Behavioral Health In The Era Of Value-Based Care:
Improving Quality & Lowering Costs Through Population Health Management

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Strategic Questions For Behavioral Health Provider Organizations. . .

• Where does behavioral health fit in a health system increasingly focused on value?
• How is ‘value’ being defined?
• How is the focus on ‘value’ affecting health care financing, delivery systems, and provider payment?
• What are the emerging roles for behavioral health provider organizations?
The Regulatory & Policy Effects Of PPACA* & Parity

Drop in the uninsured population

- From an estimated 37 million people, or 20% of the population, in 2010¹
- To 29 million, or 16%, by the second half of 2014.¹

Parity legislation provides financial equity in mental health and addiction treatment benefits for almost all Americans with health insurance²

The Affordable Care Act has over 80 provisions that went into effect between 2010 and 2015:³

- **Expanded consumer access**: expanded Medicaid coverage, health insurance exchange, and essential health benefits³

- **Insurance coverage reform**: minimum medical loss ratios (MLR) for insurers; pre-existing condition exclusions and lifetime limits prohibited³

- **Integrated care coordination models**: Medicaid health homes and accountable care organizations in Medicare³

- **Pay-for-performance**: Medicare value-based purchasing initiatives and penalties for high rates of hospital readmissions³

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*PPACA – Patient Protection & Affordable Care Act
The Expansion Of Use Of Managed Care Models – New Enrollment & New Populations

Increasing use of managed care financing and service delivery models

- Commercial
- Medicaid
- Medicare
- Dual eligible

New populations

- Complex disabilities
- Long-term care

# Managed Care Continues To Grow As Dominant Contracting Model

## Managed Care Penetration, 2014

<table>
<thead>
<tr>
<th>Segment</th>
<th>Total U.S. (Million)</th>
<th>Percent U.S.</th>
<th>Managed Care Enrollees (Million)</th>
<th>Managed Care Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>53.8</td>
<td>16.8%</td>
<td>15.6</td>
<td>29.0%</td>
</tr>
<tr>
<td>Medicaid*</td>
<td>54.0</td>
<td>16.9%</td>
<td>36.2</td>
<td>67.0%</td>
</tr>
<tr>
<td>Military</td>
<td>4.9</td>
<td>1.5%</td>
<td>4.9</td>
<td>100%</td>
</tr>
<tr>
<td>Commercial</td>
<td>165.2</td>
<td>51.6%</td>
<td>164.4</td>
<td>99.5%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>42.0</td>
<td>13.1%</td>
<td>0.0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>319.9</strong></td>
<td><strong>100%</strong></td>
<td><strong>221.1</strong></td>
<td><strong>69.1%</strong></td>
</tr>
</tbody>
</table>

*Exclusive of dual eligible beneficiaries

Proposed Consolidation Among Health Insurance Organizations, 2015

<table>
<thead>
<tr>
<th>Insurance Organization</th>
<th>Enrollment</th>
<th>Percent of Market*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigna / Anthem</td>
<td>53,000,000¹</td>
<td>19%</td>
</tr>
<tr>
<td>United Health Group</td>
<td>46,000,000⁴</td>
<td>16%</td>
</tr>
<tr>
<td>Aetna / Humana</td>
<td>33,000,000¹</td>
<td>12%</td>
</tr>
<tr>
<td>Kaiser</td>
<td>10,100,000²</td>
<td>4%</td>
</tr>
<tr>
<td>Health Net</td>
<td>6,100,000³</td>
<td>2%</td>
</tr>
<tr>
<td>All Others</td>
<td>148,200,000</td>
<td>52%</td>
</tr>
</tbody>
</table>

The 2014 insured market is estimated to be 283 million⁵

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5. U.S. Census Bureau. (September 2015). Health Insurance in the United States: 2014; Table 1. Coverage Rates by Type of Health Insurance: 2013 and 2014. Retrieved from Census.gov: http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf (Note: consumers may have selected more than one coverage type causing over-counting in some categories of health insurance. Therefore the estimate of total insured individuals may be overstated.)
Competition Among Health Plans Has Sharpened The Focus On Value

• Health plan’s responsibility is at the “population” level

• Looking to increase value by improving the consumer care experience, improving consumer health, and reducing the per capita cost of health care

• This is often referred to as “Triple Aim”

The Quest For Value Is Causing A New Focus On “Superutilizer” Management To Increase Value Of Health Expenditures

5% of U.S. population account for half (49%) of health care spending

- $11,487 per person

The 50% of U.S. population with lowest health care spending account for 3%

- $664 per person

Data are from 2002

“Super-utilizers” is the shorthand term for people with complex physical health, behavioral health, and social issues who have high rates of emergency department use and hospitalization


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The Footprint Of Superutilizers In The Health System

- **Multiple specialists (and multiple prescriptions) (2004)**
  - Consumers with 5+ chronic conditions have an average of nearly 15 office visits per year\(^2\)
  - Fill 50 prescriptions per year\(^2\)

- **Medicaid "super-utilizers" (2012)**
  - Accounted for half of all 30-day hospital readmissions for the Medicaid population in 2012\(^3\)
  - Had a readmission rate nearly six times as high as that for other Medicaid patients (52.4% versus 8.8%)\(^3\)
  - Were hospitalized for mood disorders, schizophrenia and other psychotic disorders (first and second reasons)\(^3\)
  - Are more likely to require follow-up care after discharge and to leave the hospital against medical advice compared with other Medicaid patients \(^3\)

Readmissions add $15 billion in annual Medicare payments (2007)\(^1\)

## Behavioral Health Disorders Have A Big Impact On Spending

<table>
<thead>
<tr>
<th>Condition</th>
<th>No Mental Illness and No Drug/Alcohol</th>
<th>Mental Illness and Drug/Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma/COPD*</td>
<td>$8,000</td>
<td>$24,598</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>$9,488</td>
<td>$24,927</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>$8,788</td>
<td>$24,443</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$9,498</td>
<td>$36,730</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$15,691</td>
<td>$35,840</td>
</tr>
</tbody>
</table>

*Chronic Obstructive Pulmonary Disease

Coordinated Care Models Across Medical, Behavioral, & Social Systems Are Emerging To Address The “Superutilizer” Challenge¹

The Emerging Framework For Integrated Care Coordination Involves Population Health Management At All Levels


The strategy question for mental health professionals: how do you find a value-added role in these emerging delivery systems?

Managed care programs

Accountable care organizations

Medical homes and specialty medical homes

Specialized disease management program

‘At risk’ for population health management

‘At risk’ for individual health management


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# Accountable Care Organization (ACO) Snapshot

- Over 600 ACOs in the 50 states and District of Columbia as of Q4 2013\(^1\)
- Most owned by hospital systems or community-based provider organizations\(^1\)
- 67% of Americans live in an area with ACO coverage\(^3\) (2014)
- Covers 15%-17% of the population\(^3\) (2014)

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 368 Medicare ACOs currently in three programs:(^3)(2014)</td>
<td>• Eight state Medicaid programs operate an ACO model(^2) (2015)</td>
<td>• Managed by physician groups, hospital systems, and private insurers(^5)</td>
</tr>
<tr>
<td>• Medicare Shared Savings Program(^4)</td>
<td>• Nine states are in the process of developing ACO models(^2) (2015)</td>
<td>• Around 154 commercial ACOs(^3)</td>
</tr>
<tr>
<td>• Advanced Payment ACO Model(^4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pioneer ACO Model(^4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. CMS.gov.
MCO*/ACOs** Use Medical Homes For Consumer Care Management & Risk Management


* Managed Care Organization
**Accountable Care Organization

Behaviorally-Led Medical Home

- HIT to coordinate care
- Comprehensive care management
- Care coordination
- Health Promotion
- Comprehensive transitional care
- Referral to community and social support services
- Engagement of individuals in self management and recovery
- Referral to community and social support services
Medicaid Health Homes

- As of June 2015, 28 states were operating or planning to launch Medicaid health homes
  - 18 states with approved state plan amendments (SPAs)
  - At least 8 states are in various stages of planning and implementing health homes
- Over 1 million enrollees
- Medicaid health home enrollment is focused on high-need high-cost beneficiaries. Criteria for participation is: (1) two chronic conditions; (2) one chronic condition and risk for a second; or (3) a serious mental illness.

Approved
- Alabama
- Idaho
- Iowa
- Kansas
- Maine
- Maryland
- Michigan
- Missouri
- New Jersey
- New York
- North Carolina
- Oklahoma
- Rhode Island
- South Dakota
- Vermont
- Washington
- West Virginia
- Wisconsin

Pending
- Arkansas
- California
- Connecticut
- Illinois
- Massachusetts
- Minnesota
- New Mexico
- Virginia

The Transition From Pay-For-Volume To Pay-For-Value

Fee-For-Service

Case Rates & Bundled Payments

Capitation & Population Payments

Pay For Performance (P4P)

Managed Care Plans Continue Move To “Value-Based Contracting” With Providers

- About 40% of commercial health plan reimbursements to provider organizations in 2014 were linked to value-oriented initiatives; this compares to 11% in 2013¹
- As of June 2014, 1 million+ individuals enrolled in Medicaid health homes²
- As of 2013, more than 21 million individuals enrolled in PCMHs*; this compares to 5 million in 2009³
- As of Q4 2013, there were 606 ACOs** (260 physician groups, 238 hospital systems, 55 insurers, and 53 “other” organizations)⁵
- By April 2015 there were 645 ACOs: 366 have Medicare contracts; 210 have commercial contracts, and 74 have both commercial and government contracts⁴

*Patient-Centered Medical Homes **Accountable Care Organization

An Example Of Emerging Pay-for-Value From 2015 Optum Presentation

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

Outpatient Metrics
- Quality: Case-mix adj member-reported outcomes (wellness assessment)
- Cost: Case-mix adj average visits per episode and episode cost

Results
- 15% to 20% reduction in readmit rates

Inpatient Metrics
- Quality: HEDIS 7-day follow-up; CMS readmit rate for 30 & 90 day (case-mix adj)
- Cost: Case-mix adj ALOS and episode cost

SUDS Medication Assistance Therapy (MAT) Providers - MA

Metrics
- Quality: Readmit rate for 30 and 90 day (case-mix adj)
- Cost: Case-mix adj average visits per episode and episode cost

Results expected 2016

Leverage medical-behavioral integration in health homes for payer customers

8 metrics across 6 domains
- Care coordination
- Care transition
- Referral management
- Health promotion
- Individual support
- Family/caregiver support

Early results show improved care coordination
- 9% increase in adherence to quarterly PCP visits
- 4% increase in primary caregiver or peer support linkages

Emerging Roles For Behavioral Health Provider Organizations In Population Health Management

<table>
<thead>
<tr>
<th>Emerging Program Models</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health services for individuals with acute health care conditions</td>
<td>Coronary artery bypass surgery patients; 3 people with pain</td>
</tr>
<tr>
<td>Integrated primary care/behavioral health services</td>
<td>Cherokee Health System; Intermountain Health Care</td>
</tr>
<tr>
<td>Specialized crisis diversion and hospital readmission prevention programs</td>
<td>Recovery Innovations; Baltimore Crisis Response, Inc.</td>
</tr>
<tr>
<td>Specialty medical homes and health homes for coordination of care for high-risk individuals with behavioral health conditions</td>
<td>Spectrum Human Services; Black Hawk-Grundy Mental Health Center</td>
</tr>
<tr>
<td>“Vertical” specialty health plans for individuals with serious mental illnesses</td>
<td>Magellan Complete Care; Mercy Maricopa Heath Plan</td>
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The shift to value-based continues to offer opportunities for behavioral health provider organizations and mental health professionals.
QUESTIONS