# THE EVOLUTION OF COUNTY AND MUNICIPAL BEHAVIORAL HEALTH IN NATIONAL HEALTHCARE REFORM

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**Question: Given the uncertainties surrounding healthcare transformation what should County and local government behavioral healthcare organizations do to protect and position themselves?**

There has never been a more challenging time for county behavioral health providers. The first step in the strategic positioning process is understanding the environment, key issues, drivers and players at the national, state and local levels. As the Nation waits for the Supreme Court to rule on the ACA's individual mandate requirement, most state and local budgets are seeing massive declines in funding for all essential services, including health and human services programs. Many states, including Washington, Michigan and Virginia, are looking at radically revised options for the administration and delivery of public health insurance benefits that will dramatically reshape the functions and roles of existing providers.

The predicted 33-million surge in Medicaid-eligible individuals will release a pent-up demand for all healthcare services, particularly behavioral health care. This surge, both a challenge and opportunity for traditional providers, has resulted in a national policy debate regarding the restructuring of Medicaid. The decision of the Administration to grant states greater flexibility and participation in determining Essential Health Benefits has raised the specter of state-by-state variance in the scope, duration and depth of insurance plan benefit design. The end result of the environmental scan should be a tailored list of assumptions and implications as to how these forces may affect the regulatory function and role, scope of services, workforce, capital and infrastructure and financing of the organization. What is clear to me is that Public Law 111-148, at a high level, will result in the expansion of coverage and restructuring of the current insurance system. My next point is particularly important to public providers: there will be new managers of public benefits, new public provider competition, and more complexity in payments, network/alignment costs, and administrative functions and rolls.

Most important, consumers will have both choice and portable benefits without underwriting exclusions/limits. Choice is an interesting word. Will your current consumers *choose* to remain with you? Does anyone remember the first generation Medicaid HMOs that offered toaster ovens to entice Medicaid recipients to enroll with them? Public providers need to reflect on the fact that behavioral health is roughly 5% of the health care dollar. Many consumers, with choice now an option, will be motivated to seek consolidated, convenient access to more comprehensive and consumer-friendly service ACO's.

**Question: So, given your comments , once a county or local government provider organization takes the first step of an environmental scan and develops a list of assumptions, what then?**
Bob Dyer of Criterion Health and I have always been proponents of Philip Kotler's ―4 P‖ strategic market planning model. Kotler's original formulation contained four elements: *product, positioning, promotion,* and *price*. Our model adds a fifth element: *politics*. Analyze, plan and organize around these five elements:

*Product:* What clinical or ancillary services are currently being offered? What future services will be of high value to consumers, pavers, and benefit managers? Consider offering high incident, population-based services for depression and anxiety, as well as emergency room diversion and services to medical groups to assist in consumer adherence/compliance to lifestyle and prevention areas. Services for co-morbidity in high risk consumers, such as case management and disease management, as well as medical home core elements, will be in high demand. Should you manage other ancillary services such as OT/PT/speech and hearing services? Get as far upstream as a benefits manager as possible.

*Positioning*: Getting a place at the table as far upstream as possible is critical. Be both provider and benefits manager if the politics permit. If not, would you rather be ―fox‖ or ―henhouse?‖ Take a leadership role in setting the table as an owner or partner in behavioral health partnerships or ACOs. Offer specialized benefits management in health insurance exchanges or ACOs. Consider creating a community health center if in a medically underserved area. Join associations focusing on primary health care and healthcare reform.

*Promotion*: You must prove your worth and value to all stakeholder groups. Create, use and demonstrate a public model proof-of-performance, focusing on return on investment, tax conservation, or tax contribution. Prove your worth to commercial stakeholders through reduced episodes of care costs, absenteeism, or increased productivity at less cost.

*Price*: Develop flexible accounting and episode/value pricing. Integrated Electronic Health records, financial and management systems are essential. Administrative efficiency is paramount given medical loss ratio cap of 15%. Develop public-private outsourcing models for variable volume clinical services.
*Politics:* Extend and raise your political presence in the local and state arena. Track each stage of the evolving regulatory process and develop presence and connections in the emerging health system politics in your communities, statehouses and at the county and city council level. Approach each day as if the future of your vision of healthcare transition would be tested at least once.

The key challenge in today's uncertain environment is to imagine what your organization and community will look like in three years. Your vision should include some key principles, such as ensuring that you are in a primary care or some organized healthcare system/ACO: You will be on provider panels, health insurance exchanges, cooperatives and ACO's, and be an equity partner if possible. You will be a specialist in disease management and can use outlier management utilization capabilities and work with case rates or other episode based pay-for-performance arrangements. You will have installed key elements of mental health medical home services and have moved fixed cost contract relationships where

there are variable volume risks. You will be managing defined health benefits at a level above service provider. You have in place the metrics and public message that define you as a value-added partner in service outcomes, improved health and productivity, and a cost/ return on investment community champion.