Strategic Revenue Diversification: The HealthPath Commercial Health Home Case Study

The 2017 OPEN MINDS Strategy & Innovation Institute
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HealthPath
Commercial Health
Home Case Study

Ian Lang, Executive Director, Continuum Behavioral Health
Rena Sheehan, Director, Behavioral Health, Blue Cross & Blue Shield of Rhode Island
Transforming the Behavioral Health System Through Partnership

Breaking through Barriers to Achieve Better Care at Lower Cost

Open Minds Conference
Presenters

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An insurer, a hospital system, and a community provider walk into a room…
The Need for a New Approach

RI’s Unique Population
*Highest rates of adolescent and adult illicit drug use and dependence in New England
*Highest rates of psychological distress in adults 18-64 in new England and nationally
Spend concentrated on inpatient as opposed to home and community based care

Financial Model
Predominantly fee for service
Specialty BH hospitals rely on volume, limited incentives for cost effective care,
Limited pay for value programs in BH

Care and Services
Intermediate and Home and Community Based options limited and often cost prohibitive
Lack of coordination among BH providers and between BH and medical
BCBSRI Network is large, and fragmented with the majority individual and small group practices.

• The BH system is difficult to navigate, the ER is often the fastest point of entry for MH and for SUD out of network options offer easy access
• Provider advocacy and abrasion high relative to UM and member cost sharing.

*Source: The Truven Study
What is HealthPath?

- Evidence Based Treatment Program
- Alternative Payment Model
- Patient Centered Care
Why HealthPath?

- Promote cost effective care
- Meet the member's needs
- Fill network gap
- Advance quality measurement
- Drive payment innovation
Who Are We Serving

• Total Population 225 – 165 commercially insured & 60 Medicare Advantage (5/1/2017)
• Average HealthPath member cost approximately $3,900 per month ($2,900 is their behavioral health costs) in year prior to HealthPath Enrollment
• Approximately 85% referred and engaged post inpatient admission
• Wide age range: 18-80
• Primary diagnosis include personality disorder, mood disorder, bipolar disorder, substance use, and Psychotic/schizophrenic disorder
  • 50% co-occurring substance use disorder
• Insurance risk scores rate this population as much as 18X riskier than average population
• Average DLA score at Intake of 32
Building a Foundation of Trust
Discovery of Shared Interests Serve as Foundation of Partnership
Governance Structure Critical to Success

- Leadership Committee
- Oversight Committee
- Care and Service Committee
Breaking Down Barriers
## Payers Barriers

<table>
<thead>
<tr>
<th>Barriers to Insurer</th>
<th>HealthPath Breakthrough</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber agreements define benefit structure and cost sharing.</td>
<td>Reclassify benefit and identify appropriate coding.</td>
</tr>
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</table>
| Utilization review process facilitates right care at the right level | Case collaboration  
Shared savings |
| Substance use disorder privacy laws | Three party release of information  
Process to support information transfer |
### Member Barriers

<table>
<thead>
<tr>
<th>Client Barriers to Care</th>
<th>HealthPath Breakthroughs</th>
</tr>
</thead>
<tbody>
<tr>
<td>High out of pocket costs limit access</td>
<td>One co-pay for all services&lt;br&gt;Out of pockets costs capped at $40&lt;br&gt;Benefits categorized as outpatient level of care</td>
</tr>
<tr>
<td>Services are medical in nature and don’t address social determinants</td>
<td>Case management, Primary Care Coordination, Work Support</td>
</tr>
<tr>
<td>Services aren’t available when and where clients want them</td>
<td>Evening and weekend hours&lt;br&gt;Telemedicine and community based services provided&lt;br&gt;Transportation available</td>
</tr>
<tr>
<td>Patients with complex needs must access services from multiple providers</td>
<td>Treatment team approach allows patient to receive all care under one roof&lt;br&gt;minimizing breakdowns</td>
</tr>
</tbody>
</table>
**Get out of the way and let care team provide care**

<table>
<thead>
<tr>
<th>Barriers to Provider</th>
<th>HealthPath Breakthrough</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types of services limited by billing codes</td>
<td>Bundled rate allows for flexibility in services delivered: Telemedicine; phone calls; community visits etc.</td>
</tr>
<tr>
<td>Payment tied to volume</td>
<td>Rate structure allows us to provide right service, right place, right time</td>
</tr>
<tr>
<td>Transition between levels of care complicated by prior authorization process</td>
<td>Clients can move between all BH levels of care in the CNE system without review</td>
</tr>
<tr>
<td>Multiple authorizations often needed to continue long-term treatment</td>
<td>All HealthPath clients automatically authorized for 1 year</td>
</tr>
</tbody>
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Finding the Right Financial Model

<table>
<thead>
<tr>
<th><strong>Barrier</strong></th>
<th><strong>Breakthrough</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Start Up Costs</td>
<td>Initial Investment for all partners</td>
</tr>
<tr>
<td>Cost effective and sustainable pricing model</td>
<td>Pricing based on historical claims</td>
</tr>
<tr>
<td>Accountability for both cost effective care and outcomes</td>
<td>Shared savings arrangement based on total cost of care</td>
</tr>
</tbody>
</table>
Shared Outcomes Foster Trust and Continued Collaboration

Customer Care & Experience

- Pilot participation
- Program retention
- Successful completion of program

- Financial Barriers
- DLA\(^3\) score/improvement %
- Days in Community\(^1\)
- Readmission rate % (new)
- Patient satisfaction scores
- Timely meeting w clinician after discharge (Hedis)
- Medication Adherence\(^2\)

Financial

- PMPM Reduction in total medical expenses from relevant baseline
- Shared savings distribution aligned with investment

Administrative/Operational

- Timely and accurate payments
- Timely and accurate information exchange
- Timely and accurate performance reporting
- Accuracy of processing participant cost share
- Adequacy/right-size of staffing model

Market Impact

- Pilot acceptance rate
- Number of employers participating
- Number of participating/referring orgs
- Perception of quality/service/reputation
- Brand recognition/positive press impressions

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* Level of people that stay with the program (vs. level of dropout against staff advice)
\(^1\) Not enough claims history to determine yet
\(^2\) Pilot decline or termination for financial reason (copay or deductible)
\(^3\) Daily Living Assessment – Patient Functionality Test
\(^4\) Target of 33% of total eligible (65% of 50%); actual of 39% of total identified to date
# Patient Experience

<table>
<thead>
<tr>
<th>Patient Satisfaction</th>
<th>Patient Informed Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 80% satisfaction</td>
<td>Highly effective</td>
</tr>
<tr>
<td>&gt;30% completion rates</td>
<td>67% participants</td>
</tr>
<tr>
<td></td>
<td>clinical improvement</td>
</tr>
<tr>
<td></td>
<td>76% of patients</td>
</tr>
<tr>
<td></td>
<td>within appropriate</td>
</tr>
<tr>
<td></td>
<td>clinical range</td>
</tr>
</tbody>
</table>
## Outcomes

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
</table>
| **DLA Score Improvement**        | • 53% significant improvement  
• 31% improvement  
• 16% no change |
| **Total Cost of Care**           | • 56% reduction in BH costs and 27% reduction in overall costs per month over post HealthPath period for successfully completed members vs comparison group |
| **Days/1000**                    | • 45% reduction in inpatient utilization for HealthPath members |
| **ALOS & Readmission rates**     | • Trending positively: slight decrease in ALOS for opt ins & members were 2.5 times less likely to readmit. |
The Final Frontier – Merging the Public and Private Markets

• You have the tools that will work in the private market –

• Expansion of managed Medicaid plans and decision to bring BH into plans will further blur the lines between the commercial and public markets.

• You are the only ones with the expertise to serve this population – It doesn’t exist in the traditional commercial marketplace
The Journey Never Ends
Appendix
# Appendix Proposed Revised Performance Goals

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Target</th>
<th>Goal</th>
<th>Stretch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful Completion</td>
<td>40%</td>
<td>50%</td>
<td>55%</td>
</tr>
<tr>
<td>DLA Score Improvement</td>
<td>75%</td>
<td>80%</td>
<td>85%</td>
</tr>
<tr>
<td>Days in Community (% increase)</td>
<td>60%</td>
<td>65%</td>
<td>75%</td>
</tr>
<tr>
<td>Readmission Rate 7 day (% decrease)</td>
<td>25%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Readmission Rate 30 day (% decrease)</td>
<td>0%</td>
<td>5%</td>
<td>15%</td>
</tr>
<tr>
<td>ALOS BH (% decrease)</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Med Adherence</td>
<td>Need more info</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OnTrack</td>
<td>Determine appropriate measure for engagement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMPM Reduction</td>
<td>Need comparison Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pilot Participation (% of those referred who accept)</td>
<td>70%</td>
<td>75%</td>
<td>80%</td>
</tr>
<tr>
<td>Loan Payback</td>
<td>TBD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix: Leading Indicators

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Leading Indicators Report</th>
<th>What will this report tell us?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Successful completion</strong></td>
<td>Discharge (dc) reasons</td>
<td>By reviewing the # and % of members discharged for reasons that are within the control of the Healthpath program monthly, the group will be able to identify any negative trends and problem solve ways to address in order to meet targets.</td>
</tr>
<tr>
<td></td>
<td>On track survey</td>
<td>Member completion of the alliance questions on the on track survey is an indicator of engagement in the program and engagement is an indicator of potential for success in the program.</td>
</tr>
<tr>
<td><strong>DLA Improvement</strong></td>
<td>DLA improvement</td>
<td>DLAs are completed for each member quarterly based on the completion date of the admission.</td>
</tr>
<tr>
<td><strong>Utilization Statistics</strong></td>
<td>Admissions to a higher level of care</td>
<td>How is the program impacting utilization of higher levels of care for these members?</td>
</tr>
<tr>
<td></td>
<td>Admission drivers</td>
<td>What opportunities do the admission drivers present?</td>
</tr>
</tbody>
</table>
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