Outline of some behavioral-health provider business models and strategies

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This outline presents some of the financial models and strategies by community-based behavioral health organizations observed nationwide. Some of these may be used in combination with others. This unexhaustive list presents some that are most relevant to systems undergoing change.

Reliance on legacy expense-grant funding without significant efforts to bill Medicaid or diversify

- Primary reliance on political advocacy
- Does not develop electronic health records (EHR) and related billing systems, which are expensive, specialized, and difficult
    - Often the needs and preferences of staff supersede those of patients for access (hours of operation, productivity) because staff retention is at a premium.
    - Prevents patient-centered access, needed volume of care
    - Difficult to do otherwise in some markets

Provider sells services to Medicaid and other payers at rates that cover costs (at least on an aggregate basis) by payer and population group

- Primarily uses expense-based grants to cover low-income without other coverage, important service enhancements not otherwise covered.
- Develops access systems and staffing models that support productivity
    - Staff incentive payments can help enormously for some services
- Invest in EHR and IT systems to support billing and reporting
- May be challenging in some remote areas

Provider sells to Medicaid and other payers without much regard to rates covering costs

- Same as above except sells services at below-costs rates and thereby uses the grant to subsidize other payers.
- May be difficult to do otherwise in remote areas.
- May be profitable for a time depending on relative proportions of expense-reimbursement to Medicaid and other payers.

Provide a comprehensive array of core behavioral health services for chronic conditions

- Examples: SUD full episodes, residential through low intensity outpatient with MAT and co-occurring options; MH evidence-based for adult and children's services with primary care coordination and in-community.
- Requires overall profitability for each population group and payer.
- Well positioned for case rate/bundled or capitation as services provided internally.

Exclusive focus on niche services according to the most profitable services

- Can be successful in urban areas.
- Narrows options for services for individual clients.
- But providers controlling utilization with case rates or capitation less likely to refer to them.

Specialty population, such as gender, service type, ethnicity

- Strong market position as long as funding, referrals are directly made
- May be weakened if sub-capitation or case rates dominate
- American Indian/Alaska Natives services
    - Favorable rates to tribal members at tribal facilities
    - Avoids managed care network restrictions
    - Revenue may to health center not be classified as behavioral health on revenue reports
        - Suggest BH provider also track utilization and payment
    - Even so, can be extremely challenging in remote areas

Incentive payments for clinician performance on dimensions that increase revenues

- Well-designed incentive systems have proven to greatly increase productivity and revenues associated with productivity
    - Anecdotal experience and research support that quality is not sacrificed
    - Outpatient rewards, many options
        - Bonus for productivity
        - Split fee arrangements
        - Bonuses based on revenues
    - Residential: contributions to performance, such as retention

Facility-based versus community-based models

- Especially for adult and children's MH, office-based difficult to sustain financially, questioned clinically
- Residential youth: SED, SUD – clinical skepticism and financial questions

Diversifies to appeal to a significant private-pay population

- Tends to upgrade access systems and facilities to appeal to patients with wider choice.
- Rates may not be as good as they seem because of co-pay and deductible bad debt.

Please identify other models and strategies: