Alternative Payment Models for Behavioral Health

Kim Cox – VP, Provider Network

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Vice President,
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- Kim Cox is Vice President of Provider Network. She joined Optum in February of 2011 as the Central Region Vice President of Network Services. In that role, Kim is responsible for coordinating all recruitment, contracting, and provider services for a network of over 40,000 providers, and 900 behavioral health facilities assuring members have access to quality providers and a broad continuum of care.
- In Kim's current role, she facilitates innovative network programs to address member access needs and increase provider engagement such as:
    - Telehealth implementation
    - Medical-behavioral integration
    - Pay for value programs

  As a result Optum is a recognized leader in payment reform that aligns incentives to improve member outcomes.
- Using her background in business management and health care analytics, Kim entered the managed health care field 22 years ago. She has worked in a variety of capacities including network contracting and analytics, provider service, and product development in local, regional and national organizations.
- Prior to Optum, Kim gained valuable managed care leadership experience through roles at CIGNA, Aetna, and other national health insurance companies.

About Optum's Behavioral Solutions

Optum is a collection of technology-enabled health services companies, including the largest managed behavioral health company in the country

We work with our business partners to build comprehensive and integrated systems of care that address behavioral health issues in order to improve overall population health

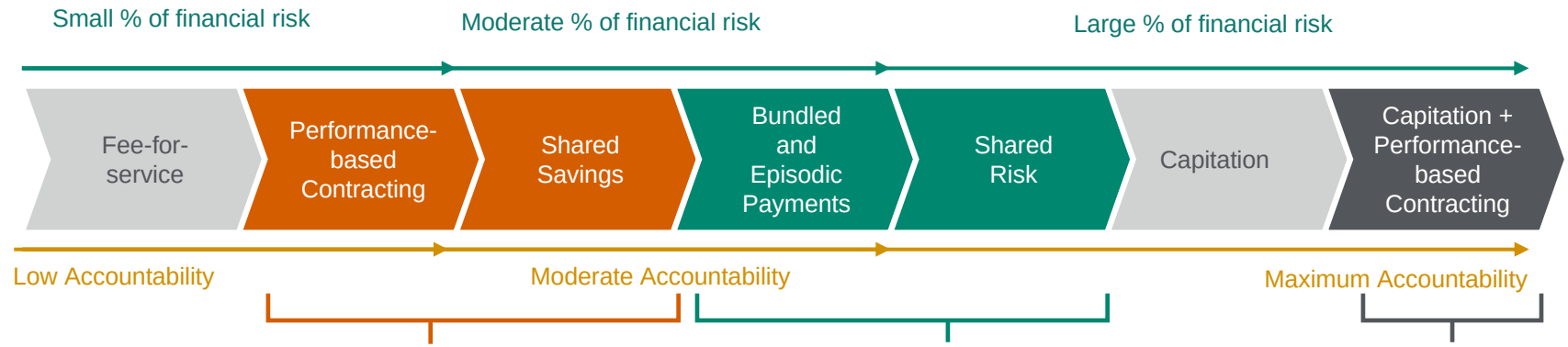
- Serving >50 million Americans[1]
- Largest performance-tiered behavioral health network in the country[3] (145,000+ providers nationally)
- Staff of 1,100+ licensed Care Advocates and 70+ board-certified psychiatrists[4]
- Recognized quality leader

1. Membership count conducted by T. Corning, Optum Finance Consultant, on 12/8/15, based on 2016 monthly average of unique contracted lives. 2. Comparison of Behavioral book of business against Fortune 500 listings by G. Chacin on 5/1/13. 3. Based on an Optum competitive study through a national third-party research firm, September 2015. 4. Clinical staff count conducted by K. Keytel, Optum VP of Care Advocacy Clinical Operations, on 11/13/15.

Optum Network Priorities

Engagement	• To become the most respected managed care organization • To treat our providers as important customers and valued resources • To listen and respond to provider's needs and expectations
Transparency	• To provide feedback to providers to promote improved performance • To facilitate informed decisions through cost and quality transparency • To provide real-time access to the right providers at the right cost
Affordability	• To use tools that support a shift towards outcome-based payment models and delivery systems • To use network tiering to support access to preferred providers or places of service • To use network tools to make the healthcare system more engaging, effective and affordable in the local community

Our work in the reimbursement continuum



Examples	P4P/Shared Savings Contracts with Qualified Facilities and Outpatient Providers (national footprint across all payor types)	• SUDS Medication Assistance Therapy (MAT) Providers • DRG	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 adj) •Cost: Case-mix adjusted ALOS and episode cost	• Quality: Readmit rate (case-mix adjusted) – 30 and 90 day • Cost: Case-mix adjusted average visits per episode and episode cost • DRG/Bundled payment methodology	8 metrics across 6 domains •Care coordination •Care transition •Referral management •Health promotion •Individual support •Family/caregiver support
Results	• 15% to 20% reduction in readmit rates • Ambulatory follow-up rate improved from 3% to 10%	Reduced readmissions Improved community tenure	Improved care coordination •9% increase in adherence to quarterly PCP visits •4% increase in primary caregiver or peer support linkages

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 search 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

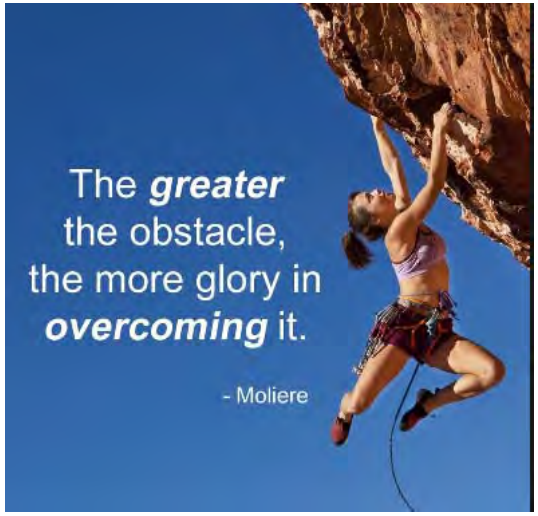
Cost

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



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)