Implementing Healthcare Reform: How Are we Going to Get Paid Tomorrow?

National Council Public Policy Committee
Tuesday, June 29, 2010
Dale Jarvis, CPA
MCPP Healthcare Consulting, Inc.
dale@mcpp.net.com
Medicaid Authorities, Health Plans, and Healthcare Delivery Systems are quickly approaching the tipping point in understanding that we cannot improve quality and bend the cost curve without addressing:

– the healthcare needs of persons with a serious mental illness and
– the mental health and substance use needs of all Americans
Three MH Studies have Caught the Attention of the Health Policy Community

The 53 year lifespan for people *with* Serious Mental Illness is comparable with Sub-Saharan Africa

NASMHPD 2006 Study: *Morbidity and Mortality in People with Serious Mental Illness*
Three MH Studies have Caught the Attention of the Health Policy Community

- 49% of Medicaid beneficiaries with disabilities have a psychiatric illness (this is new information; previous studies that excluded pharmacy claims calculated the rate at 29%)
- Substance use conditions do not show up in this study at the expected levels because it’s based on an analysis of claims and pharmacy scripts

The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions
Center for Health Care Strategies, Inc., October 2009
Three MH Studies have Caught the Attention of the Health Policy Community

<table>
<thead>
<tr>
<th></th>
<th>Medi-Cal FFS Total</th>
<th>Medi-Cal FFS SMI</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal FFS Enrollees</td>
<td>1,580,440</td>
<td>166,786</td>
<td>11% SMI % of Total</td>
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<td>Medi-Cal FFS Costs</td>
<td>$6,186,331,620</td>
<td>$2,395,938,298</td>
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<td>Medi-Cal FFS Cost/Enrollee</td>
<td>$3,914</td>
<td>$14,365</td>
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<tr>
<td>Diabetes</td>
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<td>11%</td>
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<tr>
<td>Cerebrovascular Disease</td>
<td>1%</td>
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<td>Chronic Respiratory Disease</td>
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<td>Health Failure</td>
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<td>Inpatient Acute Days/1,000</td>
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<td>Primary Care Visits/1,000</td>
<td>128</td>
<td>492</td>
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<tr>
<td>Specialist Visits/1,000</td>
<td>1,211</td>
<td>6,058</td>
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</table>

Data from JEN Associates, Cambridge, MA
So Why Does the Healthcare System Care About All This?

**Risk, Risk, Risk:** As Medicaid expands and most Aged/Blind/Disabled enrollees move from FFS to Managed Care, the risk for this population will be shifted to Health Plans!

**Note:** In CA, most of the costs are in the Medi-Medi FFS and Medi-Cal ABD FFS boxes.

![California Medi-Cal System](chart)

- **Medi-Medi (FFS)** 977,000; 14%
- **Medi-Cal ABD (FFS)** 379,000; 5%
- **Medi-Medi & Medi-ABD (Mg Care)** 434,000; 6%
- **Medi-Cal - Other** (Managed Care) 3,399,000; 48%
- **Medi-Cal Other** (Fee for Service) 1,846,000; 26%
What the Near Future Holds...

Current Healthcare Environment: Cost and Quality Problems

Coverage Expansion: Medicaid

Coverage Expansion: Exchanges

Aged, Blind, Disabled shift from FFS to Managed Care

Integrated Health Systems (e.g. Kaiser, Intermountain)

Accountable Care Organizations

Health Plans at Risk for Managing Care and Costs

Dual Eligible

Patient Centered Medical Homes

Hospitals
The Exciting Work Ahead...

- All this...
  - Will require a *new set of relationships* between the Healthcare and Behavioral Healthcare Systems
  - And necessitate *major revisions* to most MH/SU Provider and System Manager *Strategic Plans*
How Are We Going to Get Paid Tomorrow – Two Chapters

- Chapter 1: The Big Fix - Emerging Health and MH/SU Delivery System and Payment Reform Models
- Q&A
- Chapter 2: So, How Does the MH/SU System Fit into this New Ecosystem?
- Q&A
Chapter 1: The Big Fix - Emerging Health and MH/SU Delivery System and Payment Reform Models
The “Big Fix”

Fixing this problem can be described as:

- Moving further upstream with prevention & early intervention services to prevent health conditions from becoming chronic health conditions

- Dramatically improving the management of chronic health conditions for Americans with one or more such conditions

- Reducing errors and waste in the system

- Reducing incentives for high cost, low value, procedure-based care
Healthcare Reform *Elephant in the Room*

- Need to invert the Resource Allocation Triangle
- **Prevention Activities** must be funded and widely deployed
- **Primary Care** must become a desirable occupation and
- **Decrease Demand** in the **Specialty** and **Acute Care** Systems
- These are dramatic shifts that will not *magically* take place
2002-2006: Move towards Medical Home
- Email PCP
- Online Medical Records
- Same Day/Next Day Appointment
(Increased patient access but also saw provider burn-out and decline in HEDIS scores)

2007: More robust Healthcare Home Pilot
- Added more staff (15% more docs; 44% more mid-levels;
  17% more RNs; 18% more MAs/LPNs;
  72% more pharmacists)
- Shifted to 30 minute PCP slots
(Reduced burnout, increased HEDIS scores, no difference in overall costs)
Integrated Health Systems – The Holy Grail

Global Capitation to an Integrated Health System

But... Integrated Health Systems represent only 10% of the Delivery System
This Will Require New Payment Models and System Management Structures

- **Community Incentive Pool**
- **Direct Payments to Patients**
- **Provider Bonuses & Incentives**
- **Differential Rates**
- **Grants & Seed Money**
- **Bundled Payments**
- **Case Rates**
- **Global Subcapitation**
- **Primary & Specialty Subcapitation**

Can/Should Mix and Match the Components based on the Design

New Payment Models

- Low Risk
- Low Risk
- Medium Risk
- Higher Risk

New System Management Structures

- Medical Homes
- Hospitals
- Specialty Clinics
- Clinic
- Medical Homes
- Medical Homes
- Hospital
- Hospital
Two Types of Payment Reform are the Key

Value-Based Purchasing (VBP)  Value-Based Insurance Design (VBID)

Need to save for another conversation...
Value-Based Purchasing – Medical Homes

- Fee for Service is headed towards extinction
- Health Care Home models are beginning with a 3-layer funding design with the goal of the FFS layer shrinking over time
- Being replaced with case rate or capitation with a pay for performance layer

1. **Case Rate**
   - Prevention, Early Intervention, Care Management for Chronic Medical Conditions

2. **Fee for Service/PPS**
   - Per Service Payment
   - Prospective Payment System (PPS) Settlement (FQHC model) to cover shortfalls

3. **Bonus**
   - Share in Savings from Reduced Total Healthcare Expenditures (bending the curve)
Value-Based Purchasing – Inpatient Care

- Payment for inpatient care will bundle hospital and physician services
- Bundled payments that only pay for part of Potentially Avoidable Complications (PACs) will penalize providers that have higher error rates and reward those with lower PAC rates
- Bundled payments will include all costs in the 30 days post an inpatient stay, including any return to the hospital
Value-Based Purchasing – Other Strategies

- Pay for Performance funding layer
- Differential Rates for providers that use published Practice Guidelines (EBPs)
- Capacity-Based Funding to kick start innovations
- Funding to community organizations that improve health status and bend the cost curve
Accountable Care Organizations (ACOs)

- ACOs dual purpose:
  - Organization structure for managing bundled payments for inpatient care
  - Vehicle for small to mid-sized primary care practices that want to become Person-Centered Medical Homes

Harold Miller, How to Create an Accountable Care Organization, [www.chqpr.org](http://www.chqpr.org), page 4
Accountable Care Organizations (ACOs)

- Accountable Care Organization (ACO) Model

Diagram showing.Accountable Care Organization (ACO) Model with medical homes, specialty clinics, and hospitals.
Who may be ready to become an ACO now?

### Exhibit 1. Accountable Care System Models and Core Capabilities

<table>
<thead>
<tr>
<th>Accountable Care System Models</th>
<th>Redesign Care Processes</th>
<th>Teamwork</th>
<th>Care Coordination</th>
<th>Core Capabilities</th>
<th>Information Technology</th>
<th>Knowledge Management</th>
<th>Change Management</th>
</tr>
</thead>
</table>
| (1) Multi-Specialty Group Practice (MSGP)
| High                        | High                    | High     | High              | High               | High                   | High                | Medium            |
| (2) Hospital Medical Staff Organization (HMSO)
| Medium                      | Medium                  | High     | High              | High               | Low to Medium          | Medium              | Low to Medium     |
| (3) Physician Hospital Organization (PHO)
| Medium                      | Medium                  | Medium   | High              | High               | Medium                 | Medium              | Medium            |
| (4) Interdependent Provider Organization (IPO)
| Low                         | Low                     | Low to Medium | Medium           | Low                | Low                    | Low                 | Low               |
| (5) Health Plan Provider Organization / Network (HPPO/HPPN)
| Medium                      | Low to Medium           | Low to Medium | Medium to High   | Low to Medium      | Low to Medium          | Low to Medium      | Low to Medium     |

Shortell & Casalino, Accountable Care Systems For Comprehensive Health Care Reform, page 24
Four Levels of ACOs – All Healthcare is Local

- Four Levels of ACO are being proposed:

  [Diagram showing four levels of ACOs with examples of cost reduction opportunities]

Harold Miller, How to Create an Accountable Care Organization, www.chqpr.org, page 18
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Dual Eligible

Hospitals

Plans

Patient Centered Medical Homes

Specialty Clinics

Clinic
Q&A...

• Let’s shift gears for questions about:
  – Risk
  – Expansion
  – ACOs
  – Other
Chapter 2: So How does the MH/SU System Fit into this New Ecosystem?

Reconnecting the Head to the Body
The Healthcare System Needs Quality MH/SU Services to Help Manage Risk

In order to ensure that the 50% of high cost enrollees with MH/SU Disorders who are moved into managed care can be successfully managed by
- Health Plans
- ACOs
- Medical Homes

Key message: We can help you!

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Enrollees (in Thousands)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Medi (FFS)</td>
<td>977,000</td>
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California Medi-Cal System
So How does the MH/SU System Fit into this New Ecosystem?

The MH/SU delivery system has two roles to play:
- Integration of CBHOs into Person Centered Healthcare Homes
- High Performing, Recovery and Wellness-Oriented MH/SU Providers

And, in both cases, will need to learn to play by the payment reform rules
Each quadrant considers the behavioral health and physical health risk and complexity (low to high) of the population.

Generally...

Persons in Quadrants I and III should receive BH services in Primary Care.

Persons in Quadrants II and IV should receive PC services in Behavioral Health.
“Customization” of Medical Homes

- Analogy: Generic Hospital Beds and ICU
- Customization of Medical Homes – different models for different needs
  - Seniors in nursing homes
  - Youth in Families receiving TANF
  - Adults with a SMI
  - Inuits in rural Alaska
- Person-centered healthcare homes in MH/SU clinics will be one of many designs used to bend the cost curve
Behavioral Health Customization: Person-Centered Healthcare Homes

Bi-Directional Care: Behavioral Health in Primary Care and Primary Care in Behavioral Health

Clinical Design for Adults with Low to Moderate and Youth with Low to High BH Risk and Complexity

Primary Care Clinic with Behavioral Health Clinicians embedded, providing assessment, PCP consultation, care management and direct service

Partnership/Linkage with Specialty CBHO for persons who need their care stepped up to address increased risk and complexity with ability to step back to Primary Care

Clinical Design for Adults with Moderate to High BH Risk and Complexity

Community Behavioral Healthcare Organization with an embedded Primary Care Medical Clinic with ability to address the full range of primary healthcare needs of persons with moderate to high behavioral health risk and complexity
The Role of CBHOs as Wellness and Recovery Centers

- Distinctive Competence and Competitive Advantage for CBHOs
  - Ability to provide a true “holding environment” for persons with serious MH/SU disorders
  - That help consumers towards wellness and inclusion in society
  - Which are the two components necessary to bend the cost curve
So How does the Behavioral Health System Fit into this New Ecosystem?

- We’ve learned from 50 years of effort that if you work in the BH Safety Net...

- Focusing inward to create a high-performing MH/SU Provider Organization does not always prevent you from ending up at the bottom...
Are State MH Authorities Ready?

• Begin by assessing how things will unfold in your state

• **Low Change System:** Some states will acknowledge the existence of clinical dis-integration but not recognize the financial impact and not be adequately swayed by the social justice issue related to early mortality. These states will take little or no action to promote clinical integration and will not actively remove the barriers to integrated clinical designs. These states will move forward on healthcare payment reform, per the options described above, but take a laissez faire approach to promoting primary care/behavioral health integration. In this environment, it will be up to the health plans, accountable care organizations, primary care providers and MH/SU providers to integrate – or not.

• **High Change System:** Other states will buy into the hypothesis that it will be impossible to bend the cost curve without addressing the healthcare needs of the serious mentally ill and the behavioral healthcare needs of all safety net residents. These states will promote robust primary care-behavioral health integration efforts at the service delivery level. These states will include MH/SU in their payment reform redesign efforts in the variety of ways described below.

• **Moderate Change System:** A third group of states will fall somewhere in the middle, promoting clinical integration where it can be tacked onto other efforts, with varying degrees of robustness.
How Do Carve-Outs Fit with the New Ecosystem?

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

Things get really exciting when we think about MH/SU Carve-In and Carve-Out models.
Are County and Regional BH Authorities Ready?

- The answer depends on the state environment (low > hi change)
- If there are ACOs with enrolled Medicaid patients, they will quickly learn that they need to provide integrated care for those with MH/SU disorders
- If County/Regional BH Authorities are not responsive to supporting these efforts, there will be increasing pressure to push for carve-in
- If County/Regional BH Authorities cannot demonstrate that they are supportive of these efforts and are helping bend the Total HC Cost Curve, they will be at Risk
- Authorities can get out in front of this wave by sponsoring and participating in ACO Medical Home development
How do MH/SU Providers Prepare?

Integrated Healthcare System

- If you are operating in a state and community where integration efforts are under way and the IHS model is being pushed, your choices are:

- Do nothing and hope they ignore the SMI/SED population
- Become a Preferred Provider of an IHS
- Create a consortium of BH Providers and contract with the IHS as a Provider Network
- Become an Acquisition Target and become part of the IHS’ BH Division
How do MH/SU Providers Prepare?

Accountable Care Organization

- If you are operating in a state and community where integration efforts are under way and the ACO model is being pushed, your choices are:
  - I’m going to skip “do nothing”
  - Become a **Preferred Provider** to the ACO
  - Become a **Member** of the ACO
  - Get in on the ground floor and become a **Founding Member/Owner** of the ACO
Are we Ready for the Task...

...to help ACOs and Medical Homes manage the risk and help ensure that persons with MH/SUD are part of the new healthcare ecosystem?

Here’s a 12 Question Test (6 Clinical, 6 Business):
1. Clinical: Healthcare Homes

- Are you actively pursuing bi-directional involvement in your community as a person-centered healthcare home?

Person-Centered Healthcare Home Development

- Fully Integrated or Focused Partnership Healthcare Home
  - Supporting Mental Health and Substance Use Services in Primary Care

- CBHO with Embedded Medical Clinic
  - Providing Primary Care Services in Community Behavioral Healthcare Organizations
2. Clinical: Rapid Access

- Can ACOs and Medical Homes get their patients into specialty MH/SU care with same day/next day access for high risk, high need patients?

New Patient’s first Visit to PCP includes behavioral health screening

Possible BH Issues?

YES

Behavioral Health Assessment by BH Professional working in primary care

Need BH Svcs?

YES

Clients with Low to Moderate BH need enrolled in Level 1; to be case managed and served in primary care by PCP and BH Care Coordinator with support from Consulting Psychiatrist and other clinic-based Mental Health Providers

Clients with Hi Moderate to High need referred to Level 2 specialty care; PCP continues to provide medical services and BH Care Coordinator maintains linkage; this is a time-limited referral with expectation that care will be stepped back to primary care

Referrals to other needed services and supports (e.g. CSO, Vocational Rehabilitation)
3. Clinical: Matching Need and Type/Level of Care

- Do you have well defined assessment processes and a level of care system (with a high degree of inter-rater reliability) to match client need with the type, location, and duration of evidence-based care that increases the likelihood that consumers will get their needs met in a timely and effective manner?

<table>
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<tr>
<th>LOCUS Level</th>
<th>LOCS Level 0</th>
<th>LOCS Level 1</th>
<th>LOCS Level 2</th>
<th>LOCS Level 3</th>
<th>LOCS Level 4</th>
<th>LOCS Level 5</th>
<th>LOCS Level 6</th>
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<td>Clients</td>
<td>54</td>
<td>315</td>
<td>513</td>
<td>514</td>
<td>333</td>
<td>256</td>
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<td>Client Ratios</td>
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<td>17%</td>
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<td>45%</td>
<td>42%</td>
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<tr>
<td>Clients 16-40 Svc Hrs</td>
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<td>31%</td>
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<td>24%</td>
<td>26%</td>
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<td>20%</td>
<td>23%</td>
<td>27%</td>
<td>30%</td>
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<td>22%</td>
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<tr>
<td>Clients 100+ Svc Hrs</td>
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<td>7%</td>
<td>20%</td>
<td>21%</td>
<td>29%</td>
<td>10%</td>
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<td>67.8</td>
<td>69.2</td>
<td>113.2</td>
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<td>High Hours</td>
<td>73.4</td>
<td>187.9</td>
<td>239.5</td>
<td>373.2</td>
<td>856.4</td>
<td>468.7</td>
<td>630.9</td>
<td>856.4</td>
</tr>
</tbody>
</table>
4. Clinical: Stepped Care

- Doe the clinical service delivery process support stepped care?
  - The ability to rapidly step care up to a greater level of intensity when needed?
  - The ability to step care down so that a consumer’s MH/SU care is provided in primary care with appropriate supports?
  - The ability to offer “back porch” services for consumers who graduate from planned care?
  - All offered from a client-centered, recovery-oriented perspective?
5. Clinical: Care Management

- Do you have the ability to identify patients with MH/SUD who represent the top 5% to 10% of high cost consumers of health care and provide effective care management services to help them manage their MH/SU disorders AND their chronic health conditions?
6. Clinical: Measuring Individual Improvement

- Is progress being tracked each visit, recorded in an EHR, available through a Patient Registry, and used to adjust care on a regular basis?
7. Business: Participation in Bonus Arrangements

- Do you have the clinical, information and financial systems and staff to *measure your clinical and financial performance* in order to participate in pay for performance bonus arrangements?

<table>
<thead>
<tr>
<th>FOLLOW UP</th>
<th>LAST AVAILABLE</th>
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<tr>
<td># OF P.</td>
<td>MEAN #</td>
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<td>20 (87%)</td>
<td>7.5</td>
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<td>7 (88%)</td>
<td>4.3</td>
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<tr>
<td>19 (90%)</td>
<td>12.6</td>
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<td>91 (84%)</td>
<td>6.9</td>
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</table>

<table>
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<tr>
<th>PSYCHIATRY CONSULTATION</th>
<th>50% IMPROVED AFTER &gt; 10 WKS</th>
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<tbody>
<tr>
<td># REQ’D</td>
<td># W/ P/N</td>
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<tr>
<td>1 (2%)</td>
<td>29 (52%)</td>
</tr>
<tr>
<td>1 (4%)</td>
<td>11 (48%)</td>
</tr>
<tr>
<td>2 (22%)</td>
<td>7 (78%)</td>
</tr>
<tr>
<td>1 (5%)</td>
<td>8 (38%)</td>
</tr>
<tr>
<td>5 (5%)</td>
<td>55 (50%)</td>
</tr>
</tbody>
</table>
8. Business: Case Rates

- Do you have the clinical, information and financial systems and staff to support clinicians in *managing the risk embedded in case rates*?
9. Business: ACO-IHS Involvement

- Are you in conversation with local Integrated Health Systems and at the table of Accountable Care Organization development efforts in order to “pitch” the importance of MH/SUD services to improving quality and bending the cost curve and building a case for how you can help these organizations succeed in the new world of risk?

- Are you assessing the compatibility and capacity of your clinical workforce to operate in an environment where most consumers have Medicaid or Insurance and Health Plans and will be looking to contract with high-performing MH/SU Providers that can offer, in many cases, licensed professionals and certified peers that practice in an environment described by questions 1-6?

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Psychiatrist</th>
<th>Practitioner/Phys Asst</th>
<th>Registered Nurse</th>
<th>Masters Level</th>
<th>Bachelors Level</th>
<th>Peer Counselor</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency 1</td>
<td>0.0%</td>
<td>1.2%</td>
<td>0.0%</td>
<td>37.8%</td>
<td>61.0%</td>
<td>0.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Agency 2</td>
<td>3.9%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>85.0%</td>
<td>2.1%</td>
<td>9.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Agency 3</td>
<td>1.2%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>76.2%</td>
<td>16.9%</td>
<td>5.6%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Agency 4</td>
<td>3.5%</td>
<td>2.9%</td>
<td>3.5%</td>
<td>59.6%</td>
<td>21.4%</td>
<td>9.2%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Agency 5</td>
<td>2.9%</td>
<td>6.5%</td>
<td>0.0%</td>
<td>72.0%</td>
<td>10.5%</td>
<td>8.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Agency 6</td>
<td>1.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>56.1%</td>
<td>42.6%</td>
<td>0.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Agency 7</td>
<td>2.3%</td>
<td>3.3%</td>
<td>6.5%</td>
<td>39.1%</td>
<td>26.1%</td>
<td>22.8%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Average</td>
<td>2.7%</td>
<td>2.4%</td>
<td>2.4%</td>
<td>58.7%</td>
<td>25.1%</td>
<td>8.7%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
11. Business: Supporting Parity

Are you developing a Parity Monitoring and Compliance strategy to advocate for consumers affected by non-compliance with Parity?
12. Business: Enrollment Strategy

- Are you developing an enrollment strategy to assist your uninsured clients in obtaining access to Medicaid because they are under 133% of poverty or the Exchange because they are between 133% and 400% of poverty?
Many Wheels are Turning

- Uninsured
- Dis-Integration
- Fee for Service
- Uncoordinated Providers
- BH Disconnect with HC
- Insured
- Integration
- Payment Reform
- Accountable Care Orgs
- BH is Part of Health
Q&A...

• What can you tell me about your readiness to:
  1. Participate in Healthcare Homes
  2. Facilitate Rapid Access
  3. Match Need with Type and Level of Care
  4. Practice Stepped Care (Up and Down)
  5. Provide Care Management for High Cost Patients
  6. Measure Individual Improvement and Adjust Care
  7. Participate in P4P Bonus Arrangement
  8. Manage Under Case Rates
  9. Play in the ACO/IHS World
  10. Operate in an Expansion World, Contracting with Medicaid and Insurance
  11. Advocate for Consumers Affected by Non-Compliance with Parity
  12. Support Consumers in Obtaining Access to Medicaid and the Exchanges

• And what needs to be added to the list?