About Beacon Health Options

- Headquartered in Boston; more than 70 locations in the US and UK
- Programs serving Medicaid recipients in 27 states and the District of Columbia

- 5,000 employees nationally and in the UK serving 50 million people
- Serving 8.5 million military personnel, federal civilians and their families

- 200+ employer clients, including 45 Fortune 500 companies
- Partnerships with 100 health plans

- NCQA and URAC accredited
Behavioral health is playing a very small role in the recent wave of value-based payments (VBP)

Behavioral health’s historical role has minimized participation to date

- A majority of ACO-like entities and energy are related to Medicare, where BH spending is lowest as a percent of total spending
- BH as a “second class citizen” in VBPs is not limited to Medicare. Same goes for Commercial; and we have no scaled Medicaid example (excluded from Oregon and Colorado) and Massachusetts and New York have yet to determine their approach. Data and evidence are thin
- Lack of strong outcomes measurement regimes that definitively identify best-in-class provision of BH services
- BH service provision lacks the diagnostic clarity and robust evidence base that physical health VBP has been built on in medical care (e.g. knee replacement)
- BH providers, while interested in VBP, have small balance sheets and most have no experience managing VBP risk, so the first project will be a leap of faith and an exercise in planning
Beacon has a number of large-scale VBP deals, but the total is still small.

Beacon has implemented ambitious value-based payment programs in Colorado, Texas, Florida, California, and more.
The emphasis on VBPs is unlikely to ebb any time soon

- **RFPs** and ensuing **contracts include commitments** to VBPs strategies, including numeric targets (even if they are not well thought out)
  - NY – glide path to having 85% of payments through VBP structures
  - MA is ending its managed care program
  - Oregon, Colorado, Alabama are all Medicaid programs organized around provider-led structures

- Those **providers with real VBP experience actually like them**
  - Cash flow, predictability, flexibility, clinical innovation, etc.

- For BH specifically, lack of evidence notwithstanding, providers and payers both believe that **more good than harm is occurring**

- Washington remains a wildcard, but I would **bet on continued growth of VBPs**
VBPs are a spectrum of options; we must get the right mix of incentives and complexity to get desired outcomes.

**Value-Based Purchasing Options**

- **Total Health Outcomes**
  - Shared risk on total member experience

- **Behavioral Health Capitation**
  - Risk for providers
  - Full behavioral health payment
  - Defined coverage set

- **Episode Bundle**
  - Group of services
  - Combined payment
  - Quality goals
  - Defined time period

- **Case Rate**
  - Group of services
  - Combined payment
  - Monthly/weekly payment

- **Pay for Performance (P4P)**
  - "Upside only"
  - Key process measures

- **Fee-for-service**
  - One service
  - One payment

**Incentive-Based Treatment Risk**

- **Overtreatment**
- **Under-treatment**
More emphasis on “PAYMENT” than “VALUE”

- **Value** is defined as outcomes relative to the real costs
- **Outcome improvement** without understanding the true cost of care is unsustainable and does not help effective allocation of limited resources
- **Cost reduction / revenue increase** without regard to outcomes is not value

\[
\text{VALUE} = \frac{\text{HEALTH OUTCOMES}}{\text{COST}}
\]

- Negotiations are overly **focused on the financial envelope** (bottom half of the value equation)
- VBPs without changing outcomes is a very expensive way to lower cost
- Too often in healthcare organizations, the **clinical leads are not well coordinated with the contracting leads** (both payers and providers)
  - Leads to an organizational disconnect: Price changed, but things aren’t really going to be that different
## Beacon Readmission Prevention Collaboration

<table>
<thead>
<tr>
<th>Intervention Component and Approach</th>
<th>Evidence Base</th>
<th>Current Status</th>
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</thead>
<tbody>
<tr>
<td><strong>In-hospital care processes</strong></td>
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<tr>
<td>Risk stratification (use of clinical risk score) and “measurement based care” (routine use of validated BH outcome measures)</td>
<td>Models predicting BH readmission risk validated but not widely tested in practice; routine use of validated BH outcome measures to guide care improved outcomes in some settings</td>
<td>Routine assessment with validated BH outcome measures; data not used in systematic way to guide care</td>
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<td>Structured discharge planning (structured summary, planning meeting with all parties, family involvement, communication of plan to community caregivers)</td>
<td>Reduces readmission &amp; improves aftercare adherence (11 studies); mixed effect (1/3 studies); no effect among high utilizers (1 study)</td>
<td>Narrative discharge plan; no systematic implementation process across hospitals</td>
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<tr>
<td>Medication management (reconciliation, education, coordination with community providers)</td>
<td>Borderline significant; reduces medication discrepancies when supported by electronic tool</td>
<td>Medications assessed on admission and discharge; some hospitals have medication management education</td>
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<tr>
<td>Assessment of medical or BH needs (medical team or medical consults in psych units, psych in person or tele-consults in ERs or medical units)</td>
<td>Adding primary care clinician to psychiatric team can improve processes of care</td>
<td>Pilot psychiatrist tele-consult service for ER patients in some hospitals; process for medical referrals varies widely</td>
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<td><strong>Bridging transition to community</strong></td>
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<td>Telephone outreach calls (efforts to ensure timely follow-up, identify aftercare problems)</td>
<td>Can be effective, especially when used with transition manager and with 90-day post-discharge outreach</td>
<td>Nurse outreach call and assessment within 72 hours</td>
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<td>Transition managers (regular follow-up, home visits, problem solving, psychoeducation, peer support)</td>
<td>Mixed significance, but significant with home visits or peer support</td>
<td>Some hospitals have peer navigator program, but no systematic use of transition managers</td>
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<td>Patient and family skills training (psychoeducation, coping skills, living skills)</td>
<td>Consistently significant</td>
<td>Used in several hospital settings, but no systematic approach</td>
</tr>
<tr>
<td>Inpatient-outpatient provider communication (scheduling, timely communication of plan)</td>
<td>Weak significance</td>
<td>No systematic approach, varies by hospital and setting</td>
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</tbody>
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Partners in Data-Driven Care Management

The success of organizations responsible for managing chronic / complex conditions is dependent on their ability to:
1. Identify those most likely to benefit from more intensive care management
2. Secure resources required to keep members healthy
3. Maintain enrollment of members after their health has been stabilized.

- Cyft uses machine learning and natural language processing to leverage all the information in both clinical and administrative healthcare data, including HRAs and notes.

- Care Management with a focus on SMI
- Rather than using risk scores or past TME, focus on “hidden data”
  - Health risk assessments
  - Care management notes
Using Machine Learning to Target Behavioral Health Interventions

Machine learning tools can help providers target behavioral health interventions to patients who need help managing mental and physical chronic conditions.

February 06, 2017 - Behavioral healthcare has been getting a great deal of attention lately from health IT experts, and not just because of a growing recognition that good mental health is key to improving overall patients outcomes.

Behavioral health is one of the most complex, highly individualized, and notoriously underfunded components of the care continuum, which makes it a perfect test bed for deploying advanced machine learning tools. At Boston Health Options, a behavioral health management service provider partnering with health plans and employers, identifying high-risk patients before they enter a crisis is a financial and clinical imperative – one that has broad implications for an incredibly vulnerable and difficult-to-treat population.

"Mental healthcare is a perfect example of chronic disease with wide-ranging impacts and a massive number of variables," explained Dr. Emma Stanton, Associate Chief Medical Officer for Boston Health Options.

7 days and 30 days Follow-up After Hospitalization for Mental Illness (FUH)
1. Develop your program focused on hospitals readmissions.
2. Partner / Pilot with local hospital.
3. Partner with specialty managed care company.
4. Measure.
5. Measure.
6. Measure.
7. If you build it they will come is **NOT** a business plan!
Thank you

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