

Minnesota Department of Human Services Request for Information (RFI) Response: Health Care Delivery Systems Demonstration Project

Submitted by the Minnesota Association of Community
Mental Health Programs, Inc.



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TABLE OF CONTENTS

Introduction & Background	3
General Recommendations	6
Models of Care to Increase Value	9
Examples of Care Models that Could Reduce Total Cost of Care	13
Payment Models	16
Performance Measures	19
Quality/Access/Improved Health of Population	19
Patient Satisfaction/Experience	21
Risk Adjustment Strategies	21
Incorporating Performance Measures into Payment Models	22
Data to Improve Care	23
Patient Attribution	23
Pros and Cons of Attribution Approaches	24
Enrollee Choice vs. Providers' Ability to Influence Outcomes	24
Preserving Patient Access and Appealing Service Denials	24
Assumption of Risk	25
Levels of Risk Permissible	25
Types of Risk Sharing Options	26
Federal Authority	27
Evaluation	27
Conclusion	27
Appendix A	29

INTRODUCTION & BACKGROUND

The Minnesota Association of Community Mental Health Programs (MACMHP) is a not-for-profit membership organization representing community mental health and other mental health and behavioral health service provider agencies across the state. MACMHP members have come together to respond to the Department of Human Services' RFI request because we believe that the state will not achieve the quality outcomes and cost reductions that are envisioned in a redesigned health care system without specifically addressing the unique care needs of individuals with mental health and/or substance use (MH/SU) issues.

Recent studies have demonstrated that public mental health patients who suffer from serious depression, thought disorder, or other disabling mental illnesses, die as much as 25 years earlier than individuals in the general population.¹ Depression is one of the top ten conditions driving medical costs, and it is the greatest cause of productivity loss among workers. People with depression have nearly twice the annual health care costs than those without depression. In children, 5% – 9% of youth between the ages of 9 and 17 have a serious emotional disturbance, substantially impairing their functioning at home, school or in the community. Data shows that children on Supplemental Security Income (SSI) account for 2% - 9% of child Medicaid enrollees, but use 15% -17% of the Medicaid resources due to their mental and physical conditions. Students ages 14 and older with a mental disorder have the highest dropout rate of any disability group.

Many people with serious chronic medical conditions also have co-occurring mental illness. The *medical* costs for treatment of chronic medical conditions for patients with a co-occurring mental illness are as much as four times higher than the costs for patients without a mental illness.² The most recent *Faces of Medicaid* analysis conducted by the Center for Health Care Strategies and Johns Hopkins University examined the implications of multi-morbidity patterns among adult Medicaid enrollees on hospitalizations and costs and found that:

- A number of specific conditions and combinations of conditions are frequently associated with high per capita costs and hospitalization rates;
- Mental illness is nearly universal among the highest-cost, most frequently hospitalized beneficiaries; and
- The presence of mental illness and/or drug and alcohol disorders is associated with substantially higher per capita costs (figure 3) and hospitalization rates (figure 5)³

¹ Colton CW, Manderscheid RW: Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Prev Chronic Dis* 2006; 3:A42

² National Business Group on Health, Center for Prevention and Health Services, *An Employer's Guide to Behavioral Health Services*, (2005).

³ Dec., 2010 Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations. http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261201

Figure 3 | Impact of Behavioral Health Comorbidities on Per Capita Costs among Medicaid-Only Beneficiaries with Disabilities

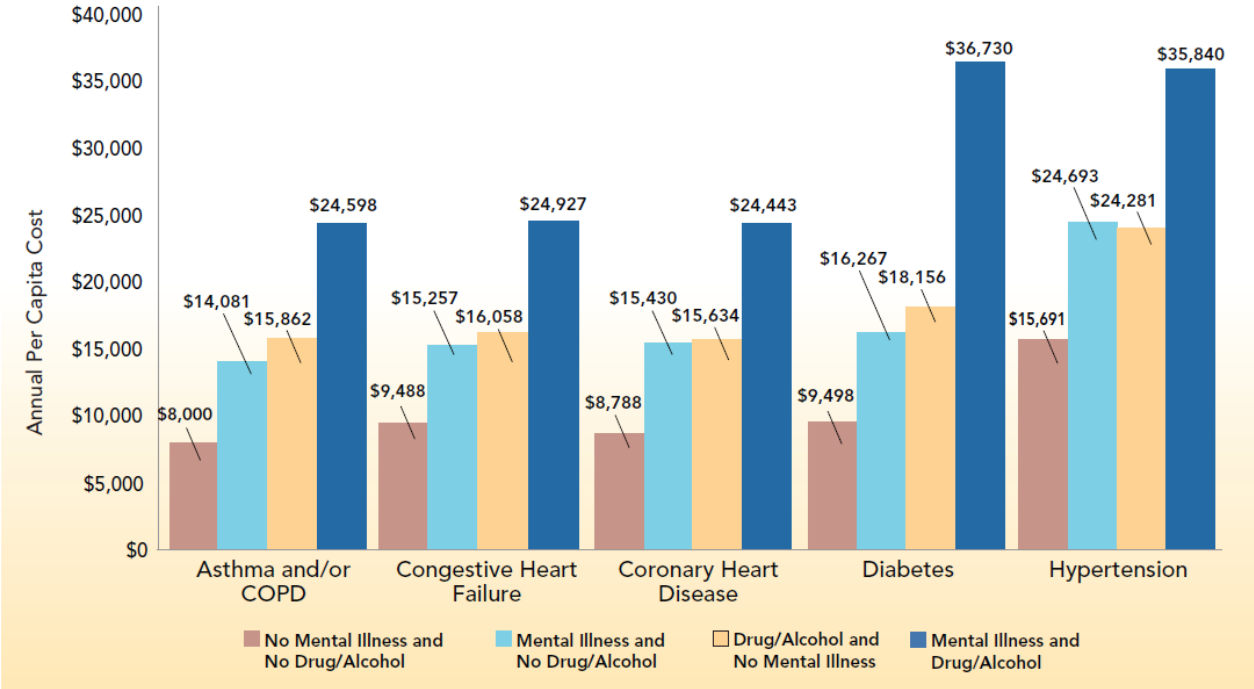
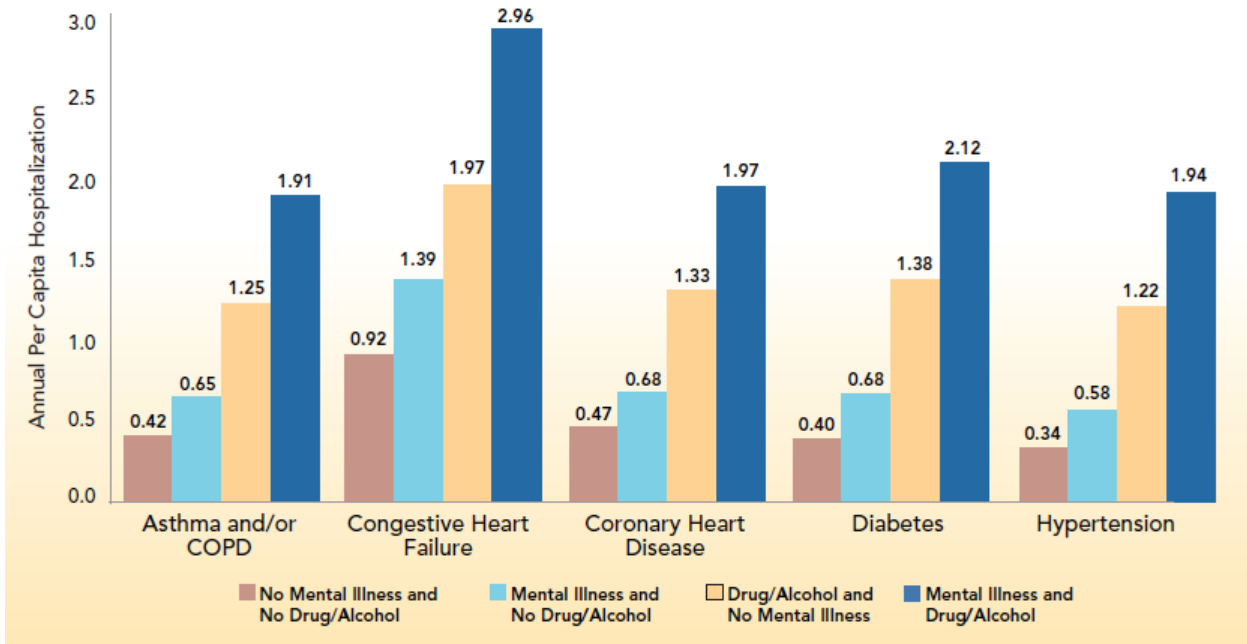


Figure 5 | Impact of Behavioral Health Comorbidities on Per Capita Hospitalization among Medicaid-Only Beneficiaries with Disabilities



Because of the historical lack of parity between funding and treatment for mental illness compared to medical conditions, as well as the stigma that discourages many people from seeking help, today fewer than half of all adults who experience serious psychological distress in a year receive any mental health services; those who do receive care are more likely to do so through a specialty mental health clinician or on an emergency basis than through primary care.⁴ Primary care providers who treat chronic *medical* conditions are often unaware of, or ill-equipped to deal with, their patients' mental illness or substance abuse. These providers' lack of knowledge or comfort with populations with mental disorders, as well as clinical demands, payment and regulatory barriers all make it difficult to address multiple co morbidities. However, research has consistently shown that successful engagement with this population is the key to effective treatment and to reducing both MH/SU costs and costs for treatment of other health conditions. For this reason, *all* health care homes and payment and care delivery models that are designed to improve care and reduce costs for chronic conditions should have a strong mental health component in the care plan, and mental health and substance abuse services should be closely coordinated with medical services.

As Minnesota explores ways to reform care delivery systems it has become increasingly clear that no *single* organization will be able to effectively care for or control the costs of their patients with serious behavioral health and/or substance abuse issues without the help of community mental health organizations and the innovative, cost-effective, community-based clinical and social services they provide. In many rural areas of the state, community mental health centers are the primary, or even the *only*, mental health provider available to local residents. Even in more populated areas community mental health providers provide a wide range of specialized services for serving low-income, disadvantaged and culturally diverse patient populations that are often not available from other sources. They are an essential component of the care delivery system for people on Minnesota health care programs that should be integrated into any new system that is established.

Community mental health organizations provide an array of mental health, substance use, and social services to over 125,000 Minnesotans each year, including approximately 13,000 people with serious and persistent mental illness, 5,000 children with serious emotional disturbance and over 50,000 people with other behavioral health diagnoses each year at 122 sites across Minnesota. These community programs provide the majority of the state's outpatient Medicaid MH/SU services and about 75% of the day treatment and community support services for people with severe and chronic mental illness. These programs have developed flexible approaches to serving people with special needs in the least restrictive setting possible by emphasizing a variety of intensive outpatient and community support services.

Many community mental health organizations provide "one stop shopping" for well-coordinated health and social services designed to support recovery and prevent further complications due to mental illness. These organizations provide clinical services such as outpatient therapy, psychiatry, and inpatient, residential and chemical dependency treatment. Many organizations also provide community based services and supports such as ARMHS (Adult

⁴ Parks et al, 2006; Burns, et al, BMJ, 2007

Rehabilitative Mental Health Services), ACTs (Assertive Community Teams), Personal Care Assistants (PCA), and supportive housing. Finally, many community mental health organizations have developed social services (employment support, special transportation, housing support services, domestic abuse, translation/minority access services, information and referral, etc.), often under contract with counties. Case management services, which are or can be provided by community mental health organizations, provide routine coordination between these clinical and social services.

People with serious and persistent mental disorders are a priority population for community mental health organizations, and these specialty providers have a commitment to serving them. The result of this long standing commitment has been the establishment of trusted relationships between community mental health clinicians and those individuals with severe and persistent mental disorders. For community mental health programs, “patient engagement” has been a priority and the key to addressing serious and persistent mental illness and substance abuse problems for low-income patients. Such relationships increase the likelihood that treatment will be accepted and followed and result in improved health, improved patient satisfaction, and reduced costs to the health care system as a whole.

GENERAL RECOMMENDATIONS

MACMHP members and other community-based, safety net, and rural providers have been researching, examining and assessing proposed new payment and care delivery models that are emerging. There are some important and positive trends that, if done effectively, should improve patients’ health and satisfaction and reduce health care costs. However, there are also serious risks that these new models, if done incorrectly, will wreak havoc on access, quality and health status for low-income and disadvantaged groups who receive their health care through Minnesota health care programs and at the same time will fail to achieve the goal of reducing health care costs. MACMHP is a member of the Alternative ACO Alliance (AACO) and participated in developing AAACO’s response to the RFI. MACMHP supports the AAACO report and the guiding principles and recommendations presented there. Several key points are worth restating here:

1. **Socio-economic factors affecting health.** Many factors in peoples’ lives affect their health and their ability to access needed treatment and manage their health conditions. These factors are especially acute for low-income populations enrolled in state health care programs. These factors include poverty, homelessness, cultural or language barriers, lack of family or friends, and others. Community mental health providers offer additional services and tailor their services and care model to address socio-economic factors. While these factors are less important for private sector, commercially insured populations, they are extremely important for many low-income and disadvantaged persons who are enrolled in state health care programs. We urge DHS to fully address these factors in the requirements for and implementation of demonstration projects through provisions incorporated into payment levels, payment methods, accountability measures and minimum standards for care models and patient engagement. Not doing so will result in cost-shifting from the providers who choose not to address these issues and therefore will not be attractive for patients who have these additional needs, to the providers who choose

to address these needs and therefore will attract the most challenging and expensive patients.

2. **Community-based care.** MACMHP supports the state’s efforts to elevate the importance of outpatient services – including primary, preventive and care coordination services and others – in order to maximize patient’s health and reduce the rate of increase in state health care spending. As payment methodologies are developed, however, it is important to recognize that for many clients, especially those with serious and persistent mental illness, primary care services and health care home services would best be provided in community settings rather than institutional settings whenever possible.
3. **Health care homes and care coordination.** MACMHP generally supports the State’s efforts to encourage and pay for care coordination provided through health care homes. Outcomes will be improved and costs will be reduced through greater integration of funding sources and coordination of all services affecting a patient’s health and treatment outcomes, including medical, mental health, substance abuse, social services, housing and other services that are particularly important to low-income and disadvantaged populations. Integration, coordination and alignment of all services through a single health care home is necessary both to produce the best possible outcome for the client but also to ensure accountability for reducing the total costs, not just reducing costs in one sector that results in an increased cost – or cost shift – in another sector. It is important, however, to avoid restricting the care coordination function to a particular type of health care provider or clinical or institutional setting. For many people on state health care programs, their ideal point of contact with the system may not be through a physician or nurse practitioner and the contact may occur primarily in community settings. Later in this document, a particular model for health care homes for people with mental illness or substance abuse is presented.
4. **Patient engagement.** Engagement of the patient is key to improving health and treatment outcomes. The current system is supply driven (driven by provider and health plan decisions and incentives) not consumer driven. Many patients do not receive the services they need when they need them and do not receive the information and support they need to be healthier and to manage their health problems. The current high percentage of Emergency Room visits in populations with co-occurring mental illness is a key indicator that the current healthcare system is not “engaging” clients in the model of care. Having the relationships and capability to develop and create a crisis plan with patients, and teaching crisis management skills will be a necessary function of any new care delivery system. Not only does capability help reduce the number of unnecessary ER visits and hospitalization, it engages the client in being responsible for their care. Community mental health programs have proven their ability to engage even the most challenging patients and have substantially lower ER and hospital admissions rates for the high-risk population compared to other types of health care and mental health providers. Proven successful experience with patient engagement should be highly valued and rewarded under payment reform demonstration projects.

5. **Limited financial resources of community providers.** Many of the vital services needed to reduce costs and achieve performance goals for low-income populations are currently provided by community-based nonprofit agencies. These agencies do not have the financial resources to assume major financial risk or invest large amounts of money immediately in system changes that may potentially be required for participation in demonstration projects, such as sophisticated electronic health record systems with information exchange capabilities. Although these providers may not have the reserves to assume insurance risk, they have the skills, services, and trusting relationships with the population essential to improving health status and bending the cost curve. Strategies must be developed that will enable patients to continue to access these important community-based services during the transition to a new system.
6. **Continuity of care and patient choice.** Demonstration projects should be implemented in ways that will not force patients currently undergoing treatment to lose their existing relationship with clinicians and service providers. It should also retain the right of patients to choose their preferred provider, as long as the provider meets standards of cost containment, quality and health. This is very important for low-income persons enrolled in state health care programs because many need the special types of enhanced, tailored and culturally appropriate services that are offered by community mental health providers. We recommend that the state continue a revised “Essential Community Provider” (ECP) approach for the new demonstration projects. ECP ensures that patients have access to unique types of providers who offer specialized tailored or enhanced services that are needed to ensure access and optimal care for people with socio-economic, cultural, language or other barriers. However, ECP also helps prevent risk-selection (cherry-picking) that can occur if a particular health plan or Accountable Care Organization (ACO) provider chooses not to contract with these specialized mental health providers and thereby avoids the need to serve the more challenging and costly patients and avoids the need to establish additional customized services in order to meet the higher level of needs of these patients.
7. **Historical underfunding of mental health services.** Demonstration projects should be implemented in ways that do not perpetuate the historical underfunding of certain mental health services in comparison to other health care services. This is not just a matter of fairness and equity, but an economic imperative in order to reduce total health care costs. Underspending on certain community-based mental health services results in *overspending* on high cost services such as ER visits, hospitalization, crisis intervention and institutional treatment. Care should be taken not to build payment models and funding levels based on historical spending for particular services but on the optimal use of cost-effective community based services that will produce a return on investment that reduces total cost of care.
8. **Integration and coordination of services.** In the mental health area, coordination of health care services with other services needed by a patient is both vitally important and particularly challenging because of the way in which MH/SU services have been funded and the heavier reliance on state and county-administered services and local sources of funding. This problem and dilemma has been acknowledged for decades and progress was made

through the work of the Minnesota Mental Health Action Group and subsequent legislative and state agency actions. Unfortunately, the progress that has been made is at risk in the current legislative and budget environment. The demonstration projects are an opportunity to accelerate efforts to achieve greater integration of funding and coordination of all needed services while reversing the perverse financial incentives that currently result in higher overall costs. This requires cooperation and creative thinking by all parts of DHS, not just health care programs, and by counties, mental health providers and other parts of the health care and MH/SU system.

- 9. Mental health component in all demonstration projects.** Research has demonstrated the inextricable and compelling link between mental health and physical health. This principle is fundamental to the success of all payment reform demonstration projects, not just those that serve people with mental illness as their primary diagnosis. People with serious, painful or chronic medical conditions often develop depression and other mental illnesses and/or substance abuse as a result of the stress, pain and anxiety of their medical problems and the personal and economic problems that can result from serious health problems. On the other side of the coin, people with serious mental illness and/or substance abuse often develop co-occurring health care conditions such as diabetes or heart disease. “Bi-directional” treatment is necessary in order to simultaneously treat both MH/SU and co-occurring health care conditions. For this reason, we believe DHS should require that all payment reform projects be able to demonstrate how they would provide a strong mental health and substance abuse component in the care plan, and how those mental health and substance abuse services would be closely coordinated with medical services.

MODELS OF CARE TO INCREASE VALUE

Community mental health programs have long experienced the frustration of knowing that many of their patients could be healthier, avoid crises leading to ER and hospital admissions, and live in the community rather than institutions. They know that the total cost of health care and related services could be reduced below current levels. They know that their patients could be more satisfied, have a higher quality of life, and succeed in work or school and live productive lives. The reason these outcomes have not been achieved is that the current payment system does not fund cost-effective preventive, outpatient and community-based services that are necessary to achieve these goals. In a number of cases, mental health providers have obtained temporary funding and have demonstrated their ability to reduce total costs and improve patient outcomes, only to have their temporary funding lapse requiring discontinuation of these services. They have come to view this state of affairs as normal because of the long-standing dysfunctions of the health care and mental health systems. The DHS demonstration project raises hope that the payment problems can be remedied.

In this section, we provide first a description of a Behavioral Health Person-Centered Health Care Home that we believe is an optimal model for certain patients where MH/SU issues are of paramount importance for the patient’s treatment and outcomes, even if the patient has serious co-occurring medical conditions. Later in this section, we provide descriptions of care models and community-based services that will reduce total costs and improve patient satisfaction and outcomes. We believe these types of services should be integrated into

demonstration projects because they represent some of the most promising – and in some cases proven – approaches:

- **Customized Health Care Homes.** Multiple models of care are needed with varying levels of intensity and services depending on what an individual needs in order to become or stay healthy. While a primary care focused health care home model will work well for many individuals, there are special populations that would benefit from an alternative, or customized, care model, such as those individuals with serious and persistent mental illness (SPMI), and those individuals who may not have the “SPMI” label, but whose mental health needs are such that they need an alternate model of care. The model of care most likely to increase the value of care provided for this population is a **Behavioral Health Person-Centered Health Care Home.**

An individual with mental illness may feel more comfortable, and therefore be more engaged with their treatment, if care were provided within a behavioral health care home setting rather than in a primary care setting where the individual has no established relationships. Currently, those with the skill and experience in establishing these effective types of relationships are the community mental health providers. Community mental health programs also already have many of the connections established with other systems necessary to effectively coordinate all facets of care. In addition, these organizations have the experiences of many years of being the main care givers for this population of SPMI individuals. Therefore, in many communities community mental health programs would, and should, become the natural behavioral health care home for those individuals with serious and persistent mental illness.

Another reason to strongly encourage the formation of behavioral health care homes would be to align the state’s efforts with the emerging requirements for similar federal initiatives resulting from the recent passage of the Patient Protection and Affordable Care Act (PPACA). PPACA establishes a Medicaid state plan option (as contrasted with a waiver), beginning January 1, 2011, for individuals with chronic conditions to designate a health home to coordinate the delivery of their healthcare. Eligible individuals are people covered by Medicaid who either have at least two chronic conditions; have one chronic condition and are at risk for having a second chronic condition; or who have a serious and persistent mental health condition. The health home can be a designated provider, a team of health care professionals operating with such a provider, or a health team, provided that the health home meets standards established by Health and Human Services. These could include: physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, or other providers that meet state and federal requirements.

- **Primary Care and Mental Health Services Capabilities.** Coordinated medical and behavioral health care services can be provided through a variety of arrangements, either by providing primary care in community mental health centers, providing behavioral health services in primary care, or by developing strong linkages as specialty mental health providers to medical homes. This would include the ability to assess, diagnose and rapidly step care up

to a greater level of intensity when needed as well as the ability to step care down so that a consumer's MH/SU care is provided in primary care with appropriate supports.

- **Care Coordination.** The behavioral health care home could both coordinate care and provide evidence-based practices and services, using a stepped-care approach, perhaps by incorporating the four quadrant clinical integration model which provides a framework for determining the type of service and organizational model for integrating the case, based on the varying needs of the population. (See Appendix A) These capabilities should be included as requirements for anyone who wants to become a behavioral health care home. Individuals would work with a Mobile Community Health Services Team (within the Behavioral Health Care Home) that fulfills the care management functions, including development of an integrated treatment/service plan. Services would follow individuals, regardless of living arrangement, and adjust in intensity as needed to sustain engagement, stability and health. The team provides directly, or arranges, facilitates access to, coordinates, and monitors all needed services including health care and social services and public health.
- **Chronic Care Management.** There needs to be a strong model for “chronic care” management for those with mental illness – which is currently not managed or treated very well in today's system. It needs to go beyond a medical model (focused on elimination of a particular symptom) to provide more of a team approach that offers support, information and problem solving. The chronic care model currently provided by community mental health providers is focused on what the consumer wants or needs in order to remain in the community. If necessary, the service “goes to the client” rather than the client going to specific appointments, etc. It is a “home based” model. The chronic care model assists the consumer with housing that meets the needs of the consumer's disability, in accessing social services that allows the client to live as independently as possible, in getting to their primary care physician appointment, as well as in securing prescriptions and any other treatment.

This type of “chronic care” model allows the client to have resources of a broad team: nurse, pharmacist, case manager, etc. It is more expansive than the primary care model – which then allows the patient to successfully remain in the community. The care model includes features of Wagner's Chronic Care Model and the Primary Care Access, Referral, and Evaluation (PCARE) model developed by Colorado Access and tailored to the population. The model involves an ongoing individual relationship usually between a bachelor's level case manager providing primarily direct face-to-face assistance in the patient's home and in various community settings. The case manager assists with maintaining housing, eligibility for various benefits, activities of daily living, and adherence to medication, as well as coordinating care between healthcare providers and attending clinic visits. Community mental health case managers have regular, on-going, face-to-face interaction with people with severe mental illness, and routinely provide care coordination, address medication adherence, and assist in accessing healthcare services. These interventions could be reasonably anticipated to improve the outcomes of chronic medical illness as well as severe mental illness.

- **Patient Engagement and Education.** The ability to sustain engagement of the individual with his/her health recovery plan is essential to both improving health outcomes and saving costs, especially for those individuals who have a mental illness. In order to achieve active patient engagement, patient education and illness management should be emphasized and reimbursed as part of a new health care delivery and payment system. Illness management (i.e., self-management) and recovery practices should be incorporated at all junctures. Using evidence-based practice implies involvement and partnership with patients and families.
- **Mobile and In-Home Services.** Services should be provided wherever that service is needed, such as the home, in the community, etc. This is an essential component to keeping those individuals experiencing intractable symptoms or contending with multiple other issues engaged in a plan to improve health and stability. This “least restrictive alternative” is a cost-effective approach focused on managing the most complex cases with a variety of intensive outpatient, home and community-based services.
- **Evidence Based Practices and Services.** This would include providing in-house primary care, ACT, Integrated Dual-Disorder treatment (IDDT), Illness Management and Recovery (IMR), Family Psycho-Education, Supported Employment, Dialectical Behavioral Therapy (DBT), Cognitive Behavioral Therapy, Supportive Housing, transportation and others. About a dozen community mental health providers are implementing a DIAMOND-like program within their clinics using PHQ-9 for screening, assessing progress, adjusting treatment, and reporting outcomes. For children and families, the state has developed a database of evidenced based services matched to specific diagnoses and clinical situations. These include multi-systemic therapy, functional family therapy, and others. These practices build upon core clinical competencies and interventions that are combined and coordinated to structure programs that can flourish with simple, flexible payment reforms.
- **Crisis Services.** Should be available 24/7, including crisis residential, mobile crisis and crisis warm lines. It is our experience that hospitalizations can be reduced with timely and appropriate alternatives but the current system does not reward or promote such alternatives. Crisis teams should be available and credentialed at all EDs in a coverage area.
- **Target High Risk Enrollees.** High risk enrollees who have both SPMI and physical health risk factors should be targeted and provided assertive outreach and engagement, including financial incentives and lifestyle coaches (using nurses, ARMHS, and Certified Peer Specialists trained as coaches).

EXAMPLES OF CARE MODELS THAT COULD REDUCE TOTAL COST OF CARE

There are a number of examples of community mental health programs both here in Minnesota and in other states that could, along with the appropriate reallocation of resources and changes to payment methodologies, serve as models of care in a demonstration project designed to effectively reduce total cost of care, improve quality and improve patient experience:

Example #1 - Touchstone Intensive Community Rehabilitation Services (ICRS): Touchstone's ICRS program offers a team approach to rehabilitation care for individuals with SPMI by providing skills building, nursing, integrated case management, psychiatry, and healing services in a customized package designed to meet a client's individual recovery goals and needs. A team meets with clients in their homes or in the community, through in-person appointments and by phone and works closely, collaborating and coordinating every week to ensure clients' needs are met. The team also works to coordinate with financial services, economic assistance, insurance providers, and other county and state partners that work with our clients. When clients experience crisis, the team coordinate with the crisis staff, hospital staff and others involved. With additional funding through a payment reform project this program could be expanded to work with Health Care Homes, primary care and dental care providers, and other partners from which individuals with SPMI would benefit from coordination efforts.

Example #2 - Touchstone Care Coordination Program: Touchstone Care Coordination offers both Care Guide services and case management services to SNBC members, based on a level of care intensity for which a person qualifies. Care Guides provide direct practice and referrals to other resources to ensure that their clients have all the providers they need to adequately address any issue or challenge that is disruptive enough to adversely affect health, healing and/or well being. Care Guides meet their clients at the Touchstone office, in their homes or out in the community or by phone. Services provided include preventative work to avoid unnecessary use of emergency room and/or hospitalization, discharge planning work when members do require emergency room, hospitalization or changes to their level of care, and IDDT chemical health screens, assessments and referrals. Navigation of the health care system and assistance in setting up and attaining transportation to appointments is also a strong area of focus.

Through a payment reform project this package of services could be expanded to more clients if the definition of a billable service were broadened. In addition, more intensive, short term case management could be provided to divert from and transition out of ER and inpatient hospitals. Touchstone would also like to provide Health Care Home services by managing and coordinating the total spectrum of care for their specific SPMI population. With a Touchstone Care Guide, a client is as likely to receive support finding and getting to the dentist as they are to receive crisis intervention and mental health support services. Care Coordination operates from a bio-psychosocial perspective, which means that every single life area, from physical wellness to mental health to leisure and recreation to vocational attainment and achievement

are recognized as important pieces of the life experience that affect not only health but also healing and well being. In addition, coordinating eligibility requirements and assessments that link to needed care would be an additional benefit that could be provided, if the necessary staff and funding were available.

Example #3 - GUILD INCORPORATED Hospital To Home (H2H): Guild Incorporated's Hospital to Home (H2H) initiative takes an innovative and collaborative care approach to assist individuals experiencing chronic health conditions, co-occurring with serious mental illness and/or other behavioral health conditions and homelessness, to get the care they need without relying on high cost and often avoidable, emergency room care. H2H engages these individuals in a plan to improve their health, stability, and quality of life. An additional goal is to reduce emergency department visits, thus freeing up emergency department resources for acute medical crises, and reducing unnecessary healthcare expenditures.

This project was undertaken in response to the increasing evidence that a disproportionate amount of hospital emergency department and inpatient resources are used by a small group of people who have chronic health conditions and also have high risk factors such as homelessness, mental health disorders, and/or substance abuse problems. These individuals have multiple, complex needs, and, for a variety of reasons, use hospital emergency departments at a high frequency for non-emergency health concerns. This results in avoidable health care expense and ties-up emergency room resources unnecessarily. Guild Incorporated provides the initial engagement and on-going community mental health services to these participants. With sustained funding and support through a payment reform project this initiative could be expanded to reach a larger population and thus have a greater impact on reducing the high cost, avoidable emergency room care visits.

Example #4 - Human Services, Inc: Community Based Mental Health Treatment for Children and Adolescents with a Severe Emotional Disorder: Human Services, Inc. has partnered with Washington County Community Services since 1981 to provide a continuum of community based mental health care to children with serious emotional disturbance. Over these years, the mutual goal has been to provide child focused, family centered and culturally appropriate mental health care to children in their homes rather than in residential treatment or other more costly out of home care. This treatment has been organized through a service delivery model by program, Family Treatment Program, Therapeutic Support Program, Adolescent Services Grant Program, Life Skills Program, Day Treatment Programs and the Parent Liaison Program. Each program tracked outcomes related to child goals and placement diversion. Today, while our overall goal of effective community based care remains the same, both the client population and the payment structures for reimbursement for mental health services and out of home placements have changed. Reduction in funding has resulted in the closure of some of these programs, and the redesign of others. The emergence of evidence based practices in children's mental health has also led to changes in our service delivery design.

A payment reform demonstration that would allow providers to be able to coordinate and provide a variety of services, sometimes simultaneously, for complex and difficult families would be desirable. Being able to wrap an appropriate service system around the family and

child is the most effective way to treat a more severe level of disorder. Packaging tiered “Treatment Levels of Care” for various levels of dysfunction and serious disorders can provide the flexibility necessary to achieve successful outcomes. Payment for such service could be based on the level of care needed and could be established as a monthly case rate that could flex to different levels when needed.

Example #5: ICBS (Intensive Community Based Services): Several mental health organizations in Minnesota have been contracted with by Health Plans to serve the clients with the most intensive needs by using a Care Coordination and Delivery model that 1) uses a case rate, 2) embeds care coordination into the care delivery system, and 3) forgoes rigid role definitions for case managers and rehab workers, allowing and encouraging the provider to arrange for or directly provide advocacy, rehab, and other services that may be needed to stabilize the individual and help them achieve the highest potential level of functioning. Care coordination focuses on identified high risk patients, follow-up to crises or urgent care, and post-hospital transitions, to support and educate patients during the transition and facilitate connection with outpatient and community-based services and avoid re-hospitalization at a critical period. These programs have drawn national attention as excellent examples of individualized and effective treatment interventions that focus on results vs. rigid process.

Example #6 - Primary Care Access, Referral, and Evaluation (PCARE): Integrated primary care and behavioral health services delivered in a behavioral health site have demonstrated an ability to improve physical health and cost outcomes for people with serious mental illness. For example, a *medical* care management intervention delivered in a community mental health center increased linkage to primary care providers, participation in recommended preventive services, use of evidenced based services for cardio-metabolic conditions, and lower cardiac risk scores than a control group that did not receive the intervention.⁵ The Veterans Administration placed primary care services in a specialty mental health clinic and found that it significantly increased the rates and number of visits to medical providers and reduced likelihood of ED use; significantly improved quality of routine preventative services; significantly improved scores on SF-36 Health Related Quality of Life; and was cost-neutral (outpatient and primary care costs offset by reduced inpatient.)⁶

Example #7 – Washburn Center for Children: The children’s mental health system in Minnesota could also reduce the costly use of psychiatric hospitalization and residential treatment by investing in comprehensive, intensive community-based mental health services. Funding for these services has eroded or been abruptly eliminated, reducing access. The system is too reliant on residential and inpatient care and has not developed and funded a comprehensive community based system to promote early identification and treatment, cover care coordination, or improve access to community-based mental health services as a strategy to reduce reliance on and overuse of inpatient and residential treatment.

The children who represent the best opportunity to reduce future deep end, expensive, intensive services are those demonstrating multiple risk factors and a prior history of accessing

⁵ B. Druss, PCARE Study, Am. J. Psychiatry, 167-151-159

⁶ B. Druss, Archives of General Psychiatry, 2001; 58(9):861-868.

those services. These children typically qualify for more than one mental health diagnosis, meet state criteria for a Severe Emotional Disturbance (SED), have experienced significant environmental stressors, and have limited access to supportive community, health and cultural resources. Compelling data exists that demonstrates community-based mental health services effectiveness in improving symptoms and functioning so that clients are able to remain in the community while minimizing hospitalization and inpatient episodes. Four primary types of services which have a demonstrated history of effectiveness in spite of eroding and inadequate funding are intensive in-home services, psychiatry, comprehensive milieu programs, and clinic and school-based outpatient services. Investment in these services could improve client mental health and satisfaction, improve timely access and reduce inpatient and residential utilization and expenses.

Example # 8: Missouri Medicaid Community Mental Health Center (CMHC) Health Home:

Missouri is currently in the process of developing a formal State Plan Amendment in order to propose developing health care homes with chronic conditions within the authority of section 2703 of the Affordable Care Act. Part of that submission will be to allow for Community Mental Health Centers to serve as the state's mental health care home and designated provider for individuals over age 5 with:

- A serious and persistent mental health condition (SMI adults and SED children);
- A mental health condition and other one chronic condition (asthma, cardiovascular disease, diabetes, substance use disorder, developmental disability, chronic pain or overweight (BMI >25)); or
- A substance use disorder and one other chronic condition (asthma, cardiovascular disease, diabetes, mental illness, developmental disability, chronic pain or overweight (BMI >25)).
- The Missouri CMHC Case Management Program realized a savings of \$311 per person per month for a total savings of over \$25 million or 17%. (Parks, et. al, Psych Annals, 2010)

PAYMENT MODELS

Multi-payer alignment will be crucial to the success of any care delivery and payment reform efforts. As the health care system adopts new provider-based ACOs and similar models, multi-payer alignment must be viewed as encompassing three categories of payers: Health insurance plans, Provider-based ACOs, and DHS when acting as the payer under fee-for-service programs.

New financing approaches are needed (e.g., to support the integration of primary care and MH/SU services) in order to better address the health care needs of persons with SMI and the MH/SU healthcare needs of all Minnesotans. In order for this to happen, the payment system and resource allocation must be altered in a number of significant ways:

1. **Increased Resources for Health Care Homes and Care Coordination.** Cost-effective preventive, outpatient and community-based services are currently underfunded, so any new payment structure must allow for, and fully cover the cost of, extended engagement, early intervention and prevention services and all additional coordination needs that this

population experiences across multiple systems, to the extent these services will produce a return on investment that will reduce total costs of care. **This would specifically include:**

- a. **Increased reimbursement for core mental health Services.** Such as diagnostic assessment, individual and family therapy and psychiatric services. Currently these reimbursement rates are far below the actual cost of providing services – about 75% of cost on average.
- b. **Care coordination and consultation services.** Today fee for service reimbursement only covers direct face to face sessions. Reimbursement should be expanded to cover:
 - i. **Consultation or coaching other professionals or family caregivers**
 - ii. **Travel time**
 - iii. **Screening to determine suitability for a program or service**
 - iv. **Functional assessment and rehabilitation or recovery planning**
 - v. **Directing and supervising care delivered by non-licensed staff**
 - vi. **Phone contacts with patients or caregivers**
 - vii. **Collaboration with other professionals involved with the client’s care**
- c. **Patient engagement.** The relationship with the enrollee and the care giver is crucial in helping to create and maintain changes in behaviors. The engagement process itself may take much more time that with other populations and therefore some mechanism for a payment structure that allows a sufficient amount of engagement time is critical. People with behavioral health problems are often slow to trust and delay treatment while “contemplating” action. There are well documented ways to accelerate this process, but the time/effort isn’t covered in current payment model.
- d. **Motivational interviewing and outreach.** Early efforts to identify, reach out, motivate, educate and engage a patient are currently not covered or who is ambivalent, or contemplating accepting help until there is a treatment plan based on a diagnostic evaluation.
- e. **Uniform access to crisis services.** Crisis services provide an essential safety net for persons with mental illness and their families. Mobile teams can go to a person’s home, assess the situation and provide services to help stabilize the individual who is in crisis. This is a cost-effective way of dealing with a mental health crisis that can prevent people from going into the emergency rooms at hospitals or even prevent a police response. Today these services do not exist in every county and their funding is precarious. Crisis Service provision should not be exclusive to ACO enrollments and all payers should be required to contract for crisis services for the designated provider using an essential community provider mechanism, to make sure everyone can get the service and to eliminate the need to confirm coverage during a crisis. ACO enrollees could get the service paid for as part of the capitation (which covers the total program cost) while other payers pay the crisis services fees, in return for coordination with their provider systems. Crisis Services should be contracted on a “firehouse” basis, scaled to the coverage area, population, and deliverables specs. There should be one provider, certified to serve both children and adults. A single, geographically based community mental health organization may have sufficient volume to operate such a service, serving multiple payers and other health systems, sharing in the savings from reduced emergency room and avoidable hospitalizations.

2. **Ensure mechanisms for payment to small networks of providers.** In the above models, there very well might be more than one agency or provider involved. A number of options for payment of a small focused network of care providers could include:
 - a. A case rate, with a hold back (or incentive) for performance.
 - b. The case rate would need to be divided among those participating, either on a per case basis, or on some other basis (i.e. based on who is doing the work).
 - c. The costs for networking would need to be supported in a case rate and required as a network performance standard.
 - d. Fee for service can still be used to access those specialized services provided by affiliated partners who are not at risk for cost or performance.

3. **Expand MA eligible Children’s Therapeutic Services and Supports (CTSS) and Adult Rehabilitative Mental Health Services (ARMHS) benefits to reimburse for services not currently covered.** There is currently a mismatch between evidence based service activities in mental health practice and what is covered in Minnesota’s CTSS state plan benefits. Since the adoption of CTSS a decade ago several years of experience and more information about evidence based practices has shown that activities like care coordination, collateral work with families and other caregivers, assessment and treatment planning services with collaboration between MH professional and practitioners are vital to improving quality and have become best practices for populations with mental health issues. Minnesota’s state plan benefits should be modified to reflect these evidence based practices. Many of these services are already defined in the CPT or HCPCS manuals (“Coding and Procedural Terminology”; “Health Care Procedures and Service Codes”) and are covered by many state Medicaid plans across the nation.

4. **Allow for various units of service.** The unit of service for MH-TCM is one month – this unit works well as number of the contacts for each recipient will vary over time. Per diem units of service work well for facility based services. To cover evidenced based practices, that combine various service components into a coordinated package, there must be either a “program payment” similar to a facility payment to cover the non-billable ancillary activities, infrastructure and team-work; or per case payment for care coordination and related services; and/or payment for specific service activities included in the care model. Current coding and billing schemes may need to be redefined to support these strategies.

5. **Blend funding streams and refinance to leverage federal financial participation.** Community mental health providers are experts in blending or braiding multiple funding streams to provide a full range of needed treatment and support services. Payment reforms can build on this as a way to enhance wrap-around services essential to support and stabilize children and adults living with a mental health disorder that complicates recovery and management of other co-occurring conditions.

There are opportunities to further leverage federal financial support as a means to finance various payment reforms, improve underfunded mental health services, strengthen provider infrastructure, and link with primary care. Currently, state and county general

funds are used to fund many services that could be redefined as part of the Medicaid program, and thus leverage FFP. Many states have defined their Medicaid rehabilitative mental health services to include certain patient-centered components of ARMHS or CTSS or community mental health teams are not reimbursable events in Minnesota’s state plan. If a portion of the appropriations for state operated services or county grants were re-directed to health care to cover the non-federal share of adding coverage for about 7-8 HCPCS codes, it could dramatically improve the ability of providers to deliver collaborative care and more intensive evidenced-based mental health services appropriate for those with more serious conditions. The current payment methods simply cannot sustain the best practices described elsewhere within this section. Note: A similar strategy was used to implement the “Model benefit set” developed and recommended by the Minnesota Mental Health Action Group. For this innovation the state retained a portion of county grants that typically are distributed to counties and used these funds to add coverage to GAMC and MinnesotaCare so that all state health plans had the same benefits, thus reducing the need to transfer among programs to access the right care.

6. **Establish a performance pool.** A “performance pool” could be used to bring partners to the table who are collectively and individually at risk for performance, where client outcomes are driven by performance of several organizations working with the same consumer. (This would essentially apply to physical health care providers and mental health care providers sharing the common outcome of reducing psychiatric and mental health care costs.)
7. **Consider MSHO’s payment model.** MSHO’s payment model should be evaluated for all chronic care conditions. It provides risk adjusted rates plus it includes the waivers – giving flexibility of services to meet the individual’s needs.
8. **Provide mechanisms for gain-sharing with community providers.** Allow community providers to share in savings from reduced hospitalizations and/or emergency visits.
9. **Retain some of the current laws for Health Plans regarding payment mechanisms.** Such as required claims payment within 30 days of submission.
10. **Essential Community Providers.** Existing state policies requiring managed care plans to contract with ECPs should continue. In addition, to the extent that DHS contracts with ACOs or other demonstration projects that propose to establish restrictions on patient choice of provider, ECP requirements should apply to them as well.

PERFORMANCE MEASURES

Performance measures that specifically address the quality of life and functional status of individuals with mental health or substance abuse issues should be part of all demonstration project evaluations.

QUALITY/ACCESS/IMPROVED HEALTH OF POPULATION

There are a number of measures that address quality of care, access and population health that would be important to incorporate, especially from a mental health and/or substance abuse perspective.

- **PHQ-9** for adult depression
- **GAD-7** for anxiety
- **AUDIT or CAGE** for drug/alcohol
- **MN 10x10 Screening Tools.** This screening tool (endorsed nationally and statewide) is designed to track five basic health care issues for individuals with bipolar or schizophrenia: maintain a healthy weight, avoid smoking, avoid or minimize alcohol use, maintain a healthy heart, and avoid (or manage) diabetes. This tool is already in widespread use across the community and is part of a collaborative statewide effort to increase lifespan of adult Minnesotans with SMI.
- **Performance Outcome Service Report (POSR).** For SPMI clients, performance measures need to include the measures surrounding overall wellness and well being – such as stable housing; decrease in number of arrests, crisis plan is developed, etc. This DHS report could be a source of some of those gross indicators such as hospitalization, jail time, days in employment, homelessness, etc.
- **HEDIS Measures** for dimensions of care and service.
- **Functional Assessment Domains** (13 domains, used by ARMHs and ACT programs): Mental Health Symptoms; Mental Health Services; Use of Drugs and Alcohol; Vocational; Educational; Social (social interactions and use of leisure time); Interpersonal (including relationships with family); Self-Care and Independent Living Capacity; Medical; Dental; Financial; Housing; Transportation.
- **Anthony Lehman’s Quality of Life Index.** Includes indicators of wellness in other dimensions of life beyond health care that are essential for the MHCP population: e.g., financial, social, emotional, occupational, intellectual, spiritual, etc. Quality of life measures encompasses functional status, access to resources and opportunities, and sense of well-being. It offers a useful perspective on the value of health care, especially for chronically disabling conditions, including chronic mental illness.
- **Strengths and Difficulties Questionnaire** for children and adolescents.

Notes on effective implementation of quality measures:

- There needs to be a better gathering and distribution of these measures, as well as ability for the “behavioral health care home provider” to access and track not only these quality measures, but the total service cost data.
- Any effort to measure quality must be reasonably simple, and clearly tied to the objective of the care management/service delivery product delivered.
- A measure of actual services provided with external review, whether a part of a case rate or other means of reimbursement provides some sense of accountability for the consumer and the buyer.
- If there is compensation for networking and ancillary services included in a case rate, some indication that those services actually occurred.
- Essential basic requirements related to provider competence needs to be documented, but kept simple.

- Timely access to services based on principles of triage should be documented.

PATIENT SATISFACTION/EXPERIENCE

Patient Engagement is an Essential Evaluation Measures. Health care demonstration projects should not only measure the patient’s satisfaction with their provider, the support staff, etc. but should also measure how much the patient knows about his/her illness, medication. There should be some kind of measurement about “engagement” of patients in their own care.

For example, Touchstone Mental Health currently uses an annual customer satisfaction survey in all programs. Similar measures are routinely used in other community mental health organizations that would get at such “engagement” levels with questions that ask about satisfaction with:

- Treatment progress
- Safety
- Improved Mental Health
- Content with housing
- Feel/stay healthy
- Addressing recovery goals and feeling productive
- Access to services
- Communication
- Accessibility of Team
- Needs being met
- Relationship with staff
- Treated with respect
- New services and service model supports recovery
- Participation in treatment plan development
- Attention to specific goals and health and wellness
- Coordination of care and services
- Support and attention to personal recovery vision

In addition, the Mental Health Statistics Improvement Program (MHSIP) developed consumer surveys that include the domains of general satisfaction, access, quality/appropriateness, social connectedness and functioning, and outcomes relative to mental health services. It is comprehensive in this way. These surveys can be used free of charge (the factor analysis, etc. is published at the website.) There is a version for inpatient services, which could easily be adapted for residential treatment, or other facility-based treatment services.⁷

RISK ADJUSTMENT STRATEGIES

⁷ <http://www.mhsip.org/surveylink.htm#mhsipapprovedsurveys>

Risk adjustment must be done well for payment reform efforts to succeed. Payments and quality measurements for payment reform demonstration projects, ACOs, health care homes and providers should be risk-adjusted to reflect the characteristics of patients that affect treatment, cost of services, and outcomes. This should include weighting for non-clinical, socio-economic factors so that providers are not disadvantaged for serving the most challenging populations. Risk adjustment must be at least as powerful as any incentive to avoid selection bias and risk-shifting. In developing risk adjustment strategies DHS should consider that this population is high risk for psychiatric hospitalizations, significant chronic physical health conditions, and it is a population that symptoms are more cyclical in nature. This means that their needs go from high to medium and back to high at any given point in time. Their level of maintenance may require much more significant care more consistently than other populations. Some of the key measures that we believe should be included in a risk adjustment formula include:

- Mental illness of a serious or serious and persistent nature as a primary diagnosis
- Co-occurring substance use disorders
- Poverty
- Homelessness
- Multiple, untreated conditions
- History of criminal behavior
- Economic distress (History of chronic unemployment/or recent job loss)
- History of use of health care (high frequency ED users)
- Lack of connection to any form of personal/professional support
- Lack of commitment to engage in any behavioral change
- Weak relationship to positive natural social supports; isolation
- Little evidence (current or past) of connection with professional supports
- History of not filling or re-filling prescribed medications
- Complex multiple medication patterns outside recommended algorithm
- Rural location (Costs for travel are essential for accessing the client to services or the services to clients. Costs for electronic infrastructure to reduce client/provider travel costs can be a barrier for rural areas to be able to deliver care. Risk adjustments on a case basis, adjusted to reflect travel costs will contribute to minimizing the barriers for rural participation in health care reform.)

For complex cases, there needs to be a way to negotiate a plan and a case rate to support the plan, not unlike the process for CADI waivers. “Difficulty of Need” indicators actuarially/historically based might help establish a way of predicting costs for these special cases, though current technology may not be as robust as necessary for the task.

INCORPORATING PERFORMANCE MEASURES INTO PAYMENT MODELS

Pay-for-performance measures should be utilized to identify specific individuals with recognized risk factors. Providers could be paid extra to do this outreach. Payers should identify specific individuals from their databases to be targeted for this outreach.

DATA TO IMPROVE CARE

Uniform Access to Data. If participating providers are going to assume any risk, they will need historical cost data to guide them in identifying different levels of cost and risk for different cohorts of patients, designing cost-effective packages of services for each cohort, pricing the services, establishing benchmarks for reducing total costs of care, and tracking and managing costs and utilization in order to optimize outcomes while reducing total costs. The Department of Human Services already collects service and cost data across health and mental health care services. The Department should query that data to assist with assessing/predicting risk and make it uniformly available to all potential ACOs, health care homes, or payment reform project participants.

Information Exchange. If providers are to going to be required to be able to track, monitor, manage risk, and report risk data to DHS, there needs to be both financial support and sufficient time to develop data management capabilities that report this data in real – or recent – time. It is unlikely in the near future that mental health programs, or other small independent, community based or safety net providers will be able to purchase the full scale electronic health records that most large systems use to collect and manage data. However, those providers should not be prohibited from participating in demonstration projects just because they do not have the resources to cover the up-front infrastructure costs associated with obtaining data information systems. Therefore, a cost effective, statewide data system exchange should be developed so that data could be transferred to all the providers who would like to take some kind of accountability for their patients.

PATIENT ATTRIBUTION

Meaningful engagement of a patient in a trusting relationship with a primary care provider (and health care home or care coordinator if needed), is the most important decision point for a patient. The patient relationship is the key to success in achieving the goals of health system improvement – health, patient satisfaction and cost containment – especially for patients with complex medical and socioeconomic needs. Every patient should be able to choose their preferred primary care provider and care coordinator/health care home based on their personal circumstances, needs and preferences, provided the provider or care coordinator meets basic requirements for accountability on cost and quality. Choice is especially important for children with serious emotional disturbance and adults with serious mental illness. Trust and engagement are central to effective mental health services, especially with a population cautious about recognizing and seeking help. By respecting established relationships, choice counterbalances a history of stigma and coercive practices with this population. Enrollment in or assignment to a health plan or ACO or health care home should follow a patient’s choice of provider and care coordinator rather than the other way around.

Individuals with serious mental illness should be allowed to choose a behavioral health care home. This option would include allowing willing CMHCs to serve as specialty providers or as

subcapitated behavioral health care homes in an ACO that would receive payment for that enrollee based on a percentage of historical cost for this subpopulation.

PROS AND CONS OF ATTRIBUTION APPROACHES

Caution is needed to avoid adversely impacting both consumers and providers in the assignment of or use of cost attribution data, in order to avoid providers seeking a safer market niche, or seriously impaired consumers losing access to care. Where a network is responsible for a client, the cost data should be assigned to that network. If a provider is held responsible for the cost of care for a client, the client should be accountable for some level of commitment to a care plan with that provider. But, if a client can have free choice of vendor, and/or can opt out of or fire a program/provider at any time, the subsequent cost associated with moving patients should not be assigned to the provider.

ENROLLEE CHOICE VS. PROVIDERS' ABILITY TO INFLUENCE OUTCOMES

Enrollees should maintain a choice of providers; however, there is not a wide swath of providers who are skilled in working with this population. Therefore, especially within a rural geographic area, there may be less choice than in other fields and populations to be served. In addition, while we support enrollees' choice of providers, once an enrollee makes a choice of their preferred health care home, any service provided should be in keeping with the treatment plan devised by the lead service provider and responsible entity, (i.e., the behavioral health care home). Under the behavioral health care home concept, or other payment models, clients could be incented to choose a more coordinated package of "value-added" services such as psycho-educational, nutrition, wellness, family support, housing support, on-call consultations, monitoring of health risks, etc. through reduced cost-sharing (co-pays, deductibles, spend-down, etc.) Another payment mechanism would be to allow a provider to collect the cost-sharing, but return it to clients who stay active in their treatment/service program. This type of incentive has been used successfully in other settings such as with multi-modal eating disorders treatment, dialectical behavioral therapy, comprehensive diabetes care, etc.

Once an individual makes a choice of provider they should be required to stay with that provider for specified amount of time. Often the length of mental health service provided depends on diagnosis, functioning, social supports, and willingness to be an active participant in treatment and recovery. This can vary somewhat with age/development. For adults: bipolar, schizophrenia, serious anxiety disorders, borderline, major depression will require at least six months of active treatment/rehabilitation with frequency/intensity of at least once per week of various services. This could be extended depending on progress and motivational/engagement. It is almost always more costly and intensive earlier in the course of treatment. For less severe or complex situations, a program like *Depression Improvement Across Minnesota, Offering a New Direction* (DIAMOND) could be effective much of the time---however, there should be a protocol for stepping up to a "level-2 or shared care" in which MH professional assumes a co-management role for a period of time (six months) for those patients who need more than the light "consultation" and care-coordination that primary care is ready/able to provide.

PRESERVING PATIENT ACCESS AND APPEALING SERVICE DENIALS

In order for patients to successfully access services they must first have access to information that helps them understand their health care problems and who can help them. In rural communities, this means a willingness on the part of providers to get information out about themselves, about the problems they have the capability of addressing, and about how to access the needed care. This can be accomplished in sophisticated and non-sophisticated ways with quality web sites, community training, newspaper articles about identification of care, etc. This type of “Social Marketing” is a support product necessary for direct service delivery. One of the ways DHS or an ACO could identify a “competent” community provider would be to identify whether they can accept some of the responsibility for this.

For the most severely impaired who may be least likely to know how to access care, or have the ability to do so, it is necessary to have an informed, active and capable referral network, with capabilities for screening and referral. Providers share a responsibility for nurturing an informed referral network. The ACO itself should be required to demonstrate that it understands what community based care is and who benefits from that model.

For the severely impaired targeted in the above described services, it will be critical to have sufficient educational information available to all parts of the existing health and mental health system in order that the right (i.e. targeted) clients get to the right services at the right time. Incorporating a “Social Marketing” component to Accountable Care organizations will be important, otherwise to avoid providing quality services intended for the most at risk to persons of less risk.

ASSUMPTION OF RISK

Providers should not be allowed to take greater financial risk than they can handle. Insurance risk should be covered through reinsurance, a health plan partner, the State acting as reinsurer, or other method, but some level of financial risk tied to performance and controlling total cost of care is appropriate for all providers. Organizations that are able to take *substantial* financial risk should not be the only organizations eligible to establish, control or manage new delivery systems or ACOs. In fact, some of the organizations that are best suited to reducing costs and improving patients’ health for high-risk and special needs populations on state programs are least able to bear substantial risk because of past and current underfunding and underpayment for primary care and care coordination services, low reimbursement rates for state programs, and growing uncompensated care due to increasing numbers of uninsured and underinsured patients.

LEVELS OF RISK PERMISSIBLE

DHS needs to be vigilant about the extent to which non-profit providers are authorized to assume financial risk, yet providers who are uniquely suited to serving particular patient populations should not be disqualified from continuing to serve patients who need these types

of services solely because they do not have the substantial reserves of a health plan or large integrated health system. The current system does not allow for non-profit mental health providers to set aside enough reserves to carry high levels of risk in a new care delivery system. Provisions need to be in place that would still allow mental health programs to share in the incentives for good outcomes, even though they may not be able to put the reserve monies up front.

Providers (and/or networks of providers) should have options for accepting risk that are dependent on their unique ability to enter into risk assumption or risk sharing relationships depending on their:

- Assets and contractual ability to put those assets at risk.
- History and level of success working in managed care/managed cost
- Evidence administrative/management, programmatic/clinical capability to accept risk.

TYPES OF RISK SHARING OPTIONS

We believe there are available mechanisms that can be used to establish reasonable financial incentives for community-based providers that will motivate them to control total costs of care and achieve performance goals. We also believe there are available mechanisms for covering the *insurance* risk and controlling hospital and specialty costs that will enable the state to achieve cost containment goals and have predictability of government program expenditures without requiring community-based providers to assume more financial risk than they are capable of assuming.

DHS should allow a variety of risk sharing options under the demonstration projects. A continuum of risk sharing options should be available for participating organizations in Accountable Care networks, including:

- No risk fee for service, and no efforts to measure results;
- Pooled risk but still on a fee for service basis, with efforts to measure outcomes;
- Case rate with exposure for some of the total cost on a per client basis, and potential for some of the cost saving;
- Case rate with exposure to all of the cost on a per client basis, with potential for more savings;
- Pooled risk with network partners, with risk and reward distributed on volume, or some other way that works for a “fair “distribution of risk and reward;
- Allowing relationships to be established between mental health programs and HMO’s, who currently have reserves set aside for this purpose;
- Allowing DHS to pay ACOs a percentage of total historical cost (such as 90%) and retain the 10% as a risk pool reserve (or purchase stop loss coverage on behalf of ACOs or a combination) to reduce or eliminate the need for large reserves. ACOs access the risk pool reserve when there is greater penetration (percentage of enrollees using services) than anticipated resulting in financial losses. ACOs would purchase their own stop loss for insurance risk.

FEDERAL AUTHORITY

Any plan should be implemented in stages so that reform can begin now but perhaps on a more graduated level. In the immediate future DHS should focus on “access” to all services – including dental services and mental health services – in a “quick turn-around” model. DHS should provide incentives to Accountable Care networks that increase all levels of access. All other models should be implemented on a longer timeframe to ensure success. This type of iterative reform is helpful in that evaluation results and “lessons learned” can be incorporated into the “wholesale change.”

EVALUATION

The overarching evaluation of the demonstration project should answer to what extent are the goals of the Triple Aim met:

1. Optimal health outcomes of the population.
2. Enhanced patient experience of care (including quality, access, and reliability)
3. Reduced or controlled the cost of care

Benchmarks should be established at specified intervals throughout the implementation to ensure that the reforms are actually changing the system in the way that is being planned. Certain populations, such as those with a serious mental illness and other disenfranchised populations, should be clearly part of the benchmarking to ensure the incremental plans are having a positive impact on all people being served.

CONCLUSION

In conclusion, we reiterate several key points:

1. Mental health and substance abuse treatment must be integrated into all demonstration project models for management of chronic conditions and coordination of care.
2. Specialized MH/SU health care homes are the optimal approach for certain types of patients and should be authorized and supported by the state.
3. Specialized MH/SU services are important components for any health care home or care model for patients who have significant MH/SU issues along with their medical conditions.
4. Evidence-based MH/SU practices already exist that will reduce total costs of care and improve outcomes, but they are not utilized today because of payment and funding barriers.
5. Due to historical underfunding of cost-effective services, fragmentation of funding and services, and perverse financial incentives, successful demonstration projects will require major changes so that funding streams, service administration and

accountability can be integrated through the health care home in a way that allows resources to be reallocated to cost-effective community-based services that will reduce total costs of care.

6. Low-income patients enrolled in state health care programs often need specialized types of services and additional non-health care services in order to access needed services and achieve optimal outcomes. Providers who offer these specialized and enhanced services and serve more complex patient populations should not be disadvantaged compared to providers who don't.
7. The community-based, nonprofit providers who specialize in serving low-income, disadvantaged and high-risk patients provide a vital service, but do not have the financial resources to assume major financial risk. They should not be disqualified from being able to continue to serve patients.
8. Patients should be able to choose their preferred provider and health care home, and should not be forced to change from an existing provider, if the current provider is able to meet accountability requirements related to cost, quality, health outcomes and patient satisfaction.
9. Community mental health centers and programs provide a valuable service to their patients, government and the community and are willing and able to achieve higher levels of accountability for costs and outcomes.

The Four Quadrant Clinical Integration Model

