

## HEALTHCARE REFORM 2009

Aligning Oregon's Behavioral Health/Primary Care Integration Efforts with National Healthcare Reform and Lessons from Other States - summary highlights of Dale Jarvis/Barbara Mauer presentation to Oregon AMH, CMHPs, MHOs, FCHPs, and other providers

May 28, 2009

1. Healthcare Reform is on a fast track and states that want to successfully leverage federal reforms need to align with the three components of reform: universal coverage, payment reform, and delivery system redesign.
2. Clinical Integration of mental health and substance abuse with physical health is necessary to achieve whole health outcomes for the safety net population.
  - \* This requires a well-defined service model and fidelity to that model in order to achieve outcomes.
  - \* Simply placing mental health/substance abuse staff in primary care settings does not necessarily achieve outcomes.
  - \* Measurement of outcomes requires a common framework for integration, consistency of service definitions, detailed specifications of each outcome measure at the beginning of the project and building detailed workflows to assure steps in process occur and data is collected.
  - \* The Four Quadrant Clinical Integration Model and The Person-Centered Healthcare Home for people with Serious mental illness are being looked at federally as key aspects of system redesign.

Clinical integration helps us focus on what people need and requires financial and structural supports in order to be successful.

3. Financing Issues that need to be addressed include
  - \* The status of Mental Health Carve-Ins (Public sector efforts focused on financial integration have had limited success).
    - New Mexico carve in did not work and had to be restructured into carve out.
    - Mid Tennessee Carve-in to Health Plan was disappointing and showed no changes on the ground.
    - The Washington Medicaid Integration Partnership, a voluntary managed care pilot project in Snohomish County, Washington, designed to improve outcomes and save money did neither.
  - \* Safety Net Mental Health Funding Gaps
    - About 15,500 individuals have a serious mental illness and are neither covered by insurance nor receive mental health services through any state programs, including OHP.
    - The Community Services Workgroup Report for the Oregon State Hospital Master Plan (Fall, 2008) estimates that approximately \$579 million biennially in additional funding is needed to provide services to all individuals who have serious mental illness and are not otherwise cared for now.
    - At a minimum, \$105 million per year would be needed to provide community-based services (Not including inpatient and residential/housing) to address this unmet need.
  - \* Payment Mechanisms: Risk-Based and Performance-Based Contracting
  - \* Funding Barriers to Primary Care/Behavioral Health Integration

Financial or structural integration does not assure clinical integration.

4. Proper Design and Sequencing of reform efforts will make the difference between state level change efforts that result in improvement and those that don't.

- \* We must do our homework and create a realistic timeline
- \* We must engage key stakeholders to design and guide the system
- \* We should create a strong clinical design supported by evidence based practices
- \* We should design a performance management system that matches the clinical design and includes outcome measures and modern data collection systems
- \* We should develop appropriate financing and management systems tailored to the clinical design.
- \* We must address regulatory barriers; waiver renewals, Medicaid State Plan amendments, and OARS.
- \* We should continue to monitor and adjust our path based on lessons learned

**Dale and Barbara ended with 4 key points:**

- 1) Clinical design comes first in planning. Funding and structural design should flow from the clinical design and be designed to support the clinical design.
- 2) Performance-based payment systems are not the same as clinical outcomes payment systems. Payment systems based on clinical outcomes are challenging and hard to measure. Performance outcomes based on processes that are highly related to positive clinical outcomes (for example health screening protocols) are easier to achieve.
- 3) Payment systems have to include case rate - type payments for things not easily lending themselves to CPT/HCPS Codes, fee for service payments (CMS is unlikely to abandon this) and performance-based incentives.
- 4) If Oregon doesn't take sufficient time to address all of the issues identified above we will have false starts, lose time, money, service capacity and impact consumer lives.
- 5) If Oregon goes too slow, we will lose the opportunity to wisely use resources and improve the health and behavioral health status of consumers.