

***Behavioral Health and Its Role in the  
Changing Healthcare Landscape  
County Alcohol and Drug Program  
Administrators Association of California  
December 9, 2009***

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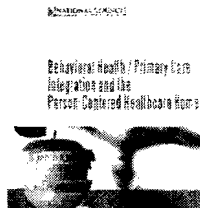


**Three “Chapters” to Guide Our Discussion**

- The National Picture of Health  
Healthcare Reform
- Behavioral Health/Primary Care  
Integration and Person-Centered  
Healthcare Homes
- Key Concepts in Developing a New  
California 1115 Waiver

### Definition of Terms – BH, SA, SU, AOD, etc.

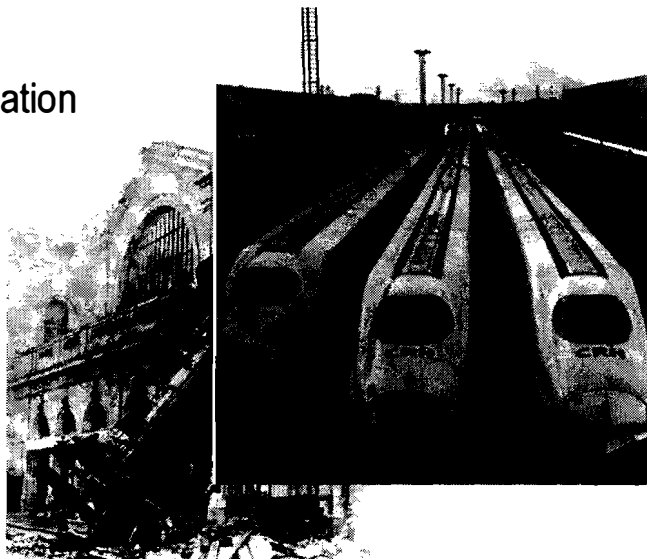
- These slides use the term “Substance Use Services” and “Substance Use Disorders” to describe the broadest context of Alcohol and Other Drug Services and Disorders, based on the recommendation of the Institute of Medicine’s Crossing the Quality Chasm report
- These slides also use the term “Behavioral Health” in a number of places to describe Mental Health and Substance Use
- We are still in the process of agreeing on a common language; this is a work in progress and we continue to work toward agreement on the language we use and the integration models we develop and deploy
- A paper is forthcoming that adds more depth to the role of SU services in the person-centered healthcare home



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### Health Reform: Implications for the Healthcare and Community Behavioral Healthcare Systems

Healthcare Reform Legislation will result in the remaking of the public behavioral healthcare system



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# The National Picture of Health Healthcare Reform

Where is National Healthcare  
Reform Headed and what are  
the implications for the Public  
Behavioral Healthcare System?



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## The Overall Design for Healthcare Reform

- U.S. health care reform legislation has been designed to address three issues



- This portion of the presentation explores the "Top 10" healthcare reform issues relevant to the public behavioral healthcare system



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## 1. Healthcare Reform will Result in Service Delivery Design and Payment Reform

***The Path to a High Performance U.S. Health System – A 2020 Vision of the Policies to Pave the Way identified 10 Health Care Reform Policies that can save \$3 trillion over 10 years***

(Commonwealth Fund 2009)

Commonwealth Fund Report The Path to a High Performance U.S. Health System	
<b><u>"Near" Universal Coverage</u></b>	
Net Savings from Insurance Expansion	-\$94
Reduced Administrative Costs	-\$337
<b><u>Payment Reforms</u></b>	
Enhanced Payment for Primary Care	-\$71
Adoption of the Medical Home	-\$175
Bundled Payment for Acute Care	-\$301
Correcting Medicare Rates	-\$464
<b><u>Improving Quality and Outcomes</u></b>	
Accelerating Spread and Use of IT	-\$261
Center for Comparative Effectiveness	-\$634
Reducing Tobacco Use	-\$255
Reducing Obesity	-\$406
<b>Net Impact 2010 - 2020 (Billions)</b>	<b>-\$2,998</b>

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## Person-Centered Healthcare Homes

- 45 percent of Americans have one or more chronic conditions.
- Over half of these people receive their care from 3 or more physicians.
- Treating these conditions account for 75% of direct medical care in the U.S.
- Person-Centered Healthcare Homes is a key strategy

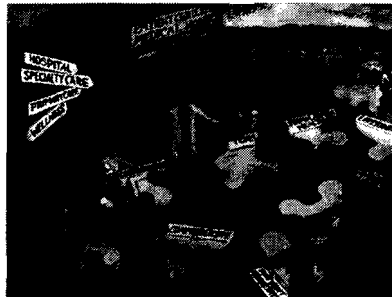


1. Healthcare Reform will Result in Service Delivery Design and Payment Reform

## Person-Centered Healthcare Homes

### Healthcare Home Principles

- **Ongoing Relationship** with a PCP
- **Care Team** who collectively take responsibility for ongoing care
- Provides all healthcare or makes **Appropriate Referrals**
- Care is **Coordinated and/or Integrated**
- **Quality and Safety** are hallmarks
- **Enhanced Access** to care is available
- **Payment** appropriately recognizes the **Added Value**



1. Healthcare Reform will Result in Service Delivery Design and Payment Reform

## Person-Centered Healthcare Homes The Group Health Cooperative Experience

- 2002-2006: increase in patient access but also increase in provider burn-out
- 2007: healthcare home pilot for 12 months with 30 minute visits and:
  - 15% more docs and 44% more mid-levels
  - 17% more RNs and 18% more MAs/LPNs
  - 72% more pharmacists



Redesign of a patient-centered medical home (PCMH) was done with the goals of improving patient experience, lessening staff burnout, improving quality, and reducing downstream costs.

■ Compared with controls, PCMH patients had a better patient experience, improved quality, and PCMH staff experienced less burnout at 12 months.

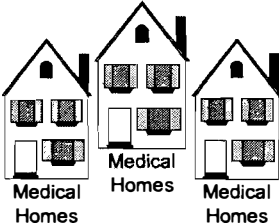
■ At 12 months, there was no significant differences in overall costs between the PCMH and control clinics.

1. Healthcare Reform will Result in Service Delivery Design and Payment Reform

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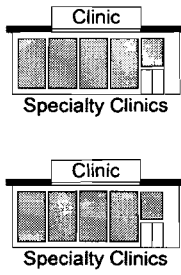
## Person-Centered Healthcare Homes

**Payment Model to cover Prevention, Primary Care and Chronic Disease Management; Bonus Structure for managing Total Health Expenditures**



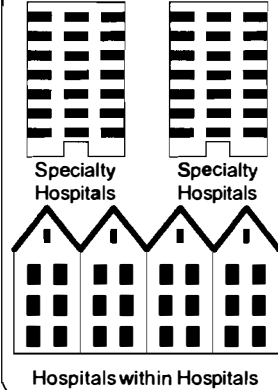
Medical Homes

**Linkages to High Performing Specialists that can support the management of Total Health Expenditures and minimize Defect Rates**



Specialty Clinics

**Bundled Case Rates that pay a Percentage of PACs and Non-Payment for Never Events**



Specialty Hospitals

Hospitals within Hospitals

**1. Healthcare Reform will Result in Service Delivery Design and Payment Reform**

**It's all about *Improving Quality* and managing *Total Healthcare Expenditures!***

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## 2. Healthcare Reform May Unfold Rapidly

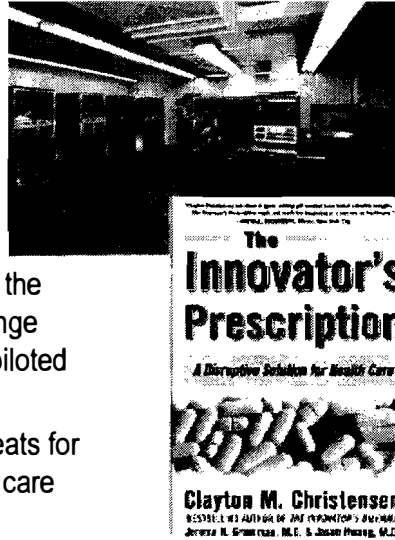
**Eight key activities begin between 2010 and 2014**  
**Requiring a great deal of implementation effort at the State and Federal levels**

U.S. Health Reform Legislation Timeline		2010	2011	2012	2013	2014	2015	2016	2017
Senate Finance Committee									
Implementation Planning Begins									
Hi Risk Pools for People with Pre-existing Conditions									
State Health Insurance Exchanges Begin									
New Payment Methods & Delivery System Redesign Begins									
Expand Medicaid to 133% Federal Poverty Level					Optional	Mandatory			
Employer Tax Credits Begin									
Individual/Family Premium Subsidies Begin									
Individual Mandates Begin; Penalties Start in 2014					\$0	\$200	\$400	\$600	\$750

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### 3. Healthcare Reform will Usher in an Era of *Disruptive Innovation* in Healthcare

- The problems facing the American healthcare system mirror nearly every other industry in their early phases
- *Disruptive Innovation* is already underway in general healthcare
- Healthcare Reform could serve as the *tipping point*, speeding up the change processes that are already being piloted across the country
- This creates opportunities and threats for existing managers and provider of care



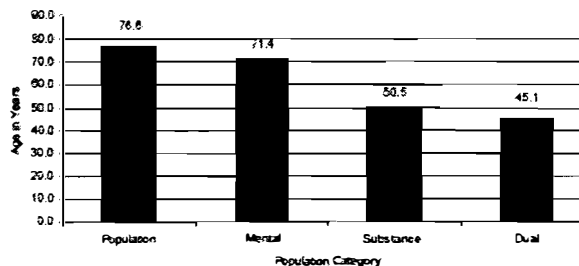
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### 4. Behavioral Health is now on the Health Policy Community's "Radar Screen"

#### Morbidity and Mortality in People with Serious Mental Illness

- Persons with serious mental illness (SMI) are dying **25 years earlier than the general population**
- While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases (NASMHPD, 2006)
- OR state study found that those with co-occurring MH/SU disorders were at greatest risk (45.1 years)

Chart 1. Average Age at Death



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#### 4. Behavioral Health is now on the Health Policy Community's "Radar Screen"

- One behavioral health condition doubles medical expenditures, emergency room visits and hospital admissions for Medicaid enrollees
- 49% of Medicaid beneficiaries with disabilities have a psychiatric illness (this is new information; previous studies that excluded pharmacy claims calculated the rate at 29%)
- Substance use conditions do not show up in this study at the expected levels because it's based on an analysis of claims and pharmacy scripts

Exhibit 7: 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%

The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions  
Center for Health Care Strategies, Inc., October 2009

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#### 5. Most Members of the Safety Net will have Coverage Including a BH Benefit

- 31% to 43% increase in Medicaid enrollees, depending on the bill
- Large reduction in uninsured (54% to 67%)

Impact of U.S. Health Reform on Coverage for Non-Elderly				
	Current Law 2019 (Millions)	Reform Impact (Millions)	Reform Total (Millions)	Reform Impact %
<b>Medicaid/CHIP</b>				
Senate Finance	35	11	46	31%
House 3962	35	15	50	43%
<b>Uninsured Persons</b>				
Senate Finance	54	(29)	25	-54%
House 3962	54	(36)	18	-67%

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## 5. Most Members of the Safety Net will have Coverage Including a BH Benefit

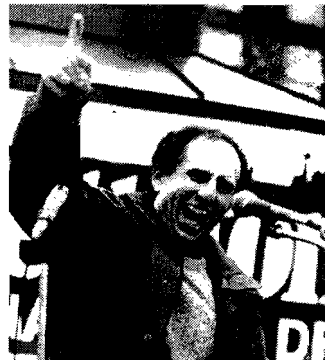
- \$16 to \$25 billion in additional spending for mental health and substance use treatment from insurance expansion
- No credible numbers yet on financial impact of Parity Act and how much additional BH spending will come out of the "healthcare pot"

House Healthcare Reform Bill	2019
Medicaid & SCHIP Expansion	\$86,000,000,000
Healthcare Exchange Subsidies	\$120,000,000,000
Total Expansion Funding	\$206,000,000,000
Number of new Americans Covered	36,000,000
Cost per Person Per Year	\$5,722.22
Cost per Person Per Month	\$476.85
Behavioral Health Spending @ 8%	\$16,480,000,000
Behavioral Health Spending @ 10%	\$20,600,000,000
Behavioral Health Spending @ 12%	\$24,720,000,000
Behavioral Health PMPM @ 8%	\$38.15
Behavioral Health PMPM @ 10%	\$47.69
Behavioral Health PMPM @ 12%	\$57.22

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## 6. Parity will Likely Improve Access and Available Services

- Mental Health and Substance Use Services must be provided at parity with general healthcare services (no discrimination)
  - Large Employers (Parity Act)
  - Medicaid (Health Reform Legislation)
  - Health Insurance Exchanges for Individual and Small Group Policies (Health Reform Legislation)
  - Medicare: on the way (Medicare Modernization Act of 2003)



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### 7. There is No Guarantee that new BH Revenues will Spent on CBHO Services

- A recent study estimates that in 2014 less than 16% of U.S. spending on MH/SU services occurred in Community Behavioral Healthcare Organizations
- We should not assume that new behavioral health expenditures will be more heavily weighted towards CBHOs

U.S. Spending on MH/SU Treatment (Millions) (pre-Healthcare Reform Legislation)	Projected	Projected
	2014	2014
Hospitals, General and Specialty	\$53,844	22.6%
Psychiatrists and Other Physicians	\$34,907	14.6%
Psychologists, Counselors, Social Workers	\$21,803	9.1%
Nursing Homes and Home Health	\$14,601	6.1%
Prescription Drugs	\$61,222	25.6%
<b>Subtotal</b>	<b>\$186,377</b>	<b>78.1%</b>
<b>Ratio</b>	<b>78%</b>	
Community Behavioral Health Care Organizations		
Multi-Service Mental Health Organizations	\$22,969	9.6%
Specialty Substance Abuse Centers	\$14,822	6.2%
<b>Total CBHOs</b>	<b>\$37,791</b>	<b>15.8%</b>
<b>Ratio</b>	<b>16%</b>	
Total Service Provider and Drug Expenditures	\$224,168	93.9%
Insurance Administration	\$14,551	6.1%
<b>Total Mental Health/Substance Use Treatment</b>	<b>\$238,719</b>	<b>100%</b>
<b>Addition of Uninsured Estimate</b>	<b>\$20,000</b>	
<b>Revised Total</b>	<b>\$258,719</b>	

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### 7. There is No Guarantee that new BH Revenues will Spent on CBHO Services

- The "big idea" is to have Medicare make capitation payments to states to organize and manage Dual Eligible Plans
- Given the effort to combine funding, it seems unlikely that Dual Eligible mental health services would be carved out; especially because of the need to address identified co-morbidities
- The following example illustrates one PIHP in Washington State

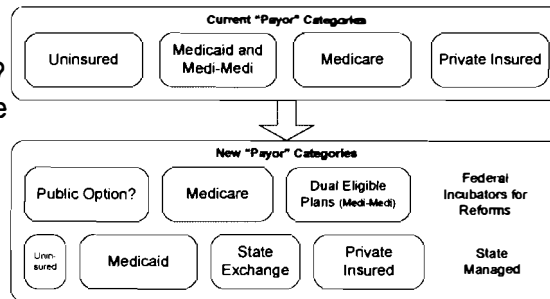
**Washington State  
Medicaid Mental Health Capitation Rates  
October 2009 - June 2010**

Prepaid Inpatient Health Plan (PIHP)	Children		Adults		Total
	Non-Disabled	Disabled	Non-Disabled	Disabled	
Clark County Rates	\$11.20	\$77.36	\$13.83	\$119.29	\$25.51
Rate % of Average	44%	303%	54%	468%	100%
Clark eligibles	38,268	1,567	11,697	6,429	57,961
Eligibles Ratio	66%	3%	20%	11%	100%
Monthly Revenue	\$428,602	\$121,223	\$161,770	\$766,915	\$1,478,510
Revenue Ratio	29%	8%	11%	52%	100%

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## 7. There is No Guarantee that new BH Revenues will Spent on CBHO Services

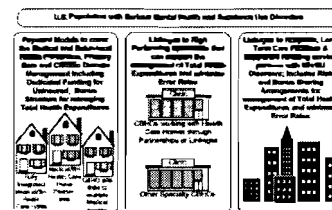
- This is particularly relevant to the fact that payor environment will be shifting
  - Medicare and Public Option slated to be federal incubators of design changes
  - Insurance Exchanges, Larger Medicaid programs, and new Dual Eligible (Medi-Medi) plans will be the state incubators of design changes
- Several Questions
  - How many uninsured will go into Exchanges?
  - How many Dual Eligible Plans develop?
  - Will CBHOs be on the Exchange and Dual Eligible Provider Networks?



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## 8. Total Healthcare Costs of Persons with MH/SU Disorders will Drive Integration, But the Integration Models are Still Evolving

- It is unclear how quick this will translate into recognizing the need to embed behavioral health clinicians in medical homes and how these models will evolve
- How quickly will healthcare homes and Accountable Care Organizations (ACOs) add BH services to their clinics?
- Will NCQA add BH capacity as a required element of Person-Centered Medical Home accreditation? If so, how long will it take for this to occur?
- How quickly will CBHOs prioritize integration, build necessary competencies, and develop relationships with the primary care community?
- Will medical homes partner with CBHOs or hire their own behavioral healthcare staff?



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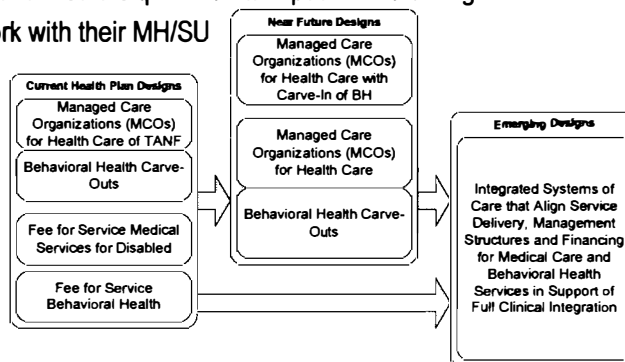
### 8. Total Healthcare Costs of Persons with MH/SU Disorders will Drive Integration, But the Integration Models are Still Evolving

- Will Accountable Care Organizations become the employers of the BH clinicians?
- How quickly will CBHOs be able to embed primary care services? If not quickly enough, will this window of opportunity close as CBHO consumers obtain primary care services in other settings?
- Will healthcare consultants and MBHOs convince states, exchanges and commercial plans that they should use disease management organizations to provide care coordination and physician extender services and rely primarily on telephonic care management, thereby removing the opportunity of CBHOs to partner with healthcare homes? Will ACOs do the same?
- Will new, innovative provider organizations disrupt both existing primary care clinics and CBHOs to provide integrated primary care and behavioral health services?

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### 9. The Need to Integrate Funding Combined with the Complexity of the Current System may Result in a Rapid Move Away from Behavioral Health Carve-Outs

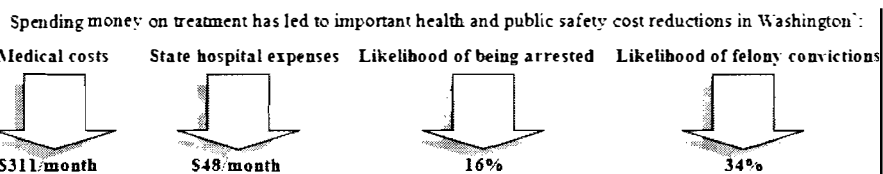
- Different Scenarios will play out across the country
  - Some states will end their carve-outs “tomorrow” to achieve clinical integration
  - Others will stay with the status quo and attempt to avoid change
  - A 3<sup>rd</sup> group will work with their MH/SU partners to move into the next generation
  - A 4<sup>th</sup> group will stay with carve-out model but re-procure the entire system



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## 10. Payment Reforms will be Linked to the Ability to Demonstrate Outcomes and Manage Costs

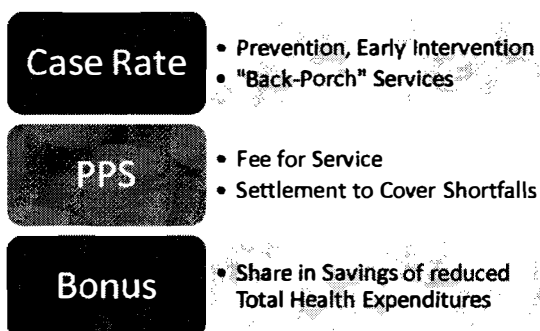
- We are moving from an era of talking about measurement to using an era where the ability to operate within a quality improvement and performance measurement framework is an entrance requirement.
- Health plans and payors will be looking at how well CBHOs manage total healthcare expenditures of persons with MH/SU conditions and the impact that providers have on to key indicators of clinical effectiveness: symptom reduction and functional life improvement. Another important indicator – Lost Work Days – will become extremely important for persons in the workforce.



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## 10. Payment Reforms will be Linked to the Ability to Demonstrate Outcomes and Manage Costs

- New funding mechanisms will be utilized to better fund services that manage total healthcare expenditures
- Many Person-Centered Healthcare Homes will be funded with a 3-layer reimbursement mechanism



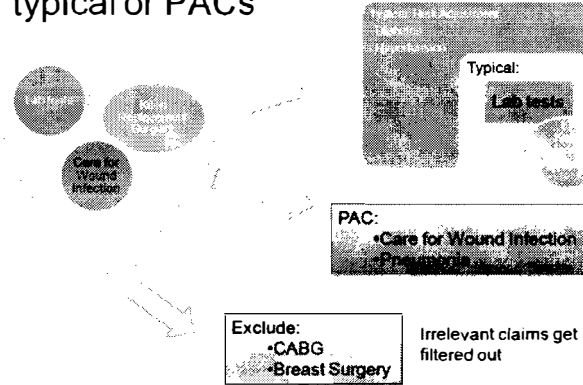
Note: PPS = Prospective Payment System, the FQHC cost-based reimbursement system

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### 10. Payment Reforms will be Linked to the Ability to Demonstrate Outcomes and Manage Costs

- Bundled payments that only pay for part of potentially avoidable complications (PACs) will penalize providers that have higher error rates

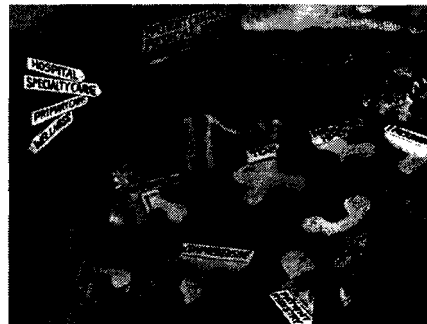
Relevant claims get navigated as typical or PACs



## Behavioral Health/Primary Care Integration and Person-Centered Healthcare Homes

NATIONAL COUNCIL ON HEALTH CARE QUALITY

Behavioral Health / Primary Care Integration and the Person-Centered Healthcare Home





### **Where Should Care Be Delivered? Stepped Care**

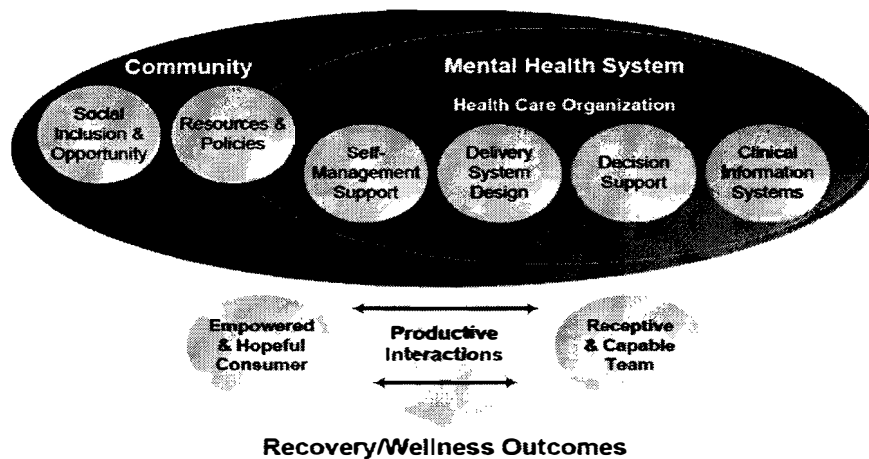
- There is always a boundary between primary care and specialty care
- There will always be tradeoffs between the benefits of specialty expertise and of integration
- *Stepped care* is a clinical approach to assure that the need for a changing level of care is addressed appropriately for each person—IMPACT research demonstrates the effectiveness of a stepped care model and is the basis for the National Council Collaborative Care Project
- We need to implement this model bi-directionally—to identify people in primary care with MH/SU conditions and serve them there unless they need specialty care, and to identify people in MH/SU care that need basic primary care and step them to a full scope medical home for more complex care—the Four Quadrant model has been revised to reflect this thinking

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### **Focus: Quadrants I and III**

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## Model for Improving Primary Care



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## AHRQ: The Research

- Quantitative and qualitative analysis of 33 trials that examined the impact of integrating MH specialists into primary care
  - Studies tended to show positive results for symptom severity, treatment response and remission when compared to usual care
  - Wide variation in levels of provider integration and integrated processes of care
  - IMPACT has strongest results for adults and older adults; limited studies exist for children
- More work is needed on understanding what elements of integration are vital to producing desired goals—“research aimed at efficiently matching clinical and organizational processes and resources to different levels of care for varying levels of severity, and patients stratified by risk and complexity, would build on the...IMPACT trials and Intermountain Healthcare's examples”

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## Core Components of IMPACT Collaborative Care Program

TWO PROCESSES	TWO NEW 'TEAM MEMBERS'	
	Care Manager/BHC	Consulting Mental Health Expert
<b>1. Systematic diagnosis and outcomes tracking</b> e.g., PHQ-9 to facilitate diagnosis and track depression outcomes	- Patient education / self management support - Close follow-up to make sure pts don't 'fall through the cracks'	- Caseload consultation for care manager and PCP (population-based) - Diagnostic consultation on difficult cases
<b>2. Stepped Care</b> - Change treatment according to evidence-based algorithm if patient is not improving - Relapse prevention once patient is improved	- Support medication Rx by PCP - Brief counseling (behavioral activation, PST-PC, CBT, IPT) - Facilitate treatment change / referral to mental health - Relapse prevention	- Consultation focused on patients not improving as expected - Recommendations for additional treatment / referral according to evidence-based guidelines

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## Substance Use Interventions in Primary Care

- Center for Substance Abuse Treatment has sponsored Screening and Brief Intervention (SBI) programs in 17 states
  - Based on more than 30 controlled clinical trials that demonstrated the clinical efficacy and effectiveness of SBI
  - Screening and brief interventions for more than 424,000 people across inpatient, emergency department, primary and specialty care settings, including CHCs
  - Newly established series of Current Procedural Terminology (CPT) SBI codes provide a vehicle for billing SBI services (99408 and 99409) <http://sbirt.samhsa.gov/about.htm>

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### **The Person-Centered Healthcare Home: Q I and III**

- Incorporate the lessons of the IMPACT model, explicitly building into the medical home model the care manager/ behavioral health consultant and consulting psychiatrist functions that have proven effective in the IMPACT model
  - DIAMOND project in MN—monthly case rate payments for covering these components in primary care practices, all major payors participating
- All healthcare is local—working out the details of who does what, for what levels of MH/SU services (Intermountain model), has to engage local partnerships

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### **Focus: Quadrants II and IV**

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### **Team-Based Models of Care: Integrated Care Clinic**

- A medical clinic was established to manage routine medical problems of patients with SMI at a VA
- Nurse practitioner provided the bulk of medical services; a care manager provided patient education and referrals to mental health and medical specialists
- Study randomized 120 veterans to either the integrated care clinic or usual care, followed for one year
  - Access: Significantly increased the rates and number of visits to medical providers, reduced likelihood of ER use
  - Quality: Significantly improved quality of most routine preventive services (15/17)
  - Outcomes: Significantly improved scores on SF-36 Health Related Quality of Life
  - Costs: Program cost-neutral from a VA perspective (primary care costs offset by reduction in inpatient costs)

1. Druss BG, et al. *Arch Gen Psychiatry*. 2001;58(9):861-868.

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### **Other Promising Approaches**

- Nurse Health Care Case Manager—monitoring, facilitation, and coordination of primary/preventative health care
- Health education activities, including diabetes groups, nutrition and diet, physical activity, agreements with local health clubs, personal trainers
- Researched disease management group and educational materials (e.g. Lorig) for population with SMI, with peers trained as health educators
- CA Frequent Utilizers of Health Services—care management reductions in ED utilization (by 60% in year two)
- Supported housing models that include on-site healthcare capacity (WA DESC—Total cost offsets for Housing First participants relative to controls averaged \$2449 per person per month after accounting for housing program costs)

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## Measurement of Health Status for People with SMI (NASMHPD 2008)

**Standard set of health indicators that will be gathered and used for the clinical care of each person served, as well as aggregated to provide population health data**

**Piloted in 2009 in NY state**

**Individual agencies piloting as well**

### Health Indicators

1. Personal History of Diabetes, Hypertension, Cardiovascular Disease
2. Family History of Diabetes, Hypertension, Cardiovascular Disease
3. Weight/Height/Body Mass Index (BMI)
4. Blood Pressure
5. Blood Glucose or HbA1C
6. Lipid Profile
7. Tobacco Use/History
8. Substance Use/History
9. Medication History/Current Medication List, with Dosages
10. Social Supports

### Process Indicators

1. Screening and monitoring of health risk and conditions in mental health settings
2. Access to and utilization of primary care services (medical and dental)

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## MH Providers Clinical Responsibility and Accountability (National Council, 2008)

- If MH services include prescribing psychotropic medications, there are a set of accountabilities related to the whole health of the person:
  - Assure regular screening and tracking at the time of psychiatric visits for all consumers receiving psychotropic medications
    - Check glucose and lipid levels, blood pressure and weight/BMI
    - Record and track changes, response to treatment and use the information to adjust treatment accordingly
    - The individual and family history, baseline and longitudinal monitoring as recommended by the ADA/APA should be the standard of practice
  - Identify the current PCP for each individual, and when none exists, assist the individual in finding a PCP and accessing care
  - Establish specific methods for communication and treatment coordination with PCPs and assure that timely information is shared in both directions

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## The Person-Centered Healthcare Home for People with SMI

- See *Behavioral Health/Primary Care Integration and The Person-Centered Healthcare Home* (National Council)
- For BH providers envisioning a future role as person-centered healthcare homes, there are two pathways to follow
  - Providers who want to become full scope person-centered healthcare homes for people with SMI should **look to the Cherokee model** and seek to become full scope providers of primary care services, for a broad community population as well as for those receiving BH services
  - Providers who want to **partner with full scope primary care** organizations to create person-centered healthcare homes for individuals with SMI should **organize a parallel to the IMPACT primary care model**, with collaborative care, care management, a designated PCP consultant, outcome measurement, and stepped care for primary care needs in BH settings

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## The Person-Centered Healthcare Home for People with SMI: Partnership

- Assure regular screening and registry tracking/outcome measurement at the time of psychiatric visits for all BH consumers receiving psychotropic medications
- Locate medical nurse practitioners/PCPs in BH clinics—provide routine primary care services in the BH setting via staff out-stationed under the auspices of a full scope person-centered healthcare home
  - BH organization hiring a nurse practitioner directly, without the backup of a skilled PCP and a full scope healthcare home cannot be described as providing a healthcare home, and is not a recommended pathway
- Identify a primary care supervising physician within the full scope healthcare home to provide consultation on complex health issues
- Assign nurse care managers to support individuals with elevated levels of glucose, lipids, blood pressure, and/or weight/BMI
- Use evidence based practices developed to improve the health status of all individuals with chronic health conditions, adapting these practices for use in the BH system.
- Create wellness programs

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## Person-Centered Healthcare Homes Sorting out Who is Served Where

### The IPI Continuum:

#### A Collaborative MH/SU/Primary Care Continuum for the Safety Net Population:

(This Continuum details the vertical MH/SU axis of the IQ Model and does not attempt to span the horizontal axis, which considers the range of general healthcare services from prevention/health promotion to specialty medical/surgical and inpatient services. The supportive services and systems in the community are also not detailed here, however it is anticipated that development of a locally specific IPI Continuum would describe these as a part of defining seamless services.)

	Mild MH/SU Complexity	Moderate MH/SU Complexity	Serious MH/SU Complexity	Severe MH/SU Complexity
Characteristics of the population with MH/SU needs to be served in each level—for all ages (children, youth, adults, older adults)	<ul style="list-style-type: none"> <li>No comorbidities</li> <li>Family/community supports OR</li> <li>Need for health behavior change related to medical presentation (e.g. sleep disorder, pain), chronic medical conditions (e.g. cardiovascular, diabetes), developmental/parenting concern</li> </ul>	<ul style="list-style-type: none"> <li>Medical comorbidity including pain, or MH/SU comorbidity, and/or</li> <li>Isolated or chaotic family/community environment</li> </ul>	<ul style="list-style-type: none"> <li>Multiple, complex medical, MH/SU comorbidities, and/or</li> <li>Isolated or chaotic family/community environment, and/or</li> <li>Previous treatment ineffective</li> </ul>	<ul style="list-style-type: none"> <li>Adults 18 years and over with a severe and/or persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment, but for whom long-term 24-hour care in a hospital, nursing home, or protective facility is unnecessary or inappropriate (NIMH) (<i>In CA, referred to as Serious and Persistent</i>)</li> </ul>
	<ul style="list-style-type: none"> <li>Standardized assessment tool<sup>12</sup> indicates mild to moderate symptoms or developmental concern</li> </ul>	<ul style="list-style-type: none"> <li>Standardized assessment tool<sup>12</sup> indicates moderate to severe symptoms and their impact on functioning</li> </ul>	<ul style="list-style-type: none"> <li>Standardized assessment tool<sup>12</sup> indicates severe symptoms and their impact on functioning</li> </ul>	<ul style="list-style-type: none"> <li>Individuals with SU disorders that require ASAM Level III or IV services</li> </ul>
	<ul style="list-style-type: none"> <li>Diagnostic examples include V-codes, mild depression, mild anxiety, sleep disorder, somatic disorder, SU disorder</li> </ul>	<ul style="list-style-type: none"> <li>Diagnostic examples include moderate depression, moderate anxiety (including PTSD), sleep disorder, somatic disorder, SU disorder (abuse)</li> </ul>	<ul style="list-style-type: none"> <li>Diagnostic examples include severe depression, severe anxiety (including PTSD), schizophrenia, bipolar disorder, schizoaffective disorder, personality disorders, SU disorder (abuse/dependence)</li> </ul>	<ul style="list-style-type: none"> <li>Diagnostic examples include schizophrenia, schizoaffective disorder, bipolar disorder, SU disorder (abuse/dependence)</li> </ul>

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## Conclusions

- What it takes to succeed at a primary care/behavioral health integration at the service delivery level *assuming that the financing barriers are addressed*:
  - Workflows: Studying each clinical workflow step (“what-is”) is necessary to design “to-be” processes that promote clinical integration
  - Clear Provider Responsibilities: New tasks (e.g., behavioral health screening in primary care and registry management) should be assigned to the appropriate staff
  - Data is Clinical Information: Data collection related to clinical progress typically requires a change of culture in which data is used to inform clinical practice
  - Registry Tracking: Registries are a baseline technology that must be in place; one cannot succeed at integration without registry software
- “It will always take longer than anticipated. The simpler one can make the process for providers of care, the more likely that process will be successful.” (Illinois site, National Council Collaborative)

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## Key Concepts in Developing a New California 1115 Waiver



### Key Waiver Development Concepts

- Begin with Clinical Design that Integrates Primary Care, Substance Use Treatment and Mental Health
- Embed the Design in Population-Based Planning that Projects Demand, Capacity, Revenue, Costs and Cost Offsets
- Design the Management Structure to Support the Clinical Design (not the other way around)
- Design the Financing Structure to Support the Clinical Design (not the other way around)
- Build a Business Case that Demonstrates that CADPAAC and its Members will be Value-Adding Partners in a Reformed Environment

## Clinical Design that Integrates Primary Care, Substance Use Treatment and Mental Health

- Starting with the principal that...



System design should be clinically driven and then tested for financial feasibility; *not the other way around!*

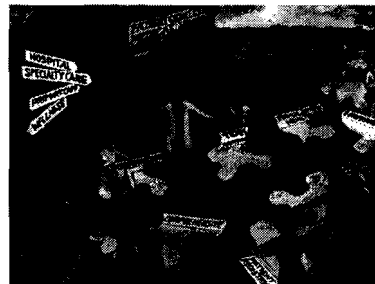
- The substance use community needs to participate in clarifying the clinical design of the person centered healthcare home for persons with substance use disorders; this needs to be followed by design of the management structure, followed by the financial design
- This means figuring out what SU services will look like inside of a primary care setting

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## Clinical Design that Integrates Primary Care, Substance Use Treatment and Mental Health

Grounded in the **4-Quadrant Model** and the **Healthcare Home Principles**

- Ongoing Relationship** with a PCP
- Care Team** who collectively take responsibility for ongoing care
- Provides all healthcare or makes **Appropriate Referrals**
- Care is **Coordinated and/or Integrated**
- Quality and Safety** are hallmarks
- Enhanced Access** to care is available
- Payment** appropriately recognizes the **Added Value**



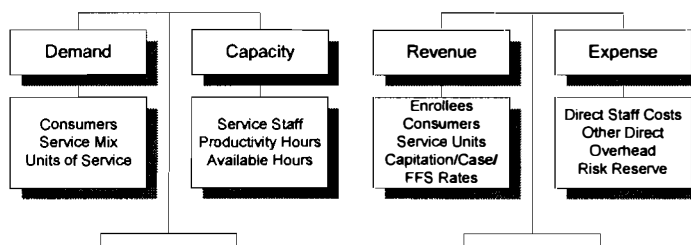
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## Population-Based Planning Questions

- CADPAAC should complete a Population-Based Planning Project that Estimates Demand, Capacity, Revenue, Expenses and Cost Offsets, answering the following questions:

**Demand:** How many Californians need substance use services during the course of a year, stratified by level of need? What percentage of need can be met in a fully functioning system?

**Demand:** How much of what types of evidence-based services ought to be provided for each clinical cohort?



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## Population-Based Planning Questions (All 4 Quads)

**Demand:** Where should the services described above be provided?

**Capacity:** What is the current capacity (clinicians, beds, etc.) to address the demand?

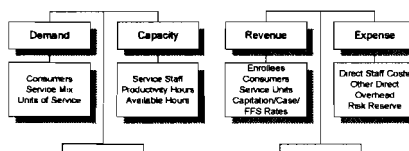
**Capacity:** What gaps exist (including skills) and how is the capacity aligned (or not) with how it should be deployed?

**Revenues:** What is the projection of available state, federal (including Medicaid expansion), local and other funds?

**Expenses:** What are the estimated ongoing costs of meeting the demand?

**Expenses:** What startup costs are needed to build adequate capacity, skills and infrastructure?

**Cost-Offsets:** If adequate capacity is available to meet demand, what cost offsets will likely occur?



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## Population-Based Planning Examples

### How Many People need Service?

**Part II. Prevalence Forecasting\***

**Target XYZ Estimates for County Managed Services**

	Total	Medi-Cal Plan A	Medi-Cal Plan B	Low Income Uninsured	Medi-Cal Ptnr/ Low Income Uninsur Total
Total XYZ, all ages	379,331	11,654	30,346	27,312	57,658
Total XYZ over 18	265,152	5,827	15,173	13,656	28,829
Ratios			53%	47%	100%
9% of XYZ over 18*	34,140	524	1,366	1,229	2,595
2% of XYZ over 18 (Severe)	7,587	117	303	273	577
<b>Dual Diagnosis Estimates</b>					
Total XYZ over 18	265,152	5,827	15,173	13,656	28,829
SMI is 5.42% of XYZ	14,371	316	822	740	1,563
Public sector SMI	6,050	316	822	740	1,563
40% of SMI have dual dx	2,420	126	329	296	625
60% of SMI have dual dx	3,630	189	493	444	938

This is an example from 2003 for a California County that was planning for the equivalent of Quadrants II and IV; the format is more important than the actual numbers

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## Population-Based Planning Examples

### How Much of What Types of Service are Needed?

**Part VI.a. Service and Cost Projections**

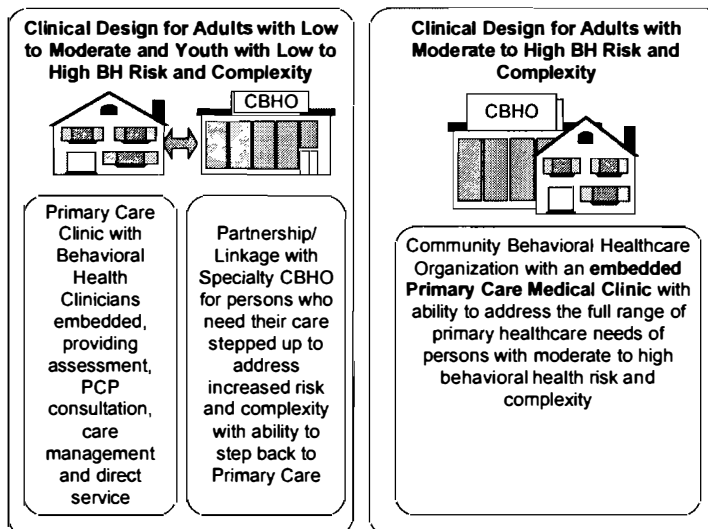
High Scenario	9.0% penetration		Complete 40% Units Svc	Partial* 60% Units Svc	Total Service Units
	Average Svc. Units	Number of Users			
<b>Entry Services</b>					
<i>Detox</i>	5	934	1,868	1,401	3,269
<i>Extended Stabilization</i>	5	234	467	350	817
<i>Pre Treatment</i>	5	584	1,168	876	2,043
<b>Subtotal</b>		1,751	3,503	2,627	6,130
<b>Ongoing Services</b>					
<i>Intensive OP/day habilitation</i>	14	350	1,962	1,471	3,433
<i>OP Level 1</i>	27	976	10,542	7,906	18,448
<i>OP Level 2</i>	131	1,027	53,840	40,380	94,219
<i>OP Level 3</i>	340	-	-	-	-
<b>Subtotal</b>		2,004	64,382	48,286	112,668
<i>Residential 1</i>	28	-	-	-	-
<i>Residential 2</i>	178	117	8,313	6,235	14,548
<i>Residential 3</i>	365	23	3,409	2,557	5,966
<i>Residential 1a</i>	90	234	8,407	6,305	14,712
<b>Subtotal</b>		374	20,129	15,097	35,226

This is an example from 2003 for a California County that was planning for the equivalent of Quadrants II and IV; the format is more important than the actual numbers

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## Population-Based Planning Examples

### Where Should Healthcare Home Services Be Provided?



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## Population-Based Planning Examples

### What Revenues are Available and How are they Organized/Restricted?

SUBSTANCE ABUSE FEDERAL FUNDS (SAFT)									
	Discretion-ary	Prevention	Club Live	Friday Night Live	HIV Set-aside	Perinatal Set-aside	Youth Treatment Services Disc	Youth Development Crime Prevention (YDCP)	Prop 36
<b>Total Current Year Budget</b>	\$1,534,060	\$509,955	\$15,000	\$15,000	\$151,453	\$162,217	\$33,156	\$156,961	\$562,041
<b>Expansion Dollars</b>									
<b>Total Available Funds</b>									

SUBSTANCE ABUSE STATE FUNDS									
	Drug Medi-Cal Regular	Drug Medi-Cal Prenatal	State General Fund Regular	State General Fund Perinatal	Drug Court Adult	Drug Court Youth	Family Drug Court	BASN/ CDC	Private Insurance
<b>Total Current Year Budget</b>	\$296,292	\$31,313	\$245,712	\$259,338	\$55,000	\$15,000	\$132,000	\$400,000	\$25,000
<b>Expansion Dollars</b>									
<b>Total Available Funds</b>									

OTHER FUNDS									
	County General Fund-Probst.	County General Fund-Sheriff	SASCA/ CDC	CMSP-regular	Cal-Works	MSA Tobacco	Prop 10	Medi-Cal Health Plan	Totals
<b>Total Current Year Budget</b>	\$144,000	\$320,000	\$47,000	\$5,000	\$762,356	\$100,000	\$159,000	\$100,000	\$6,252,756
<b>Expansion Dollars</b>									
<b>Total Available Funds</b>									

This is an example from 2003 for a California County that was planning for the equivalent of Quadrants II and IV; the format is more important than the actual numbers

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## Population-Based Cost Planning - Adequacy of Rates

Cost Planning must be based on the true cost of efficient care

Designing case rates and fee for service rates that do not reflect market wages, benefit rates and "everything else" rates, undermines the capability to hire and retain staff and maintain service quality

This slide is from a 2009 Washington State Cost Study

	Facility-Based BRS	Treatment Foster Care BRS	Child Placing Agency
DSHS Average Payment Rate	\$6,605	\$3,314	\$529
Total Cost per Child per Month	\$7,972	\$3,902	\$1,087
DSHS Rates Shortfall \$	-\$1,367	-\$588	-\$558
DSHS Rates Shortfall %	-17%	-15%	-51%
<b>Scenario 1 - Market Adjustment A</b>			
Wage Adjustment 3%	\$111	\$39	\$14
Benefits Adjustment 1%	\$38	\$13	\$5
Total Adjustment	\$149	\$53	\$18
Revised DSHS Shortfall	-\$1,516	-\$641	-\$577
Shortfall %	-19%	-16%	-53%
<b>Scenario 2 - Market Adjustment B</b>			
Wage Adjustment 16%	\$591	\$210	\$73
Benefits Adjustment 3.3%	\$141	\$50	\$17
Total Adjustment	\$732	\$260	\$91
Revised DSHS Shortfall	-\$2,099	-\$848	-\$649
Shortfall %	-26%	-22%	-60%
<b>Scenario 3 - Market Adjustment C</b>			
Wage Adjustment 24%	\$887	\$314	\$110
Benefits Adjustment 9.8%	\$449	\$159	\$56
Total Adjustment	\$1,335	\$473	\$165
Revised DSHS Shortfall	-\$2,702	-\$1,061	-\$723
Shortfall %	-34%	-27%	-67%

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## Population-Based Planning Examples

### At What Cost?

This is an example from 2003 for a California County that was planning for the equivalent of Quadrants II and IV; the format is more important than the actual numbers

Part VI.a. Service and Cost Projections				
High Scenario				
	Total Service Units	Average Cost Unit	Other Costs (UA's)	Projected Cost
<b>Entry Services</b>				
<i>Detox</i>	3,269	\$75.00	\$0	\$245,193
<i>Extended Stabilization</i>	817	\$75.00	\$0	\$61,298
<i>Pre Treatment</i>	2,043	\$39.91	\$4,904	\$86,459
<b>Subtotal</b>	6,130		\$4,904	\$392,950
<b>Ongoing Services</b>				
<i>Intensive OP/day habilitation</i>	3,433	\$75.00	\$29,423	\$286,875
<i>OP Level 1</i>	18,448	\$35.14	\$16,398	\$664,651
<i>OP Level 2</i>	94,219	\$34.33	\$86,308	\$3,321,046
<i>OP Level 3</i>	-	\$35.43	\$0	\$0
<b>Subtotal</b>	112,668		\$102,706	\$3,985,697
<i>Residential 1</i>	-	\$55.00	\$0	\$0
<i>Residential 2</i>	14,548	\$50.00	\$0	\$727,405
<i>Residential 3</i>	5,966	\$50.00	\$0	\$298,318
<i>Residential 1a</i>	14,712	\$50.00	\$0	\$735,578
<b>Subtotal</b>	35,226		\$0	\$1,761,301
<b>Less Readiness Groups &amp; Billable Tx Svcs Provided by Co Staff</b>				(\$261,330)
<b>Total Service Cost</b>				\$6,165,493
<b>ATU Substance Abuse Costs</b>				\$ 935,977
<b>Other County Substance Abuse Costs ***</b>				\$1,608,224
<b>Subtotal ATU/Other County SA Expenses ***</b>				\$2,544,201
<b>Use of Mental Hlth Resources for the ATU</b>				\$82,317
<b>Total Expenses</b>				\$8,709,694

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## Population-Based Planning Examples

### With What Cost Offsets?

#### Public Assistance in Washington

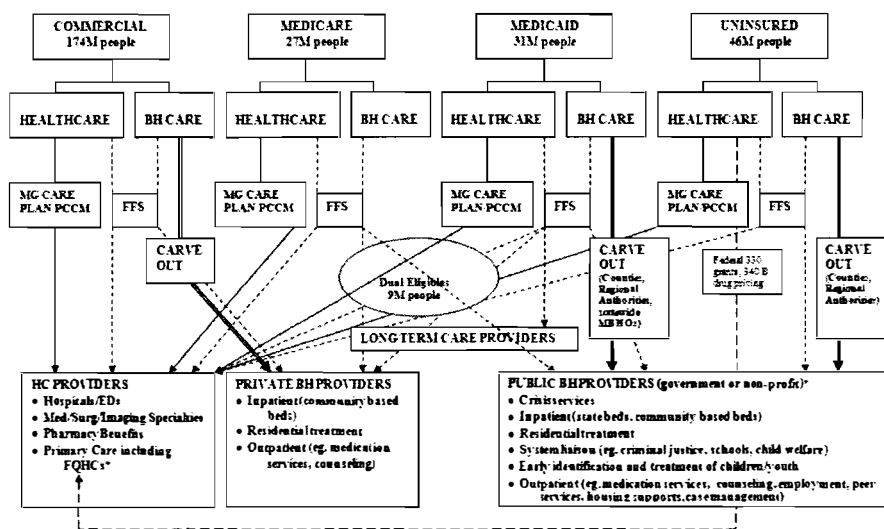
A comparison of medical expenses of Medicaid clients<sup>6</sup> who received treatment noted these savings:

Modality	Savings per Medicaid member per month
Inpatient	\$170
Outpatient	\$215
Methadone	\$230

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## Management Structures: the complexity of the current system

Healthcare Reform. Financing Streams and Behavioral Health: Current System



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## Management Structures

- Design the Management Structure to Support the Clinical Design (not the other way around); this starts with developing a conceptual model that addresses:
  - Medicaid AOD Services in California constitute a separate “silo” with separate regulations, funding sources, financing methods, and reporting mechanisms
  - Medicaid AOD Services in California have not been in formal managed care systems operated under CMS managed care regulations
  - There has been limited integration of primary care, substance use and mental health services in the California public sector
  - There is great variation in how each County is funded and operates; it will be hard to sell 58 AOD + 57 MH Medicaid managed care carve-outs as being compatible with healthcare reform

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## Management Structures

- The Management Structure needs to begin with a conceptual model that describes how:
  - The Management structure supports and ensures that the clinical activities mirror the healthcare reform goals of Improving Quality and managing Total Healthcare Expenditures
  - Substance Use services will be clinically integrated with primary care and mental health and the management structure supports clinical integration, versus hinders it
  - Substance Use services will be provided through an “Organized System of Care” (managed care) that operates within a quality improvement and performance measurement framework
  - The Management Structure will seamlessly manage both Medicaid and non-Medicaid funds and services

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## Management Structures

- The Management Structure must address the 10 Core Health Plan Functions:

Health Plan Function	Description
Governance	Provide governance for the PIHP that meets HRSA contract requirements and oversees the contract
Provider Relations	Ensure adequate service capacity for each region, manage the relations with network providers, coordinate with other systems, and meet other contract requirements
Billing & Reimbursement	Design payment mechanisms and manage provider payment and third party coordination processes
Member Services	Ensure enrollees are properly informed, provide customer service, ombuds service and manage grievance system
Care Management	Design and manage a care management system addressing access, authorization, intake and assessment, coordination of care, and ongoing utilization and resource management
Quality Management	Design and manage a quality management system, working under an annual quality plan to monitor performance and improve services
Information Technology	Design and manage IT system to collect, analyze, and submit data to appropriate bodies
Decision Support	Develop and manage data warehouse and design and publish useful reports to support decision making at every level of the PIHP
Accounting & Financial Management	Provide financial planning and management for the PIHP and meet contract reporting requirements
Compliance	Design and operate compliance plan

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## Management Structures

Options for Management Structures include:

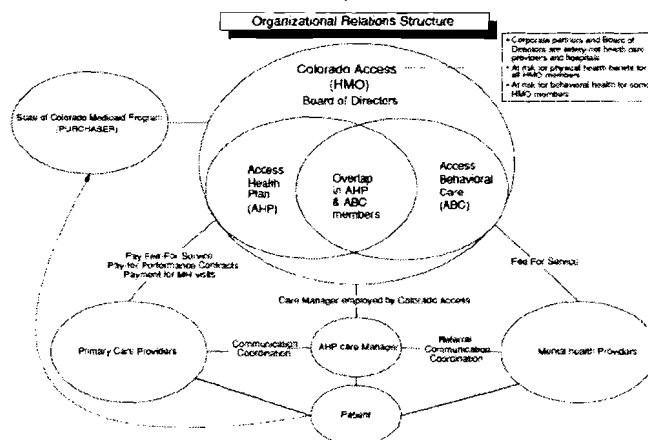
- Design a managed care framework based on the current system that includes a SU carve-out with 58 SU Plans that can demonstrate how this is the best approach for creating successful clinical integration, improved outcomes and bending the cost curve
- Design a regional managed care framework that includes a SU carve-out with a relatively small number of regional SU Plans that can demonstrate... (see above)
- Design a statewide managed care SU carve-out that can demonstrate...
- Design a managed care framework that consolidates the 58 SU and 57 MH organizations into county-based behavioral healthcare carve-out plans that can demonstrate...
- Design a regional managed care framework that consolidates 58 SU and 57 MH organizations into a small number of regional behavioral healthcare carve-out plans that can demonstrate...
- Design a statewide managed care behavioral health carve-out that can demonstrate...
- Partner with one or more health plans to design an integrated Health and SU carve-in model that can demonstrate...
- Partner with one or more health plans and the County MH Plans to design an integrated Health and Behavioral Health carve-in model that can demonstrate...

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## Management Structures

### Colorado Access Model as a Template for a Carve-In:

- Colorado Access is a non-profit Medicaid health plan that was formed in 1994 by a number of the state's safety net providers. Colorado Access has several product lines including a fully capitated Medicaid physical health HMO, Access Health Plan (AHP), and a behavioral health plan, Access Behavioral Care (ABC), which holds the carved-out Medicaid mental health contract in Denver County



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## Financing Structures Overview

- The Financing Structure design must address three issues:
  - What are the funding sources that will be managed through the managed care plan?
    - You should plan to coordinate and blend Medicaid, Medicare, SAMHSA/CSAT, Other Federal, Private, and Self-Pay Funds
  - How will funds in other systems be integrated to support clinical integration?
  - How will those funds be managed to ensure that they improve quality, manage costs, and align with payors' regulations, laws and contract requirements?
    - This includes linking the clinical design and workflows with access, authorization and utilization management systems with provider payment systems

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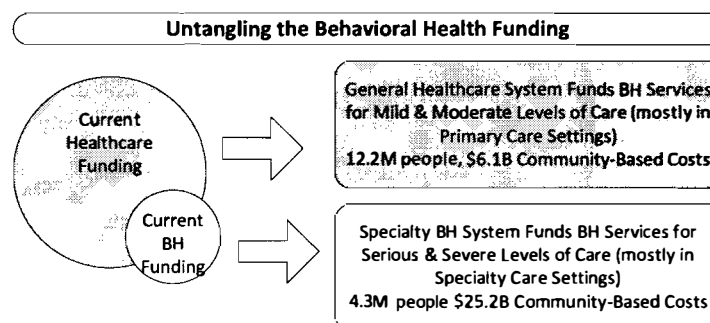
## Financing Structures: Integrating Funding

- How will funds in other systems be integrated to support clinical integration?
  - We need a **new paradigm**—none of the old models work for implementing bidirectional integrated care for the whole population
  - Lessons from the “field”:
    - MN—financing the DIAMOND project out of the healthcare side (rather than the mental health side) believing that cost and quality improvements will be there
    - WA General Assistance project—explicit stepped care model that finances both Level 1 (primary care) and Level 2 (specialty) MH/SU benefits; dedicated financing for Levels 1 and 2; neither draw on dedicated mental health funding
    - Washtenaw Co, MI—global budget for Medicaid population; local consolidation of medical and behavioral health funding streams
    - Medical Home Pilots—case rate in addition to FFS, to cover prevention, care management of chronic medical conditions (why not build the BHC in PC role into the case rate?)

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## Financing Structures: Integrating Funding

- Assuming that parity will be embedded as a requirement for most health plans in the final healthcare reform legislation and a broader behavioral health benefit will be available for most people with coverage, and ...
- Drawing on the California Integration Policy Initiative framework of Mild, Moderate, Serious and Severe Levels of Care...



- ...as we make the transition to an integrated system at every level (Clinical, Financial and Structural)

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### **Financing Structures: Managing Financial Risk**

- The Financial Design must be based on a deep understanding of managing financial risk
  - There are multiple levels of financial risk
  - The other side of financial risk is reward
  - The payment mechanism is the method by which risk is transferred from payer to provider
  - Payment mechanisms carry varying incentives for both payer and provider
  - Quality management must be consistent with the level of risk held by payer and provider

### **Build a Business Case that Demonstrates that CADPAAC and its Members will be Value-Adding Partners in a Reformed Environment**

- Because we have finally reached the tipping point in understanding the importance of treating the healthcare needs of persons with serious mental illness and the behavioral healthcare needs (MH & SU) of all Americans...
- Behavioral healthcare has become very important to managing Total Health Expenditures in the U.S. and bending the cost curve
- This makes it absolutely critical that CADPAAC recommendations describe a managed care management and financing structure that is the best approach for creating successful clinical integration, improved outcomes and bending the cost curve
- Anything less than this will likely not gain traction!

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