Healthcare Payment Reform and the Behavioral Health Safety Net Presentation to the National Council Public Policy Committee

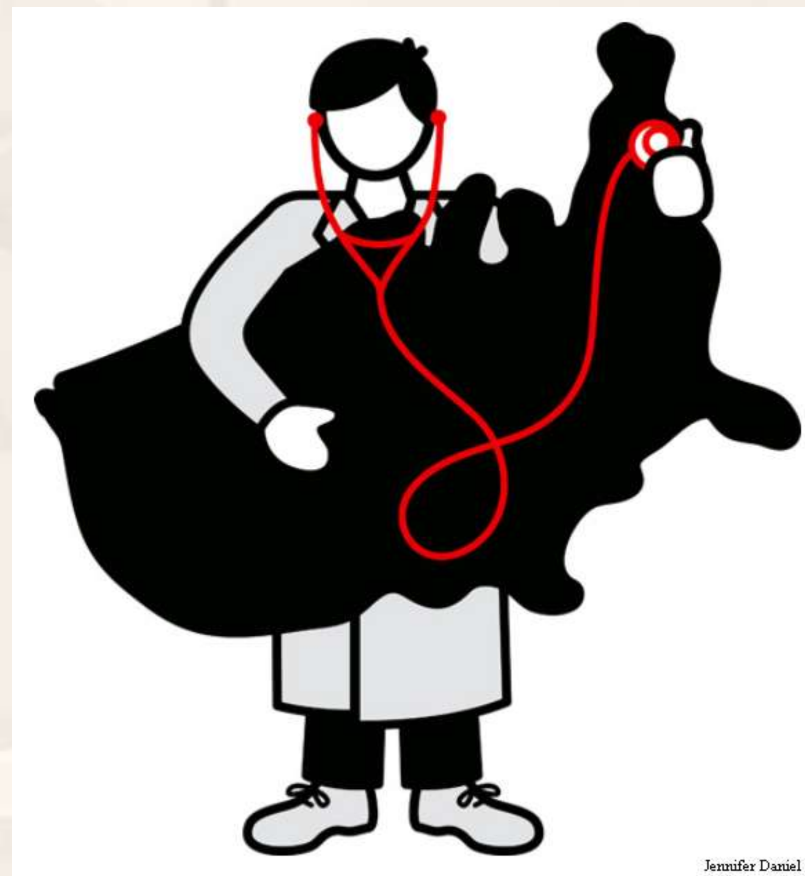
Dale A. Jarvis, CPA
MCPP Healthcare Consulting Inc.
dale@mcpp.net

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

Healthcare Payment Reform and the Behavioral Health Safety Net Overview

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

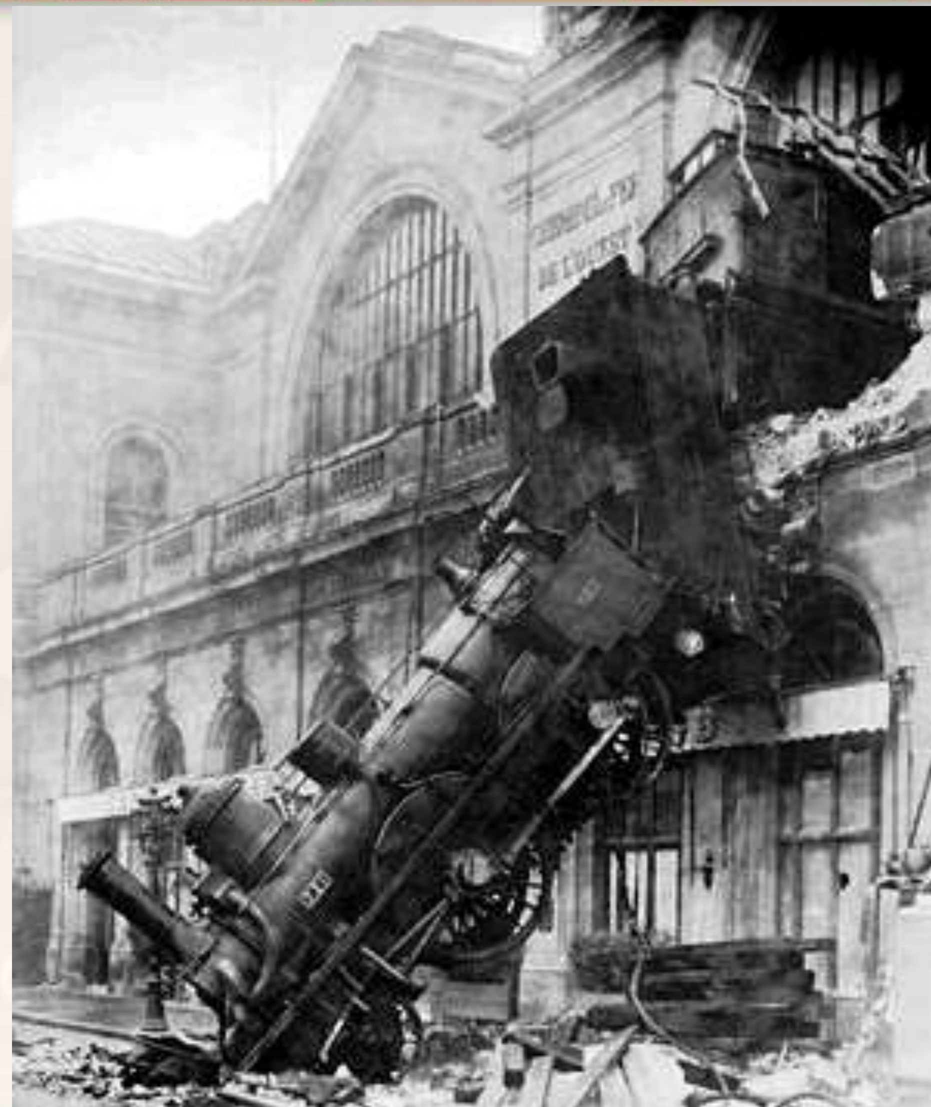
- The American healthcare system is broken. It is too expensive, leaves tens of millions of Americans exposed to poor health outcomes and economic ruin, and has driven many healthcare providers from the field in search of less stressful work.
- At current rates, this troubled system will grow from 17% of the U.S. economy in 2009 to 21% by 2020, a doubling of costs from $2.5 to $5.2 trillion per year.



Healthcare Payment Reform and the Behavioral Health Safety Net Overview

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

- The Safety Net Behavioral Healthcare System faces even greater challenges including serious funding shortages, fragmentation from federal policy changes that created a 50 states/50 sets of rules model, overreliance by states on Medicaid at the expense of indigent/uninsured persons, and more.



StupidVideos.com

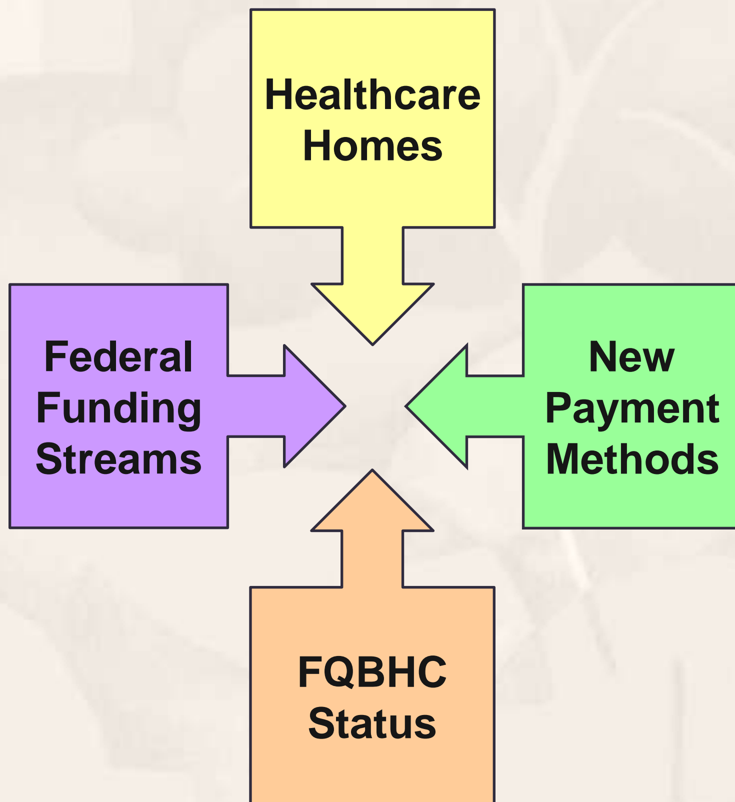
Healthcare Payment Reform and the Behavioral Health Safety Net Overview

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

- Health care reform design work is just beginning that is 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.

Healthcare Payment Reform and the Behavioral Health Safety Net Overview

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE



- To address this potential gap, we're recommending four delivery system and payment reforms for the safety net behavioral healthcare system that are necessary to address the particular challenges faced by persons with serious mental health and substance use disorders and the provider organizations that serve them.
- But first I'm going to make some connections to where the general healthcare system is headed.

Consensus is Building about the Design for Healthcare Reform – Universal Coverage

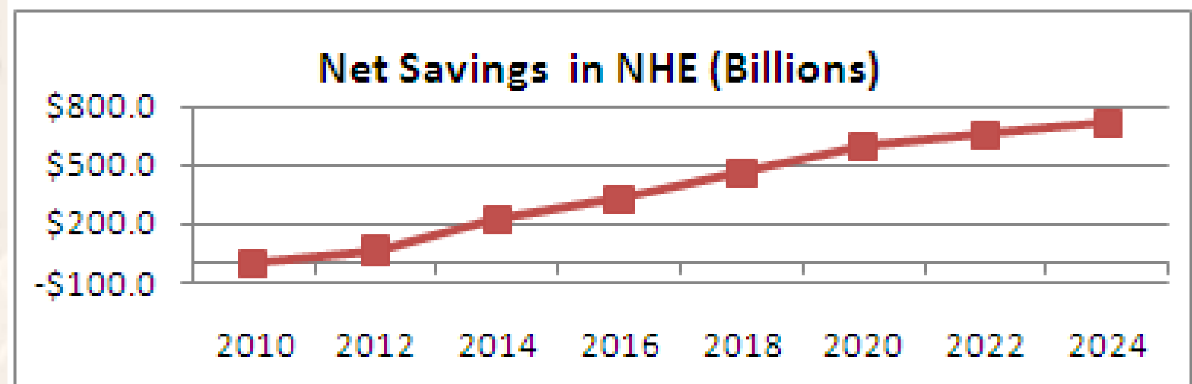
- General agreement already exists about the contours of U.S. health care reform – reform must address three issues – universal coverage, payment system reform, and delivery system redesign.

Consensus is Building about the Design for Healthcare Reform (Payment & Service Delivery System)

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

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 covering the three components that can achieve 99% coverage by 2012 and reduce the growth in national health spending between 2009 and 2020 by $3 trillion.

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%



Consensus is Building about the Design for Healthcare Reform (Payment & Service Delivery System)

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

The 2020 Report was developed by the Commonwealth Fund, with analytical support from The Lewin Group; they've identified ten health care reform policies in this report and quantified their impact on reducing the growth in health care spending.

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

Healthcare Reform is Already Underway

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

- 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).

Healthcare Reform is Already Underway
Chronic Medical Conditions

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- 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.
- 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.
- 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**.

Healthcare Reform is Already Underway
Chronic Medical Conditions & Medical Home

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

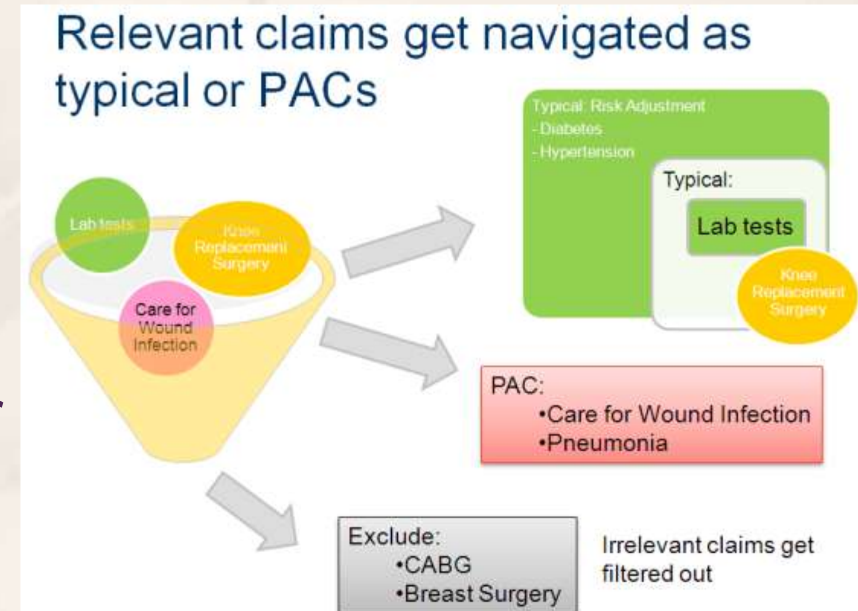
The Patient-Centered Medical Home has emerged as the leading model for treating chronic medical conditions in primary care settings.

- **Federally Qualified Health Centers** (FQHCs) have a long history of following many principles of a medical home and several studies have found that health centers save the Medicaid program more than 30% in annual spending per beneficiary due to reduced specialty care referrals and fewer hospital admissions.
- **Primary Care Case Management** (PCCM) programs in the Medicaid program use primary care physicians to coordinate care and manage total health expenditures. Studies of these programs have shown cost savings up to 10% per year after the initial ramp up period.

These models, especially Medical Homes, are seen as a key to addressing cost and quality problems in health care and have implications for Community Behavioral Healthcare Organizations.

Healthcare Reform is Already Underway: PACs

- **Potentially Avoidable Complications (PACs)** is a 2nd area relevant to CBHOs. PACs are 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, etc.

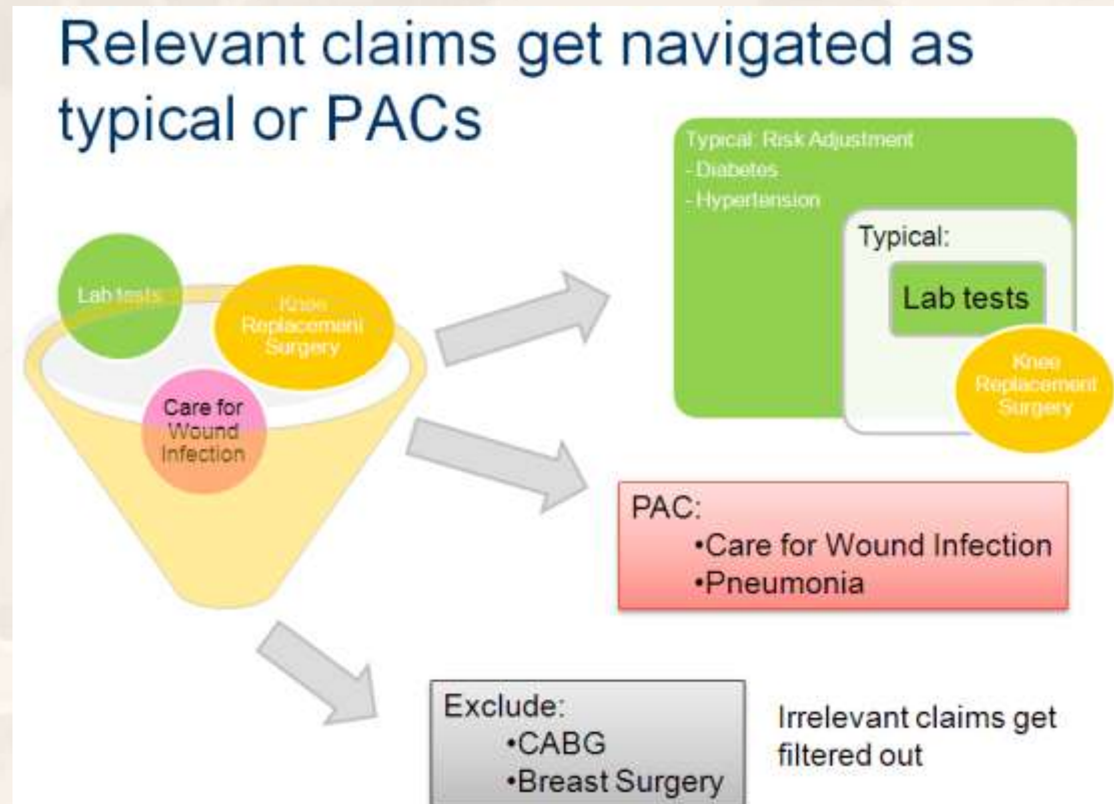


- Robert Wood Johnson Foundation and Commonwealth Fund have been funding research to understand these phenomena and develop an approach to payment reform called **Evidence-informed Case Rates (ECRs)**.

Healthcare Reform is Already Underway: PACs

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- Based on an evaluation of the eleven conditions analyzed to-date, 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 a chronic care conditions.
- We are going to see significant movement in the area of risk-based payments, performance-based contracting including bonuses and gain-sharing, and non-payment for certain events, in order to address these issues.



The Role of Key Behavioral Health Stakeholders Third Experiment

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

Healthcare Reform is Already Underway

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- 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 health care reform will likely unfold.
- Reducing costs is inextricably linked to improving the health status of Americans and improving quality, **payment models are moving towards payment for outcomes**, most notably reduced waste, error, and complication rates and reduction in total health expenditures. The overall clinical strategy is to **promote Centers of Excellence in preventive, primary, specialty and tertiary care**.

Behavioral Health Payment and Delivery System Reform Overview

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- In a "new world" of parity and universal coverage where Medical Homes become accountable for the total healthcare expenditures of their patients, with associated financial risks and rewards,
- Medical practices and health systems will quickly learn that the elderly with multiple medical conditions and persons with serious mental health and substance use disorders are two populations critical to getting a handle on U.S. health care expenditures.

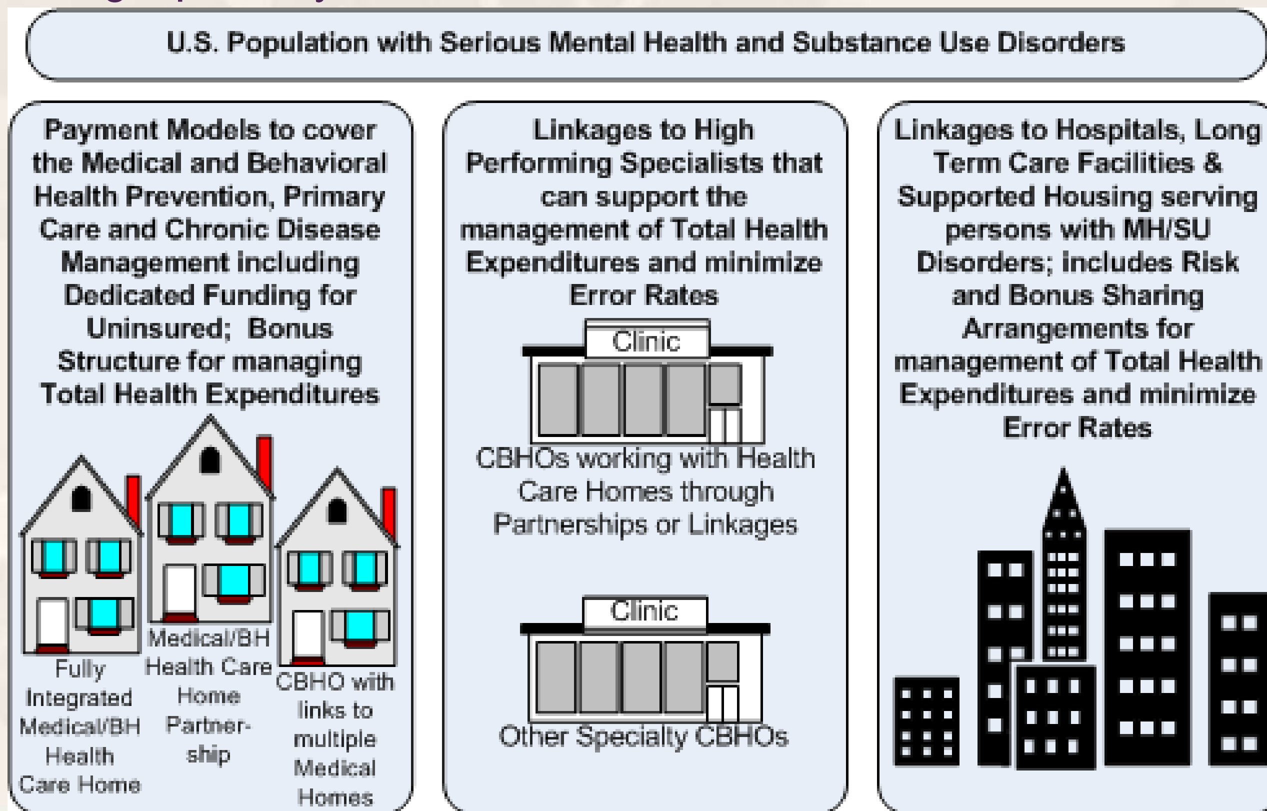
Behavioral Health Payment and Delivery System Reform Overview

- This is going to put both populations under a large magnifying glass and create 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.
- My hypothesis is, 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 health care that manages the total healthcare expenditures of their clients will be at risk.

Behavioral Health Payment and Delivery System Reform Overview

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- Community Behavioral Healthcare Organizations (CBHOs) have two important roles in a reformed health care environment that addresses the needs of persons with serious MH/SU disorders: 1) Serving as an integral part of Medical Homes and 2) Providing Specialty Behavioral Healthcare Services.

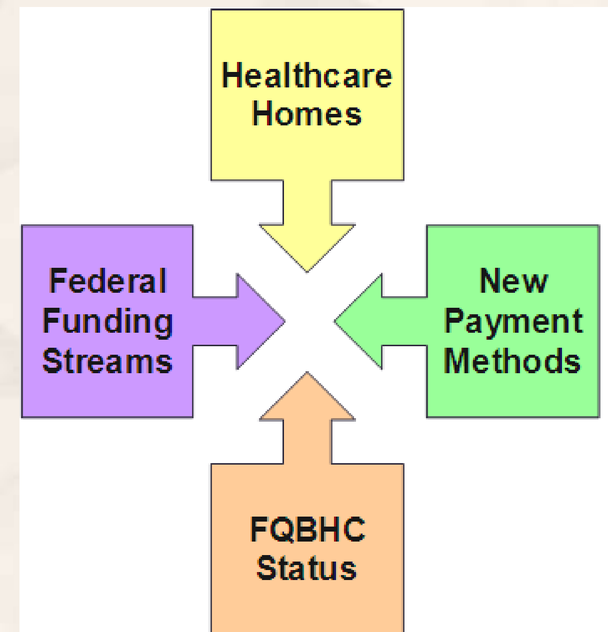


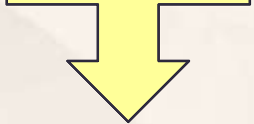
Behavioral Health Payment and Delivery System Reform Overview

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

The following four behavioral health payment reform and delivery design initiatives are essential foundation components of a reformed system.

1. ***Medical Homes*** need to be re-envisioned as ***Person-Centered Health Care Homes*** with additional Federal funding and active participation of Community Behavioral Healthcare Organizations;
2. **Federal designation** should be created for ***Federally Qualified Behavioral Healthcare Centers*** (FQBHC) with accompanying benefits and responsibilities; and
3. ***Dedicated Federal Funding Streams*** should be developed to support behavioral health ***workforce development*** and FQBHCs that will have additional responsibility to serve ***uninsured and underinsured persons*** with serious mental health and substance use disorders.
4. ***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;





Reform 1: Person-Centered Healthcare Homes

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

Behavioral Health / Primary Care
Integration and the
Person-Centered Healthcare Home

Behavioral Health Payment and Delivery System Reform
1. Person-Centered Healthcare Homes

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- In April the 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 health care reforms under consideration.
- Using the National Council's Four Quadrant Model, 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 health care home model that may be more appropriate.

Behavioral Health Payment and Delivery System Reform
1. Person-Centered Healthcare Homes

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- 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.

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
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.

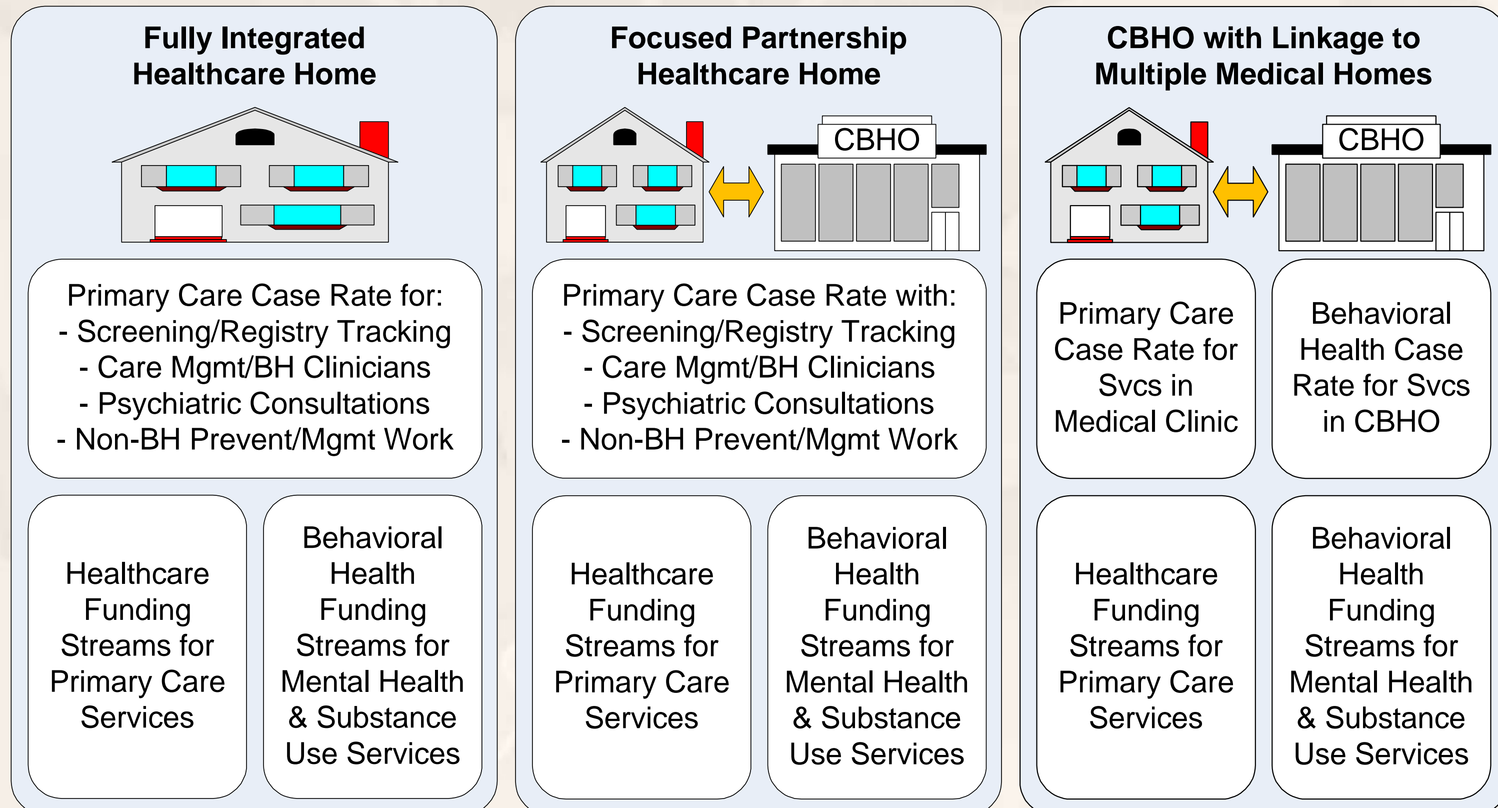
Behavioral Health Payment and Delivery System Reform
1. Person-Centered Healthcare Homes

- As noted, 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 health expenditures, they will prioritize working with Community Behavioral Healthcare Organizations that can assist them in managing the total health 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.

Behavioral Health Payment and Delivery System Reform
1. Person-Centered Healthcare Homes

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

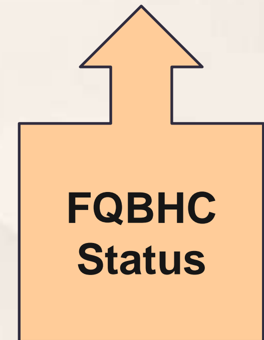
- CBHO involvement in the ***Medical/Healthcare Home*** can occur in one of three ways.



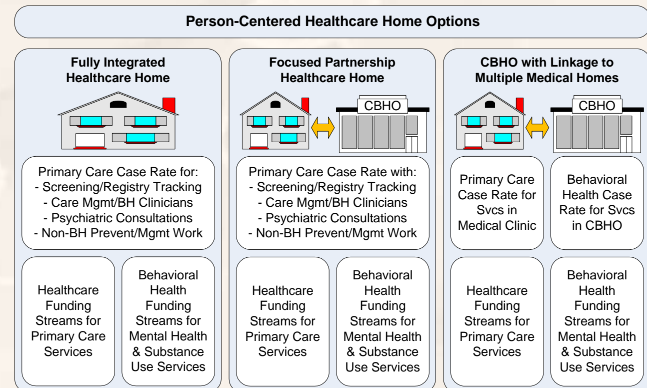
Behavioral Health Payment and Delivery System Reform
1. Person-Centered Healthcare Homes

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- 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 (Quadrants II and IV). 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 health care 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 needs of all four sub-populations.**



Reform 2: Federally Qualified Behavioral Healthcare Centers



Behavioral Health Payment and Delivery System Reform
2. Federally Qualified Behavioral Healthcare Centers

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

- 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.
- 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, 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.

Behavioral Health Payment and Delivery System Reform
2. Federally Qualified Behavioral Healthcare Centers

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

- This table shows 2007 Revenues by payor for the 1,067 Federally Qualified Health Centers that have Section 330 Grants. Note that revenue from the 330 Grants and Indigent Care programs are not available to CBHOs. FQHCs also have higher Medicaid and Medicare revenue due to favorable Federal legislation.

	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	

Behavioral Health Payment and Delivery System Reform
2. Federally Qualified Behavioral Healthcare Centers

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

- As we have studied the FQHC model, 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.
- Specifically, we have been looking at the 10 benefits and the 8 responsibilities that come with FQHC status.

Federally Qualified Health Centers Existing Benefits	FQBHC Proposed
1. Operating Grants: Federal Grants to support the costs of otherwise uncompensated comprehensive primary health care 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)	Yes
Access to Construction Grants as authorized and funded by Congress.	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.	Yes
Access to the Federal Vaccine For Children program and eligibility to participate in the Pfizer Sharing the Care Program.	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 … donations, loans, etc., which benefit the medically under… served by the Center	Yes
8. FTCA Coverage: Access to Federal Tort Claims Act (FT… the Center and its health care professionals, including c… professionals in lieu of purchasing malpractice insurance	
9. Recruitment: Access to providers through the Nation… Corps if the Center's service area is designated as a he… shortage area	
10. Quality Improvement: The opportunity to participate in … Health Care disease management learning models and the … Collaboratives	

Federally Qualified Health Centers Existing Requirements	FQBHC Proposed
1. Eligible Entities: Private, charitable, tax-exempt nonprofit organization or public entity	Parallel Requirement plus Note A
2. Clinical Operations: Must employ a core staff of clinical staff that is multi-disciplinary, and culturally and linguistically competent Must provide either directly or through contract or established arrangement: • 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	Parallel Requirement based on Defined Array of BH services, see Attachment I
3. IT System: Must have an IT system that is able to collect, organize and analyze data for reporting and to support management decision-making • HRSA collects data annually from section 330 funded health centers through the Uniform Data System (UDS) • The data are reviewed to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments • UDS data are compared with national data to look at differences between the U.S. population at large and those individuals and families who rely on the Centers	Parallel Requirement
4. Service Area: Must serve a high need designated area. • "Catchment Area" is the area in which the majority of the health center's patients reside • Section 330 requires that each grantee periodically review its catchment area • Should be identifiable by census tracts and zip codes • Must be federally designated as a Medically Underserved Area (MUA) in full or in part or contain a federally designated Medically Underserved Population (MUP), which may include groups of persons who face economic, cultural or linguistic barriers to health care	Parallel Requirement See Note B
5. Target Population: Medically underserved population to be served • Usually a subset of the entire service area population, but in some cases may include all residents of the service area	Parallel Requirement See Note C
6. Service Sites: A location where a health center, either directly or through an established arrangement, provides services to a defined service area or target population	Parallel Requirement
7. Service Providers: Providers are individual health care 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	Parallel Requirement See Note D

Behavioral Health Payment and Delivery System Reform
2. FQBHC Benefits

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- Note that items 1, 2 and 4 relate to the revenue rows in the slide above.

Federally Qualified Health Centers Existing Benefits	FQBHC Proposed
1. Operating Grants: Federal Grants to support the costs of otherwise uncompensated comprehensive primary health care 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)	Yes
Access to Construction Grants as authorized and funded by Congress.	Yes

Behavioral Health Payment and Delivery System Reform
2. FQBHC Benefits

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- The following support cost savings rather than new revenue.

Federally Qualified Health Centers Existing Benefits	FQBHC Proposed
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 health care 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 Health Care disease management learning models and the Health Disparities Collaboratives	Yes, BH-oriented

Behavioral Health Payment and Delivery System Reform

2. FQBHC Requirements: The following constitute the potential "entrance requirements".

Federally Qualified Health Centers Existing Requirements	FQBHC Proposed
1. Eligible Entities: Private, charitable, tax-exempt nonprofit organization or public entity. **Note A:** FQBHC could add: plus Licensed or certified by the State in which it is located as a community mental health center and substance use services provider.	**Parallel Requirement** plus Note A
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.	**Parallel Requirement** plus should designate SMI/SED as MUPs
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. **Note B:** 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.	**Parallel Requirement** See Note B.
4. Clinical Operations: Must employ a core staff of 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. Must provide either directly or through contract or established arrangement all required primary and preventive services; supplementary services; case management services; enabling services including outreach, transportation and translation; education regarding the availability and proper use of health services; and additional health services to meet the needs of the population.	**Parallel Requirement** based on a nationally agreed-upon Defined Array of BH Services

Behavioral Health Payment and Delivery System Reform
2. FQBHC Requirements

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

Federally Qualified Health Centers Existing Requirements	FQBHC Proposed
5. Service Providers: Providers are 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. **Note C:** For FQBHC, substitute "behavioral healthcare professionals" for "healthcare professionals" and add language about the ability of peers and non-licensed providers to work under the oversight of a licensed provider.	**Parallel Requirement** See Note C.
6. IT System: Must have an IT system that is able to collect, organize and analyze data for reporting and to support management decision-making. • HRSA collects data annually from section 330 funded health centers through the Uniform Data System (UDS). • The data are reviewed to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments. • UDS data are compared with national data to look at differences between the U.S. population at large and those individuals and families who rely on the Centers.	**Parallel Requirement**
7. Quality Improvement Activities: FQHCs must participate in Health Disparities Collaboratives and other structured quality improvement activities in order to stay in good standing as an FQHC.	**Parallel Requirement**
8. Productivity Expectations: Physicians are expected to provide 4,200 encounters and midlevel clinicians 2,100 encounters per FTE per year. **Note D:** 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.	**Parallel Requirement** See Note D.

Behavioral Health Payment and Delivery System Reform
2. Federally Qualified Behavioral Healthcare Centers

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

- The ability to achieve FQBHC designation and the accompanying financial benefits are necessary components for Community Behavioral Healthcare Organizations to be able to adapt to the changes that will occur in the general healthcare system.
- FQBHC status will create <u>one set of national standards</u> 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.

Behavioral Health Payment and Delivery System Reform
2. Federally Qualified Behavioral Healthcare Centers

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

- This leads to the recommendation that Congress 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.
- Key questions that will need to be answered include:
  - What help does the National Council need to turn this idea into law?
  - What is the best way to build a campaign to mobilize partner groups and win over potential critics?
  - How can the Healthcare Home concept be integrated with the FQBHC concept to strengthen it?
  - How can the National Council get out in front of the rule making process?
  - Which federal agency will oversee the program and how will they ramp up?

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

Reform 3: Targeted Funding for FQBHCs

	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

Behavioral Health Payment and Delivery System Reform
3. Targeted Federal Funding for Behavioral Health

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- There are approximately 21 million low income Americans with a mental health and/or substance abuse 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) receive service in specialty behavioral healthcare or primary care in a year.

	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%	

Behavioral Health Payment and Delivery System Reform
3. Targeted Federal Funding for Behavioral Health

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- As the effects of parity begin to unfold and the nation moves towards meaningful health care reform, there are three major challenged that will be faced by the public and private behavioral health systems.
- **Workforce and Capacity Issues:** As people become served by Medical Homes, there will be a clinical and financial incentive to ensure that their behavioral health needs are met in order to better manage both their chronic medical conditions total medical expenditures. This will increase the demand for mental health providers.
- **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.
- **Serving the Indigent, Uninsured and Underinsured:** If Community Behavioral Healthcare Organizations obtain FQBHC status, which may bring added obligation to serve additional safety net residents in their catchment area and if universal coverage unfolds over several years, CBHOs could be faced with a substantial unfunded mandate unless additional funds are earmarked for this population.

Behavioral Health Payment and Delivery System Reform
3. Targeted Federal Funding for Behavioral Health

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- We've quantified what it might cost to address the uninsured/underinsured portion of the problem - $1.7 billion per year.
- And the CBHO workforce shortage – 30,000 full time equivalent clinicians.

	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

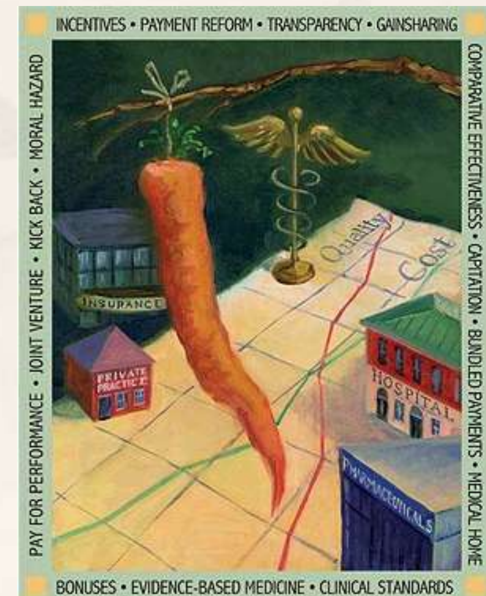
Behavioral Health Payment and Delivery System Reform
3. Targeted Federal Funding for Behavioral Health

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

- We have concluded that, for health care 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, uninsured and underinsured persons** who are not currently being served.

New Payment Methods

Reform 4: Federal and State Payment Methods



Behavioral Health Payment and Delivery System Reform
4. Federal & State Payment Methods

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- Funding methods for CBHOs are also going to need to change to address the imbalances in the current system and reverse existing incentives.
- **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.

Behavioral Health Payment and Delivery System Reform
4. Federal & State Payment Methods

- One model, which combines designs from pending health reform legislation and FQHC funding, includes three funding components:
  - **FQHC-Like Prospective Payment System** for mental health and substance use services that are part of formal planned care and not included in the case rate.
  - **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.
  - **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.

Behavioral Health Payment and Delivery System Reform
4. Federal & State Payment Methods

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

This flowchart provides a *before and after* view to illustrate how new payment mechanisms will unfold. A Pay for Performance layer will be added to incentivize quality and outcomes.

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

1174424858workinghard.wmv

The Role of Key Behavioral Health Stakeholders Next Steps

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

The Role of Key Behavioral Health Stakeholders
Next Steps

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

- An important aspect of the change process is to build momentum and support for these behavioral health reforms. This includes:
  - **Legislation:** Working with Congress and the Administration to create enabling legislation for these initiatives.
  - **Education:** Educating NCCBH members, behavioral health partner organizations, state Medicaid and behavioral health authorities, health care policy experts, and key members of the healthcare community about the opportunities and risks that healthcare reform creates for persons with SMI/SED in order to create momentum for needed legislation and regulatory change and lay the groundwork for implementation.

The Role of Key Behavioral Health Stakeholders Next Steps

- **Support for Consumers:** Helping consumers and advocacy groups expand their voices as healthcare reform unfolds to ensure that their needs are not lost in the shuffle.
- **Support for CBHOs:** Helping CBHOs prepare for the changes they will need to make in order to successfully operate in the new environment and take advantage of the initiatives.
- **Planning Workgroup**: Bringing a workgroup together to add more detail to the initiatives to influence the Federal budget and rule-making processes, addressing a number of key issues:
  - Who would administer a FQBHC program and the related funding?
  - How should the program ramp up?
  - How do these initiatives stay aligned with state activities and general healthcare reform initiatives?