

# The Colorado State Innovation Model: Integrating Medical and Behavioral Health Care

Thanks to funding from the Center for Medicare and Medicaid Innovation (CMMI), the state of Colorado soon will implement and test its proposed model for health care innovation, entitled “the Colorado Framework.” This article discusses how and why the model, integrating primary care and behavioral health as its cornerstone, creates a system of clinic-based and public health supports to spur innovation and health care cost savings. It also describes the current health care delivery challenges in Colorado and how payment model reforms—including capitation, risk adjustment and gain sharing—are necessary to achieve sustainability.

by **Steve Melek** | *Milliman*

The state of Colorado will receive up to \$65 million from the Center for Medicare and Medicaid Innovation (CMMI) between February 2015 and July 2019 to implement and test its proposed model for health care innovation. The plan, entitled “the Colorado Framework,” creates a system of clinic-based and public health supports to spur innovation. The state will aim to improve the health of Coloradans by (1) providing access to integrated primary care and behavioral health services in coordinated community systems; (2) applying value-based payment structures; (3) expanding information technology efforts, including telehealth; and (4) finalizing a statewide plan to improve population health.

The Colorado Framework defines *integrated behavioral*

*health care* as “the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.”<sup>1</sup> This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms and ineffective patterns of health care utilization.

## Why Integrated Medical and Behavioral Health Care?

Mental health has become the most costly condition in the United States, with an estimated \$201 billion spent in 2013 (Roehrig, 2016). The health care costs resulting from mental

health conditions largely are medical costs, not behavioral health care costs (Melek & Norris, 2008). In particular, costs associated with patients who have chronic illness can differ substantially when comparing patients with and without a comorbid mental health condition or substance use disorder. For example, a patient with diabetes costs an average of \$811 per member per month (PMPM) with no mental health diagnosis but costs an average of \$1,775 PMPM when the patient has a comorbid serious and persistent mental illness (Melek, Norris, & Paulus, 2014).

The majority of adults (Kessler & Wang, 2008) and many children (Anderson et al., 2015) with behavioral health needs do not receive behavioral health or substance use treatment. Rather, approximately half of adults with poor mental health receive care solely from primary care providers (Pettersen et al., 2014). Although an estimated 20% of primary care visits are related to mental health (Centers for Disease Control and Prevention, 2010), 67% of primary care providers report being unable to connect their patients to outpatient behavioral health providers (Cunningham, 2009). Integrating behavioral health into the primary care setting attempts to address these gaps in care to address the behavioral health needs of patients (Hall et al., 2015; Blount & Miller, 2009).

The integration of primary care and behavioral health is the cornerstone of the Colorado model. Proponents strongly believe that coordinated, accountable systems of care begin with primary care and expand from there. More mental health and substance use conditions are seen in primary care than in any other health care setting, and patients in primary care frequently exhibit behavioral health issues along with chronic medical conditions, making it logical and imperative to incorporate behavioral health into the organization and delivery of primary care. Accordingly, Colorado has developed a model for integrating primary care and behavioral health and sustaining it through outcomes-based payments. This model embodies a bold and important goal: **By 2019, 80% of Coloradans will have access to integrated behavioral health care in primary care settings.**

### Challenges for Colorado

From the outside, and on the surface, Colorado can seem like a very healthy state. Indeed, more than 27%

of Coloradans regularly meet the federal physical health guidelines—more than any other state in the nation—and Colorado ranks tenth among states in healthy living. Colorado continues to lag behind, however, on several critical measures of health care provision, ranking 28th in prevention and 40th in health care access.<sup>2</sup> Other challenges<sup>3</sup> include:

- **The state's rising obesity rate.** While Colorado continues to have the lowest rate of obesity in the nation, that rate has been steadily rising and recently exceeded 20%, a number that would have made us the most overweight state in the nation just 15 years ago. Altogether, more than 60% of the state is either overweight or obese, including almost one in three children.
- **Tobacco use.** Colorado has a lower rate of smoking than the U.S. average. Only 18.3% of the state population smokes, compared with 21.2% for the nation. Unfortunately, that rate has been increasing and is up from the all-time low of 17% in 2010.
- **Access to mental health and substance use treatment.** Three in ten Coloradans need treatment for mental health or substance use disorders each year, yet less than half of them are able to access care. Colorado also lags in mental health spending, currently ranking 32nd out of the 50 states, and spends less than one-third the national average to treat substance use disorders. Mental health concerns are especially pronounced in the Colorado adolescent population, where the suicide rate is the eighth highest in the nation. Colorado ranks second in the nation for alcohol use and fifth for both dependence on and abuse of illicit drugs and alcohol.
- **Racial and ethnic disparities.** Minority populations in Colorado are growing and are disproportionately affected by poor health and poverty. Overall poverty rates in Colorado topped 13.5% in 2011, but 27.3% of the African-American community lived below the federal poverty line. The Latino population had the next highest rate at 24.3%. Meanwhile, white non-Hispanics had a much lower poverty rate, with only 9.4% of the population living in poverty.

### Achieving a Return on Investment

One of the major objectives of CMMI in granting federal funds for a State Innovation Model (SIM) is achieving a favorable return on investment (ROI) over the funding period. This is possible when the innovation results in reduced health care costs during the study period that exceed the amount of the federal SIM investment. The Colorado integrated care model seeks to reduce total health care costs for Coloradans through increased access to behavioral health care in primary care settings, increased knowledge among patients of how their behaviors affect their health, better patient adherence to medical treatment regimens, improved behavioral and general health, better patient experience with the health care system and improving the work life of health care providers.

If these improved clinical outcomes are achieved, it is expected that health care cost savings will be achieved. The Colorado integration model seeks to spend more in primary care settings through its approach to integrated medical-behavioral health care, which would then lead to reduced spending in emergency rooms, shorter or avoided hospital stays, and reduced spending on specialty physician care. In the application to CMMI, the projection for health care cost savings totaled \$126.6 million, which represents an ROI of 1.95 during the study period. This total savings is projected over the entire Colorado population reached by the SIM program. It translates to a modest savings PMPM of \$1.83 to \$1.90.

### The Need for Payment Model Reform to Achieve Sustainability

A key goal of the Colorado SIM project is sustainability of integrated primary care and behavioral health services after the end of the award period. The program likely will not be sustainable without payment model reform. Continuing the fee-for-service approach to paying for these health care services will not lead to long-term, sustainable integration because of the inherently misaligned incentives they may create. The payment model reforms reflect multipayer, multistakeholder input that was sought out and obtained during the preimplementation year as well as ongoing input and learning during the test years. Options likely will be devel-

oped that allow for different levels of provider readiness, different structures of integration and differences in geography across the state.

The SIM project cannot expect providers of the integrated services to attempt to achieve the *Triple Aim* (improving the patient experience of care including quality and satisfaction, improving the health of the state population of Colorado and reducing health care costs) if the payment system does not provide sufficient financial payment to accomplish these goals and support for provider efforts. This is regardless of their motivation to accomplish the SIM goals. As well, it may be unrealistic to expect Colorado payers to be willing to pay more or differently for integration without some assurances that the quality of care will be improved and that spending will be the same or, even better, lower after integrated care. One element of the Triple Aim is reduced health care costs, and the SIM project has to achieve this goal in order to be determined successful. In order for the SIM efforts to be successful from the perspective of patients, providers and payers, payment model reform efforts should be designed to achieve certain goals:

- Appropriate flexibility in care delivery across the state
- Appropriate accountability for all spending
- Appropriate accountability for health care quality
- Payment adequacy for providers.

In addition, there are a few other fundamental elements for payment model reforms. To avoid payment reform design from being incomplete, the following items also will need to be considered:

- The definition of services to be covered by each provider payment
- The approach to controlling utilization and spending
- The approach to ensuring good quality and outcomes
- The approach for ensuring payment adequacy for providers.

### Primary Care Capitation Payments

A capitation reimbursement model is one in which a payer contracts with a provider or provider group to perform a specific range of services in return for receiving a fixed payment amount per enrollee per month, regardless of the amount or intensity of services provided. The various pro-

vider value-based payment models represent a spectrum of risk for both providers and payers, and capitation is at the far end of that spectrum in terms of minimizing risk for the payer. Under a capitation model, the financial risk associated with performance is passed on to the provider or practice. The remaining insurance risk to the payer is limited to the solvency of participating providers and their ability to provide the agreed-upon services. Capitation payments typically are adjusted for age and gender of the covered members and can (and likely should) be adjusted for the morbidity risk of the population as well. Primary care capitation payments likely will be highest for Medicare beneficiaries and lowest for Medicaid-covered lives.

In the health care cost projections, primary care costs are split out from all other categories of health care services. The primary care costs indicate a possible starting point for determining a primary care capitation rate. In developing these rates, the costs for each SIM practice were calculated separately so that capitation rates could be developed accurately for each such practice. It also likely will be necessary to include some form of risk adjustment and to develop calculations for practice credibility and potential pooling needs.

### ***Risk Adjustment***

An important component of payment model reform is risk adjustment. This already is partially accomplished by using different patient populations, such as the different Medicaid eligibility categories that are used in Colorado (adult, child, aged, adults with dependent children, etc.). However, additional risk adjustment may very well be needed to account for morbidity differences of the patients attributed to their practices. An arrangement may be established in which capitation rates by practice (or pooled practices) are agreed upon prior to the start of the program year. At the end of the year, actual costs may be calculated and risk adjusted, allowing for a retrospective true-up adjustment to the original capitation rates. It is recommended to use a retrospective payment and risk adjustment approach in order to most accurately reflect the disease burden for the participating SIM primary care practices.

### ***Gain Sharing***

Gain-sharing programs aim to reduce costs by aligning the incentives for payers and providers participating in a capitation arrangement. These programs are intended to create incentives that encourage providers to act in the best interests of the system, rather than in their own self-interest. The goal of a gain-sharing program is to reduce overall health care costs while maintaining or improving the health of the covered population by creating incentives to provide high-value services and health care that is appropriate and cost-effective.

These programs are particularly important in a primary care capitation model or in a partial capitation model to prevent shifting of utilization to specialists and other noncapitated providers. Gain sharing typically takes the form of a direct payment to providers (physicians and/or hospitals), with the goals of reducing overall costs and meeting standards for quality of care.

Gain sharing can be implemented in a number of ways.

- **Withholds.** A portion of the capitation payment, usually a percentage, can be withheld from the provider until the end of the fiscal year. If the health plan has favorable financial results, the withheld funds are paid to providers. If the plan does poorly, the money is kept to help cover financial losses.
- **Risk pools.** Funds withheld from the capitation payment can be placed in a risk pool shared with all providers and are only paid out if the entire group meets quality and cost metrics.
- **Risk-adjusted targets or budgets.** The health care cost targets used to set capitation payments, amount of gains shared with providers (such as beating a medical loss ratio target of a patient panel) or certain utilization metrics (for example, emergency room visits and inpatient admissions) can be adjusted for the underlying risk and morbidity of the covered population. Setting a target for noncapitated costs and sharing the risk with primary care providers can help reduce total health care costs.
- **Quality thresholds.** It is possible to structure the arrangement where payment of any achieved savings is granted only if predetermined quality measures are

met. Alternatively, the allocation of savings among participating providers can be done proportionally to the achieved quality metrics of each physician.

An additional goal of implementing gain-sharing programs is to convince participating providers to work together to manage the costs and health of the covered population. Rather than focusing on their own revenue and costs, providers would have a financial interest in the overall cost of providing care to the covered members since providers would share in the financial success of the plan or miss out on potential shared gains if cost and quality targets are not achieved.

### Next Steps

During 2017, the SIM office will coordinate significant evaluation activities, including the progress of practice transformation activities, health care utilization and cost improvements for Coloradans reached by the SIM practices, better health outcomes in physical and behavioral health, better patient experiences and improved provider satisfaction levels. As actual experience emerges throughout this year and the next few years, rapid-cycle feedback approaches will be used to provide results to SIM primary care practices to help them achieve the desired results and make course changes along the way to improve such results. 

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### Endnotes

1. See [www.colorado.gov/healthinnovation/what-is-sim](http://www.colorado.gov/healthinnovation/what-is-sim).
2. From Colorado proposal to CMMI.
3. Ibid.

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