NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

Healthcare Payment Reform and the Behavioral Health Safety Net:

What's on the Horizon for the Community Behavioral Health System

FULL REPORT

APRIL 2009

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Prepared by
Dale A. Jarvis, CPA
MCPP Healthcare Consulting Inc.

This full report has been prepared under the auspices of the National Council for Community Behavioral Healthcare. Comments are welcomed and should be directed to the National Council offices at 1701 K Street NW, Suite 400 Washington, DC 20006-1526.www. TheNationalCouncil.org. Communications@thenationalcouncil.org. 202.684.7457.

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Overview

The American healthcare system is broken. It is too expensive, leaves tens of millions of Americans exposed to poor health outcomes and economic ruin, and has driven many healthcare providers from the field in search of less stressful work. At current rates, this troubled system will grow from 17 percent of the U.S. economy in 2009 to 21 percent by 2020, a doubling of costs from $2.5 to $5.2 trillion per year. Experts from across the political and economic spectrum agree that this trend will seriously damage the competitiveness of American businesses and prevent the federal and state governments from meeting other critical obligations.

The sheer magnitude of these challenges appears to be forging a coalition of consumers, public policy experts, healthcare providers, hospitals, and insurance companies that is getting closer each day to agreement on how to address the three key components of healthcare reform – universal coverage, payment system reform, and delivery system redesign. While it is not yet clear how universal coverage will unfold, there is a clear consensus about the methods for improving quality and containing costs – healthcare reform must include simultaneous reengineering of the payment and delivery systems.

Healthcare reform efforts are already underway in the public and private sectors. Testing of new methods for organizing and funding care in the areas of *chronic medical conditions and potentially avoidable complications* provides a window into how general healthcare reform will occur. Medical homes are being piloted to manage the health status of persons with chronic medical conditions, while bundled payment pilots are testing risk and reward arrangements for acute care episodes. Together, these types of efforts are leading to three fundamental system improvements – healthcare will become better coordinated; prevention, early intervention and disease management services will grow with a corresponding decline in secondary and tertiary care; and errors and overuse will be disincentivized by replacing fee for service payments with risk and reward financial arrangements.

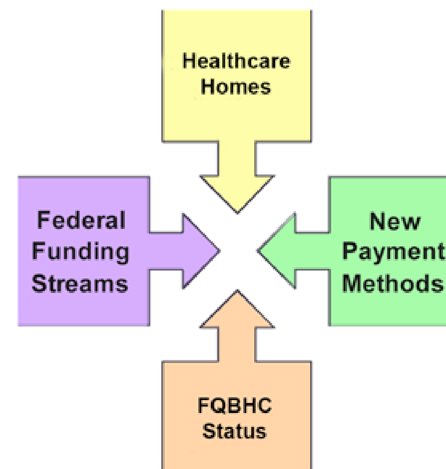
To-date, there has been very little healthcare reform design work focused on the needs of Americans with serious mental health and substance use disorders and the challenges faced by community behavioral healthcare organizations. A set of funding and structural problems have resulted in a public behavioral healthcare system that is lacking in essential payment and regulatory supports necessary for success – in many cases to a much greater degree than the general healthcare system. These topics, though seemingly mundane, take on real-world importance when one looks at the situations of the people involved. If you are a person living with serious mental illness, you are likely to die 25 years earlier than someone with similar

demographic characteristics but who does not have a serious mental disorder. This stunning disparity clearly indicates that, whatever the situation within the general healthcare system, even more extreme challenges confront the behavioral health safety net system and the people it is intended to serve.

The "new world" of healthcare will see the implementation of parity, universal coverage, and Medical Homes accountable for the total healthcare expenditures of their patients, with associated financial risks and rewards. When this happens, medical practices and health systems will quickly learn that there are certain populations critical to curtailing U.S. healthcare expenditures, such as the elderly with multiple medical conditions and persons with serious mental health and substance use disorders. These populations will be put under intense scrutiny, which will afford significant opportunities for addressing the current health disparities for persons with serious mental illness as well as opportunities and threats to the community behavioral healthcare delivery system. Centers that don't become part of the Medical Home structure and/or aren't able to demonstrate through measureable results that they are able to provide high quality specialty behavioral healthcare that manages the total healthcare expenditures of their clients will be at risk.

This paper has been written to explore these issues in order to bridge the current gap between efforts within the behavioral health community and those of general healthcare reformers. The paper then examines four behavioral health payment reform and delivery design changes that can help bring the behavioral healthcare community into alignment with general healthcare reform.

1. *Medical Homes* need to be re-envisioned as *Person-Centered Healthcare Homes* for persons with mental health and substance use disorders, with additional Federal funding and active participation of Community Behavioral Healthcare Organizations;
2. *Federal and State Payment Methods* must change to address the disincentives that hinder provision of the right care at the right time in the right place;
3. Federal designation should be created for *Federally Qualified Behavioral Healthcare Centers* (FQBHC) with accompanying benefits and responsibilities in order to shore up the behavioral health safety net delivery system; and
4. Dedicated *Federal Funding Streams* should be developed to support behavioral health workforce development and Federally Qualified Behavioral Healthcare Centers that will have additional responsibility to serve uninsured and underinsured persons with serious mental health and substance use disorders.



The paper concludes with the roles of key stakeholders in supporting reform efforts for persons with serious mental health and substance use disorders.

The ideas in this paper present one framework for creating behavioral health-specific solutions that fit with larger healthcare reform. Other perspectives and ideas will be critical as community behavioral healthcare stakeholders come together to assist Congressional leaders, the Administration, and health policy experts in addressing the needs of Americans with serious mental health and substance use disorders.

The American Healthcare System is Broken

We've all read the statistics, and they are chilling – 47 million Americans uninsured; 86.7 million uninsured at one point during the last two years; 18,000 unnecessary deaths each year due to lack of health insurance; U.S. infant mortality rate twice as high as those in Japan, Sweden, and Finland; U.S. ranks 37th among health systems in the world – the list of headlines goes on, but the story is clear. The American healthcare system is broken.

As the table below makes clear and more recent studies reinforce, the U.S. healthcare system is the most expensive in the world, yet it is the worst performing and least equitable of any wealthy nation.

Health Care System Indicators and Rankings in Selected High-Income OECD Countries, 1997-1999

Indicator	Health Spending % of GDP 1998	Infant Mortality Rate 1998	Fairness of Financial Contributions 1997	Responsiveness of Health System 1997	Health System Overall Performance
Country	(Percent)	(Rate)	(Rank)	(Rank)	(Rank)
United States	13.6	7.2	54	1	37
Australia	8.5	5.2	27	12	32
Canada	9.5	5.2	18	7	30
Denmark	8.3	5.2	4	4	34
Finland	6.9	3.9	10	19	31
France	9.6	4.6	27	17	1
Germany	10.6	4.9	7	5	25
Italy	8.4	6.1	23	22	2
Japan	7.6	4	9	6	10
Luxemburg	5.9	5.1	2	3	16
Norway	8.9	4	11	8	11
Sweden	8.4	3.5	14	10	23
Switzerland	10.4	4.7	39	2	20
UK	6.7	5.9	8	26	18
Source	OECD	US Census	WHO	WHO	WHO

Figure 1: Health Indicators and Rankings[i]
WHO = World Health Organization OECD = Organization for Economic Cooperation and Development; Red shading = lowest rank/score;

A brief look at what some of the leading healthcare policy experts have concluded provides additional discouragement.

"The American healthcare system is a dysfunctional mess." (Ezekiel Emanuel, MD, Chair of the Department of Bioethics at the Clinical Center of the National Institutes of Health)[2]

"…the major shortcomings of American healthcare are the result of deep and irreparable flaws in the way the country finances, organizes and delivers care." (Victor Fuchs, Stanford University Professor of Economics and of Health Research and Policy, emeritus)[3]

"In many ways, the nation's current healthcare payment system blocks, rather than supports, the nation's health goals: The system does not effectively reward wellness or high quality. The system does not encourage societal benefit such as access to care. And the system creates financial instability by adding cost and complexity to health administration, by rewarding high-cost practices, and by focusing on expensive sickness-focused interventions rather than wellness." (Healthcare Financial Management Association)[4]

This situation has led to broad support for overhauling the healthcare system. However, the current consensus about the need for change is as powerful as the failed history of reform efforts by Presidents Roosevelt, Truman, and Clinton. One major difference in the current environment is the recognition that maintaining the status quo is economically unsustainable, if not morally unacceptable.

The consequences if reform efforts fail were recently quantified by The Lewin Group, a healthcare policy research and management consulting firm. At current growth rates, healthcare costs will increase from $2.5 trillion in 2009 to $5.2 trillion by 2020.[5]

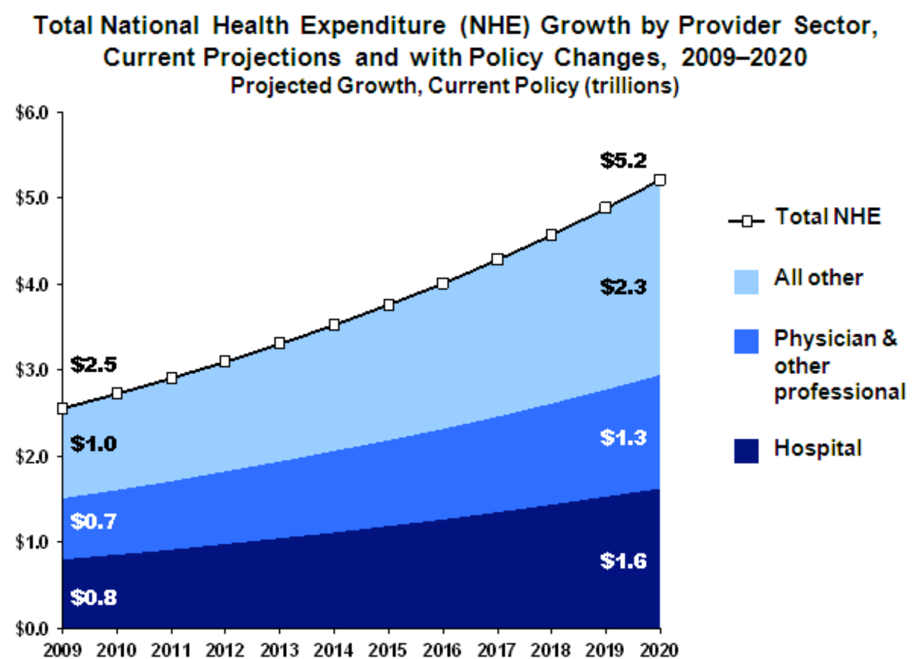


Figure 2: Projected Change in National Health Expenditures[6]

Figure 2 separates the total National Health Expenditure into three bands – hospital costs, clinician costs, and all other health expenditures. The growth from $2.5 trillion to $5.2 trillion means that health expenditures will grow from 16.9 percent of the U.S. economy to 20.8 percent between 2009 and 2020, with similar rates of increase in each band

Experts from across the political and economic spectrum agree that this trend will seriously damage the competitiveness of American businesses and prevent the federal and state governments from meeting other obligations including education, social services, public safety, economic development, and transportation.

Consensus is Building about the Design for Healthcare Reform

General agreement exists about the contours of U.S. healthcare reform, with consensus that reform must address three issues: universal coverage, payment system reform, and delivery system redesign.

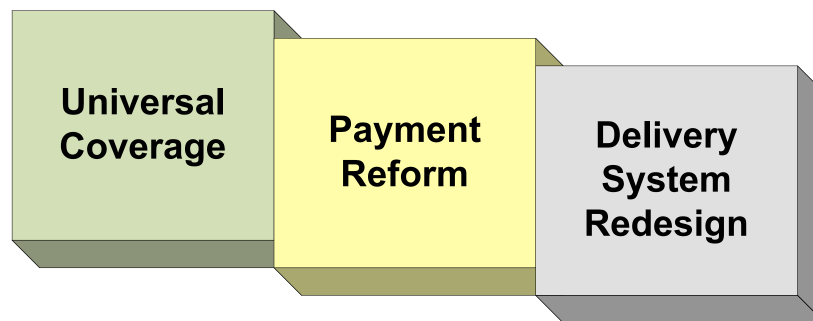


Figure 3: Components of Healthcare Reform

Universal Coverage

According to the Institute of Medicine, 18,000 Americans die prematurely each year because their lack of insurance prevents them from getting necessary healthcare interventions in time.[7] Earlier treatment and more effective management of chronic medical conditions through the availability of affordable coverage for all Americans, combined with comprehensive benefits, access to services, and a re-engineered delivery system, could eliminate these premature deaths.

Although universal coverage will increase the use of healthcare services, The Lewin Group has estimated that expanding coverage to 99 percent of Americans will result in a ***net savings of $94 billion*** between 2010 and 2020[8] due to addressing health conditions earlier and more effectively. Although general agreement exists about the need for universal coverage, several different approaches are being actively debated, which makes the outcome difficult to predict.

Payment System Reform and Delivery System Redesign

There is a clear consensus that health reforms efforts in the United States will not succeed unless quality is improved and costs are contained. Recent information coming out of the three-year old Massachusetts universal coverage experiment reinforces this concern. Although the state succeeded in implementing universal coverage, cost containment measures were deferred to a future policy-making cycle. As a result, growth in health spending per person continues at an unsustainable rate, much faster than that in the rest of the country.[9]

There is also an emerging consensus about the methods for improving quality and containing costs – healthcare reform must include simultaneous reengineering of the payment and delivery systems. In February 2009, The Commonwealth Fund released a report that includes many of the methods currently under discussion in Washington, D.C. ***The Path to a High Performance U.S. Health System – A 2020 Vision of the Policies to Pave the Way*** contains a set of strategies encompassing the three components listed above that can achieve 99 percent coverage by 2012 and reduce the growth in national health spending between 2009 and 2020 by $3 trillion. Figure 4 illustrates the projected trend lines with and without reform.

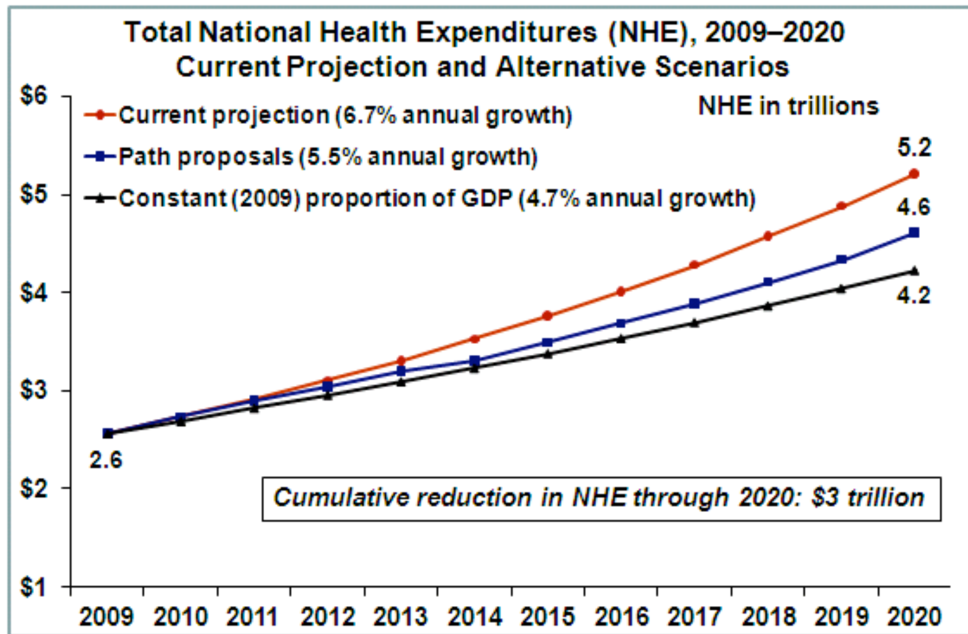


Figure 4: National Health Expenditure Trend Lines[10]

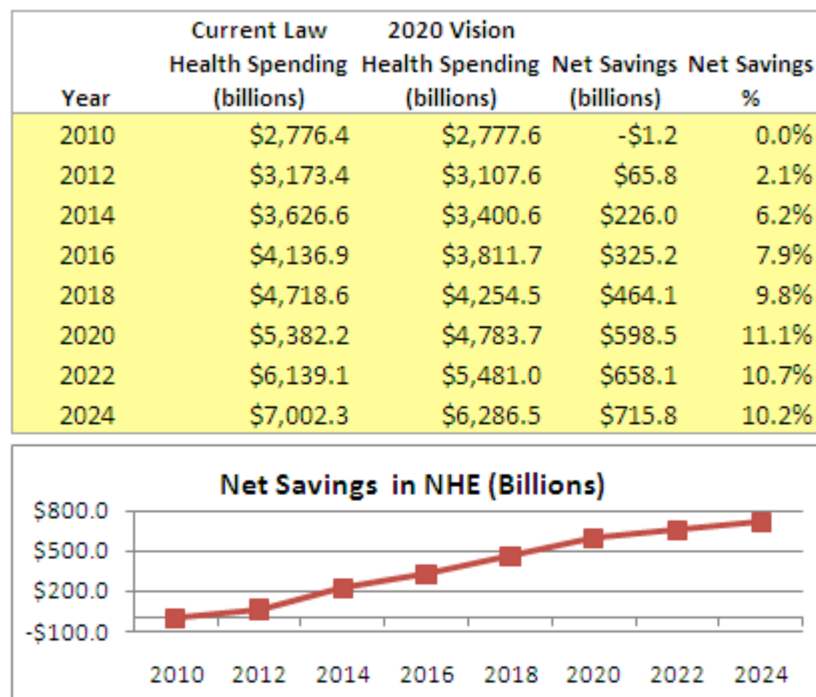
Major Sources of Savings Compared with Projected Spending, Net Cumulative Reduction of National Health Expenditures, 2010–2020

Affordable Coverage for All: Ensuring Access and Providing System Reform Foundation	
• Net costs of insurance expansion	–$94 billion
• Reduced administrative costs	–$337 billion
Payment Reform: Aligning Incentives to Enhance Value	
• Enhancing payment for primary care	–$71 billion
• Encouraging adoption of the medical home model	–$175 billion
• Bundled payment for acute care episodes	–$301 billion
• Correcting price signals	–$464 billion
Improving Quality and Health Outcomes: Investing in Infrastructure and Public Health Policies to Aim Higher	
• Accelerating the spread and use of HIT	–$261 billion
• Center for Comparative Effectiveness	–$634 billion
• Reducing tobacco use	–$255 billion
• Reducing obesity	–$406 billion
Total Net Impact on National Health Expenditures, 2010–2020	–$2,998 billion

Figure 5: Components of Commonwealth Fund Proposal Savings[11]

The Commonwealth Fund, with analytical support from The Lewin Group, has identified ten healthcare reform policies and quantified their effect on reducing the growth in healthcare spending.

The plan described in the ***2020 Vision Path*** is ambitious, but not unrealistic, and the rewards are significant, reducing the growth in national health spending between 2009 and 2020 by $3 trillion. Even more important, the savings are modest in early years, growing over time. If implemented in 2009, net savings in National Health Expenditures is projected to be $66 billion in 2012, growing to $716 billion by 2024.



Year	Current Law Health Spending (billions)	2020 Vision Health Spending (billions)	Net Savings (billions)	Net Savings %
2010	$2,776.4	$2,777.6	-$1.2	0.0%
2012	$3,173.4	$3,107.6	$65.8	2.1%
2014	$3,626.6	$3,400.6	$226.0	6.2%
2016	$4,136.9	$3,811.7	$325.2	7.9%
2018	$4,718.6	$4,254.5	$464.1	9.8%
2020	$5,382.2	$4,783.7	$598.5	11.1%
2022	$6,139.1	$5,481.0	$658.1	10.7%
2024	$7,002.3	$6,286.5	$715.8	10.2%

Figure 6: Change in National Health Expenditures under the 2020 Vision Path[12]

All of the healthcare reform plans under consideration by Congress and the Obama Administration move toward universal coverage and leverage payment system reforms and delivery system changes to improve quality and contain cost.

Healthcare Reform is Already Underway

Despite all of the different agendas and proposals, it is clear that one of three healthcare reform scenarios is likely to occur by the end of 2010.

- True reform, similar to the program being put forward by The Commonwealth Fund will occur;
- The reform process will be diluted and Congress will pass a less-than-robust reform plan; or
- The current recession and political headwinds will create a stalemate in Congress and no reform legislation.

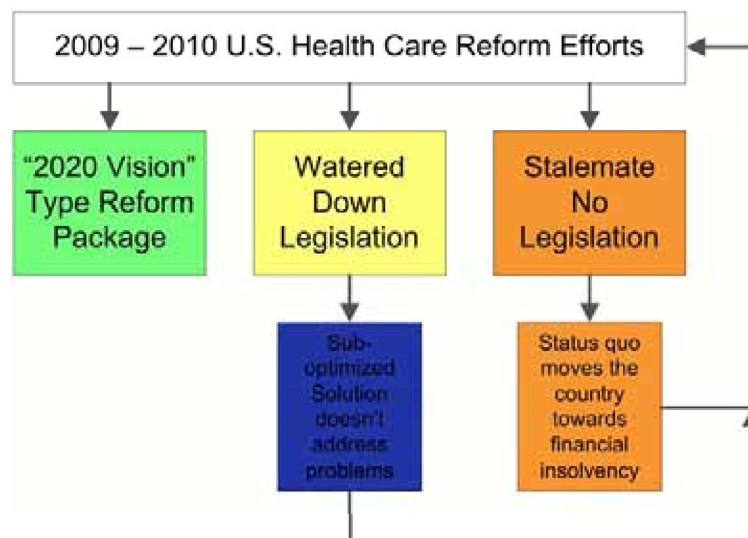


Figure 7: 2009-2010 Reform Scenarios

Because of the weight of the economic pressures, genuine reform efforts will need to be revisited if either of the second two scenarios unfolds.

While these political and legislative wheels turn, cost and quality issues are already being addressed through a series of public and private reform pilots. Two areas of experimentation provide a window into how payment reform and delivery system redesign are likely to unfold in the United States – initiatives to manage **chronic medical conditions and pilots to reduce potentially avoidable complications** (PACs).

Chronic Medical Conditions and the Medical Home

Currently, 45 percent of Americans have one or more chronic conditions such as diabetes, hypertension, arthritis, depression, or dementia. Half of this group has two or more chronic conditions. Over half of the people with serious chronic conditions – almost one quarter of the people in the United States – are receiving care from three or more physicians.[13] This scattering of care can result in duplicate tests, conflicting medical advice, and prescriptions for contraindicated mediations. All of these factors help to explain why treatment of chronic disorders accounts for three-quarters of direct medical care costs in the United States.[14]

The Lewin Group has estimated that the United States could save more than half a trillion dollars over ten years through various improvements to the treatment of chronic conditions and the adoption of the medical home. An estimated $418 billion could be saved on chronic care management through implementation of a *Center for Comparative Effectiveness* and increased adherence to published guidelines for patients in disease management programs from the current rate of 55.9 percent to 90 percent by 2019.[15] An additional $175 billion could be saved by encouraging the adoption of the medical home model as noted in Figure 5.

In recent years the Patient-Centered Medical Home has emerged as the leading model for treating chronic medical conditions in primary care settings. In 2007 the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association released the following Joint Principles of the Patient-Centered Medical Home:

- Each patient has an ongoing relationship with a personal physician,
- The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients,
- The personal physician is responsible for providing for all of the patient's healthcare needs or appropriately arranging care with other qualified professionals,
- Care is coordinated and/or integrated across all elements of the healthcare system,
- Quality and safety are hallmarks,
- Enhanced access to care is available, and
- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home.[16]

Federally Qualified Health Centers (FQHCs) have a long history of following many principles of a medical home, with significant measurable results related to chronic medical conditions. Several studies have found that health centers save the Medicaid program more than 30 percent in annual spending per beneficiary due to reduced specialty care referrals and

fewer hospital admissions.[17] Having benefited from financing arrangements to support costs not covered by typical fee for service payment arrangements, FQHCs can be considered a large scale pilot in the use of Medical Homes to manage chronic conditions.

Other segments of the Medicaid system have experienced improved health outcomes and cost savings through **Primary Care Case Management** (PCCM) programs. These programs use primary care physicians to coordinate care and manage total healthcare expenditures. Studies of these programs have shown cost savings up to 10 percent per year after the initial ramp up period.[18]

A number of **Medical Home**-related clinical and financial designs and Medicare pilots are being explored, and the concept will gain further traction with or without Congressional legislation. In all of the designs there is an acknowledgement that continuing a **fee for service** payment mechanism does not support the costs associated with the Joint Principles listed above and reverses the financial incentives. Two payment models in The Commonwealth Fund's 2020 Vision report are representative of efforts to correct these problems.

The first of these models involves **Mixed Case Rate and Fee-for-Service** (FFS). In this system, certified practices would receive a per patient per-month Medical Home fee in addition to all currently covered FFS payments. The amount of the Medical Home fee would vary depending on the illness severity of the enrolled patient, but would average $8.00 per member per-month.

In the other model, a **Primary Care Medical Home** would be advanced. Under this payment structure, certified practices would receive a risk-adjusted per-patient global fee per-month to cover all primary care services (not including labs, radiology, pharmacy, vaccines, etc.). This fee would initially be set at the expected risk-adjusted average payment for primary care services, taking into account geographic differences in the prices of practice inputs.[19]

Potentially Avoidable Complications (PACs)

Overlapping the discussion of chronic condition management and medical homes is the concept of potentially avoidable complications (PACs). PACs can be defined as medical conditions resulting from improper diagnosis, medication errors, patient confusion about self-care, poor communication between providers at hand-offs, the absence of hand-offs, inpatient adverse events, and other related activities. Obviously such items present rich territory for improving quality, containing cost, and revamping the delivery of care.

Researchers examining healthcare expenditures for specific conditions have begun to sort the costs for an increasing number of conditions into "typical claims" and "PAC-related claims" in order to understand how much money is being spent on each. Figure 8 illustrates this process for knee replacement surgery. The surgery itself and the lab tests represent typical claims; the care for wound infection and pneumonia represent the PAC claims.

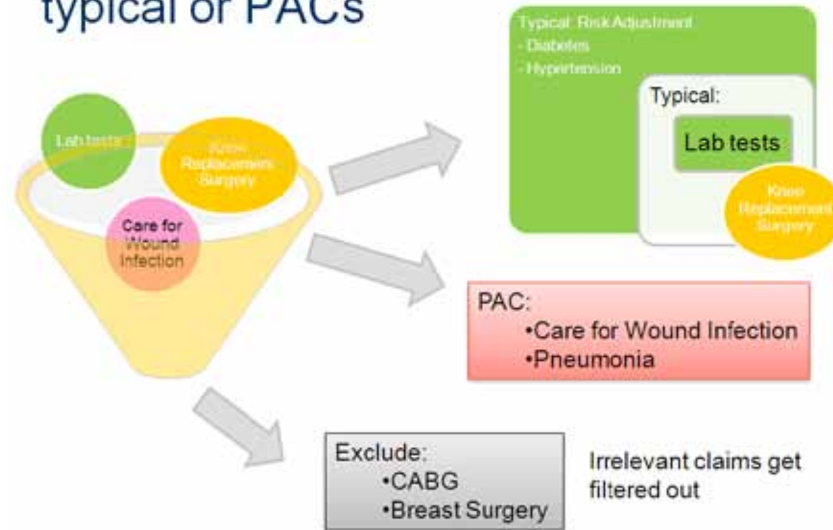


Figure 8: Cost Components of Knee Replacement Surgery[20]
(Note: CABG = coronary artery bypass graft)

The Robert Wood Johnson Foundation and Commonwealth Fund have been funding research to understand these phenomena and develop an approach to payment reform called **Evidence-informed Case Rates** (ECRs). Based on an evaluation of the eleven conditions analyzed to-date,[a] errors (PACs) consume an average of 25 cents on every acute care or procedural dollar and an average of over 60 cents on every dollar of chronic care conditions.[21] This sorting, which covers look-back and look forward time windows, is handled differently for acute and chronic conditions, as described in Figure 9.

Type of ECR	Trigger	Time Window	Examples
Chronic Medical	Outpatient Professional	One year from trigger	Diabetes, CHF, COPD, Asthma, CAD, HTN
Acute Medical	Inpatient Facility	3-day look-back; 30-day look-forward	AMI, Pneumonia
Inpatient Procedural	Inpatient Facility	30-day look-back; 180-day look-forward	Hip Replacement, CABG, Bariatric Surgery
Outpatient Procedural	Outpatient Facility/ Professional	30-day look-back; 180-day look-forward	Angioplasty, Lap Cholecystectomy, Hernia Surgery

Figure 9: PAC Window Framework[22]
(Note: ECR = Evidence-informed Case Rate; see footnote for explanation of the medical condition acronyms)

[a] The eleven conditions studied include diabetes, acute myocardial infarction (AMI), congestive heart failure (CHF), hip replacement, knee replacement, chronic obstructive pulmonary disease (COPD), asthma, coronary artery disease (CAD), hypertension (HTN), bariatric surgery, and coronary artery bypass graft (CABG).

Several items of the $3 trillion potential cost savings discussed above relate to addressing this issue, including "bundled payment for acute care episodes" ($301 billion savings). Under a bundled payment arrangement such as Evidence-informed Case Rates, a single payment is made for the entire time window, covering all the providers and facilities involved in the ECR. Mechanisms are put in place to allocate payments to providers and institutions for "typical" services and manage incentives and penalties related to PACs.

Currently, a number of private health plans and the Centers for Medicare and Medicaid Services are piloting initiatives that include financial incentives and penalties related to PACs. Most notably is the CMS policy to refuse payment for "never events."

CMS is currently not paying for several hospital-based conditions:

1. Catheter associated urinary tract infection
2. Pressure ulcer
3. Object inadvertently left in after surgery
4. Air embolism
5. Blood incompatibility
6. Selected surgical site infections
7. Hospital acquired injuries
8. Vascular catheter associated infection
9. Blood glucose levels in certain surgical patients
10. Deep vein thrombosis/pulmonary embolism

This list constitutes only CMS' FY2009 "Never Events," which also includes the stipulation that more may be added next year.[23]

Architecture of a Redesigned Payment and Service Delivery System

The approaches to better treatment of *chronic medical conditions and reducing potentially avoidable complications,* while not the only reform efforts currently underway, serve to illustrate how healthcare reform will likely unfold. These and other reform efforts are in the process of reversing the current perverse incentives at the core of the U.S. healthcare system's payment and delivery methods, which effectively promote more care rather than better care.

> *"In many ways, the nation's current healthcare payment system blocks, rather than supports, the nation's health goals: The system does not effectively reward wellness or high quality. The system does not encourage societal benefit such as access to care. And the system creates financial instability by adding cost and complexity to health administration, by rewarding high-cost practices, and by focusing on expensive sickness-focused interventions rather than wellness." (Healthcare Financial Management Association)* [24]

Nation's Health Goals	Wellness	High-quality care	Access to care and other societal benefits	Stable health system
Payment System Barriers	Minimal incentive for prevention	Minimal incentive for quality and coordination	Limited payment for charity care/ bad debt or other community benefits	Limited incentives for efficiency; payment complexity adds expense

Figure 10: HFMA - Current Payment System Barriers

Because improving the health status of Americans and improving quality are inextricably linked to reducing costs, **payment models are moving toward payment for outcomes,** most notably reduced complication rates and lower total healthcare expenditures. The overall strategy is to **promote Centers of Excellence in preventive, primary, specialty, and tertiary care**. Figure 11 provides an overview of how these reforms efforts may affect the delivery system.

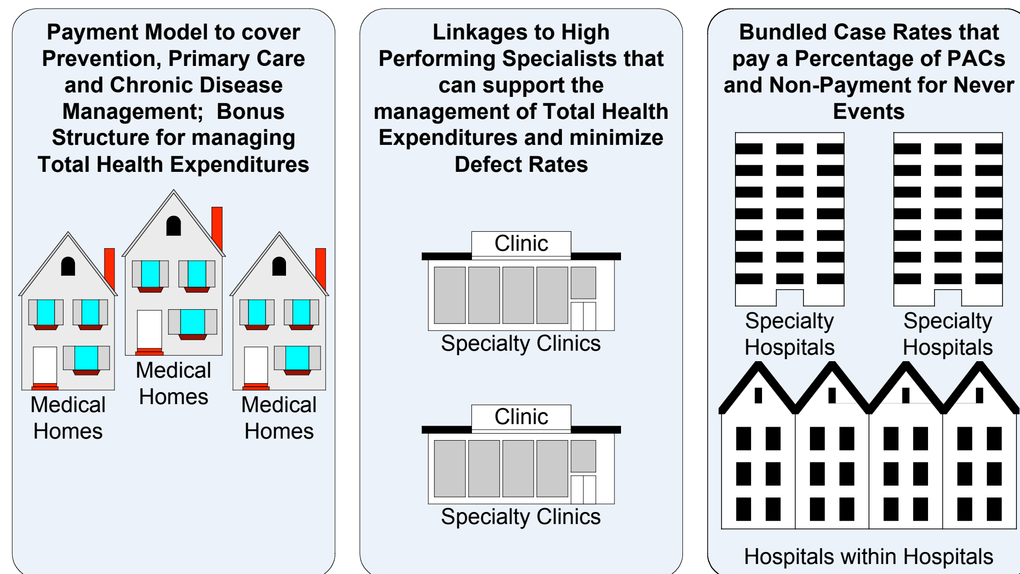


Figure 11: Emerging Service Delivery System

Financial incentives and disincentives are being structured into payment mechanisms to increase preventive care, improve the coordination of care, create interdependency within the delivery system, and reduce error rates. Strategies include:

- **Disease Management:** Increasing the quality and quantity of contact between patients with chronic medical conditions and the staff in medical homes by paying for additional staff and longer visits and providing bonuses for practices that lower total healthcare expenditures for the patients of the practice.

- **Clinical Guidelines:** Continuing research through the *Center for Comparative Effectiveness* and expanding the use of Published Clinical Guidelines in all settings to improve care and reduce errors by tying what may be a significant portion of provider payments to management of PACs and total healthcare expenditures.
- **Hospital Incentives:** Incentivizing hospitals to select high performing specialists/surgeons with demonstrated track records through bundled payments that cover the cost of hospital care, specialist fees, and post discharge care, placing the parties at risk for a portion of the avoidable complications costs. This approach creates disincentives for hospitals to perform low volume, high complexity procedures that could result in medical errors. As a result, hospitals will be *forced* to become centers of excellence by creating "hospitals within hospitals" or develop specialty hospitals, both of which focus on groups of related conditions (e.g. orthopedic, cardiology, cancer).
- **Primary Care Incentives:** Incentivizing primary care practices that are medical homes to refer to high performing specialists and hospitals by tying bonuses to the total healthcare expenditures of the practice's patient population.
- **Prevention and Early Intervention:** Initiatives and incentives are put in place to prevent illness, expand immunizations, reduce obesity and decrease tobacco use and promote healthy lifestyles. This will include physician incentives, direct payments to patients, and grants for targeted programs such as obesity prevention.

Clinician specialists that are not able to fit into the new framework will see their reimbursement rates decline and, in the case of potentially avoidable complications, not be paid for care provided above certain error rates. **Primary care providers** that do not focus on managing their patients' chronic medical conditions may be similarly affected.

Additional Design Considerations

A number of health policy experts question how well and how quickly members of the healthcare delivery system community will be able to succeed at improving quality and reducing costs. These are valid concerns that will need to be addressed by providers and policymakers. In addition to the topics addressed above, there are four additional ideas emerging as central players associated with healthcare reform.

Integrated Healthcare Systems: A model already exists that aligns the healthcare reform policy goals – integrated healthcare systems such as Kaiser Permanente, Group Health Cooperative, Intermountain Healthcare, and Geisinger Health Systems. These organizations, which are a combination of an insurance company and staff model integrated delivery system, receive fixed fee payments from private and government payors to provide all of the care necessary to meet the needs of enrolled populations. Engineering elaborate incentive and disincentive mechanisms to promote coordination and reduce error rates is unnecessary. Indeed, clinical practices within these systems are being used by health reformers as models. A number of policy experts predict that the United States will see a substantial increase in market

share among these types of organizations and a corresponding decrease in use of insurance companies not connected to a delivery system.

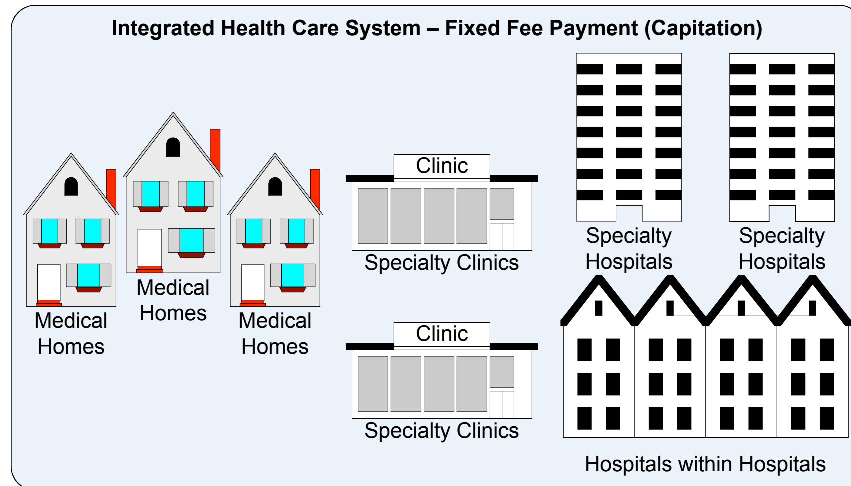


Figure 12: Integrated Service Delivery System

Report Cards: Performance Measurement in the form of web-based Report Cards will become the norm and will be used by patients, employers, and primary care providers to direct care choices. The Integrated Healthcare Association in California is recognized as a model in this effort. Started in 2002, the IHA supports a pay for performance program for six major private health plans that cover 7 million enrollees, 215 medical groups and 45,000 physicians. The clinics are evaluated on a set of agreed-upon performance measures such as the rates of childhood immunizations and breast cancer screening. All results are put up on the web and easily searchable. These data become the basis for substantial bonuses to well performing medical practices. Figure 13 is a snapshot of clinic breast cancer screening performance in Los Angeles in 2005.

Breast Cancer Screening (Los Angeles)

Physician Group	Clinical Results
La Salle Medical Associates, Inc.	70%
Alliance Pioneer Medical Group	68%
Associated Hispanic Physicians of Southern CA	61%
AltaMed Medical Group	60%
West Covina Medical Clinic	59%
Access Managed Care/Access Medical Group	58%
Doctors Medical Group West Covina IPA	57%
New Horizon Medical Group	56%
Eastland Medical Group, Inc.	53%

Figure 13: Integrated Health Association Physician Ratings (“Report Card”) Example

Healthcare Information Technology (HIT): It will be virtually impossible to achieve the type of coordination of care and reduction in error rates envisioned by policy experts without significant deployment of electronic health records that are interconnected through Health Information Networks (HINs). Clinicians, wherever they are located, need to have access to prescribing records, laboratory results, diagnostic imaging, and patient alerts to inform treatment decisions and prevent errors. Web-based clinical guidelines, long touted as being just around the corner, will become common for supporting clinician decision-making. Whatcom County in Northwest Washington is now considered the most "wired" healthcare community in the United States. Nearly every provider and facility in the county is connected through their Health Information Network, a significant number of county residents have Personal Health Records, and a pilot is about to examine providing laptops in ambulances and EMTs with handheld PDAs wired into the Health Information Network.

Medical "Home Runs:" There is a great deal of skepticism about the ability of primary care physicians to successfully transform their practices into medical homes. Arnold Milstein, the Medical Director of the Pacific Business Group on Health, recently published an article in Health Affairs on his quest to find medical homes that were "medical home runs" – clinics with average or above average quality scores and total healthcare expenditures for their patients that were 15 percent to 20 percent less on a risk adjusted basis than regional peers. Studying four clinics that met these criteria, Milstein identified two key features common to the practices – "personal zealotry in preventing urgent and emergent hospitalization for chronic illnesses; and equally zealous concentration of referral care with high-quality medical specialists who are sparing in their use of 'supply-sensitive services,' as defined in the Dartmouth Atlas."[25] Milstein found that the clinics considered themselves hospitalization prevention organizations for patients with chronic medical conditions, accomplishing this by having at last one primary care team member demonstrating to each patient that "protection of your health matters to me personally" and backing it up with action. He also discovered that the clinics used available physician report cards to identify specialists with high quality and lower total cost of care ratings and develop strong referral arrangements with those specialists.

Healthcare quality and cost are tricky issues and the above four ideas/challenges will need to be addressed to craft a redesigned payment and service delivery system. While research of these topics will be critical, the economic imperatives of the situation are such that progress will likely need to come before each component can be conclusively analyzed. Payment and design issues in the general healthcare system provide important direction-setting guidance to the behavioral health community.

The Challenge for Persons with Serious Mental Health and Substance Use Disorders

To-date, there has been very little healthcare reform design work focused on the needs of Americans with serious mental health and substance use disorders and the challenges faced by Community Behavioral Healthcare Organizations. The many issues specific to the Community Behavioral Healthcare system will not automatically be resolved if general healthcare reform is enacted. As it sits, behavioral healthcare operates as a system within, beside, beneath, and, at times, totally separate from the broader healthcare arena.

In late 2006 the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council released the landmark Morbidity and Mortality Report. That report pointed out that people living with serious mental illnesses are dying 25 years earlier than the rest of the population. This disparity in mortality is found to be due, in large part, to unmanaged physical health conditions "caused by modifiable risk factors such as smoking, obesity, substance abuse, and inadequate access to medical care."[26]

The report observes that lack of access to primary care services and lack of focus on unmanaged physical health conditions in community mental health centers are two major barriers to addressing the disparity in the morbidity and mortality of persons with serious mental illness (SMI). These statistics suggest that persons with SMI may be the population with the greatest health disparity in the United States.

The underlying causes of the health disparity for persons with serious mental illness have many similarities with the problems experienced by the general healthcare system and addressed in the 2001 Institute of Medicine (IOM) report, ***Crossing the Quality Chasm: A New Health System for the 21st Century***. In that report the IOM described the components of an effective healthcare system, including the need to have a supportive payment and regulatory environment that supports provider organizations in developing and maintaining high performing patient-centered teams that can assist individuals in achieving optimal health. Figure 14 illustrates this framework.

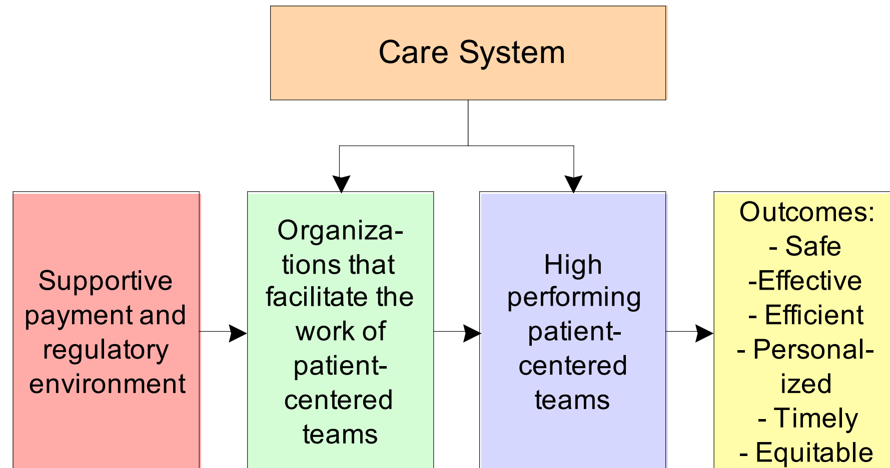


Figure 14: Components of an Effective Care System

Several issues that have been faced by Community Behavioral Healthcare Organizations for decades run counter to the foundation of the IOM's identified components of an effective care system – creating a supportive payment and regulatory environment.

In order to ensure that the needs of persons with serious mental health and substance use disorders are *properly addressed* in the larger healthcare redesign process, additional consideration must be given to the challenges confronting the *specialists* that have been serving this population – the Community Behavioral Healthcare System. This means understanding and addressing the following issues.

- **Funding Shortages:** Historically mental health and substance use treatment has been significantly underfunded throughout the country. At the same time, the portion of this population served by the public sector is among the most complex and highest need of any group of Americans. Unlike the general healthcare system, whose costs need to be contained and in some cases lowered, behavioral health systems in most states are not able to meet basic needs within existing resource levels.

- **Fragmentation:** The de-federalization of community mental health in 1981 resulted in an extremely complicated, 50 states/50 sets of rules regulatory environment. In a number of states that have regionalized the management of their mental health systems, different payment models, authorization processes, care models, and utilization management processes create additional levels of complexity. For example, in Washington, Oregon, and California alone, there are 80 regional mental health authorities.

- Fee for Service: Community Behavioral Healthcare reimbursement in many systems is based on the same types of fee for service models that create strong financial incentives to deliver more services but often financially penalize provider organizations for providing better services and improving health.

- **Fixed Fee Payments:** In communities where grants and capitation models are used to fund Community Behavioral Healthcare Organizations, these payment models are

based on historical underfunding of services that put providers at financial risk by providing insufficient funds to cover the cost of services rendered and place consumers at health and safety risk by not adequately funding needed behavioral health services and supports.

- **Medicaid-Only Systems:** There has been a twenty year trajectory of turning state behavioral health systems into Medicaid-Only Programs in order to leverage the federal match dollars. This has resulted in the disenfranchisement of many hundreds of thousands of persons with serious mental health and substance use disorders and created a two-class system. Medicaid eligible individuals have also suffered from this problem because of the frequency that they move on and off the eligibility rolls.
- **SMI/SED System Designs:** Most states have designed authorization criteria that restrict services to adults with serious mental illness (SMI) and youth with serious emotional disturbances (SED). These decisions have been followed by Medicaid actuarial studies that base Medicaid capitation rates on services to this high need population only. This has resulted in the inability of Medicaid enrollees and uninsured persons with low to moderate need to obtain services, even if those services would reduce their total healthcare expenditures.

These funding and structural problems have created a Community Behavioral Healthcare system that is lacking in essential payment and regulatory supports necessary for success – in many cases to a much greater degree than the general healthcare system. At the same time, a great deal of work is taking place inside the behavioral health community to develop and pilot service delivery designs that address prevention, disease management, expansion of evidence-based practices, outcomes and performance measurement, and care coordination – concepts at the core of general healthcare reform. These challenges and strengths form the basis of behavioral health payment and delivery system reform.

Behavioral Health Payment and Delivery System Reform

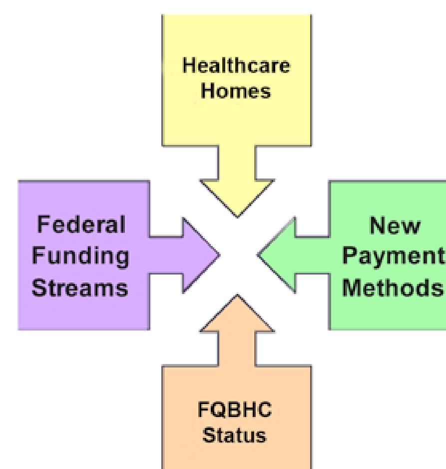
This portion of the paper attempts to bridge the gap between efforts within the behavioral health community and those of general healthcare reformers, with a focus on behavioral health payment reform and delivery design changes that align with general healthcare reform.

The "new world" of healthcare will see the implementation of parity, universal coverage, and Medical Homes accountable for the total healthcare expenditures of their patients, with associated financial risks and rewards. When this happens, medical practices and health systems will quickly learn that there are certain populations critical to curtailing U.S. healthcare expenditures, such as the elderly with multiple medical conditions and persons with serious mental health and substance use disorders. These populations will be put under intense scrutiny, which will afford significant opportunities for addressing the current health disparities for persons with serious mental illness as well as opportunities and threats to the community behavioral healthcare delivery system.

Community Behavioral Health Centers that don't become part of the Medical Home structure and/or aren't able to demonstrate through measureable results that they are able to provide high quality specialty behavioral healthcare that manages the total healthcare expenditures of their clients will be at risk.

The following four initiatives offer great opportunities for improving the lives of Americans with serious mental health and substance use disorders. As reform of the overall healthcare system unfolds, these initiatives can also become key strategies for addressing the challenges faced by Community Behavioral Healthcare Organizations.

1. *Medical Homes* need to be re-envisioned as *Person-Centered Healthcare Homes* for persons with mental health and substance use disorders, with additional Federal funding and active participation of Community Behavioral Healthcare Organizations;
2. *Federal and State Payment Methods* must change to address the disincentives that hinder provision of the right care at the right time in the right place;



3. Federal designation should be created for *Federally Qualified Behavioral Healthcare Centers* (FQBHC) with the accompanying benefits and responsibilities in order to shore up the behavioral health safety net delivery system; and

4. Dedicated *Federal Funding Streams* should be developed to support behavioral health workforce development and Federally Qualified Behavioral Healthcare Centers that will have additional responsibility to serve uninsured and underinsured persons with serious mental health and substance use disorders.

These recommendations, if rolled out as a package, have the potential to make the community behavioral healthcare system an integral and effective part of a reformed healthcare system in a way that meets the needs of persons with serious mental health and substance use disorders.

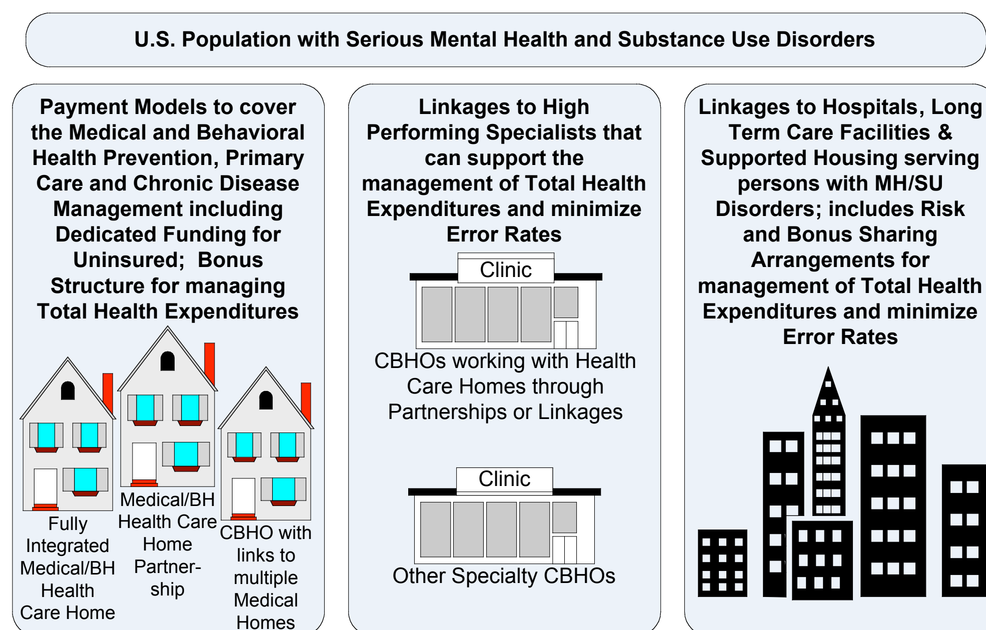


Figure 15: Conceptual Framework for Behavioral Health Reform

Community Behavioral Healthcare Organizations (CBHOs) have two important roles in a reformed healthcare environment that addresses the needs of persons with serious mental health and substance use disorders:

- Serving as an integral part of Medical Homes and
- Providing Specialty Behavioral Healthcare Services.

The ideal funding and care delivery model for a reformed behavioral healthcare system is relatively straightforward, matching a number of general healthcare payment reform concepts. CBHOs would be paid case rates for the prevention, education and care management services that don't lend themselves to fee for service payment mechanisms, and sufficient funding would be available to support the continuum of specialty clinical services needed by this population. CBHOs would also have linkages to other parts of the service delivery system to ensure proper

coordination of care for behavioral health consumers and, in some cases, would participate in risk and bonus sharing arrangements tied to the total healthcare expenditures of the population they are serving.

1. Person-Centered Healthcare Homes and Community Behavioral Healthcare Organizations

Recently the National Council for Community Behavioral Healthcare (National Council) released a report, *Behavioral Health /Primary Care Integration and The Person-Centered Healthcare Home*, which addresses the gap between current Medical Home designs and the needs of persons with serious mental health and substance use disorders. This report presents a three-option blueprint for how CBHOs can come into alignment with healthcare reforms under consideration. The report "emphasizes the need for a bi-directional approach, addressing the integration of primary care services in behavioral health settings as well as the need for behavioral health services in primary care settings."

Using the National Council's Four Quadrant Model, which is summerized in Figure 16, the report articulates the different needs of population subsets. Each quadrant considers the behavioral health and physical health risk and complexity of the population and suggests the healthcare home model that may be more appropriate.

Quadrant II	Quadrant IV
The Population: Moderate to high behavioral health and low to moderate physical health complexity/risk. **The Model:** Person Centered Healthcare Home: primary care capacity in a behavioral health setting, including medical nurse practitioner/primary care physician, wellness programming, screening for health status concerns, and stepped care to a full-scope healthcare home. Access to the array of specialty behavioral health services designed to support recovery.	**The Population:** Moderate to high behavioral health and moderate to high physical health complexity/ risk. **The Model:** Person Centered Healthcare Home: primary care capacity in a behavioral health setting, including medical nurse practitioner/primary care physician, nurse care manager, wellness programming, screening/tracking for health status concerns, and stepped care to a full-scope healthcare home. Access to the array of specialty behavioral health.
Quadrant I	**Quadrant III**
The Population: Low to moderate behavioral health and low to moderate physical health complexity/risk. **The Model:** Person Centered Healthcare Home: a primary care team that includes a behavioral health consultant/care manager, psychiatric consultant, screening for behavioral health concerns, and stepped care.	**The Population:** Low to moderate behavioral health and moderate to high physical health complexity/ risk. **The Model:** Person Centered Healthcare Home: a primary care team that includes a behavioral health consultant/care manager, psychiatric consultant, screening for behavioral health concerns, stepped care, and access to specialty medical/surgical consultation and care management.

Figure 16: Summary of the Four Quadrant Clinical Integration Model

As the Four Quadrant Model illustrates, persons with low to moderate behavioral health complexity and risk (Quadrants I and III) would receive their behavioral healthcare in the Primary Care setting. Persons with moderate to high complexity and risk (Quadrants II and IV) would receive their behavioral healthcare at CBHOs.

The expanded scope of the Medical Home with behavioral health capacity and the ability to seamlessly engage higher need individuals in specialty behavioral health settings (stepped care) broadens the definition from a ***Patient-Centered Medical Home*** to a ***Person-Centered Healthcare Home,*** "signaling that behavioral health is a central part of healthcare and that healthcare includes a focus on supporting a person's capacity to set goals for improved self management, using the resources of the community and personal support systems."[27] A person-centered healthcare home should accept 24/7 accountability for a population and include:

- Preventive screening/health services
- Acute primary care
- Women and children's health
- Behavioral health
- Management of chronic health conditions
- End of life care

These services are supported by enabling services, electronic health records, registries, and access to lab, x-ray, medical/surgical specialties, and hospital care.[28]

As noted above, Medical/Healthcare Homes are likely to become a core component of healthcare reform. As the payment models change for Healthcare Homes, including bonus-type arrangements for managing total healthcare expenditures, they will prioritize working with Community Behavioral Healthcare Organizations that can assist them in managing the total healthcare expenditures of persons with serious mental health and substance use disorders.

In this new environment, Community Behavioral Healthcare Organizations will need to decide whether to continue providing specialty behavioral healthcare services only (Quadrants II and IV) or also become more integrally involved in being part of a Healthcare Home. CBHO involvement in the ***Person-Centered Healthcare Home*** can occur in one of three ways illustrated in Figure 17.

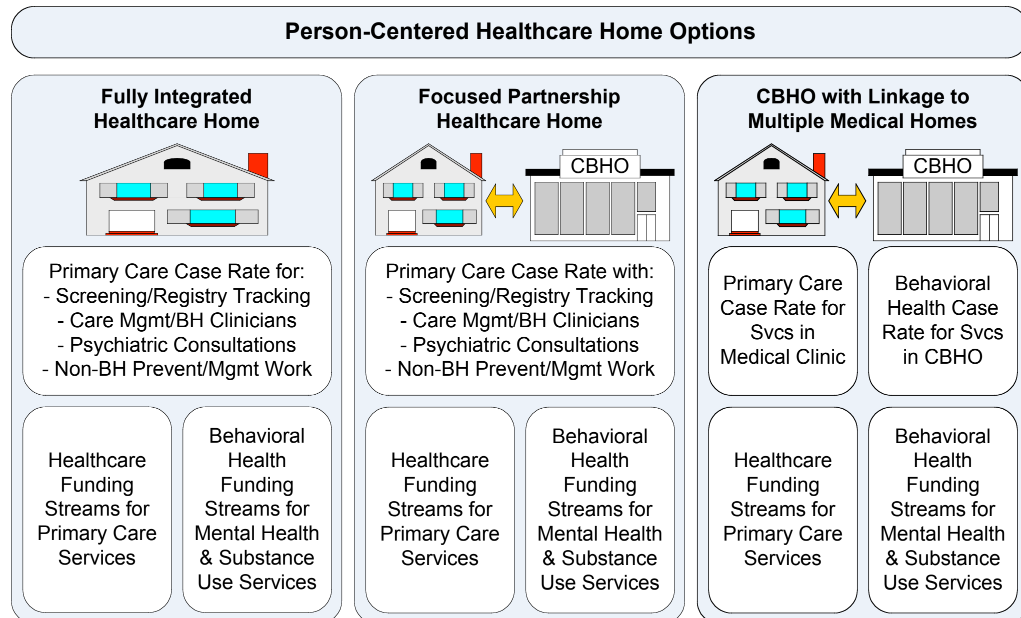


Figure 17: Roles of Primary Care Clinics and Community Behavioral Healthcare Organizations in the Healthcare Home

Fully Integrated Medical and Behavioral Healthcare Home

In this model, ***a single organization provides primary and behavioral healthcare***. A leading example of this approach is Cherokee Health Systems in Tennessee with 23 sites in 13 Tennessee counties.

For consumers who fall into Quadrants I and III (low to moderate behavioral health complexity/risk), Cherokee embeds a behavioral health consultant full-time on the primary care team. A psychiatrist is also available, generally by telephone, for medication consultation. The behavioral health consultant provides brief, targeted, real-time interventions to address the psychosocial needs and concerns in the primary care setting.[29]

For individuals that need specialty behavioral health services (Quadrants II and IV), there is a primary care provider embedded in the specialty behavioral health team. Cherokee hires primary care providers who are comfortable with mental health issues and believes that all front line, administrative, and support staff must be essential players, committed to the holistic approach. The local community is aware that people are treated for all types of illnesses at Cherokee, and mental health consumers find that all are treated in the same way, reducing the stigma of seeking mental health treatment.[30]

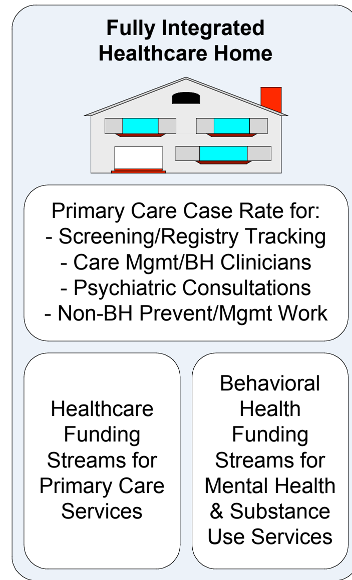


Figure 17a: Fully Integrated Medical and Behavioral Healthcare Home

It's important to note that the focus on primary care/behavioral health integration is part of Cherokee's mission. Just placing the behavioral health and primary care functions under the same organizational structure or within a physical facility is co-location, not necessarily collaborative care. Similarly, placing all of the funding into a single budget will not alone result in co-location, much less clinical collaboration. The focus upon the clinical process creates collaborative care.

Focused Partnership between the CBHO and a Primary Care Practice

An alternative to the fully integrated model is a focused partnership between two separate organizations – the Primary Care Clinic and Community Behavioral Healthcare Organization. In this model, role clarification is achieved among the two parties and processes are put in place to ensure collaboration and true clinical integration. The National Council recommends that six components be available as part of the partnership and the first three should be in place as a minimum:

1. Regular screening and registry tracking/outcome measurement at the time of psychiatric visits
2. Medical nurse practitioners/primary care physicians located in behavioral health
3. Primary care supervising physician
4. Embedded nurse care manager
5. Evidence-based practices to improve the health status of the population with serious mental illnesses
6. Wellness programs

Further descriptions of these components can be found in *Behavioral Health /Primary Care Integration and The Person-Centered Healthcare Home.*

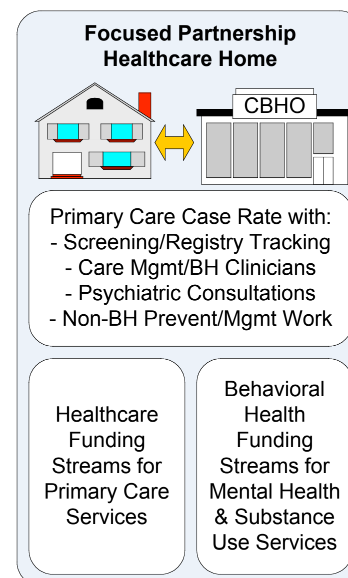


Figure 17b: Focused Partnership Model

Specialty CBHO with Linkages to Primary Care Practices

Community Behavioral Healthcare Organizations that do not want to provide the primary care services of an integrated or focused partnership Healthcare Home inside their clinics, still have a clinical responsibility and accountability to address the issues raised in the Morbidity and Mortality report. If the CBHO's services include prescribing psychotropic medications, the organization needs to build the following capabilities into the ongoing clinical workflows.[31]

- Ensure **regular screening and tracking at the time of psychiatric visits** for all behavioral health consumers receiving psychotropic medications – check glucose and lipid levels, as well as blood pressure and weight and Body Mass Index (BMI), record and track changes and response to treatment and use the information to obtain and adjust treatment accordingly. The individual and family history, baseline, and longitudinal monitoring as recommended by The American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity in 2004 should be the standard of practice.
- Identify the **current primary care provider for each individual**, and when none exists, assist the individual in establishing a relationship with a primary care provider and accessing care.
- Establish specific **methods for communication and treatment coordination with primary care providers** and assure that timely information is shared in both directions.
- **Provide education** and link individuals to self-management assistance and support groups.

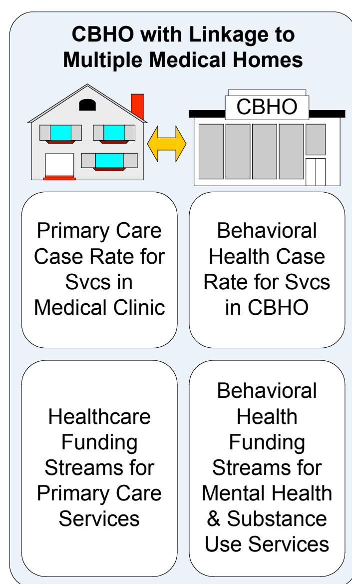


Figure 17c: CBHO with Linkages to Multiple Medical Homes

Regardless of which model is used, both Healthcare Homes and CBHOs will be actively involved in meeting the behavioral health and healthcare needs of the populations they serve. Healthcare Homes will need to have sufficient behavioral healthcare provider capacity to address the needs of persons fitting into Quadrants I and III (low to medium behavioral health complexity/risk) as well as care coordination capacity to assist in managing the care of their patients in Quadrants II and IV (medium to high) who require specialty mental health services from CBHOs. Community Behavioral Healthcare Organizations that are not part of a Healthcare Home will need additional capacity and funding for the screening, tracking, and coordination activities described above.

Currently, there is inadequate funding to provide primary care medical services to persons with serious mental health and substance use disorders who lack this care. In addition, because most states do not adequately fund behavioral health services for persons with low to moderate behavioral health risk and complexity – Quadrants I and III – there is insufficient funding to meet their behavioral healthcare needs (which should be provided in primary care settings).

Recent Congressional action to provide $7 million in new SAMHSA funding to co-locate primary care capacity in Community Mental Health Centers is an important start. For healthcare reform to succeed for persons with moderate to high mental health and substance use disorders, it is critical to increase this funding to levels that address the mortality/health disparity described earlier.

2. Federal and State Payment Method Changes

Federal and State Payment Methods must change to address the disincentives that hinder provision of the right care at the right time in the right place. The framework for a new CBHO payment model should be based on three payment reform approaches that are in use or being developed for the general healthcare system.

- **Case Rate** layer of funding for the prevention, education, and care management services that don't lend themselves to fee for service-type payment mechanisms. Currently these services are unfunded or, in some cases, funded with limited grant dollars.
- **FQHC-Like Prospective Payment System** for mental health and substance use services that are part of formal planned care, not included in the case rate, and cover the services that can be identified by CPT and HCPCS codes.
- **Bonus-Type Gainsharing** mechanism where providers who contribute to the reduction in total healthcare expenditures for a given population receive a share of those savings in the form of a bonus.

Figure 18 describes how these approaches fit with payment mechanisms for the full array of mental health and substance use services.

Community Behavioral Healthcare Organization Payment Framework

Service Area	Payment Mechanism	Requirements
Prevention, Education and Care Management	Per Consumer **Case Rate** to Cover Cost of Services	Definition of Population to be served, services included, service frequency and duration expectations
Mental Health/Substance Use Services that are part of formal, planned care	Paid using mechanism in place in each state (fee for service, sub-capitation, etc.) with year end reconciliation and **Prospective Payment System (PPS)** settlement	Enabling federal legislation required for Prospective Payment System (PPS) mechanism based on FQHC model, which will contain requirements
Mental Health/Substance Use Acute Care Services (Crisis, Inpatient, Diversion)	Paid using **mechanisms in place** in each state (per diem, case rate, etc.); may or may not be included in PPS	No change in current state-level requirements unless part of PPS
Supportive and Ancillary Services (Housing, Transportation, Translation, etc.)	Paid using **mechanisms in place** in each state; may or may not be included in PPS	No change in current state-level requirements unless part of PPS
Total Healthcare Expenditures	**Bonus-type Gainsharing** mechanism for management of Total Health Expenditures for the population served	To be determined in conjunction with payment reform in the general healthcare system

Figure 18: Payment Framework for Behavioral Health Reform

The following flowchart provides a before and after view to illustrate how and why the new approaches are needed. The flow follows persons with moderate to high mental health/substance use risk and complexity that are served in the Specialty Behavioral Health System.

Community Behavioral Healthcare Organization
Clinical - Financial Flow

Process of Care Step	Service Provided	Current Payment Mechanism	Proposed Payment Mechanism	Comment
Services Provided Pre-Enrollment	**Prevention & Early Intervention**	Grant funds or no payment	Part of New Case Rate	Modeled on Medical Home Case Rate
Client Entry into Service	**Screening & Intake**	Existing mechanism	Prospective Payment System	Modeled on Federally Qualified Health Center model
Service Planning	**Assessment**	Existing mechanism	Prospective Payment System	Modeled on Federally Qualified Health Center model
Planned Service Delivery	**CPT/HCPCS-Type Services**	Existing mechanism	Prospective Payment System	Modeled on Federally Qualified Health Center model
Planned Service Delivery	**Education & Care Mgmt**	Some services covered	Part of New Case Rate	Modeled on Medical Home Case Rate

Figure 19: CBHO Service Flow and Payment Models

Under this model, persons with moderate to high mental health/substance use risk and complexity would be engaged earlier through a new case rate type funding mechanism. In many states, funds for this type of service are not available.

Consumers that choose to receive formal, planned care would be served by Community Behavioral Healthcare Organizations with a new payment mechanism modeled on the Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs). This model, based on enabling federal legislation, would ensure that CBHOs would be adequately compensated for necessary services, regardless of the payment mechanisms and levels in any given state.

Education, care management, and recovery-oriented services that do not lend themselves CPT-HCPCS type service tracking would also be covered through the new case rate type funding mechanism. This includes email and phone-based services that support more timely care without an appointment, wellness education in a classroom setting, maintaining tracking registries, and other services being designed into Medical Home case rates with the support of the Centers for Medicare and Medicaid.

3. Federally Qualified Behavioral Healthcare Centers

For reasons noted above Community Behavioral Healthcare Organizations are at a significant disadvantage, compared with other types of provider organizations, in their ability to flourish in a reformed environment. Funding shortages, system fragmentation, problematic payment methods, and the drive to leverage every possible federal Medicaid match dollar has resulted in Community Behavioral Healthcare systems that lack adequate funding, standardized performance measures, and agreement about what constitutes the desired array of behavioral health services needed in a community. Further, CBHOs are continually given different messages about the service delivery model the local payor wants to purchase.

This contrasts with the Community Health Center system. As this system evolved, a federal designation of Federally Qualified Health Centers (FQHC) was added that strengthened the level of standardization in oversight, accountability, services, and payment structures. FQHCs have access to a dedicated funding stream – Section 330 grants, a Medicaid prospective payment system that approaches covering the full cost of doing business, and favorable Medicare reimbursement rules. In addition, FQHC designation brings a number of other favorable financial benefits such as access to favorable drug pricing under Section 340B of the Public Health Service Act.

Figure 20 lists 2007 Revenues by payor for the 1,067 Federally Qualified Health Centers that have Section 330 Grants. In 2007 the 1,067 FQHCs in the United States received over $1.6 billion of Section 330 Grants, $335 million of revenue from indigent care programs, and higher reimbursement rates for the $3.9 billion of Medicaid and Medicare receipts because of their FQHC status – funds that are not available to CBHOs. As a result, **the total $9 billion of 2007 revenue for FQHCs is approximately 25 percent higher than comparable revenue levels for CBHOs**.

	2007 Revenue	Ratios
Grant Revenue		
Section 330 FQHC Grants	$1,683,908,963	18.5%
Other Federal Grants	$200,676,524	2.2%
State/Local Grants/Contracts	$886,402,060	9.8%
Foundations/Private Grants/Contracts	$378,384,064	4.2%
Total Grant Revenue	$3,149,371,611	34.6%
Patient Service Revenue		
Medicaid	$3,320,438,823	36.5%
Medicare	$548,357,016	6.0%
Other Public	$238,597,215	2.6%
Third Party Insurance	$666,521,498	7.3%
Patient Self-Pay	$597,170,297	6.6%
Total Patient Service Revenue	$5,371,084,849	59.1%
Revenue from Indigent Care Programs	$335,084,637	3.7%
Other Revenue	$234,496,445	2.6%
Total Revenue	$9,090,037,542	100.0%
Number of Grantees	1,067	
Average Revenue per Grantee	$8,519,248	

Figure 20: 2007 FQHC Revenues

In this environment Federally Qualified Health Centers have moved to the forefront of the healthcare delivery system in providing high quality, evidence-based care that is clinically effective. FQHCs have also been able to demonstrate that they are better than most provider organizations at managing the total healthcare expenditures of the patient populations they serve. This success in serving safety net populations across the country was recognized in 2001 through the Health Center Growth initiative, resulting in a near doubling of the federal appropriation between 2000 and 2007.

It has become clear that a parallel structure for Community Behavioral Healthcare Organizations, *Federally Qualified Behavioral Healthcare Centers* (FQBHC), based on the FQHC accountability and payment structures, has the potential to address a number of problems facing the Community Behavioral Healthcare system. To accomplish this Congress must pass enabling legislation that will support the creation of *Federally Qualified Behavioral Healthcare Centers* with benefit and responsibility structures that parallel the FQHC system as articulated in Section 330 of the Public Health Services Act.

FQHC/FQBHC Benefits

Figure 21 provides an overview of the Benefits that accompany Federally Qualified Health Center designation and their relevance to FQBHCs. Note that items 1, 2, and 4 relate to the revenue rows in Figure 20 above.

Federally Qualified Health Centers Existing Benefits	FQBHC Proposed
1. Operating Grants: Federal Grants to support the costs of otherwise uncompensated comprehensive primary healthcare and enabling services delivered to uninsured and underinsured populations at sites within the approved scope of project.	**Yes**
2. Medicaid Reimbursement: Enhanced reimbursement under Prospective Payment System (PPS) or other state-approved alternative payment methodology for services provided under Medicaid.	**Yes**
3. Medicaid Enrollment Workers: The right to have Medicaid eligibility workers on site, or receive reimbursement for out-stationed Medicaid activities (intake and enrollment functions) conducted by Center personnel.	**Yes**
4. Medicare Reimbursement: Reimbursement by Medicare for the "first dollar" of services rendered to Medicare beneficiaries (e.g., deductible is waived).	**Yes**
5. Capital Improvements: Access to Federal loan guarantees • For the costs of developing and operating managed care and practice management networks or plans • For capital improvements (including IT) Access to Construction Grants as authorized and funded by Congress.	**Yes** **Yes**
6. Drug Pricing: Access to favorable drug pricing under Section 340B of the Public Health Services Act. Centers that provide or contract for the provision of pharmaceuticals are entitled to favorable pricing from drug manufacturers. Access to the Federal Vaccine For Children program and eligibility to participate in the Pfizer Sharing the Care Program.	**Yes** **N/A**
7. Safe Harbor: Safe harbor under the Federal anti-kickback statute for: • Waiver of co-payments to the extent a patient is below 200% of Federal income poverty guidelines • Certain arrangements with other providers or suppliers of goods, services, donations, loans, *etc.*, which benefit the medically underserved population served by the Center.	**Yes**
8. FTCA Coverage: Access to Federal Tort Claims Act (FTCA) coverage for the Center and its healthcare professionals, including certain contracted professionals in lieu of purchasing malpractice insurance.	**Yes**
9. Recruitment: Access to providers through the National Health Service Corps if the Center's service area is designated as a health professional shortage area.	**Yes**
10. Quality Improvement: The opportunity to participate in Bureau of Primary Healthcare disease management learning models and the Health Disparities Collaboratives	**Yes, BH-oriented**

Figure 21: Crosswalk of FQHC to FQBHC Benefits

FQHC/FQBHC Requirements

There are a number of important requirements for Federally Qualified Health Centers that translate to the Federally Qualified Behavioral Health Center setting.

1. Eligible Entities: An FQHC must be a private, charitable, tax-exempt nonprofit organization or a public entity.

2. Service Area: In order for a nonprofit or government-run primary care clinic to quality for FQHC status, it must be located in a high need designated area. All or part of the geographic region, identified by census tracts and zip codes, must be federally designated as a Medically Underserved Areas (MUA) or contain a federally designated Medically Underserved Population (MUP). These populations include groups of persons who face economic, cultural, or linguistic barriers to healthcare.

Note that people with Serious Mental Illnesses (SMI) are not currently identified in medically underserved or health disparities populations, except that they meet one of the criteria (e.g., poverty, older than 65). A designation of the population with SMI will need to accompany the creation of FQBHCs.

Figure 22 is an example of a crosswalk of Medically Underserved Areas to a FQHC's service area.

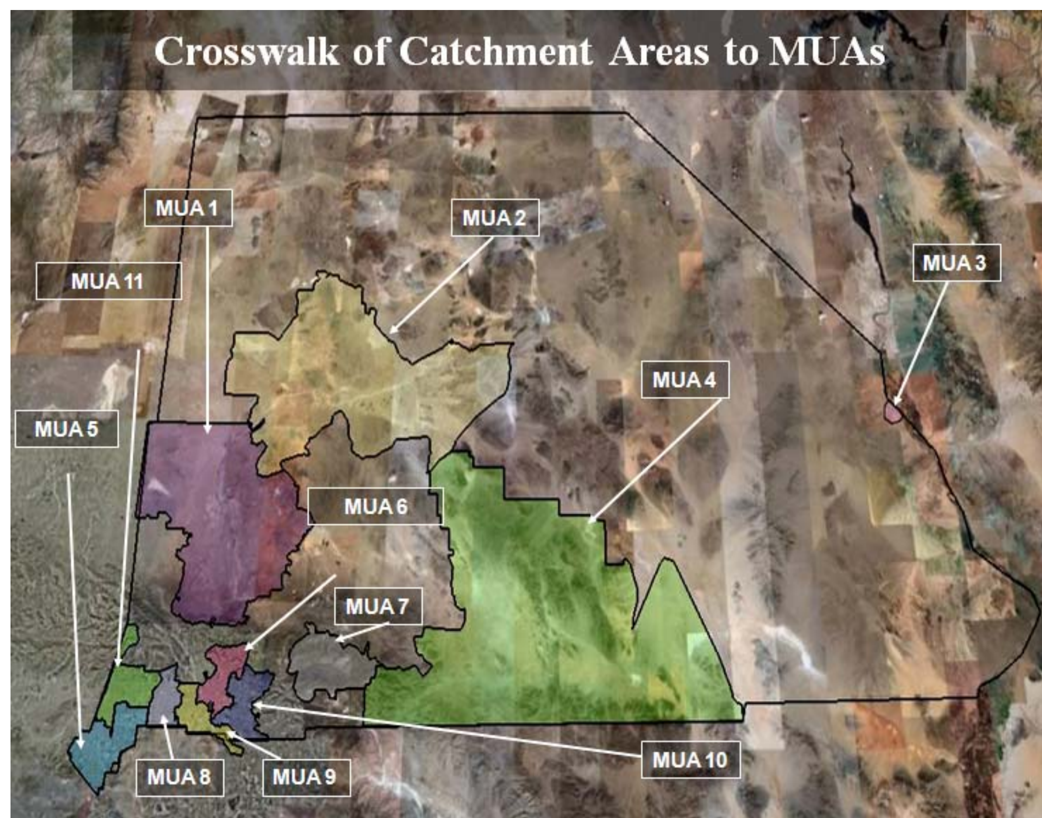


Figure 22: FQHC Service Area Analysis

3. Target Population: Each FQHC must identify the medically underserved population to be served. This is usually a subset of the entire service area population, but in some cases may include all residents of the service area.

Generally FQBHCs will follow the same approach, focusing on residents with mental health and substance use disorders. Depending on the type of Healthcare Home model, a FQBHC could serve all Quadrants (I-IV) in an integrated model, partnership or linkage model. Regardless of the approach, there will be a need to define the priority population of residents in the service area. This will likely draw on the Federal definitions of Serious Mental Illness and Serious Emotional Disturbance.

- **SMI:** 5.4 percent of adults are considered to have a serious mental illness (SMI). Serious mental illness is a term defined by Federal regulations that generally applies to mental disorders that interfere with some area of social functioning. About half of those with SMI (or 2.6 percent of all adults) are identified as being even more seriously affected, that is, by having severe and persistent mental illness (SPMI).

- **SED:** Federal regulations also define a sub-population of children and adolescents with more severe functional limitations, known as serious emotional disturbance (SED). Children and adolescents with SED comprise approximately 5 to 9 percent (depending on level of poverty) of children ages 9 to 17.

4. Clinical Operations: FQHCs must employ a core clinical staff that is multi-disciplinary, and culturally and linguistically competent. The FQHC must provide an agreed-upon set of clinical services either directly or through contract or established arrangement. These include:

- All required primary and preventive services
- Supplementary services including referrals to other providers
- Case management services
- Enabling services including outreach, transportation, and translation
- Education regarding the availability and proper use of health services
- Additional health services as appropriate to meet the needs of the population

Federally Qualified Behavioral Health Centers will have a parallel set of service requirements that match the needs of the population served. One approach to defining these requirements is being developed in California that crosswalk services to four Levels of Care that describe persons with mental health and substance use disorders based on their complexity and risk.

Care Level	Characteristics of the Population
Mild MH/SU Complexity and Risk	• No comorbidities • Family/community supports • Standardized assessment tool indicates mild to moderate symptoms and severity • Diagnostic examples include mild depression, mild anxiety, sleep disorders, SU disorder, somatic disorder (Note: 10.5% of the U.S. population 18+ will fall into this level.)
Moderate MH/SU Complexity	• Medical or MH/SU comorbidities, including pain, or • Isolated or chaotic family/ community environment • Standardized assessment tool indicates moderate to severe symptoms and impact on functioning • Diagnostic examples include moderate depression, moderate anxiety (including PTSD), sleep disorders, SU disorder, somatic disorder (Note: 9.7% of the U.S. population 18+ will fall into this level.)
Serious MH/SU Complexity	• Multiple, complex medical, MH/SU comorbidities, and • Isolated or chaotic family/ community environment • Standardized assessment tool indicates severe symptoms and impact on functioning • Previous treatment ineffective • Diagnostic examples include severe depression, severe anxiety (including PTSD), bipolar disorder, SU disorder. schizophrenia, schizoaffective disorder, personality disorders (Note: 3.12% of the U.S. population 18+ will fall into this level.)
Severe and Persistent MH/SU Complexity	• Adults 18 years and over, with a severe and/or persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment, but for whom long-term 24-hour care in a hospital, nursing home, or protective facility is unnecessary or inappropriate (NIMH) • Diagnostic examples include schizophrenia, schizoaffective disorder, and bipolar disorder (NIMH) (Note: 2.6 % of all adults are even more seriously affected by having "severe and persistent" mental illness.)

Figure 23: FQBHC Level of Care Example

It is envisioned that persons with **Mild** mental health and substance use risk and complexity will have their behavioral health services provided in the Healthcare Home; persons with **Serious and Persistent** risk and complexity will be served in a Community Behavioral Healthcare Organization; the service setting for persons with **Moderate** and **Serious** risk and complexity will vary from community to community based on the method of integration that is occurring, available service delivery resources, and other local factors. The following table describes the types of services that should be considered for FQBHCs based on these four risk and complexity levels.

Figure 24 describes the types of services that should be considered for FQBHCs based on these four risk and complexity levels.

MH/SU Services to be made available at each Level of Care	Mild	Moderate	Serious	Serious/ Persistent
Screening and assessment of commonly presenting MH and SU conditions	X	X	X	X
Brief problem-oriented counseling/therapy	X			
Brief treatment of MH and SU conditions, crisis plan		X		
Care management as needed	X			
Prescribing		X	X	
Medication Management				X
Care management/registry tracking of those receiving services		X	X	X
Self management goal setting (for MH/SU as well as health conditions) education, activation	X	X plus relapse planning	X plus relapse planning	X + relapse planning/ WRAP
Referral to community and educational resources	X	X	X plus housing	X
Stepped care (changes in the types and intensity of services, medications) within this level or to another level	X	X	X plus crisis & inpatient	X plus crisis & inpatient
Peer and family supports		X	X	X
Psychiatric consultation for care manager/PCP		X	X	X
Person-centered treatment plan			X	X
Risk assessment and crisis plan			X	X
Assessment and monitoring of key health indicators			X	X
Treatment of MH and SU conditions, including intensive outpatient and residential treatment for SU conditions			X	X
Intensive Case Management Team/Assertive Community Treatment				X
Family Psychoeducation				X
Co-occurring treatment for MH/SU conditions/ Integrated Dual Diagnosis Treatment				X
Intensive Outpatient SU services				X
Detoxification				X
Supported Education				X
Supported Employment				X
Supported Housing/Housing First models				X
Consumer-Operated Service Programs				X
Clubhouse				X
Mental health crisis outreach				X
Psychiatric emergency room/crisis triage center				X
Residential Treatment (MH/SU)				X

Figure 24: Sample Array of Required FQBHC Services

5. Service Providers: FQHC regulations list a set of provider-related requirements and define providers as individual healthcare professionals who exercise independent judgment as to the services rendered to health center patients and document services in the patient's record on behalf of the health center. The relevant requirements have been revised below to reflect FQBHC provider types.

- Providers are individuals licensed by the state in which the FQBHC is located and include:
  - o Physicians
  - o Nurse practitioners
  - o Clinical psychologists
  - o Clinical social workers
  - o Other clinicians with a graduate degree in a behavioral science field
- If state regulation requires that services be provided by or under the oversight of a provider with a specific state designation (e.g., a Qualified Mental Health Professional or QMHP), providers shall meet the requirements of that designation as well.
- Peer services will be delivered by Certified Peer Counselors. Peers and other staff who provide direct services "incident to" the services of providers as defined here or as a part of the cost reimbursable services of the FQBHC.
- FQBHCs utilize a variety of mechanisms for provider staffing (directly employ, contract with individual providers, or contract with other organizations).
- All providers must be properly credentialed and licensed to perform the activities and procedures expected of them.

6. IT Systems: FQHCs must have an IT system that is compatible with the Federal Uniform Data System (UDS) that is used to compile enrollment, utilization, revenue, cost, and performance data into a single national database. FQHCs are expected to use their IT systems for reporting and to actively support management decision-making. UDS data are reviewed to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments.

The benefits to FQBHCs of a standardized set of data requirements feeding into a single database are enormous. Figure 25 is an exhibit from the 2007 UDS Site Summary Report for all 1,067 Section 330 Grantees.

FQHCs are also required to have **Patient Registries** to assist in management of patients' chronic medical conditions. This is a term unfamiliar to most Community Behavioral Healthcare Organizations and a number of Behavioral Health IT vendors.

A Patient Registry is defined as a clinical database to manage chronic, complex, and preventive health needs for individual patients and a clinic's patient population. Registries summarize relevant clinical information from the patient record (preferably in table and

CLINICAL INFORMATION	
Service Patients to Target Population Ratios	
Pap smear patients per fem. patients 15+ yrs	21.75%
Well child patients per Patients < 12 yrs	57.82%
Family planning patients per fem. patients 15-44 yrs	20.82%
Proportions of medical paitents with key diagnoses	
Asthma	3.37%
Hypertension	11.35%
Diabetes	7.24%
Otitis Media	4.02%
Mental Disorder	8.65%
Visits per year for patients with specific diagnoses	
Asthma	1.76
Hypertension	2.30
Diabetes	3.12
Otitis Media	1.46
Mental Disorder	2.92
Perinatal Care	
Total Patients	461,605
% Prenatal teen patients	18.2%
% Newborns Below Normal Birthweight	7.8%
% Late Entry Into Prenatal Care	35.8%
% Deliveries with Postpartum Visit	68.9%
% Deliveries with Newborn Visit	66.3%

Figure 25: 2007 UDS Clinical Information for 1,067 FQHCs[32]

graphic format) to highlight condition-specific clinical indicators that are due or out of range as well as tracking clinical change over time.

Registries support proactive care management at the individual level (reminders to make a care management call or flagging an abnormal lab result) and the population level (computation of the percentage of patients that have received needed follow-up related to a specific condition or clinical expectation).

☑ Actionable items only.

Measure Name	Last Value	Date Last Value	Patient Goal	Population Goal	Due Date
Social					
Tobacco pack years	55	4/10/2007	= 0	= 0	
Clinical					
BP SBP	187	7/2/2007	<= 140	<= 140	
BP DBP	112	7/2/2007	<= 90	<= 90	
Body Mass Index	52.1	4/10/2007	< 25	< 25	
Asthma - # Days symptoms/wk (Last 2-4 weeks)	3	4/10/2007	<= 0	<= 0	
Asthma - # Nights awakened/wk (Last 2-4 weeks)	2	4/10/2007	<= 0	<= 0	
LAB/Testing					
LDL	140	7/6/2007	<= 130	<= 130	7/5/2008
Total Chol	160	7/6/2007	<= 150	<= 150	7/5/2008

Figure 26: Sample Patient Registry Report

Note: BP = Blood Pressure; LDL = Low-Density Lipoprotein

7. Quality Improvement Activities: The Bureau of Primary Healthcare, the Federal agency that oversees FQHCs, began a project in 1998 to use the Institute for Healthcare Improvement's Health Collaborative model to promote meaningful and effective quality improvement in FQHCs. 88 centers participated in the first round of Health Disparities Collaboratives, with the goal of transforming "how providers deliver primary care, how patients understand and participate in managing their own care, and how communities support provider-patient partnerships."[33]

In 2002 the Bureau of Primary Healthcare issued regulations that all but mandated FQHC participation in Health Disparities Collaboratives.[34] These efforts have been instrumental in building improvement into the fabric of FQHCs in ways that are not possible for a system that has 50 states/50 sets of rules. Similar types of requirements should be built into the FQBHC regulations.

8. Productivity Expectations: A core FQHC expectation since shortly after the inception of the program is the number of visits expected for each full time equivalent clinician. Physicians are expected to provide 4,200 encounters and midlevel clinicians 2,100 encounters per FTE per year. These numbers, in many ways, have been the tool that has both pushed efficient service delivery models and prevented micromanagement by oversight bodies. It is unlikely that a FQBHC program can be created without a productivity requirement. Figure 27 shows the composite staffing and productivity-related figures for the 1,067 FQHCs in 2007.

STAFFING, PRODUCTIVITY AND SUPPORT RATIOS	
Full Time Equivalents	
Primary care physicians FTE	7,752.69
Other physicians (not incl psych) FTE	241.37
NPs / PAs/ CNMs FTE	4,692.86
Dental FTE	2,107.50
Dental Hyg FTE	806.01
Total Admin/Fac FTE	41,343.69
Total FTE	104,923.10
Support Ratios	
Direct medical support	1.72
Direct dental support ratio	1.37
Patient support ratio (front office)	1.23
Productivity and Patient Ratios	
Physician Productivity (excl. Psych)	3,826
Mid-Level Productivity[a]	2,868
Medical Team Productivity[a]	4,248
Dentist Productivity	2,669
Dental Hygienist Productivity	1,341
Dental Team Productivity	2,671
Medical Patients per Medical Provider[a]	1,101
Dental Patients per Dental Provider	964

Figure 27: 2007 UDS Staffing and Productivity Information for 1,067 FQHCs

These eight FQHC requirements help clarify the type of clinical, administrative, quality, measurement, and coverage requirements that CBHOs will need to meet in order to qualify for Federally Qualified Behavioral Health Centers designation.

4. Federal Funding for Behavioral Health Workforce Development and Coverage for the Uninsured and Underinsured

There are approximately 21 million low income Americans with a mental health and/or substance use disorder that need treatment in a given year. Of this group, 16 million have moderate to high behavioral complexity and risk. At last count, just less than half of the larger group (10 million people) receives service in specialty behavioral healthcare or primary care in a year, leaving over 11 million unserved. . Figure 28 shows the estimated distributions based on the most recent National Co-morbidity Study as well as studies in Washington State and California.[35]

	Served by CBHOs	Served by Other	Total Served	Number Not Served	Total MH/ SU Need	Ratios
Low Impairment	800,000	1,650,000	2,450,000	3,530,000	5,980,000	27%
Moderate Impairment	1,380,000	2,950,000	4,330,000	6,390,000	10,730,000	49%
High Impairment	3,560,000	210,000	3,780,000	1,360,000	5,130,000	23%
Total	5,750,000	4,810,000	10,560,000	11,280,000	21,840,000	100%
Ratios	26%	22%	48%	52%	100%	
Medicaid	4,130,000	4,740,000	8,860,000	5,890,000	14,760,000	68%
Indigent, Uninsured	1,620,000	80,000	1,700,000	5,390,000	7,080,000	32%
Total	5,750,000	4,810,000	10,560,000	11,280,000	21,840,000	100%
Ratios	26%	22%	48%	52%	100%	

Figure 28: Estimate of U.S. Mental Health/Substance Use Need and Served

As the effects of parity begin to unfold and the nation moves toward meaningful healthcare reform, there are three major challenges that will be faced by the public and private behavioral health systems.

Over the last several years most states have shifted toward funding services for persons with moderate to high impairment in the Medicaid population. Note that in Figure 28, CBHOs have served approximately one-quarter of the total need (26 percent); have served the vast majority of persons with High Impairment (3.6 of the 3.8 million total); and have predominantly served Medicaid enrollees (more than 70 percent).

- **Workforce and Capacity Issues:** As people become served by Medical Homes, there will be a clinical and financial incentive to ensure that behavioral health needs are met in order to better manage both chronic medical conditions and total medical expenditures. This will increase the demand for mental health providers to treat, at a minimum, the persons with moderate to high impairment that are not currently served (7.7 million). If slightly more than half of these individuals were served, it would represent a 41 percent increase in demand for behavioral health services.

- **CBHO Demand:** If priority is given to serving unserved persons with high-moderate and high impairment (Quadrants II and IV) CBHOs would become the predominant

provider of care for this group – if the organizations are able to demonstrate that they can meet the behavioral health needs in quantifiable ways and are successful partners in reducing total medical expenditures for the persons they serve. This could increase the demand at CBHOs by as much as 46 percent. This represents an increase of 30,000 CBHO service providers nationally.

- **Serving the Indigent, Uninsured, and Underinsured:** If Community Behavioral Healthcare Organizations obtain FQBHC status, which brings the obligation to serve all safety net residents in their catchment area (Medicaid and Indigent) and if universal coverage unfolds over several years, CBHOs would be faced with a substantial unfunded mandate unless additional funds are earmarked for this population. We estimate that an additional $1.6 billion would be needed to meet the behavioral health needs of the Quadrants II and IV portions of the indigent, uninsured, and underinsured population. As parity and universal coverage increase, these funds could decrease over time. (See Figure 30)

Figures 29 and 30 provide a high level view of the estimates listed above. These figures are based on data from the National Co-morbidity Study and utilization and cost studies in Washington State and California.

	Number Not Served	% to Serve	Total New to Serve	CBHO Share	CBHO New to Serve
Low Impairment	N/A	N/A	N/A	N/A	N/A
Moderate Impairment	6,390,000	50%	3,195,000	25%	1,598,000
High Impairment	1,360,000	85%	1,156,000	75%	1,020,000
Total	7,750,000	56%	4,351,000	34%	2,618,000
Currently Served			10,560,000		5,750,000
% Increase			41%		46%

Figure 29: Estimates of Additional Persons Served in Reformed Environment

Figure 29 assumes that 50 percent of persons with moderate impairment and 85 percent with high impairment not currently served would be served by all systems, with 25 percent moderate and 75 percent high served by the Community Behavioral Healthcare system.

	CBHO New to Serve	% Indigent/ Uninsured	# Indigent/ Uninsured	Average Cost/ Case	Additional BH Cost	CBHO FTE Estimate
Low Impairment	N/A	N/A	N/A	N/A	N/A	N/A
Moderate Impairment	1,598,000	48%	763,583	$500	$382,000,000	7,000
High Impairment	1,020,000	48%	487,394	$2,660	$1,296,000,000	23,000
Total	2,618,000		1,250,977	$1,341	$1,678,000,000	30,000

Figure 30: Estimates of Additional CBHO Costs and Full Time Equivalent Staff (FTEs)

Figure 30 cost and FTE data are based on a Washington State pilot project treating persons in primary care and specialty mental health. **The cost to CBHOs of serving these additional indigent, uninsured persons would be $1.6 billion, requiring an additional 30,000 service providers.**

For healthcare reform to succeed for persons with moderate to high mental health and substance use disorders, it will be critical to address these workforce and funding issues. **This will require dedicated *Federal Funding Streams* for behavioral health provider workforce development and funding for indigent, moderate to high need uninsured and underinsured persons who are not currently being served**.

Aligning the Behavioral Health Delivery System

Deciphering what these changes mean for the average Community Behavioral Healthcare Organization in Fort Smith, Arkansas or Tacoma, Washington is the major purpose of this paper. If one assumes there is a moderate to high likelihood that meaningful payment and delivery system reform will occur by the end of 2010 and the reform legislation will contain a number of ideas discussed in this paper, CBHOs should focus on how they will align with the following changes in the landscape.

The Far Reaching Effect of Medical Homes

Community Behavioral Healthcare Organizations will need to decide which of the three options makes most sense for their consumer population and community – Fully Integrated Healthcare Home, Focused Partnership Healthcare Home, or Linkages with multiple Medical Homes. Selecting "door 4 – none of the above" is not likely to be a reasonable option and will create significant risk for a CBHO.

Primary care practices that serve persons with serious mental health and substance use disorders through Medical Homes will have significant financial incentives (and possible penalties) to ensure that medical conditions are properly managed and behavioral health disorders are treated by specialists with measureable track records. This has the potential to shift the locus of control over who provides behavioral health services to the Medical Home. As performance measurement increases and public report cards are made available, consumers will have more opportunity to learn where the most effective behavioral health care relevant to their disorder is being provided and Medical Homes will know which CBHOs are doing a good job helping manage the total healthcare expenditures of their patient population.

The Implications of Federally Qualified Behavioral Healthcare Center Status

The ability to achieve FQBHC designation and the accompanying financial benefits including Federal funding for indigent, uninsured, and underinsured persons with serious mental health and substance use disorders are necessary components for Community Behavioral Healthcare Organizations to be able to adapt to the changes that will occur in the payment and service delivery systems. FQBHC status will create one set of national standards that can serve as a blueprint for the types of services and infrastructure that need to be in place to better support the full healthcare needs of persons with serious mental health and substance use disorders. In addition, FQBHC status has the potential to serve as a *Good Housekeeping Seal of Approval* for CBHOs as they interact more with the general healthcare system.

Core Competencies of the Community Behavioral Healthcare Organization of the Near Future

In the environment envisioned in this paper, Community Behavioral Healthcare Organizations will need to ensure that they meet a set core competencies in order to continue being an important part of the healthcare delivery system. The following partial list is drawn from the reforms discussed in this paper.

- A **clear Model and Strategy** for participating with Person-Centered Healthcare Homes based on one of the three models of integration - Fully Integrated Healthcare Home, Focused Partnership Healthcare Home, or Linkages with multiple Medical Homes.
- A **full Array of Specialty Behavioral Health Services** provided inside the organization and/or through contract with specialty behavioral health partners that align with the service requirements described above.
- A well defined **Assessment Process and Level of Care System** for identifying the level of need of the persons being served and ensuring that each individual is being treated in the right location with the right medical and behavioral health services at the right time.
- A **solid approach to Prevention, Early Intervention, and Recovery** that includes critical components of managing the total healthcare expenditures for persons with serious mental health and substance use disorders.
- The ability to **practice as a Team to Coordinate Care** within the CBHO and across services in the behavioral health and medical service delivery system in order to ensure that the total health care of consumers is coordinated and properly managed.
- Demonstrated use of **Clinical Guidelines** that are embedded in the fabric of each clinician and case manager's practice in order to ensure that effective treatment is occurring based on the clinical needs of each consumer.
- **Measurement Systems and Tools that measure improvement** in each consumer's behavioral health status and processes that use those data on a timely basis to adjust care as needed.
- A robust **Electronic Health Record** that includes **Patient Registry** functionality and the ability to electronically share medical records with other provider organizations and receive that information for the consumers served by the CBHO.
- **Quality Improvement Processes and supporting Data Systems** that allow organizations to run continuous experiments in improvement at every level of the organization in order to increase the effectiveness and efficiency of services and the infrastructure that supports service delivery.
- **Financial Systems** that have the ability to manage Case Rate Payments, the FQBHC Prospective Payment System, and the ability to track the total healthcare expenditures down to the individual level provided inside the organization.

The Roles of Key Stakeholders in Supporting Reform for Persons with Serious Mental Health and Substance Use Disorders

Although this paper is intended as a concept paper (versus an implementation plan), it is important to begin to describe the roles of key stakeholders in moving these ideas from concept to reality.

Federal Government

Enabling Federal legislation will be required to create the designation of Federally Qualified Behavioral Health Centers. The Congressional Budget Office (CBO) will need to evaluate the financial impact of this legislation, including an assessment of the cost offsets for this program. Similar to existing proposals about Medical Homes, Congress and the Administration will need to determine how offset-related funds can be shifted from other parts of the healthcare system and what the source will be for additional funds, if necessary.

Federal budgetary decisions requiring Congressional approval will be needed to fund FQHC-like Operating Grants to support indigent, uninsured, and underinsured persons in FQBHCs and Behavioral Health Workforce Development. This will also require CBO analysis along with stakeholder recommendations about where existing funds could be shifted and what new funds would be required to support these two critical funding components.

Once turned into law, regulation writing will be needed for all three initiatives. It will be important to leverage existing Federal FQHC regulations as well as State and Federal workforce development initiatives that have been implemented. The California Mental Health Services Act (MHSA) Workforce Development initiative is one such model to consider.

State and Local Governments

Policy makers inside State Medicaid programs, other State Departments and Regional and County authorities that have funding and oversight responsibility for behavioral health services have a responsibility to assess where Federal legislation is headed and evaluate how existing programs align with these efforts.

There is a high degree of likelihood that current State approaches to funding, program and benefit design, oversight and management, and reimbursement will need to be reengineered in order to complement emerging Federal legislation. This work is already occurring in a number of States. Organizations like the National Governors Association, the National Association of State Mental Health Program Directors, and the National Association of County Behavioral Health Directors are well positioned to support cross jurisdiction knowledge transfer.

Community Behavioral Healthcare Stakeholders

Every Community Behavioral Healthcare stakeholder in the United States must become active in addressing the fact that people living with serious mental illnesses are dying 25 years earlier than the rest of the population. This group cannot be left behind as healthcare reform moves forward.

Organizations such as the National Council for Community Behavioral Healthcare, the National Alliance on Mental Illness, Mental Health America, the State Associations of Addiction Services, their members, and a number of other stakeholder groups committed to addressing the needs of persons with serious mental health and substance use disorders need to become the organizing force for developing and promoting solutions for improvement.

The ideas in this paper present one framework for creating behavioral health-specific solutions that fit with larger healthcare reform. Other perspectives and ideas will be critical as community behavioral healthcare stakeholders come together to assist Congressional leaders, the Administration, and health policy experts in addressing the needs of Americans with serious mental health and substance use disorders.

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