together, these changes will create a tipping point in how healthcare needs of persons with serious mental illness and behavioral healthcare needs of all Americans are addressed. The following diagram illustrates these key shifts.



This monograph has been written to update my 2009 white paper, *Healthcare Payment Reform and the Behavioral Health Safety Net: What's on the Horizon for the Community Behavioral Healthcare System?* In that paper, I explored the following ideas.

Healthcare reform efforts are already underway in the public and private sectors. Testing of new methods for organizing and funding care in the areas of chronic medical conditions and potentially avoidable complications provides a window into how general healthcare reform will occur. Medical homes are being piloted to manage the health status of persons with chronic medical conditions, while bundled payment pilots are testing risk and reward arrangements for acute care episodes. Together, these types of efforts are leading to three fundamental system improvements – healthcare will become better coordinated; prevention, early intervention and disease management services will grow with a corresponding decline in secondary and tertiary care; and errors and overuse will be disincentivized by replacing fee for service payments with risk and reward financial arrangements.

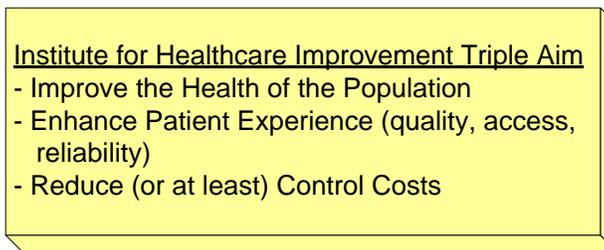
The “new world” of healthcare will see the implementation of parity, universal coverage, and Medical Homes accountable for the total healthcare expenditures of their patients, with associated financial risks and rewards. When this happens, medical practices and health systems will quickly learn that there are certain populations critical to curtailing U.S. healthcare expenditures, such as the elderly with multiple medical conditions and persons with serious mental health and substance use disorders. These populations will be put under intense scrutiny, which will afford significant opportunities for addressing the current health disparities for persons with serious mental illness as well as opportunities and threats to the community behavioral healthcare delivery system. Centers that don’t become part of the Medical Home structure and/or aren’t able to demonstrate through measureable results that they are able to provide high quality specialty behavioral healthcare that manages the total healthcare expenditures of their clients will be at risk.

From this vantage point, let’s explore the world of healthcare payment reform and service delivery redesign, circa 2010.

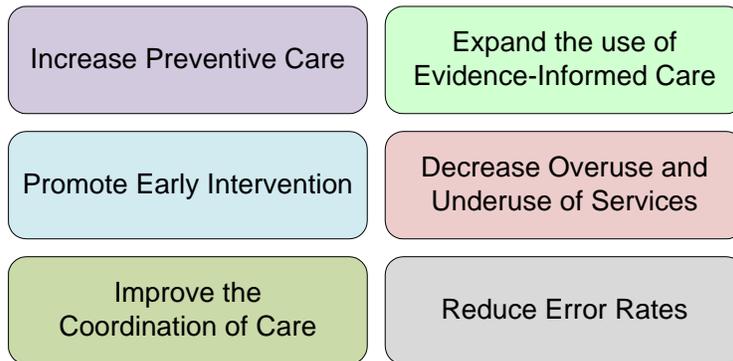
Emerging Healthcare Delivery System Models

Goals and Incentives

Most current delivery system design work is grounded in the Institute for Healthcare Improvement’s Triple Aim.

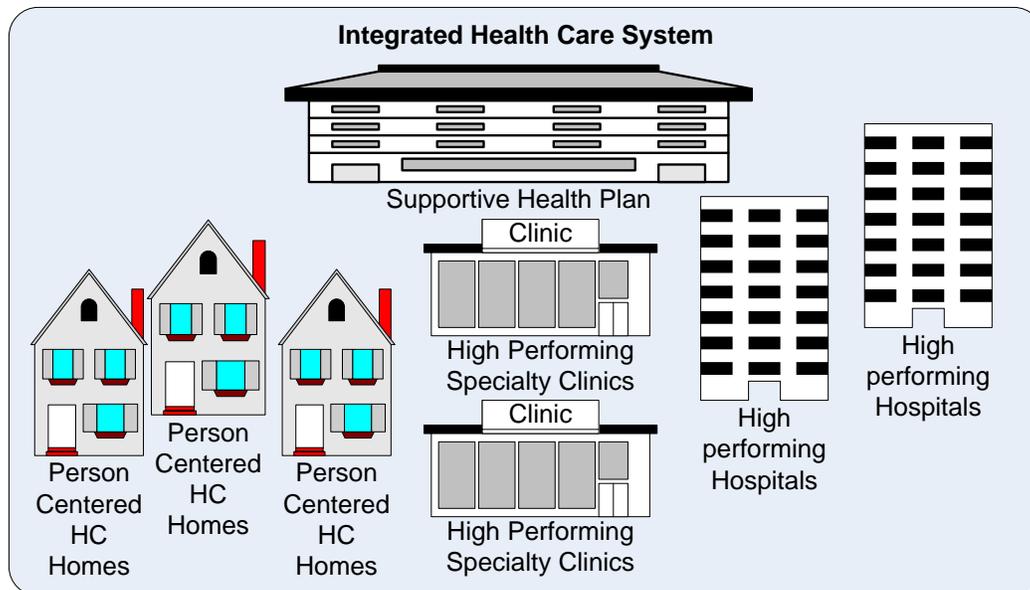


Delivery system redesigners have an obligation to address all three aims in any change project, rather than focusing on one or two. In addition, redesign should focus on one or more of the following objectives in order to improve quality and bend the cost curve.



As planners and researchers examine existing models that achieve these aims and objectives, Kaiser, Group Health and Intermountain always enter the conversation. The common denominator is that each is an integrated health system that is a combined health plan and service delivery system with a large number of employed clinicians.

This model removes the disincentives and incentive barriers in the current, mostly fee for service healthcare system that are considered by most health economists as a major barrier to healthcare reform. The following diagram illustrates an integrated healthcare system.



Care Models

An integrated healthcare system can develop and fund robust person centered healthcare homes to provide prevention, early intervention, and robust chronic care management following the principles developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association in 2007.

The principles include having an ongoing relationship with a PCP who is working inside a team that collectively takes responsibility for patients, including ensuring that patients are referred to high quality specialists and hospitals, and their care is well coordinated with a focus on quality and safety. The practice has extended hours including 24 hour coverage.

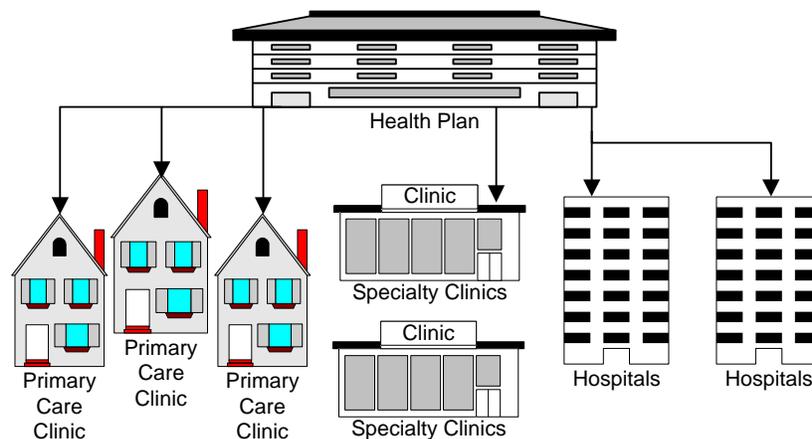
One illustrative example of person centered healthcare homes within integrated healthcare systems is Group Health Cooperative in Seattle. Between 2002 and 2006, Group Health implemented a series of reforms to improve efficiency and access, including same-day appointment scheduling, direct access to some specialists, and a patient Web portal to enable patients to email their doctors and do online medication refills. What they found was that patient access and satisfaction increased, but physician workload increased and this was accompanied by provider fatigue, lower work satisfaction and reductions in nationally reported quality-of care indicators.

To address these problems they began a Patient Centered Medical Home pilot at one of their clinics with 9,200 adult patients. During this pilot they increased visit length to 30 minutes, reassigned 25% of patients to other doctors and hired 59% more PCPs and

significantly more nurses and support staff in order to provide more time to accomplish the objectives of a healthcare home.

After 12 months they found significant improvements in patients' and providers' experiences and the quality of clinical care and despite the significant monetary investment in the redesign, the costs were recouped within the first year. In year two (2008), they found that for every one dollar invested in the health care home, inpatient costs fell by four dollars. In mid-2009, Group Health announced they were moving their entire system to the healthcare home model.

They were able to pursue the pilot and then spread the design because they know that if they saved money on inpatient services they could reinvest those monies further upstream, inside their system or reduce the growth in insurance premiums. Most healthcare delivery organizations don't have this flexibility, as illustrated by the following graphic of funding flows in a fee for service system.



Alignment of Goals, Incentives and Care Models

In a fee for service, non-integrated model the payor capitates a health plan to ensure that needed care is provided to the enrolled population. Health plans typically have separate relationships with primary care providers, specialty providers, and acute care facilities. (For purposes of this monograph, long term care services are not addressed; they are part of the equation but require a separate conversation.) This model contains many disincentives that lead to overuse, misuse, and underuse of clinical services. It has been estimated that by correcting these problems, as much as 30 percent of health care costs, or approximately \$700 billion, could be eliminated without reducing quality.

In the Group Health setting, clinicians and managers can continue to focus on improving their specialty and acute care systems with the knowledge that over time, as their prevention, early intervention, and chronic care management systems continue to evolve, they will need fewer and fewer specialists and hospital beds.

Emerging Behavioral Healthcare Delivery System Models

The Business Case

There has been a great deal of discussion about the bi-directional person-centered healthcare home as a clinical model for integrating behavioral health into primary care and primary care into behavioral health. Behavioral healthcare organizations that wish to participate in these healthcare homes through merger, partnership and linkage, have a great deal to offer in helping bend the cost curve.

There is a growing array of data being published about the dramatic total healthcare cost difference between persons with mental health and substance use disorders and those without such disorders. The follow table summarizes research JEN Associates recently completed for the California Medi-Cal system.

California Fee for Service Medi-Cal Analysis - 2007			
	Medi-Cal FFS Total	Medi-Cal FFS SMI	Metric
Medi-Cal FFS Enrollees	1,580,440	166,786	11% SMI % of Total
Medi-Cal FFS Costs	\$6,186,331,620	\$2,395,938,298	39% SMI % of Total
Medi-Cal FFS Cost/Enrollee	\$3,914	\$14,365	3.7 SMI/Non-Ratio
Diabetes	4%	11%	2.8 SMI/Non-Ratio
Ischemic Heart Disease	2%	6%	3.0 SMI/Non-Ratio
Cerebrovascular Disease	1%	3%	3.0 SMI/Non-Ratio
Chronic Respiratory Disease	5%	13%	2.6 SMI/Non-Ratio
Arthritis	2%	7%	3.5 SMI/Non-Ratio
Health Failure	1%	3%	3.0 SMI/Non-Ratio
Inpatient Episodes/1,000	100	293	2.9 SMI/Non-Ratio
ER Visits/1,000	337	1,167	3.5 SMI/Non-Ratio
Inpatient Acute Days/1,000	609	2,094	3.4 SMI/Non-Ratio
Primary Care Visits/1,000	128	492	3.8 SMI/Non-Ratio
Specialist Visits/1,000	1,211	6,058	5.0 SMI/Non-Ratio

Prepared by JEN Associates, Cambridge, MA

When the 11 percent of the Medi-Cal enrollees in the fee for service system with a serious mental illness were compared with all Medi-cal fee for service enrollees, the SMI group's spending was 3.7 times higher than the total population (\$14,365 per person per year compared with \$3,914). This ratio continued through the analysis with much higher prevalence rates for high cost health disorders and much higher utilization rates. Because of the size of the study, the results are compelling – persons with serious mental illness have much higher total healthcare expenditures than the general population.

Recent data is also demonstrating that the prevalence of mental health disorders is much higher in certain populations than previously expected. An October 2009 report from the Center for Health Care Strategies found that nationally, 49 percent of Medicaid beneficiaries with disabilities have a psychiatric illness. The subset of this population

who had both Medicare and Medicaid coverage had a 52 percent prevalence of psychiatric illness. These figures are significantly higher than the 29 percent overall prevalence rate reported in a previous report from the Center. In the 2009 study, the Center added pharmacy claims data which captured patients whose psychiatric diagnoses were underreported in the encounter data.

A second set of findings from the Center for Health Care Strategies study aligned with the JEN Medi-Cal data, that disabled Medicaid-only enrollees in the U.S. with a mental illness has greater rates of chronic health conditions. The following table illustrates this finding.

Frequency of Diagnostic Dyads by Cost among Medicaid-only Beneficiaries with Disabilities, 2002, CDPS + Rx Data

Diagnosis 1	Diagnosis 2	Frequency among all beneficiaries	Frequency among most expensive 5%
Psychiatric	Cardiovascular	24.5%	40.4%
Psychiatric	Central Nervous System	18.9%	39.8%
Cardiovascular	Pulmonary	12.5%	34.3%
Cardiovascular	Central Nervous System	13.1%	32.9%
Psychiatric	Pulmonary	11.2%	28.6%
Cardiovascular	Gastrointestinal	10.2%	27.8%
Central Nervous System	Pulmonary	7.0%	26.2%
Cardiovascular	Renal	7.1%	24.6%
Pulmonary	Gastrointestinal	5.9%	24.2%
Psychiatric	Gastrointestinal	9.5%	24.0%

As noted in the exhibit title, the Center studied diagnostic dyads by cost for the top 5 percent most costly disabled Medicaid-only beneficiaries. In three of the top five pairs, psychiatric illness was present.

From a treatment perspective, many health and behavioral healthcare providers report that for persons with mental health and substance use disorders, it is very difficult for an individual to manage their chronic health condition unless they are managing their behavioral health condition. One colleague provided a very relevant example; when his mother was taking her depression medication she was able to take her diabetes medication, but when she stopped taking her depression medication it was virtually impossible for her to manage her diabetes.

These cost and prevalence data suggest that it may be *very difficult to bend the national healthcare expenditure cost curve without addressing the healthcare needs of persons with serious mental illness and the behavioral healthcare needs of all Americans.*

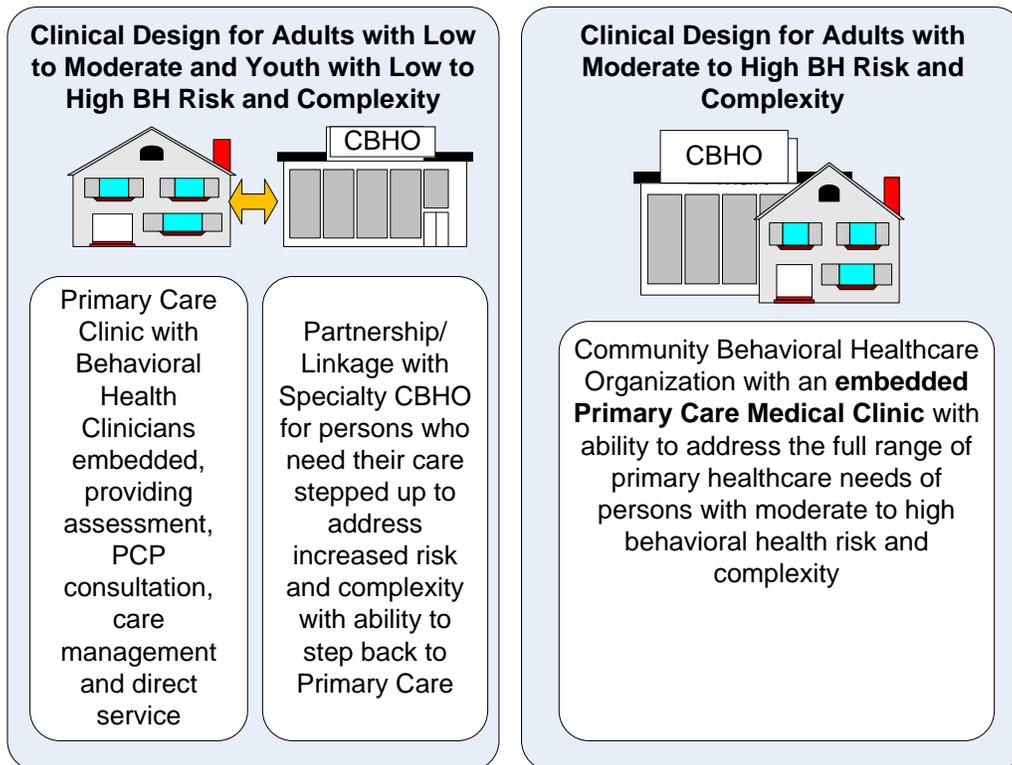
The Customization of Person-Centered Medical Homes

Dr. Arnold Milstein, a healthcare reform thought leader, recently described the need to *customize* the medical home. Comparing medical homes to hospital beds, Dr. Milstein believes that the general hospital bed's relationship to the intensive care unit bed is analogous to comparing a medical home for a relatively healthy population (e.g. insured youth) to a relatively ill population (e.g. senior citizens). Some medical homes, like ICUs, need to be organized to serve populations with much higher levels of severity and there

need to be many types of medical homes customized to the needs of the population being served.

For persons with serious mental illness, medical homes should be designed as primary care clinics embedded in a community mental health center. For persons with serious substance use disorders, another customization variation might be in the form of a primary care clinic embedded in methadone clinic. For persons with low to moderate mental health and/or substance use disorders, another model would be a primary care clinic with embedded behavioral health clinicians.

This following diagram illustrates two approaches to bi-directional care for persons with behavioral health disorders.

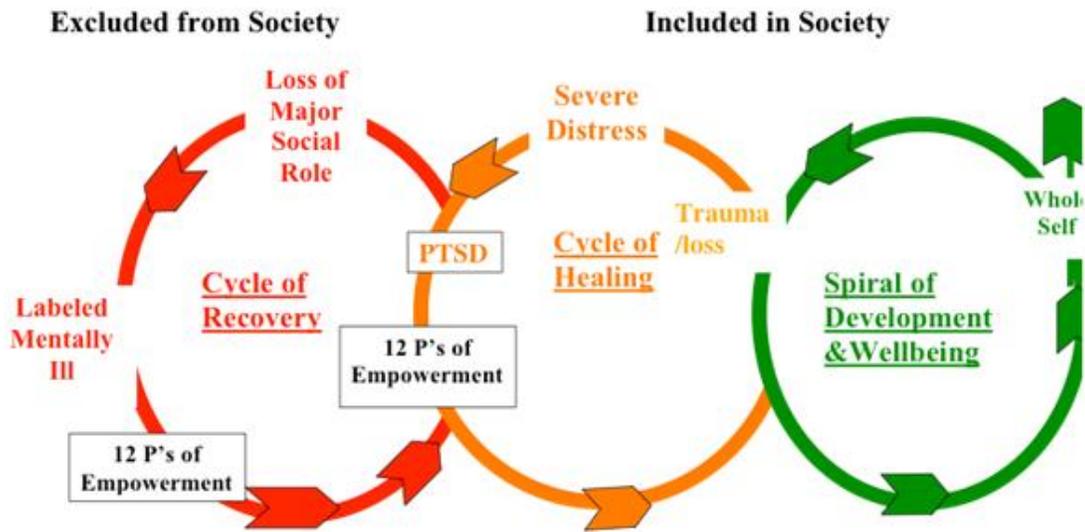


Rather than seeing the development of community behavioral healthcare organizations (CBHOs) with embedded primary care clinics as another plea for exceptionalism, this model will simply become one of many versions of the *customized medical home* that will be designed to improve outcomes and better manage total healthcare expenditures.

High Performing, Recovery-Oriented Specialty Behavioral Health Centers

The second behavioral health service delivery model that will be important under healthcare reform is the high performing, recovery-oriented specialty behavioral health center. While taking many shapes and forms, this type of organization will have one important common denominator – the ability to help persons with mental health and/or substance use disorders progress on their journey toward recovery and wellness.

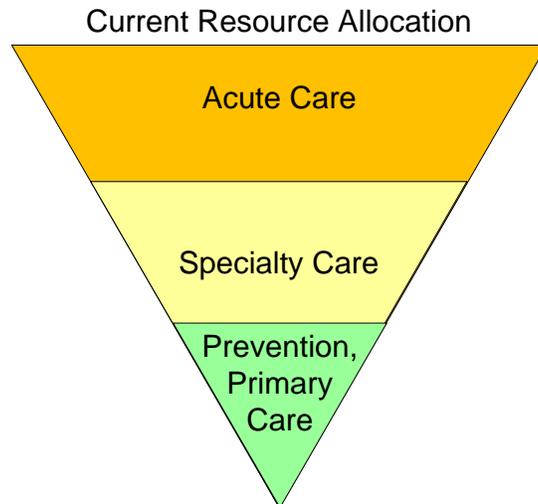
The following diagram from Dr. Dan Fisher at the National Empowerment Center provides a compelling vision of moving from a position of being excluded from society due to mental illness through three cycles – the cycle of recovery, the cycle of healing, and the outward spiral of development and wellness.



Without this type of journey, supported by formal and informal support networks including recovery-oriented behavioral health centers, it will be very difficult for society to reduce the high healthcare costs of individuals with serious mental illness. Centers that are able to demonstrate success in this arena will be identified with a distinct competence providing substantial value to the general healthcare system.

The Delivery System Redesign *Elephant in the Living Room*

Looping back to the discussion about integrated healthcare systems such as Kaiser, Group Health, Geisinger, and Intermountain, many see this model as the “holy grail” of an ideal delivery, management, and financing structure where clinical and financial alignment can easily be achieved. Unfortunately, less than 10 percent of insured Americans are enrolled in integrated healthcare systems and we are not going to be able to wave a magic wand and have the remaining 90% of the delivery system *defragment* like one can do with their computer’s hard disk drive. Thus we have to deal with the reality illustrated by the following diagram.



Very little money is spent on prevention and primary care, more than half the physician workforce consists of specialists, and an inordinate amount of resources is allocated to acute care. Primary care physicians earn a fraction of their specialist peers' compensation and the only way they can pay their bills is to produce large numbers of seven-minute encounters.

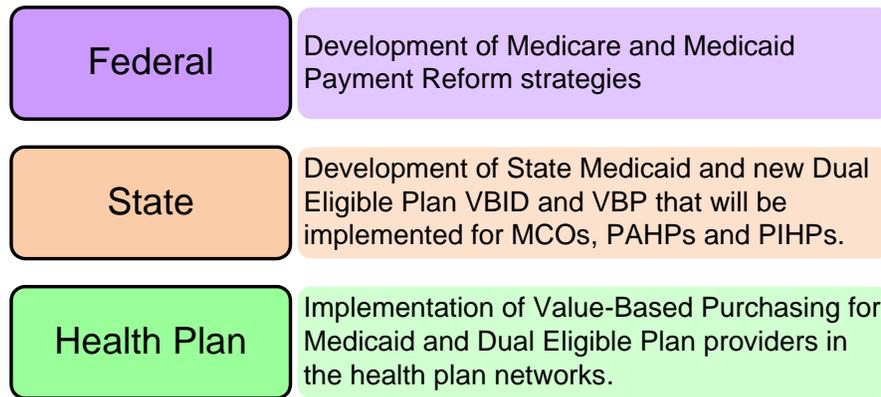
It's very clear that the only solution is to invert the resource allocation triangle to achieve the delivery system objectives noted above. Prevention activities must be funded and widely deployed; primary care must become a desirable occupation; and demand must decrease in the specialty and acute care systems.



What to Do about the Other 90%

While integrated healthcare systems might be the holy grail, even doubling their current enrollment would only increase their market share to 20 percent. With this in mind, it is critical to develop mechanisms that can restructure the other 80 to 90 percent of the system.

The Obama Administration along with a number of states and health plans have determined that healthcare payment reform is the key and are moving forward at an accelerated pace to advance the constructs of “Value-Based Insurance Design” (VBID) and “Value-Based Purchasing” (VBP). The Centers for Medicare and Medicaid Services (CMS) has been working closed with health policy experts to align this work at three levels:



This work is being supported by the National Quality Forum, which is in the process of designing and supporting the deployment of the *Quality Enterprise* to support VPB, VBID, and overall quality improvement.

What follows is an exploration of how Value-Based Purchasing and Value-Based Insurance Design are unfolding, followed by the new Healthcare System Models that will support these efforts.

Emerging Value-Based Purchasing Models

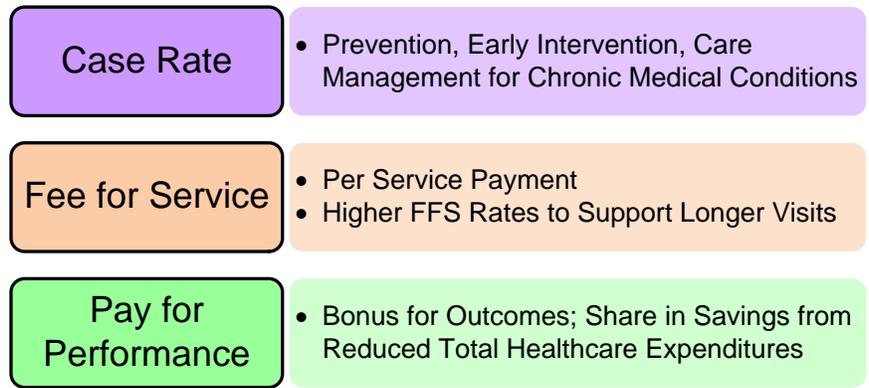
Value-based purchasing (VPB) is the umbrella for the mechanisms that move away from paying for volume and towards paying for outcomes. The following strategies describe key clinical goals and how payment mechanisms help achieve them. Note that a number of mechanisms are overlapping.

- **Prevention and Early Intervention:** Initiatives are being pursued to prevent illness, expand immunizations, reduce obesity and decrease tobacco use and promote healthy lifestyles. These initiatives are supported by financial incentives that include *case rates* to fund additional staff positions, *practice incentives*, and *grants* for targeted programs such as obesity prevention. *Capitation* payments that include a prevention and early intervention cost layer can also support these initiatives.
- **Care Management:** Increasing the quality and quantity of contact between patients with chronic health conditions and the staff in person centered medical homes is a critical goal of healthcare reform. This can be supported by using *case rates* to pay for additional staff and longer visits and providing *bonuses* for practices that successfully implement care management systems and can demonstrate improved clinical outcomes and lower total healthcare expenditures for patients of the practice. *Capitation* payments that include a care management cost layer can also support these services.

- **Primary Care Incentives:** Incentivizing primary care practices that are person centered medical homes to improve quality and manage total healthcare expenditures through prevention, early intervention, effective care management and referring patients to high performing specialists and hospitals. This is done by setting healthcare home certification standards as an entry requirement and tying *bonuses* to meeting these certification standards, achieving clinical outcome measures, and managing the total healthcare expenditures of the practice's patient population. These incentives will often be layered on top of case rates and capitation payments.
- **Clinical Guidelines:** Continuing research through the *Center for Comparative Effectiveness* and expanding the use of Published Clinical Guidelines in all settings to improve care and reduce errors and paying *differential rates* to providers using such guidelines and tying what may be a significant portion of provider payments to quality and cost measures through *bonus structures*.
- **Hospital Incentives:** Incentivizing hospitals to select high performing specialists/surgeons with demonstrated track records through *bundled payments* that cover the cost of hospital care, specialist fees, and post discharge care, placing the parties at risk for a portion of the avoidable complications costs. This approach creates disincentives for hospitals to perform low volume, high complexity procedures that could result in medical errors. As a result, hospitals will be *forced* to become centers of excellence by creating "hospitals within hospitals" or develop specialty hospitals, both of which focus on groups of related conditions (e.g. orthopedic, cardiology, cancer).
- **Expansion of Person Centered Healthcare Homes:** Providing *seed money* and *ongoing funding* of new venues for person centered healthcare homes including embedding primary care capacity in mental health centers, mobile primary care capacity to supported housing facilities, and telemedicine and home visits to homebound Medicare and Medicaid enrollees.

These new models *consciously break* the link between how much service a provider/facility provides and what that provider/facility is paid. One example is the English model being studied for application to U.S. financing mechanisms. A widely used primary care pay for performance model in England provides pay for performance incentives that constitute as much as 30% of primary care practice income based on clinical outcomes and cost growth management.

In the United States, the person-centered medical home payment model has been envisioned to include three payment layers. A case rate will be calculated to support sufficient care managers including nurses, nutritionists, behavioral health clinicians, and related professionals. A fee for service layer will pay for the typical CPT/HCPCS-type services, but at a higher rate than currently paid. Finally, a pay for performance layer will be added (minimum of 10%) to incentive performance including managing total healthcare expenditures for the clinic's patients.

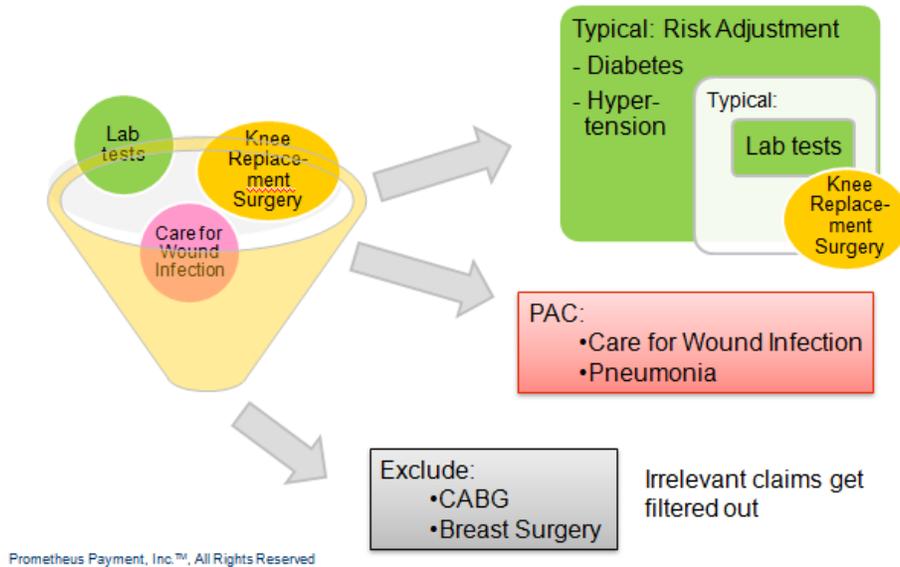


Some health policy experts suggest that the average per primary care provider FTE budget of a medical home needs to be twice that of current primary care practices. Karen Davis, the President of the Commonwealth Fund, has described person-centered medical homes as the “next generation of pay for performance.”

Also in the United States, Prometheus Payment Reform design pilots are receiving a great deal of attention from CMS and private health plans. The Prometheus Payment Reform group, funded by the Robert Wood Johnson Foundation and Commonwealth Fund, has been able to sort historical costs for a number of acute and chronic conditions into “typical” claims and “Potentially Avoidable Complications” related claims. They have determined that PAC costs range from 25% to 60% of total services costs and have thus designed risk-adjusted Evidence-informed Case Rates (ECRs) that pay the full cost of the “typical costs” plus one-half of PAC costs.

The following diagram illustrates the process for knee replacement.

Potentially Avoidable Complications (PACs)



In the example, “typical services” represent evidence-based care, taking into account and risk adjusting for co-morbid conditions – in this case diabetes and hypertension. The surgical wound infection and pneumonia represent the potentially avoidable complications (PACs). As noted above, a bundled risk adjusted payment (case rate)

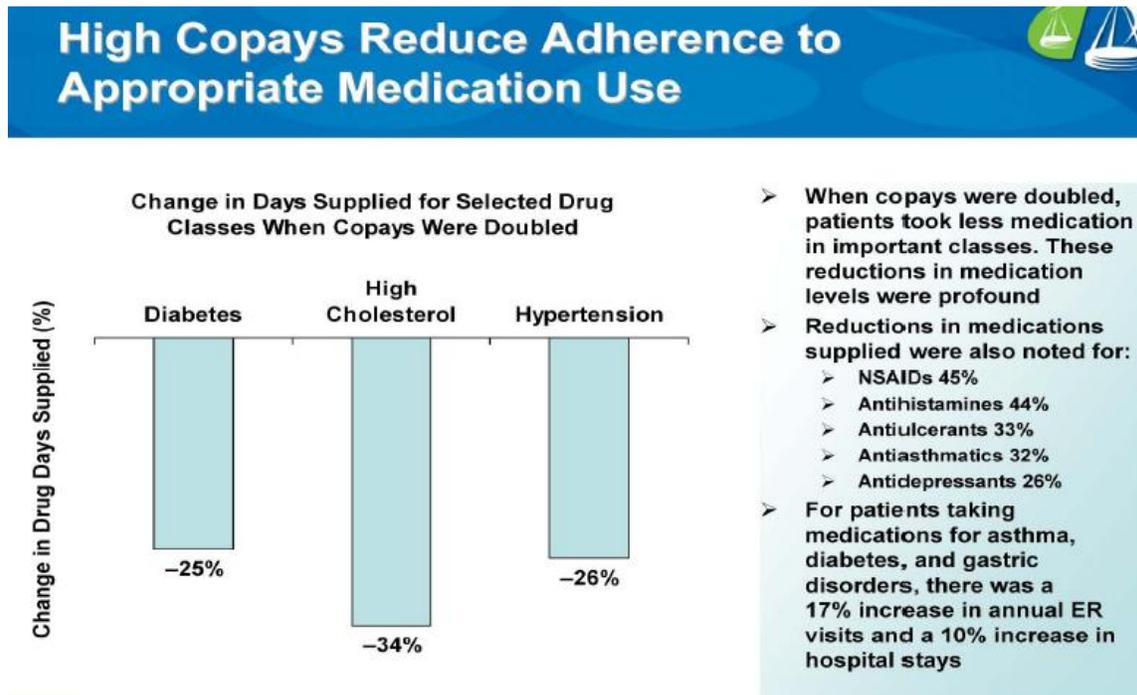
would be paid for the full cost of the typical care and a second layer of payment would be added that represents one-half the average PAC costs for all knee replacements. Hospitals and providers that achieved average PAC rates would break even; those doing better than average would receive a bonus; and those doing worse than average would be responsible for the difference between payment and actual costs.

Value-Based Insurance Design

Value-Based Insurance Design focuses on *patient* financial incentives and disincentives, not how the provider is paid. The goal of VBID is to influence the individual consumer to make informed choices at many levels:

- To live a healthy lifestyle
- To seek preventive services and care when sick
- To share in and make the right treatment decisions
- To actively engage in your care, especially self-management activities
- To select a provider that can help you achieve and maintain wellness

While VBID has been under study for many years, work has accelerated as employers and insurance companies have made across the board increases in co-payments in order to save money. The following diagram illustrates the problem.



Note that in the study noted above, when copays doubled, patients taking medications for asthma, diabetes, and gastric disorders experienced a 17% increase in emergency room visits and a 10% increase in hospital stays.

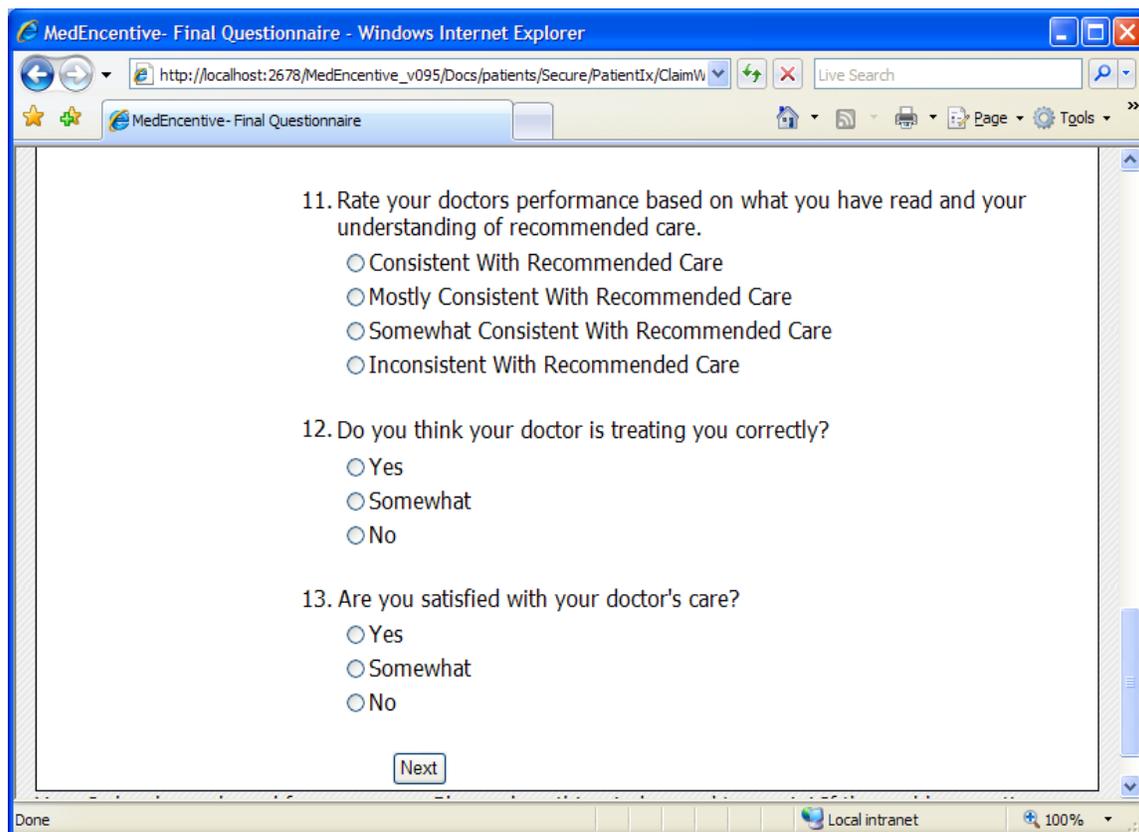
Value-Based Insurance Design contains four main features.

Decreased Cost Sharing: Drawing from the example above, co-payments and/or co-insurance should be lowered for interventions that are known to be effective such as diabetes, high cholesterol and hypertension medication to remove what is, in effect a financial disincentive.

Increased Cost Sharing: For services that are *not* known to be effective, VBI principles would suggest that co-payments and/or co-insurance should be increased. A common example is MRI scans for many types of lower back pain.

In safety net populations, increasing or decreasing cost sharing has limited application because most cost sharing has the effect of creating significant barriers to care. In the future, more Medicaid plans may consider putting cost sharing mechanisms in place for services that are *not* known to be effective.

Patient Financial Incentives: A great deal of work has occurred in the field of behavioral economics providing guidance about how and when financial incentives can influence desired behaviors and decision-making choices. The following screen shot illustrates one way patient financial incentives are used.



MedEncensive- Final Questionnaire - Windows Internet Explorer

http://localhost:2678/MedEncensive_v095/Docs/patients/Secure/PatientIx/ClaimW

MedEncensive- Final Questionnaire

11. Rate your doctors performance based on what you have read and your understanding of recommended care.

- Consistent With Recommended Care
- Mostly Consistent With Recommended Care
- Somewhat Consistent With Recommended Care
- Inconsistent With Recommended Care

12. Do you think your doctor is treating you correctly?

- Yes
- Somewhat
- No

13. Are you satisfied with your doctor's care?

- Yes
- Somewhat
- No

Next

Done Local intranet 100%

In this example, patients are asked to complete an online education module followed by a questionnaire that asks the patient to rate the doctor's performance. Patients completing the education module and questionnaire are provided with a cash payment.

Recently, discussions have taken place in the safety net behavioral health community about using consumer financial incentives to support recovery and wellness efforts. One idea is to create a Futures Fund that would have deposits linked to milestones on an

individual's recovery plan. The consumer could direct how these funds could be used to further support their recovery, such as supporting hobbies and paying for education classes. This mechanism would be quite consistent with VBID-related behavioral economics research.

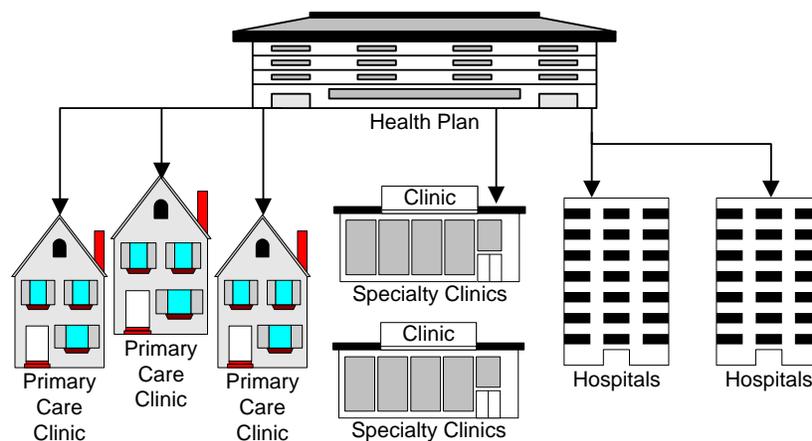
Patient Education: The above example also illustrates a key feature of VBID – providing extensive education to patients to guide their decisions about selecting high-value services and avoiding low-value interventions. Patient Health Records (PHRs) can be an important patient education and empowerment component that align with VBID efforts in both health and behavioral healthcare.

Emerging Healthcare System Models

Many in the health policy community are looking to the (re)emergence of four management models that create the foundation for replacing the fee for service system with value-based purchasing and value-based insurance design to support the new delivery models that will drive quality and wellness and bend the cost curve.

Fee for Service, Non-Integrated Model

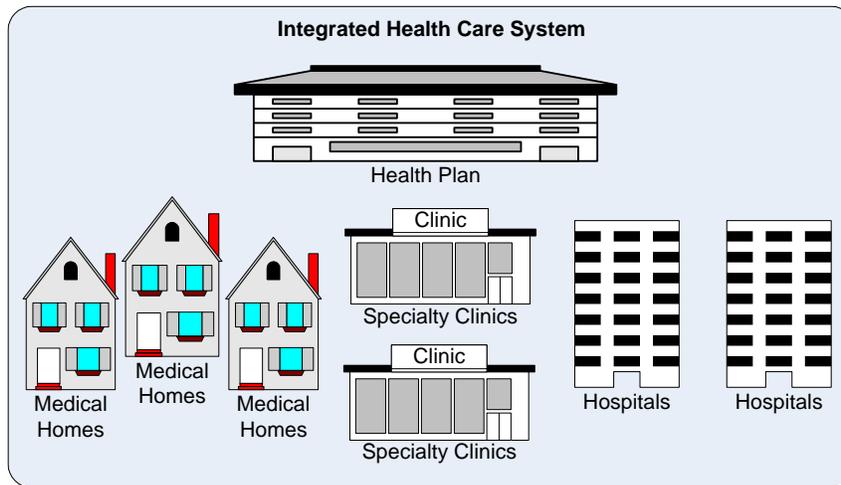
The prevailing model for 90 percent of Americans not in integrated healthcare systems is the fee for service, non-integrated system.



Under this model a health plan is paid to ensure that needed care is provided to the enrolled population. Health plans typically have separate relationships with primary care providers, specialty providers, and acute care facilities. (Again, for purposes of this paper, we are choosing to not include long term care facilities, which are part of the equation but lend themselves to a separate conversation.) This model contains many disincentives that lead to overuse, misuse, and underuse of clinical services. As mentioned above, it has been estimated that by correcting these problems as much as 30 percent of health care costs, or approximately \$700 billion, could be eliminated without reducing quality.

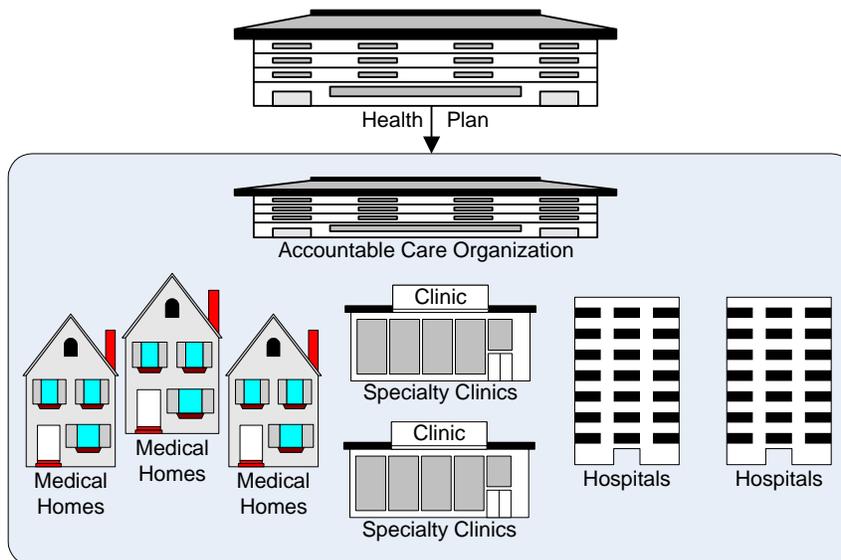
Integrated Healthcare System

At the other end of the spectrum is the Integrated Healthcare System discussed above.



Under this model the payor capitates an organization that is a *combination* health plan and delivery system. The integrated healthcare system's actuaries and clinical leadership forecast service demand, compute costs, determine the necessary risk reserves, and then budget money for each service area. Clinicians are often on salary and a bonus is sometimes used to reward clinicians, teams or clinics for achieving desired outcomes. This model is considered by many to be the optimal system design.

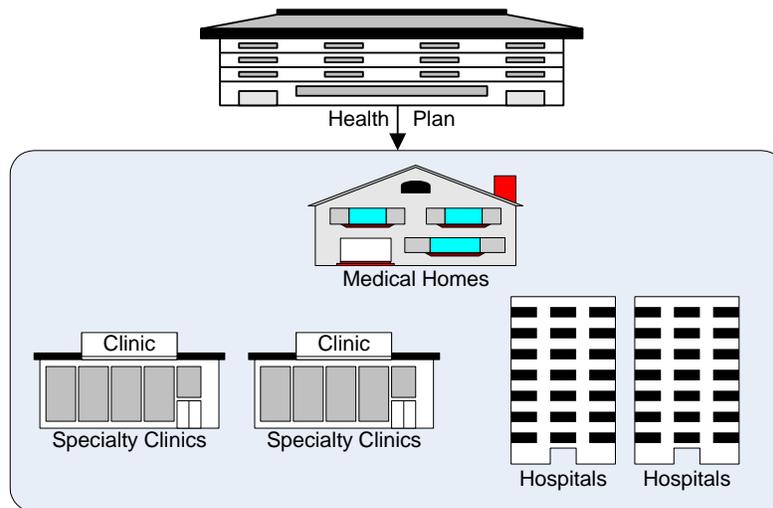
Accountable Care Organization Model



This model might be described as Integrated Healthcare System *Light*. The payor capitates a health plan. The health plan then contracts with one or more Accountable Care Organizations, entering into a risk sharing arrangement where it pays the ACO a subcapitation payment or case rate for each enrollee who selects a primary care provider inside a patient-centered medical home that's a member of the ACO. The intent is that the

health plan will bear some of the acuity mix risk so that if the enrollees assigned to an ACO have extraordinary medical costs, the health plan will pick up the difference. This will likely be done through the use of risk corridors; e.g. the ACO is responsible for costs up to 110% of capitation payments; costs above that level will be covered by the health plan. Pay for Performance is added as a second payment layer by the health plan to the ACO to incentivize access, quality and cost management. The ACO itself can pay the providers in the ACO in a number of ways including subcapitation, case rate, or fee for service. In all cases the ACO should also use pay for performance mechanisms with the provider members.

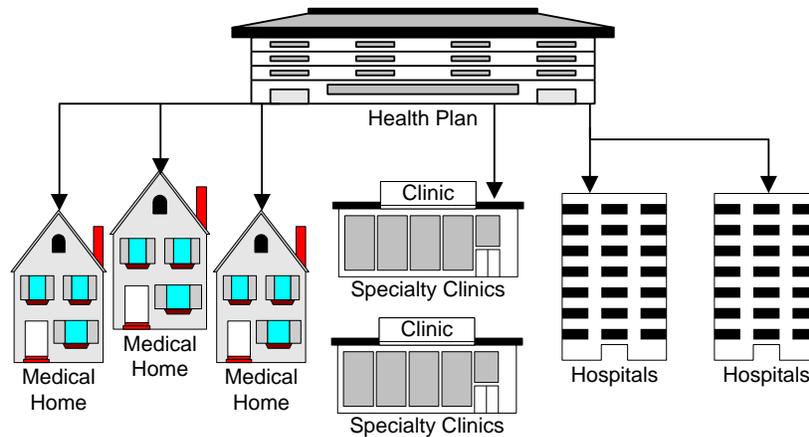
Primary Care Capitation Model



In the primary care capitation model, the payor capitates the health plan and the health plan subcapitates the person-centered medical home with a global capitation that covers the full healthcare costs. The medical home then contracts with, makes referrals to, and pays the specialists and hospitals. Thus the medical home also plays the role of an type of ACO. This model will also contain risk sharing arrangements between the health plan and medical home in order to address extraordinary risks that may be borne by the medical home.

Hybrid Model

The final model is a combination of the Non-Integrated and Primary Care Capitation Models.



Under this model the health plan pays the medical home a primary care subcapitation or case rate payment, but manages the contracts with specialists and hospitals. This model limits the ability of the medical home to influence specialist behavioral and hospital costs. It is better than fee for service, but has limitations in terms of coordinating care and minimizing overuse, misuse, and underuse of clinical services.

It is anticipated that the Accountable Care Organization model will become the predominant management model in U.S. healthcare during the next decade. Hospitals and physician groups throughout the country are already in the process of organizing ACOs and retooling existing Independent Practice Association (IPAs) into ACOs. The Obama Administration is also supporting these efforts and plans to fund a series of ACO pilots throughout the country in the near future.

Mental Health, Substance Use and the Emerging Models

How will mental health and substance use systems, services, and providers fit into these emerging management models?

We've learned from 50 years of effort that if you work in the safety net behavioral healthcare system, focusing inward to create a high-performing provider organization does not always prevent a center from ending up at the bottom of the food chain. We also know that creating a single answer to this question is unrealistic in a community behavioral healthcare system that is often been described as the 50 states, 50 sets of rules system.

Low, Moderate and High Change States

I am anticipating that states' safety net mental health and substance use systems will respond in one of three ways to the healthcare reform service redesign and payment reform initiatives.

- **Low Change System:** Some states will acknowledge the existing problems and the theoretical importance of payment reform and service delivery redesign, including primary care/behavioral health integration, but not fully understand the business case for change or have the resources to bring about such a change process. These states will take little or no action to promote clinical integration and will not actively remove the barriers to integrated clinical designs, not champion medical homes and will make minimal effort to implement VBP and VBID methods in their safety net systems. In this environment, it will be up to the health plans, accountable care organizations, primary care providers and MH/SU providers to integrate and innovate – or not.
- **High Change System:** Other states will buy into the hypothesis that it will be impossible to bend the cost curve without addressing the healthcare needs of the serious mentally ill and the behavioral healthcare needs of all safety net residents and acknowledge the importance of addressing the needs of other high need/high cost populations. These states will promote the development of robust medical homes, primary care-behavioral health integration, and VBP and VBID mechanisms.
- **Moderate Change System:** A third group of states will fall somewhere in the middle, promoting medical homes, payment reform, and clinical integration with varying degrees of robustness.

Eventually all payors, including every state will come to recognize that behavioral health is part of health, behavioral health prevention works, behavioral health treatment is effective, people recover, and they cannot afford to continue in a state of dis-integration.

The implications for the MH/SU provider community is that organizations need to gauge where their payors fall on the dis-integration – integration continuum and be on the leading edge, but not bleeding edge of clinical integration efforts.

To Carve-Out or Carve-In

Things get more exciting when it comes to the world of health plans, carve-ins and carve-outs. The following table illustrates how this may play out in the State Medicaid systems.

	Low Change	Moderate Change	High Change
Carve-In	Carve-in will continue to be used to organize service delivery integration; very few examples of this model	Carve-in will continue to be used to organize service delivery integration; very few examples of this model	Carve-in will continue to be used to organize service delivery integration; very few examples of this model
Carve-Out	Carve-out will remain in place; it will be up to the plans and providers to integrate	Carve-out will likely remain in place but large emphasis will be placed on building contractual relationships at the health plan and service delivery levels to promote and support integration	Higher probability that carve-out will be replaced with carve-in; carve-outs will need to develop robust case for demonstrating that current design will do a better job than a carve-in integrating at the service delivery level
Fee for Service	States will likely move their Medicaid health care into managed care and may carve-in or carve-out MH/SU	States will likely move their Medicaid health care into managed care and will lean towards carving in MH/SU	States will likely move their Medicaid health care into managed care and will probably carve-in MH/SU

The color coding corresponds to the degree of system change that will be *injected* into the public mental health and substance use systems. Blue signifies a relatively low level of change, yellow a modest level of change, and red a high level of change.

Action is already occurring in the carve-in, carve-out debate. Oregon has begun a process to support pilot projects where Medicaid health plans voluntarily integrate with the Medicaid mental health plans and County mental health departments to pool Medicaid and non-Medicaid dollars in the healthcare, mental healthcare and substance use treatment systems. Illinois is designing a pilot to move the Medicaid population in six collar communities surrounding Chicago into a managed care plan that integrates health, mental health and substance use through the procurement of a managed care entity. Discussions are occurring in a number of other states (e.g. California, Florida, Washington) to integrate management systems in order to bend the cost curve and provide relief to stressed state budgets.

I predict that in 10 – 15 years, we will have moved beyond the constructs of carve-ins and carve-outs at the management level. Behavioral health/primary care integration at the service delivery level will be widespread, if not universal, and funding and management structures will be integrated.

I also predict that carving in mental health and substance use treatment prematurely will create serious and significant unintended consequences, especially for persons with serious mental illness. Premature dismantling of carve-out structures

will likely lead to a loss of important intellectual property due to layoffs of many of the Medicaid Prepaid Inpatient Health Plan employees. Without strong firewalls to protect mental health and substance use dollars, health plans may repeat past practices and divert these funds to other areas and/or direct funding that had previously been used to serve the seriously mentally ill to serve individuals with mild and moderate behavioral health disorders. It is also very possible that the value of high cost, high impact services such as ACT, MST and DBT may not be recognized by health plan executives and such programs could be cut back or dismantled. Any combination of these events would likely reduce the ability of health plans to reduce the total healthcare expenditures for persons with serious mental illness and serious substance use disorders.

Options for MH/SU Providers in a Changing Management Structure Environment

In moderate to high change States the mental health/substance use (MH/SU) delivery system will need to proactively address how it's going to integrate with primary care at the service delivery level. This work is the subject of two National Council papers, *Behavioral Health / Primary Care Integration and the Person-Centered Healthcare Home* (Mauer, April 2009), and *Substance Use Disorders and The Person-Centered Healthcare Home* (Mauer, February 2010).

In those same States the MH/SU provider community will also need to re-think its relationships with payors and managers, taking into account the four emerging delivery system, payment and management models described in this monograph. The following table illustrates what may be necessary.

	Scenario 1	Scenario 2	Scenario 3
Health Plan	Preferred Provider: Become a preferred provider of the health plan	Provider Network: Form a consortium of BH providers and contract as a provider network	Co-Owner: Form a consortium of BH providers and become co-owners of an integrated health plan
Integrated Healthcare System	Preferred Provider: Create a preferred provider relationship with the IHS	Co-Owner: Merge with the IHS, becoming part of their BH Division	
Accountable Care Organization	Preferred Provider: Become a preferred provider of the ACO	Co-Owner: Become a <i>participating</i> member/owner of the ACO	Co-Owner: Become a <i>founding</i> member/owner of the ACO
Primary Care Capitation	Preferred Provider: Become a preferred provider of the medical home	Partner: Become a bi-directional partner of the medical home	Merger: Merge with a medical home; become a person-centered healthcare home
Hybrid Model	Preferred Provider: Become a preferred provider of the health plan	Partner: Become a bi-directional partner of the medical home	Merger: Merge with a medical home; become a person-centered healthcare home

It's very important for MH/SU providers to understand that in most situations, they are going to need to focus on more than clinical integration and strengthening their capacities as a high performing, recovery and wellness-oriented CBHO; they are going to need to examine how the management systems might change and be ready to proactively respond in order to not fall to the bottom of the food chain, or worse, to prevent being cut out of the game altogether. As noted above, this may range becoming a *preferred provider* to becoming a *co-owner* of a health plan to *merging* with an integrated healthcare system.

Conclusion

We are on the cusp of an era of unprecedented change in the health and behavioral care systems. The service delivery models will be changing with an emphasis on the customization of medical homes; workforce requirement will shift; inappropriate financial disincentives will be dramatically reduced as fee for service is replaced with financial approaches that align payment with desired clinical approaches and outcomes; most healthcare will be managed, but by patients and providers united in the common goals of improving health and reducing overuse and medical errors; new management structures will evolve to support these efforts, many with risk sharing arrangements with health plans and disincentives for inappropriately rationing care; and more.

Like it or not, the mental health and substance use systems are going to end up embedded in these new structures. My vision is that the MH/SU communities will be strong components of this new world, adding value and helping their healthcare partners demonstrate that behavioral health is part of health, prevention works, treatment is effective, and people recover.

End Notes

(Footnotes to be added.)