Paying For Value In Mental Health Services: Perspectives From The Field

Deborah Adler
Senior Vice President of Network Services
OptumHealth

Maurice Lelii
Director of Outpatient and Managed Care
Gracepoint Wellness, Inc.
Deb Adler is senior vice president for Optum’s Network Strategy department. She joined the company in 2008 and is currently responsible for coordinating all recruitment, credentialing and contracting for a network of over 170,000 providers, assuring members have access to quality providers and a broad continuum of care.

With a team of over 250 staff, Deb has facilitated innovative network programs, including implementing tele-health programs to address member access needs and developing credentialing and operational requirements to incorporate peer- and family-run organizations as part of the array of behavioral network services.

Using her background in statistics, Deb began her career in behavioral health as a quality director in two state-run psychiatric centers. Since entering the managed behavioral health care field 20 years ago, she has worked in a variety of capacities including network executive, quality management executive and chief operating officer. She has a Master’s degree in educational psychology and evaluation from Catholic University of America and is a Certified Professional in Health Care Quality (CPHQ).

Maurice Lelii, LMHC, is the Director of Outpatient and Managed Care at Gracepoint, Inc. He joined the company in 2013 and is responsible for oversight of the adult and child outpatient services. The outpatient division which maintains a 3 million dollar budget provides a range of services which includes psychotherapy, medication management, case management, and psychosocial rehabilitation. He has a team of 90 clinical and administrative staff that serve over 15,000 unduplicated clients annually in the Tampa Bay region. Maurice also serves as Gracepoint’s managed care liaison. He provides oversight for contracting, credentialing, utilization management, and revenue cycle management.

Maurice has over 30 years experience in the behavioral health field. As a clinician, he has been a service provider in all levels of care including EAP, outpatient, Intensive outpatient, partial hospitalization, inpatient, and residential. As a manager, he has managed outpatient, IOP, PHP, and residential programs. Maurice has also 15 years experience in the managed behavioral arena which include call center operations, utilization management, and case management for Medicaid, Medicare, ASO, Government EAP, and Commercial product lines. Maurice maintains a private practice in Largo, Florida.
This program is paid for by Otsuka Pharmaceutical Development & Commercialization, Inc. and Lundbeck, LLC
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Otsuka Pharmaceutical Development and Commercialization, Inc. (OPDC) and Lundbeck, LLC. have entered into collaboration with Open Minds, LLC. to explore new ways of bringing/increasing awareness around serious mental illness.

OPDC/Lundbeck’s interaction with Open Minds is through PsychU, an online, non-branded portal dedicated to providing information and resources on important disease state and care delivery topics related to mental illness. One of the methods employed for the sharing of information will be the hosting of virtual fora. Virtual fora conducted by OPDC/Lundbeck are based on the following parameters:

When conducting medical dialogue, whether by presentation or debate, OPDC/Lundbeck and/or its paid consultants aim to provide the viewer with information that is accurate, not misleading, scientifically rigorous, and does not promote OPDC/Lundbeck products.

OPDC/Lundbeck and/or their paid consultants do not expect to be able to answer every question or comment during a PsychU Virtual Forum; however, they will do their best to address important topics and themes that arise.

OPDC/Lundbeck and/or their paid consultants are not able to provide clinical advice or answer questions relating to specific patient’s condition.

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OPDC and Lundbeck operate in a highly regulated and scrutinized industry. Therefore, we may not be able to discuss every issue or topic that you are interested in, but we will do our best to communicate openly and directly. The lack of response to certain questions or comments should not be taken as an agreement with the view posed or an admission of any kind.
Objectives

- Understand why models of reimbursement are moving from volume-based to value-based.
- Understand the role of payers in value-based purchasing – what tools do payers offer to providers to meet quality goals?
- Understand the responsibilities of providers in value-based delivery – what are providers doing to meet the expectations of payers and consumers?
Why Are We Moving Reimbursement From Volume to Value?¹

POOR PERFORMANCE!

- High rate of uninsurance
- High cost – per person and as % of GDP – as a nation
- Lower levels of consumer satisfaction rates
- Increasing % of GDP spent on health care
- Increasing employer cost and tax burden from health care
- Questionable outcomes and performance – with little data
- Higher medical error rate than other countries

GDP-Gross domestic product

The Affordable Care Act Provides A Framework For Achieving Value

The goal of the Affordable Care Act is to change how health care is organized, delivered, and paid for in the United States. It supports:

1. Testing new models of health care delivery
2. Shifting from a reimbursement system based on the volume of services provided to one based on the value of care
3. Investing in resources for system-wide improvement.

These Changes Spell The End Of “Business As Usual” For Every Stakeholder¹

<table>
<thead>
<tr>
<th>Consumers</th>
<th>Provider Organizations</th>
<th>Professionals</th>
<th>Health Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>• More cost sharing</td>
<td>• Strategic ‘re-engineering’ in value chain</td>
<td>• Move away from ‘more is better’</td>
<td>• MLR</td>
</tr>
<tr>
<td>• More requirements for engagement</td>
<td></td>
<td>• Participation in population health management and standardization of care delivery</td>
<td>• Downward pressure on rates</td>
</tr>
<tr>
<td>• The “activity tracker” revolution</td>
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<td></td>
<td>• Competition from other health plans and provider systems</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Backward integration and gainsharing reimbursement arrangements with providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Smaller subsidies and more stringent ratings for health exchange, Medicaid, and Medicare populations</td>
</tr>
</tbody>
</table>

MLR=Medical loss ratio

What Is The Role Of Payers In Value-based Purchasing?

Deborah Adler
Senior Vice President of Network Services
OptumHealth
### What Is Value-based Purchasing?¹

“Any purchasing practice aimed at improving the value of health care services, where value is a function of both quality and cost.”

<table>
<thead>
<tr>
<th>Strategies</th>
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<tbody>
<tr>
<td>1. Focus on influencing the decisions or behavior of individuals (i.e., employees, beneficiaries, or patients)</td>
<td>2. Aim to change the behavior or performance of health care entities, usually providers and/or plans.</td>
</tr>
</tbody>
</table>

Optum’s Work In The Reimbursement Continuum

**Small % of financial risk**
- Fee-for-service
- Performance-based Contracting
- Low Accountability

**Moderate % of financial risk**
- Shared Savings
- Bundled and Episodic Payments
- Moderate Accountability

**Large % of financial risk**
- Shared Risk
- Capitation
- Maximum Accountability

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**Examples**
- P4P/Shared Savings Contracts with Qualified Facilities and Outpatient Providers (national footprint across all payor types)
- SUDS Medication Assistance Therapy (MAT) Providers
- ACOs, medical-behavioral integration in health homes

**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 adjusted)
- Cost: Case-mix adjusted average visits per episode and episode cost

**Results**

**Outpatient**
- 15% to 20% reduction in readmit rates
- Ambulatory follow-up rate improved from 3% to 10%

**Inpatient**
- Quality: Readmit rate (case-mix adjusted) – 30 and 90 day
- Cost: Case-mix adjusted average visits per episode and episode cost

**ACO=Accountable Care Organization, ALOS=Average length of stay, CMS=Centers for Medicare and Medicaid Services, HEDIS=Health Effectiveness Data and Information Set, P4P=Pay For Performance, PCP=Primary care provider, SUDS=Substance use disorders**

1. Optum internal data.
Optum’s Behavioral Solutions: ACE Optimizes Provider Performance¹

Achievements in Clinical Excellence (ACE)

Guiding and rewarding providers for delivering services more effectively and efficiently by:

- Gathering unbiased, risk-adjusted data that is benchmarked against regional clinicians and facilities
- Pinpointing and eliminating variations in practice patterns that drive costs and create poor outcomes
- Assign specific tier designations and incentivize providers and facilities to achieve and maintain high performance

Improving quality and affordability for customers:

Alternative Reimbursement Model
Improvement on clinical metrics driven through performance-based contracting

Telehealth
Offering member convenience and improved access

¹. Optum internal data.
Achievement In Clinical Excellence Metrics Guide - Performance-Based Contracting

- Outpatient providers achieving two-star rating (effectiveness first and supplemented with efficiency ratings) earn enhanced reimbursement
- Facility pay-for-performance incentivizes improved member outcomes and rewards facility for results

<table>
<thead>
<tr>
<th>Clinician Metrics</th>
<th>Facility Metrics</th>
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</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td><strong>Quality</strong></td>
</tr>
<tr>
<td>▪ Severity-adjusted effect size from the Wellness Assessments</td>
<td>▪ 30-day readmission rate</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>▪ Risk-adjusted 30-day readmission rate</td>
</tr>
<tr>
<td>▪ Case-mix-adjusted average number of visits</td>
<td>▪ Follow-up after mental health hospitalization (HEDIS)</td>
</tr>
<tr>
<td>▪ Average cost per episode</td>
<td>▪ Peer review rate</td>
</tr>
<tr>
<td></td>
<td><strong>Cost</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Case-mix-adjusted average length of stay</td>
</tr>
<tr>
<td></td>
<td>▪ Spending per beneficiary</td>
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ACE=Achievements in Clinical Excellence, HEDIS=Health Effectiveness Data and Information Set; 1.Optum internal data.
What Is The Responsibility Of Providers In Value-based Delivery?

Maurice Lelii
Director of Outpatient and Managed Care
Gracepoint Wellness, Inc.
Gracepoint Overview

Gracepoint, formerly Mental Health Care Inc., is a private, non-profit behavioral healthcare organization founded in 1949 by the Tampa Junior League.

Gracepoint annually provided services to more than 21,000 individuals (2015) in Hillsborough County, and employs 600 staff members.

Specific Populations Served

- Children & adults seeking counseling for life changes & crises
- Children & adults with depression, anxiety, substance abuse, co-occurring disorders
- At-risk children and teens & their families
- Teen & adult case management
- Homeless individuals who are mentally ill, in need of supportive housing
- Children in the child welfare and justice systems

# Gracepoint Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Supporting Service</th>
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<tbody>
<tr>
<td>Central Intake – Baker Act Receiving Facility</td>
<td>Community Action Team (CAT)</td>
</tr>
<tr>
<td>Adult Crisis Stabilization Unit - 60 bed</td>
<td>Mobile Crisis Response Team</td>
</tr>
<tr>
<td>Children’s Crisis Stabilization Unit - 14 bed</td>
<td>Family Infant Wellness</td>
</tr>
<tr>
<td>Forensic Treatment Program - 24 bed</td>
<td>Homeless Services</td>
</tr>
<tr>
<td>Outpatient Program</td>
<td>**Telehealth</td>
</tr>
<tr>
<td>Psychotherapy/Medication Management Clinics</td>
<td>**Onsite Pharmacy</td>
</tr>
<tr>
<td>Case Management – Role Recovery</td>
<td>**Tampa Family Health (Integrated Primary Care)</td>
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<tr>
<td>Psychosocial Rehabilitation Program</td>
<td>**Value-Added Services</td>
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</tbody>
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**Value-Added Services**

## Gracepoint Value-Added Services

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<tr>
<th>Health Home¹</th>
<th>Telehealth¹</th>
<th>Onsite Pharmacy²</th>
</tr>
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<tr>
<td>- Onsite integrated medical primary care services</td>
<td>- Currently used in our central intake, CSU, outpatient medication clinics and case management</td>
<td>- Joint venture with Genoa Healthcare</td>
</tr>
<tr>
<td>- Joint venture with Tampa Family Health (FQHC)</td>
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## Value-Based Contracting: Health Plan

You are as good as your network!

<table>
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<th>Full continuum of services</th>
<th>Intensive Case Management</th>
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<tr>
<td>Comprehensive high quality clinical team</td>
<td>Pharmacy Management</td>
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<tr>
<td>Open Access System of Care</td>
<td>HEDIS/Quality Measures</td>
</tr>
<tr>
<td>Inpatient Crisis Stabilization</td>
<td>Primary Care Integration</td>
</tr>
<tr>
<td>Aftercare Services</td>
<td>Affordable pricing of services</td>
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HEDIS=Health Effectiveness Data Information Set
Value-Based Contracting: Provider

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HEDIS=Health Effectiveness Data Information Set
# Gracepoint Capitation Model¹

One of the five founding members of Florida Health Partners – contract entity with Florida’s Agency for Health Care Administration

Area 6 Medicaid waiver program 1992-2014

Partnership between regional providers and ValueOptions

Capitation based on covered lives, provider’s revenue based on 90% encounter MLR, shared risk with Area 6 partners

Reporting requirement: service encounters, quality audits

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MLR=Medical loss ratio, UM=Utilization management

¹ Gracepoint internal data.
## Model Comparison

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<th>Fee For Service</th>
<th>Capitation</th>
<th>Value Based</th>
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<tr>
<td>• Greater Administrative Costs</td>
<td>• Lower Administrative Costs</td>
<td>• Incentive Program to Drive Provider Performance</td>
</tr>
<tr>
<td>• Lower Cost Controls</td>
<td>• Greater Cost Controls</td>
<td></td>
</tr>
<tr>
<td>• Greater Risk of Strained Partnership</td>
<td>• Greater Risk of Collaborative Partnership</td>
<td></td>
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DISCUSSION
QUESTIONS
CLOSING