Behavioral Health Value Based Payment Provider Perspectives
September 27, 2016

David Woodlock, MS
President & CEO
ICL
People get better with us.

The Perfect Public Health Storm

- High Rates of Illness
- High Rates of Suffering
- Extremely High Costs
- Early Death
Why CBO’s Are Important

• “Healthcare” has been unable to locate, engage or improve the health outcomes of people who visit CBO’s everyday
• There is a trust with CBO’s
• Emerging role of CBO’s in Health Care Reform
People get better with us.

The CBO’s Challenge

- Structure Agency Around Outcomes
- DSRIP/PPS Active Participant
- New Business

AR Baseline Shifts 98% to 85%

Capital, Human Capacity

Straddling 2 Worlds Creates Conundrum: Risk – Capital – Keeping Trains Running
2015 Year-End Highlights

Selected Outcomes for Behavioral Health Programs

Our Goal: People Get Better With Us

Results from the most recent Consumer Evaluation Survey indicate that 90% of individuals agree that: “This program’s staff believe I can grow, change, and recover.”

People feel better

- 42% increase: “I deal more effectively with daily problems.”
- 44% increase: “I am better able to control my life.”
- 40% increase: “The quality of my life has improved.”

ICL supports recovery

- Trauma-informed
- Recovery-oriented
- Person-centered
- Integrated physical and behavioral health care

At ICL, individuals report on their progress throughout the course of services. The data are analyzed and used to guide ICL’s work supporting recovery.

Meaningful connections

Connections to community and family are important resources that support recovery.

- 87% report being connected to family
- 78% report being connected to friends
- 95% report being engaged with mental health treatment
- 95% report being connected to primary care

Behavioral health hospital use is cut in half

Current individuals, enrolled 2014 or later:
- 58% reduction in hospitalizations for mental health reasons
- 50% reduction in ER visits for mental health reasons
- 33% reduction in hospitalizations for physical health reasons

Mental Health Clinics

Among individuals who enrolled with ICL since 2015:

ICL’s services range from long-term programs such as supported housing to shorter-term programs such as treatment apartment programs and clinics. The box below illustrates the impact on mental health that individuals served at ICL achieved in just 6 months.

- 88% decrease in ER visits for mental health reasons
- 50% decrease in hospitalization for mental health reasons

www.ICLinc.org
People get better with us.

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Commitment to VALUE
Capacity to GET to VALUE
People get better with us.
The definitive leader in healthcare improvement for individuals with complex care needs through evidenced-based, technology-enabled whole person care.

Healthcare

- 1 in 4 individuals in any Medicaid MC program
- 1 in 10 individuals in Medicare Advantage plan
- Over 1 in 10 individuals in commercial programs
- 23.8 M lives Commercial Behavioral Health
- 24.6 M lives Commercial Specialty
- 5.4 M lives Government

✓ Magellan has a global footprint:
  - 8,000 employees worldwide
  - Federal services nationwide and 8 countries, 200 sites
  - Health plan and employer services nationwide

✓ Pioneer in behavioral, specialty, pharmacy and complex population care - including SMI, LTSS and DD

✓ Behavioral healthcare management and EAP services

✓ Specialty healthcare management, including musculoskeletal, cardiac and advanced imaging management

✓ Integrated management for special populations, including SMI and LTSS
Magellan’s Provider Network Approach

Proven results and innovative solutions to ensure adequacy, access, and promote alternative payment

• Leading national network of over 113,000 providers at 140,000 locations

• 12,500 facilities and organizations offering full array of behavioral health and specialty services for commercial, Medicaid and Medicare
  o Over 2500 Autism providers nationally and 2000 substance abuse facilities

• Continuous network development, shaping and refining to meet current and future needs
  o Industry leader in e-commerce increasing administrative efficiency
  o Using business intelligence approach to development/management

First Managed Behavioral Health Organization to achieve NCQA designation as Credentials Verification Organization
Improving Productivity, Quality, and Provider Alignment

Align provider incentives with organizational and individual goals, incenting behavior and driving outcomes.

Building Provider Compensation for an Evolving Healthcare Market

1. Prioritize population management, team-based care, and member access
2. Integrate new quality and efficiency standards into compensation
3. Remove compensation barriers to population goals

Engaging and Empowering Providers in Compensation Model Evolution

4. Employ transparency to ease compensation shift
5. Partner with provider leaders around compensation design
6. Create meaningful incentives for providers

Source: Medical Group Strategy Council interviews and analysis.
Incentive Structure Progression Over Time

Providers are in different phases of readiness and will need a graduated maturity model to move them from the most basic to the most complex arrangements.

**Metrics and incentive payment shift in step over time**

- **Stage 1**: Learning the Behavior
  - Activity Incentives

- **Stage 2**: Transitioning
  - Activity Incentives
  - Shadow reporting on quality and efficiency

- **Stage 3**: Transforming Care Delivery
  - Outcomes-based incentives or a mix of a PMPM payment for care management activities and outcomes-based incentives

- **Stage 4**: Financial "drivers" and "owners"
  - Profit-and-loss sharing option

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1. Physician Quality Reporting Initiative.
Clinical Delivery Transformation is at the Heart of Success

We couple our VBP strategy with tactical provider support to ensure success

The WHAT
1) Engaging providers,
2) Digging in deep to understand the market and provider readiness
3) Developing the alternative payment methodologies that will be supported by the provider community
4) Implementing the models to achieve savings and improved quality across product lines

The Magellan HOW
1) Provider Education: The Magellan Learning Alliance
2) Magellan Provider Readiness Assessment
3) Magellan Led Provider Advisory Council
4) Magellan Operational Support: Provider relations, Population Health Managers

Magellan Value

We will support the alignment between both public and commercial products to support provider success and reward integrated quality of care for both behavioral health and physical health coordination
## Focused Provider Strategies Improve Quality, Care and Outcomes for Systems, Providers, and Members

<table>
<thead>
<tr>
<th>Magellan Value Alliance</th>
<th>Facility Incentive Program</th>
<th>Assertive Community Treatment</th>
<th>Other Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider profiling program and algorithms</td>
<td>Reduces unwarranted variation in practice patterns to decrease gap between cost and quality in our facility provider network</td>
<td>Performance based program focused on Assertive Community Treatment Providers and reimburses based upon community tenure metrics</td>
<td>Currently paying providers with nine different payment models under Value Based Purchasing</td>
</tr>
<tr>
<td>Allows for stratification of our providers in search tools utilized by Magellan staff and members</td>
<td>Aligns reimbursement with performance</td>
<td>Reimbursement based on provider meeting pre-defined value definitions (lowest cost/highest quality)</td>
<td></td>
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<tr>
<td>Network steerage initiative - Inpatient facility unit cost trends held to less than 1% per year*</td>
<td>Participating facilities in west market have average lower cost per episode of care of $4000 *</td>
<td>21% decrease in inpatient admissions and 24% decrease in readmission rate**</td>
<td>Continuous Improvement</td>
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</table>

*BCBS 2015/16 and **LA ACT Program 2015
In closing: Value based purchasing is not a one size fits all

- Magellan is commitment to a high touch approach with providers
- Focused on support of clinical integration and practice transformation
- Focus on implementation of value based purchasing models and identification of high performing providers
- Meet providers where they are
- Our intent: work closely with providers to support our members in living healthy vibrant lives

High performing networks are established by doing the basics well
Alternative Payment Models for Behavioral Health
Deb Adler – SVP, Network Strategy
Our work in the reimbursement continuum

<table>
<thead>
<tr>
<th>Financial Risk</th>
<th>Accountability</th>
<th>Examples</th>
<th>Metrics</th>
<th>Results</th>
</tr>
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<tbody>
<tr>
<td>Small %</td>
<td>Low</td>
<td>Fee-for-service</td>
<td>Outpatient: Quality: Case-mix adjusted member reported outcomes (wellness assessment)</td>
<td>• 15% to 20% reduction in readmit rates</td>
</tr>
<tr>
<td>Moderate %</td>
<td>Moderate</td>
<td>Performance-based Contracting</td>
<td>Inpatient: Quality: HEDIS 7-day follow-up; CMS readmission rate for 30 and 90 day (case mix adj)</td>
<td>• Ambulatory follow-up rate improved from 3% to 10%</td>
</tr>
<tr>
<td>Large %</td>
<td>Maximum</td>
<td>Bundled and Episodic Payments</td>
<td>Reduced readmissions</td>
<td>• Quality: Readmit rate (case.mix adjusted) – 30 and 90 day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shared Risk</td>
<td>Improved community tenure</td>
<td>• Cost: Case-mix adjusted average visits per episode and episode cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Capitation + Performance-based Contracting</td>
<td>8 metrics across 6 domains</td>
<td>• DRG/Bundled payment methodology</td>
</tr>
</tbody>
</table>

ACOs, medical-behavioral integration in health homes

Examples: P4P/Shared Savings Contracts with Qualified Facilities and Outpatient Providers (national footprint across all payor types)

Metrics:
- Outpatient:
  - Quality: Case-mix adjusted member reported outcomes (wellness assessment)
  - Cost: Case-mix adjusted average visits per episode and episode cost
- Inpatient:
  - Quality: HEDIS 7-day follow-up; CMS readmission rate for 30 and 90 day (case mix adj)
  - Cost: Case-mix adjusted ALOS and episode cost

Results:
- Outpatient:
  - • 15% to 20% reduction in readmit rates
  - • Ambulatory follow-up rate improved from 3% to 10%
- Inpatient:
  - • Reduced readmissions
  - • Improved community tenure

Optum
Performance-Based Contracting – At A Glance

Incentivizing provider performance leads to better outcomes for consumers.

**Facility Participation Requirements**
- Adheres to our utilization management process, Level of Care Guidelines and Coverage Determination Guidelines, including attending MD visits, pre-authorization requirements, and discharge planning
- Qualifies as an OptumHealth High-Volume provider
- Participates in periodic meetings with OptumHealth clinical operations staff to review data
- Submits claims electronically

**Metrics**
- Balance of Cost and Quality Measures
  - Reduced average episode costs
  - Reduction in 30 day Readmission rate to any inpatient LOC
  - Member reported instruments regarding outcomes
  - Improved results on ambulatory follow-up rates (7 days post inpatient discharge)

**Performance Incentives**
- Provider searn escalator based sharing of savings if performance is within targeted range
- Bonus payment tied to quality metrics
- Provider earns additional escalator through greater sharing of savings if performance exceeds range (up to a cap)
ACE Metrics Guide Performance-Based Contracting

• In our 3rd year of outpatient for providers achieving two-star rating (effectiveness first and supplemented with efficiency ratings)

• Enhanced facility pay-for performance initiative to tie to enhanced facility metrics under ACE – Achievements in Clinical Excellence

**Clinician Metrics**

**Quality**
- Severity-adjusted effect size from the Wellness Assessments

**Cost**
- Case-mix-adjusted average number of visits
- Average cost per episode

**Facility Metrics**

**Quality**
- 30-day readmission rate
- Risk-adjusted 30-day readmission rate
- Follow-up after mental health hospitalization (HEDIS)
- Peer review rate

**Cost**
- Case-mix-adjusted average length of stay
- Spending per beneficiary
Challenges – Solution Identification in process

• Lack of an industry-standard outcome tool (Optum working with ABHW – Association for Behavioral Health and Wellness to encourage standardization)
• Low number of patients/admits; many low-volume providers
• Lack of assignment of members challenges use of capitation
• Provider readiness to manage risk and challenges to achieve metrics

The greater the obstacle, the more glory in overcoming it.
- Moliere
Facilitating Provider Performance

- Additional incentives to achieve 7 and 30 day follow up metrics (Bridge programs and telemental health potential)
- Appointment Reminders to “no shows” (Appointment Reminders)
- Member Engagement/Community Tenure (Peer Services/Recovery and Resiliency Toolkit)
- Data Review (e.g., provider practice patterns)
- Reducing Administrative Burden (Quick Cert, Rewards for High Performance that reduce burden, Review Online)
Behavioral Health Value Based Payment Conference

Opportunities for Providers
The Old World: Fee for Service; Each in its Own Silo

- There is no incentive for coordination or integration across the continuum of care
- Much Value is destroyed along the way:
  - Quality of patient care & patient experience
  - Avoidable costs due to lack of coordination, rework, including avoidable hospital use
  - Avoidable complications, also leading to avoidable hospital use
How an Integrated Delivery System should Function

- **Integrated Primary Care**
  - Includes social services interventions and community-based prevention activities

- **Maternity Care** (including first month of baby)
- **Chronic Care** (Asthma, Diabetes, Depression and Anxiety, Substance Use Disorder, Trauma & Stressors…)
- **HIV/AIDS**
- **Managed Long Term Care**
- **Severe Behavioral Health/Substance Use Disorders** (HARP Population)
- **Intellectually/Developmentally Disabled Population**

Population Health focus on overall Outcomes and total Costs of Care

Sub-population focus on Outcomes and Costs within sub-population or episode

- **Episodic**
- **Continuous**

September 2016
## Different Types of VBP Arrangements

<table>
<thead>
<tr>
<th>Types</th>
<th>Total Care for General Population (TCGP)</th>
<th>Integrated Primary Care (IPC)</th>
<th>Care Bundles</th>
<th>Special Need Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>Party(ies) contracted with the MCO assumes responsibility for the total care of its attributed population</td>
<td>Patient Centered Medical Home or Advanced Primary Care, includes:</td>
<td>Episodes in which all costs related to the episode across the care continuum are measured</td>
<td>Total Care for the Total Sub-pop</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Care management</td>
<td>• Maternity Bundle</td>
<td>• HIV/AIDS</td>
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<tr>
<td></td>
<td></td>
<td>• Practice transformation</td>
<td></td>
<td>• MLTC</td>
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<tr>
<td></td>
<td></td>
<td>• Savings from downstream costs</td>
<td></td>
<td>• HARP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Chronic Bundle (includes 14 chronic conditions related to physical and behavioral health related)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contracting Parties</td>
<td>IPA/ACO, Large Health Systems, FQHCs, and Physician Groups</td>
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<td>IPA/ACO, FQHCs, Physician Groups and Hospitals</td>
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</tbody>
</table>

September 2016
Financial Incentives for VBP Contractors and Other Providers: Shared Savings and More

- Potential for shared savings: incentives for a reduction in net spending for a defined patient population/bundle, and reinvestment of those savings back into the provider system
- Performance adjustments for those VBP contractors that are high value performers before the contract year starts
- Stimulus adjustments for those VBP contractors moving to Level 2 or higher
- *All these incentives have their opposites: shared losses, downward performance adjustments, penalties for providers that could but are not moving to VBP*
Alignment Will Be Implemented From 2017 Onwards

The **State** will adjust MCO premiums based on value delivered to their total membership per VBP arrangement type (whether actually contracted or not) and on meeting yearly targets to move to 80-90% VBP.

**MCOs** will subsequently drive providers to improve this value of care. VBP arrangements and insight in the potential performance of providers will be actionable entry point for MCOs.

**Providers**: Deliver better quality and efficient care for Medicaid beneficiaries, allowing for further re-investment into the delivery system.

Feedback-loop facilitates control of the overall Medicaid spend.

**September 2016**
How MCOs Can Improve the Value of Care

• Contract and reward high value care, and incentivize improvement
• Help bolster lower value providers where possible
• Move beneficiaries to higher value providers where possible and increase their volume
• Discontinue contracts with low value providers where no improvement is deemed feasible
• Adapt to new contracting mechanisms through compensating them for start up costs

From 2018 on, MCOs can pass on potential downwards adjustments to providers.
What Drives (In)Efficiency: Four Key Drivers

Costs of a VBP arrangement = total episode or PMPM costs from MCO/State perspective calculated from claims data

- **Price**: The price of a service can vary based on providers’ own costs (e.g. wages). For ranking purposes, price will be taken out of the equation (“proxy-priced”). For budget setting, negotiations & influencing opportunities for shared savings, real priced data remain key.

- **Avoidable Complications**: Includes PPRs, PPVs, PQIs, PDIs and non-hospital based complications.

- **Volume**: The volume of services rendered (e.g. # of office visits, admissions, expensive imaging).

- **Service Mix**: The mix of services and intensity of care received during the episode (e.g. inpatient vs. outpatient vs. office-based point of care; generics vs. specialty drugs; choice of diagnostics).
There are Significant Opportunities to Increase Value

- Reduce PACs & Episode Costs to be a High Performer
- Reduce PACs to be a High Performer
Key Success Factors and Capabilities

- Clinical integration across delivery network
- Full C-suite & Board engagement
- Commitment by willing plan AND provider
- Sense of urgency
- Accurate and complete claims and eligibility data
- HIT Systems

Organizational Readiness
Partnerships
Care Delivery
IT & Data Analytics Capabilities
1. Assess your readiness; address issues to be able to start at Level 1 and Level 2 if capable

2. Understand what types of contracts you want to engage in based on the services you provide, the attributed population and outcome measures that impact savings, and the potential for realizing savings

3. Choose the partners that will help you succeed and that are adequate for the contracts you chose – build your partnerships

4. Familiarize yourself with and utilize available resources (data from the State, technical assistance from potential partnering contractors, etc.)
Top 4 Steps for Experienced Contractors

1. Understand your current VBP contracts and what adjustments have to be made based on new VBP framework: check definitions, adjust quality measures, check levels of risk, partner with CBOs, etc.

2. Re-assess your capabilities and network partnerships; and gain understanding in readiness for advancement in VBP risk levels and expansion in scope.

3. Consider re-investing savings in other innovative interventions to continually improve member health and consequently generate further savings.

4. Keep current with yearly benchmarks and modify strategy and risk arrangements based on performance.
Am I ready to assume risk?

A **readiness assessment** is recommended to evaluate current state and capabilities, identify and prioritize financial and operational gaps. Suggested assessment areas include but are not limited to:

- Financial Sustainability
- Organizational Readiness
- Partnerships
- Care Delivery
- IT Capabilities
Care Delivery

Before entering a VBP agreement, ask:
- Especially for IPC and TCGP arrangements: are existing population health efforts adequate?
- Is clinical staffing adequate?
- Is the organization ready to engage patients?

Recommended ideal/perfect state is when you:
- Have experience managing care for groups of members and/or populations with various conditions
- Have experience managing high-utilizer/high cost members
- Have experience providing robust care coordination
- Have linguistic and cultural competency at all levels of the organization
- Have care standardization processes in place
- Demonstrate excellent chronic care management and post-discharge follow-up
- Offer integrated behavioral health and primary care services
- Have engagement, activation, and outreach strategies in place to connect with attributed population

The delivery of care model must change to satisfy requirements of payment reform
Financial Stability

Before entering a VBP agreement, ask:

- Do you recognize your data; do they seem accurate and complete?
- Do you understand your part of the total cost of care / episode of care?
- Do you see ways to improve patient outcomes that would realize savings? Or realize savings while keeping care quality at the same level?
- Based on your own insights and the data, do you see opportunities to increase revenue for you and your partners through realizing shared savings, either through:
  - Increasing your own efficiency
  - Realizing savings downstream (i.e., outside of the group of partners you’re working with)
- What is your current financial situation?
- Would you see yourself taking risk for a specific VBP arrangement? As a lead, as a partner? Or perhaps joining a Level 2 arrangement while yourself taking minimal risk?
- Are you able to draw your own administrative and clinical data to monitor progress and outcomes of the VBP arrangement you are interested in?

Organizations lacking financial strength and understanding will find it difficult to set up and maintain VBP contracts
Financial Stability (Cont.)

Recommended ideal/perfect state if when you:

- Have a clear understanding of up-front costs you will incur with implementation and an estimated return on investment
- When considering Level 2, have cash reserves on-hand appropriate to manage the relative risk of your VBP arrangement
- Have considered / included innovative ways to realize upfront investment (DSRIP, MCOs, other health care providers, banks, investors, etc.)
- Have (a clear growth path to) the ability to track and report on system-level utilization and cost data (coding accuracy is very important)
- Have a clear strategy in place for transforming your business model towards paying for value across business lines
- Have a strategy in place to coordinate the inevitably varying approaches towards VBP across payers?
- Demonstrate an understanding of the quality metrics that drive patient outcomes rather than volume
- When considering Level 2, have the ability to engage in risk-based contracts, supported by legal and compliance expertise

Organizations lacking financial strength and understanding will find it difficult to maintain VBP contracts
Organizational Readiness

Before entering a VBP agreement, ask:

- Is the board of directors knowledgeable about payment reform efforts and their implications for the organization’s mission and services? Are they supporting the transition?
- Does the organization have the experience with and capacity to implement the organizational changes required?

Recommended ideal/perfect state is when you:

- Have a shared organizational vision for and commitment to involvement in payment reform amongst administrative and clinical leadership (from staff to C-suite level)
- Promote an overall organizational culture that prizes value and patient outcomes
- Have leadership tools and processes in place to monitor performance (robust technical infrastructure)
- Have identified specific opportunities in relation to the existing mission, service area, and scope of services
- Have change management practices in place to aid the transition

Significant organizational change must take place to accommodate payment reform. Everyone in the organization must understand what is changing and why to ensure a smooth transition.
IT & Data Analytics Capabilities

Before entering a VBP agreement, ask:

- Does the organization have an IT strategy for the transition to payment reform?
- Has a current systems hardware and software analysis been performed to ensure the organization’s IT capabilities are sufficient to participate successfully in VBP?

Recommended ideal/perfect state is when you:

- Staffed IT departments adequately and have the capacity to support payment reform efforts
- Have appropriate hardware and software systems in place with trained staff
- Demonstrate and utilize interoperability and real-time data access
- Have your Health Information Technology (HIT) reliably achieving performance targets and allowing for the continuous quality improvement (CQI), management of population/members through provider alerts, decision tools/dashboards, registries, enhanced access to data, etc.

Organizations must be able to collect and analyze large amounts of clinical and claims data to inform decisions related to VBP
Partnerships

Before entering a VBP agreement, ask:

• Has the organization developed partnerships to address service area needs and take advantage of opportunities in the local healthcare marketplace?
• Is data sharing among partners sufficient?
• Are all contracting entities ready to participate in payment reform?
• Which providers do you want to contract with – and which not, or perhaps, later?
• How can you engage CBOs – and not because the State asks you to?

Recommended ideal/perfect state is when you:

• Have established appropriate partnerships with other providers in order to execute and meet the goals of your arrangements
• Have established relationships with social services and/or other organizations in the community in order to develop community-level systems of care
• Have begun developing new products and services in order to meet target population needs
• Have a clear understanding of the cost effectiveness and outcomes of partnership efforts

Smart partnerships between plans and providers are vital to the success of VBP
Thank You

Contact: elynam@kpmg.com