



National Trends in Behavioral Health – Value-Based Reimbursement, Performance Data Development, & Performance-Based Management

New Mexico Statewide Behavioral Health Summit, September 17, 2019

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National Trends in Behavioral Health –

Performance-based
contracting and value-based
reimbursement drives
performance-based
management and
performance data
development

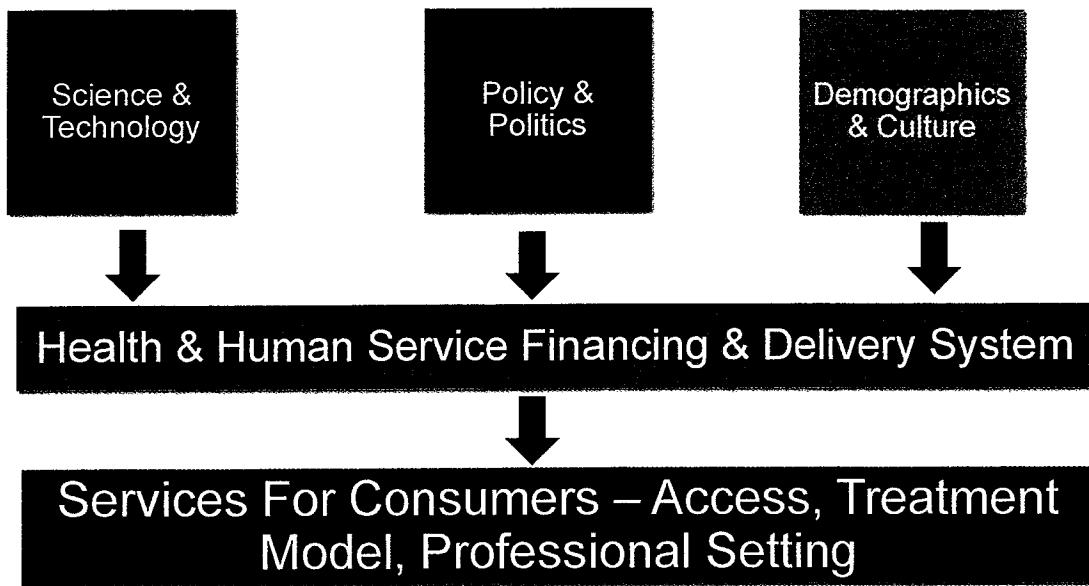
1. National Trends In The Behavioral Health Landscape
2. Performance-Based Contracting & Value-Based Reimbursement In Behavioral Health–
 - The Payer Perspective
 - The Health Plan Perspective
 - The Provider Perspective
3. Best Practice Performance Management



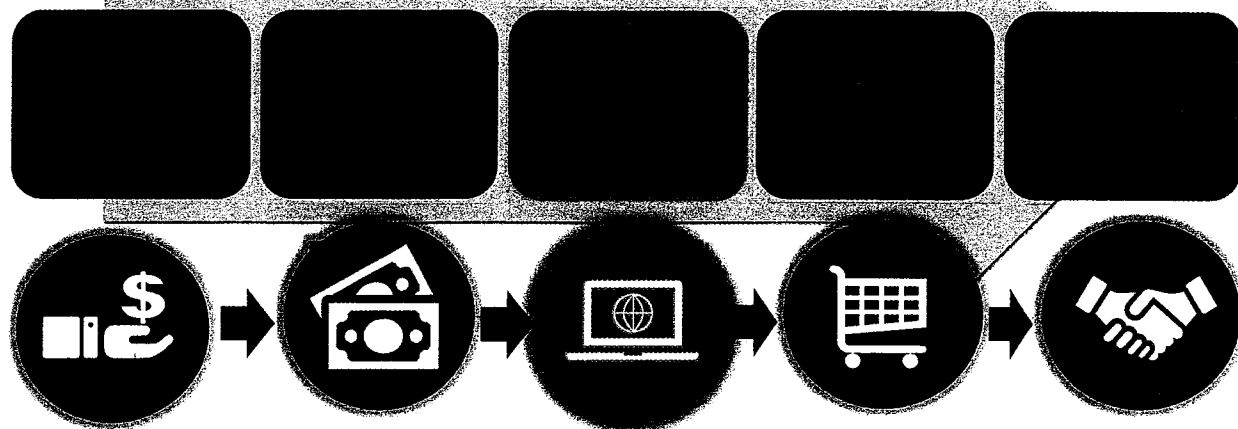
National Trends In The Behavioral Health Landscape

Service Delivery System Is Evolving – The Market Results Are An Unpredictable Synergy Of Many Factors

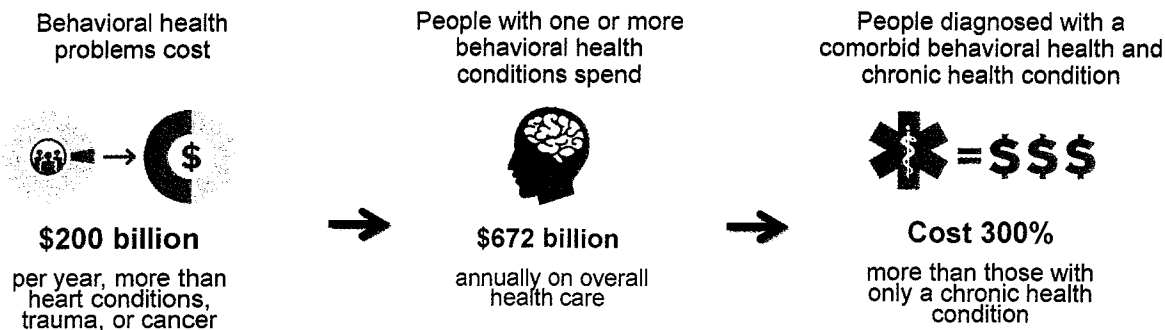
The Landscape



The Drivers Of The Changing Service Delivery Landscape



Behavioral Health Conditions Predict Increased Health Care Spending



1. Sources: The Robert Wood Johnson Foundation, The Synthesis Project: New Insights From Research Results
 2. Charles Roehrig, "Mental Health Disorders Top the List of the Most Costly Conditions in the United States: \$201 Billion," Health Affairs 35, no. 6 (2016): 1130 – 1135
 3. Thorpe, Jain, and Joshi, "Prevalence and Spending Associated with Patients Who Have a Behavioral Health Disorder and Other Conditions," Health Affairs 36, no. 1 (2017): 124-132

The Behavioral Health Challenge Among Medicaid Enrollees



Widespread

1 in 5 Medicaid adults and 1 in 10 Medicaid children are affected each year by mental health and substance use disorders.¹

21% of adults with any mental illness were covered by Medicaid²

30%-70% of individuals with I/DD have a co-occurring mental health condition^{5, 6, 7, 8}



Unaddressed

Nearly 60% of adults with any mental illness didn't receive mental health services in the previous year³

Only 1 in 10 Americans with a substance use disorder receives treatment⁴

Individuals with I/DD and co-occurring mental health conditions are often poorly identified and lack appropriate resources



Costly

4x higher Medicaid spending for people with mental health conditions, compared to other enrollees¹

48% of Medicaid expenditures were for enrollees with behavioral health conditions¹

Up to \$200B estimated total economic cost to the U.S. from untreated behavioral health issues⁹

Behavioral Health Issues Of Children In Foster Care



Children in foster care, compared to other children, are:¹

2x

as likely to have learning disabilities and developmental delays

3x

as likely to have ADD/ADHD

5x

as likely to have anxiety

6x

as likely to have behavioral issues

7x

as likely to have depression

3%

of non-disabled children in Medicaid are in foster care²

and account for



15%

of behavioral health services used by children in Medicaid³

Medicaid children in foster care are

4x

more likely to use psychotropic medications than other children in Medicaid³

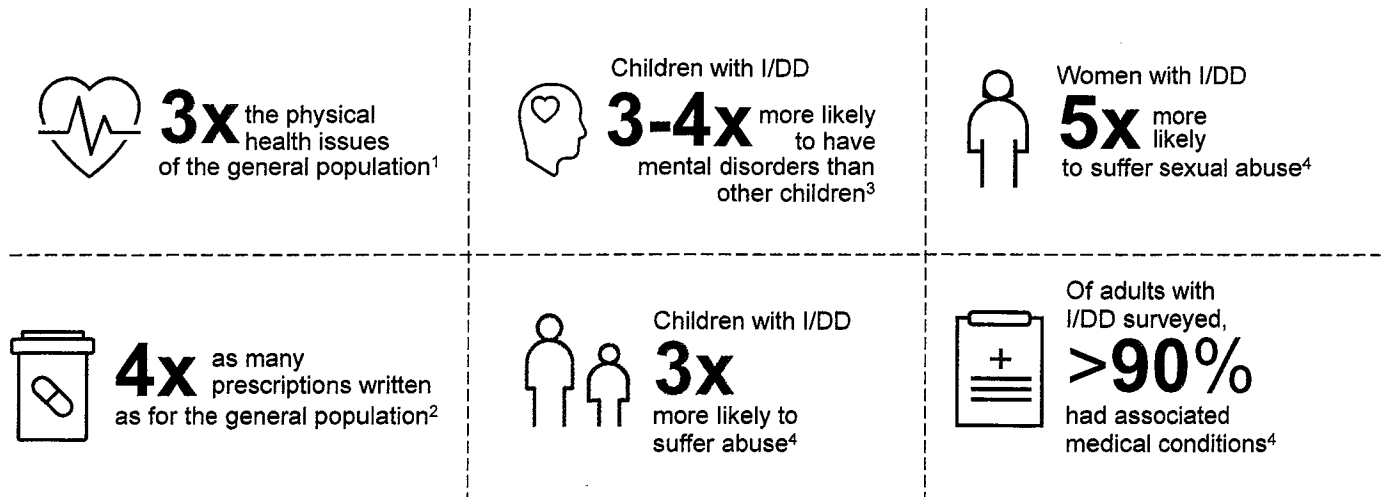
and represent

13%

of ALL Medicaid enrollees receiving psychotropic medications³



Health Issues Of Individuals With I/DD



Health Care Utilization For Individuals With I/DD

More than 5 million people with I/DD in the United States:

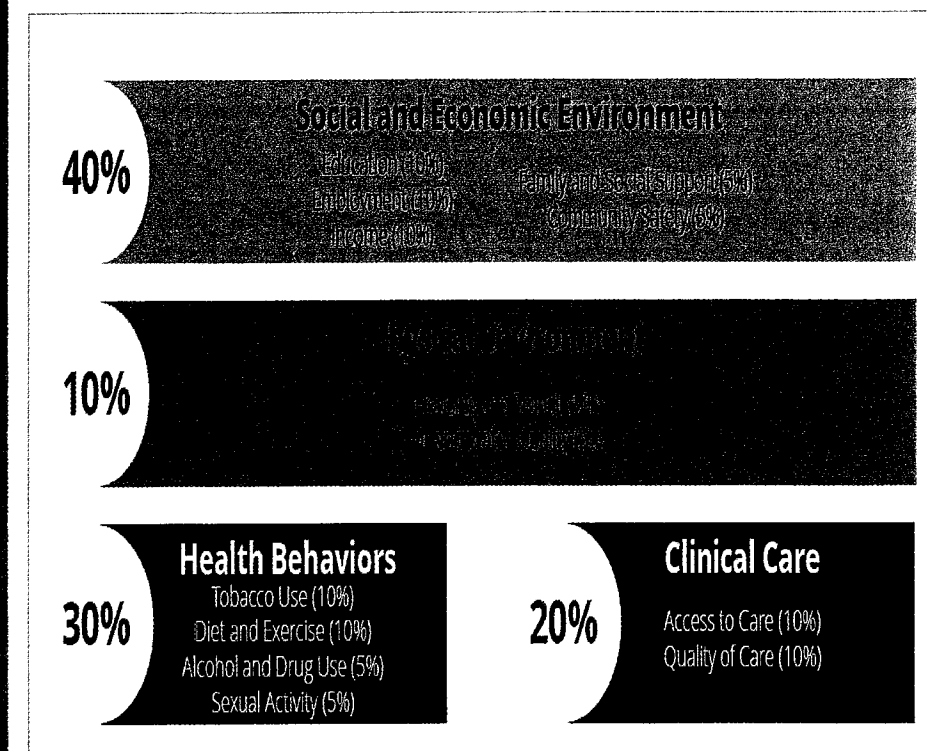
- **More than 60%** rely on Medicaid for their health care coverage
- Approximately **350,000** receiving health care services via managed care
- An estimated **80%** are Medicaid eligible
- Nearly **75%** live with family members

Sources: Thomas Cheetham, MD; David Braddock, PhD; Open Minds.

High level condition summary for people with I/DD

Co-occurring mental illness	35%
Including SUD(SA)	50%+
Cardiovascular disease	38%
Central nervous system diseases	28%
Three or more chronic conditions	45%

The Importance Of Social Factors – The Drivers Of Health Care Costs

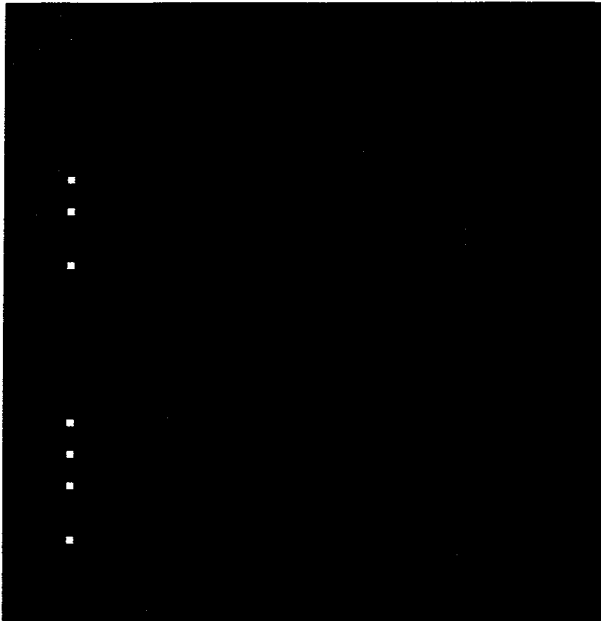


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The Landscape

- Much of this is due to frequent and preventable use of expensive health care settings - due to lack of a coordinated, person-centered care management
- Upon discharge from a hospitalization due to mental illness, HEDIS measures show that more than 47% of commercially-insured individuals, 55% of Medicaid enrollees, and 64% of Medicare enrollees did not receive follow-up care within 7 days

Changing Provider Reimbursement Models To Support “Integration”



NEWS REPORT 05/25/2018 11:00 pm ET

UnitedHealthcare’s Bundled Payment Program For Joint Replacement Cut Readmissions 22%

Cigna’s Accountable Care Program Lowers Cost, Improves Care at The Jackson Clinic

Humana Partners With CleanSlate Centers To Provide Outpatient Addiction Treatment Services In 8 States

BCBSA Value-Based Plan Outperforms in Key Health Metrics

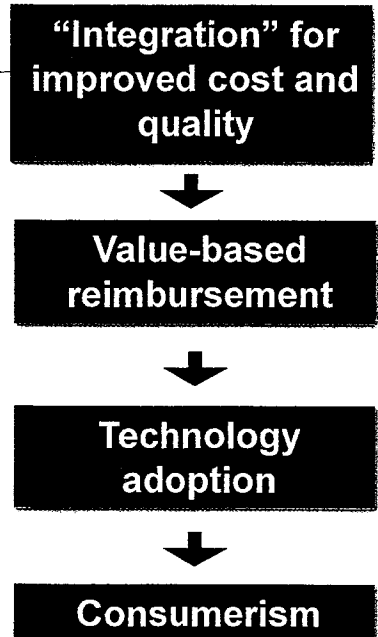
Gregory A. Freeman, April 30, 2018

Humana Expands Value-Based Orthopedic Specialty Care Model To Seven More States

Value-Based Reimbursement Here To Stay Because...

- Political and competitive pressure on payers – federal government and employers
- Downward price pressure on health plans
 - Pressure on health plan medical loss ratios
- The success of ‘some’ ACOs
- The early findings of the Medicare bundled rate initiative

Return to fee-for-service not feasible – only “lever” in FFS is to reduce rates



More Managed Care

Payer Type	2011, % Of U.S. Population Covered	2016, % Of U.S. Population Covered	2011, % Of Population Enrolled In Managed Care	2016, % Of Population Enrolled In Managed Care
Medicare, non dual eligible	14%	15%	23%	32%
Medicare, dual eligible	3%	3%	25%	38%
Medicaid	18%	23%	50%	70%
Commercial	52%	54%	93%	98%
Military	3%	3%	57%	49%
Uninsured	15%	9%	N/A	N/A

More Managed LTSS

States with MLTSS including I/DD (2017)

- Arizona
- California
- Florida (optional)
- Iowa
- Kansas
- Michigan - MSSP
- North Carolina
- Tennessee
- Vermont
- Wisconsin

States with MLTSS excluding I/DD

- Delaware
- Hawaii
- Illinois
- Massachusetts
- Minnesota
- New Mexico
- New York-MLTC & MAP
- Pennsylvania
- Rhode Island
- Tennessee
- Texas
- Virginia

Growing Competition For LTSS \$

Aging population in need of increased supports with activities of daily living

- In 2000, 35 million Americans were over 65 (12.4% of the population) – by 2016, 49.2 million Americans were over 65 (15.2% of the population)
- **By 2030, the number is projected to be 98 million, or 24%**

Increasing prevalence of multiple chronic conditions and disability for under 65 population

- In 2010, 21% of people between 45-65 had multiple chronic conditions – only 16.1% in 2000
- **By 2030, this will be 25.9% of the under-65 population**

Increase in incidence of Alzheimer's and dementia

- In 2017, 5.5 million people had Alzheimer's, an increase of 3.7% since 2010
- **By 2025, 7.1 million people are projected to have Alzheimer's, a 35% increase**

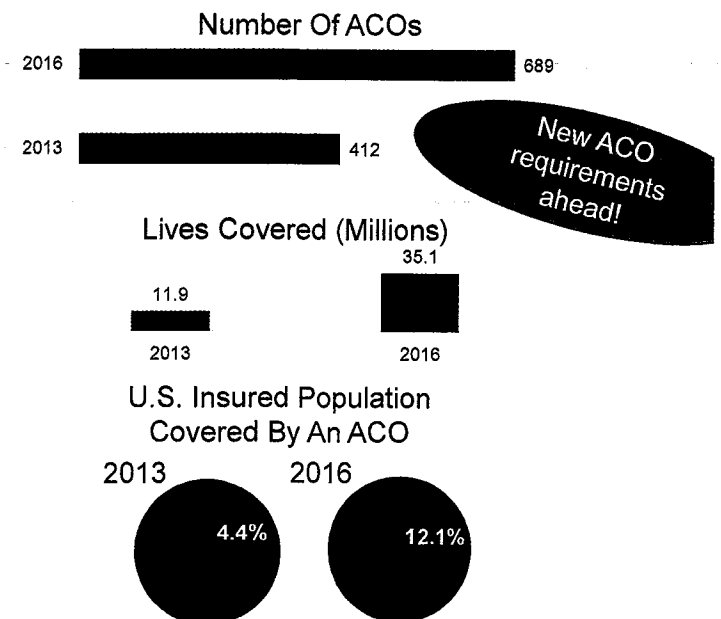
Increase in prevalence of autism

- **1 in 59 children have autism spectrum disorder (1.7%) – up from previous 2014 estimates of 1 in 68 children (1.4%)**

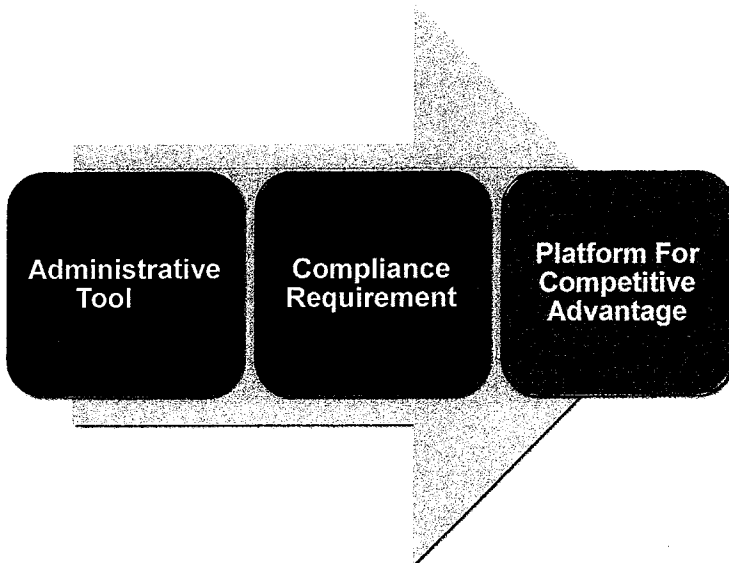
More ACOs

ACO Overview, 2016

ACO Contract Payer	Number Of ACOs	Number Of Contracts	Total Beneficiaries	Percent Of Attributed Consumers
Medicare	412	485	14,615,007	41.7%
Medicaid	44	55	3,243,728	9.2%
Commercial	156	229	17,219,745	49.1%
Multiple Contracts	77	-	-	-
Total	689	769	35,078,480	100%

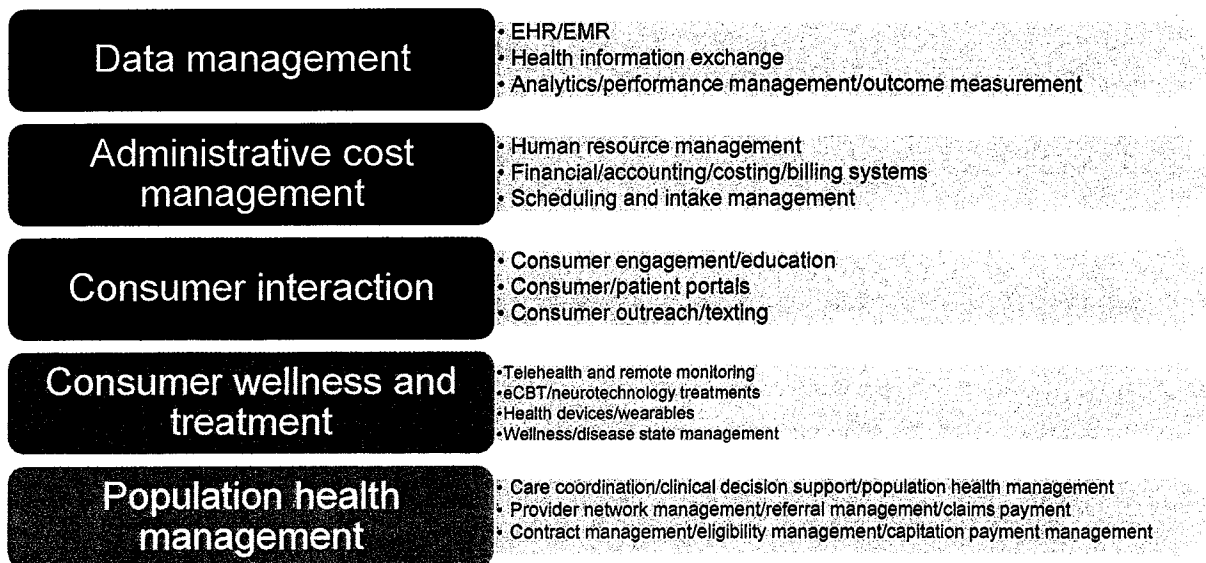


Shifting Role Of Technology In Health & Human Services

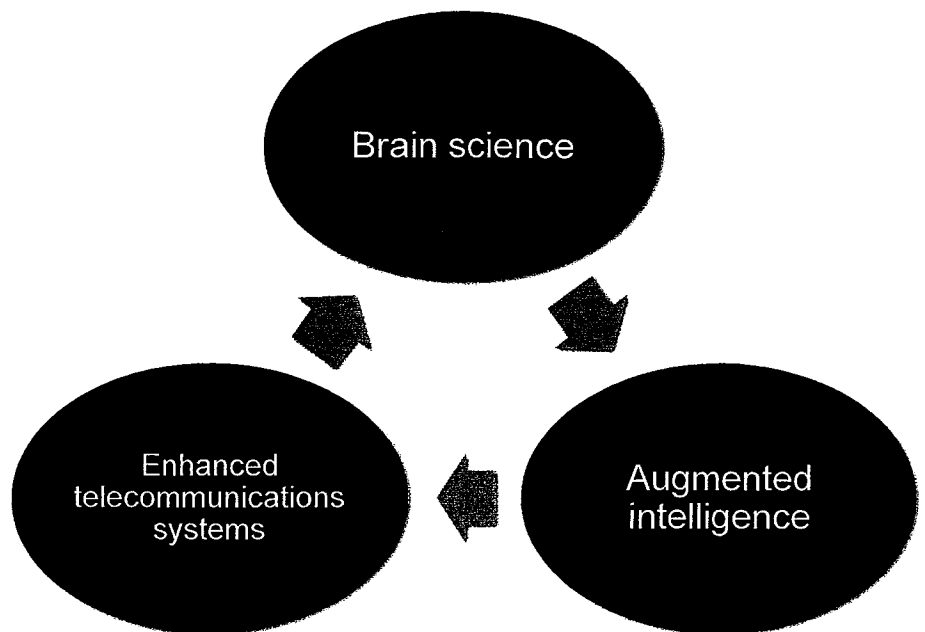


- Compliance focus the past ten years
 - Result - less focus on usability and clinical effectiveness
- From 'cost' to 'investment'
- From 'administrative management' to 'imbedded in service lines'
 - Essential for competitive advantage – and market positioning - over the next five years

Technologies Driving Health & Human Service Delivery

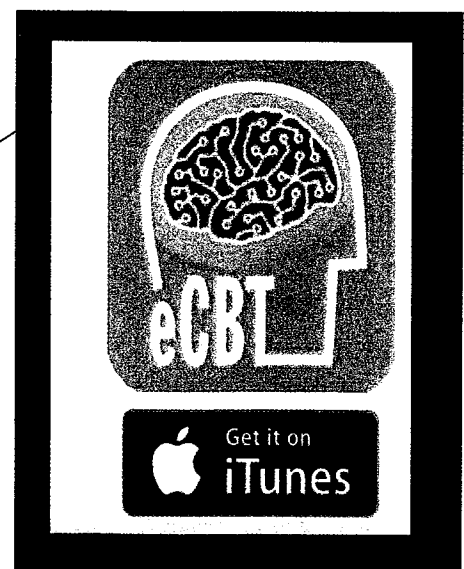


New developments in many scientific domains are reshaping health and human services



The Changing Science – Brain Science

- Epigenetics and the effects of trauma
- Brain stimulation therapies
- Virtual automated mental and cognition therapies
- Nutritional psychiatry
- Personalized medicine and 'precision psychiatry'



The Changing Science – Augmented Intelligence



Diagnostics

Treatment Matching



NEWS REPORT 09/05/2017 11:00 pm ET

University Of Alberta & IBM Testing Artificial Intelligence To Diagnose Schizophrenia

In July 2017, the University of Alberta and IBM launched a cooperative initiative to test the potential for artificial intelligence (AI) in diagnosing schizophrenia. They announced that researchers had developed an AI system that used brain scans to diagnose schizophrenia with 74% accuracy. The AI system was also able to predict the severity of specific schizophrenia symptoms, such as attention problems, bizarre behaviors, positive formal thought disorder, lack of motivation or apathy, and the negative symptom of alogia (minimal use of words).

**Data driven solutions
People-focused outcomes**

Medics can appreciate

The ActX Service

The ActX Service

Read Patient Stories

Talk to Your Doctor

Request more Information

ActX Mobile App

Healthcare Professionals - Click Here

Use the Power of Genetics to Personalize your Healthcare with Actionable Genomics Screening

The Changing Science – Enhanced Telecommunications

New hybrid treatment systems emerging based on new telecommunications and data aggregation technologies

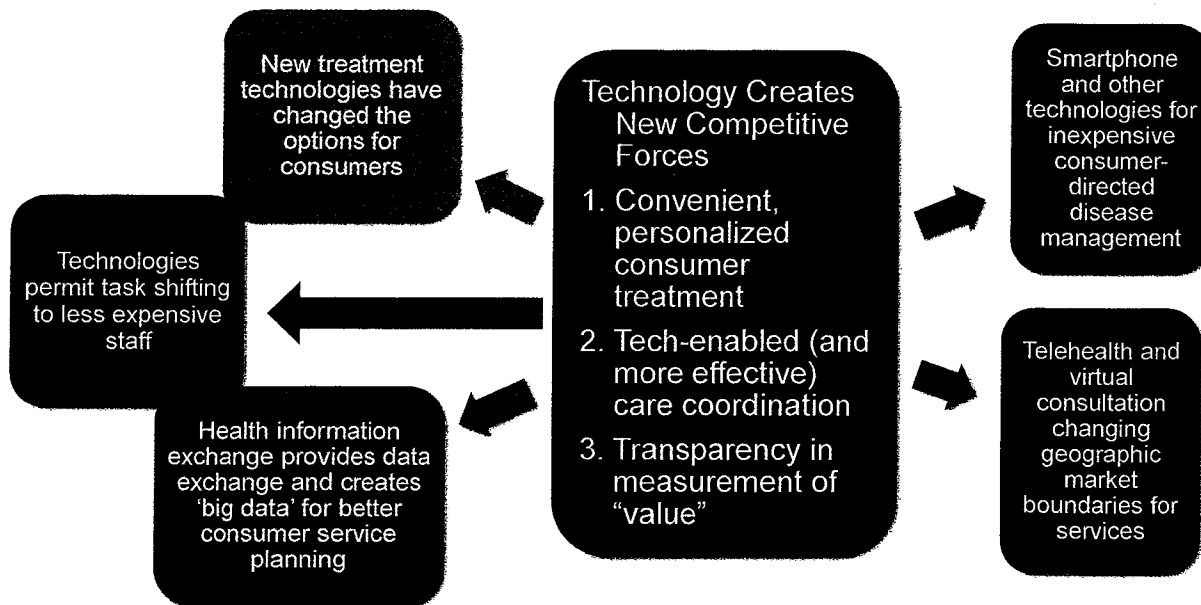
- Telehealth
- Store-and-forward
- Automated therapies
- Text
- Wearables

Platforms emerging integrating these technologies - real-time remote monitoring, consumer engagement, disease state management platforms

Hi, I'm Woebot.

I'm here for you, 24/7. No couches, no meds, no childhood stuff. Just strategies to improve your mood. Plus the occasional dorky joke. 🤖

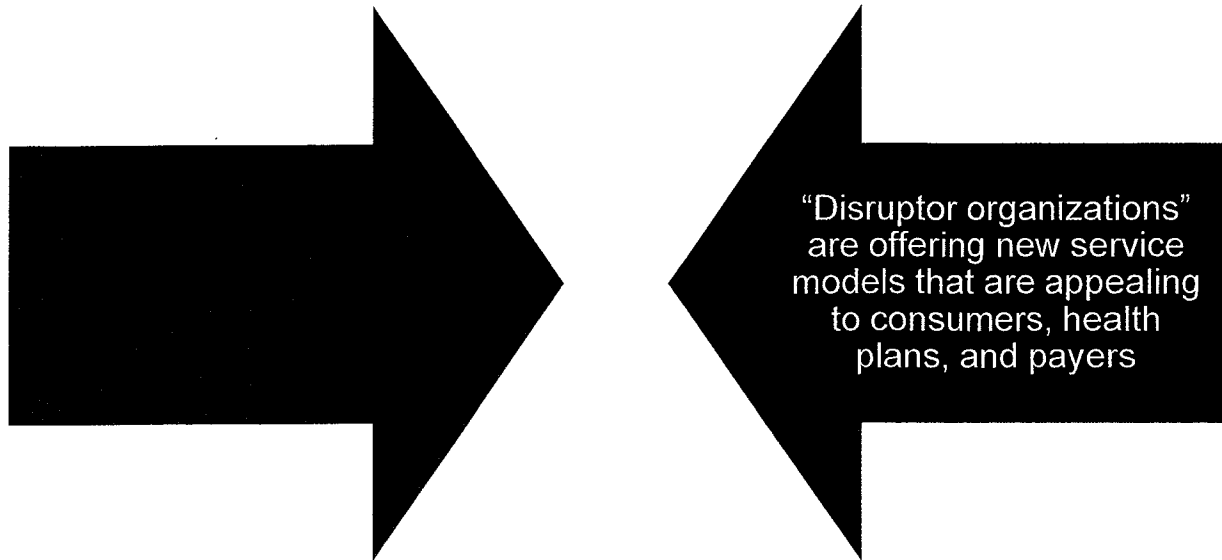
Leverage Of Technology To Reinvent Services Key To Long-Term Sustainability



The New Consumerism

	<p>Consumer engagement = Process to help individuals take action to improve their health, make informed decisions, and engage effectively and efficiently with the health care system</p> <p>Expected results = Improved health status, reduced costs, and better access</p>
	<p>Consumer transparency = Making available, in a reliable, and understandable manner, information on the health care system's quality, efficiency and consumer experience with care, which includes price and quality data</p> <p>Expected results = Improved service quality and reduced costs</p>
	<p>Consumer financial participation = Proportion of health care spending paid by the consumer</p> <p>Expected results = Reduced costs by increasing engagement and reducing unnecessary expenses</p>
	<p>Consumer experience = How consumers perceive their interaction with an organization, evaluated as useful, usable, and enjoyable - resulting in the consumer perception of an organization's brand</p> <p>Expected results = Improved consumer preference for certain provider organizations – while improving their level of engagement</p>

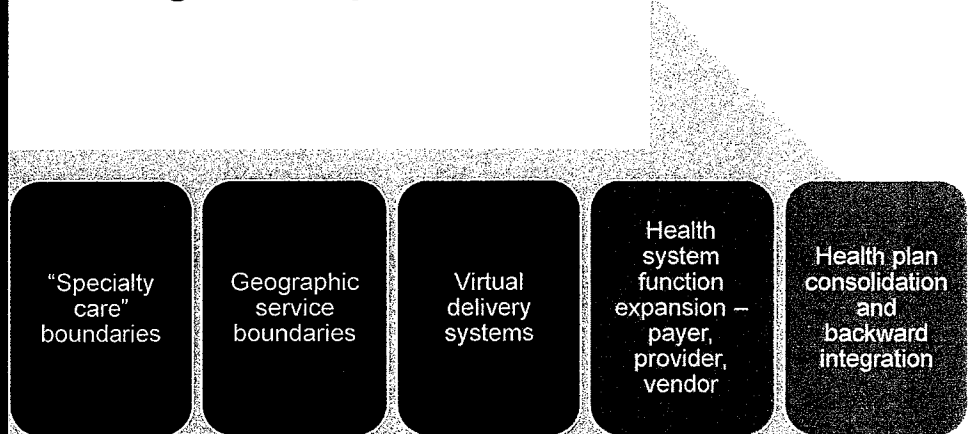
New Competition Drives Consolidation
















The New Lexicon Of MA&A

- Health plan merger
- Health plan backward integration
- Health system merger
- National health systems evolution
- Health systems acquiring specialty capabilities
- Specialty provider organization merger
- National 'specialty' delivery system evolution
- Health plans/pharma combinations
- Provider organizations/pharma combinations
- Pharma/tech combinations
- Tech-enabled service delivery

The 'Melting' Value Chain Driving Mergers, Acquisitions, & Affiliations



Consolidation Continues in Health Systems

Some Of The Largest Health Systems – Annual Revenue	
Ascension Health – \$22.6 Billion	 ASCENSION
Trinity Health – \$17.6 Billion	 Trinity Health
Catholic Health Initiatives – \$15.5 Billion	 Catholic Health Initiatives
UPMC - \$11.4 Billion	 UPMC <small>LIFE CHANGING MEDICINE</small>
Dignity Health – \$10.2 Billion	 Dignity Health
Atrium Health - \$9.8 Billion	 Atrium Health
John Hopkins Medicine - \$8 Billion	 JOHNS HOPKINS MEDICINE
Mercy Bon Secours – \$8 Billion	 MERCY HEALTH
LifePoint Health - \$6.3 Billion	 LIFEPOINT HEALTH
Providence Health & Services - \$6 Billion	 PROVIDENCE Health & Services
Northwestern Memorial Healthcare - \$4.6 Billion	 Northwestern Medicine
Adventist Health System – \$3.9 Billion	 Adventist HEALTH SYSTEM
Prime Healthcare - \$3.3 Billion	 Prime Healthcare

Consolidation Continues In Specialty Service Providers

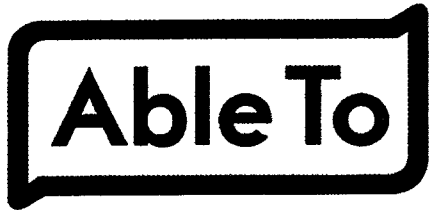
Universal Health Services (UHS) – \$10.4 Billion	Elwyn - \$276 Million
Kindred Healthcare – \$6 Billion	Mosaic – \$232.3 Million
Acadia Healthcare – \$2.8 Billion	Bancroft – \$146 Million
ResCare – \$1.5 Billion	Woods Services – \$132 Million
Civitas Solutions – \$1.4 Billion	Public Health Management Corporation – \$155.5 Million
Sunrise Senior Living – \$1.2 Billion	Uplift – \$118.1 Million
Merakey – \$525 Million	Atria Senior Living – \$64.2 Million
Capital Senior Living – \$463.6 Million	Enlivant – \$34 Million
Devereux – \$429 Million	Sequel – \$33.5 Million
Centerstone – \$400 Million	Strategic Behavioral Health – \$29.6 Million
American Addiction Centers – \$318 Million	KidsPeace – \$28.5 Million

Private Equity Investments In The Complex Consumer Space Increasing – Creating New Well-Capitalized Stakeholders

- CareGiver - I/DD
- ExpertCare - I/DD
- Suncoast New Options – I/DD
- Florida Autism Center - Autism
- Community Psychiatric – Mental Health
- Agape – Addiction Treatment
- Haven Behavioral - Mental Health
- InnerChange - Mental Health
- Walden Behavioral – Mental Health
- Sun Behavioral - Mental Health
- Sequel Youth & Family – Children’s Residential
- Center For Autism & Related Disorders – Autism
- AdvoServ - I/DD
- ResCare - I/DD



Virtual Behavioral Health Delivery Systems Created With Private Equity Investments



And Then. . . Possible Pending Disruptive Forces In Health & Human Services

1. Transportation companies facilitating in-home services – Uber, Lyft, UPS
2. Performance-based purchasing of pharmaceuticals (UPMC Health Plan, State of Oklahoma)
3. Amazon's investment in PillPack – what else will they (and others) sell online?
4. Pharmaceutical companies entering the tech-enabled service space (Otuska and MyCite, Sandoz and Pear Therapeutics)
5. Payers limiting consumer choice for specialty services to "Centers of Excellence (WalMart)
6. Chains of low-cost, convenient service centers (CVS/Aetna)
7. Health plans paying for, and being reimbursed for, social services (Kaiser, United, Humana – CMS/Medicare rule changes)
8. "Netflix" pricing model for pharmaceuticals – and what else? (State of Louisiana, State of Washington)
9. Augmented-intelligence companions (Amazon's Alexa, Jibo, Paro)
10. National chains for high-value specialty providers winning national contracts with payers (Clean Slate, Virtua, SurgCenter Development)
11. Smart homes (Google-powered AI in health care – Nest & Google Home)
12. The expansion of virtual care (United/Optum – telehealth expansion)



II. Performance-Based Contracting & Value-Based Reimbursement – The Payer Perspective The Health Plan Perspective The Provider Perspective

VBR Models Moving Ahead In Most Payer Sectors & Health Plans

2,875 views | Feb 7, 2018, 07:03am

Cigna Eclipses 50% In Value-Based Care Pay To Providers

CMS 'Pathways To Success' Medicare ACO Overhaul Limits ACO Time Without Risk

Payment
VERMA: CMS VALUE-BASED MODELS COULD STRETCH BEYOND MEDICARE

Only 13% of Hospital CFOs Prepared for Value-Based Reimbursement

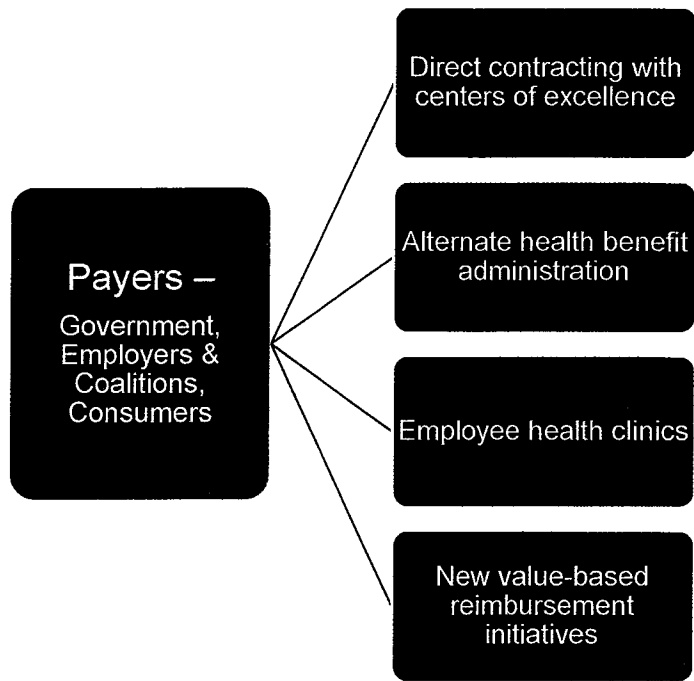
NEWS REPORT 11/18/2018 11:53 pm ET
UnitedHealth Moves Half Of Reimbursement To Value-Based Models

NEWS REPORT 12/02/2018 11:03 pm ET
75% Of Clinical Episodes Had Lower Costs In Medicare Bundled Payment Program

NEWS REPORT 09/12/2018 11:04 pm ET
Nearly 11,000 Skilled Nursing Facilities Receive Medicare Rate Cut Due To Hospital Readmission Rates



The Payer Perspective



Kalamazoo approves \$2.2M contract for employee health clinic

Posted Aug 6, 2019

Walmart Selects Covera Health Radiology Centers of Excellence




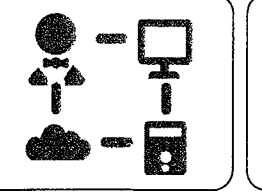
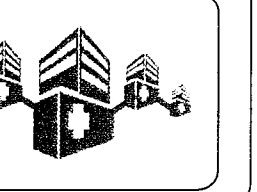
Employers Nationwide

GlobeNewswire • August 13, 2019

Apple explored buying a medical-clinic start-up as part of a bigger push into health care

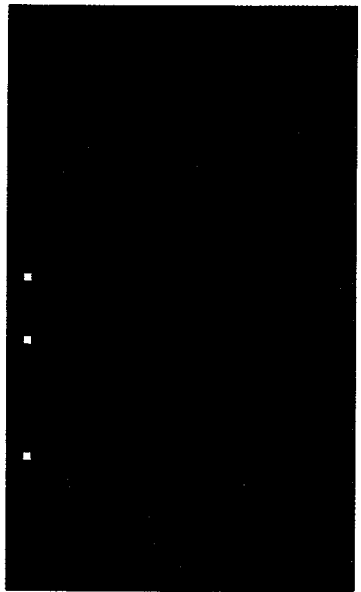
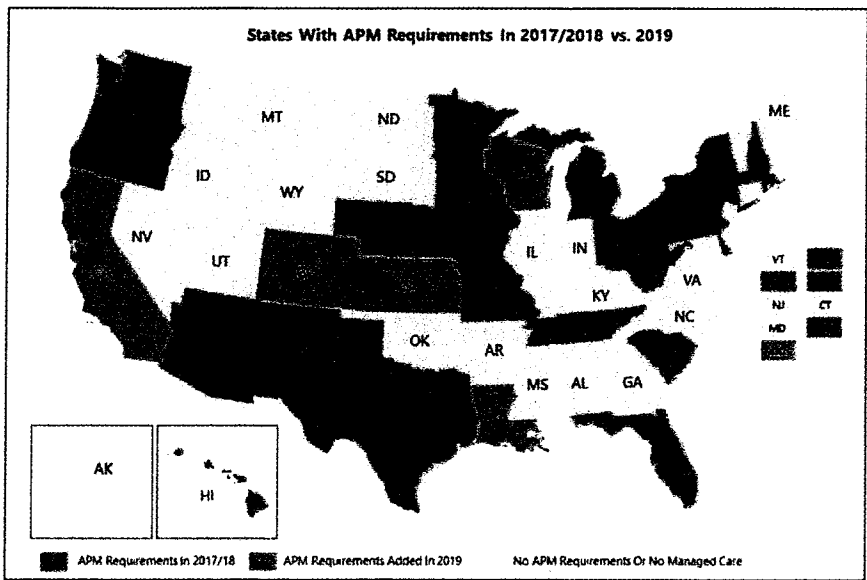
- Apple's health team was until recently deep in talks to buy Crossover Health, the venture-backed start-up that runs its on-site medical clinic.
- It's not clear if Apple wanted to own and operate a network of health clinics.

Recent Changes In Medicare

				
<ul style="list-style-type: none">• October 1st 2018 launch of the new BPCI model• Next application period in January of 2020	<ul style="list-style-type: none">• CMS proposed to pay clinical professionals for virtual check-ins• Proposed CMS payments for evaluating patient-submitted photos• Expansion of Medicare-covered telehealth services to include preventative services that are prolonged	<ul style="list-style-type: none">• CMS is also proposing to implement a flat FFS rate for physician office visits as of January 2019	<ul style="list-style-type: none">• MyHealthEData initiative• Relaunch of the Medicare Blue Button• Overhaul of Medicare & Medicaid EHR platforms – providers will be required to update their systems to 2015 Edition certified EHR technology (CEHRT)	<ul style="list-style-type: none">• MSSP ACOs may have two years of upside-only participation before three years of increased two-sided risk• Expansion of direct provider organization contracting (DPC) models

Changes Ahead For Medicare

1. **“Primary Cares Initiative”** -- On April 22, 2019, CMS announced the the “Primary Cares Initiative” to implement five new value-based primary care models for Medicare fee-for-service (FFS) beneficiaries. CMS projects that nearly 11 million Medicare beneficiaries (25% of the total Medicare FFS population) could be served through the five new models. The six-year demonstration that will begin in January 2020.
2. **Medicaid health homes for children** - CMS is planning to launch Medicaid health homes to provide care coordination for children with medically complex or chronic conditions, with an option for pmpm reimbursement. By October 1, 2020, CMS will issue guidance on implementing this option with a target date of October 1, 2022.
 - The health homes are intended for children with serious, long-term physical, mental or developmental disability, or disease such as cerebral palsy, cystic fibrosis, HIV/AIDS, blood diseases, such as anemia or sickle cell disease, muscular dystrophy, spinal bifida, epilepsy, severe autism spectrum disorder, and serious emotional disturbance or serious mental health disorder.



The Health Plan Perspective

Intermediaries Managing Health Benefits –
Insurers, Health Plans, MBHOs, PBMs

Insurers “backward integrating” by buying and creating service provider organizations

Risk-based partnership arrangements with individual provider organizations and ACOs

Management contracts with health systems

Investment in tech companies

Management of health care provider organizations

CVS to open 1.5K HealthHUB stores in next 2 years

Anthem partners with startup K Health symptom checker and telehealth app

The co-branded application will open up access to K Health's AI-driven triage and symptom checker tool to Anthem's more than 4 million members

Humana Contracts with CleanSlate Centers to Provide Opioid Addiction Services

SEPTEMBER 27, 2017

Humana Jointly Acquires Kindred, Expands Into Patient Care

New agreement provides Humana Medical Group with access to Kindred's

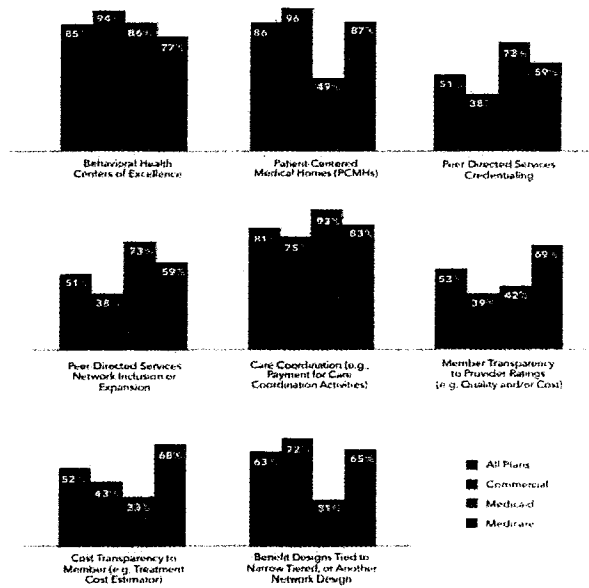
UnitedHealth's Optum To Take Over California Health System's Non-Clinical Operations

Beacon brings mental health services to Texas Walmart store

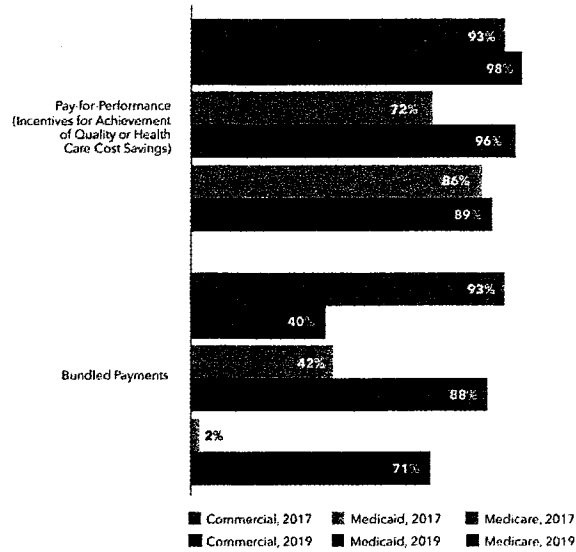
Beacon Care Services, which is part of behavioral health company Beacon Health Options, has opened a mental health clinic at a Walmart location in Carrollton, Texas.

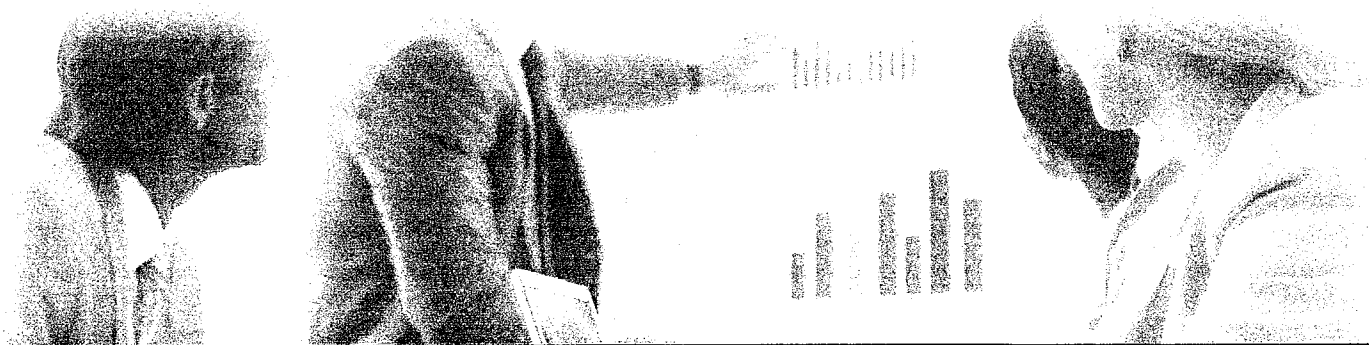
By ERIN DIETSCH

Utilization of Quality Initiatives, Benefit Design, Innovations, and Member Transparency Strategies, by Plan²



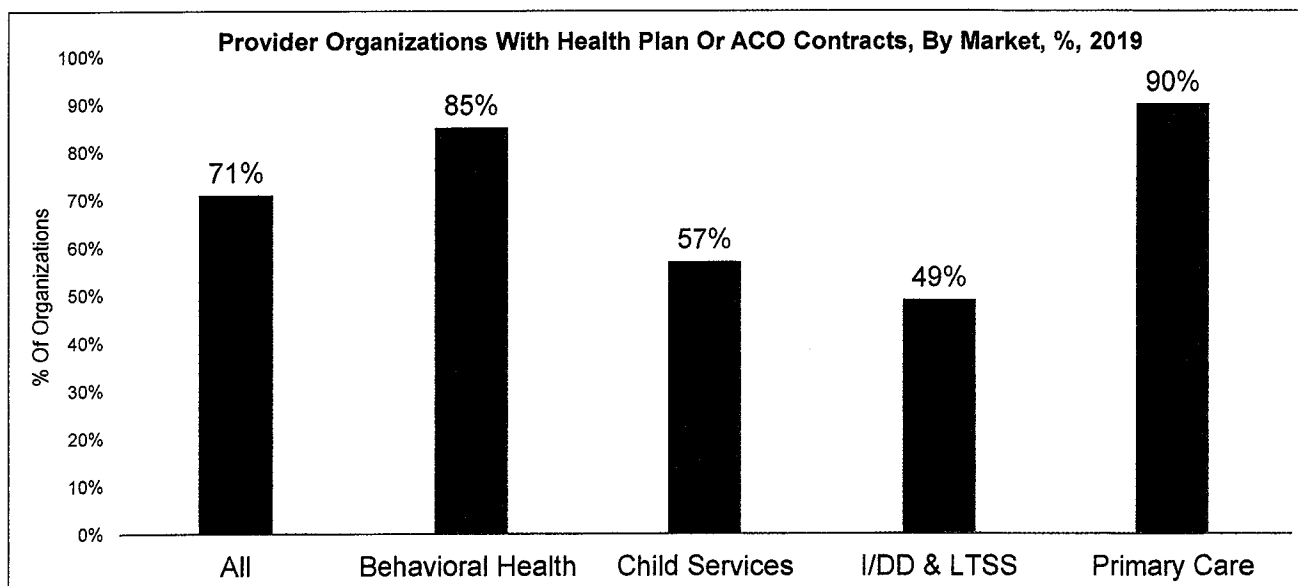
Utilization of Alternative Reimbursement Strategies, 2017 and 2019, by Plan²





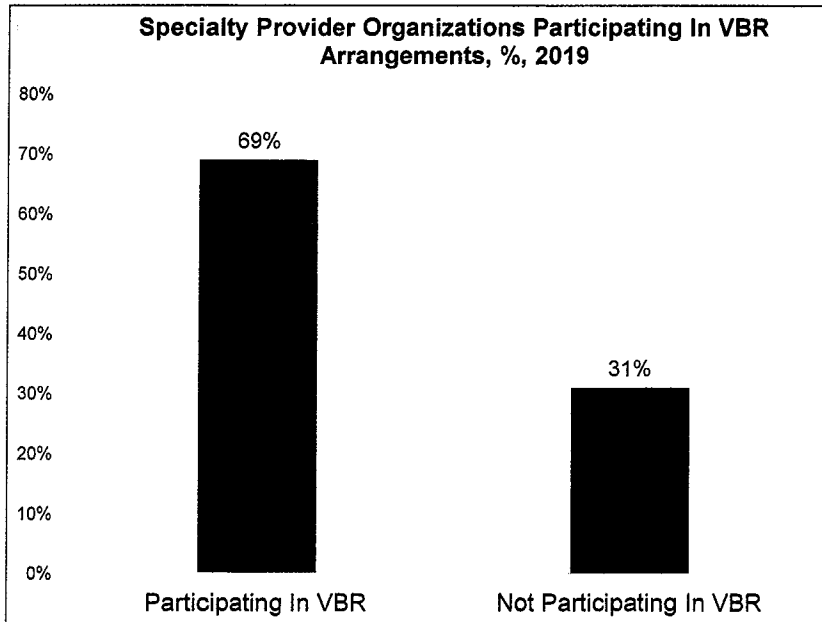
The Provider Organization Perspective

71% Of Specialty Provider Organizations Have Contracts With Health Plans



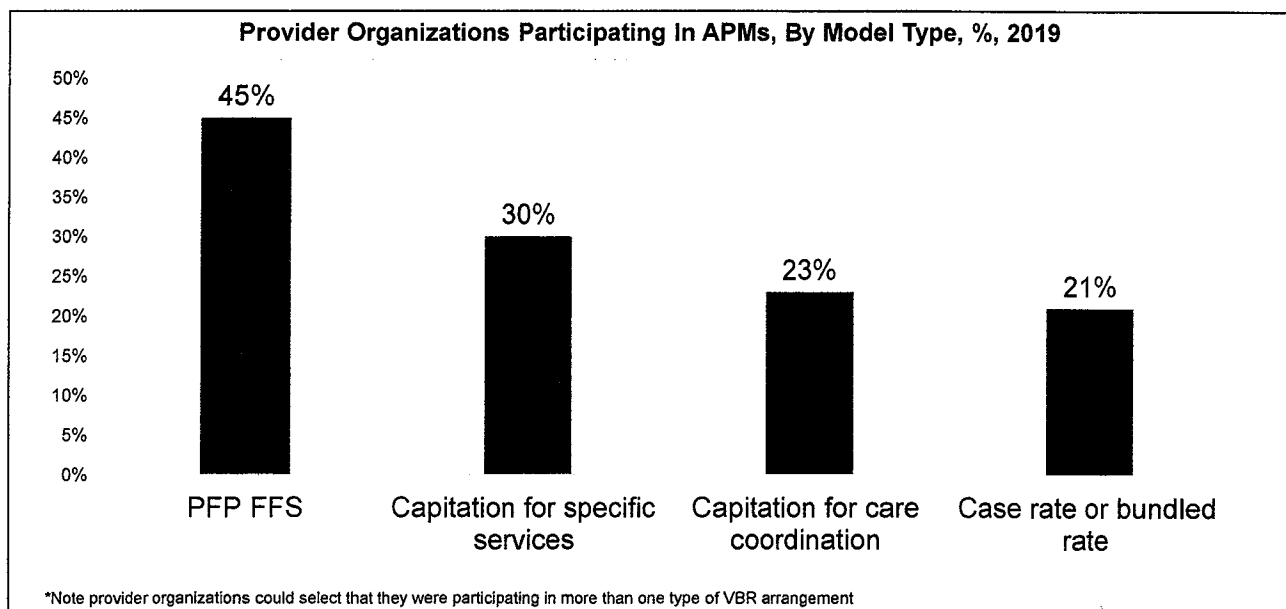
Health plan includes commercial health plans, Medicaid managed care plans, and Medicare Advantage plans

69% Of Provider Organizations Are Participating In VBR Or PFP Arrangements

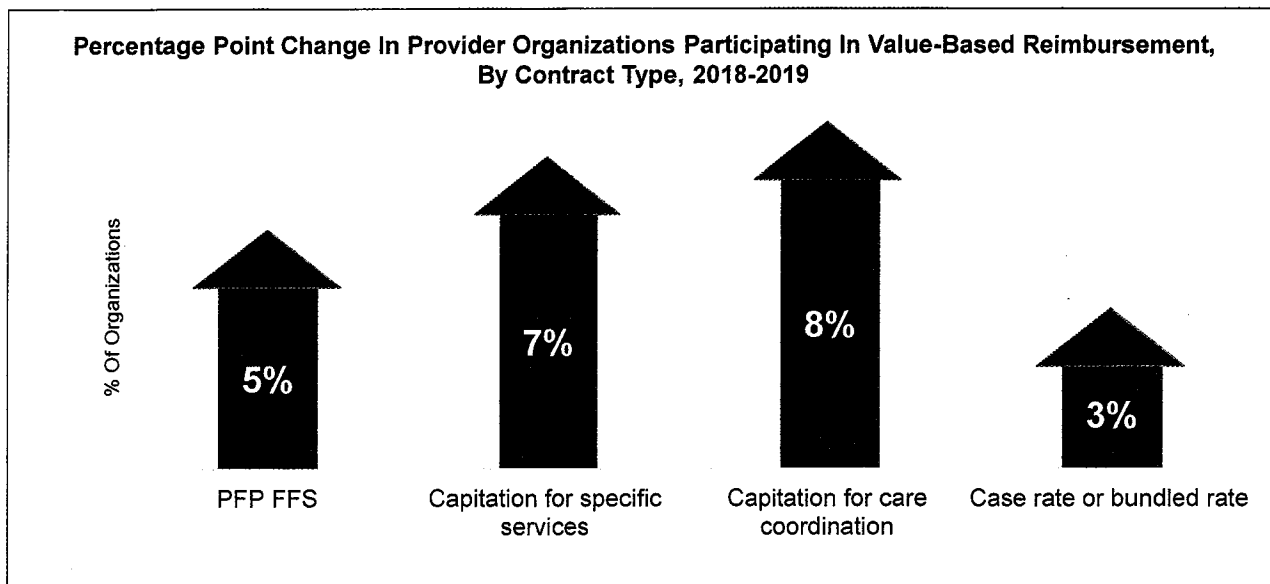


58% realizing any revenue from these contracts. . .

Distribution Of VBR Models Is Changing



Percentage Point Change In Specialty Provider Organizations Participating In Value-Based Reimbursement, By Contract Type, 2018-2019

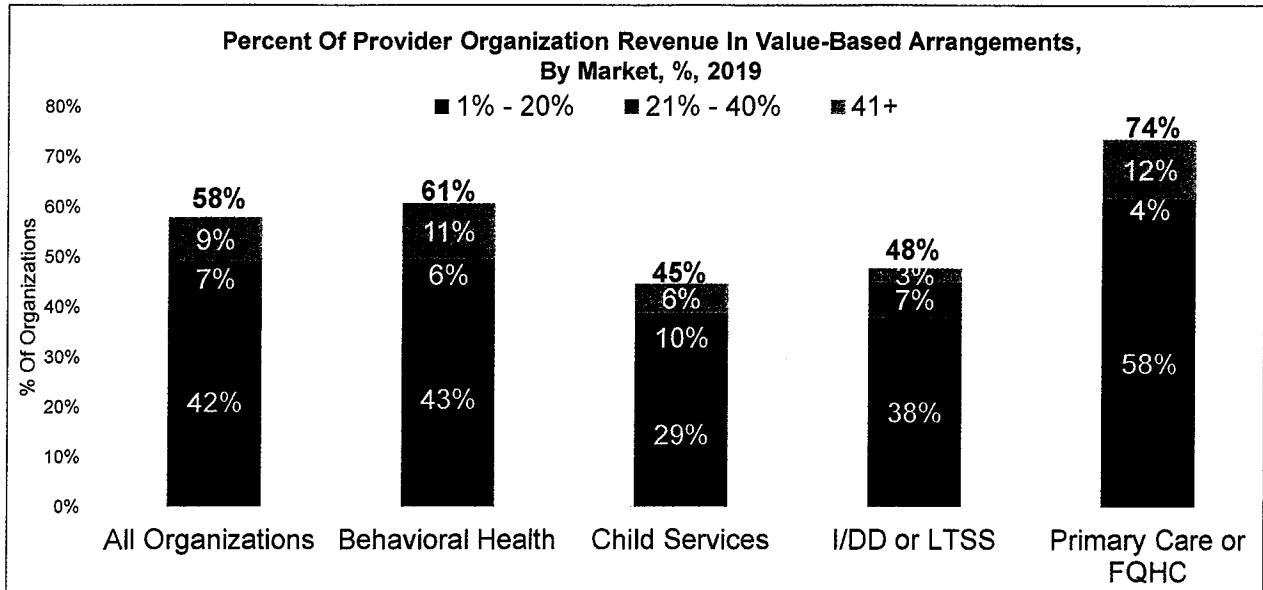


Participation In VBR Arrangements, By Market, %, 2019

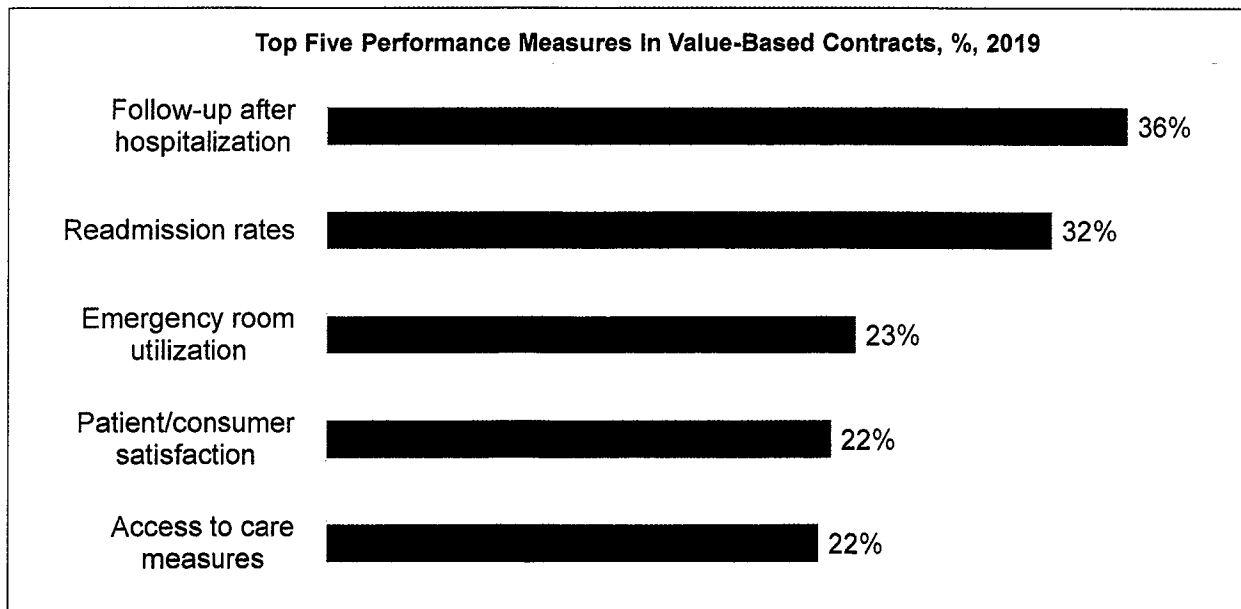
	Participation In Any VBR Arrangement	PFP FFS	Capitation For Specific Services	Capitation For Care Coordination	Case Rate Or Bundled Rate
Primary Care or FQHC	85%	77%	31%	50%	15%
Behavioral Health	72%	46%	32%	20%	24%
Child Services	58%	35%	29%	16%	23%
I/DD or LTSS	55%	24%	21%	17%	17%

*Note provider organizations could select that they were participating in more than one type of VBR arrangement

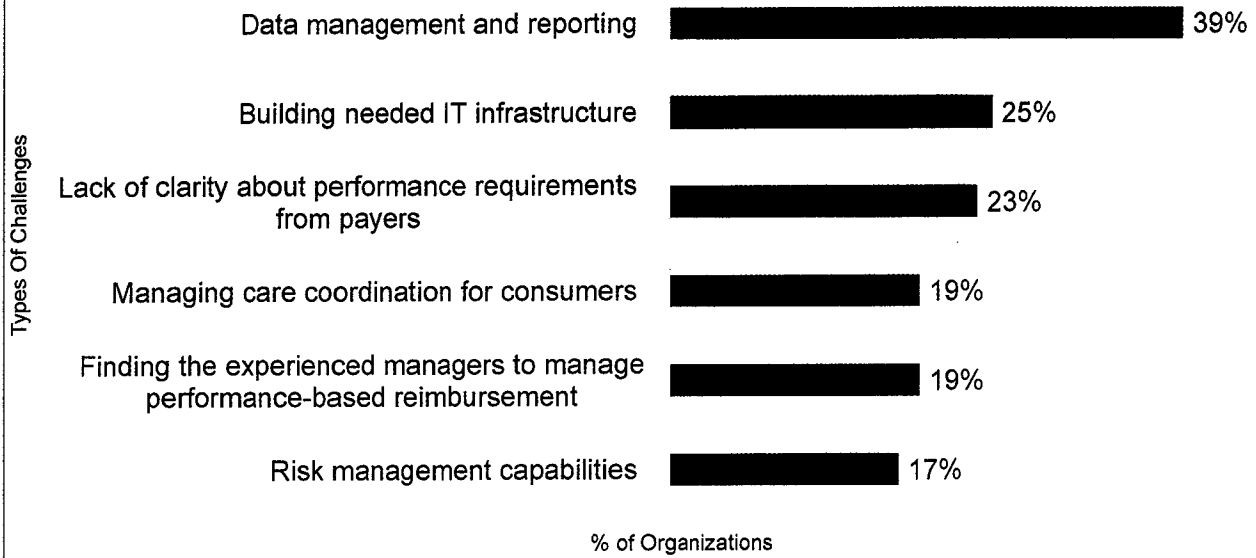
Proportion Of Revenues From VBR/PFP Contracts Varies. . .



Follow-Up After Hospitalization & Readmission Rates Are The Most Common Measures Of Performance



**Top Five Challenges To Managing Value, %, 2019
Specialty Provider Organization Executive Teams**



Why Is “Value” The Big Focus?

Payer costs continue to escalate
– employers, Medicaid, Medicare

- Aging population, population with more disabilities, cost of new administrative and service fragmented services

Public policy and payer policy to ‘integrate’ care coordination for high-needs consumer

- Volume-based reimbursement ineffective reimbursement model for consumers

Lack of link of payment quality, outcomes, performance or consumer experience

A “great experiment” underway in non-volume-based payment – PFP, APM, VBR, PFS

The Move To “Value” For Consumers With Chronic Conditions & Complex Needs – The Issues

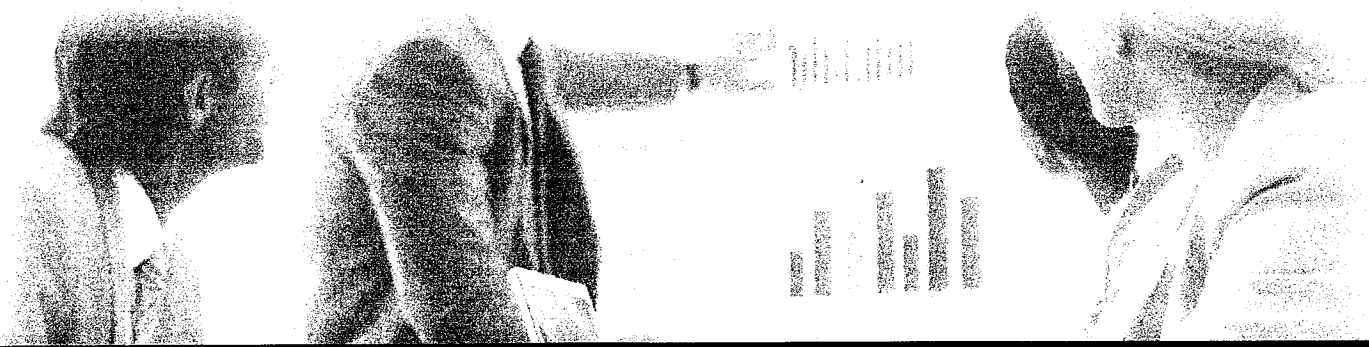
1. The ‘integration’ versus ‘specialization’ argument
2. Adapting performance measures for appropriateness for these consumer groups
3. Financing and reimbursement models that are adjusted for consumer characteristics
4. Organizations serving these consumer groups are ‘behind the curve’ – culturally and administratively
5. The health data interoperability mess
6. The missing ‘metrics’ view of consumer wellbeing and experience at the provider/professional service level

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For health plans – identifying best model for most effective services – and performance measures - for consumers with chronic conditions and complex needs

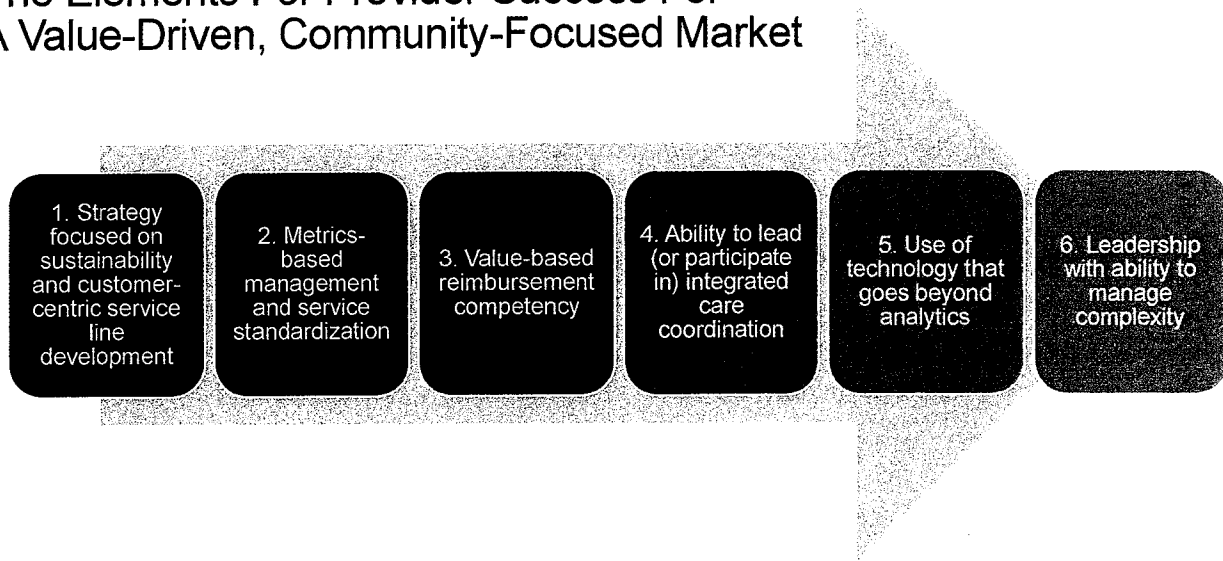
For provider organizations – creating platform for performance measurement of service system and using that to develop ‘most desirable’ models



III. Best Practice Performance Management

6 Key Competencies

The Elements For Provider Success For
A Value-Driven, Community-Focused Market



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