Five Trends Changing Behavioral Health Managed Care
Participating speakers in “Five Trends Changing Behavioral Health Managed Care” have the following conflict of interest to disclose relative to the content of the presentation:
Gary M. Henschen, MD: Full time employee of Magellan Healthcare
Population Health Management in Behavioral Health Care

PRESENTED BY:
John P. Docherty, MD
ODH, Inc.
Why Behavioral Health (BH) Needs Population Management

- Serious Mental Illness (SMI) Benefits
- Affordable Care Act (ACA) Requires It
- Population Management Needs BH
- Psychiatry Shortage Requires It
Evolution of Population Health and Population Health Management

1990 Evans et al. describe common focus to understand determinants of health

2003 Kindig and Stoddart refine definition to focus on subpopulations and recognizes multiple determinants of health including physical, social and medical care environments

2010 PPACA becomes law, various payment reform programs develop to operationalize Triple Aim and population health management

1997 Kindig defines population health with consideration of cost effective resource allocation

2007 Triple Aim introduced by IHI, provides boost in use of term, population health

2010-2015 many models develop for population health management
The Institute for Healthcare Improvement’s (IHI) Triple Aim

The IHI Triple Aim

Population Health
Experience of Care
Per Capita Cost
Population Health Definitions

The health of the population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services (Dunn and Hayes, 1999)

A conceptual framework for thinking about why some populations are healthier than others as well as the policy development, research agenda, and resource allocation that flow from it (Young, 2005)
Population Health Management: 2 Core Pillars

Identification & Management of Clinically Meaningful Population Segments

Identification & Management of Variables that Influence the Health of the Population Segments
Population Management Care Principles

- Population-based
- Data-driven
- Evidence-based
- Client-centered
- Addressing all the Determinants of Health
- Team-based
- Integration of Behavioral and Medical Care
Drivers of Healthcare Costs in the US

A Small Proportion of Patients Account for Large Share of Cost

- Five percent of patients account for almost half (49%) of total health care expenses in the US\textsuperscript{1-3}
  - Mental disorders are one of the key drivers of this cost, with the top five conditions accounting for the largest shares of total medical spending\textsuperscript{1-3}

Note: Treatment expenditures for individuals in nursing homes, prisons, or under other institutional care are not included. Treatment expenditures for co morbidities and secondary effects of listed diseases are also excluded.

2. MEPS, NHIS, Milken Institute.
Population Condition Overlap

Population with Comorbidities

Mental Illness/Substance Use Conditions

Medical Illness
SMI Experience Higher Mortality Rates


Modifiable and Unmodifiable Risk Factors for Poor Mental Health Outcomes

- Poorer medication management/med discontinuation
- Symptom severity
- Substance use
- Illness course
- Hospitalizations
- Previous relapse
- Incarcerations and violent behavior
- Suicide attempts
- Presence of other psychopathology (particularly schizoaffective disorder)

- Functional status
- Quality of Life
- Family Burden and Social adjustment
- Daily activities
- Cognitive function
- Individual variables
- Medication/med effects
- Previous trauma or developmental disturbances
- Gender
- Age
- Body Mass Index
Advanced Population Health Management

Clinically Meaningful Segmentation + Influencing Variable Management

Population Segments:
- Risk
- Demographic Program-specific
- Health Services
- Personal Health Practices
- Economic
- Health Services Providers
- Legal
- Personal Competence
- Individual Biology
- Childhood Experiences
- Physical
Comprehensive Population Health Management Solution for Behavioral Healthcare
How We Got Here

ODH Uses Select IBM Technologies in the Development of the Mentries™ Behavioral Healthcare Population Management Technology

During Development, ODH and IBM Studied the Needs and Challenges of Managed Care Organizations and Providers Responsible for Populations of People with Behavioral Health Disorders, and Identified Numerous Issues in an Ecosystem Assessment ...
Ecosystem Findings: Problems Facing Health Plans & Providers…

ODH and IBM Worked Together to Conduct an Ecosystem Assessment and What We Found is:

- Disparate data sources – difficult to pull all relevant information together
- Available predictive models focus on Physical Health
- Meaningful advances needed for Behavioral Health
- Challenging governmental reporting environment
- Need for new technology to optimize staff insights & action
- Provider Network Management
  - Transition to alternate payment model
  - Need improved referrals for specific conditions
Information silos create cumbersome user interfaces
The Solution – Mentrics

• Mentrics is a comprehensive behavioral health population management solution
• Mentrics is designed to enable improvements in service performance and identify those persons that would most benefit from care coordination

Coordinate Consumer Care for Those Who Would Most Benefit
Optimize Provider Network Performance Management
Monitor Organizational and Population Health Performance
Identify Pathways to Improve Care Quality
How It Works

+ Authorizations
  - Clinical
  - Local Services

+ Claims
  - Financial
  - Customer Data Source

Data Transformation and Behavioral Health Expertise

Improve Provider Network Performance Management & Population Health Management
Mentrics Analytic Innovations

• Behavioral Health Risk Adjustment System

• Mentrics Cost Deviation Detection System

• Opportunity Analysis

• Risk-Adjusted Rate of Return
How It Works: Background

Risk Stratification

A tool for identifying and predicting who is at high risk, or likely to be at high risk, and prioritizing the coordination of their care in order to prevent poor outcomes

<table>
<thead>
<tr>
<th>Diagnostically-Based Grouping</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chronic Illness &amp; Disability Payment System (CDPS)</td>
</tr>
<tr>
<td>• Hierarchical Conditions Categories (HCC)</td>
</tr>
<tr>
<td>• Health &amp; Human Services (HHS)</td>
</tr>
<tr>
<td>• Centers for Medicare &amp; Medicaid Services (CMS)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Drug-Based Grouping</th>
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<tr>
<td>• Medicaid Rx</td>
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<table>
<thead>
<tr>
<th>Dx/Rx</th>
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</thead>
<tbody>
<tr>
<td>• Chronic Illness &amp; Disability Payment System (CDPS-Rx)</td>
</tr>
<tr>
<td>• Johns Hopkins Adjusted Clinical Groups (ACG Hopkins)</td>
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</tbody>
</table>
Cost Trend for Predicting Change in Risk

Proprietary Cost Trend Analytics Engine Drives Timely Alerts Regarding Unexpected Cost Deviation for Each Person in Treatment

- Cost acceleration
- Cost deceleration

Mentrics’ “Early Warning” System – MCDDS™ (Mentrics (Individual) Cost Deviation Detection System™)

- Identifies critical changes in utilization
  - Normal or expected vs outlier or abnormal (Deviation from normal)
- Alerted prior to bearing full burden of cost acceleration
  - Enables rapid intervention
What is the Significance of Each ODH Segment?

<table>
<thead>
<tr>
<th></th>
<th>High BH Risk</th>
<th>Low BH Risk</th>
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<tbody>
<tr>
<td></td>
<td>High Year 2 Total BH Cost</td>
<td>Low Year 2 Total BH Cost</td>
</tr>
<tr>
<td>High Year 1 Total BH Cost</td>
<td>Persistent High Cost</td>
<td>Cost regressors I (or effectively treated)</td>
</tr>
<tr>
<td></td>
<td>Fraud, waste, abuse or Undertreatment (High PH Risk)</td>
<td>Cost regressors II (High PH Risk)</td>
</tr>
<tr>
<td>Low Year 1 Total BH Cost</td>
<td>Prime targets for intervention</td>
<td>Persistent Low Cost</td>
</tr>
<tr>
<td></td>
<td>Unpredicted high cost</td>
<td>Low'utilizers</td>
</tr>
</tbody>
</table>

High Priority Members are shaded in Red
Control Members are shaded in Green
Cost Regressed Members are shaded in Orange
Summary

- Behavioral Health needs population management
- Remember the Triple Aim
- Focus efforts
- Replace data silos with best practice technology
Trends in Managed Medicaid
Magellan Healthcare's Experience

PRESENTED BY:
Gary M. Henschen, MD, LFAPA
Chief Medical Officer-Behavioral Health
Magellan Healthcare

September 22, 2016
Promoting Better Care

Emphasize population health

Engage technology

Promote effective care coordination

Integrate behavioral health and pharmacy
Care Coordination
Care Coordination

• Identify opportunities for improvement

• Engage stakeholders in plan

• Train plan staff, providers, community

• Measure outcomes

• Reassess to improve interventions
Magellan Healthcare: Looking at Suicide Differently
Background

• With Arizona ranked seventh-highest in the nation for the number of reported suicides, Magellan focused the spotlight on one of the most high-risk groups: those experiencing mental illness.

• It is a fact that individuals suffering from severe mental illness are six to 12 times more likely to die from suicide than the general population.
Purpose

We reviewed suicides from 2009 until 2012 in Maricopa County (Phoenix), Arizona* in the Medicaid population to determine if there were any differences in the risk factors or protective factors for individuals diagnosed with a mental illness and who were receiving treatment, as compared to other studies with similar cohorts.

* Former Magellan customer
Methods

- Extensive review of medical records for 100 consecutive completed suicides during the period from 2009-2012
- Cases identified when autopsy reports noted manner of death as suicide
- Diagnoses and other information (risk/protective factors) were gathered from review of clinical records. Diagnoses based on DSM-IV criteria

We examined risk factors such as:
- Means of suicide
- Number of prior suicide attempts
- Differences in suicide rates by age bands
- Identification of any precipitating events leading up to suicide

Additionally, we examined:
- Support systems in place for the individuals
- Adherence to treatment
- Last behavioral health or other medical provider visit
- Recent hospitalizations or crisis interventions
Our data confirms the considerable rate of seeking medical/psychiatric care prior to suicide. Causal risk factors for Medicaid beneficiaries (involuntary psychiatric exam/hospitalization), occurring within 30 days of suicide, suggest suicide treatment/intervention was not being utilized at the time of the involuntary hospitalization.

Those diagnosed with bipolar disorders were five times more likely to commit suicide than those diagnosed with major depressive disorder, contrasting with prior studies documenting the opposite. This implies the need to develop strategies to treat/intervene within this high-risk group of those psychiatrically diagnosed.

The most striking finding: the number of younger women (ages 16-34) who used suicide with a high lethality, including gunshot and hanging, which are more typical of men. Women generally use less lethal means of overdosing and wrist-cutting, which was true for the middle age female group.
Magellan’s Driving Suicide to Zero Initiative
Objectives

- **Preparation** of the clinical workforce to confidently identify at-risk individuals and improve treatment access and engagement.

- **Integration** of a sustainable and replicable clinical and support model and program tools into an EMR to ensure that health care providers can, from a single source, identify, manage and plan for zero suicides through the safe management of those at risk.

- **Incorporation** of family and community participation to better identify early warning signs, navigate the clinical system, and support members at risk.
• Formed a collaborative committee comprising clinical leadership from Magellan and healthcare providers to address the high rates of suicide in AZ.

• After an extensive review of best practices, the committee identified the need for workforce development (Magellan adopted the Applied Suicide Intervention Skills Training [ASIST]) as the training component for the behavioral health workforce.

• This protocol was implemented in 12 outpatient mental health clinics within the Maricopa Behavioral Health System.

• This is in addition to five components of care:
  1. Standardized screening
  2. Suicide risk assessments
  3. Appropriate interventions to ensure safety
  4. Treating and caring for individuals at risk of suicide
  5. Follow up
Results

• Magellan successfully trained over 90% of the workforce in ASIST, and found that after ASIST training there was a significant increase in the workers who “felt strongly” they could engage and assist those with suicidal desire and/or intent.

• A comprehensive clinical decision support tool was implemented in the EMR.

• The screens, risk assessments and interventions used for all members underwent continual review with the clinics, and the taskforce addressed processes, barriers and solutions for improvement.

• During the first 90 days of implementation, over 15,500 screens were completed. 8.5% of individuals had a positive screen and then received the Suicide Risk Assessment.
Results

• There were no reported suicides in the Medicaid behavioral health population during this three-month period.
• The Magellan-led collaborative efforts with the behavioral health community in Arizona have decreased the suicide rate (# suicides per 100,000) 67% for the population, and 42% in people with serious mental illness.

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</tr>
</thead>
<tbody>
<tr>
<td>SMI</td>
<td>174.8</td>
<td>140.7</td>
<td>82.3</td>
<td>110.9</td>
<td>158.7</td>
<td>101.0</td>
<td>42%</td>
</tr>
<tr>
<td>Child</td>
<td>5.4</td>
<td>10.6</td>
<td>0.0</td>
<td>4.3</td>
<td>6.1</td>
<td>0.0</td>
<td>100%</td>
</tr>
<tr>
<td>GMH/SA</td>
<td>58.1</td>
<td>25.0</td>
<td>32.4</td>
<td>37.8</td>
<td>30.8</td>
<td>12.7</td>
<td>78%</td>
</tr>
<tr>
<td>Total BH</td>
<td>77.2</td>
<td>52.8</td>
<td>35.8</td>
<td>47.5</td>
<td>47.8</td>
<td>25.7</td>
<td>67%</td>
</tr>
</tbody>
</table>
Conclusions and Implications

- Employing a rigorous, data-driven, scalable and reproducible population health approach to address suicide prevention, and creating a sustainable ecology of support around the individual and the community, is possible.

- The **Magellan Driving Suicide to Zero** Initiative successfully incorporated population surveillance, analytics, research, early detection, intervention and monitoring to shift the paradigm from crisis mitigation to early prevention of suicide.
Integration of Behavioral Health and Pharmacy
Behavioral Health & Pharmacy Integration

• Too often behavioral health & pharmacy operate in silos

• Critical to share information to design interventions

• Inappropriate use of medications in certain cohorts

• Collaboration to design interventions
Integrated Substance Use Solutions
Evidence-based and cost-effective treatments

- **Medication Assisted Treatment (MAT)**
  Use of medications, in combination with counseling and behavioral therapies, to provide whole-patient approach to treatment

- **Office-Based Opioid Treatment (OBOT)**
  Breakthrough for patients who find it difficult to abstain from opioids and cannot successfully complete treatment

- **Ambulatory Detoxification**
  Cost-effective and safe service for members requiring detoxification

- **Co-occurring Disorders**
  Improved identification and treatment of co-occurring mental health and substance abuse disorders

- **Screening Tools and Processes**
  SBIRT and other screening tools that direct PCP to the appropriate treatment (referral, brief intervention, CCBT)
### Findings: Key Characteristics

#### Predictors: Diagnoses

<table>
<thead>
<tr>
<th>Condition</th>
<th>Odds Ratio (p&lt;.001)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spondylosis and other back problems</td>
<td>5.3</td>
</tr>
<tr>
<td>Substance Related and Addictive Disorders</td>
<td>4.6</td>
</tr>
<tr>
<td>Sleep-Wake Disorders</td>
<td>2.2</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>1.7</td>
</tr>
<tr>
<td>Headache</td>
<td>2.1</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>1.5</td>
</tr>
</tbody>
</table>

#### Predictors: Utilization

<table>
<thead>
<tr>
<th>Service</th>
<th>Odds Ratio (p&lt;.001)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse Services</td>
<td>4.5</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>4.2</td>
</tr>
<tr>
<td>ER</td>
<td>3.2</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>2.3</td>
</tr>
<tr>
<td>Surgery</td>
<td>2.0</td>
</tr>
<tr>
<td>OP Surgery</td>
<td>1.3</td>
</tr>
</tbody>
</table>
Magellan’s Clinical Monograph

- Work group reviewed current literature.
- First draft reviewed, discussed with internal and external stakeholders.
- Tip sheets allow easy reference to latest recommendations.
- Bibliography up-to-date and extensive.
- Can be used by Magellan care managers, medical directors in educating practitioners.
- Can be used by advocates, parents, consumers to educate regarding appropriate use.
Open access is a good way to stay involved in your child’s intervention.

1. The treatment options
   - Are these medications needed?
   - Will my child benefit from these services?
   - Will I get a child’s perspective from your health professional?

2. The medication
   - How do medications and treatment options affect the child’s behavior?
   - How will my child be treated if they are using medication?
   - Are there other medications that are available?
   - What lifestyle changes should I ask for and when?
   - Should I do this on my own?
   - Will the treatment be noted in your child’s health care records?

3. The treatment plan
   - How will I know my child is being treated?
   - Are there other medications my child is taking and are there risks in combining them?

GOAL: TO GET THE RIGHT TREATMENT FOR EACH CHILD’S NEEDS.
Five Trends Changing Behavioral Health Managed Care

Value-based payment models

PRESENTED BY:
Razili Lewis

September 22, 2016
5 trends changing behavioral health managed care

5 Trends

- Importance of population health management
- Role of technology
- Integration with pharmacy
- Approach for care coordination
- Value-based payment models
There are several levers to align and improve BH incentives

**Importance of aligning incentives**
- In an increasingly value-based payment world, it’s important to align incentives to create a delivery system that provides quality, coordinated BH care at a lower cost
- Incentives can also be used to drive desired outcomes, e.g., increased physical healthcare integration or improvement on certain quality metrics

<table>
<thead>
<tr>
<th><strong>Episode-based care delivery</strong></th>
<th>Accountability for all services related to a specific BH condition (e.g., ADHD, depression, bipolar disorder)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care coordination incentives</strong></td>
<td>Reimbursement for selected new services, e.g., intensive care management, crisis intervention</td>
</tr>
<tr>
<td></td>
<td>Potential to create linkage to desired outcomes (quality, efficiency)</td>
</tr>
<tr>
<td><strong>Reimbursement adjustments</strong></td>
<td>Modifications to encourage appropriate diagnosis and utilization (e.g., appropriate time limits on unspecified diagnosis; pharmacy management rules)</td>
</tr>
<tr>
<td><strong>Other risk-based payments</strong></td>
<td>Capitated or sub-capitated payments for a defined set of services</td>
</tr>
<tr>
<td><strong>Policy changes</strong></td>
<td>Support for payment initiatives (e.g., changes to certifications for providers)</td>
</tr>
</tbody>
</table>
Episode-based models can complement population health approaches for behavioral health

**Population-based**
(PCMH, Health Homes, ACOs, capitation)

- Primary identification and prevention for lower-needs members (can be embedded in PCMH model)
- Intensive care coordination for higher needs members (focused on behavioral health)
- Ideal for conditions where there is clarity and consistency of clinical pathway and recommended treatment (focus on variation that is actually reducible)
- Discrete services correlated with favorable outcomes or lower cost

**Episode-based**

**Fee-for-service**
(including pay for performance)
Example: ADHD episode includes patients aged 6 - 17 without behavioral health comorbid conditions

<table>
<thead>
<tr>
<th>Treatment recommended in AAP/AACAP guidelines</th>
<th>Not indicated by evidence-based guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD with no BH comorbid conditions, positive response to medication</td>
<td></td>
</tr>
<tr>
<td>▪ 4 - 6 physician visits / year</td>
<td></td>
</tr>
<tr>
<td>▪ Rx medication</td>
<td></td>
</tr>
<tr>
<td>▪ Parent / Teacher administered behavioral support¹</td>
<td></td>
</tr>
<tr>
<td>▪ Psychosocial therapy</td>
<td></td>
</tr>
<tr>
<td>▪ In-office psychotherapy</td>
<td></td>
</tr>
<tr>
<td>ADHD with no BH comorbid conditions, sub-optimal response to medication</td>
<td></td>
</tr>
<tr>
<td>▪ 6 physician visits / year</td>
<td></td>
</tr>
<tr>
<td>▪ Rx medication</td>
<td></td>
</tr>
<tr>
<td>▪ Parent / Teacher administered behavioral support¹</td>
<td></td>
</tr>
<tr>
<td>▪ Psychosocial therapy if needed</td>
<td></td>
</tr>
<tr>
<td>Included in version 1.0</td>
<td></td>
</tr>
<tr>
<td>ADHD and Behavioral Health comorbid condition(s)</td>
<td></td>
</tr>
<tr>
<td>▪ Varies by comorbidity</td>
<td></td>
</tr>
<tr>
<td>▪ Significant psychiatric involvement necessary</td>
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</table>

¹ Defined as education via books, videos, or a one-time series of in-person training sessions

SOURCE: American Academy of Child and Adolescent Psychiatry, 2007; American Academy of Pediatrics, 2011; Scottish Intercollegiate Guidelines Network, 2009; Canadian ADHD Resource Alliance Guidelines, 2011; interviews with clinical experts, including pediatricians, child psychiatrists, and child psychologists; Arkansas Payment Improvement Initiative
Health homes are one example of care coordination incentives: 17 states have implemented a CMS-approved Medicaid Health Home for members with behavioral health conditions.

Inclusion criteria:
- Orange: Only focused on members with BH conditions
- Blue: Broader population, including members with BH conditions

SOURCE: Centers for Medicare & Medicaid Services, Approved Medicaid Health Home State Plan Amendments, as of June 2015
Incentives can align clinical models for subpopulations, including level and site of care coordination

Heat map of behavioral health members as a function of behavioral health and medical spend ranks

These individuals could benefit from specialty BH care that partners closely with a primary care practice

These high-needs patients may benefit from intensive coordination led by BH provider with strong primary care capabilities

These individuals have significant medical needs – coordination may be best driven by primary care provider

Color gradation reflects the concentration of members
- >3,300
- 2,500 – 2,600
- <1,500

SOURCE: Disguised Medicaid data from one state
Thank you and Questions