The Business of Integrated Behavioral Health: Designing Sustainable Programs & Contracting Models

Monica E. Oss, Chief Executive Officer, OPEN MINDS
Arizona State University
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<th>Agenda</th>
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I. The Shifting Health Care Financing Landscape: Where Specialist Provider Organizations 'Fit'
The Big Picture Drivers Of Positioning

Health care reform moves ahead

“Bend the cost curve” is the theme

“Beyond FFS” is the model

Focus on complex high-cost consumers
Payer Focus On Reducing Health Care Costs of 5% Of Consumers

5% of U.S. population account for half (49%) of health care spending
- $11,487 per person

50% of population account for only 5% of spending
- $664 per person
What Does This Mean?
Two Delivery Systems Emerging... Both Based on “Coordinated Models”
Who Is In This 5% Using 50% Of Resources?

- Services to support chronic illnesses contribute to 75% of the $2 trillion in U.S. annual spending.

- Patients with co-morbid chronic conditions costs 7x as much as patients with one chronic condition.

Nine Highest–Cost Chronic Conditions

1. Arthritis
2. Cancer
3. Chronic pain
4. Dementia
5. Depression
6. Diabetes
7. Schizophrenia
8. Post traumatic conditions
9. Vision/hearing loss
## Comorbid Chronic Physical & Behavioral Disorders Increase Annual Medicaid Costs by 75%

<table>
<thead>
<tr>
<th>Condition</th>
<th>No Behavioral Health Disorder</th>
<th>With Mental Illness And/Or Addiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma/COPD</td>
<td>$8,000</td>
<td>$24,598</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>$9,488</td>
<td>$24,927</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>$8,788</td>
<td>$24,443</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$9,498</td>
<td>$36,730</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$15,691</td>
<td>$35,840</td>
</tr>
</tbody>
</table>

*Total private insurer medical costs for children with autism is 3 to 7 times greater than for those children without autism.*

Rhonda Robinson-Beale, M.D.
Dual Eligibles Account For More Than A Third Of Medicare & Medicaid Spending

- 21% of 43 million Medicare beneficiaries – account for 36% of all Medicare spending in 2007
- 15% of the total 58.1 million Medicaid beneficiaries — and use 39% of Medicaid resources

Dual eligibles:
Consumers eligible for both Medicare and Medicaid based on disability and low income
Problem With Current “System Of Care” For Consumers With Chronic Conditions

• Multiple specialists (and multiple prescriptions)
  ◦ Consumers with 5 or more chronic conditions see 16 physicians a year with 37 office visits
  ◦ Fill 50 prescriptions per year

• Poor follow-up from ER visits and hospitalizations
  ◦ 20% of Medicare hospitalizations are followed by readmission within 30 days
  ◦ Among <65 Medicaid patients, 10% were readmitted within 30 days

Readmissions add $15 billion in annual Medicaid and Medicare payments
For The 95%: Primary Care–Focused Models Spend Less Via Consumer Engagement

- Management via ACOs, medical homes, and primary care
- Specialist role is secondary
- Focus on prevention and wellness
- Consumer self-care and consumer convenience is key
- Web presence (optimization, reputation, etc.) critical for consumer referrals
- Health information exchange a requirement

Services for 95% of consumers via primary care–directed models

- Primary care relationships with clearly defined specialty service
- Consumer ‘experience’ (and preference) critical
- Web presence key referral mechanism
- Health information exchange capabilities
For the 5%: Intensive Coordinated Care Models Spend Less By Investing More

- Coordination of medical, behavioral, and social service needs by specialty group within larger system
  - Health homes
  - Waiver-based HCB programs
  - PACE programs
  - Specialty care management programs
- Assumption of performance risk (with or without financial risk)

- Cross-specialty and cross-system care coordination capability
- EHR system and HIE with real-time care management metrics
- Performance-based contracting and risk-based contracting capabilities

Specialty coordinated care systems for ‘high needs’ consumers -- the new ‘carve out’ model
Change in Payer & Consumer Preferences Also Fueled By New Science

Synergistic Environmental Factors In Current Market

- New Functionality In Telecommunications
- New Health Data Systems & Informatics
- Emerging Developments in Neuroscience
Emerging Developments in Neuroscience

Scientific Discoveries Fueling Commercial Neuroscience Offerings

- Ability to monitor brain functionality and changes
- Discovery of possibility of brain cell regeneration
- Better understanding of brain chemistry
- Identification of genetic and epigenetic factors in behavioral and cognitive disability

Changing theory of brain development and maturity - longer and later

Requires expanded range of medical expertise to serve consumers
New Functionality In Telecommunications

Telehealth Technologies

- Telecare & Assistive Technology
  - Smart home Technology
  - Tech-assisted cognitive retraining
  - Companion robots
  - Remote monitoring systems
    - Remote vital sign sensors
    - Wearable wireless devices

- ehealth
  - mhealth
    - Smartphone applications
    - Text message alerts
  - Telehealth
    - Real-time consultation
    - Remote audio/video therapy

Reshaping geographic boundaries – and labor cost metrics
Bioconnectivity Platform For Health Informatics

EMRs & EMR Data (NHIN of the future)

Clinical Data From New Diagnostics & Neurotech

Bioconnectivity
Single Real-Time Clinical, Admin, & Cost Data Set

Clinical Metrics From Telehealth

Connection of & Access To All Data Sets Via Web Tools -- For Consumers, Professionals, Health Systems

New Health Data Systems & Informatics
Ten “Must Consider” Technologies In Developing Sustainable Business Models

- Electronic health recordkeeping systems
- Computer-assisted treatment planning and clinical expert systems
- Predictive clinical analytics
- Remote monitoring and smart homes
- Web-based consumer interaction and consumer self-management
- Telehealth, virtual and alternate reality technologies, and web-based treatment management
- Neurotech devices and computer-based cognitive retraining tools
- New pharmacological delivery systems – smart drug delivery systems: patches, injectibles, microchips, etc.
- New diagnostics – scans, biologic testing, web-based assessments, etc.
- Integrated performance metrics monitoring – clinical, HR, financial, marketing
Technology Is Changing The Playing Field...

New Technologies Allow Greater (& More Effective) Coordination Of Care

Telehealth and virtual consultation

Participation in health information exchange programs

Interoperable electronic recordkeeping systems

Smartphone and other technologies for consumer-directed disease management

Key Market Effects Of Telehealth Adoption

- Consumer preference in retail market
- Lower cost monitoring in chronic care market
- Lower per-visit cost (e.g. $45 NowClinic rate)
- Increased productivity yield on staff time in organizations using telehealth
- Geography no longer market boundary
Budget Pressures & New Technologies Driving Changing System Delivery & Financing Model

New Service Management & Service Delivery Models  More P4P  Less FFS

Changes in health care financing will drive sharp line between “health” and “social service” – with cost shifting to non–health systems
The Challenge...

- Previous relationships with payer changing
  - Role of mission-based, tax-exempt organizations evolving
- More competition
- Technological substitution reducing price point on rates

“Specialist” organizations need strategic repositioning to maintain competitive advantage

“To win, create what is scarce”
For 95% of population, primary care-based care and referrals from ACOs/medical homes

For 5% of population, coordinated service delivery for complex consumers

Less “specialist care” in the new models

Where Do Specialist Professionals & Provider Organizations Fit?
The Strategic Advantage Issue... Alignment in three changing domains

Programmatic offering for service delivery and positioning (horizontal)

Role in care management and structural positioning (vertical)

Financing options

Balancing these three elements is key to specialist organization market positioning
II. Integrated Care Management: The Behaviorally-Led Medical Home Model & The Health Home Model
Confusion in Strategy For Specialist Organizations

- “Integrated” vs. coordinated
- Integrated care management vs. integrated service delivery
- Whether integrated care management and integrated service delivery are options depends on the market and the payer
Emerging Integrated Care Management Models Frame The New Market

- Expanded managed care models – increasing use for SMI, I/DD, and LTC
- Accountable care organizations (ACOs)
- Medical homes and health homes
- Disease management programs
Shift Toward Managed Care For All Payers

<table>
<thead>
<tr>
<th>Payer Type</th>
<th>% Managed Care: 1995</th>
<th>% Managed Care: 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer–Sponsored Health Insurance</td>
<td>73.0%</td>
<td>99.0%</td>
</tr>
<tr>
<td>Medicare</td>
<td>0.0%</td>
<td>24.0%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>29.4%</td>
<td>71.5%</td>
</tr>
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</table>
# Managed Care In The Works For Dual Eligibles

<table>
<thead>
<tr>
<th>State</th>
<th>All Dual Eligibles?</th>
<th>Financing Model</th>
<th>Long –Term Care?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona, Hawaii, Idaho, Michigan, Minnesota, South Carolina, Vermont, New Mexico, Ohio, Rhode Island &amp; Texas</td>
<td>Yes</td>
<td>Capitated</td>
<td>Yes</td>
</tr>
<tr>
<td>California</td>
<td>Yes</td>
<td>Capitated (excludes BH – with counties)</td>
<td>Yes</td>
</tr>
<tr>
<td>Colorado, Connecticut, Iowa, North Carolina, Oklahoma</td>
<td>Yes</td>
<td>Managed fee–for–service</td>
<td>Yes</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>No</td>
<td>Capitated</td>
<td>Yes, but excludes LTSS under I/DD waivers</td>
</tr>
<tr>
<td>New York, Washington</td>
<td>Yes</td>
<td>Both</td>
<td>Yes</td>
</tr>
<tr>
<td>Oregon</td>
<td>Yes</td>
<td>Capitated</td>
<td>No</td>
</tr>
<tr>
<td>Tennessee</td>
<td>Yes</td>
<td>Capitated</td>
<td>Yes, but excludes LTSS for I/DD</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>No</td>
<td>Capitated</td>
<td>Yes</td>
</tr>
<tr>
<td>Illinois</td>
<td>Yes</td>
<td>Capitated</td>
<td>Yes, but excludes I/DD institutional and HCBS waiver services</td>
</tr>
<tr>
<td>Missouri</td>
<td>No (only those in health homes)</td>
<td>Managed fee–for–service</td>
<td>Yes</td>
</tr>
<tr>
<td>Virginia</td>
<td>Yes</td>
<td>Capitated</td>
<td>Yes, but excludes waiver populations, 27</td>
</tr>
</tbody>
</table>
Policy Makers & Insurers/HMOs Like The “Accountable Care Organization” Concept

• Construct to pay health care provider organizations based on value as opposed to volume

• ACOs are groups of physicians, hospitals, and other health care professionals and provider organization, who come together voluntarily to provide coordinated for their patients.

• The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

• Financial effectiveness depends on financial risk. (Most recent GAO analysis of CMS financing pilots show only those competitively bid and where system at financial risk resulted in positive cost offset.)
Current Evolution of ACOs

- No official definition for ACOs
- ACOs are being developed for both private and public payers
- ACOs are based on enhanced primary care model for care coordination
- Rely on primary care (in form of medical home or health home) to manage consumer utilization

- Medicare models dominated by hospital systems
- 254 Medicare ACOs currently in three programs:
  - Medicare Shared Savings Program
  - Advanced Payment ACO Model
  - Pioneer ACO Model
- There are 221 commercial ACOs in 45 states
- 50% of Americans live in area with ACO coverage
Medicare Sharing Savings ACOs

- Shared Savings Program begins with a spending benchmark — an estimate of what Medicare would spend on a certain population in the absence of the ACO
  - Calculation based on total expenditures for the ACO’s patient population in the three years prior, adjusted for relevant beneficiary characteristics, market factors and growth rates

- ACOs are to be rewarded or penalized based on its actual performance relative to the projected benchmarks

- ACOs are eligible for a capped percentage of the savings they generate—or liable for a share of the costs above expected levels

- To be accepted, Medicare ACOs:
  - Must meet all eligibility and program requirements
  - Must serve at least 5,000 Medicare FFS patients
  - Agree to participate in the program for at least 3 years
  - Will continue to receive payment under Medicare FFS rules
Financing Of Medicare Pioneer ACO Model Program

- Federal officials estimate the 32 Pioneer ACOs will manage care for about 860,000 Medicare patients and save Medicare $1.1 billion over five years

- For ACOs, five payment models – all variants of the core Shared Savings model with some moving to capitation in subsequent years
Commercial ACOs Sponsorship

- Hospital System: 118
- Physician Group: 70
- Community-Based Organization: 29
- Insurer: 4
Example: Aetna/Sharp ACO

- Aetna announced formation of an ACO with Sharp — a large independent practice association employing 700 physicians in San Diego — in December 2011
- Aetna will tie physician incentives to improvements in patients’ health
- Performance measure examples:
  - The percentage of Aetna members who receive recommended preventive care and screenings
  - Reductions in hospital readmission rates within 30 days following discharge
  - Reductions in avoidable emergency room visits resulting from expanded access to primary care physicians
  - HbA1C (blood glucose) tests each calendar year for members with diabetes
The Medical Home Model

- Model for coordinated and personalized patient care

- Each consumer has a primary care professional responsible for coordinating all of his/her care -- across all settings and specialties

- Consumers have expanded health care access via e-mail, telephone, etc.

- Primary care professionals paid a care coordination fee in addition to their regular office visit fee and may receive bonus payments for meeting quality and efficiency targets such as reduced use of emergency rooms, hospitals, and diagnostic testing
Why Medical Homes?

Percent Of US Adults Reporting Care Coordination Failures In Past Two Years, 2007–2008

- My specialist did not receive basic medical information from my primary care doctor
- My primary care doctor did not receive a report back from a specialist
- Test results/medical records were not available at time of appointment
- Doctors didn’t give other providers important medical information I think should have it
- I was not contacted or had to call repeatedly to get test results
- Any of the above


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Seventeen “Leading” Medicaid Medical Home States

29 states had enacted medical home legislation as of July, 2010

22 had one or more public, private or public-private medical home pilot programs
Examples of Medical Home Initiative: Community Care of North Carolina

- A Medicaid managed care pilot program in 1998. Since then, the legislature has expanded it to a statewide program that includes more Medicaid enrollees.

- Today, CCNC consists of 14 local nonprofit community networks across the state. The networks, which serve more than 950,000 Medicaid enrollees, are comprised of hospitals, health and social service departments, and 1,380 practices and clinics.

- Medicaid pays networks $3 per member per month ($8 for populations with complex medical conditions, such as the aged, blind and disabled) to coordinate care.

- Medical home providers receive $2.50 per member per month ($5 for those with complex medical conditions) to implement evidence-based patient treatment plans and provide 24/7 access.
Medicare Transitional Services Payment

- CMS creating a ‘medical home’ type of service in FFS Medicare
- New Current Procedural Terminology (CPT) codes 99495 and 99496 for care coordination pay physicians for the management of patients who have recently been discharged from a hospital
  - 99495: $135 in facility; $164 non-facility
  - 99496: $197 in facility; $231 non-facility
- Does not require face-to-face visits
- Will increase payments to family physicians by about 7 percent and to other primary care professionals between 3 percent and 5 percent.
- CMS is estimating the codes would apply to about 10 million discharges in 2013.
Health Home Model

- Health homes are a population-based medical home care management model focused on consumer model with chronic conditions.

- Health homes:
  - Grew out of the medical home model
  - Build on the medical home model’s focus on acute care by incorporating linkages to other community and social supports
  - Enhance coordination of medical and behavioral health care in order to better meet the needs of people with multiple chronic illnesses.
Section 1945(h)(4) of the Act defines health home services as “comprehensive and timely high quality services,” and includes the following health home services to be provided by designated health home providers or health teams:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives;
5. Referral to community and social support services, if relevant; and
6. The use of health information technology to link services, as feasible and appropriate.
Medicaid Health Home Adoption

States with approved SPA as of December, 2011
- Missouri (one approved SPA—CMHCs)
- Rhode Island (two approved SPAs)

States with SPAs ready to launch:
- Oregon
- Missouri’s – 2nd SPA
- Washington
- North Carolina
- New York

13 states with approved health home planning requests:
- Arizona, West Virginia, Mississippi, Arkansas, Nevada, New Jersey, New Mexico, North Carolina, California, Washington, Idaho, Alabama, Wisconsin
Core Health Home Care Management Functions

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care from inpatient to other settings
5. Individual and family support
6. Referral to community and social support services
7. Use of health information technology, as feasible and appropriate
State Medicaid Incentives For Health Homes

• Increased federal matching percentage for the health home services of 90 percent for the first eight fiscal quarters that a State plan amendment is in effect.

• The 90 percent match does not apply to other Medicaid services a beneficiary may receive.

• States could receive 8 quarters of 90% FMAP for health home services provided to individuals with chronic conditions – and a separate 8 quarters of enhanced FMAP for health home services provided to another population implemented at a later date.

• Additional periods of enhanced FMAP would be for new individuals served through either a geographic expansion of an existing health home program, or implementation of a completely separate health home program designed for different individuals.

• It is important to note that States will not be able to receive more than one 8-‐quarter period of enhanced FMAP for each health home enrollee.
## Health Homes: Missouri & Rhode Island

<table>
<thead>
<tr>
<th>Status Of SPA</th>
<th>Missouri</th>
<th>Rhode Island</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Approved by CMS on 10/20/2011</td>
<td>Approved by CMS on 10/23/2011</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Missouri</th>
<th>Rhode Island</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. They have a serious and persistent mental illness, including adults who meet the criteria for enrollment in Community Psychiatric Rehabilitation (CPR) programs, and children with SED 2. They have a mental health condition and a substance abuse disorder 3. They have a mental health condition or substance abuse disorder in combination with another chronic health condition</td>
<td>1. Adults over the age of 18 with SPMI, including dual eligibles 2. Children with special health care needs and their families who receive services through the Rhode Island Department of Human Services’ comprehensive, evaluation, diagnosis, assessment, referral, and re-evaluation initiative</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Designated health home providers</th>
<th>Missouri</th>
<th>Rhode Island</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CMHCs meeting State qualifications for a CMHC</td>
<td>Seven Community Mental Health Organizations (CMHOs) and two smaller providers of specialty mental health services (Fellowship Health Resources Inc. and Riverwood Mental Health Services)</td>
</tr>
</tbody>
</table>
Missouri Health Home Payment & Performance Measures

- The Missouri CMHC health homes receive $78.74 per member per month
- Pay–for–performance funding based on CMHC performance against six benchmarks
  1. Completion rate of metabolic screenings
  2. Enrollment and outreach percentage of clients in The Disease Management 3700 Project (DM 3700)*
  3. Completion rate for CPS adult and youth status reports
  4. Completion rate for Mental Health Statistics Improvement Program (MHSIP) adult consumer surveys
  5. Cyber access patient history utilizations
  6. CMHC behavioral pharmacy management (BPM) benchmark report
Rhode Island Health Home Payment & Performance Measures

• Monthly case rate of $442 PMPM to cover the cost of providing the health home services
• CMHOs will be evaluated (but not compensated) on the basis of six benchmarks:
  1. Reduction of readmissions per 1,000 member months
  2. Improvements in care coordination measured as changes in completeness of patient record documentation; % of patients who have a primary care professional and who have an annual physical exam; and % of patients who receive timely follow-up care following a hospital discharge
  3. Reduction in preventable emergency department visits
  4. Increased use of preventive services
  5. Improved management of chronic conditions for which medication adherence levels will be the primary metric for assessing quality of care
  6. Improved transition to CMHO services measured as % of inpatient mental health discharges where the patient had an outpatient follow-up visit within seven days of discharge; % contacted by the CMHO within two days of discharge; and % of patient transition records transmitted within 24 hours to the facility or primary physician, or other health care professional designated for follow-up care
# Difference Between Health Homes & Medical Homes

<table>
<thead>
<tr>
<th>Category</th>
<th>Health Homes</th>
<th>Medical Homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Populations served</td>
<td>Individuals with approved chronic conditions</td>
<td>Serve all populations</td>
</tr>
<tr>
<td>Staffing</td>
<td>May include primary care practices, community mental health centers, federally qualified health centers, health home agencies, ACT teams, etc.</td>
<td>Are typically defined as physician-led primary care practices, but also mid-level practitioners</td>
</tr>
<tr>
<td>Payers</td>
<td>Currently are a Medicaid-only construct</td>
<td>In existence for multiple payers: Medicaid, commercial insurance, etc.</td>
</tr>
<tr>
<td>Care focus</td>
<td>Strong focus on behavioral health (including substance abuse treatment), social support, and other services (including nutrition, home health, coordinating activities, etc.)</td>
<td>Focused on the delivery of traditional medical care: referral and lab tracking, guideline adherence, electronic prescribing, provider-patient communication, etc.</td>
</tr>
<tr>
<td>Technology</td>
<td>Use of IT for coordination across continuum of care, including in-home solutions such as remote monitoring in individual homes</td>
<td>Use of IT for traditional care delivery</td>
</tr>
</tbody>
</table>
Integrated Care Management Models About Accountability

Clinical Innovation
- EHR & Medication Management
- Meaningful Use
- Clinical Decision Support

Care Coordination
- Information Exchange
- Primary Care Integration
- Population & Community Health Management

Business Efficiencies
- Hosting & SaaS
- Revenue Cycle Management
- Managed Services
- Technology Partners

Improve Outcomes
Reduce Cost
Delivering Accountable Care
## Key Competencies For Medical Home & Health Home Success

<table>
<thead>
<tr>
<th>Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robust health record keeping and the ability to do health information exchange</td>
</tr>
<tr>
<td>Organizational performance metrics available with the use of metrics–based management to improve performance, and manage financial risk and unit cost</td>
</tr>
<tr>
<td>Deployment of automated clinical decision support tools across all chronic disease states</td>
</tr>
<tr>
<td>Infrastructure to locate and coordinate both health-related services and non–health social services</td>
</tr>
<tr>
<td>Systematic approach to consumer engagement and improving the consumer experience</td>
</tr>
</tbody>
</table>
Environmental Impediments to Medical Home & Health Home Success

- Difficulty in locating and assisting consumers in accessing social support services
- Difficulty securing appropriate housing
- Difficulty accessing appropriate health care services and coordinating care
- Difficulty sharing data
# Change Of Focus To Move From Care Delivery To Care Management

<table>
<thead>
<tr>
<th>Element Of Change</th>
<th>Today</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Focus</td>
<td>Sick care</td>
<td>“Healthcare” wellness and prevention, disease management</td>
</tr>
<tr>
<td>Care Management</td>
<td>Manage utilization and cost within a care setting</td>
<td>Manage ongoing health (and optimize care episodes)</td>
</tr>
<tr>
<td>Delivery Model</td>
<td>Fragmented/silos</td>
<td>Care continuum and coordination (right care, right place, right time)</td>
</tr>
<tr>
<td>Care Setting</td>
<td>In office/hospital</td>
<td>In home, virtual (e-visits, home monitoring, etc.)</td>
</tr>
<tr>
<td>Quality Measures</td>
<td>Process-focused, individual</td>
<td>Outcomes-focused, population-based</td>
</tr>
<tr>
<td>Payment</td>
<td>Fee-for-service</td>
<td>Value-based (outcomes, utilization, total cost)</td>
</tr>
<tr>
<td>Financial Incentives</td>
<td>Do more, make more</td>
<td>Perform better on measures, make more</td>
</tr>
<tr>
<td>Financial Performance</td>
<td>Margin per service, procedure (bed, clinician, etc)</td>
<td>Margin per life</td>
</tr>
<tr>
<td>Market-based provider fees (rather than cost-based reimbursement)</td>
<td>Fewer admissions to inpatient and residential levels of service</td>
<td>Creation of diversion programs and increased investment in community-based alternatives</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Shorter lengths of stay in inpatient and residential services</td>
<td>More ready acceptance of tech-based alternatives</td>
<td>More value-based purchasing models (P4P, risk-based, etc.)</td>
</tr>
</tbody>
</table>
III. Integrated Service Delivery: Primary Care/Behavioral Health Integrated Delivery Models
Elements Of Integrated Care Service Delivery From The Specialist Provider Perspective

Integrated care is a model of health care delivery that engages people in the full range of physical, behavioral, preventive and therapeutic services to support a healthy life.

In an integrated care setting, behavioral health and medical providers work together to coordinate treatment and follow-up of a person’s health care.
Billing screening codes, such as screening, brief intervention and referral to treatment, patient health...

Source: The Colorado Blueprint for Promoting Integrated Care Sustainability, March 2012
Funding Obstacles For Integrated Care Programs

- Same-day billing restrictions
- Need for grant funding dollars
- Inability to bill health and behavior codes
- Inability to bill for screening codes
- Inability to bill Healthcare Common Procedure...
- Inability to establish effective/effectiveness
- Need for initial/ongoing staff training
- Need for technical assistance
- Government/regulatory concerns
- No business/fiscal plan for sustainability
- Licensing issues
- Scope of practice concerns

Source: The Colorado Blueprint for Promoting Integrated Care Sustainability, March 2012
1. Specialist organizations adds primary care capacity

2. Specialist organization co-locates services in primary care organization

3. Specialist organization merges with primary care organization

4. Primary care organizations provides behavioral health services using specialist web-based and telehealth services

5. Care coordination through shared consumer data
Three Step Model In Evaluation Of Primary Care Options For Specialist Organizations

<table>
<thead>
<tr>
<th>Payer Market Mapping &amp; Identification of Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Payer market share</td>
</tr>
<tr>
<td>• Payer reimbursement model</td>
</tr>
<tr>
<td>• Payer reimbursement rates</td>
</tr>
<tr>
<td>• Competitive relationships for payer volume</td>
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<tr>
<th>Service Model Development</th>
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<tbody>
<tr>
<td>• Integrated care model</td>
</tr>
<tr>
<td>• Staffing</td>
</tr>
<tr>
<td>• Operating processes</td>
</tr>
<tr>
<td>• Costs of licensure and accreditation</td>
</tr>
<tr>
<td>• EHR platform</td>
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<tr>
<td>• HIE connectivity</td>
</tr>
<tr>
<td>• Decision support tools</td>
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</tbody>
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<thead>
<tr>
<th>Financial Sustainability Modeling</th>
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<tbody>
<tr>
<td>• Breakeven analysis</td>
</tr>
<tr>
<td>• Profit/loss projections</td>
</tr>
<tr>
<td>• Cash flow requirements</td>
</tr>
</tbody>
</table>
Conduct a breakeven analysis

Develop profit/loss projections

Business model to embed in organizational strategic plan, operating plans, and final budget
<table>
<thead>
<tr>
<th>Conduct Breakeven Analysis</th>
<th>Key Elements In Breakeven Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Breakeven analysis answers question ‘at what level of revenue will the program break even’?</td>
<td>• Key breakeven analysis factors:</td>
</tr>
<tr>
<td>• Breakeven analysis is a supply side (<em>i.e.</em> costs only) analysis – does not address revenue side of the equation</td>
<td>◦ Annual yield/productivity of service units (by type) per direct service (billable) clinical team member</td>
</tr>
<tr>
<td>• Construct breakeven analysis for the specific coordinated care business model both with and without organizational overhead</td>
<td>◦ Average annual total compensation cost per direct service (billable) clinical team member</td>
</tr>
<tr>
<td></td>
<td>• Assumptions in breakeven analysis:</td>
</tr>
<tr>
<td></td>
<td>◦ Constant fixed costs</td>
</tr>
<tr>
<td></td>
<td>◦ Average variable costs with assumptions</td>
</tr>
<tr>
<td></td>
<td>◦ Relationship of revenue to variable expense in assumptions</td>
</tr>
<tr>
<td></td>
<td>◦ Factors affecting assumption of yield/productivity of team members</td>
</tr>
<tr>
<td>Develop Profit/Loss Projections</td>
<td>Key Variables In FFS Profit/Loss Projections</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Financial statement summarizing revenues (with associated costs and expenses) incurred during a specific period of time</td>
<td>• All services provided (and paid) in integrated care setting (assessment codes, etc.)</td>
</tr>
<tr>
<td>• Illustrate the ability of the program to generate a margin by increasing revenue and reducing costs</td>
<td>- Address same-day billing restrictions of specific payers</td>
</tr>
<tr>
<td>• Revenue projections – and assumptions – are key element of P/L projections</td>
<td>• Number of annual unique consumers by payer</td>
</tr>
<tr>
<td>• Typically, revenue projections in health and human services are created by payer/contract</td>
<td>• Number of annual service units (by type) per consumer by payer</td>
</tr>
<tr>
<td></td>
<td>• Negotiated contract rate for each service unit by type and by payer</td>
</tr>
<tr>
<td></td>
<td>• Billing and collections yield (% of total units billed that are collected) by payer</td>
</tr>
<tr>
<td></td>
<td>• If P4P bonuses or penalties, the projected performance on each P4P performance measure</td>
</tr>
</tbody>
</table>
Financial Sustainability Issues Are Critical

- Dependent on payer arrangements
- Value of coordination vs. integrated is entirely in operational excellence
- Management of volume and productivity are key factors
4. Reimbursement In The New Financing Landscape
Reimbursement Changes Follow “Big Picture” In Policy

- Federal government and state government looking for shared accountability (and shared risk)
- Has resulted in more managed care for Medicaid, largely via competitive bidding among insuring organizations
- New Arkansas CMS waiver may further move system to large insurers
- PPACA has created a new landscape for insuring organizations – with significant implications for traditional provider organizations
Shift in Strategy of Health Insuring Organizations The “Elephant” Of The Market

- Use of technological substitution for services
- Reduction in MLR
- Backward integration by adding service delivery capabilities
- Risk-based contracting with providers

Disintermediation concerns
<table>
<thead>
<tr>
<th>Insurer Use of Technological Substitution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna offers free Aetna mobile apps</td>
</tr>
<tr>
<td>• DocFinder online provider director</td>
</tr>
<tr>
<td>• Urgent care finder</td>
</tr>
<tr>
<td>• Price-a-Drug</td>
</tr>
<tr>
<td>• Claims search</td>
</tr>
<tr>
<td>Cenpatico partners with myStrength.com</td>
</tr>
<tr>
<td>• Partnership adds myStrength.com individualized mental health wellness tools to redesigned Cenpatico website</td>
</tr>
<tr>
<td>ValueOptions partners with American Well</td>
</tr>
<tr>
<td>• Partnership to develop a national network of telehealth-enabled behavioral health professionals</td>
</tr>
<tr>
<td>Optum partners with RiteAid</td>
</tr>
<tr>
<td>• National partnership to provide NowClinic online care services to Rite Aid customers</td>
</tr>
<tr>
<td>Aligne Health Resources (now MD Aligne)</td>
</tr>
<tr>
<td>• Aligne Health Resources, now MD Aligne, offers insurers and HMOs remote-based telephone and online doctor consultations, medical advice, diagnoses, prescriptions, and testing – no health insurance needed</td>
</tr>
</tbody>
</table>
### Insurer Backward Integration To Acquire Service Capacity

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Acquisitions</th>
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</thead>
<tbody>
<tr>
<td><strong>Humana</strong></td>
<td>• Acquired SeniorBridge Family Cos., a New York–based chronic-care provider with about $72 million in sales in 2012</td>
</tr>
<tr>
<td></td>
<td>• Acquired Texas–based work injury clinic operator and drug-screening business Concentra Inc. in 20120 – Concentra has since acquired 2 primary care operations, Mid America Medical Associates and Garcia, Rosenberg &amp; Associates, in Illinois</td>
</tr>
<tr>
<td><strong>UnitedHealth Group</strong></td>
<td>• Acquired Monarch HealthCare, a California physician group that includes 2,300 physicians in a range of specialties – and assumed management of AppleCare Medical Group and the Memorial HealthCare Independent Practice Association</td>
</tr>
<tr>
<td><strong>WellPoint</strong></td>
<td>• Acquired CareMore, a multispecialty clinic and insurance company with 26 offices in the Los Angeles area with expertise in managing seniors with chronic conditions</td>
</tr>
<tr>
<td><strong>Highmark</strong></td>
<td>• Acquired Jefferson Regional and Premier Medical Associates in Pennsylvania; acquisition of West Penn Allegheny Health System still pending</td>
</tr>
</tbody>
</table>
Aetna/Sharp ACO

- Aetna and Sharp Community Medical Group (SCMG) launch an ACO for Aetna members in San Diego

Aetna/ Aurora Health Care

- Aetna partners with Wisconsin provider Aurora Health Care to create Aurora Accountable Care Network and a price guarantee for employers

Wellmark BCBS of Iowa/Genesis Health System

- Wellmark Blue Cross and Blue Shield of Iowa collaborating with Iowa–based Genesis Health System to create an ACO

Blue Shield of CA/John Muir Health ACO

- Blue Shield of California and integrated delivery system John Muir Health partnering on an ACO to cover plan members using a John Muir PCP

Blue Shield and San Francisco Health Service System

- Blue Shield ACO partnership created between Brown & Toland Physicians Group and California Pacific Medical Center (a Sutter Health affiliate)
Drivers Of Performance Measurement & Performance-Based Contracting

1. Increase transparency of performance
   ◦ Increase ‘pressure’ for improvement
   ◦ Facilitate consumer-directed care

2. Link professional, service provider organization, and care manager reimbursement to desired performance
   ◦ Improved access to care
   ◦ Increase care integration and coordination
   ◦ Person-centered planning and recovery focus

3. Control costs of care
   ◦ Financial incentives to help consumers become and remain healthy for longer periods of time
   ◦ Increase lower-cost interventions for ‘not yet seriously ill’ population
   ◦ Reduce unnecessary use of high-cost services
More Organizations Are “Rating” Performance In Health & Human Services

<table>
<thead>
<tr>
<th>CMS Quality Initiatives</th>
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<tbody>
<tr>
<td>National Committee for Quality Assurance (NCQA)</td>
</tr>
<tr>
<td>National Quality Forum (NQF)</td>
</tr>
<tr>
<td>Substance Abuse and Mental Health Services Administration (SAMHSA)</td>
</tr>
<tr>
<td>The Joint Commission</td>
</tr>
<tr>
<td>Center For Excellence in Assisted Living</td>
</tr>
<tr>
<td>Payer and care management organizations (states, counties, HMOs, MCOs, PPOs, ACOs, etc.)</td>
</tr>
<tr>
<td>Consumer–driven open–source rating organizations</td>
</tr>
</tbody>
</table>
In selected provider arrangements, we will be transitioning and supporting financial risk, accountability and utilization management practices.

Compensation Continuum
(Level of Financial Risk)

- Fee-for-service
- Performance-based Contracting
- Bundled and Episodic Payments
- Shared Savings
- Shared Risk
- Capitation
- Capitation + Performance-based Contracting

No Accountability  Moderate Accountability  Full Accountability

- a. 100% case by case UM
- b. Utilization stats review supplemented by case review
- c. Data management and system Modifications to achieve targets
- d. Internal ownership of performance using data management

Basic Q and U measurements
Max quality process and outcomes driven measurements

Passive involvement  Provider engaged  Provider active in management  Assumes accountability
New Service Delivery Models Moving To New Financing Beyond FFS: More Risk–Based Reimbursement

**FFS Financing**

- Payer (or MCO) maintains risk for unit cost and quantity of services used
- Consumers request services
- Provider organizations deliver services and are reimbursed based on volume
- MCO “approves” service

**Beyond FFS Financing**

- Payer (or MCO) contracts with provider organizations to deliver services to a population for a fixed amount of dollars
- Consumers request services
- Provider organizations determine type and amount of service, delivers service, and manage pool of dollars
Three Types Of Reimbursement Option

- Fee-for-service
- Case rates, episode-based payments, or bundled payment rates
- Capitation (and subcapitation)
Fee-For-Service

• Provider paid an established fee for a defined service
  ◦ Clearly defined package of services to be provided
  ◦ Quality standards can be established for defined services

• Fee schedule an issue

• Varying degrees of ‘management’
## Case Rate

- Payment of a flat amount for a defined group of procedures and services
  - Per treatment episode
  - Per time period

- Based on
  - Diagnosis
  - Assignment of a patient to a given type of treatment
  - Other patient characteristics

## What Factors Affect Case Rate Risk?

- Definition of the “package” of consumer services over a specific time period

- Risk of controlling cost per case
  - A function of both # of units used and cost per unit of service
## State/Initiative

<table>
<thead>
<tr>
<th>State/Initiative</th>
<th>Financing &amp; Approximate Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut Continuum of Care Model</td>
<td>Case rate, about $48,000 for 15 month, plus bonus tied to performance</td>
</tr>
<tr>
<td>Delaware CPS Low Risk Intervention</td>
<td>Case rate with 2 providers, $1250–$1500, with a $250 bonus (other providers FFS)</td>
</tr>
<tr>
<td>Delaware</td>
<td>$4,239 per child per service month</td>
</tr>
<tr>
<td>Family Builders</td>
<td>Case rate $3,500</td>
</tr>
<tr>
<td>Florida District 13</td>
<td>Case rate of $15,200 FY98, now capitated</td>
</tr>
<tr>
<td>Foster Care</td>
<td>Case rate $14,022 for 1-year reunification</td>
</tr>
<tr>
<td>Indiana</td>
<td>$2,000 annually (SED), $2,500 annually (substance abuse)</td>
</tr>
<tr>
<td>Indiana Child Welfare Demonstration</td>
<td>Case rate of no more than $9,000 per child. $20.4 million for 24 months</td>
</tr>
<tr>
<td>Kansas Family Preservation</td>
<td>Case rate $3,719 for 1 year</td>
</tr>
<tr>
<td>Maryland Baltimore City</td>
<td>Case rate for 3 years, not yet established, not more that $3500 per month</td>
</tr>
<tr>
<td>Massachusetts Commonworks</td>
<td>Leads have case rate of $4,447</td>
</tr>
<tr>
<td>Michigan– Michigan Families</td>
<td>Case rate of $1,500 per month per case for IV–E eligible, plus other state and local $</td>
</tr>
<tr>
<td>Ohio Hamilton County Creative Connections</td>
<td>Case rate $3130.29 per member per month</td>
</tr>
<tr>
<td>Oklahoma Children's Service Initiative</td>
<td>No risk Year 1, up to $3000 per family, with up to $400 in goods; case rate Year 2, perhaps $400 per month for up to 6 months</td>
</tr>
<tr>
<td>Permanency–Focused Reimbursement</td>
<td>Performance–based: $1,700 initial, $14.95 per day, $1,500 for meeting permanency goal or TPR, Bonus of $750 for good outcome at 6 months post–placement</td>
</tr>
<tr>
<td>South Carolina Privatized Adoption</td>
<td>FFS, performance–based schedule of payments, maximum of $13000 per child; $15,700 per sibling group</td>
</tr>
<tr>
<td>Texas Project PACE</td>
<td>Fixed daily rate of $72.40 per day, regardless of level of care. Case rate possible in later years</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>$2,200 per child per service month (Dane County)</td>
</tr>
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Episode-Based Payments

• Payment by episodes of care
  ◦ An episode of care includes services associated with a desired clinical outcome, such as the stabilization of a consumer’s depression

• Episodes of care have two major dimensions:
  ◦ A clinical dimension, including what services or clinical conditions comprise the episode
  ◦ A time dimension that reflects the beginning, middle and end of an episode

• Commonly includes a number of treating professionals
CMS Bundled Payments Initiative

- Bundled payments ‘combine’ FFS payment – and replace FFS payment – by creating a single payment amount (the ‘bundle’) irrespective of the kinds and quantities of the services provided
- CMS recently issued awards to health systems interested in receiving bundled payments
  - The initiative will permit bundle payment across provider sites for multiple services given during an episode of care
<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
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<tbody>
<tr>
<td>Acute Care Stay Only</td>
<td>An acute care hospital stay only for all MS–Diagnosis Related Groups (DRGs); the bundle includes all inpatient hospital services</td>
</tr>
<tr>
<td>Acute Care + Post–Acute Care</td>
<td>The acute care stay plus associated post–acute care for targeted clinical conditions based on MS–DRGs for an inpatient hospital stay; the bundle includes inpatient and physician services, related post–acute care services, related readmissions, and other services to be defined in the application</td>
</tr>
<tr>
<td>Post–Acute Care Episode</td>
<td>Post–acute care following discharge for targeted clinical conditions based on MS–DRGs for an inpatient hospital stay; the bundle includes post–acute care services, related readmissions, and other services to be defined in the application</td>
</tr>
<tr>
<td>Acute Care With M.D. Services &amp; Readmissions</td>
<td>Single prospective bundled payment for inpatient stays only for targeted clinical conditions based on MS–DRGs for an inpatient hospital stay; the bundle includes inpatient and physician services and related readmissions</td>
</tr>
</tbody>
</table>
CMS Bundled Payments For Care Improvement Initiative

- Three–year initiative to improve patient care and lower costs
- CMS will compensate participating providers via bundled payments rather than the traditional fee–for–service (FFS) payments for providing certain services to traditional Medicare beneficiaries.
  - **Model 1** includes an episode of care focused on the acute care inpatient hospitalization. Awardees agree to provide a standard discount to Medicare from the usual Part A hospital inpatient payments.
  - **Models 2 and 3** involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Models 2 and 3 applies to post–acute care; Model 2 also includes the inpatient acute care hospitalization
  - **Model 4** involves a prospective bundled payment arrangement, where a lump sum payment is made to a provider for the entire episode of care.
Capitation

- An entity (health plan or provider organization) is paid a contracted rate for each member assigned, referred to as "per-member-per-month" (PMPM) rate.
- Regardless of the number or nature of services provided.
- Contractual rates are usually adjusted for age, gender, illness, and regional differences.
- In subcapitation, responsibility and risk move from primary insuring entity to secondary.

What Factors Affect Capitation Risk?

- Consumer utilization.
- Provider payments and facility costs.
- Program design and control issues.
- Benefit plan coverage provisions.
V. Management Competencies For New Environment
Managed Care Systems Require New Administrative Capabilities

<table>
<thead>
<tr>
<th>Provider Organization Administrative Capabilities</th>
<th>Care Management Entity Administrative Capabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed care contracting and referral development</td>
<td>Member and customer service functions with eligibility determination</td>
</tr>
<tr>
<td>Systems to address preauthorization and utilization management requirements, including denials and appeals</td>
<td>Clinical and utilization management system</td>
</tr>
<tr>
<td>Enhanced clinical documentation requirements</td>
<td>Provider relations and network management</td>
</tr>
<tr>
<td>Billing and collections</td>
<td>Claims management and payment system</td>
</tr>
<tr>
<td>Collection of consumer payments – copayments, deductibles, non-covered services, etc.</td>
<td>Financial management system</td>
</tr>
<tr>
<td>Enhanced information systems capabilities to support care authorization, billing, reporting, and HIE</td>
<td>Organizational legal and financial requirements</td>
</tr>
<tr>
<td>Information systems and reporting systems</td>
<td>Information systems and reporting systems</td>
</tr>
</tbody>
</table>

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It’s All About the Risk! The Difference Between Risk & Uncertainty...

- Risk: probability of loss
- Uncertainty:
  - Condition of being in doubt
  - Odds are not known

Uncertainty  Information  Risk
Risk Categories With Direct Financial Impact

- Utilization Risk
- Price Risk
- Morbidity Risk
- Demand Risk
- Beta Risk

Risk Categories With Indirect Financial Impact

- Regulatory Risk
- Insurance Risk
- Liability Risk
- Contract Risk
- Infrastructure Risk
- Professional Risk
Risk–Based Premium Is A Function Of Four Costs:

1. **Cost of care**
   - Delivery system composition and model
   - Delivery system rates and rate structure
   - Utilization of services

2. **Cost of care management infrastructure**

3. **Risk reserve amounts (including accruals for P4P penalties)**

4. **Profit/net proceeds**
What Factors Affect FFS Risk?

- **Risk Of Controlling Cost Per Unit Of Service**
  - Wages of direct care staff
  - Overhead/administrative costs
  - Staff productivity
  - Volume of consumers served
  - Length of stay/average visits per case
  - Acuity/service needs of consumers

- **Risk of managing fee-for-service performance metrics (if P4P)**
The Cost Of Care Management Infrastructure

• Some rules of thumb...

  ◦ Don’t underestimate care management functionality requirements (this is different that underestimating ‘cost’ of functionality)

  ◦ Do consider all options for gaining functionality
#1. Intake, Referral & Member/Customer Service Functions

- **Member/customer access**
  - Decisions: 24/7, toll-free, on-line, walk in
  - Eligibility determination
  - Non-emergencies
  - Emergencies/hospital diversion resources

- **Service referral process**
  - Preauthorization requirements
  - Matching of consumer preferences
  - Assistance with scheduling

- **Member/consumer inquiries**
#2. Clinical & Utilization Management System

Processes
Four key processes:
1. Preauthorization requirements
2. Continued stay or concurrent reviews
3. Retrospective review
4. Quality review

- Structured processes to ensure placement in levels of care that are:
  - Least restrictive
  - Least expensive
  - Clinically appropriate

Implications
- Need to understand clinical algorithms of MCOs and adopt programming to fit new models
- Need administrative infrastructure to support the rapid, time-effective means of participating in clinical authorization process
#2. Clinical Criteria Set Key to Clinical Management Decisions

1. Clinical care criteria identifies ‘appropriate’ levels of care based on functional needs of consumer

2. Three steps in decision making:
   - Medical necessity – match of dx to proposed treatment
   - Clinical appropriateness – is proposed treatment at the least restrictive, least expensive level
   - Social necessity – are there non-medical, non-clinical reasons for approving level of care

3. Medical necessity determinations include appropriateness of treatment; match of proposed treatment to treatment goals; likelihood of treatment improving consumer functioning
#3. Provider Relations & Network Management

**Processes**

Functional areas:
- Credentialing
- Contracting process
- Profiling
- Sanctioning process

Ensure network adequacy
- Geographic accessibility
- Timely availability
- Adequate ratios of providers to covered members

Monitor contract performance
- Reward or penalize providers for performance against contract standards

**Implications**

- Each MCO has different contracting and credentialing processes
- Opportunities to fill ‘gaps’ in MCO networks
#3. Provider Relations & Network Management (For Contract Providers)

- Functional areas: credentialing, contracting process, sanctioning process, and profiling systems
- Issues in provider relations:
  - Provider standards: education, licensure, training, and experience
  - Risk-bearing arrangements and performance-based payments
  - Profiling plans: performance, outcomes, and quality assurance
  - Dismissal process
  - Data capture requirements
#4. Claims Management & Payment System (For Contract Providers)

- Accept submission of electronic and paper claims
- System links member/consumer eligibility, service authorization, and network provider information
- Coordination of benefit (COB) capabilities for claims editing & payment adjudication (including Medicare crossover claims)
- Coinsurance, deductible calculation, and accumulation capabilities
- Paper EOB and provider payment information generation
- Link to IBNR reporting
#5. Financial Management: Billing & Account Reconciliation Capability

- PMPM billing
  - Retroactive reconciliation of premium based on monthly eligibility records
- Case rate billing
- Performance–based contract compliance, billing, and reconciliation
#5. Financial Management System: Risk Management

- Responsible for monitoring and supporting the fiscal “success” of risk-based plan
- Key element is routine real-time clinical utilization and cost reporting (including IBNR)

- Overall cost accounting system
  - Cost per unit of treatment
  - Cost per course of treatment
  - Cost per patient
Loss Ratio

• Ratio between costs incurred for services and premiums received
  ◦ Total premium received in month: $45,000
  ◦ Total cost for services: $37,550
  ◦ Loss ratio = ($37,550 / $45,000) = 83%

IBNR = Incurred But Not Reported

• Outstanding claims for services that:
  ◦ Have not been received or
  ◦ Have not been captured by the authorization system
• An accrual for these claims necessary to accurately report claims expenses for given period.
Reporting For Financial Management

- IBNR
- Total days/visits per 1000
- Days/visits per 1000 for each level of care
- Admissions per 1000 for each level of care
- Gross costs per 1000 population for each level of care
- Average length of stay or average visit per case
  - In aggregate
  - By diagnosis and presenting problem
  - By age group
  - By level of care
#6. Organizational Legal & Financial Capabilities

- Suitable legal entity with appropriate licensure and accreditation
- Financial statement demonstrating liquidity and financial stability
- No factors that would impair financial viability
- General liability coverage and individual professional liability coverage and group insurance policy covering case management, utilization review, peer review, and quality improvement activities
- Definition of and understanding of reinsurance needs and availability
- Financial reserves for risk variance
#7. Information Systems & Reporting Systems

1. A revenue cycle and contracts management application that evolves to span the continuum of care
2. Care management systems that span the continuum for individuals and populations
3. Rules engines, workflow engines and intelligent displays of data that enable intelligent processes across the continuum, defined by best practices
4. Sophisticated business intelligence and analytics
5. Systems that enable interoperability between affiliated providers
6. Technologies that support the engagement of patients
## Four Big Implications For Strategy

<table>
<thead>
<tr>
<th>The segmentation of the market into the 5% and 95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>The blurring of the lines between payer, care manager, and service provider</td>
</tr>
<tr>
<td>The use of technology to increase the value equation</td>
</tr>
<tr>
<td>Disruption in definition of ‘market’ and labor force – telehealth, bundled rates, P4P, managed care expansion</td>
</tr>
</tbody>
</table>
### Making New Models A Sustainable Reality Takes New Management Practices & Management Discipline

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Develop vision of future competitive advantage and market positioning</td>
</tr>
<tr>
<td>2</td>
<td>Scenario–based strategic plan incorporating alternate future positioning options</td>
</tr>
<tr>
<td>3</td>
<td>Detailed plans – marketing, financial, operational, capital, HR, etc. – to implement strategy and future vision</td>
</tr>
<tr>
<td>4</td>
<td>Key performance metrics and metrics–based management to track strategy implementation (and allow mid–course adjustments)</td>
</tr>
<tr>
<td>5</td>
<td>Optimization of current operations to keep current programs as competitive (and profitable) as possible as long as possible</td>
</tr>
<tr>
<td>6</td>
<td>New service model development to support future vision</td>
</tr>
<tr>
<td>7</td>
<td>Collaborations as needed to facilitate new market vision</td>
</tr>
</tbody>
</table>
Some Closing Thoughts On The “Business” Of Integrated Behavioral Health

1. Wide variations by market – state policy, dominant payers, system consolidations, consumer demographics
2. “Footprint” of insuring organizations is the ‘elephant’
3. Policy and payer moving away from FFS in both care management and service delivery
4. Whether there is an eventual merger of the financing of care management and service delivery at the provider level dependent on market
5. Planning the future sustainable role of specialist is matter of marketing analysis
The market intelligence to navigate.
The management expertise to succeed.