Healthcare System Reform
and
The Essential Role of Behavioral Healthcare Providers

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Introduction

This presentation does NOT represent the position of any department within Rutgers University on the subject of reforming the current healthcare system.

*Intended outcomes* of this presentation:

1. **Stimulate thinking** about how best to reform the current healthcare system.

2. **Elicit a vision** in each of us regarding what role we, as behavioral healthcare professionals, can play in reforming the American healthcare system.

- What is presented here is *not intended* to persuade you to agree with what is shared here.

- What is presented here is *not designed to cover all aspects of a healthcare system reform movement*.

- **Attention is focused on** those significant areas for *system change* and on the role *behavioral healthcare providers* can play in reforming the current healthcare system.
Healthcare Reform

**Right time** to create a healthcare system (HCS) that assures both **improving** and **maintaining** the well-being of the population of **all Americans**.

• Regarding the Affordable Care Act system (**ACA**) – **talk of** - either 1. **significant reform** or 2. **replacement** (my recommendation).

• **Not sufficient changes** as neither alternative moves far enough to address the several other necessary changes required to establish a cost-effective national HCS.

Creating a HCS that assures increasing well-being of all Americans requires **several additional complex changes** in the current American healthcare system.
Core System Changes Proposed

1. The method of funding the HCS. YES- it’s like the tax we pay for Medicare – like in “Medicare for all”.

2. Integrating medical and behavioral services into a value-based care (VBC), population-based system. (VBC system broadly considered - VBC “aims to increase healthcare quality and decrease costs by using financial incentives to promote cost effective health care services and consumer choices” (Wikipedia).

3. Primary focus on addressing the social determinants of health disorders by behavioral providers.

4. Significant change in the role of the current Commercial-Private Insurance system (CPI) whose role has been to finance, structure, manage and sell much of the HCS services in America for the past several decades.

The HCS proposed here is a replacement for the current ACA and a change in the role of the currently operating CPI companies.
An integrated, VBC system of healthcare integrates all elements of healthcare, inclusive of general medical services, specialty medical services, dental, podiatry, physical therapy, behavioral health, etc.

- Control of the PFHS is in the hands of the primary stakeholders at the local level:
  - Consumers who use the system
  - Providers of treatment services within the system of care and
  - Other healthcare professionals at the local community level.

A “shared decision making” system.

- Proposed PFHS is not a socialized system of healthcare.

- Beneficial aspects of free market capitalism provide the most sound foundation for the proposed PFHS.
A Publicly Funded Healthcare System (PFHS)

• **Focus here** = components that make up that *proposed* PFHS.

• Proposed PFHS - designed to address healthcare needs of the *entire population of Americans*.

• Includes *so called pre-existing conditions* (*more accurately* “pre-diagnosed” conditions)

• **Aim** = conserve healthcare resources while delivering the *most effective evidence–based, cost-effective services available to the population being served*. 
Profit Motive and Competition in Healthcare

- **Profit motive** is essential within almost all areas of our American economy.

- **Profit dynamic** has a significant place in the proposed PFHS.

- **Primacy of market-based, corporate healthcare profit actualization** has failed to bring about an uncomplicated, cost-effective HCS required to enhance the well-being of most Americans (Rosenthal, 2017).

- Persuasive data = laissez-faire market economy **controlled by corporate entities** is not the most enabling foundation upon which to establish a cost-effective system of healthcare services (Kuttner, 1999; see also Emery, 1999).

- **Profit dynamic** must function **primarily within the community of the competing providers of care** and **not primarily** within the community of corporate insurance entities.
Healthcare as a Common Good

- **Basic premise** = all Americans have a right to healthcare as a shared *common good*.

- **Common good defined** as “what is shared and beneficial for all or most members of a given community, or alternatively, what is achieved by citizenship, collective action, and active participation in the realm of politics and public service” (Wikipedia).

- **Common goods** = prepaid publically funded *facilities/services* available as shared benefits among all persons in the USA such as roads, highways, bridges, recreational parks, military defense systems, police, public education, etc.

- **Prepaid** through a shared, *obligatory tax* from all who partake in the benefits of these *common goods*.

- **Proposed here** = healthcare, including healthcare facilities, staff and services, be considered a *common good* as defined above.

A *common good resource is not for sale*. *Healthcare is not for sale as a primary resource.*
Medicaid – an Undesirable American Category

• Proposed PFHS eliminates Medicaid as a healthcare category into which many Americans are assigned.

• Assignment to Medicaid is an act of discriminatory categorization within the HCS.

• Medicaid enrollment requires that persons accept their Medicaid designation by a third party who has assessed them as:

  1. “poor” by virtue of their being judged eligible for Medicaid funding based on their position on the qualifying Federal Poverty Level
     or
     2. “disabled” upon being assessed as essentially unable to fully function and to engage in gainful employment.
Medicaid – an Undesirable American Category II

Both classifications enable a **discriminatory placement** of those who accept these labels for the purpose of obtaining healthcare benefits under the Medicaid program.

- Medicaid assignment serves to **encourage**:
  1. a sense of *low self-worth* among those so assigned.
  2. a **prejudice** toward those assignees among other members of the American population.

- This class structuring will not be acceptable within the proposed PFHS.

- The proposed **new PFHS creates a level healthcare playing field** for all Americans as assessed as equally eligible for healthcare services **regardless of annual income level and level of functioning**.
Services Behavioral Clinicians Have Been Providing

- Psychotherapy – individual CBT, psychoanalytic, DBT, ACT, mindfulness, etc.
- Couples therapy
- Group therapy
- Supportive counseling
- Residential LOC for MH disorders
- Medication management
- SUD treatment- All LOC & MAT

- All are tertiary levels of treatment for disorders already diagnosed and active.
“Lifestyle Disorders” are the basis of the majority of human disorders [AMA. (1993); LaPuma, J. (1996), pgs. 56-57; Curtis and Aunger, (2012)]

Each lifestyle disorder = treated most effectively by behavioral clinicians in collaboration with medical clinicians.

- Core psychology driving these disorders is a behavioral deficit or excess.
- Behavioral procedures = potential to reduce utilization of high intensity, higher cost medical treatments.
- Need for a collaborative care working relationship between medical and behavioral providers.
Medical-Behavioral Link in Health Disorders II

Social determinants of health status- Poverty based community conditions such as lack of access to:
- economic opportunities
- well-maintained and affordable housing
- high-quality schools
- healthy food
- safe parks
- clean water and air

Foundations for disordered health in populations and high utilization of high cost care.

Requires a public health, population-based approach on a state by state basis.

Several behaviorally-based cost drivers to consider in preparing to replace the ACA and current CPI with a PFHS.
Behaviorally-Based Life Style Illnesses

- “Chronic - and often preventable - diseases are a huge driver of personal health spending” (Johnson. December 2017).

- "the three most expensive diseases in 2013 were" -
  - diabetes ($101 billion) - sugar cravings
  - heart disease ($88 billion) - diet, weight, exercise behaviors
  - back and neck pain ($88 billion). - body mechanics, exercise

- (depression was sixth and not far behind the fifth, i.e. falls, for driving healthcare costs)

- Behavioral approaches that address lifestyle behaviors + appropriate medical care for these disorders = reduce high intensity, high cost treatments and to enable a healthier population.

Behavioral providers are well equipped to address the social determinants of illness.
Medical-Behavioral Link in Health Disorders III

• Value of integrating medical with behavioral services = behavioral nature of medical disorders.

• “Cancer deaths rate drops 25% from 1991 peak.” [Star-Ledger, January 6, 2017, pg. 5)

• “… reductions in smoking and improvements in early detection and treatment of cancer” – related to patient motivational counseling.

• Gender gap in the cancer death rate = “40 percent higher for men than women, and the incidence of cancer I = 20 percent higher in men. [Star-Ledger, January 6, 2017, pg. 5)

• “cancer death rate remains 15 percent higher for blacks than in whites”.

• Data = linkage between cancers and behaviors of individuals and groups of individuals who may benefit from behavioral counseling as targeted populations.
Medical-Behavioral Link in Health Disorders IV

- “…reduce cancer risks by focusing on risk factors:
  - Weight
  - diet
  - physical fitness
  - exposure to ultraviolet radiation” [Star-Ledger, (December 29, 2016. pg. 27)

- Skin cancer dropped in the northeast due to preventive use of sunscreen, (Tanner, 2016)
  a teachable behavior.

- With behavioral components amenable to behavioral, life-style change interventions via psycho-ed instruction and motivational counseling.

- Providers within the proposed PFHS = employing behavioral clinicians.

- Expectation = behavioral interventions = increased population well-being and a reduction in utilization of high intensity, high cost services.
Lifestyle Factors that Decrease Risk of Breast Cancer
(Byrnes, A., 2019)

1. Keeping a healthy weight

2. Exercise regularly

3. Don’t drink alcohol or at least limit alcoholic drinks (harm reduction)

4. Stop smoking (vaping?)

5. Discuss cancer risks with your doctor when on hormone replacement therapy

6. Be alert to a family history of breast cancer (BRCA 1 & 2 gene issues)

Amenable to a behavioral interventions that include both instruction and motivation enhancing procedures delivered by behavioral professionals.
Medical-Behavioral Link in Health Disorders

Behavioral clinicians trained to address life style disorders with an early intervention approach intended to prevent illness, slow its development and reduce unnecessary and inappropriate treatments:

- **smoking cessation** (Star – Ledger, January 12, 2017, pgs. 29 &32)
- **psycho-ed for improved nutrition, weight control (obesity reduction)**
- **psycho-education addressing “weight discrimination” stress related to obesity** (Daly, et al. 2019. pgs. 1030-1039)

“Fat shaming doesn’t need to end. Needs to make a comeback. Some amount of shaming is good”. (Bill Maher)

- **safe sex education**
- **stress inoculation/management**
- **violence/anger management**
- **alcohol/drug abuse prevention education**
- **parent training** regarding risky behavior during pregnancy
- **parenting/child management** skills reducing adverse childhood experiences
- **psycho-education for proper exercise**
Medical-Behavioral Link in Health Disorders

- psycho-education for healthy **sleep**
- education for **safe driving**
- **couples/family counseling**

► Provided via Tele-health via telephone, interactive skype and other media methods *AND by peers in the community* especially for consumers who are unable to be present at a provider physical site.
Financial Wellness Training

- **Poverty** is a significant **social determinant** of ill health.
- Training persons affected by poverty in what is called “financial literacy and financial wellness” will move individuals to more **self-sufficiency and less dependence on public assistance**. (see Brandow, Swarbrick and Nemec. 2019)
- **Behavioral providers are positioned to train regarding:**
  - income management
  - debt management
  - credit rating
  - saving methods
  - financial capability
  - credit terms
  - financial products and services
  - financial planning
  - budgeting

All training to improve **self-sufficiency and independence fostering more resilience and resistance to illness— it’s a prevention strategy.**
Illness Prevention Strategies

• Unfortunately, primary prevention has not been well funded in the current national HCS.

• Recent editorial (Cape Cod Times, August 18, 2017, pg. B8) = prevention is still not now viewed as high priority. The editorial states that in Massachusetts,

“When state lawmakers fine-tuned their 2018 budget numbers late last month, they sliced out millions of dollars for local wellness programs…”

“… We avoid self-destructive behaviors such as smoking and excessive alcohol consumption to avert the need for drastic medical intervention later in life. Inevitably, those who decide to ignore such advice end up paying a dramatically higher cost later.

“Similarly, more than a few government programs out there on both the state and federal level deal with taking care of problems that exist only because simpler preventive steps were previously ignored. Thus, instead of doing the wise thing and paying a minimum amount up front to prevent a problem, we seem content to use our tax dollars to clean up the much bigger mess later on.”
Primary Prevention “aims to prevent disease or injury before it ever occurs. This is done by preventing exposures to hazards that cause disease or injury, altering unhealthy or unsafe behaviours ...” (http://www.iwh.on.ca/wrmb/primary-secondary-and-tertiary-prevention).

A primary care approach = increase consumer health status and lower the utilization of high cost, high intensity healthcare services.

Dr. Ezekiel Emanuel, advisor to the previous administration = “Few public health dollars focus on lifestyle conditions that ultimately contribute to the majority of chronic illnesses seen today” [Johnson. (December 29, 2017), pg. 27].

Coile (1990, pg. 152) “... antibiotics and therapeutics had less to do with the real health of populations than a variety of economic, social, nutritional, and behavioral factors”.

Strong incentives within the provider and consumer communities of the proposed PFHS to pursue those essential changes in life-style that result in increased wellbeing and conservation of healthcare resources.
Cross-Training of Medical and Behavioral Staffs in IDSs

• Collaborative relationship between medical staff and behavioral staff will require.

• Medical staff = understand concepts and procedures used by behavioral clinicians in assessing and treating lifestyle disorders, chronic illness (mental health and substance-use disorders).

• Medical staff = provide initial assessments of lifestyles that expose consumers to health risks and initial brief screenings for both mental health (e.g., childhood disorders, depression, early onset psychosis) and substance-use disorders (alcohol, opioids, etc.).

• Behavioral staff = trained to understand medical disorders with a special emphasis on the behavioral components of the medical disorders.

• Behavioral staff = cross-trained to treat both mental health and substance use disorders.
Value-Based Care Healthcare Services (VBC)

VBC includes addressing both sides of the healthcare equation:

A. Provider/Supply side and B. Consumer/Demand side

A. Provider/Supply side: *incentivizing providers of care* to deliver healthcare services that:

1. enable consumer to access services that *prevent* and/or to *slow* development of health problems.
2. manage consumer’s *already existing acute and chronic* healthcare (disease management).

B. Consumer/Demand side: *incentivizing consumers* to:

1. use healthcare services that enable their ability to prevent and/or to slow development of health-related problems.
2. manage *already existing acute and chronic* healthcare problems.
Value-Based Care Healthcare Services II

Overarching principle = remove and/or reduce barriers to both the provider delivery and consumer use of “cost effective health care services”.

A. Barriers to Provider provision of VBC services are financial and structural in nature.

B. Barriers to Consumer are financial and logistical.

VBC system requires:

A. Provider Incentives to deliver VBC services and

B. Consumer Incentives to utilize VBC services
A. Provider Incentives:

1. From FFS, volume-based, single consumer focused payment system, to a capitated, at-risk, VBC and population-based payment system.

   Move thru phases of:

   a. a combination of FFS, case rate and capitation/sub-capitation payment arrangements

   b. then to a fully capitated, at-risk, population-based payment system- a PREPAID common good system.

2. Behavioral Providers at the forefront of health service delivery – a significant adjustment.

Assess the readiness of the provider system in each state and specific state regions - cities to develop and implement a capitated, at-risk, VBC system.
B. Consumer Incentives address two categories of barriers: 1. Financial and 2. Logistical.

1. Financial Barrier Reduction: Remove/reduce financial burdens that diminish consumer motivation to use preventive/wellness and/or disease management procedures:

   a. Copays and/or Deductibles Lowering/Eliminating - designed to increase consumer motivation to use these VBC services.

   b. Treatment Utilization Points (TUP) system

   c. Contingency Management (Petry, 2006) contracting strategy used in alcohol and other drug abuse (AOD) treatment to encourage positive behavior change (e.g., decrease use, increased abstinence) = providing reinforcing consequences when patients meet treatment goals and by withholding those rewarding consequences or providing costly measures when patients engage in the undesired behavior (e.g., drinking, drugging).
Incentivizing Preventive Care Services

Consumers assessed as unable to pay the co-payment at the point of service= system that awards consumers an amount of “Treatment Utilization Points” (TUP) at the beginning of each year. TUPs are reduced as treatment resources are consumed (Morreim. 1998, pg. 295)

- Morreim recommends that “To encourage preventive care, patients might earn extra points for seeking immunizations, mammograms, or the like. Those with chronic illnesses might likewise be awarded points for securing important follow up care. Patients wanting interventions exceeding the MCO’s guidelines, such as CT scan for ordinary tension headaches, or a costly drug not on their formulary, might ‘purchase’ it by spending points”.

- “At the end of each year, points (“not used” – insert added) might be redeemed for cash, or rolled over into next year’s account, or perhaps used for in-kind rewards, such as health club memberships or even ordinary household goods” (pg. 296).

- The consumer is incentivized to ask, thoughtfully, “Do I really need this service”
Value-Based Care Healthcare Services VI

2. Logistical Barrier Reduction - Providers = offer consumers Care Coordination services (CC).

CC services = by staff dedicated to assist and support the consumer with case management to assure the efficient engagement of the consumer with all necessary appropriate care recommended.

CC staff include Case Managers and Peer Navigators = assigned to consumers who require assistance in accessing and committing to service system interventions.

The logistical barriers:

- Deficit in motivation to complying with clinician recommends
- Unavailability of services – (provide recovery support while on a wait list)
- Transportation problems
- Child care needs
- Housing needs
- Paperwork
Providers in the PFHS will provide recovery support/care coordination services.

Addresses:
- waiting for admission
- multiple providers
- deficit of motivation to pursue the treatment(s) appropriate to their recovery.

Recovery support/care coordination services assure consumer engagement with all providers/clinicians who render appropriate treatment to the patient.

Case Managers and Peer Navigators = a critical role in the recovery support/care coordination effort designed to strengthen each patient’s commitment to pursuing their individual recovery from any disorder.
Population-based Healthcare I

- **Population-based framework** = the conservation of limited healthcare resources.

- Population-base approach = “balance the needs of any one individual against the needs of the larger community.” [Armenti, (1999). pg. 46].

- In an **at-risk capitated system** = significant concern.

- Integrated delivery systems (IDS/ACOs) will need to **assess their sub-populations to identify those at-risk of high utilization of especially high intensity, high cost services.**

- Identification of those at-risk of high utilization will be the focus of **demand management strategies.**
Provider of IDS will offer:

1. **primary prevention** to mitigate the development of chronic disorders
2. **disease management strategies**

Providers partner with their consumers in shared decision making.

**Purpose for managing those chronic illnesses** via primary prevention and disease management = **enable more cost-effective and wider delivery of care to more covered persons** within a **population-based framework** to healthcare - **while not compromising required care**.
Diverse Populations of Americans Need Different Approaches
(Whitlock, et al. 2017)

Each state is composed of sub-populations and each of these requires a somewhat different approach to healthcare delivery within each state’s environment.

- **Sub-populations that require different approaches to health care delivery** may be categorized broadly as:
  - children
  - pregnant women
  - elderly
  - disabled
  - workmen’s compensation cases
  - incarcerated persons
  - American Indian groups
  - working adults
  - veterans
  - Et al

- **Each state** will design a PFHS that addresses the unique healthcare needs of each of the sub-populations residing within their state.
Primary Provider and The Structure of the Integrated Delivery System (IDS)

- **Need to** establish of an Integrated Delivery System (IDS)/Accountable Care Organization (ACO) (Institute of Medicine, 2006).

- **Selected IDS/ACO** = maintain integration of all healthcare services incorporating primary, secondary and tertiary preventive care approaches.

1. **All treatment levels of care and specialties** i.e. outpatient, residential, inpatient, surgical and special treatment services
2. **All healthcare specialties** – medical specialties, pharmacy services, behavioral healthcare services, dental services, podiatry, physical therapy, etc.

- Integration of medical and behavioral (mental health/substance use disorders) will be an essential and a required systems feature.

- **IDS/ACO likely will be, in most state health region areas, hospital based** with a network of providers at all levels of care and all healthcare disciplines located throughout the regional healthcare areas.

- **Hospital-based IDSs = all required services** either directly within their own system or within sub-capitated/case rated affiliations with other provider entities within their regional areas.
Primary Provider and The Structure of the Integrated Delivery System (IDS) II

• Integration of medical with behavioral providers = passing of licensing procedures and regulations that will enable that integration.

• Co-location of medical and behavioral services = necessary but not sufficient foundation

• Especially when co-locating substance-use services in the same space with general medical services is planned (Quinn, et al. 2016).

• Enabling state policies and procedures will be required within the PFHS.

• Incorporate Federally Qualified Health Centers (FQHCs).
Selected IDS in each state = “real” and “virtual” networks (Burns, 2012) of multi-level of care and multi-disciplinary clinicians.

The IDS = small groups of clinicians and solo clinical practices into the IDS.

This will result in at least the following IDS advantages:

- economies of scale
- facilitating communication among providers/clinicians via shared EHR connectivity
- consumer coordination of care among providers/clinicians
- coordinated reporting of BHC and Medical HC data (encounter data) within the healthcare region (county, city, state region, statewide) for CQI purposes.
Managed Care I

- The at-risk capitated IDS will incorporate all managed care procedures required to assure accountability for the necessity for and appropriateness of treatment requested/rendered by its consumers, providers and clinicians.

- The IDS becomes its own managed care entity.

- Within the frame work of managed care, the IDS will develop its own internal utilization management (UM) and utilization review (UR) procedures.

IDS = covered consumers and its providers and clinicians to justify, according to criteria developed or adopted by the IDS, the necessity for the treatment of the disorder presented and the appropriateness of the treatment requested for that disorder through its UR procedures.
Managed Care II

• Consumers and Provider clinicians requesting treatment = present consumer’s impairments of function due to the disorder presented.

• Clinicians = show that the Severity of the Illness (SI) presented by the consumer/patient matches the Intensity of the Service (IS) requested by both consumer/patient and/or clinician (IS=SI), prior to treatment requested being certified/authorized by the IDS UM staff.

• Establishes provider/clinician accountability via a “sentinel effect” in which “performance increases when one believes they are being watched” (Armenti, 1999, pgs. 23-24).

• “Trust will no longer substitute for accountability” (Gray, 1991, pg. 320).

• “Trust but verify”, even, or especially, within one’s own at-risk, capitated healthcare entity.
Managed Care III

- Confluence of:
  - patient clinical information
  - cost-effectiveness
  - resource conservation factors (population based)

guide the certification (also called authorization) of treatment procedures executed within the IDS.

- Coverage is portable.

- Required healthcare treatment in any other state or other country = the IDS in the state region of the consumer’s home-state will be contacted by the out of home-state or other country’s provider to review the request for treatment with the UR staff of the IDS.

- Treatment certification and payment decisions will be negotiated between the out of home state or other country provider and the applicable IDS.
Local Control of the PFHS – Essential in the PFHS

• Discontinues any direct federal (central) government’s control and management of the remainder of the HCS for all Americans - including Medicare and Veterans healthcare programs.

• Primary control of the management of both healthcare funding and service delivery to each of the fifty states.

• Expanded democratization of healthcare services at the local level.
Healthcare Fraud

► Healthcare Fraud has been a pervasive reality within the American HCS.

► “According to a report (Health Insurance, 1992) published by the General Accounting Office in the US, healthcare fraud and abuse costs the US as much as 10% of its annual spending on healthcare, representing US$ 100 billion per year.” Yang and Hwang (2006, pg. 56)

Proposed PFHS has the structural design to reduce level of fraud within the HCS by:

1. enabling primary control of funding and management of the HCS at the local level – closer surveillance.

2. eliminating claims–based payments for all ambulatory (outpatient levels of care).

Result = a large cost savings in terms of:
1. dollars taken fraudulently
2. dollars required to administer fraud prevention, detection, prosecution and recovery.

• Visit to the GAO website (www.gao.gov) for most current data on healthcare fraud.
Funding the PFHS Healthcare System

- **All able Americans** (means tested) and **business entities** = obligated to contribute an assessed “Healthcare Tax” (HT).

- HT amount will differ for individuals, for families and for business corporations.

- **Federal government will transfer** all dollars in their systems that are related to any aspect of healthcare delivery (including Medicare and Veterans programs) to each state during the period of conversion.

- Federal dollars = available to each state to fund their respective statewide PFHSs - used to **supplement state tax funding** in covering:
  1. Costs of those Americans not financially able to contribute their fully assessed HT
  2. State reserves required to meet **unplanned healthcare needs**.
The Healthcare Tax (HT) Determination

Determining the **amount of HT** will require a different approach for the three (3) taxable contributors to the PFHS:

1. **Individuals Not as a Member of a Family**

2. **Individuals as Members of a Family**

3. **Business Corporations**
Individuals Not as a Member of a Family – 1

- **HT** = assessment of individual’s:
  - healthcare history
  - current health status and treatment needs
  - financial ability to contribute – means testing.

- **Purpose** = arrive at a Healthcare Risk Level (HRL).

- Assessment of the individual’s HRL = completed with each **individual, the individual’s personal medical doctor(s) and other healthcare professionals** familiar with the individual’s health status and treatment Hx.

- **HRL** = **actuarially projected service utilization level** and their costs for the coming year (or two).

- **HRL in conjunction with the individual’s financial resources** = individual’s obligated annual HT amount to be contributed to the state entity that will manage the state’s HT fund.
**Individuals Not as a Member of a Family - II**

- “Declaration of Healthcare Tax Due for Year = __$$__” (DHT) for each individual American is issued to the individual and to the individual’s employer (if they are employed).

- For individuals who are **employed**, the annual HT may be contributed to the state within an **employer-based payroll deduction system**.

- Individuals **not employed**, HT, = submitted by individual to their state’s designated PFHS managing entity.
Individuals as Members of a Family

- Individuals who are members of a family, the HT contribution to the state is ultimately determined as a Bundled Family HT (BFHT).

- Determine the BFHT = assessment of HRL for individual in a family unit (adults and dependent children).
Healthcare Saving Accounts (HSA).

• There is a place in the proposed PFHS for the HSA.

• Individuals and families who wish to save their dollars for out of pocket healthcare co-payments which they believe they will be required to pay in the coming year when seeking treatment, will have this feature available to them.
Business Corporations - Employers

- **Business corporations** = manage the **payroll deductions** for each of their individual employee’s HT and BFHT using standard enterprise wide software.

- Business corporations will **not be required to manage** their employee healthcare **coverage** within the new proposed PFHS.

**Employers will benefit:**

1. *relieved of the cost burden* for managing employees’ healthcare coverage.
2. expected benefit in terms of a *healthier work force* (fewer absences, more productivity).

**Corporations will be assessed a Corporate Healthcare Tax (CHT) =** based on factors related to:

1. annual profit realized
2. number of employees, etc.

The state’s Health Authority = **conduct audit** of each corporation doing business in the state to assess the corporation’s asset level and other factors that will influence the determination of the corporation’s total annual CHT.

- **CHT** = sent to the state’s healthcare managing entity on a periodic basis.
Addressing Individual Financial Deficits

• Some individuals = *not financially able to contribute* the full or the assessed total amount of annual HT.

• Condition referred to as the Individual Healthcare Tax Gap (IHTG).

• Will qualify for a Healthcare Tax Credit (HTC).

• IHTG/HTC = requires other individuals, families and business corporations assessed as having resources that enable their *consuming an amount above* their assessed minimum Annual HT.
Addressing Unplanned Healthcare Events

- Funding IHTG/HTC and **unplanned healthcare emergencies and disasters** = need to assess some individuals, families and business corporations an “**Add-on Healthcare Tax Reserve**” (AHTR) to their assessed minimum HT.

- AHTR determined by the state health authority as an additional % of the HT contributor’s assessed annual HT minimum.

- **AHTR = set aside by the state health authority** to cover all IHTG/HTCs and any **unplanned healthcare costs** arising from health **emergencies and/or disasters**.
Flow of HT Dollars Through the PFHS

- Individual, family and business corporation HT plus AHTR, and applicable federal balance of healthcare–related funds to
  ↓
- State Healthcare Commission to
  ↓
- State regional “Healthcare Management Groups” with Community Advisory Boards, to
  ↓
- Local primary provider, Integrated Delivery System – at-risk capitation (pmpm) with incentive pools, to
  ↓
- Affiliated provider groups in geo-local areas – at-risk sub-capitation/case rates, to
  ↓
- Clinician - compensation (salary + benefits + merit/bonus).

PLUS

- Specialist/hospital providers - claim submission for surgical and ER/inpatient care required
Performance Requirements

Cost allocation within the IDS:

1. fifteen percent (15%) to twenty percent (20%) to administrative activity
2. at least eighty percent (80%) to eighty five percent (85%) to treatment services.

Percentage of the capitation amount awarded to the selected IDS = set aside as an incentive poll from which the selected IDS is paid for meeting Performance Requirements.

- **Provider Performance Requirements** = established by each state healthcare authority for each state region in collaboration with the local advisory board.

- Performance Requirement reporting must comply with pre-determined schedule for complete and timely submission.

For example, the EQP may earn their incentive dollars from the pool at a rate of 1% for each required data set reported fully and timely on a monthly or quarterly basis.
Identifying the Primary Provider Entity Within a State Healthcare Region

• Competitive RFP process.

• All interested and eligible provider entities = respond with proposal addressing the healthcare needs in their region of interest as presented in the RFP.

• Bottom-line actuarially determined per member per month (pmpm) cost covering all actuarially projected administrative and treatment activities within the region’s population.

• Responding providers = present approaches to funding the population being served:
  1. administrative activities
  2. routine services
  3. emergency services
  4. high cost procedures, such as surgeries and special treatments (both short and long term), inclusive of chronic disorders.

• IDS = all levels of care and for all disorders presented by their consumer community, including those consumers with so called pre-existing conditions.

• The IDS selected = receive the healthcare dollars (pmpm) within an at-risk capitation payment methodology.

• Selected IDS and its affiliates = required to report their healthcare encounter data, outcome data and financial data, etc., for CQI purposes to the state healthcare authority according to a predetermined reporting schedule.
Payment to Providers/Clinicians within the EQP I

- **Actuarially determined at-risk capitation** method = the essential VBC payment arrangement to the IDC provider.

- **Reducing claims–based payment** = a significant reduction in provider and clinician time spent with administrative activity and in administrative costs within the healthcare systems.

- **Claims–based payment, for ambulatory-outpatient services will be eliminated.**

- **Comparatively less well defined treatments in terms of procedural complexity and intensity**, such as surgeries and emergency procedures in EDs, will **require some form of claim submission to effectively bill the capitated EQP for those complex and often high intensity procedures.**

- **Hospitals/residential facilities** = paid per diems for **authorized lengths of inpatient stays and the intensity of treatment rendered** in the ED, surgery units, inpatient and residential levels of care.

- **Merit/bonus payments** to hospitals for ER/inpatient/residential service efficiencies = available according to **incentive systems** developed by the selected EQP addressing the provision of value-based care.
Clinician Compensation

- Compensation to healthcare clinicians within this at-risk capitated system will take the form of **base salary and benefits**, i.e., vacation days, holiday time off, limited on-call.

- There may be situations where payment with **case-rates** are appropriate.

- In addition to base salary and benefits, **merit/bonus pay systems** will be in place to incentivize providers to execute cost-effective, value-based treatment to all consumers.

- **Some specialists** (surgeons, who deliver the more complex, higher intensity service), = compensated with base pay plus *preauthorized* claims-based specialty service fees for services rendered.

- ** Eligible for merit/bonus pay** based on performance measures to be established.
Payment to Providers/Clinicians within the EQP III

In population–based, capitated, at-risk payment system = “balance the needs of any one individual against the needs of the larger community” is a particular concern

Provider is financially:

either

1. **At risk to lose $$ by expending dollars in excess** of what funds available for service delivery and program administration.

or

2. **Positioned to profit** by expending less than the healthcare funding available

To avoid losing $$$ and to realize the second outcome- to profit = risk to consumers that providers may underprovide necessary and appropriate services = contrasts with the risk of overproviding care in a FFS, volume-based payment system.

Both payment systems require:1. behavioral clinicians to address life-style disorders 2. a monitoring mechanism (UM/UR, advisory board review) to assure that consumers receive the necessary and appropriate care required to meet their healthcare needs.
• **Value-based co-payments** at point of service (no other consumer out-of-pocket costs are required, such as deductibles and co-insurance).

• **Co-payment enables** management of *demand for services* as out-of-pocket co-pays enable consumers to exercise a degree of *thoughtful utilization of services* and addresses resource conservation from the demand side of the healthcare equation.

• **Co-payments levels = value-based**, meaning that the co-payment amounts are related to the criteria determining necessity for and appropriateness of the *service being requested by the consumer*.

• The consumer is incentivized to ask, thoughtfully, “Do I really need this service”
Co-payments = zero to some pre-determined upper limit amount, with the amount of co-payment linked to the requested treatment’s level of Necessity and Appropriateness as determined by the internal utilization review (UR) conducted by the IDS UM staff.

When consumer is assessed as not having the means to pay determined co-payment, there will be in place measures to discount partially or completely the value-based co-payment.
Managerial Competence in Healthcare

• Selected IDS = **managerial expertise** to assure that the cost of delivering necessary treatment does not exceed their funding limits.

• Partnering with former **CPI entities/staff** will be an advantage here.

• **Effective management** = **realize annual profit income** - they retain the dollars remaining after costs are determined.

• **Realization of profit** within the at-risk capitation funding system = **challenge** as providers will need to **balance the treatment needs of patients against the costs** of administrative activities - necessary treatments must be rendered.

• Provider approaches to healthcare that incorporate **primary prevention and life-style disease management** provided by **behavioral staff** become **core interventions** to increase consumer well-being that result in a decrease in healthcare service utilization by the consumer and increased profits for providers.
Commercial-Private Insurance System (CPI)

- **Role of CPI entities** as primary designers and financially at-risk funders of healthcare services within the American HCS **may change** within the proposed PFHS.

**Current CPI entities** = an **opportunity** within the proposed PFHS to:

*either*

1. **Continue**, after the PFHS is implemented, as entities that **design and sell insurance-based coverage** for healthcare services in the competitive marketplace as alternatives or supplements to the PFHS.

*or*

2. **Play a significant role in the management** of each state’s PFHS.

**Alternative role** for entities that make up membership in the current CPI system is for any CPI entity to compete for a role in the management of the new PFHS at the state level.
A core activity for CPI staff will be in the area of collection and management of healthcare encounter/utilization data to advance CQI.

This activity is currently the foundation for quality improvement efforts globally at all levels of healthcare systems.

Healthcare data management in the proposed PFHS will be a critical activity at the national, state and local community levels to assure the continuous quality assurance efforts in the pursuit of best practices guided by VBC principles.
Consumer Access to Care Within a State Regional Healthcare Area

- **Access to care** = walk-in basis to providers locations in emergencies and by appointment arranged via telephone and/or on-line services (where that service is available).
- **Toll-free telephone access** for care referral and appointment scheduling 24/7/365 basis for both emergency and routine treatment.
- **Call centers** may be established statewide or regionally depending on the healthcare access issues peculiar in each state region.
- **Call centers** will be required to collect consumer call data and to generate reports related to that data for CQI.
- **Vulnerable individuals** in need of healthcare services, especially the disabled, pregnant women and elderly will be assisted, when requested, by a team of peers trained to provide navigation through the HCS to assure that barriers to care are resolved and access to care is timely.
Thank You

Q & A
REFERENCES


27. Tanner, L. (December 29, 2016). Skin cancer drop in Northeast bucks the trend. Star Ledger, pg. 27.
