Financing Prevention Services:
Emerging Payment Models in the Shifting Prevention Landscape

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Integrating Primary and Behavioral Health Care Through the Lens of Prevention
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OBJECTIVES

1. Highlight recent shifts in the prevention landscape
2. Examine prevention efforts under the Affordable Care Act (ACA)
3. Explain the role of substance abuse prevention within broader medical "prevention"
4. Present a "101 level" glossary of health care payers and payment models for a prevention audience
5. Discuss potential roles for prevention professionals to leverage relationships and evolving funding opportunities to promote health for individuals and communities

THE PREVENTION LANDSCAPE

PREVENTION IN THE 21ST CENTURY

- A paradigm shift
- Mental Health and physical health are inseparable
- Successful prevention is inherently interdisciplinary
- Coordinated community-level systems are needed.

THE EVOLVING LANDSCAPE

A Decade Ago

- Isolated
- Direct Service
- Youth Focused
- Community Focused
- Single Issue Coalition
- Evidence Based Interventions
- Grant Funded

Evolving

- Integrated
- Direct / Indirect Service
- Across the Lifespan
- Ecological Focused
- Public Health Focused
- Evidence Based Programs, Practices, and Process
- Services Reimbursed

CONTINUUM OF CARE

Promotion

Prevention

Universal

Selective

Indicated

Treatment

Case Identification

Standard Treatment

Long-Term Treatment

Recovery

Maintenance

After-care and Rehabilitation

Promotion

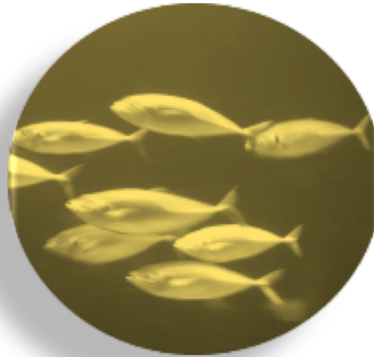
Promotion

CONTINUUM OF CARE: SECTORS

Universal

General public or a whole population (community or school) that has not been identified on the basis of individual risk

Selective



High risk subgroup for behavioral health disorders whether an imminent risk or lifetime risk.

Indicated

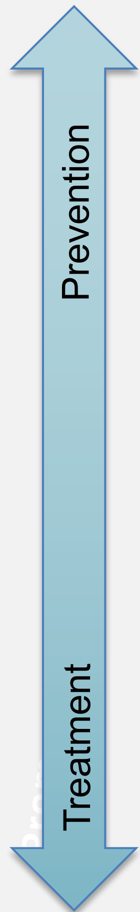
Identified, high-risk individuals with symptoms of behavioral health disorders, but who do not meet diagnostic levels at the current time.

EXAMPLE: INTERDISCIPLINARY

- Education
- Child Welfare
- Public Health
- Juvenile Justice
- Early Education
- Community Programs
- **Primary Medical Care**

LEVELS OF PREVENTION

IN CONTRAST TO MEDICAL TREATMENT



Level	Audience	Example

Prevention keeps harm from occurring in the first place or detects a health problem early enough to cure or ameliorate it.

Treatment is defined as “what a health care provider does to relieve, reduce or eliminate harm once it has become manifest in an ailment.”

LEVELS OF PREVENTION

IN CONTRAST TO MEDICAL TREATMENT

	Prevention		
	Population-based, systems, environmental	Community-based programs	Clinical preventive services
Setting	Workplace, neighborhood, county, city state,	Home, school, childcare, workplace, local	Primary care office, clinic, hospital, behavioral health provider
Delivered to…	All residents in a geographic area	Program participants, individuals, families, groups	Patients, clients, consumers
Examples	• Smoke-free workplace law • Impaired driving law	• Community health worker • Home-visiting program	• Nutrition counseling • Screening for depression or suicide risk
Level of Prevention	Mostly Primary Prevention	Primary and Secondary	Mostly Secondary

Treatment, disease management, recovery, tertiary

EXAMPLE: INTEGRATED

Opioid Abuse

Chronic Pain →

Headaches →

Suicidality

← Depression

← Anxiety

Physical Health Problems

Behavioral Health Problems

Trauma/Adverse Childhood Experiences

Social Isolation

Intersection

Quinlan, K. and Crosby, A. (2018, June 5). *The Intersection of Opioid Abuse, Overdose, and Suicide: Understanding the Connections.* [Webinar]. In Center for the Application for Prevention Technologies/Suicide Prevention Resource Center Webinar Series. Education Development Center, Waltham, MA.

EXAMPLE: ECOLOGICALLY FOCUSED

General socio-economic, social, and cultural conditions

Living and Working Conditions

Transportation

Unemployment

Work Environment

Water and Sanitation

Education

Health Care Services.

Agriculture Food Production

Housing

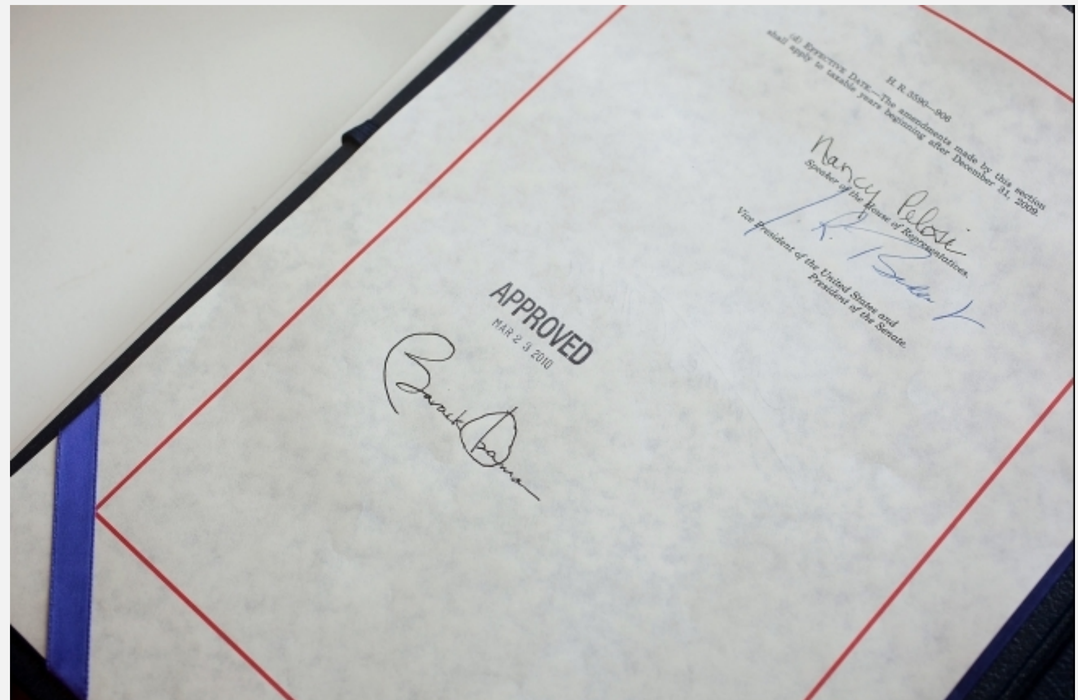
Social and Community networks

Individual Lifestyle Factors

THE PREVENTION LANDSCAPE

Behavioral Health
Trauma-Informed
Credentialing
Managed Care
Medicaid
Recovery
Healthcare Reform
Medical Homes
FQHC
Reimbursed Services
Primary Care
Heath Disparities
Payers

THE AFFORDABLE CARE ACT (ACA)



THE ACA'S 3 PILLARS

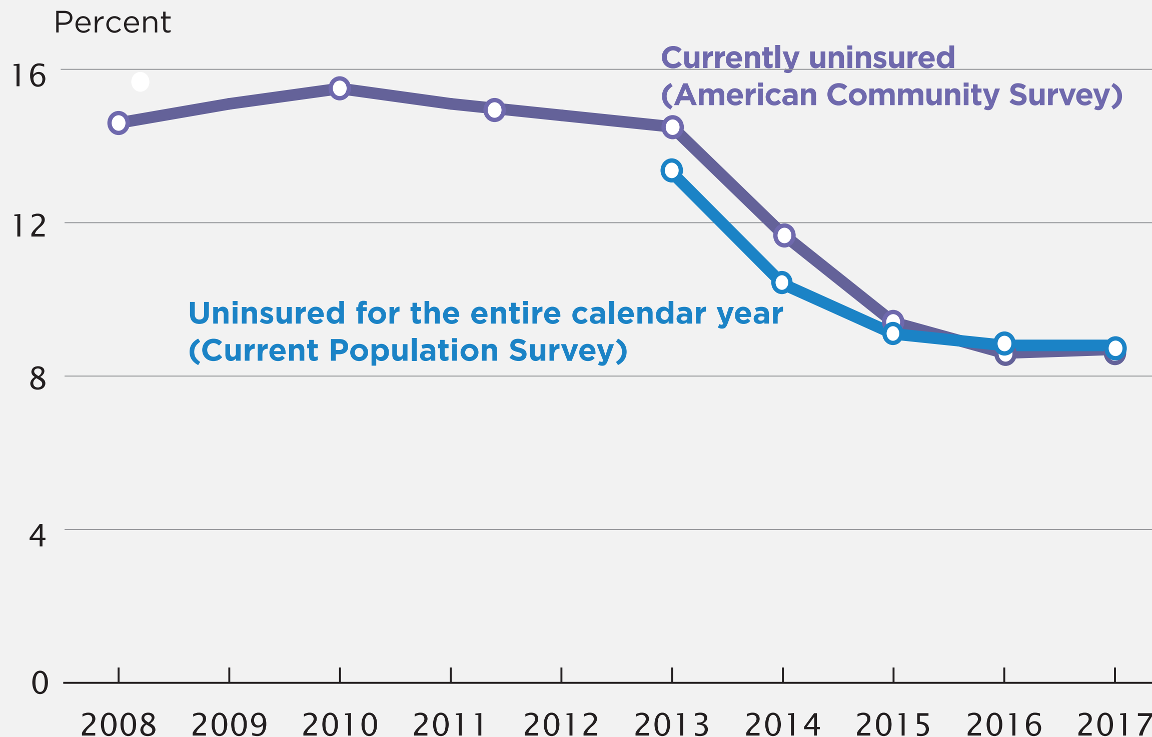
- Expand insurance coverage
- Improve health care quality
- Slow health care cost growth

Historical Context

- Passed in 2010
- Most implementation began 2013/2014
- Lots of moving parts over 8 years!

Key Pieces: Medicaid Expansion, Marketplaces (and subsidies), Essential Health Benefits, Integrated Care & lots of other things!

COVERAGE INCREASED!



2 Primary Components

- Medicaid Expansion
- Health care marketplaces

Note: Estimates are for the civilian noninstitutionalized population. For the Current Population Survey, estimates reflect the population as of March of the following year. For the American Community Survey, estimates reflect the population as of July of the calendar **Source: U.S. Census Bureau, Current Population Survey, 2014 to 2018 Annual Social and Economic Supplements and 2008 to 2017 American Community Survey, 1-YearEstimates.**

IMPROVING QUALITY OF CARE

- Essential Health Benefits (EHB) Mandates
  - A set of 10 services required under ACA-approved plans (this is changing)
  - **Mental health and substance use disorder services, including behavioral health treatment**
  - **Preventative health and wellness services**
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) reforms and expansion
  - Payment vehicle for Screening Brief Intervention and Referral to Treatment (SBIRT) programs
- **Integrated care models/payment mechanisms**
- And new prevention initiatives…

THE ACA & PREVENTION

Most prevention programs focus on somatic health (e.g., diabetes, heart disease, etc. **BUT**… Substance use prevention **IS** part of this change

- Prevention and Public Health Fund
  - "Improve health and help restrain the rate of growth in private and public health care costs"
  - First mandatory funding stream dedicated to improving US public health system
  - Funded suicide prevention as well as tobacco prevention (SAMHSA)

Enhanced Medicaid funding for services with "A" or "B" grades from the U.S. Preventative Services Task Force. Most private plans must cover 71 preventive services w/o cost sharing, including:

- Alcohol screening & counseling for adults, depression screening for adults and children
- Alcohol & drug use assessments for adolescents, comprehensive behavioral health assessments for children

PREVENTION & PRIMARY CARE

70% of all health care visits are driven by psychosocial factors

80% of people will visit a health care provider during a year

National Research Council and Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: The National Academies Press. Cooper, S., Valleley, R.J., Polaha, J., Begeny, J., and Evans, J.H. (2006). Running out of time: Physician management of behavioral health concerns in rural pediatric primary care. Pediatrics, 118, e132-e138.

PRIMARY CARE PARTNERSHIPS…

- Reach a large audience of **individuals in need**
- Integrate behavioral health prevention into **“mainstream prevention”**
- Facilitate a **coordinated approach** to health/wellness
- Reinforce the **integrated nature of health**
- Generate significant **cost savings**
- Lessen the **burden on other systems**

HEALTH CARE PAYERS

- **Private**
  - Employer-sponsored
  - Individual
- **Public**
  - Medicare
  - Medicaid
  - VHA, IHS & TRICARE

WHY HEALTH CARE PAYERS?

A health care provider's funding sources

- –Drive service delivery decisions
- –Determine the services customers can receive
- –Dictate where individuals can receive care
- –May open up population-level options

Health care providers **WILL** make decisions based on payer policies

HEALTH CARE PAYERS: PART 1

Private Insurance. Any insurance not provided by the government

- Employer-Sponsored vs. Individual Insurance
- Private insurance has risen under the ACA (ASPE, 2016; U.S. Census Bureau, 2015)
- Coverage for prevention screenings and early interventions will become increasingly important

Medicare. The country's federally funded health care program for the elderly

- Parts A through D
- Because of its size, Medicare is the focus of myriad integration and cost savings initiatives
- Covers and promotes a wide-range of preventive and screening services, including tobacco cessation counseling and yearly wellness visits

HEALTH CARE PAYERS: MEDICAID

Medicaid. State Medicaid programs offer health coverage to low-income Americans, including adults, children, pregnant women, and individuals with disabilities

- Every state has a Medicaid program, but each is unique
- States administer their own Medicaid programs
- Jointly funded with the federal government
- CMS sets basic Medicaid requirements, but states have wide latitude
- Children's Health Insurance Program (CHIP)

Medicaid Waiver/Medicaid State Plan Amendment (SPA). States can use Medicaid waivers or SPAs to modify their Medicaid programs

- Adding/changing coverage or adjusting payment methodologies
- CMS must approve proposed changes
- Must not offer less than federal requirements or increase federal costs
- States may be able to modify their programs through these mechanisms to better partner with substance use prevention initiatives

MEDICAID EXPANSION – 34 (37)

Status of State Medicaid Expansion Decisions

WA, OR, CA, AK, HI, NV, ID‡, MT*, WY, UT‡, CO, AZ*, NM, ND, SD, NE‡, KS, OK, TX, MN, IA*, MO, AR*, LA, WI, IL, MI*, IN*, OH, KY^, TN, MS, AL, GA, FL, SC, NC, WV, VA◊, PA, NY, VT, ME◊, NH*, MA, RI, CT, NJ, DE, MD, DC

- Adopted (34 States including DC)
- Considering Expansion (3 States)
- Not Adopting At This Time (14 States)

NOTES: Current status for each state is based on KFF tracking and analysis of state activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 expansion waivers. ^On June 29, 2018, the DC federal district court invalidated the Kentucky HEALTH expansion waiver approval and sent it back to HHS to reconsider the waiver program. ‡UT passed a law directing the state to seek CMS approval to partially expand Medicaid to 100% FPL using the ACA enhanced match. ID, NE, and UT have measures on their November ballots to fully expand Medicaid to 138% FPL. ◊Expansion is adopted but not yet implemented in VA and ME. (See the link below for more detailed state-specific notes.)

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated September 11, 2018.
https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

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PAYMENT SYSTEMS

- FFS
- “Managed Care”
  - HMOs and MCOs
- Accountable Care Organizations
- Patient Centered Medical Homes
- Health Homes (Medicaid only)
- Capitated & Bundled Payments

WHY PAYMENT SYSTEMS?

- How providers get paid **WILL** influence how they think about prevention partnerships
- Determine who to approach and how
- Understand and anticipate partner concerns
- Consider broader implications of shift to integrated care and "next steps" for prevention

FEE FOR SERVICES (FFS)

- The most “basic” health care payment model
- Providers receive payments for each service delivered
- Many payers are attempting to phase out FFS
- Straightforward financial incentive to implement new substance abuse prevention initiatives (e.g., screenings) **BUT**
- Incentive only exists if the applicable payer covers services
- A provider operating under FFS for one patient may operate under a different payment structure for another patient

"MANAGED CARE"

- A number of related strategies designed to reduce the cost (and improve the quality) of health care. Including but not limited to:
  - Contracting with a select set of providers
  - Incentives for providers and/or patients to choose less costly care (e.g., by changing their reimbursement systems)
  - Reviewing the medical necessity of specific services
  - Intensive management of high-cost patients
- May utilize several different payment structures
- Not restricted to private insurance
  - 39 states use Medicaid managed care organizations (MCOs)
  - Medicare Advantage

MANAGED CARE - HMO

- **Health Maintenance Organizations** (HMOs): A common managed care strategy in private insurance to control costs by restricting patients to a certain network of providers with pre-negotiated (and lower) fees

- **Provider Network.** In certain managed care systems, the provider network is the group of organizations (including physician groups, hospitals etc.) that agree to accept pre-negotiated payments for a set of enrollees from one specific payer
  – Under an HMO, "in network" providers accept their patients' insurance payments because they are part of the managed care system
  – "Out of network" providers do not have those agreements with the payer

ACCOUNTABLE CARE ORGANIZATIONS

Accountable Care Organizations (ACOs). Collaborative organizations that comprise numerous health care providers (e.g., doctors and hospitals, often including specialty care) and one or more payers to coordinate care for shared patients

- Members agree to be accountable for the quality, cost, and care of their patients
- Originally limited to Medicare; now in Medicaid and private insurance
- Coordinate and improve care
- Emphasize prevention to improve outcomes & reduce costs
- Likely to value SUD prevention partnerships that can help prevent more costly treatment (but may worry about costs)

Accountable Care Communities (ACCs) – Expand ACOs to be responsible for entire communities, incorporating non-health care entities.

HEALTH HOMES & PCMHS

Health Homes (Medicaid Only). Optional under Section 2703 of the ACA, they are a service delivery model to help states coordinate care for populations with chronic conditions, which can include substance abuse. States have flexibility to set providers and payment methodologies.

Patient Centered Medical Homes (PCMH). A service delivery model based on comprehensive and coordinated care through a team of providers that spans prevention/wellness, behavioral health, acute care, and choric care across office-based primary care, hospitals, specialty care, home care, and the community. PCMHs emphasize patient-centered principles, accessible services, and quality & safety. *Adapted from AHRQ. https://pcmh.ahrq.gov/page/defining-pcmh*

"VALUE BASED" PAYMENTS

Capitated Payments. Providers receive a lump sum payment for each patient for a set period of time (e.g., one year)

- Providers cover all patient costs during that time period, keep remainder as profit
- Providers using capitated payments may be resistant to new prevention services that were not considered as part of their capitated payment
- They may also recognize prevention as a way to achieve long-term savings (e.g., by preventing a more costly SUD treatment)

Bundled Payments. Providers receive a single payment for all services that a patient receives for one health condition within a set period of time

- Providers using bundled payments may resist new prevention services that were not considered as part of their capitated payment **BUT**
- They may also favor those services to achieve long-term savings

COLLABORATION: THE COOL KIDS ARE DOING IT!

- **Be Strategic:** Decide who to approach based on your and *their* goals
- **Remember**: They are trying to make money
- **Make it About THEM**: Explain how working with prevention can help THEM (e.g., cost effectiveness, new billable services?)
- **Be Understanding**: Showing them that you understand how they get paid (and their need to do so) goes a long way
- **Make a Clear Ask:** Suggest a specific way they can work with you
- **Be Flexible**: Funding mechanisms WILL complicate the collaboration – work together to find a compromise
- **Prepare for Personnel Challenges**: Crucial for reimbursement
- **Take the Long View**: Work with partners to get services billable

https://www.integration.samhsa.gov/financing/billing-tools

Discuss potential roles for prevention professionals to leverage relationships and evolving funding opportunities to promote health for individuals and communities.

About the Great Lakes PTTC

- Training and technical assistance to the SUD **prevention** field
- Based at the UW-Madison
  - Funded by SAMHSA, eff. 9/30/2018
  - Part of SAMHSA's ***new*** Technology Transfer Center (TTC) Network
  - Serving HHS Region 5

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