Behavioral Health, the Changing Healthcare Landscape, and California 1115 Waiver Opportunities January 5, 2009 Webinar Questions and Answers

Q: what do you mean by Exchanges?

A: The Senate and House bills call for the development of state, federal or non-profit managed Health Insurance Exchanges (insurance pools) that allow small employers and individuals (initially) to purchase coverage as a large group. This type of structure will save significant administrative costs, which can run as high as 30% for these groups. The pooling of risk is expected to lower premiums for small employers and individuals, especially if modest to large numbers of "young invincibles" buy insurance. It is anticipated that the freestanding small employer and individual market will completely dry up as all small employers and individuals move into the exchanges. The Senate bill allows employers up to 100 workers to participate until 2017, after which larger business can join.

Q: Does the bundled rate of physician/hospital payments help with the DSH challenge that public hospitals face?

A: Currently the feds make DSH (disproportionate share hospital) payments when a hospital has a large number of patients who are indigent and uninsured. Most public hospitals in the United States receive substantial amounts of DSH funding. Under both the Senate and House bill, DSH payments will be reduced over time based on the assumption that most of the uninsured will be covered by Medicaid or receive subsidies and buy insurance. This is a very controversial issue because there is no guarantee that the ramp down will line up with reduced indigent costs for a given hospital.

Although bundled payments are a completely different animal, this is a very interesting question. Under the bundled payment proposals, it is likely that hospital and physician groups will receive a bundled payment to cover all facility and professional services during the inpatient stay and some period after discharge (e.g. 30 days). The amount of the payment will be based on providing all needed care, based on the current evidence, plus some percentage (e.g. 50%) of the potentially avoidable complications (PAC) costs.

If the bundled payments are appropriately risk adjusted so that sicker patients receive proportionately more money, high performing public hospitals that are able to minimize PACs will earn bonuses that can be used to subsidize other services in the hospital. These amounts can be fairly substantial. For example, in one study the average cost of an AMI (heart attack) admission was $53,000 including $39,000 of needed care and $14,000 of PAC costs. If the bundled payment included 50% of the PAC rate, the hospital could earn up to a $7,000 bonus for the admission by minimizing complications.

Q: Won't correction for 'Medicare overpayments' result in a reduction in effective coverage of patient conditions?

A: The short answer is, "we hope not". To understand this short answer we have to look at what *corrections* are in the bill. The main correction is to restructure payments to Medicare Advantage

(MA) plans so that they are brought down to rates equally fee-for-service payments plus bonuses for higher quality. A number of studies show that these higher rates have been translated into profits and currently there is little or no difference in quality between those in fee for service and those in a MA plan. There are similar adjustments planned to address large profits that are being made in some home health programs and other program categories. Bundled payments to reduce payment for excess readmissions and potentially avoidable complications (PACs) are other types of corrections.

The goal is quite ambitious – and important: reduce payments where excess profit-making is occurring and put in place numerous payment and delivery system innovations to 1) incentivize addressing the chronic health conditions of the elderly earlier rather than later; and 2) disincentivize potentially avoidable complications. Note that cutting DSH payments is also in this correction category; thus the qualified short answer.

Q: Why isn't tort reform part of the cost savings plan? Legal malpractice fears are driving MDs to refer out to specialist care and a big part of rising health care costs.

A: The Democratic leadership in Congress has shied away from including national tort reform in either the Senate or House bill. Instead tort reform is treated like service delivery design and payment reform ideas in the bills – the funding of the equivalent of pilots. Included in the reasons for this approach is the fact that many health policy experts believe that tort reform will not have a significant impact on bending the cost curve. A recent study Congressional Budget Office concluded that tort reform would have only a 0.2% to 0.3% impact on utilization.

The Senate bill awards five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance. (Funding appropriated for five years beginning in fiscal year 2011)

The House bill provides incentive payments to states that enact alternative medical liability laws that make the medical liability system more reliable through the prevention of or prompt and fair resolution of disputes, encourage the disclosure of health care errors, and maintain access to affordable liability insurance. (Effective upon enactment)

Q: How are these payment reforms you mentioned included in federal reform?

A: We have identified over two dozen payment reforms in the Senate healthcare reform bill. A number mandate specific pay for performance, value-based purchasing programs for the Medicare program. A second major thrust in the bill is the development of a Center for Medicare and Medicaid Innovation, whose purpose is to test innovative payment and service delivery models. This is where the Senate has thrown everything including the kitchen sink into the bill. A few examples include:

- Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

- Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.
- Establishing comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

Q: In these integrated models are funds from DCHS and DMH all used? Or do we assume the state abolishes these categories?

A: Because California is so large and diverse, healthcare reform becomes an extremely complex challenge and the term "all healthcare is local" takes on great significance. In this environment, we are thinking that different counties and regions will develop solutions tailored to their local needs, facts and circumstances; thus our presentation of multiple models. One way for the state to support this approach is to encourage these local solutions and then let each county or region develop their best-practice-based clinical design and wrap the management and financing structures around the clinical design to support, rather than hinder, that design. These efforts, in effect, become pilots to test what works and what doesn't to improve quality and better manage costs.

So how does this relate to your question? During this "pilot phase", it might make more sense for the state to not mess too much with non-Medicaid funding streams and allow the pilots to unfold without additional sweeping financing changes, which could create widespread confusion and cause those developing the pilots to take their eye off the ball of clinical redesign, which we see as the key. Given the proposed models for local coordination, the next step is to think about models for the state agencies and to focus on removing technical obstacles to integration that are already known and arise during the process.

Q: How would the current senate bill/assembly bill affect the BH services current being provided to undocumented individuals?

A: We aren't certain which bill you are referencing and would suggest you contact Kirsten Barlow at CiMH for a direct dialogue.

Q: Will a state be expected to participate in the additional cost for the large projected increase in its Medicaid population, or will this be funded totally by the Feds?

A: The House bill has an easy answer. Medicaid expansion will be financed with 100% federal financing for two years and 91% thereafter. The Senate will provide 100% federal financing for the first three years. After that the formula is extremely complicated. This is clearly an area where the House and Senate will be negotiating, especially in light of concerns raised by states such as California and the reaction to the special arrangement for Nebraska.

Q: How will additional funding for MH & SA be affected by state budget cuts for Medicaid MH and SA services?

A: As we all know, the current recession is having a great impact on state budgets due to high unemployment and lack of revenue from property and income taxes. In the summer of 2009 it

was reported that 48 of the 50 states were faced with budget shortfalls totaling $166 billion for FY2010 (all except Montana and North Dakota). This has translated into State Mental Health Authority budget cuts across the nation with at least 28 states cutting mental health funding and many states cutting substance use treatment funding even further.

Many expect further cuts in MH/SU services before new funding from the federal healthcare reform legislation kicks in. There are four keys to how this will play out in each state:

1) **The state's fiscal condition in Fiscal Years 2011, 2012, and 2013.** California is facing a $19 billion deficit over the next 18 months. On Friday January 8th, Governor Schwarzenegger released a budget plan to close this gap by discontinuing the Healthy Families program and making deep cuts to health care, social services and other programs. Although this is not the final word, something must be done to close the deficit gap.
2) **The state's price tag for Medicaid expansion.** The House and Senate have different formulas for how much the states will have to pay for Medicaid expansion. Governor Schwarzenegger contends that California's price tag will be $3 billion. Speaker of the House Nancy Pelosi and Democratic Sens. Dianne Feinstein and Barbara Boxer, have questioned the Governor's estimate, stating that the federal government would cover most of the costs. No one knows for sure because we don't have a final bill.
3) **The date when Medicaid expansion begins.** The Senate bill allows for an optional start date of January 1, 2011 and a mandatory start date of January 1, 2014. Expansion begins on January 1, 2013 in the House bill with no clause for an early start. Washington State, for example, is preparing to shift into Medicaid expansion at the earliest date because they have concluded that regardless of the final details, moving uninsured people onto Medicaid has the potential to save the state substantial funding and help address their budget deficit.
4) **How MH/SU services are perceived by decision-makers.** The Governor, Legislature, and Medicaid Director in each state have perceptions about the relative value of publicly funded mental health and substance use services in their state. States with leaders that perceive low value have cut budgets. States such as Colorado, where MH/SU stakeholders have succeeded in demonstrating value have seen no cuts.

The combination of these four factors will drive what happens to the MH/SU budgets in California. We don't have a computer with enough processing power to make a prediction for California.

Q: How do we get California to take advantage of optional Medicaid expansion in first couple of years.....the Governor says it will cost California a huge amount. Do we know how current expenditures for uninsured at state and local level would be offset by new Medicaid coverage?

A: See the answer to the MH/SU budget question above. Once the Medicaid expansion wording for the final bill is finalized, each state, including California, should complete the following math problem.

1) How many uninsured persons are receiving healthcare and much money is being spent on their care at the state and local levels?
2) How many of these individuals will become insured? How many will convert to Medi-Cal? How many will obtain coverage through the Healthcare Exchange?
3) How many people will remain uninsured and what are the projected costs of serving them?
4) What will be the total price tag of serving the Medicaid expansion population?
5) How much of the additional Medicaid costs will be paid with state/local funds; using an average of the first 5 years?

6) What is the net impact on the state and local coffers?

To illustrate how this formula works, we've taken 1,000 uninsured persons and used actual figures from the House bill, which has higher Medicaid numbers, to provide an example. In our example, the average state would spend more on Medicaid but substantially less on the uninsured, resulting in a net savings to the state.

Example: Expansion Impact on State/Local Budgets

	Amount	Source
Number of Uninsured	1,000	
Covered through Private Insurance	420	House Bill
Covered through Medicaid	300	"
Newly Covered	720	"
Still Uninsured	280	
State/Local Cost per Uninsured Person	$894	Health Affairs
Current State/Local Cost of Uninsured	$893,617	Calc
Revised State/Local Cost of Uninsured	$250,213	Calc
Savings	$643,404	Calc
Cost/Year/Person of Newly Insured	$5,800	House Bill
Total Medicaid Expansion Costs/Year	$1,740,000	Calc
Average Yearly Federal Share Yrs 1-5 (94.3%)	$1,646,040	House Bill
Average Yearly State Share Yrs 1-5 (5.7%)	$93,960	Calc
State/Local Savings per 1,000	($643,404)	
Added Medicaid Costs	$93,960	
Net Savings	($549,444)	

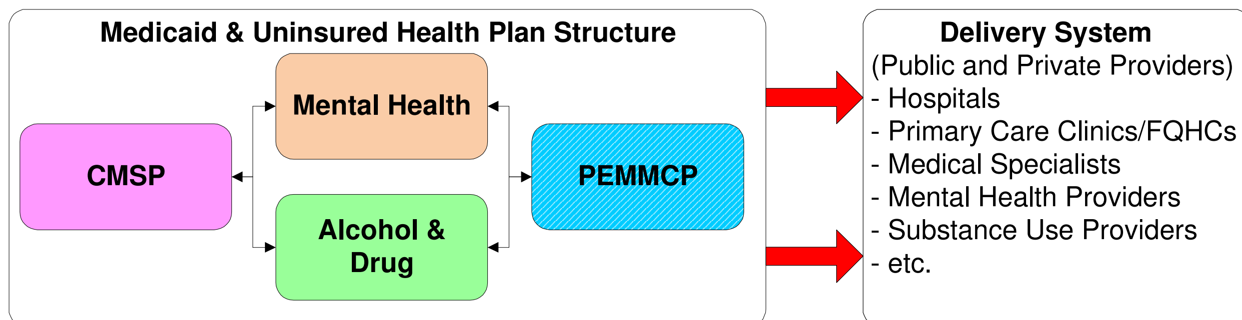
Q: Can you clarify the distinction between the payor and provider components of your proposed management and financing design options?

A: Important question! California has a very different model for organizing the payor and provider components than most states, especially in the public mental health system. South Carolina (population 4.5 million) is the only state with a more blurred distinction between the two; their public mental health system is entirely state run, all employees work for the state, and the payor is the provider. Similarly, the county-based structure in California has counties as *the* Medicaid Mental Health Plans (58 counties, 57 plans) and a great deal of mental health care is provided by county employees. There are also more Public Entity Medi-Cal Managed Care Plans in California than other states and a large number of public hospitals providing important safety net healthcare services. This is not a negative critique of California; it's simply a description of what is!

For an outsider (such as us Seattleites) this can be very confusing because most of the country has much greater distinction between payor and provider. Generally, when a government entity in another state is both the health or mental health plan and provider, firewalls are put in place between the two. The health plan staff (payor) are separate from the provider staff and the health

plan considers the county clinic as just another member of the provider network subject to the same rules as non-government providers. Rural counties often address the separation by creating County Medical Services Program (CMSP)-like entities to be the Medicaid plan covering multiple counties, while the providers continue to work for the county (for example, this is the model in Oregon for public mental health).

The following picture does a better job making the payor/provider distinction, using the Small County Collaboration Model and the creation of a Public Entity Medi-Cal Managed Care Plan (PEMMCP) as our example.



Q: Will the Medical Hospitals be run much as the managed care plans currently function with total oversight of utilization, payments, requests for high-level service authorizations and second opinions with regards to mental health, or will they use unique MH/SU providers who will oversee all utilization?

A: There are two parts to the answer to this question. First, as noted above, we need to make sure to keep the delivery system separate from the payor. Medical Hospitals will continue to be providers with relationships to multiple payors (Medicare, Medi-Cal, Private Insurance Companies). As such, they will have to work within the authorization and utilization management structures and rules of each health plan.

Second, as bundled payment systems roll out for inpatient admissions, Medicare and health plans will be pushing risk for potentially avoidable complications down to the provider level. Hospitals and clinicians will need to develop some type of business arrangement to ensure that the care related to that admission is properly managed, payments are made to the relevant parties (hospitals, labs, doctors, etc.) and the right thing is done at the right time by the right party to prevent errors, miscommunication, and increase the likelihood of a good clinical outcome. Unlike a health plan model, where the health plan is managing a population of enrollees, this is an episode based care model and for financial management related to a single patient for a single admission with a set payment for that admission.

Q: What types of infrastructure and workforce development issues should we be considering to prepare?

A: Following the theme of the previous questions, California stakeholders need to think separately about payor and provider infrastructure and workforce development.
On the payor side, those considering preparing for the future by pursuing one of the models we described to "organize the raw ingredients" into an "organized delivery system of care" will need to design a physically integrated or virtually integrated health plan to manage the care for the

Medi-Cal and uninsured populations. This means building an integrated infrastructure and in some cases increasing competency in each of the ten health plan functional areas listed on slide 47 and repeated below.

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

On the provider side, you need to continue developing the clinical and care coordination competencies described in the IPI Report, the Person-Centered Healthcare Home paper, and other sources of guidance for improving quality and managing costs of health, mental health and substance use services.

Q: What is an Accountable Care Organization? Do they exist yet?

A: In the early 1990s, a new structure evolved in healthcare – the Independent Practice Association, or IPA. IPAs were generally made up of groups of small medical clinics who banded together to create an infrastructure to manage care. The IPA headquarters would offer a suite of services including IT, quality management, billing, etc. Often the goal of these IPA was to obtain capitation contracts with health plans and then set up risk management mechanisms along with the infrastructure so that the small practices could operate in the risk bearing environment and reap the financial rewards of improving quality and lowering cost.

ACOs are the IPA of the future – with a twist. Most ACOs will include hospitals, primary care physicians, specialists and potentially other providers such as MH/SU health clinics, to carry out two primary functions: 1) provide infrastructure support to Healthcare Homes (like the IPAs); and 2) serve as the management entity for bundled payments for inpatient admissions.

ACO language is in the health reform bills and groups around the country are already organizing these entities or working to turn existing IPAs or IPA-like entities into ACOs.

Q: It seems that there is a presumption that medical homes will be solely primary care organizations, excluding mental health agencies as the possible healthcare home. What is this assumption based on?

A: The answer to this question depends on who to you talk to. Many in the medical community were operating on the assumption you noted in your question because that has been their existing paradigm. The Carter Center Medical Home Summit in July 2009 started a change process. A rich conversation has been underway nationally to think about healthcare homes more broadly. For example, SAMHSA's 2009 funding of primary care in community MH organizations is testing the model of Mental Health Centers as healthcare homes. One hypothesis is that there are many venues besides traditional primary care clinics that could embed the clinical services and processes that fit the definition of a healthcare home. All healthcare is local. That said, to be a healthcare home (and access the associated payment models), an organization will have to meet the NCQA certification standards. In other words, you can't just declare yourself to be a healthcare home!

Q: What types of structures/organizations do you envision evolving to really track/monitor these outcomes/avoidable complications etc.

A: The National Quality Forum has already been given the job at the federal level to develop outcome and performance measures for all sectors of the healthcare system including mental health and substance use. This group is in the driver's seat regarding what will be measured and included in federally sponsored initiatives. Draft NQF mental health measures cover domains such as Symptoms, Function, Service Utilization, Mortality, Patient Safety and Recovery.

On a second front, the health reform bills include sections on a "National Strategy for Quality Improvement in Health Care" that tasks the DHHS Secretary with being in charge of developing and implement a "national strategy to improve the delivery of health care services, patient health outcomes and population health." The legislation includes a plan for "Collection and Analysis of Data for Quality and Resource Use Measures" and "Public Reporting of Performance Information". These activities assume that there will be national data submission requirements that all healthcare providers will need to comply with to receive federal dollars and the data "shall be made available to the public, through standardized Internet websites".

A third component is the transformation *inside* health care organizations such that clinicians begin using data on a daily basis to support clinical care, using patient registries, clinical decision support tools, electronic health records, etc. as an integral part of every clinician's day to day activities.

The fourth component is Personal Health Records that are owned by consumers. These health records will include data entered by the consumer as well as health data from all of the consumer's providers, all of which can be made available to any provider at any time based on consumer authorization.

To support these requirements, all health and MH/SU healthcare providers will need IT systems that include the necessary functionality, using systems that can connect to community health information exchanges (HIEs) so that data are shared across organizations and with payors and regulatory bodies.

Q: Do you see all the same forces at work for BH for children and youth, particularly those with Medicaid in the EPSDT program? What, if any, are the differences?

A: The medical home model came out of pediatrics and is very much related to the children's system of care movement and the wraparound concept. The four quadrant model is equally relevant for children and youth and the IPI concept of mild, moderate, serious and severe also fits. Again, all healthcare is local and each community will need to design the healthcare home models that meet the needs of children, youth and families. As we move further upstream with prevention and early intervention, having robust healthcare homes for children and youth that include MH/SU clinicians who can identify problems early and intervene with appropriate clinical strategies is essential.

Q: How do you believe this MH/SU health/multiple chronic conditions approach will be impacted by existing Cal State and Federal client info privacy and security laws and regulations? These laws and regulations currently prohibit, in many cases, our ability to share information without signed client authorizations. For providers? For payers?

A: HIPAA allows sharing of information (not clinical notes) for the purposes of care coordination. Many states have information sharing laws that are more restrictive than HIPAA, especially for MH/SU. States will need to do what Washington State did in the last legislative session—revise those laws to better support integration. Congress is going to need to change 42 CFR Part 2 which makes information sharing related to substance use services more of a barrier to integrated care than is necessary. This is a very important issue to address while continuing to safeguard the rights of patients/consumers.

Q: How do we avoid the state choosing a commercial McKesson-like care coordination vendor as they have done in the past...despite the lack of effectiveness with our populations?

A: As a bit of background, the two main models of care coordination include phone-based services by individuals who often work for a disease management company that contracts with a health plan or provider to manage the chronic health conditions of patients; and care coordination that occurs on-site, in-person with consumers. A number of people looking at the studies that have come out recently are concluding that phone-based care coordination does not seem to be working for the disabled population, including persons with mental illness. Studies are also showing that in-person, embedded care coordination is being effective at improving outcomes and lowering total healthcare expenditures. This is intuitively sensible to persons working in mental health and substance use, although the work is different than traditional case management.

Thus, the best way to prevent deployment of care coordination models that may not work is to compile the studies, summarize them (there is a new Robert Wood Johnson Foundation report that does this) and get them into the hands of the decision-makers. No state can afford to have too many missteps in their healthcare reform efforts.

Q: How will existing County Mental Health and Substance Use services integrate into these newer models?

A: We're assuming that this question is about the provider side, not the health plan side of the discussion. The National Council's Person-Centered Healthcare Home paper had identified three

options for mental health and substance use clinics, including county-run clinics, to operate in the new world.

1) **Integrated Healthcare Homes**: where a single organization (county or non-governmental) develops a healthcare home where the primary care, mental health and substance use clinicians are all employed by the organization and work together as a team to provide integrated care.
2) **Partnership Healthcare Homes**: where two (or possible three) organizations work together to integrate care via a staff sharing arrangement so that the primary care, mental health and substance use clinicians are co-located, working as a team, but happen to work for two or three different organizations.
3) **Linkage Model**: where the mental health and/or substance use organization(s) chooses not to physically integrate with primary care. These organizations have a minimal set of responsibilities if they are prescribing psychotropic medications to consumers, which are listed on slide 40 and written about in the National Council's Person-Centered Healthcare Home paper.

Q: Is the embedding of physical health within the specialty mental health sites still in the pilot or beginning stages as we determine best models, operationalizing and structures?

A: As noted in previous answers, embedding primary care in specialty MH/SU settings is an ongoing pilot activity. Funding for this work in mental health centers was recently increased by Congress and we are expecting that there will be different models for medical homes and integration that are tested in the couple of years after healthcare reform passes.

Q: Might FQHC clinics be "presumptively" designated as Medical Homes?

A: Unlikely. All discussion is pointing towards the need for all Medical Homes to be certified by a body such as the National Committee for Quality Assurance (NCQA) in order to access the related payment reforms. The Commonwealth Fund has a project underway, operated by Qualis, to work with FQHCs in selected states (Oregon is one state) to develop their capacity as medical homes.

Q: How do 'wellness & recovery principles' fit into the integrated medical home model?

A: There is a strong crosswalk between prevention and early intervention and patient-centeredness in the medical home principles and wellness and recovery principles. That said, many primary care clinics are not familiar with the concepts of recovery and resilience that have come out of the MH/SU systems. There is a need to further cross-pollinate these ideas in order to ensure that healthcare homes are able to succeed at meeting the needs of persons with MH/SU disorders –from both a quality and cost perspective. See the IPI principles, which reinforce these ideas.

Q: Will there still be a Substance Abuse Block Grant that will be administered through the Counties?

A: The short answer is, we don't know. SAMHSA is going to be coming up for reauthorization in Congress; SAMHSA has a new head, Pam Hyde; and there is a great deal of effort in the Obama Administration to push the various federal agencies to work together in a new way – doing joint projects (i.e. combine HUD vouchers with DHHS service dollars with Agriculture Food Stamps for homeless families and individuals).

Assuming SAMHSA is re-authorized, the MH and SA Block Grants could be continued as is, expanded, contracted, or converted into something completely different.

Q: For people with significant social barriers to appropriate care (i.e., people who are homeless), does the IPI report include any recommendations for linking people to community social services?

A: Yes, see the opening statement in the IPI principles, and Principle 10, which references "collaborative links between the integrated healthcare system and other systems, community services, and resources."

Q: For counties from a planning perspective - efforts to identify clients with multiple chronic conditions?

Other projects around the country are using software that analyzes claims data and identifies individuals with multiple inpatient stays, emergency department visits, prescribing relationships, etc. These software packages use a method of risk factor scoring to identify those who are at high risk of high future cost (but the scoring is not based on cost alone, it is based on diagnoses and other clinical data—assuming that past cost is only one piece of predicting future complexity). For example, there is a risk scoring methodology developed by Richard G. Kronick, PhD at the University of California San Diego, which compiles a score based on about 100 different variables.

Those who are considering the creation of a risk-bearing Public Entity Medi-Cal Managed Care Plan for the FFS Medi-Cal population and/or the Medi-Medi population should obtain this type of software and analysis in order to understand financial implications and to develop very structured care coordination mechanisms that use the information in order to identify and outreach to clients at high risk.

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