The Shifting Opportunities For Value-Based Contracting In The Behavioral Health Market – Implications For CCBHC Programs, CMHCs & FQHCs: A Discussion With Mike Rhoades

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Hello everyone. I'm Monica OSS founder and chief executive officer of open minds. Welcome back to our executive perspectives interview series. Today we're going to focus on how clinically integrated networks can support support provider organizations on the path to value based contracting, particularly in CCBHC demonstration states, and how those same clinically integrated networks can support revenue diversification plans. Joining me for this conversation is Mike Rhodes. He's the CEO and founder of alira health, a leading manager of behavioral health integrated systems of care and an expert on clinically integrated networks. In his role, Mike oversees the development and coordination of governments tech analytics and alternate payment model contracting across eight different one care networks, which collaboratively served more than 4 million consumers. Prior to founding alira health, Mike served as the vice president of population health at Community Care of North Carolina, and he was formerly the Chief Operating Officer at RHA services. Mike, welcome. Great to have you with us. Thanks, Monica, it's a pleasure to be here. We take pride in the accomplishments of the one care networks, and we are excited, not only in our partnership with open minds, but also to see those one care networks expand beyond North Carolina and Arizona into Indiana, Florida, Georgia, Kentucky, Louisiana and Missouri.

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Great to see the growth of opportunities for value based contracting for behavioral health provider organizations. As you know, I've been a long term proponent of behavioral health organizations developing strategies to participate in value based care, and those opportunities for those organizations to join a clinically integrated network is an important component of that. I'm looking forward to your upcoming One Care cafe at our Open Minds Tech Institute in October in Philly. This is a place just a

pitch, where executives can learn more about the clinically integrated network concept and how it fits into value based care strategies. Yeah, and we appreciate the alignment in our philosophies here we have worked very closely with you all and carrying forth the message that the time is right for value based contracting for behavioral health providers as well as primary care and the role of clinically integrated networks in accelerating that journey and pulling together the resources to collectively negotiate these contracts. We're thrilled to be together with you at the technology and analytics Institute. That's a great opportunity, if you're a provider, to get in an intimate setting, both with your peers, but also managed care organizations, to hear what that journey looks like as we move from contracting to collaboration between these partners? Well, Mike, you mentioned the time is right, and that brings to mind the whole issue of everything that's happening in Washington, the provider organization execs are really paying pretty close attention to the last budget bill. How do you think the bill is going to affect health plans and their use of value based contracting, and how will that trickle down to provider organization strategy? Yeah, in a word that we use in population health, really pay attention to this phrase, medical loss ratio, and it's critically important, this is the composite between premium divided by spend, and it's often represented in a percentage.

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And typically the premium should cover the average spend of a population writ large. However, when you have these kind of sentinel events that we're experiencing, that we experienced during covid, and we're about to experience in the future that can disrupt that medical loss ratio, and it takes a long time for equilibrium to re establish itself. So as many people remember during covid, we expanded Medicaid and ACA to provide health care services and coverage to people as they dealt with the the after effects of covid in their lives. Those people stayed on Medicaid and ACA for a number of years, and in 2022 many of you will remember we had the great Medicaid unwinding, or sometimes called the covid redetermination, where we started moving. Those people were temporarily on Medicaid and ACA back off. The thing to focus on at that moment is that the people we moved off of Medicaid and HCA at that moment were typically young and healthy. In a sense, they were profitable. Their costs were less than the premium that was coming in from the managed care organizations perspective.

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So that suddenly hit their bottom line. And you can see this reflected as late as July of this year. You're watching the financials for our managed care partners, and they're saying now, as they're finally getting those claims in and they're settling it out, they're finding that their spend is higher than their premium coming in, and that's creating losses for them that they're adjusting to today, even in 2025 so it takes years for those claims to be settled out. So fast forward to the second perfect storm that's occurring, the recent one big, beautiful bill, Act that was passed is projected to redetermine out an additional 30 million Medicaid and ACA lives. The vast majority of those lives are non disabled, healthy or profitable adults. So just like we did with the covid redetermination, we're about to take a lot of lives out of the system, and that really has managed care organizations on their heels and trying to adjust to that. This will disrupt MCO margins, and it's going and it's forcing them to investigate where there is overspend in their remaining populations. For example, managed care organizations are identifying some small pockets of behavioral health overspend. You're hearing noise about higher than average inpatient behavioral health costs. ABA for autism is also being called out as a target for scrutiny. But keep in mind, behavioral spend is a

minuscule portion of total cost of care, less than 2% of the total spent. So even if every behavioral health dollar spent was canceled tomorrow, it's not going to have any significant impact on medical loss ratio. In fact, for every dollar spent in effective outpatient behavioral health treatment, there can be up to $12 returned on the lower medical spend keeping people out of the medical hospital.

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But effective is the operative word, Monica, and that's why the one big, beautiful Bill Act has ironically been a boon for value based contracting, particularly with cins that have the experience and infrastructure to help their providers improve behavioral health and medical health outcomes for you know, let's take that one step further. Mike, you know, specifically for our audience that isn't as familiar with clinically integrated networks, how does joining a clinically integrated network help a provider organization position them as a solution to MCOs challenges with total cost of care and medical loss, ratio management. With that question, let me just step back. A clinically integrated network is a group of providers that come together and share resources and work together to standardize care, apply the data and analytics related to their population to target interventions to generate significant health outcome improvements, ultimately resulting in a lower total cost of care. You're sharing resources, you're sharing expertise, you're sharing wisdom, and then you're translating that to improved health outcomes and lower costs for your population. With that, you're able to come together and negotiate with payers on kind of these collective contracts that are called alternate payment model agreements here. But with that being said, I want to kind of go back to that one big, beautiful bill without a doubt, the shrinkage of people enrolled in health insurance is a huge net negative to the person to the member, and it will have a significant impact on provider and MCO finances, as I shared earlier, regardless of anything I say today, people without health insurance inevitably delay care, and for some of those people that could be a life or death decision that said, MCOs will not only be facing the acuity crisis caused by member shrinkage, but a loss of revenue that will force them to cut costs and staffing like any other business. To this end, MCOs will be looking for trusted and scalable partners to which they can delegate certain administrative duties that they would otherwise need to hire staff for. We are seeing more and more contracts that include delegated care management, delegated credentialing, reporting, quality improvement, and even gold carding of um, which removes some of that burdensome um requirements. Essentially, the MCOs are asking clinically integrated networks they trust to play a greater role in self management of quality and performance. MCOs are also looking to nationally standardize their contracts with cins to minimize the confusion and costs of managing 10s of 1000s of unique direct contracts with providers. Lastly, MCOs will be looking for partners who can manage redetermination and eligibility, and this is critically important in the future. This will be the single most important quality measure, starting in 2027 and for providers and cins and shared savings agreements, this is a mutually beneficial measure to ensure that the member that you have spent months coordinating a highly effective care plan is not suddenly dropped from Medicaid or ACA, wiping out your.

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Bonuses are, you know, I want to talk about a related issue. We've been talking about value based care. You know, the importance to the health plans, the importance to behavioral health providers. But this, you know, the whole VBR movement has happened at the same time we've had this health plan push for integrated care and whole person models, you know, in, you know, especially for consumers with CO

occurring disorders. You know, how does the recently passed budget bill affect the push towards integrated care? Is it the same or different than the push towards value based contracting? Yeah, well, the new budget bill makes no specific mention of care models like integrated care, it's safe to infer that behind that budget bill is a growing concern that health care costs are unsustainable, and that this Congress is not afraid to take controversial steps to mitigate regardless of how we personally feel about it. I think we need to take that that

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seriously. To this end, I've heard from several colleagues that I respect in the healthcare industry that say we should not assume that this Congress is done taking action. One comment that's come up multiple times is for behavioral health, is that there are rumblings that the definition of Mental Health Parity might be revisited, which would be a huge step backwards for our industry. Now, more than ever, it's important that the behavioral health industry lean into health outcome and Cost Management solutions by taking every opportunity to link the $1 we just build to a downstream cost that was avoided. To this end, most of our one care providers are actively providing or preparing to provide in house primary care services along with their behavioral health services to the patient, integrated care is simply more convenient, accessible and understandable, which translates to better avoidance of hospitalizations and other high cost care. That said, primary care may not be accessible to every provider, particularly in rural areas where there are simply no PCPs or extenders to recruit. In this instance, the cin can be can help by recruiting high value collaborations with sibling clinically integrated primary care networks. So think ACOs for primary care, as well as referral and Co Location partnerships with health systems and hospitals, the cin provides a level of scale and standardization that is attractive to large groups such as these providing referral pathways to behavioral health providers to ensure that those patients get timely access to primary and specialty care. If integrated care is what happens within the clinic, one care helps build integrated systems of care with the broader health neighborhood. Well, you know, there has been, I think, what for the past decade, the federal government has been trying to move behavioral health into both Whole Person Care and prospective payment through CCBHC initiatives, you know, and I view them as one, you know, for most provider organizations we work with, I tell them they should be participating in sort of every value based arrangement they can to try to both build their competency and, you know, diversify their kind of reimbursement rates. How does how do the CCBHC programs fit within a clinically integrated network model. And the question we often get, does that participation affect their prospective payment rate? Yeah, in a nutshell, no, it does not affect their their PPS perspective, payment rate. And for those who don't know, ccbhcs are the kinfolk to federally qualified health centers, right? This is instead of taking a primary care group and building up their specialty capacity, including behavioral health, we're taking a behavioral large behavioral health organization and bolstering its primary care capacity, among other services as well, including crisis and care management, and really creating these one stop shop of convenience for members. Cins are a complimentary tool for ccbhcs and FQHCs, where you can timeshare population health expertise and technologies, particularly in very expensive data aggregation and reporting tools. In addition, the cin negotiates a value based contract that can provide earnings on top of the enhanced PPS rate, and as said before, that does not affect or reduce the PPS rate.

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Ccbhcs have a contractual obligation to utilize their clinical resources to improve health outcomes, in short, to provide population health services to their members. While the PPS rate covers the cost of providing those services, it does not provide value based incentives or bonuses that can further stabilize the organization financially. While a particular CCBHC always has the option to negotiate their own BBC value based care arrangements with managed care organizations, keep in mind that those are the MCOs that are looking for efficiency.

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Of a single signatory contract with hundreds of providers, not 100 different contracts. And so the cin is more likely to negotiate better terms as we go into the future. Our one care networks include ccbhcs, we also include FQHCs, cmhcs, community service boards and just plain old private behavioral health and integrated care providers. Roughly 40% of our one care providers offer primary care alongside their behavioral services, and that's growing every day,

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and all of our one care networks have high value collaboration arrangements that give us extraordinary access to primary and specialty care Well, Mike, you've given us a lot to think about starting with. You know, all things start in Washington, kind of, what's the implications of the big, beautiful bill? I think the interesting thing about the budget bill that just passed, and many of the executive orders coming out of the new administration is their impact on health plans. And I think you've done a good job for our audience about, you know, the need to for every provider organization exec to reframe how they're thinking and think about it through a health plan lens. You know the issues of acuity, medical loss ratio, and even your last point, which is, you know, the move to more narrow networks with fewer contracts, which I think is going to be an increasingly big issue as health plans try to slim down their administrative expenses. But last but not least, I think, from a strategy perspective, it's critical that specialty provider organizations, you know, mental health, addictions, autism, you know, IDD, you know, develop some kind of strategy for participating in performance based contracting. I think, you know both, fee for service is hard to I think fee for service is going to be increasingly hard to make your bottom line just in billing units. That's one. And the other is, I think health plans are going to start preferentially referring to folks that are participating in their value based agreements. I mean, I think that's the other piece. And I think the clinically integrated network in many markets, for many health plans is really the right solution. Any final closing thoughts, I just totally agree with your comments right there. I mean, we're already seeing managed care organizations define their networks in tiering. You know, who's our high performance tier one network versus everybody else's in a tier two, your high performance network gets better terms, better rates, better value based incentives, and that's where they steer the majority of referrals in business. And so the question, if you're in a fee for service world looking over the precipice, what is the opportunity you're leaving on the table? If you don't get involved in value based contracting, it may be more than a few bucks of incentive. You may be leaving hundreds, if not millions, of dollars, on the table, but more importantly, you might be stuck in a tier two network, and what does that mean for your organization? Great point. And for those of you tuning in, I just want to make a plug for attending our tech and analytics Institute in Philadelphia in October, you will get a chance to meet with Mike and me at the Allura One Care cafe and learn more about clinically integrated networks and how they fit into your long term strategy. Thanks, Mike, you.