The Voice of Accountable Physician Groups

January 26, 2016

Senator Hatch
104 Hart Office Building
Washington, DC 20510

Senator Isakson
131 Russell Senate Office Building
Washington, DC 20510

Senator Wyden
221 Dirksen Senate Office Building
Washington, DC 20510

Senator Warner
317 Hart Senate Office Building
Washington, DC 20510

Re: Bipartisan Chronic Care Working Group Policy Options Document

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

We appreciate the opportunity to comment on the Bipartisan Chronic Care Working Group Policy Options Document released in December 2015. CAPG represents over 210 multispecialty physician organizations across 40 states, Washington, DC and Puerto Rico. CAPG members participate in value-based payment models across Medicare Advantage and traditional Medicare. CAPG members have successfully operated under risk-based payment models for over two decades.

CAPG strongly supports the Working Group's efforts to improve care for the chronically ill. The CAPG member model – prepaid capitation with clinical accountability and robust quality performance standards – is uniquely well-suited to bring better care to the chronically ill. This "alternative payment model" (APM) promotes an investment in the healthcare infrastructure needed to identify, treat, and prevent chronic disease. For patients with multiple chronic conditions, our coordinated delivery model is particularly essential.

APMs have the potential to align incentives for the right care, encourage preventive services, and improve treatment for seniors with chronic diseases. A recent study by the Integrated

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Healthcare Association (IHA) showed that "health plans that rely primarily on integrated delivery networks, such as HMOs and Medicare Advantage, generally have higher quality scores without using more resources."[1] The IHA study looked at data from 11 participating health plans for 19 million lives in California. The study found that models largely relying on capitated payments to providers – like Medicare Advantage – had significantly higher quality scores than fragmented models such as traditional Medicare. A summary of the relevant findings is attached.

While the quality differences between these capitated models and fragmented fee-for-service are striking, CAPG also knows that these percent of premium arrangements (where the physician organization is paid a negotiated percentage of what CMS pays the health plan) are somewhat rare. Because this model holds so much promise for the chronically ill, we encourage the work group to consider incorporating policies that would incentivize risk-based APMs in Medicare Advantage in the same way that Congress is currently encouraging the development of risk-based APMs in traditional Medicare. CAPG recommends a three-pronged approach to achieving this parity across all of Medicare's physician payments: (1) modify the Medicare Access and CHIP Reauthorization Act (MACRA) to fully account for risk-based arrangements between physicians and health plans in Medicare Advantage; (2) consider incentives for physicians and physician groups taking risk in Medicare Advantage; (3) consider incentives for health plans that are engaged in risk-based APMs with contracted provider organizations in Medicare Advantage. Additional details on these three recommendations are attached.

As to the specific proposals in the working group document, our comments are provided below.

Medicare Advantage Recommendations

In general, CAPG supports these recommendations pertaining to Medicare Advantage:

- Extending or permanently authorizing MA special needs plans;
- Allowing all MA plans to provide tailored benefits that would reasonably improve the care and/or prevent the progression of chronic conditions affecting MA enrollees;
- Permitting MA plans to include certain telehealth services in the plan's annual bid amount; and
- Making changes to the CMS-HCC risk adjustment model to improve accuracy.

CAPG would like to emphasize the importance of improving the accuracy of CMS-HCC risk adjustment. A recent analysis by Avalere shows that the 2014 MA risk adjustment model under-predicts costs for individuals with multiple chronic conditions by $2.6 billion on an annual basis. The study additionally shows that the model under-predicts costs for beneficiaries with specific

[1] Integrated Healthcare Association, Healthcare Hot Spotting: Variation in Quality and Resource Use in California, available at http://www.iha.org/sites/default/files/resources/issue-brief-hedis-by-geography-2015.pdf (accessed Jan. 26, 2016).

conditions, such a rheumatoid arthritis, dementia, and lower levels of chronic kidney disease. The report findings indicate that the model needs to be improved to appropriately pay for MA enrollees with chronic conditions.

CAPG further recommends that the working group consider the creation of an advisory committee on CMS-HCC risk adjustment. The risk adjustment model in Medicare Advantage is critical to accurate and appropriate payment for patients with chronic conditions. Yet, this is a highly technical area of law and policy that has critical implications for clinical practice. We believe that a multi-stakeholder advisory body, including clinical experts, would vastly benefit the development and improvement of new risk adjustment models.

ACO Recommendations

In general, CAPG supports these recommendations pertaining to accountable care organizations:

- Modifying the requirements for reimbursement for telehealth services provided by ACOs; specifically ACOs in the Medicare Shared Savings Program in two-sided risk models may receive a waiver of the geographic component of the originating site requirements as a condition of payment for Medicare's telehealth services;
- Clarifying that ACOs participating in the MSSP may furnish a social or transportation service for which payment is not made under traditional Medicare (ACOs may use their own resources to offer a broader range of services and capabilities to serve their patients);
- Allowing ACOs in Track One the choice of whether their beneficiaries are assigned prospectively or retrospectively;
- Allowing Medicare beneficiaries to voluntarily elect to be assigned to the ACO in which their main provider is participating;
- Allowing two-sided risk ACOs to waive beneficiary cost sharing for items and services that treat a chronic condition or prevent the progression of a chronic disease.

The working group solicits input on whether ACOs that provide services to beneficiaries that are prospectively or voluntarily aligned to the ACO should receive an upfront collective payment for all services provided to these beneficiaries. CAPG recommends that the working group review and consider adopting CAPG's Third Option model, which would incorporate the features of a pre-paid capitated payment model and a number of other attributes that contribute to success in such a model.

Improving care management for individuals with multiple chronic conditions

The working group is considering establishing a new high-severity chronic care management code that clinicians could bill under the Medicare Physician Fee Schedule. This new code would

reimburse clinicians for coordinating care outside of a face-to-face encounter for Medicare's most complex beneficiaries living with multiple chronic conditions.

CAPG supports the establishment of codes that accurately and appropriately pay for the management of chronic diseases in traditional Medicare. We believe that traditional Medicare must continue to improve its focus on care coordination and care management to meet the challenges of an aging population.

While we support the improvement of fee-for-service payment, we point out that there is broad agreement in the health policy community that the dominant fee-for-service payment system provides the wrong incentives for healthcare delivery. While we believe that there is a role for fee-for-service, its prominence in Traditional Medicare does nothing to encourage providers to work together to ensure the best care and best outcomes for patients. CAPG believes that new payment models outside of fee-for-service have significantly greater potential to improve care for all patients, including those with multiple chronic conditions. We encourage the working group to simultaneously pursue other policies that move away from fee-for-service as a dominant payment model and move toward population-based payments to physician organizations.

Addressing the need for behavioral health among chronically ill beneficiaries

The working group is considering developing policies that improve the integration of care for individuals with a chronic disease and behavioral health disorder. Policies would encourage care integration in traditional Medicare and Medicare Advantage. The working group is also considering a Government Accountability Office (GAO) study on the current status of integration of behavioral health and primary care across different delivery models.

CAPG supports these recommendations. We are including a case study from one of our members that has successfully integrated behavioral health with primary care as an attachment to this letter.

Increasing transparency at the Center for Medicare & Medicaid Innovation

The working group is considering modifications that would require the Innovation Center to issue notice and comment rulemaking for all models that affect a significant amount of Medicare spending, providers, or beneficiaries; or require CMMI to issue notice and comment rulemaking for all mandatory models and at least a 30 day public comment period for all other innovation models.

CAPG appreciates the working group's concerns around transparency at the Innovation Center. We believe that it is critically important to balance the interest in transparency with the pace of innovation. We believe that there may be instances where notice and comment rulemaking is appropriate, for example, in the case of CJR. However, pursuing greater transparency may also

hamper the Innovation Center's ability to rapidly develop and test new alternative payment models. In light of the enactment of MACRA and the existing APM model options, we believe that there will be a need for rapid development of new models to meet the needs of the physician community. We look forward to working with the working group to explore policies that can achieve these twin aims of transparency and innovation.

Conclusion

Again, we applaud the work group's efforts to improve and modernize Medicare for the challenges that lie ahead. We look forward to working with you to advance the policy aim of providing better care for seniors with chronic conditions and for preventing and slowing the progression of chronic conditions for all seniors.

Sincerely,

Donald H. Crane
President and CEO
CAPG

The Voice of Accountable Physician Groups

RISK-BASED COORDINATED CARE LEADS TO BETTER QUALITY OF CARE

Pursuant to a grant from the California HealthCare Foundation, the Integrated Healthcare Association (IHA) performed a study based on data from 11 participating plans (including Kaiser Permanente) for 19 million lives, approximately one half of California's population.

The IHA brief concludes that **"health plan products that rely on integrated care delivery networks, such as HMOs and Medicare Advantage, generally have higher quality scores without using more resources."** Several findings from the brief are highlighted below.

- Medicare Advantage outperforms traditional Medicare on all three resource use measures: readmissions, ED visits, and inpatient bed days (Table 1).
- Medicare Advantage has consistently high performance across clinical quality measures, outperforming the average clinical quality performance across all product lines (Table 2).
- There is a substantial difference in utilization rates between Medicare Advantage and FFS Medicare. Medicare Advantage is about 40 percent more efficient than FFS.

Table 1: Resource Use Measures: Traditional Medicare Compared to Medicare Advantage

	CALIFORNIA STATEWIDE AVERAGE	
Measure	**Traditional Medicare**	**Medicare Advantage**
Readmissions (% of admissions)	18.4	11.2
ED Visits (per thousand member years)	567	372.3
Inpatient bed days (per thousand member years)	1,363	758.3

Table 2: Clinical Quality Measures: MA Compared to all Products (e.g., Commercial, Medicaid)

	CALIFORNIA STATEWIDE AVERAGE	
Measure	**Medicare Advantage**	**All Product Lines**
Breast Cancer Screening	86.8%	80.7%
Colorectal Cancer Screening	79.4%	67.1%
Blood Sugar Control for People with Diabetes	77.9%	62.4%
Blood Sugar Screening for People with Diabetes	95.0%	89.3%
Kidney Disease Monitoring for People with Diabetes	95.8%	87.5%
Medication management for people with asthma	N/A	39.7%

To view the full IHA Brief, visit http://www.iha.org/pdfs_documents/resource_library/HEDIS-by-Geography-Issue-Brief-Final-20150729.pdf.

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MACRA: Medicare Advantage Alternative Payment Models Should Count in 2019 Toward the Alternative Payment Model Threshold

Today, Medicare Advantage enrollment makes up nearly a third of overall Medicare enrollment. The MA program has seen explosive growth, due in large part to the superior value it provides for seniors. All indications are that this program will continue to grow at a rapid clip in the coming years. However, under the Medicare Access and CHIP Reauthorization Act (MACRA), Medicare Advantage alternative payment models (APMs) are included only in the all-payer threshold beginning in 2021. MA's inclusion in the All-Payer Threshold is an important step but does not go far enough to recognize the value and importance of this program in achieving high quality, risk-based coordinated care. Physician groups should be able to qualify for APM incentives based on their participation in Medicare Advantage APMs for 2019 to 2024.

We encourage three important steps to remedy the problem:

- **First, rather than a Medicare Part B threshold, organizations should be able to qualify based on a Medicare threshold** (Medicare Part B and Medicare Advantage). MA contracts that include payment with more than nominal financial risk should count toward achieving the Medicare threshold for 2019-2024. APM contracts between MA plans and physician organizations where the physician group takes more than nominal financial risk, including capitation, should then explicitly count toward achieving this Medicare threshold.
- **Second, the same financial incentives for risk in traditional Medicare should be available for physician groups taking risk in MA.** That is to say, for a group that participates in MA, the APM incentive should apply to their MA revenue for physician services, not just their Part B revenue. This incentive should be paid directly to the physician or physician group taking the risk. The structure should be the same as MACRA: once a physician organization exceeds the threshold for risk, bonuses should be paid equally for both traditional Medicare and Medicare Advantage. The amount of the bonus should be adjusted to account for the financial incentives for health plans (our third recommendation).
- **Third, financial incentives should be available to health plans that enter into two-sided risk arrangements with physician groups.** With increasing frequency, CAPG hears from its members—among the most sophisticated risk-bearing physician organizations in the country—that many health plans are unwilling to offer risk-bearing arrangements to capable physician groups. Therefore, we encourage you to consider incentives for plans

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that enter capitated, delegated arrangements with physician groups. We believe that this type of incentive could be achieved through the Star Ratings program.

We believe this incentive structure is important for several reasons. Research shows that Medicare Advantage, when offered through an integrated, capitated delivery system (which is an APM and should be deemed as such), provides higher quality for seniors than traditional Medicare. The quality difference is striking. For example, some CAPG members have readmission rates as low as six or eight percent as compared to a fee-for-service average readmission rate that hovers around 18 percent. Medicare Advantage plays a crucial role in advancing high quality care for seniors.

In addition to being a high value option for seniors, Medicare Advantage plays a critical role in delivery system reform. While physician relationships with health plans generally are on the same trajectory from fee-for-service to alternative payment models, Medicare Advantage has the distinct advantage of having already "reached the destination" when it comes to risk-bearing relationships with providers. While not every arrangement between a plan and physician is risk bearing, Medicare Advantage is the one place today where two-sided risk-bearing relationships between payers and providers not only exist, but succeed. Some CAPG members currently participate in two-sided risk arrangements, including capitation, with health plans in Medicare Advantage. Other CAPG members are actively seeking out these relationships. But there are still large swaths of the United States where these types of risk-bearing relationships do not exist and should be encouraged. CAPG has tried to gather information about what percentage of MA is tied to risk-bearing or capitated arrangements, but has not been able to determine the percentage with certainty. We estimate that less than 20 percent of MA is currently capitated when considering the relationship between the health plan and the physician group. This represents substantial opportunity to improve care for seniors.

As a final note, the Affordable Care Act sought to achieve parity between Medicare Advantage and traditional Medicare, bringing the MA benchmarks, on average, to 100 percent of fee-for-service across the country. We believe that MACRA has inadvertently tipped the balance in favor of traditional Medicare, offering payments substantially above 100 percent of fee-for-service in traditional Medicare but not in Medicare Advantage. Yet all the while, MA has offered the most innovative, advanced payment arrangements in Medicare. CAPG looks forward to continuing to work with Congress and the Administration to explore ways of advancing delivery system reform across all of Medicare.

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CAPG's PROPOSAL TO CREATE A NEW MEDICARE OPTION:

THE THIRD OPTION

Introduction

Decades of experience show that coordinated care delivers higher quality, lower cost healthcare than any other model of care. Currently, Medicare beneficiaries are presented with two choices for Medicare participation: Original Medicare and Medicare Advantage. Neither model is perfectly designed to achieve the high quality, low cost healthcare our seniors deserve. Furthermore, our fiscal situation requires that more be done to control costs in the healthcare system. Original Medicare allows unfettered freedom of choice in the beneficiary's selection of physicians, but this fee-for-service model is widely acknowledged to be fragmented, inefficient, impervious to quality improvement, and financially unsustainable. Medicare Advantage is considered by many to be the best example of coordinated care, but there have been concerns in the past regarding the cost of the program to the Government as compared to Original Medicare.

There is an emerging consensus that something innovative is needed in addition to traditional Medicare and Medicare Advantage. Several think-tanks and other stakeholders have recommended concepts for improving Medicare, reforming the delivery system, and delivering healthcare at a lower cost trend.

We too believe that a better, more innovative program needs to be added to the currently available Medicare options. CAPG developed this policy paper based on our extensive experience with capitated, coordinated care to present recommended design elements for what we are calling "The Third Option." The proposal outlined below is an evolution and amalgam of extensively tested delivery models, addressing the flaws of existing models and incorporating sensible elements already proven to be successful.

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Design Elements for the Third Option

Clinically Integrated Organizations

Under our proposed Third Option, CMS would contract directly with clinically integrated organizations ("CIOs"). CIOs may be existing physician organizations or newly formed entities.

The CIO would be explicitly physician group centric. However, other providers could take ownership stakes, or could accept a measure of risk and accountability through affiliation agreements. This could include a broad spectrum of health care providers, including physicians, hospitals, nursing homes, home health organizations and other entities wishing to be accountable for the delivery of coordinated care to a defined population across the continuum of care. The CIOs would feature team-based care, led by primary care physicians and supported by other primary care providers operating at the top of their licenses (e.g., nurse practitioners, physicians' assistants, pharmacist, social workers).

Active Beneficiary Enrollment

Beneficiaries could enroll in a CIO at any time throughout the year. Beneficiaries would have a choice among traditional fee-for-service Medicare, Medicare Advantage, and a CIO. When the beneficiary elects the CIO, the beneficiary would also elect a primary care physician associated with the CIO. The beneficiary would then commit to receiving services in the CIO model for one year. Experience has taught us that active, intentional enrollment by an engaged and informed beneficiary is vastly superior to the retrospective attribution models that CMS has experimented with in the MSSP and Pioneer ACO programs.

By allowing enrollment throughout the year, this program would permit CIOs to efficiently employ their own sales staffs. This will enhance the accountability of the organization to its beneficiaries, from the point of sale onward.

To facilitate the election of the Third Option, quality and service information about available CIOs would be made available to the beneficiary. This CIO level information would be developed by stakeholders, including physicians, approved by CMS, and then disseminated by both CMS and the CIO to allow consumers to make fully informed choices about their care. Beneficiaries would be empowered with information regarding the package of services available under each of the three models, including any additional care management programs or benefits.

Benefits

The Third Option would cover the standard Medicare Part A and Part B benefits. CIOs would have the option to work with a Medicare drug plan to offer Part D

benefits as well, but CIOs would not be required to offer pharmacy benefits. If the CIO did not offer Part D benefits, such benefits would continue to exist alongside the Third Option.

Premium

In the Third Option, the Part B premium would be reduced for beneficiaries that (1) select the Third Option for a fixed one year period; and (2) actively select a primary care physician within the CIO who will be charged with coordinating all aspects of the enrollee's care. The percentage to be waived is to be determined with the aim of providing sufficient incentive for beneficiaries to select our proposed Third Option while at the same time providing sufficient funding for the program. This partial waiver of premium, coupled with the provisions relating to Medicare Supplemental insurance below, should make the Third Option an attractive alternative for seniors.

Beneficiary Alignment

As with Original Medicare, beneficiaries would be free to access services from any Medicare contracted physician. However, to incentivize beneficiaries to access care in-network as directed by their chosen primary care physician, services rendered by out-of-network providers would be subject to higher out of pocket costs. Prior authorization for certain high cost services would be required. The higher cost-sharing for use of services outside the CIO is designed to achieve the twin goals of allowing freedom of choice but incentivizing the efficiencies and higher quality that can be obtained by consistently accessing a highly organized, financially aligned, and electronically connected network of team-based providers. To encourage beneficiaries to seek needed care, including preventive care services, beneficiaries would not need to pay a deductible and would have no copayments for preventive services. To provide beneficiaries with additional incentives to access service in-network, Medicare supplemental insurance policies sold to CIO beneficiaries would be required to provide coverage for in-network services only. Beneficiaries would remain free to access services out-of-network, but would do so without the benefit of supplemental insurance coverage.

Payment to CIOs

Using regional historical Part A and Part B cost information, CMS would each year establish an actuarially sound, risk adjusted, global capitation payment to be made to the CIO for the entire population assigned to the CIO through the beneficiary selection process described above. CIOs would be free to accept these cap rates, or elect not to enter into a contract with CMS. The capitation amount would be published in advance, to allow CIOs to decide whether to continue participation, and to permit an orderly transfer of beneficiaries to other options if the CIO found that the proposed capitation was inadequate.

CMS would pre-pay this amount to the CIO each month in lieu of Medicare Part A and Part B fee-for-service payments for those beneficiaries, thus creating the alignment and incentives to produce lower cost trend and higher quality than experienced in the past. The CIO would be responsible for the payment for all professional and hospital services, whether provided in-network or out of network.

In addition to base capitation, CIOs would be eligible to receive incentive payments for meeting certain quality targets much as Medicare Advantage organizations do in the Medicare Advantage 5 Stars program. Importantly, the incentives would be paid to the CIO organization, not to individual physicians or health plan intermediaries. This will foster alignment of incentives with high performing physicians within the CIO.

Administration and Operations

Rather than building expensive health plan infrastructure and capacity, CMS would, at its expense, contract with one or more highly capable Affiliated Service Organizations ("ASOs") to administer the eligibility and enrollment process, make the global capitation payments, receive encounter data from the CIOs, operate the quality and incentive bonus program, and conduct all other functions necessary to operate the Third Option. In particular, the ASO will be necessary to handle the complexities associated with administering differential cost sharing for the out-of-network benefit. CMS may elect to contract with one or more national insurance carriers with the existing infrastructure and systems necessary to rapidly implement this program at scale. The expectation is that the use of national health plans in this ASO, non-risk bearing capacity will result in lower cost for these services than currently experienced within Medicare Advantage. This ASO model will mimic the use of an ASO by self insured employers in the commercial context.

Quality and Efficiency Measurement

To ensure that the CIOs have a strong business case for the delivery of high quality care, CIOs would be required to maintain a pay-for-excellence program to incent their downstream providers to deliver high quality care. The compensation payable to providers under these programs would be paid by the CIO from the global capitation it receives, and would not be deducted or withheld from the capitation paid by CMS to the CIO. Under this program, incentive compensation of as much as 15% of total provider compensation will be tied to high performance on quality measures, a model which has been demonstrated to successfully drive provider behavior. Individual CIO performance would be publicly reported. Quality measures would be developed, tested, and rolled out

consistent with accepted practices. These measures would apply and be reported at the level of the CIO, rather than individual provider level.

CIO performance on these quality measures would be publicly reported so that beneficiaries will be able to make informed decisions during enrollment. These measures should be the same as, or align closely with, measures in Medicare Advantage Stars program and Original Medicare so that beneficiaries can readily compare the three options.

Organization Eligibility

CIOs that wish to participate in the Third Option must be credentialed and certified by an independent third party organization. We believe that the criteria for certification should include: (1) ability to accept and distribute globally capitated, population-based payments; (2) care management processes; (3) health information technology; (4) patient centered care; (5) primary care team-based approach; (6) physician leadership; and (7) meeting state licensing requirements and solvency standards.

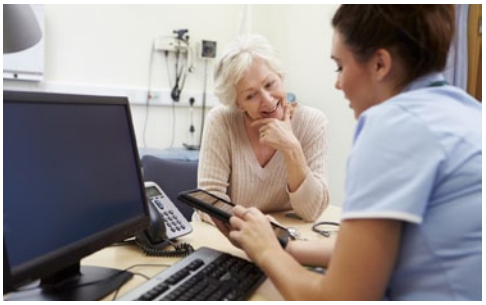
Conclusion

Medicare provides healthcare coverage for over 50 million Americans. Over the coming decade, enrollment is expected to increase due to a combination of longer life spans and an aging baby boomer generation. We must do more to address the flawed incentives of the fee-for-service payment system in order for the program to meet the demands of the future. The Third Option described above would provide for a payment, delivery, and benefit model that will foster both financial and clinical integration across the entire continuum of care, creating a far more optimal model that can deliver the lower cost, better care, and better service our nation's seniors deserve.

Integrating Behavioral Health with Primary Care

UCLA Medical Group

Los Angeles, California



INTRODUCTION

Behavioral health conditions drive higher utilization and worse health outcomes, making them important and early targets for UCLA Medical Group's accountable care strategy to deliver higher-value, population-based care. We successfully established a program of behavioral health (BH) that we call Behavioral Health Associates (BHA), co-located with primary care. BHA has grown to 20 BH specialists who see over 2,000 new, unique patients a year.

THE CHALLENGE

Similar to the U.S. population, around 25 percent of UCLA patients have a diagnosed behavioral health condition, which is leading to acute facility utilization at double the rate as the rest of our population. In 2012, only a small minority of these patients was receiving care from behavioral health specialists at UCLA Health and, even if care was provided, the primary care providers (PCPs) generally got very little assessment or follow-up information. The challenges we faced included enhanced regulatory requirements for protecting behavioral health data, inability to obtain health insurance reimbursement, and the lack of coordination between these services and the rest of the patient's healthcare. A strong opportunity presented itself to achieve the Triple Aim for our populations by overcoming these barriers and integrating behavior health services as part of our system.

INTERVENTION

We embedded behavioral health associates with psychiatrists and therapists within eight primary care practices. These BH specialists deliver behavioral health services through a collaborative care model, where short-term therapy of 12 weeks is provided and the patient is transitioned back to the PCP for maintenance healthcare.

The rules around behavioral health medical record releases are different from other types of medical care records, requiring specific training. To promote integration of behavioral health associates and maintain security of the medical records, we established the BHA program within the electronic medical records (EMR) as a confidential department whose internal staff can view schedules and documents. We developed a lean staff to handle BHA operations, and only these highly trained employees have access to BHA patient schedules. External physicians and staff are required to "break the glass" and provide a reason for viewing a record.

This setup allows referrals to be entered and processed, behavioral health appointments made, and documentation created for sharing within medical and behavioral departments through the EMR—all while adhering to strict legal requirements.

UCLA Medical Group was able to secure reimbursement for the professional services of BHA providers by adding them to mental health carve-out plan contracts relevant to the majority of our members. We did this by building on our experience with our Resnick Neuropsychiatric Hospital professional and facility mental health contracting resources. Specifically, we added the BHA providers to monthly rosters submitted to our existing carve-out plan contracts with the health plans. Typically, the plans update the listings within 30 to 90 days. Listing the providers in this way enabled us to bill the payer directly and to provide the patient an estimate of his/her share-of-cost before treatment. However, we have not yet contracted with every plan relevant to our populations, and we continue to work with mental health carve-out plans for professional services-only contracts.

RESULTS

BHA has successfully grown from a pilot started in November 2012 to a broad-scale population health program. The 20 BHA providers have served nearly 4,500 unique patients during that time, and are progressively growing their capacity to see larger numbers of patients each quarter (Figure 1). By offering integrated behavioral health services, we have been able to treat substantially more UCLA primary care patients with a psychiatric diagnosis because they can receive their behavioral healthcare within our primary care system (Figure 2).

We will be evaluating how this integrated local care delivery model improves medical and behavioral management of our UCLA patients. The BHA program still requires a subsidy from the health system, and program growth has been made sustainable in part by the funds received through health plan payments. Satisfaction among UCLA's PCPs has been very high, as BHA offers previously inaccessible services with easy communication through the EMR.

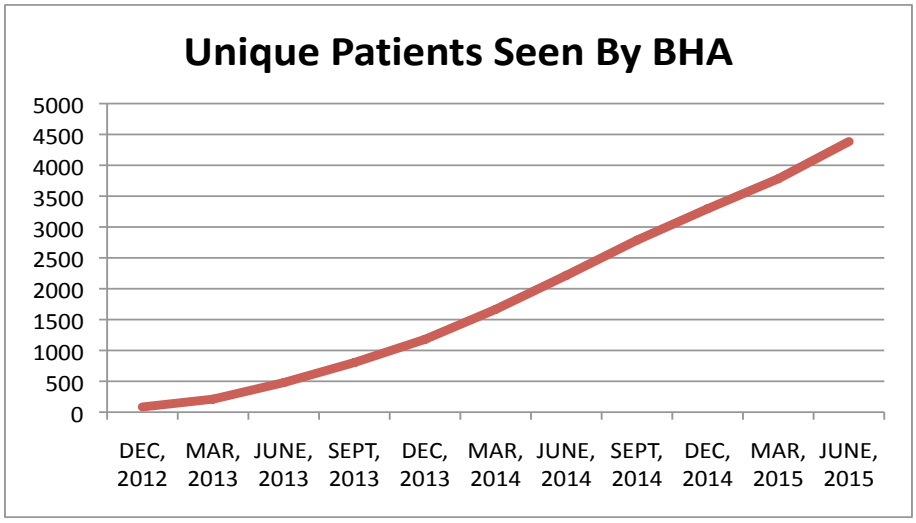


Figure 1

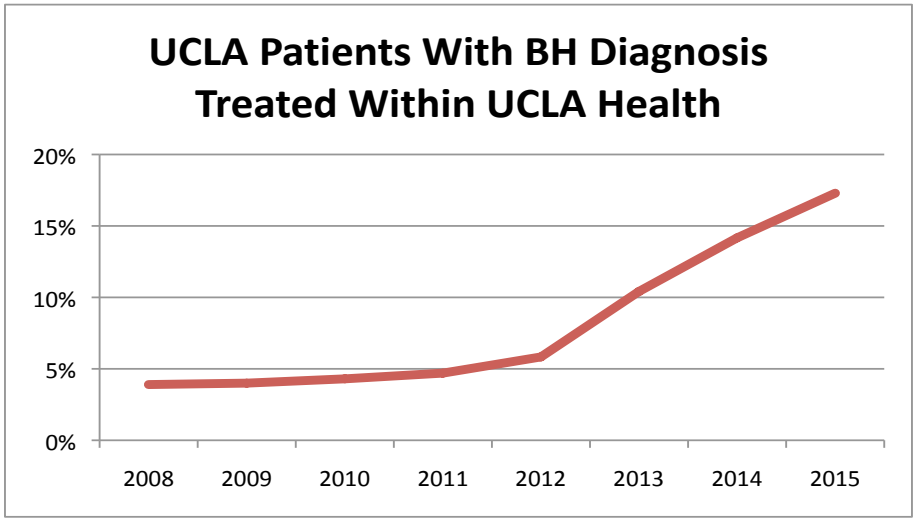


Figure 2

UCLA Health

WHO WE ARE

UCLA Medical Group is a component of UCLA Health, an integrated, academic medical center affiliated with the David Geffen School of Medicine at UCLA. UCLA Medical Group has held partial and full-risk capitation contracts for commercial and Medicare Advantage members for over 30 years. UCLA Health includes four hospitals, 180 primary care physicians practicing in 35 practices, and 1,200 medical and surgical specialists in 110 practices.