

Health Elevations



A Quarterly Journal on
Health Policy in Colorado

Spring 2015



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Health Elevations



THE COLORADO HEALTH FOUNDATION

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Spring 2015

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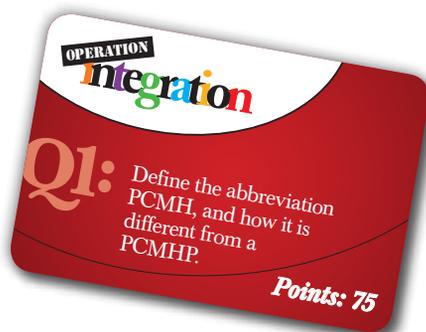
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Play Operation Integration, and rate your knowledge of advanced health care lingo.



Play Operation Integration and Score Yourself a Genius

How deep is your lingo know-how when it comes to the big terms of integrated health care? Test yourself throughout this issue of *Health Elevations*, beginning with the first question card on page 7. Add up your correct answers in our game key on page 21 and see if you're an Integration Intellectual, or someone in serious need of a new health dictionary.

About the Colorado Health Foundation

HEALTH ELEVATIONS seeks to further the goals of the Colorado Health Foundation by highlighting problems that can be solved, illuminating the people who are making progress in solving them and provoking a new way of looking at complex health issues. The journal will report on and synthesize a variety of sources to provide information that can further the work of policymakers, grantees, providers and the engaged public in advancing better health care, health coverage and healthier living. Useful information presented in a memorable way is indispensable to the complex field of health policy.

THE COLORADO HEALTH FOUNDATION works to make Colorado the healthiest state in the nation by ensuring that all Colorado kids are fit and healthy, and that all Coloradans achieve stable, affordable and adequate health coverage to improve their health with support from a network of primary health care and community services. To advance our mission, the Foundation engages the community through grantmaking, public policy, investing in evaluation, private sector initiatives and strategic communications. For more information, please visit www.ColoradoHealth.org.

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Walking the Talk



Integrated Care Poised for Next Challenge

It's a baffling, complex challenge:

Shifting all the moving pieces of Colorado health coverage and care into an integrated, whole-body system, where patients' needs are handled in one stop and providers are paid fairly to manage care for higher quality outcomes.

Oh yes, and save us all some money at the same time.

This goal of integrating health care, while paying people fairly and efficiently to do it, is the right target. What we hope to show in this edition of *Health Elevations* is that 1) it's actually getting done, in a surprisingly large number of places across Colorado, and 2) focused help from the right policymakers could push success over the top.

Patient after patient, doctor after doctor, counselor after counselor will tell you that smoothing the flow from physical care to behavioral care for the many patients who need both is a clear winner for the individual's health. They feel better, they are more productive, their families are relieved, and studies show money gets saved for both government and private payers.

What the detailed reporting in this edition shows is that Colorado safety net clinics — often perceived as bare-bones care for the desperate — are in fact leading the way on integrated care. Progressive offices like Clinica, Salud, Peak Vista, Denver Health and others have knitted psychologists, dentists and other whole-body providers right into the fabric of traditional physical care. And as a major payer, Colorado's Medicaid office has been a leader in putting more than three-quarters of a million patients under a case-management umbrella.

There are vivid stories of how integrated care changes lives. My experiences in small-town Iowa came to mind when hearing about

La Junta residents no longer embarrassed to seek mental health care from thought-leader clinics like Southeast Health Group.

With so many models developing and succeeding in Colorado, now it's time for policymakers to do their share. Will they compensate doctor offices and mental health clinics enough to truly manage cases, for help that is often hard to pay by the billing code? Will they simplify quality measurements so that managing care isn't buried in expensive bureaucracy? Will they steer provider training to create more integrated teams of professionals who respect and complement each other's abilities? Will they break down licensing and payment barriers for innovative telehealth arrangements?

The Colorado Health Foundation wants everyone in the state to experience seamless, integrated care. We hope these wide-ranging articles will shine a spotlight on success and probe into corners where more needs to be done.



Rahn Porter, Interim CEO
The Colorado Health Foundation



The Integrated Care Issue

The May edition of *Health Elevations* is dedicated entirely to assessing where Colorado stands on integrating all forms of health into primary care, and what else needs to change to spread integrated care through the entire state. We travel Colorado in search of best practices and biggest challenges, and focus on policy barriers that still must come down. Our cover image "flags" echo the friendly patient-and-provider signals used at some team-based primary clinics, with help from The Noun Project to visualize fully integrated care.

Please send your thoughts on this issue via Twitter to @COHealthFDN or @MBoothDenver.

From Reform

By Michael Booth, Editor in Chief
Photography by James Chance

Norm?



Collaborative, team-based physical settings are one key to fully integrating primary care offices, evaluators say. Axis Health Systems brings integrated care to the Four Corners region in Durango and Cortez.

to the

2015 is the year when integrated care and payment overhaul begin in earnest.

If integrating behavioral and physical health, while reforming what doctors get paid for, have long been the holy grails for health system change, then 2015 may someday go down as the year the quest could claim true success.

A slow-moving but determined army of Colorado reformers — battle-hardened over years of trying preparations — has now maneuvered to a point where jobs are changing, new hires are arriving on scene, and reward checks are getting cut in support of integration and payment change.

A revolutionary form of global payment system for all of a patient's health needs is finally in place and seeing real clients on the Western Slope. More than half of for-profit giant Anthem's primary care doctors are getting paid extra to manage whole-patient health. A major federal State Innovation Model, or SIM, grant will spread best integration practices to hundreds more health locations in Colorado. A collective impact effort — recently named BC3, or Better Care, Better Costs, Better Colorado — is now aligning partners across government, philanthropy, nonprofits and business that are targeting delivery system and payment reform to speed up integration. And the massing of three-quarters of a million Colorado citizens in one Medicaid management model will produce visible savings, teachable failures, enormous piles of data and new opportunities for innovation in both integration and payment.

“So after all these years of work and talk and planning and organizing and advocating and cajoling, we're really jumping into this,” said Rocky Mountain Health Plans Vice President Patrick Gordon, one of the leaders of the Western Slope global payment design and a member of the BC3 working group.

Reflecting on how long it has taken for some integration and reform efforts to move from plan to reality, Gordon added, “All of this is much harder to do than it is to talk about.”

The personal and fiscal toll of keeping physical and behavioral health separate is enormous, and increasingly apparent. A Milliman study pegged the price of ineffective treatment of comorbid (concurrent) behavioral health conditions at \$350 billion a year, much of it for unnecessary medical and surgical services. About 30 percent of adults with a medical condition also have a behavioral health condition, such as depression or addiction, yet many are not treated at all for the behavioral problem.

One groundbreaking, randomized study of integrating care found that patients assigned to a progressive integrated model saved more than \$3,000 in total health care costs for each patient over four years. The return on investment was \$6.50 for each dollar spent, with improved outcomes.

“It's just been proven over time that the person with behavioral care problems is less compliant and costs more on the medical side,” said Ken Nielsen, president and CEO of the practice management group Physician Health Partners, which has long integrated case managers and social workers and now is embedding mental health clinicians in its primary offices. Patients with behavioral issues won't take necessary prescriptions and will seek treatment through emergency room visits and overnight hospital stays far more often than needed, Nielsen said. “So if you're not treating the whole person, medical costs will go up four or five times what they should be.”

Surveying the Land

In this edition of *Health Elevations*, we survey the terrain of integrated care and payment reform efforts in Colorado, point to the remarkable progress made so far and highlight policy changes still needed to win the long battle. From the Western Slope to Westminster, from Cortez to Colorado Springs, our reporters and writers have put together a robust picture of the state of integrated care with vivid personal illustrations.

We begin knowing that things will have changed again even before these words are printed. Knowing whether change worked is at least as tough as making the changes in the first place.

“There's a newness to all of this. It's important to recognize that not everything is supported yet by evidence,” said Lorez Meinhold, formerly a top health care advisor to Gov. John Hickenlooper and now a reform consultant with the Keystone Center.

To survey the field, it's helpful to agree on a brief glossary for this edition: **Integrated care** at its core is the acknowledgment — medically, psychologically and financially — that behavioral health is as much a key to overall health as are healthy eating, exercise and primary medical care. In practice, this must mean a patient's primary medical provider also manages that patient's behavioral health issues and sets up the practice to monitor and adjust for all needs. Integration, which is further defined below, can mean something as simple as a family doctor reading the chart notes from a patient's stay at a drug treatment center to something as complex as a medical practice hiring staff psychologists in-house and getting a “global payment” to directly treat all of a patient's needs. Increasingly in Colorado, it may also mean an expert behavioral health center adding medical



providers on-site, an apparently effective flip side to traditional “integration.” Other core providers, such as Mental Health Center of Denver, continually look for new services to round out the definition of “integrated.” MHCD, which built an innovative main campus bringing Denver Health medical clinicians into its behavioral practice, also provides extensive housing and benefits connections.

Payment reform recognizes that far too much Colorado money is spent on the back end of health care — at the hospital — instead of the front end of primary medical care. The system has tilted for too long toward high payments for expensive imaging and surgery rather than the more effective but less sexy primary patient intake and office visit. Reform usually means paying the primary providers more so that they can afford to spend more time with patients, screen them for behavioral and substance problems, and hire case managers and mental health staff to fully integrate care. In the past, providers lamented “there was no billing code for that.” In the innovative extreme, payment reform has a payer — a government or insurance company — writing one “global” check to a provider to handle all of a patient’s needs, from strep throat to substance abuse to spinal surgery.

“You can’t tinker enough with a typewriter to make it a computer. And you can’t tinker enough with traditional fee-for-service to make it

integrated care,” said Bern Heath, CEO of Axis Health System, which has combined physical and mental health staff into single locations and practice models for southwestern Colorado.

“We’ve seen magic happen in our clinics,” he said. “We’ll look back on this in years to come as primitive, but right now we’re doing stuff nobody else is doing.”

Promoting Triple Aim

Most health care experts believe the U.S. economy will not truly get a handle on rising health costs until a combination of integration and payment reform shifts spending to the places where it does the most good for patients. The push toward integration and payment reform sometimes falls under a broader rubric of “Triple Aim,” the high-minded goals of 1) improving the patient experience and individual outcome, and 2) controlling costs, while 3) boosting the health of the entire population.

Before the BC3 working group aligned its targets to achieve this Triple Aim, the Advancing Care Together initiative was



Axis teams meet to prepare for upcoming cases and make handoffs to the needed form of care and provider.

funded by the Colorado Health Foundation and launched in 2011. ACT chose 11 physical and mental health provider offices around the state to participate in a push for integrating care. Grant money set up a home office to select and advise the providers and to evaluate progress over three years. (Axis and others mentioned in this edition are ACT-selected sites.)

During the ACT transformation, Axis’ Heath worked with federal officials from the Substance Abuse and Mental Health Services Administration’s Center for Integrated Health Solutions to create a guidebook and common set of definitions. Heath’s hierarchy of integration is broken into six levels:

Health’s hierarchy of integration is broken into **SIX LEVELS:**

Level 1 – Minimal Collaboration. Behavioral and physical providers are at separate locations, with separate computer systems and no regular consultation scheme. Any consultation that does occur is case-by-case, initiated by one of the providers.

Level 2 – Basic Collaboration at a Distance. Still with separate locations and systems, behavioral and primary care providers consult on a more regular basis, but primarily on individual case events. Behavioral care is still considered specialty care.

Level 3 – Basic Collaboration On-Site. Behavioral and primary care co-locate their offices in the same building or clinic. Computer and billing systems are still separate, but collaboration and consultation occur more regularly because of the physical proximity. Consultation is still driven primarily by a provider’s initiative on a case.

Level 4 – Close Collaboration with Some System Integration. Mental and physical health providers now share actual practice space, not just the same building. Their computer systems begin to talk to each other and allow cross-reading of charts. A behavioral health specialist embedded in this practice runs appointments through the main desk and can add notes to medical charts.

Level 5 – Close Collaboration Approaching Integrated Practice. Teams with members across the primary and behavioral spectra meet regularly to discuss cases, but also make proactive screenings and flag issues in the day’s appointments. Case managers begin to bridge any remaining gaps in care. Some medical record access issues may persist.

Level 6 – Full Collaboration in a Transformed/Merged Practice. Patients walk into an office with one name that provides the full spectrum of care from all staff operating on equal levels, with all physical and behavioral appointments and charts flowing through a common system. “The principle of treating the whole person is applied to all patients, not just targeted groups” such as diabetic patients or clinically depressed patients, the guidelines note.

Source: Bern Heath, Axis Health; and federal advisories

One thing we can say with confidence: If you give the primary care and behavioral health folks a chance to work together, they will take it.

Larry Green, MD



In practice, Heath said, integrated care looks like this at Axis sites in Cortez and Durango: An overweight patient walks in, and standard Axis physical and mental health screenings reveal he is borderline obese. A traditional, isolated primary care doctor would say, “You gotta lose some weight,” and then it’s up to the patient. At Axis, Heath said, “We’ll say, ‘You need to lose weight, and here’s three possible programs: diet, exercise and a support group. Which ones do you want? We’ll bring you into our slightly larger exam rooms, which can fit a consultation team with a nutritionist and a physical therapist and the doctor; we’ll tell you about the Tuesday night group and get you the transportation to get there.’”

The problem remaining, Heath added, is that Axis currently loses money under these integration changes because most payers don’t compensate for those moments that don’t have a defined billing code. “It’s great care,” he said, “but care management like that is not paid for. You can’t fix this by tinkering with the codes. That’s like moving deck chairs on the Titanic.”

A partial solution at Axis was to apply for federal community clinic status, which pays a higher reimbursement for Medicare and Medicaid cases that the clinic sees. Axis can also get a six-figure grant for treating the un- and underinsured. Axis, Heath said, is the only clinic in Colorado that’s a member of both a behavioral health and a community health association. “I can barely scrape by with that structure,” he said.

Working Together

With so many forces moving forward on all fronts to integrate care and to reform the Colorado health care payment structure, broader policy changes must keep pace. An enthusiastic doctor group can hire a psychologist on staff, but can’t control what Medicaid pays for a “warm handoff” to an effective counselor; a social worker might intuit that a client’s painkiller addiction started with

true physical mishap, but can’t change a rule that denies access to checking a prescription history.

ACT’s leaders are in the midst of wrap-up evaluations of their three-year work with 11 Colorado practices and will publish a series of peer-reviewed academic papers at the end of the year. Their evaluations will have one eye toward pushing policy change that can further the work of integration.

ACT leaders Larry Green, MD, and Maribel Cifuentes, RN, enumerate some of the policy changes they will be looking for:

- *Synthesis of “literally thousands” of state-based laws constraining what data can be recorded and shared among practitioners and payers, crossing behavioral and physical health boundaries.*
- *Education and licensing reciprocity among states so that, for example, a telehealth psychologist in Maine can treat Colorado patients and be paid from in-state sources.*
- *Grand experimentation within the federal SIM grant to Colorado for integrating care and trying global payments for all of a patient’s mental and physical needs.*
- *Creation of integrated care certification for medical assistants or navigators trained at the community college level, with curriculum designed from best practices learned in the various integrated care pilots.*

Gordon of Rocky Mountain Health Plans adds another, one he sees the Western Slope global payment system bumping up against frequently: overlapping and conflicting measurement of patient outcomes. Each government and commercial payer has its own set of quality measures and is loath to give them up for a standardized system. One goal of collective impact efforts in Colorado, Gordon said, could be to push all Colorado payers to adopt standard measures so that providers understand their targets.

The most important lesson for 2015 that Colorado health care reformers have learned, Green said, is that the two very separate “cultural tribes” of behavioral and medical care are ready for integration when it is offered to them in well-thought-out ways.

“One thing we can say with confidence: If you give the primary care and behavioral health folks a chance to work together,” Green said, “they will take it.” •

Play Operation Integration, beginning here. (Answers on inside back cover.)

Q1: Define the abbreviation PCMH, and how it is different from a PCMHP.

Points: 75

Integration

ON THE GROUND:

Going Deep with an ACT Practice

By Michael Booth
Photography by James Chance

LA JUNTA, Colo. — We could describe integrated care in thousands of words, or we could tell a few quick stories.

Story One

Some months ago, Southeast Health Group took in a new patient who had worn out her welcome at other practices in southeastern Colorado. She reported consistent rectal and belly pain, but also exhibited schizophrenic behaviors that led her to ramble in conversations and try her providers' patience with irrelevant or misleading talk. In short, other providers gave up.

Mendoza-Werner eventually heard enough to believe the pain in her patient's torso was all too real, she sought specialists. And she didn't just send the patient scared and alone to Pueblo for an appointment her mental health issues might force her to skip. At Southeast Health, there's a "warm handoff" to a navigator, who even drives patients to distant appointments.

Turns out the "noncompliant" patient had Stage IV rectal cancer with a huge mass. "We drove her to Pueblo five days a week for eight weeks for radiation treatment," Mendoza-Werner said. "We were furious at the other practice — do you understand she needs more than a door slammed in her face? Behavioral health patients can be hard to take care of, and you have to be willing to stick to it. She's a classic story. She would have died of

unknown causes, and nobody would have helped her."

Story Two

Southeast Health had been seeing a veteran for years for some behavioral needs, and he had been stable and well on psychiatric medication for a long time. Then his behavior started blowing up again. His regular mental health clinician suspected there might be an answer in an office down the hall,

so walked the veteran to a quick appointment with Mendoza-Werner and her medical assistant, Rochelle Peil.

"It turned out he hadn't seen a medical doctor in years, and he had strep throat that had thrown him off," Peil said. "If we weren't talking with behavioral health, they would have just increased his psychiatric meds. That kind of answer doesn't happen if we're not all here together."

Story Three

Before Southeast Health added medical practitioners to its staff, a local resident had been a regular mental health patient for ongoing depression. Each visit, he would park his big, brightly colored pickup truck two blocks away so that small-town friends wouldn't know where he was headed.

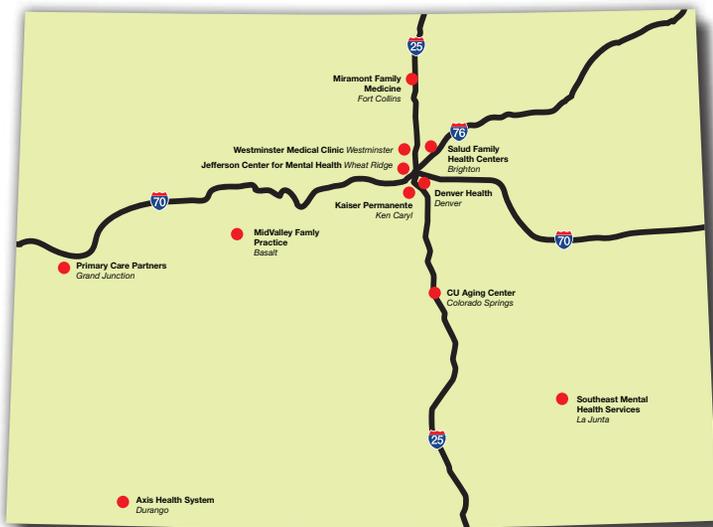
Now the whole town knows Southeast Health is the place to go for all forms of medical and behavioral care. The longtime patient summarized it for clinic chief operations officer JC Carrica: "It's good to be able to park in the parking lot," he told Carrica. "Now people don't have to know why I'm here."

Southeast Health, practicing in La Junta (population: 7,500) as well as other farming and ranching communities in the region, is one of the state leaders in integrated health care. The multisite behavioral health group had much experience embedding its mental health practitioners with primary care offices, but was often frustrated with the results. Co-location is not true integration, Carrica said, echoing the declarations of integrated care proponents across the nation.

As part of the Advancing Care Together practice innovation model launched by the University of Colorado Denver and funded by the Colorado Health Foundation in 2011, Southeast Health decided to bring primary medical care in-house to better serve the community. Previously, Southeast Health had concentrated solely on counseling, substance abuse and other mental health needs.

Integration is being tried in many different forms. The more common method, even among ACT's 11 sponsored innovation sites in Colorado, is to bring a behavioral health specialist full or part time into an existing primary care medical practice. A 2013 ACT evaluation of lessons learned at its 11 sites identified advantages and challenges with that format; at some practices, the new behavioral health practitioner lasted only a few weeks before leaving in frustration.

Carrica and other leaders at Southeast Health saw potential in the reverse: A midlevel medical practitioner with experience in the local population could fit right in. A full-time psychiatrist could theoretically balance physical and mental health in one new position, Carrica said, but the salary is steep at \$250,000 plus benefits, and even then, it's hard to attract a psychiatrist to La Junta. It's easier for Southeast to "outsource" psychiatric professionals through telemedicine links.



"She'd been labeled a noncompliant patient," said Kali Mae Mendoza-Werner, a physician assistant hired as the first primary medical provider within Southeast Health's traditional behavioral health practice.

But Mendoza-Werner had time for the rambling. It's built into her schedule, which currently has her at 13.5 patient appointments a day, where other primary providers might be pressured into handling 20 to 25. When



Southeast Health Group is a longtime behavioral and substance abuse provider now adding physical care to its location for better integration. At right, P.A. Kali Mae Mendoza-Werner has more time with patients than many primary providers.

Carrica's dissertation held the answer. "I found that midlevels find more behavioral cases and refer them more often. And that's what we need — identification and referral."

It took a few months to draw enough patients to fill Mendoza-Werner's schedule and to tweak appointment times to leave enough room for the longer conversations at the core of integrated care. The primary care load is now at about 700 patients, with 17 percent of those also using the behavioral health side of Southeast Health.

"She's going to hit 800 patients in July," Carrica said, which is the trigger Southeast Health leaders agreed on for considering another primary care hire. In discussing expansion, Carrica said, the Southeast Health governing board asked him, "What are others doing?"

"And I said, 'There is no standard in this.'" Progress at practices like Southeast Health is solid proof that when behavioral health and primary care practitioners are given the right setting to work closely together, "they will take it," said Larry Green, MD, ACT program director and professor of family medicine at the University of Colorado Denver. "That may sound silly, but these are different cultural tribes, that have lived in separate worlds their entire careers. If you can build a place where the worlds come together, there are members of these tribes chomping at the bit to do it"

For the next step in advancing integration, Carrica said, "Our biggest barrier is paperwork. As a new patient, you may have to fill out two hours of forms. You may have been suffering for two years with depression without coming in, and then when you do, we ask just enough to

...
If we weren't talking with behavioral health, they would have just increased his psychiatric meds. That kind of answer doesn't happen if we're not all here together.

Rochelle Peil, medical assistant

rip the scar and get it bleeding, and then we say, 'Come back in two weeks and we'll start fixing it.'"

Part of that barrier, Southeast Health officials said, is the doubling of paperwork for its growing population of state Medicaid patients because of the "carve-out" of behavioral health benefits from the standard medical benefit.

"Until we get that intake down to 15 minutes, that patient will not be seeing the advantage of payment reform and practice integration," Carrica said.



Still, the staff is visibly fired up about growing into a fully balanced health center for all of southeast Colorado.

"We are identifying cancer more often here than at the big federally qualified clinics," Mendoza-Werner said, "because we slow it down."

Carrica summed it up even more simply: "You come here for what you need. Everybody is treated the same." ●

OPERATION
Integration

Q2: True or False: Colorado has a pioneer ACO in operation?

Points: 100

Answers on inside back cover.



Juggling Act:

How One Group of Physicians Toys with Every Integrated Payment Model

By Michael Booth

If you sought your MBA in how health care delivery innovation actually happens in Colorado, the headquarters of Physician Health Partners could be your classroom.

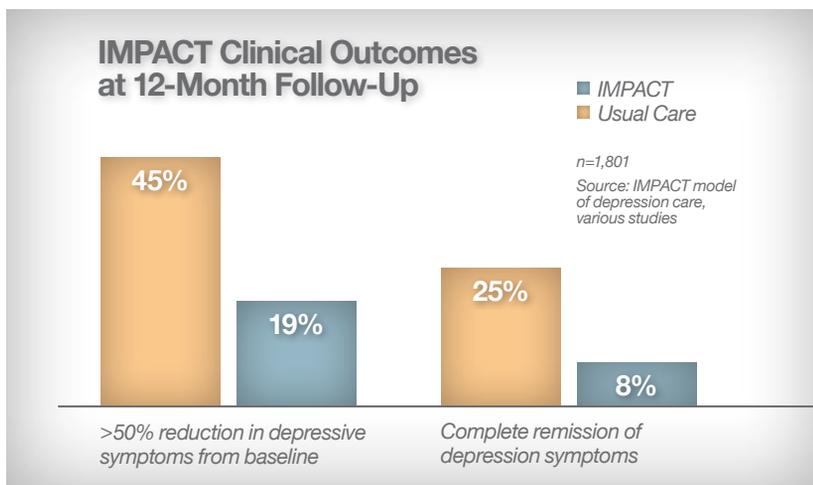
With more than 400 primary care physicians under management contracts, hundreds of thousands of patient lives, and agreements covering most forms of private and public reform models, PHP alternately juggles and analyzes at the forefront of health change.

Medicare Pioneer models. Medicaid Regional Collaborative Care Organizations. Primary care payment reforms launched by a consortium and expanded by for-profit Anthem. Pushes on many fronts to integrate mental health with physical health — PHP negotiates and navigates it all, and is willing to share lessons learned so far.

“It would be impossible to do integrated care without payment reform,” said PHP President and CEO Ken Nielsen. “If you’re not treating the whole person, medical costs will go up four or five times what they should be.”



Integration=Better Outcomes



For example, Archer said none of the private insurers offer case management fees that cover the true costs of adding the services at a given practice, while Nielsen praised Anthem's payments for creating a backbone for promising reform.

As part of *Health Elevations'* survey of ongoing integrated care and payment reform efforts in Colorado, we sat down with PHP leaders to review what they see firsthand.

Medicare Shared Savings, formerly a Pioneer accountable care organization. PHP was originally Colorado's leading charge at the Pioneer ACO model, which was a federal Medicare effort to boost quality and cost savings by more tightly managing Medicare patients. ACOs like PHP had the chance to earn big money, in theory, by demonstrating large savings over the projected costs for its book of patients. But PHP and other "pioneers" were also at substantial risk of losing money when those savings evaporated.

PHP left the Pioneer model for the less-risky Shared Savings program, covering about 30,000 Medicare patients that PHP doctors serve. The main problem? Medicare set the benchmark projected spending for each patient too low. Medicare might set the per-month allowance for each patient in the Denver area at about \$800 a month, while allowing Boston-area patients about \$1,300, Archer said.

Under that system, Colorado doctors are in effect penalized for the efficiencies they have created over many years. Their low benchmark left no more room for savings while still hitting quality goals. "Some of the low-hanging fruit had already been picked here," Nielsen said.

While about half of the pioneers have switched to the less-risky Shared Savings program, Nielsen said, the design has proven that quality goes up. "We had definitely improved the quality across the whole panel. Readmission rates were low and getting lower. But it takes more than one year to create the efficiencies you need. We feel like we'll have more time in this program before we go back to the risk model."

Anthem's primary care innovation. With about 46,000 patients using Anthem insurance at various PHP practices, the physicians are in close partnership with the for-profit insurer, which is a division of the national giant WellPoint. The ACO created by the partnership has Anthem paying per-member-per-month fees for case management based on acuity of the population, coordinated care and potential shared savings.

While PHP management and its independent physicians strongly support integrated care goals and payment innovation, they can be blunt about which models are working best so far and which efforts are more words than deeds. And those "independent" physicians remain an opinionated bunch in occasionally separating themselves from management — one insurer's model may get high marks from the MBAs, but take a few hits from the doctors carrying it out.

"Trying to get hundreds of doctors to toe the line, it's like herding cats. It really is," said Mike Archer, MD, a physician with PHP member Complete Family Medicine in Westminster. "Primary care doctors are busy — you can't overload them with extras."

• • •

If you sought your MBA in how health care delivery innovation actually happens in Colorado, the headquarters of Physician Health Partners could be your classroom.

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“We just got our first shared savings payment,” Nielsen said. “The Anthem product has been fantastic. It’s made us better and it’s been good for patients. We’ve seen we’re not perfect in the quality metrics. We can have a conversation with Anthem about where the opportunities are, and now we have incentives to find those opportunities.”

As an example, Nielsen said, in sharing data with Anthem, PHP’s managers and doctors might create a list of patients who could be using a cheaper, equally good generic. “But it takes a lot of doctor and patient education. A doctor might say, ‘I have three dozen patients on this medication. How do I get them in here to talk about this?’” The case management funding from Anthem might allow PHP to hire three new pharmacy case managers who can contact the doctors, set up patient education and guarantee the switches happen, Nielsen said.

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It would be impossible to do integrated care without payment reform.

Ken Nielsen, President and CEO, PHP

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Medicaid’s Regional Care Collaboratives. PHP’s practices together treat more than 100,000 state Medicaid patients, primarily in Jefferson and Boulder counties, and PHP is part of the consortium that operates the Regional Care Collaborative for the western suburbs and close-in mountain counties (the Colorado Community Health Alliance). That makes PHP a two-way hub for information, administering the Medicaid patient management funds to its doctors and to other physicians, and overseeing quality measures and data analysis for the state.

Archer’s practice, a member of PHP, coordinates with Jefferson County Mental Health to provide integrated mental health services under the Medicaid managed care program. He believes that has worked better for most cases than for a medical practice to try and hire full-time behavioral health staff in-house.

Nielsen said the Medicaid program, which aims eventually to get each Colorado Medicaid user into a primary care home, has made it easier to convince PHP doctors to take more Medicaid patients. While they may still lose money treating Medicaid cases, the gap has narrowed, and they get more support for the challenges some Medicaid patients bring.

“They have always said reimbursement is the biggest issue, but the next thing they tell us is these are fairly complex patients, and state requirements make it very expensive to serve them,” Nielsen said. “Let’s say your path to Medicaid is you are disabled, and maybe on top of that, English is not their first language. And the doctor may need help with the social issues surrounding the case, such as, they need a new hot water heater so they’re not taking cold showers. And in a Latino family, you may need to talk to other family members because they are the caregivers for that one patient’s chronic issues.”

Other private payers. PHP sees most payers for health care moving in the same general direction of integrated practices and primary care payment reform, but some are leaders and others are followers.

UnitedHealthcare, for example, contracts with PHP on potential shared savings based on estimates of how much patients have traditionally cost to treat. But it does not contract for the kind of per-member-per-month upfront fees that can help physician offices and managers like PHP put in place the infrastructure to improve care and analyze data. Medicaid, for one, and private payers like Anthem, are stepping up with that upfront money, Nielsen noted.

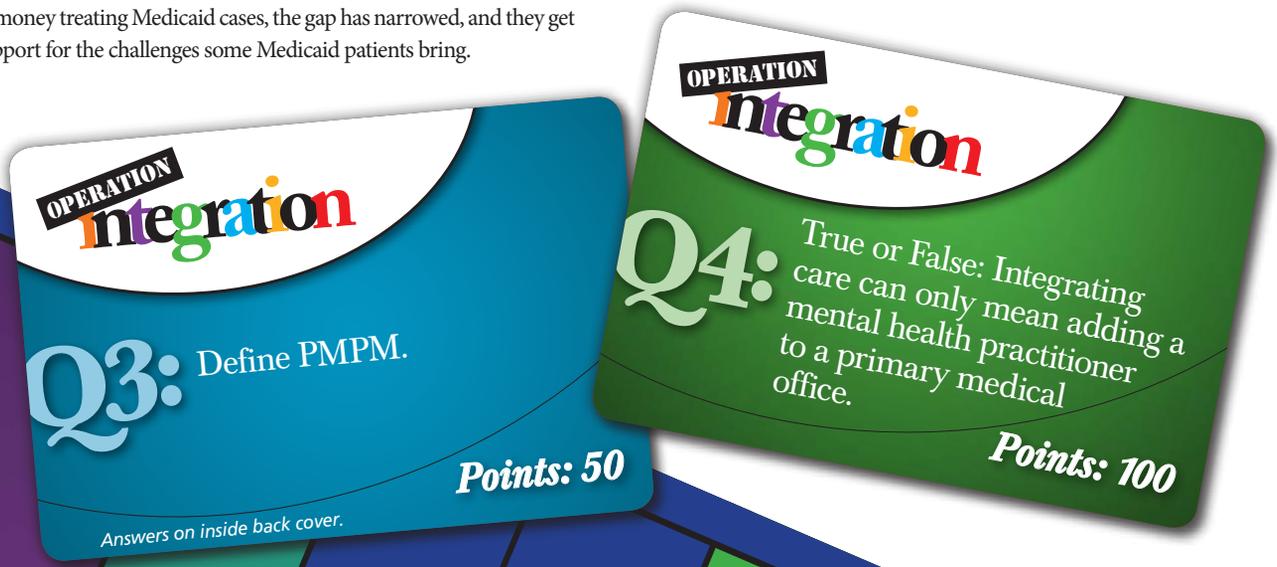
Since those new systems get used for all PHP patients, “United is kind of getting it for free, on everybody else’s back,” Nielsen said, “because they have that negotiating power. We could tell them to take a hike and exit their product, but we haven’t done that so far.”

A UnitedHealthcare spokeswoman said the big insurer “has a variety of value-based contracting arrangements in place with primary care practices and other providers in Colorado. These arrangements include performance-based contracting, bundled payments and episode-specific programs, medical homes and accountable care organizations.”

UnitedHealthcare does pay the kind of care management fees PHP is talking about to some Colorado practices through its work with the Comprehensive Primary Care Initiative, a spokeswoman for the insurer said. The CPCI is a partnership among insurers, the U.S. Centers for Medicare and Medicaid Services and some physician practices to manage cases and coordinate services.

“In Colorado, more than 47 percent of our reimbursements to care providers are tied to value-based contracts,” the UnitedHealthcare spokeswoman said in a statement responding to questions.

“By creating a flexible approach,” she said, “We are able to customize payment models and incentives and meet providers where they are in terms of readiness to move from fee-for-service to value-based contracts.” •



Safety Nets

LEAD INSTEAD OF FOLLOW WITH INTEGRATION

By Kelly Dwyer
Photography by James Chance



Peak Vista providers in El Paso County have embraced integration and “warm handoffs.”

Something incredible happens each morning inside the clinics operated by Colorado Springs-based Peak Vista Community Health Centers. Small teams of primary care doctors, nurses, medical aides, behavioral therapists and care managers huddle to discuss which patients are coming in that day, pull needed reports and check off which lab or diagnostic tests need to occur. They review the prior day’s visits and map out follow-up steps for certain patients.

This is integrated care at work, in which “we wrap the services around the patient,” said Pam McManus, CPA, MBA, CEO of Peak Vista, a nonprofit Federally Qualified Health Center with 25 clinics. Alongside other safety net clinics in Colorado, Peak Vista is defying perceptions of beleaguered clinics scrambling to merely keep up with demand and is instead leading the integration revolution through better design.

Executing on integrated care generates many new challenges, from managing disparate billing methods to marrying dissimilar workplace cultures. Integration is not intuitive, but it is logical and it is leading to better patient outcomes, according to McManus and her leadership team, making all the hard work and complexities worthwhile.

Patients First

A fair share of Peak Vista’s patients and their families miss work without pay to get to the doctor’s office. Some ride the bus to get there, which makes it convenient to schedule back-to-back visits with the dentist and pediatrician, for example.

A team-based approach to care allows primary care providers to intervene the moment they recognize a behavioral or dental issue.

“When you get emotional outpouring from a patient, you have a way to say, ‘I can help with that,’” said pediatrician Barbara Divish, MD, who makes frequent “warm handoffs” to a pediatric psychologist on-site. Peak Vista’s behavioral care providers typically spend 10 to 15 minutes with patients on those handoff visits, then schedule longer follow-up visits if needed.

Patients are more likely to see a dentist or therapist on the spot than they are to follow through on a referral at a different office and possibly weeks later. Primary care providers also gain latitude in their practice with a team-based approach, said pediatrician Darvi Rahaman, MD, Peak Vista’s vice president of medical services.

He recently visited with a mother and her teenage son who came in for a flu shot. Rahaman sensed the mother was upset.

“I know I can (ask how she’s feeling) because we have the behavioral support piece here,” he said. “If the parent knows I’ve spent extra time with them, they are more likely to trust me.”

Sid Nichols, a licensed clinical social worker at Peak Vista’s Wahsatch location, meets with patients for a range of mental health needs, but he spends most days tag-teaming with primary care practitioners to help patients who are coping with chronic pain or managing diabetes.

“Chronic pain impacts patients’ moods and how they feel about themselves and life,” Nichols said. “That, in turn, impacts how they care for themselves. With diabetes, people tend not to access the mental health system until their needs are more critical.”

Nichols helps patients to identify obstacles to caring for their health and set goals around lifestyle and behavioral changes, be that cutting down on salt, getting more exercise or breaking free of a negative mindset. Nichols, along with Peak Vista care coordinators and resource navigators, also assists patients with logistical challenges such as accessing affordable, healthy foods and finding reliable transportation to the doctor’s office.



Lessons Learned

Peak Vista, which opened its doors in 1971 as a part-time clinic run by volunteers, began offering integrated behavioral and primary care services at its Women’s Health Center in 2003, funded by a grant from the federal Health Resources and Services Administration. The clinic partnered with AspenPointe, a local nonprofit mental health practice, for behavioral health services.

“Both leadership entities understood why we were integrating and that we needed to integrate,” said Michael Welch, DO, Peak Vista’s chief medical and dental officer. “It fell apart quickly.”

Behavioral health providers were accustomed to appointments lasting 45 to 60 minutes, not the fast pace of primary care. They bill on a capitation model versus fee-for-service system standard in primary care. And providers got signals crossed communicating about patients. For example, a care plan for a diabetic will include recommendations around diet, exercise, medications and frequency of lab tests and appointments. By contrast, creating a mental health care plan is a lengthy, detailed process that involves a host of parties and documentation.

Leaders on both sides worked to improve communications and train providers on integrated models, a process that continues as the landscape shifts in terms of payer models, Medicaid eligibility and other changes. More than a decade later, Peak Vista successfully operates integrated practices in most of its 25 clinics.

Paying for Progress

Peak Vista credits the recent expansion of Medicaid under the Affordable Care Act for reducing uninsured patient visits from 34 percent of total visits in 2013 to 15 percent in 2014. Last year, 68 percent of patient visits were covered by Medicaid, 10 percent by Medicare, 5 percent by commercial insurance and 2 percent by Child Health Plan Plus (CHP+).

In spite of those changes, the clinic relies on contributions and private donations for more than 20 percent of its annual funding.

Peak Vista has nimbly and strategically invested in areas that improve efficiency and the patient experience, from electronic health records and care coordination to a sophisticated and supportive enrollment system that enrolled more than 10,000 families last year.

“We went from people lining up outside our doors at 6 a.m. to patients being able to make an appointment for enrollment, look online prior to the appointment so they know what materials to bring, and offer walk-in appointments,” McManus said.

Peak Vista also is strategic about staffing investments.

A host of graduate students work under Peak Vista and AspenPointe’s experienced practitioners. Peak Vista plans to launch a nurse practitioner fellowship program in September and a family medicine residency program in June 2016 — moves that will help the clinic address industry workforce shortages head-on and train incoming providers on integrated models and new payer models.

“We’re having a paradigm shift in health care,” explained Kandi Buckland, RN, chief operating officer at Peak Vista. “Care teams are becoming more critical for patients and providers to help connect what’s disconnected.”

Outcome-based payer models will be a welcome change because current payer systems prevent Peak Vista from billing for integrated services.

McManus said she believes Peak Vista’s providers and staff are paid fair wages, but acknowledged that “everyone here could make a lot more money” working elsewhere. “Quality is our focus, whether it’s in our facilities, providers, follow-up or how we work with the community,” she said. “I believe our employees live that.”

Divish, who joined Peak Vista five years ago, is a case in point. “For me, the impact is greater where the need is greater,” she said. “It’s hard to be poor. I was poor. I understand that and relate to that.”

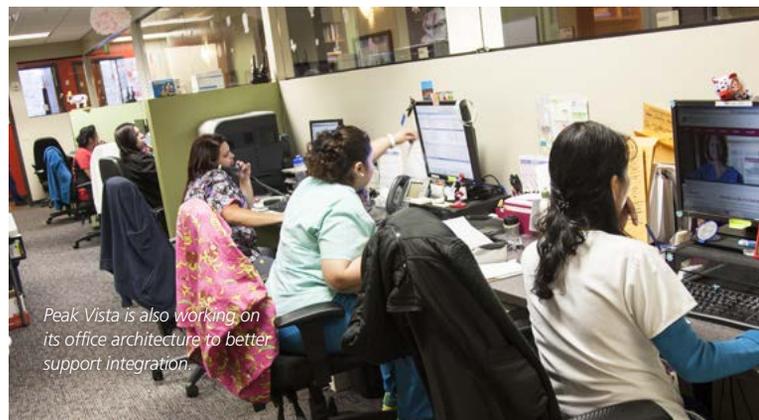
Patient-Centered, Start to Finish

While integration is at the heart of patient-centered care, Peak Vista goes several steps further. Several years ago, the pediatric office opened a drop-in child care room for healthy siblings, slashing the clinic’s no-show rate.

More recently, Peak Vista has invested in architecture and design to support integration in functional ways, such as clustering offices for care team members, as well as aesthetic ones.

In the Pediatric Health Center, a dog-size yellow frog and a half dozen colorful birds cover the walls of an expansive waiting area illuminated by large windows. As kids walk to their exam room, they may notice photos of polar bears and penguins lining the hallways. Perhaps seeing a doctor doesn’t seem as scary.

Welch explained that Peak Vista’s recent design focus is inspired by the book “Setting the Table,” in which author Danny Meyer describes the power of hospitality in business. “We want to evoke a patient response of ‘here I will be well cared for’ when they enter our health centers.” ●



Peak Vista is also working on its office architecture to better support integration.

Can a \$65M SIM Golden Goose Pay for Next-Level Integration?

By Elise Oberliesen

As Colorado health system reformers toiled away on experiments, pilot programs, Affordable Care Act mandates and other complex problems in recent years, the potential of a large gift from the U.S. government colored their outlook.

Colorado is a recognized innovator in integrating physical and behavioral health through primary care offices. But a boost that would come as a monetary endorsement from Uncle Sam might push those ideas into every corner of the state, from government agencies deep into the nonprofit and commercial worlds. Now that golden goose is well within the clutch of the reform community — in the form of a \$65 million SIM, or State Innovation Model, grant. It's an award born out of years of planning, strategizing and creating bold policy changes. Funding like this could help the state, along with groups of anxious public and private stakeholders, decipher better ways to enhance patient outcomes, expand service delivery and drive down health care spending in the state.

At least that's the hope.

With these funds, the state aims to integrate behavioral health and primary care in coordinated community systems.

According to Susan Birch, executive director for the Colorado Department of Health Care Policy & Financing, another goal is "improved health system performance," something Birch said is taking shape from partnerships with private and public sector entities like insurance carriers, Medicare and the Children's Health Plan.

Under this integrated approach in health care, SIM funding would allow the state to "leverage the power of public health," Birch said, which includes "broader population health goals." As one example, Birch said it will be important to more closely address mental health issues like depression.

That means early intervention and treatment from the right health care providers.

"We're going to use this grant for paying people for outcomes and value, and that will further inspire them to keep delivering services in the right way," Birch said.

Oftentimes people visit their primary care doctors because they have multiple diseases and troubling symptoms coalescing all at once. Maybe they have battled with anxiety and asthma or depression and diabetes for many years. Medical experts refer to these co-occurring conditions as comorbid diseases.

Problem is, in the typical primary care setting, not even the most talented physicians, physician assistants or nurse practitioners are necessarily trained or equipped to treat all these symptoms, let alone in just one visit. Even if they could, there would be no clear mechanism to pay providers for the nonphysical care or case management required to do a good job.

In essence, SIM funding allows for some experimentation or creative thinking in terms of figuring out how to deliver better treatment, expand services that reach more Coloradans and create a way of paying for it.

"Primary care is at the heart of SIM.

(Primary care is) the largest platform for health care delivery, and it's an ideal setting to focus on health care policy and health care redesign," said Benjamin Miller, PsyD, director of the Eugene S. Farley, Jr. Health Policy Center at the University of Colorado School of Medicine.

Under this new integrated approach, theoretically, patients would see better health outcomes because of increased access to both physical and mental health practitioners in one location. Essentially this kind of health care delivery could provide patients "instantaneous access" to mental health care professionals, Miller said.

"One in four individuals in the U.S. will have a diagnosable mental health condition in a given year, and upwards of 80 percent of those diagnosed visit the primary care setting at least once. Yet the traditional primary care setting isn't optimized to provide comprehensible behavioral health care," Miller said. And frankly, he said, we can do better than that.

According to Miller, integrating primary care and behavioral health would strengthen the "Triple Aim," which strives for better patient experiences and better health for the entire population while controlling costs.

Based on reports from the Institute of Medicine, he said, strong evidence suggests that separating primary care and behavioral health diminishes the level of care.

Solving Reimbursement Riddles

Traditionally, primary care and behavioral health are separate billing entities, from a third-party payer perspective. Figuring out how the two can coexist harmoniously while allowing for proper reimbursement will come as a challenge.

To make this integrated care model a success, compensation protocols must change, said Vatsala Pathy, SIM director at the Office of the Governor.

"So the primary care physician is compensated in a way that allows him or her to have a psychologist on staff," Pathy said. "If the patient needs behavioral therapy, they can be handed off to the therapist in that clinical setting."

The SIM project team will be tasked with designing payment protocol models that would allow for proper reimbursement when both primary care and behavioral health services are rendered simultaneously, she said.

"One thing the federal government wanted to see through the SIM projects across the board was an interest and willingness on the part of (health plans) to explore both the barriers to pay

differently and the opportunities to do it in a way that helps support their bottom line,” she said.

Policy changes would be necessary from the health plans, Pathy added. They would need ways to “reimburse our (primary care physicians) differently and to incent this type of (integrated) care.” Such examples might come in the form of “enhanced per-member-per-month reimbursement or care coordination payments,” she added. An earlier version of that model is already in place for most Medicaid patients. SIM aims to extend the idea to many more Colorado patients, including those paid for by commercial insurance.

Costs would not be transferred to the members who visit their primary care physicians under this integrated care model, she said.

Birch said the goals laid out in SIM are “very ambitious.” And it will take a certain mindset to make this work.

“We want to be forward thinking in the way we structure service delivery and how we pay for these services,” she said.

Steve Melek, an actuary with Milliman, also played a role in Colorado receiving SIM funding. He helped demonstrate to the federal government that this integrated approach (blending primary care and behavioral health) would, over the long run, save money in Colorado while creating a sustainable infrastructure that continues to save money upon SIM’s conclusion.

He also said it was important to demonstrate a “portable” component — something that could be “replicated in other states.”

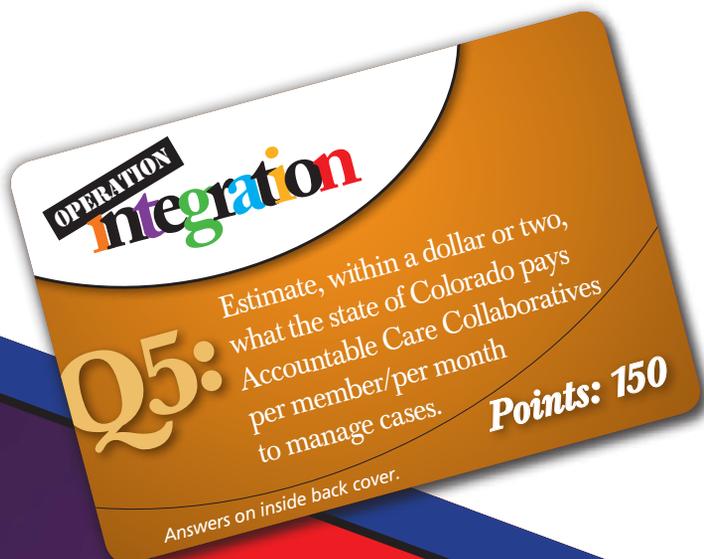
No doubt a tall order.

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We’re going to use this grant for paying people for outcomes and value, and that will further inspire them to keep delivering services in the right way.

Susan Birch, executive director, Colorado Department of Health Care Policy & Financing

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Melek has risk-benefit analysis models down to a science. He digests algorithms and turns them into calculations of which types of patients cost the most to care for.

“The average member costs about \$400 per month; the diabetic, about \$800 to \$1,000; and the depressed diabetic, about \$2,000 per month,” he said.

Knowing these numbers makes it especially advantageous to fully understand the full range of symptoms diabetics struggle with so they can receive the right balance of care.

People with comorbid diseases like depression and diabetes are more likely to end up in emergency rooms, hospitals or inpatient settings, Melek said, all carrying exorbitant price tags. And that’s why it’s critical to provide comprehensive primary care with a behavioral health component. Giving patients the right care at the right time could prevent unnecessary hospital visits and ultimately drive down health care costs, he said.

Pathy agreed with Melek’s analysis on cost savings.

“Over time, (integrated care has) been demonstrated to lower costs for health plans, so they would save money over the long run,” Pathy said.

However, initially, it’s likely that health care plan payers would take a hit and pay more until costs equalize or balance out.

That’s because initial early spending would account for those Coloradans who have traditionally had limited access to integrated care, Melek said. Expanding services and increasing health care access to more people carries some initial costs.

“The goal is to more than recover the additional costs through medical cost offsets,” he added.

Proof of SIM success in the long run, Colorado health system experts said, will come when private commercial payers adopt more integration and payment reform. That will spread the best concepts of SIM well beyond the few dozen practices currently on the leading edge.

“The key is how these monies flow down to the practitioners that make it happen,” said Marshall Thomas, MD, president and chief medical officer of Colorado Access, which manages care for hundreds of thousands of Medicaid patients and also provides behavioral care services. “The state can do things, but how does it get UnitedHealthcare and Anthem and all the others to do payment reform? That’s the million-dollar question. You can have all the structure and process in the world, but you’ve got to have some beef. Who’s going to pay for that behavioral specialist to show up?” •

Next-Level Medicaid

Innovation and Integration Reach Critical Mass

By Michael Booth

Photography by James Chance

One of the nation's largest experiments with reforming how primary care is delivered and paid for has reached a critical mass that begs for both detailed examination and further innovation, according to statewide health experts.

More than 800,000 Colorado Medicaid patients are now enrolled in the Accountable Care Collaborative that is the heart of public health reform in the state, meant to bring coordinated primary medical homes to the most vulnerable citizens. With nearly 1.2 million Coloradans now signed with Medicaid overall, the state health insurance system has the challenge and the opportunity to improve care for more than 20 percent of the population.

State officials believe they have demonstrated enough cost savings and quality marks in the ACC program to ensure legislative support for the near future. In fiscal year 2013-2014, with an average 609,000 Medicaid clients enrolled in a primary care collaborative, better management of care resulted in \$100 million in gross savings over expectations for those clients, according to a state report. After subtracting the care management payments to providers and the cost of administering the regional collaboratives, net savings to Medicaid were \$31 million last year.

Now their goals are to tweak reimbursement, benefits and other factors under their control to improve access and care, and reach higher quality goals along the way.

Medicaid leaders also want to dig into a growing pool of data to better understand and redirect major subgroups. In a sample of 800,000, for example, "super-utilizers" stand out — those who might have gone to an emergency room eight times in two months. Medicaid can send those users "neutral" letters that send a message without threatening, such as "Were you aware how many times you used the emergency room, and that you might avoid future visits by using the following nurse help line?" said Laurel Karabatsos, Medicaid deputy director.

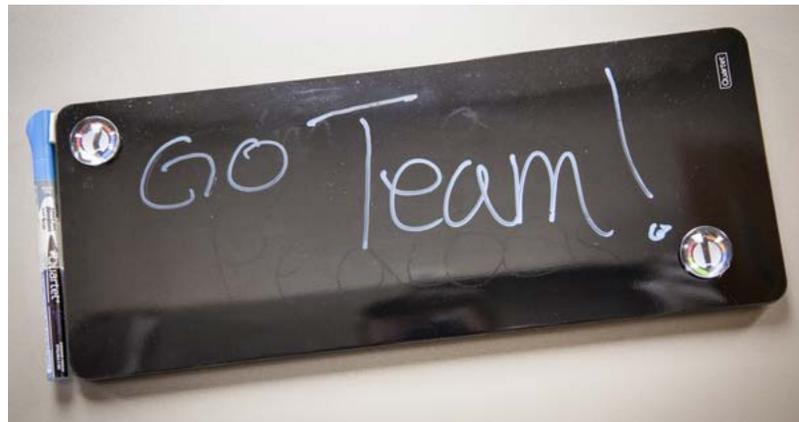
Medicaid also wants to know more about the hundreds of thousands of relatively new clients brought into the fold by the Affordable Care Act's expansion of who is eligible. "The expansion population is a different population, so how do we bring them in well?" Karabatsos asked.

Some of the expansion population is more transient than past Medicaid clients, both physically and financially, she noted. They may cycle in and out of Medicaid as they gain or lose jobs and go above or below eligibility levels. Some also come in with a pent-up demand for behavioral health hospitalizations or other mental health services. They were used to finding the nearest emergency room for basic medical services since they had no other coverage.

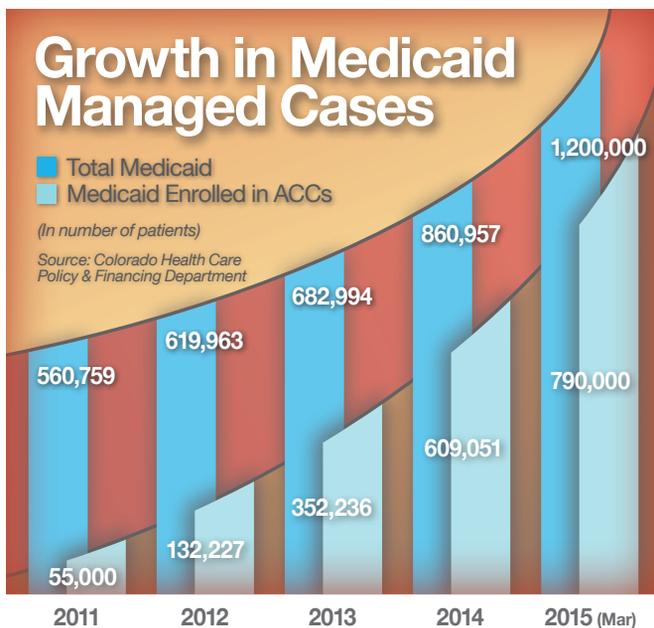
"We have so many people enrolled now, we have better numbers to work with," said Susan Mathieu, manager of the Accountable Care program at Medicaid.

Relatively new incentives for improving the patient experience in primary care: Primary care practices can earn an extra 50 cents per member per month when they meet "access and coordination" goals, such as adding after-hours office time for busy patients. There are nine categories of better access and coordination, and a practice needs to meet five of those nine to receive the per-member boost.

That change matched with a new billing code primary care providers could use for that after-hours care, providing a \$7 "pop" on top of the underlying diagnostic code.



A sign in southwestern Colorado reminds staffers of the team-based care and case management that Medicaid encourages.



There are also some sticks sitting alongside the carrots, as Medicaid administrators dig into their large enrollment numbers and look at remaining gaps. For example, if a regional collaborative administrator has not found a primary care home in a Medicaid client's area within six months of that client enrolling in Medicaid, the collaborative loses some of its per-member-per-month payment.

Bolstering Colorado's Medicaid system for the near future was the continuation of better reimbursement rates for providers that was originally paid for by the Affordable Care Act. That boost, which allowed doctors to bill many primary care codes at the same higher rate paid by federal Medicare, expired in some states this year and threatened patient access.

The 2014 Colorado Legislature appropriated \$40 million to keep Colorado's Medicaid rates at the higher Medicare level through at least June 2016, said Marc Williams, spokesman for the Colorado Department of Health Care Policy & Financing. For a routine office visit such as new patient intake, history and exam, the enhancement is 34 percent above traditional Medicaid payments.

The Legislature removed another barrier when it said doctors don't need to "attest" to being primary care physicians to get the higher rate, Williams said. That means OB-GYNs, geriatricians and others can get the higher rate when they provide primary care services, further expanding access for patients.

Finding money to keep the Medicaid primary care reimbursement rate at the same higher levels as Medicare was a big victory for Colorado, said Ken Nielsen, president and CEO of the large doctor network Physician Health Partners. PHP providers care for more than 100,000 Medicaid patients, primarily in Jefferson and Boulder counties; convincing more providers to take on new Medicaid patients remains tough, but would be nearly impossible without the continuing boost in reimbursement, Nielsen said.

"It's huge. That's been a big win," he said. "If that drops back down, it will be a step back."

"We're not only seeing more new providers accepting Medicaid, but we're seeing established Medicaid providers accepting more Medicaid patients," said Judy Zerzan, MD, chief medical officer, Medicaid.

"We have always said that we support primary care and we want this to continue," she said. "Now we're able to show that we're walking the talk and are putting our money where our mouth is. We totally support primary care. We believe this is so important and we need to continue it."

A long-standing goal for Medicaid and other health reformers in Colorado is deeper integration of behavioral health care into the primary physical health care model. Colorado's Medicaid program does have mental health benefits and substance abuse coverage, but they are paid through a behavioral health "carve-out" and administered by separate regional organizations.

The next step would be paying providers a "global cap" fee for each Medicaid patient for the year, and the provider manages all of that patient's physical and mental health needs for that fee. However, it puts the provider at risk of costs rising above the fee, noted Bern Heath, CEO of Axis Health System, a network of integrated clinics in southwestern Colorado. But it's also a risk for the state because it's harder to account for each dollar spent than under a fee-for-service model.

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Judy Zerzan, MD, chief medical officer, Medicaid

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"They're so scared someone will say, 'You misused those dollars,'" Heath said. "Only very administratively skilled organizations can handle that. Everybody wants to get rid of the carve-out. We're trying to find the 'easy button' to help get the state to move toward a global cap."

HCPF Executive Director Susan Birch responded that she appreciates how Axis is evolving as an integrated health system: and "Bern and his team are valuable partners." Birch added, though, that "paying for these new services requires the department to balance the protection of Medicaid entitlement benefits within the framework of stewarding precious state resources. This means the department needs to carefully mature how we pay. Global capitation implies risk. For some areas of the state and services, that approach may not best serve our clients. We are evolving the way we pay, and we're doing so collaboratively with our community, state and federal partners as fast as we can safely go." •



Private Pay, Public Goals

How Anthem is Pushing Primary Care Reform

By Michael Booth
Photography by James Chance

While public and nonprofit insurers and providers slowly broaden their experiments transforming primary care in Colorado, the for-profit giant Anthem Blue Cross Blue Shield has quietly taken payment reform from model to standard practice.

Anthem, one of the two health insurers dominating the for-profit market in Colorado, keeps setting new targets for expanding progressive payment reform and then knocking those targets down. By the beginning of 2015, Anthem had signed 54 percent of its widespread primary care physician network to so-called “value-based” contracts, in which the providers receive upfront payments to better manage patient care and bonuses if they cut spending while meeting quality goals.

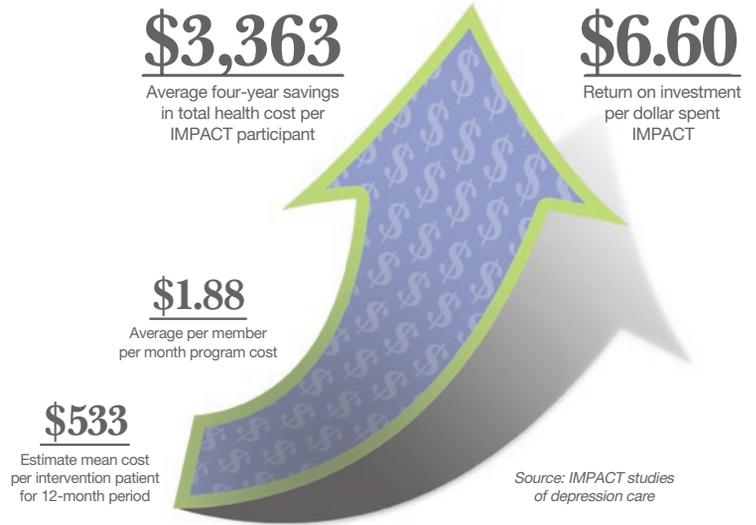
For Anthem, with nearly a million members in Colorado, hitting that goal set in early 2014 means 1,600 primary care physicians have value-based contracts for more than 200,000 patients in the Anthem network, according to Kelly Henry, network director of payment innovation programs at Anthem.

“This is how we do it now. We know it’s working,” Henry said.

The three main features of the Anthem contracts with primary care offices have remained consistent throughout the program, which began as part of a statewide, multipayer pilot program in 2009:

- Providers receive per-member-per-month fees meant to pay for care coordination employees and tools that will better manage overall care. Common use of the money includes upgraded electronic health record and other information technology systems, in coordination with Anthem’s software tools, and hiring of case managers and navigators.

Integration=Efficient Care



- Providers can earn shared savings payments from Anthem when actual costs for the covered patients turn out to be lower than projected based on medical history. The payments back to doctor offices can be as high as 35 percent of the identified savings.

- Savings are shared if the practices meet quality metrics established by national groups, such as the American Diabetes Association and the National Committee for Quality Assurance.

Previous pilots turned up enough measurable savings and quality improvements for Anthem to “make it our contracting norm across all 14 states” in which it insures patients, Henry said.

The earlier pilot programs found the newly coordinated care produced an 18 percent reduction in hospital admissions and a 15 percent reduction in emergency room visits for those members. Such changes in two of the most expensive categories of health care can reduce spending by tens of thousands of dollars for each admission avoided.

“I would say the change in the partnership between the provider and the payer is unprecedented,” Henry said. “It hasn’t been that way in the past — aligning the incentives so both parties are marching in the same direction — and that ultimately becomes a win for the consumer as well.”

Some providers who work with Anthem in the primary care partnerships are highly complimentary of the system, even as they continue to work out needs in data analysis and making the changes pay at the practice level.

“I’ve given Anthem a lot of credit. They are doing a lot of things correctly,” said Bruce Minear, CEO of Mountain View Medical Group in the Colorado Springs area. The practice, with 65 providers in 15 locations spread from Monument to Woodland Park, put an agreement with Anthem in place in mid-2013.

“They approached this whole project assuming we knew nothing and they were going to help us, and that’s exactly what we needed,” Minear said.

Integration

What is Global Payment?

Points: 150

ers on inside back cover.



Primary care offices that focus on communication and open collaboration boost patient experiences, according to numerous evaluations. Referrals to outside providers are often ignored or dropped by overwhelmed patients, studies show.

When Mountain View needs a meeting, Minear said, Anthem sends seven or eight team members to make sure all the questions are covered. The upfront payments for each member provided “infrastructure dollars” to hire RNs as case navigators and software tools to analyze information buried in the practice’s existing EHR.

“It will tell us that we’ve got X number of patients who have missed their annual physical, and Y number of diabetic patients we haven’t seen for nine months,” he said. “Anthem has stepped up to the plate with some dollars to help. There are other folks out there who aren’t doing that. They just throw the demands out there.”

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Anthem has stepped up to the plate with some dollars to help. There are other folks out there who aren’t doing that. They just throw demands out there.

Bruce Minear, CEO, MountainView Medical Group

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For patients, Minear said, it may mean getting a phone call to make an appointment for that physical, or a phone call when they leave the hospital asking what medications were prescribed, whether patients filled them, and if patients need help filling them and delivering them.

There are at least two more levels to reach, though, in truly reforming primary care, according to Minear and other physicians. One level is better synthesis and analysis of data. For example, Mountain View can lose track of detail if one of its patients is admitted to a hospital without a coordinated EHR or to a specialist prescribing high-cost labs and imaging, Minear said.

“We have no idea from a cost perspective what happens after we send that patient out, and we need to know that,” he said. “And we need to know those quality specialists that are doing good work but also controlling costs.”

Truly integrating behavioral health care is the other next-level step many practices have yet to take, Minear added. Directly embedding a behavioral health specialist within the practice is tricky among 15 Mountain View locations, though the group is intent on exploring those arrangements.

Other providers said extra payments from Anthem and other payers are not quite enough to pay for the changes needed to improve coordination. Meeting the federal standards of an accredited primary care patient home is a very high bar that constantly changes, said Mike Archer, MD, of Complete Family Medicine in Westminster. His practice, part of the Physician Health Partners management umbrella, has the equivalent of 3.5 providers, requiring a support group of 12 employees.

“The per-member-per-month is not enough money to add a case manager” in that size of practice, Archer said. “It’s still survival for a lot of us.”

Minear echoed those smaller practice worries. While Mountain View has the size to cope with major changes, he said, “My concern is for the one-, two-, three-doctor practices. That’s the hard part. How will they survive?” ●

OPERATION

Integration



1. PCMH stands for Patient-Centered Medical Home. PCMHP is close, but different: Primary Care Mental Health Practitioner, most often used in the British medical system.
2. False, but it was once true. Physician Health Partners started a Pioneer ACO, but changed to the less-risky Shared Savings relationship with Medicare.
3. Per Member/Per Month is a fee a payer gives to primary care managers for better monitoring and managing the whole health needs of an enrolled patient. The fees are often used to hire navigators and case managers, or to improve software to highlight patient needs.
4. False. Integrating care can also mean a behavioral health clinic hiring and embedding primary care doctors, physician assistants or nurse practitioners to provide integrated medical care.
5. Colorado currently pays about \$3 per member, per month to primary care offices that manage the whole-health of Medicaid patients.
6. RCCO stands for Regional Care Collaborative Organization, which administers Medicaid's managed fee-for-service program. CPCI is the Comprehensive Primary Care Initiative by federal Medicare and Medicaid innovators. SIM is the State Innovation Model, providing grants to Colorado and other states to improve patient care and reform payment models.
7. A global payment is a per-patient annual fee given by an insurance payer to a primary care office to pay for all the health needs of that patient in the year, including mental health and specialty medical care. The provider may be at risk for losing money if it mismanages a patient that subsequently requires expensive ER, surgical or substance abuse care.

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Visual Guide to the Integrated Care Issue

Integrating care is not just an abstract debate among policy wonks. Sometimes it's a simple matter of putting mental health counselors chair-to-chair with doctors and nurses, with a dental exam available right nearby. This month's *Health Elevations* video walks through the physical layout of fully integrated Colorado providers, and gives visceral lessons on what works. Go to www.ColoradoHealth.org/journal.

Exclusive Online Video Content

The screenshot shows a YouTube video player interface. The video title is "Health Elevations" by coloradohealth. The video content shows a dentist in a white coat and glasses examining a patient in a dental chair. The patient is wearing a clear protective shield. The video player includes a search bar, "Upload" button, "Sign in" button, and a playlist of related videos. The playlist items are:

- 1 Health Elevations: Integrated Care by coloradohealth
- 2 Health Elevations: Heading Off Trouble by coloradohealth
- 3 Health Elevations: Colorado Culture by coloradohealth
- 4 Health Elevations: Greenleaf by coloradohealth
- 5 Health Elevations: One Family's Journey by coloradohealth

Read related story on page 13 in this edition of *Health Elevations*.