Growing Your Market: Focus on New Payment Methodologies

Colorado Behavioral Healthcare Council
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Sandy Forquer, Ph.D. Senior Vice President State Government Programs
OptumHealth™ Public Sector

Agenda

- About OptumHealth
- About Building Sustainable Health Communities
- New/Proposed Payment Reform Methodologies
- The Role of Payment Reform Methodology in Driving Change
- An OptumHealth example
- Roles for Community Mental Health Centers (CMHCs) in Supporting Commercial Membership
- How to Prepare

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About OptumHealth

- Industry leader in population health management, serving both the medical and behavioral health needs of consumers and communities nationwide
  - Over five million Medicaid and Medicare members
  - Every kind of organizational/program type (carve-out, carve-in, integrated, etc.)
  - Persons from all walks of life in employer- and government-sponsored programs
- Part of the Optum™ family of companies owned by UnitedHealth Group:
  - OptumHealth
  - OptumInsight™ (formerly Ingenix®), one of the largest health information, technology, and consulting companies in the world
  - OptumRx™ (formerly Prescription Solutions®), the pharmacy management leader in service, affordability, and clinical quality
- Intensely recovery-focused organization

Our **MISSION** is to help people live their lives to the fullest

The Optum Family

Information and technology enabled health services platform encompassing:

- Technology solutions
- Intelligence and decision support tools
- Health management and interventions
- Administrative and financial services
- Pharmacy solutions

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Optum and Sustainable Health Communities

- We believe that the health system is going to work better one community at a time
- We believe that no single payer can create meaningful and lasting change alone
- We need to begin to work together in new ways across the health system – consumers, providers, employers, support services, government, and individuals
- To be sustainable the Health Community must be; Connected, Intelligent and Aligned
- We can ultimately enable better care outcomes, more efficient use of resources and happier and healthier people
- New payment methodologies can help drive the development of sustainable health communities

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OptumHealth's Public Sector Commitments

Significant **capital and infrastructure investments** over the last 4 years	**2.9 million** Medicaid and State Children's Health Insurance Program (SCHIP) members in 22 states	**1.7 million** Medicare members in 33 states
1,500 Public Sector staff	Strong Colorado Presence **710,000** commercial lives **84,000** Medicare lives	**400** consumer and family organizations trained

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New/Proposed Payment Reform Methodologies (PRMs)

- Summary of February 2011 RAND® Technical Report on:
  - Payment Reform: Analysis of Models and Performance Measurement Implications (by Eric C. Schneider, Peter S. Hussey, and Christopher Schnyer)
- This study, funded by the National Quality Forum, cataloged nearly 100 implemented/proposed payment reform programs
- As a result of their analysis, eleven payment models were identified as well as the performance measurement needs associated with each model
- All performance measurements were designed to address one of two goals-quality improvement and/or cost containment
- Measures are aligned with the Triple Aim

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Payment Reform Goals

Quality Goals

- Increase or maintain appropriate and necessary care
- Decrease inappropriate care
- Make care more responsive to patients
- Promote safer care

Cost Containment Goals

- Reverse fee-for-service (FFS) incentive to provide more services
- Provide incentives for efficiency
- Manage financial risk
- Align payment incentives to support quality goals

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Function of Metrics

- RAND study concluded that measures must perform two functions:
  - Measures need to set performance-based incentives
    - New PRMs create incentives by adjusting payment amounts based on measured performance:
      - Determining whether a payment occurs or determining non-payment for services if linked to poor quality of care
  - Measures need to protect against unintended adverse consequences such as:
    - Avoidance of high risk, high cost patients by providers
    - Other barriers to access and underuse of evidence-based services

Note the evolving relationship between quality and finance

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Brief Descriptions of New/Proposed PRMs

Global payment	• Single pmpm for all services delivered to patient
Accountable Care Organization (ACO) shared savings program	• Groups of providers that voluntarily assume responsibility for the care of a population of patients and share payer savings if they meet quality and cost performance benchmarks
Medical home (RAND does not address Health Home)	• A physician practice or other provider is eligible to receive additional payments if medical home criteria are met. Payment may include calculations based on quality and cost performance using a Pay-for-Performance mechanism
Bundled payment	• A single “bundled payment which may include multiple providers in multiple care settings, is made for services delivered during an episode of care related to a medical condition or procedure
Payment for coordination	• Payments are made to providers furnishing care coordination services that integrate care between providers. Approaches offer flexible financing to multidisciplinary teams of providers and then measure cost and health outcomes to assess how cost and quality improve over time
Payment adjustment for readmissions	• Payments are adjusted based on the rate of potentially avoidable readmissions

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Attributes of PRMs

- Models presented can be categorized by four attributes:
  - Performance measured by a population
  - Performance measured by an Episode of Care
  - Performance across more than one type of delivery organization
  - FFS payment applied to one or more newly specified services
- Only three of the PRMs accommodate all four attributes:
  - Medical homes
  - Bundled payment
  - Payment for coordination

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RAND Guidance for Development of Performance Measures

- Important to note that while the RAND study has highlighted principles of performance measure development and specific design recommendations, performance measures still need to be defined

Guidance for Global Payment Methodology

- Need to reflect broad range of services used to care for a population
- Need to include key indicators such as health outcomes
- Need to enable longitudinal population-based measurement of the care services
  - Length of time period addressed by longitudinal measure-fixed or variable
  - ID provider holding global payment
  - Range of providers participating
  - Range of services provided

Guidance for ACO Methodology

- Same as guidance for Global Payment Methodology plus features of ACO management responsible for allocating shared services

Guidance for Medical Home Methodology

- Performance Measures need to reflect the adoption of care processes and structural capabilities that enhance continuity of care and its coordination
- Also need to assess whether care is patient-centered, including the outcomes of primary care, patient experience and patient-caregiver engagement

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RAND Guidance for Development of Performance Measures

Guidance for Bundled Payment Methodology

- Need to relate to conditions targeted by bundles
- Need to be tailored to care delivery settings that participate in delivering components of the care bundle
- Can be used to detect negative consequences of the payment model
- Need to assess care coordination within and across episodes (or bundles)

Payment for Coordination Methodology

- Assess whether care coordination activities are accomplished
- Assess costs, service utilization, patient experience, and health outcomes of persons who receive care coordination services

Payment Adjustment for Readmissions Methodology

- Needs to emphasize aspects of care under organization's control
- Can be used to address adverse outcomes (such as patient's experience measures)
- Can be used to understand processes that influence risk of readmission and can help redesign the discharge transition to reduce readmission rates

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The Role of Payment Reform Methodology in Driving Change

Major message:
“Health care reform is a journey to top performance”

- Shift from acute-care focus to a population-management focus; shift from “sick care” to “health care”
- IT systems will need new “robust” functionality for bundled payments, sub-capitation and data reporting in order to manage risk effectively in new financial arrangements
- New relationship between quality and finance
  - Recent article in *Hospital and Health Networks* (November 2010) discusses finance-quality integration
  - “Quality will explicitly determine how you are paid”
  - Finance needs to understand quality measures attached to payment; quality needs to understand financial impact of each quality/performance measure and its cost, if not met
  - Value-based purchasing

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An OptumHealth Example: Setting the Stage in New Mexico

- Beginning in 2004, New Mexico formed the Behavioral Health Collaborative, which consists of 15 state agencies who pool all behavioral health funds, including Medicaid.
- These funds have been managed by OptumHealth New Mexico (OHNM) since July 2009.
- 25% of the population is enrolled in Medicaid
- 23% of the population remains uninsured
- New Mexico child poverty rates rank with W. Virginia, Louisiana and Mississippi

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Setting up the Pilot

- Goal: Increase community tenure for consumers with history of Out-Of-Home (OOH) placements
  - Measured by: Reduction in OOH placements of 15-25% or more during measurement period and no significant increase in incident rate or readmit rate (Inpatient and Residential Treatment Services)
  - Population: Children and adolescents (under 18 years old) who had at least one out of home placement
  - Baseline Measurement Period: 7/1/09-4/30/10
  - Performance Contract/Review Period: 9/0/10 – 2/28/11 and 10/1/10-2/31/11 (six months)
  - Three Core Service Agencies in three different counties were chosen to participate

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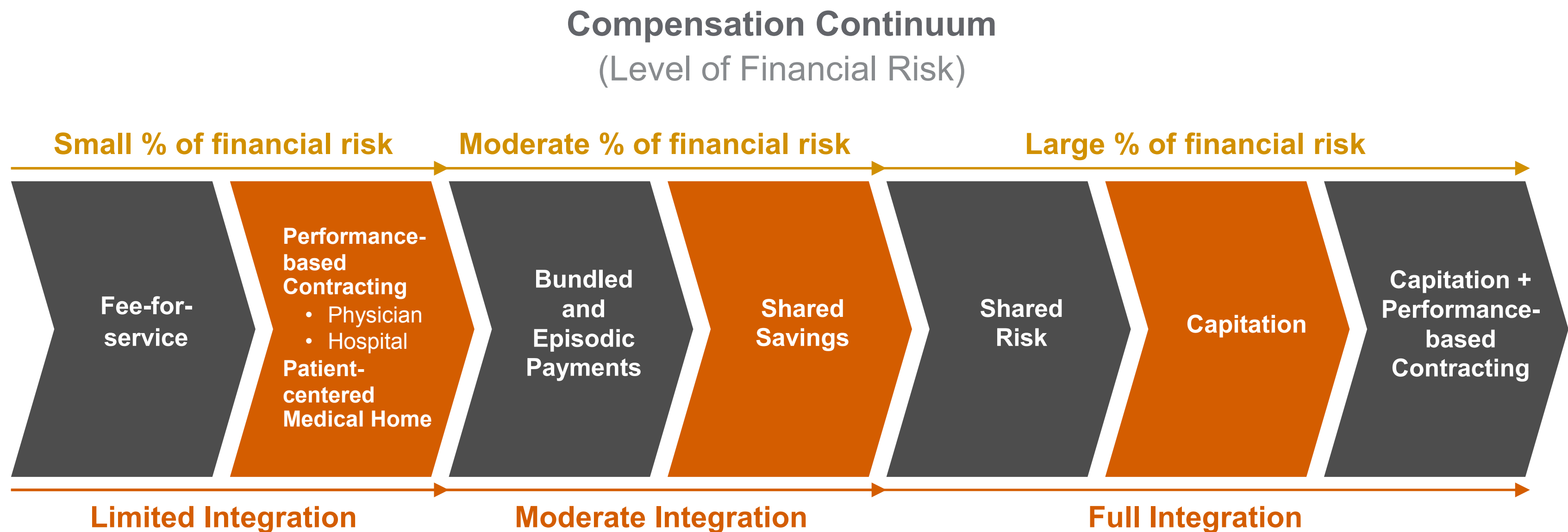
Value-based Payments and Network Innovation as Tools

- The shift toward increased collaboration, outcome-based payment, and new benefit design is driving innovation in both payment models and delivery system configuration.



Continuum of risks represents multiple value-based contracting options. OptumHealth is working to deploy a variety of options with its network of providers based on their readiness to accommodate varying levels of risk.

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Provider Participation Requirements

- Approved Core Service Agency provider
- Demonstrated use of Evidence-Based Practices (EBP) including Multi Systemic Therapy as well as offering Behavior Management Services and Comprehensive Community Support Services (CCSS)
- Current OOH membership of 10 or more consumers
- Demonstrated use of peer and/or family support models (e.g., hiring of peer advocates, use of peers/family members as non-independent providers where regulatory requirements allow)
- Participated in weekly clinical rounds with OHNM staff
- Participated in regular meetings to review data findings
- Claims to be submitted within 15 days

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Metrics

- Total OOH units Inpatient, Residential Treatment Center, Group Home, Transitional Living Services, Treatment Foster Care and outpatient by member
- Migration Reports (illustrating cohort across each level of care)
- Readmit rate for Residential Treatment Centers and Inpatient hospital setting
- Critical Incident reporting – Count and % of membership cohort

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Performance Awards

- Percent reduction in OOH units pmpm comparing baseline period to the performance review with a target threshold of 20% reduction
- Payment is contingent upon review and compliance with the following quality measures:
  – Readmit rate for Residential Treatment Centers or Inpatient for performance period will not exceed baseline period by >2%
  – Incident rate for performance period will not exceed baseline period by >2%
- Migration reports demonstrate increase in cohort use of community-based services

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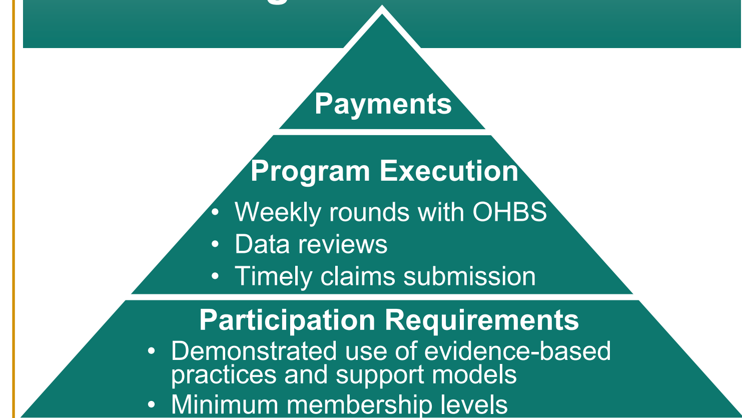
Pay-for-performance contracting shows encouraging results to date and result in system of care improvement

Pilot Background & Objectives

- In New Mexico, a performance-based contracting initiative aimed at improving affordability, quality outcomes and member health was launched July 2010
- Specific objectives were to increase community tenure for consumers with history of Out-Of-Home (OOH) placements within the New Mexico public sector population

Program Structure



Measured Outcomes

Metric	*Target*	*Achievement*
Reduction in OOH Units	20%	55%
Readmit Rate	Not to exceed baseline by more than 2%	Readmit Rate Declined
Critical Incidents	Not to exceed baseline by more than 2%	Critical Incident Rate Declined

Post-Pilot Expansion

- Identified ~25 high volume facilities serving both commercial and public sector members as part of a phased implementation effort
- Aligning incentives to achieve reduction in average length of stay (ALOS), readmissions, and improvements in HEDIS 7-day ambulatory follow up
- Provider has opportunity to earn rate escalator based on achievement levels

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Roles for CMHCs in Supporting Commercial Membership

- Provide mechanisms for commercial membership to navigate peer recovery and or health/wellness programs
- Provider direct service especially in areas with shortage of behavioral health providers
- Become spokesperson for how to manage within a system of care model (e.g., ACO or BHO-like model)
  - CMHCs have always had to operate more within a Core Service Agency type approach vs. commercial providers that operate in a more “stand-alone” approach
  - Provide Peer Bridger Services
- Become advocates for medical/behavioral integration

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What You Can Do Now to Prepare:

- New focus on top performance both inside your walls and in the community at large
  - Taking health care to the community vs. bringing the community to you
  - Building new community relationships, strategic partnerships with allied systems of care
  - Care coordination and clinical integration
- **Use data:** invest in data capture and management
- **Track your outcomes:** talk about your accomplishments

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What You Can Do Now to Prepare (cont.):

- Be creative: conduct pilots and share what you learn
- Stick to your budgets: operating discipline could be the difference between remaining viable and closing your doors
- Consider reading The Innovator's Prescription: A Disruptive Solution for Health Care by Clayton M. Christensen
- Notice emphasis on creating value networks
- Think about how peer- and family-run programs can become part of your future value network

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Thank you.

For more information, please contact:
kenneth.anderson@optum.com
sandra.forquer@optum.com

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