



## How Managed Care is Planning for Integration

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### Unprecedented Legislative Change and Impact

<b>Federal Mental Health Parity</b>	<b>New Populations Entering the System</b>	<b>Autism</b>
<ul style="list-style-type: none"> <li>• Took effect for plans that began or renewed on, or after, July 1, 2010*</li> <li>• Requires group health plans covering large employers (50+ employees) to ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/ surgical benefits.</li> </ul>	<p><b>Coverage for those aged 18-26</b></p> <ul style="list-style-type: none"> <li>• 18- to 26-year-olds newly eligible on employer plans are increasing behavioral inpatient utilization and costs</li> </ul> <p><b>Coverage for millions of uninsured</b></p> <ul style="list-style-type: none"> <li>• 2014 planned influx of newly insured consumers is expected to drive major increases in behavioral utilization — affecting entire service delivery system</li> </ul>	<ul style="list-style-type: none"> <li>• 33 states and the District of Columbia have legislative requirements</li> <li>• An “essential health benefit” under the Affordable Care Act*</li> <li>• Total private insurer medical costs for children with Autism is 3 to 7 times greater than for those children without Autism<sup>11</sup></li> <li>• 1.1% of children aged 3 to 17 have Autism<sup>12</sup></li> <li>• Cost of Services range from XXXXX</li> </ul>

\* Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

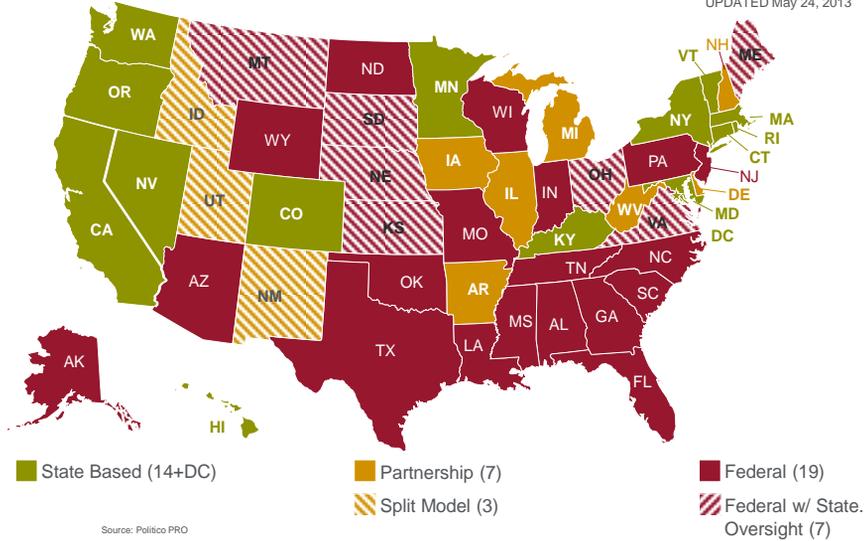
\* Title I, Part A, Subpart II, Sec. 2714 of the Patient Protection and Affordable Care Act extends health care coverage for young adult children under their parent's health plan up to the age of 26.

• **Cost**  
\* Federal Patient Protection and Affordable Care Act (ACA); Section 121022



## Current tally of states on setting up health benefits marketplaces

UPDATED May 24, 2013



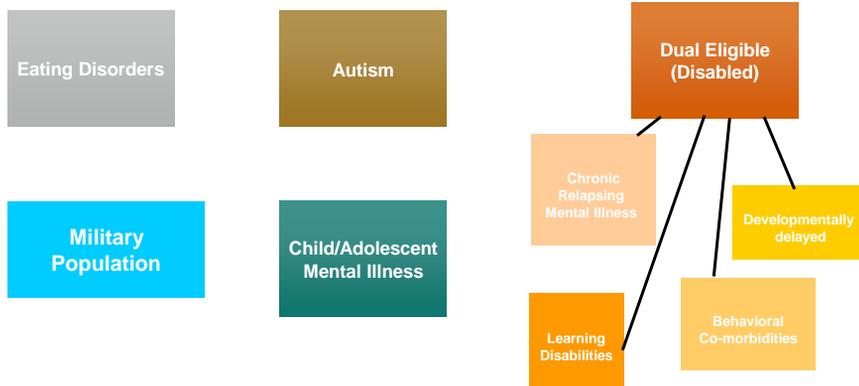
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## Greater Need for Clarity of Provider Competences Especially for Complex/High Cost Conditions

Complex and high cost populations need specialized trained provider types and systems to be maximally effectively. Research has shown in many areas that highly trained clinicians had a better outcome than care through a generalized usual care provider. Current generalized training and licensure does not clarify experience nor competence for these populations

The system will need to have processes to measure and identify competencies

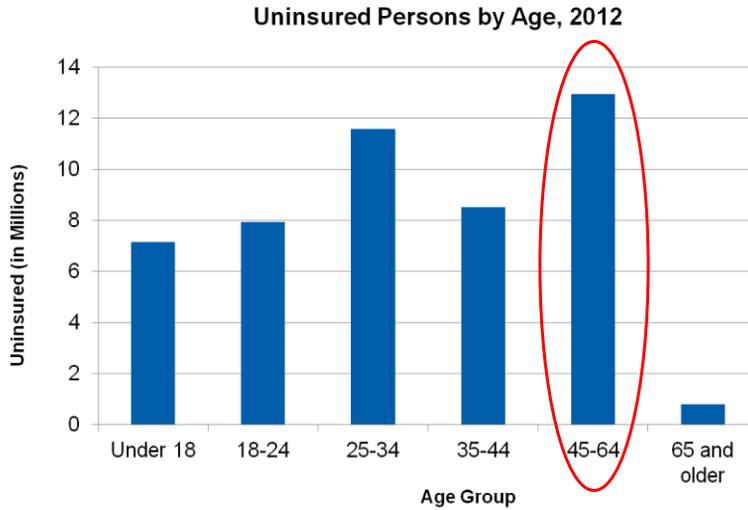


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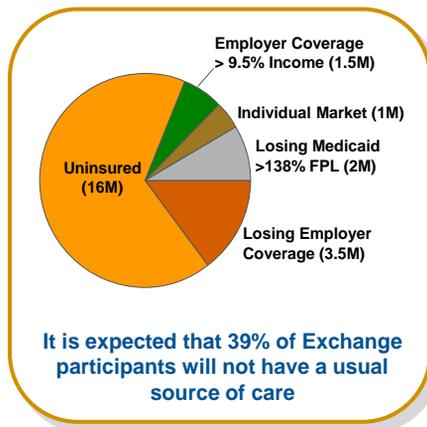
## Largest uninsured category is 45-64-year-olds



Sources: HealthLeaders-InterStudy, U.S. Census  
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## Exchange Consumers Will Look Very Different from Our Traditional Commercial Consumers

**Kaiser Family Foundation Study: Analysis of people likely to purchase on Individual Exchanges (CBO ~ 24M)**



	Exchange	Privately Insured
Fair/Poor Health	13%	6-7%
Fair/Poor Mental Health	8%	4%
No more than High School Diploma	77%	55%

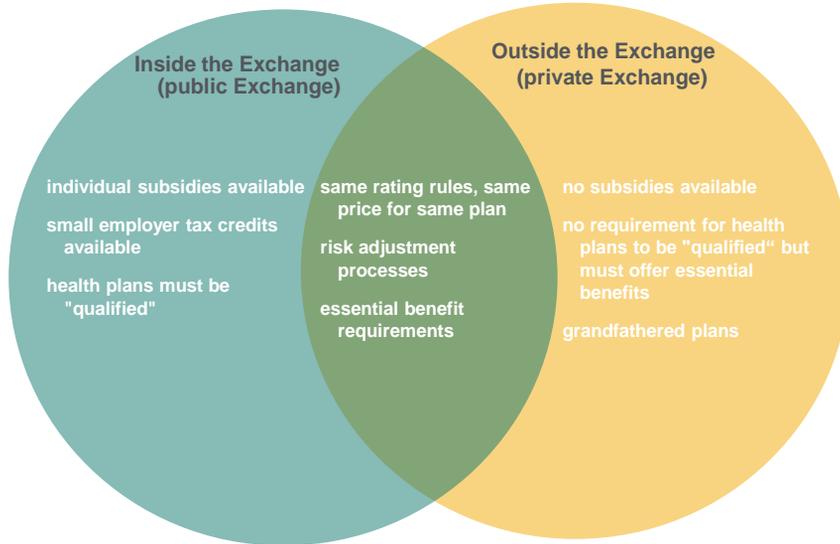
### Exchange Members Are Expected To Be:

- Lower income
- Less educated
- More diverse
- In poorer health
- Less sophisticated consumers

It will be important to evaluate the product, clinical and network offerings to effectively manage and engage this Exchange population

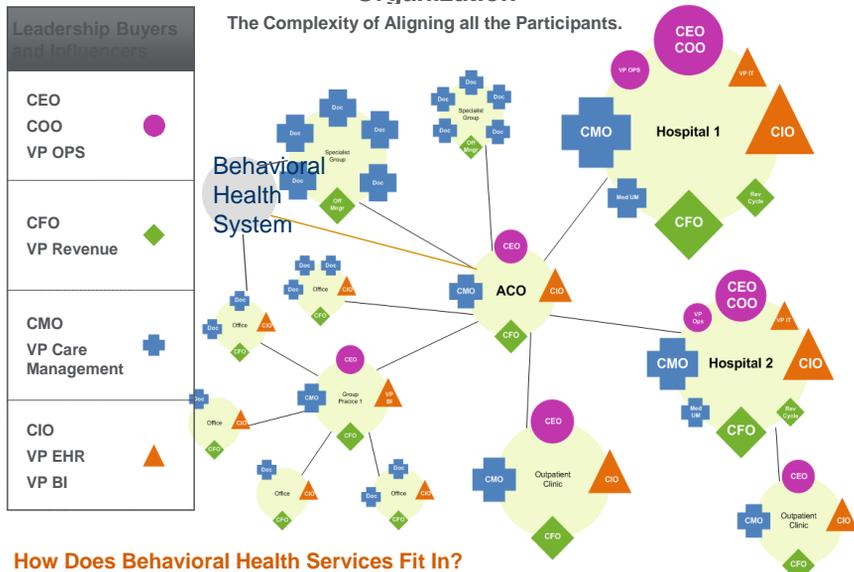
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### Characteristics of the market inside and outside the Health Benefits Exchange



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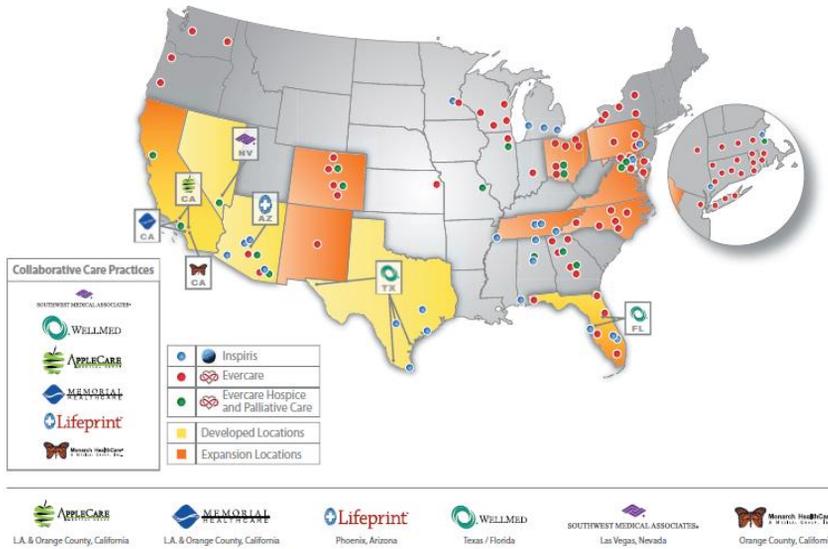
### Reorganizing the Health Care System – Medical Accountable Care Organization



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## OptumHealth Collaborative Care



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## Achieving the Triple Aim

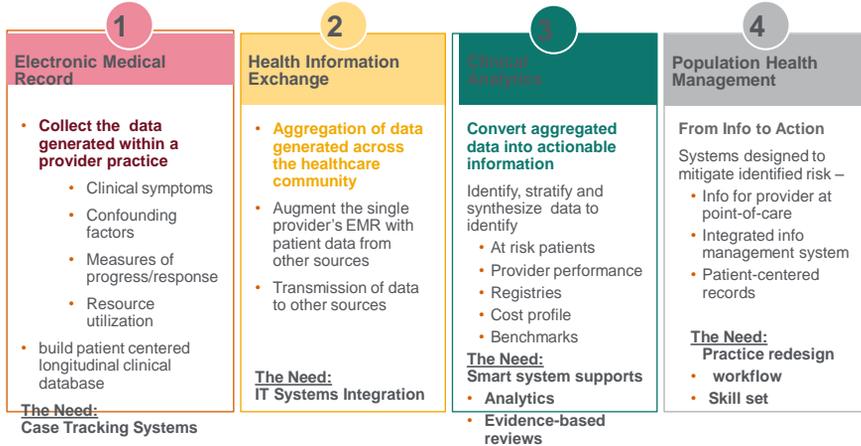
*Improved Population Health, Patient Centered and Affordable*

### Fundamental Levers Within The Triple Aim

Performance Measurement	Transparency	Accountability	Payment Reform
<p>Moving to national standard measurements</p> <p>Measuring performance on population touched or in catchment area</p> <p>Shared measurement across levels of care and different providers</p> <p>Currently focused on process, outcomes based soon</p>	<p>Transparent on a individual provider, group or organizational level</p> <p>Focus on cost , experience and process milestones</p> <p>Focus on tools to help consumers decision making</p> <p>Info available to Competitors and Prospective Payers</p> <p>Advantages high performing networks</p>	<p>For effectiveness and cost of care episode</p> <p>Shared vs. singular accountability</p> <p>Shifting more to provider level</p> <p>Balancing clinical and financial decisions</p>	<p>Shifting from multiple sources of funding to a more combined approaches</p> <p>Move from volume based payments to fee for service</p> <p>Inclusion of performance-based incentives or contracting.</p> <p>Bundling rates across disciplines and levels of care</p> <p>Shifting more financial accountability to providers</p>

## Information Technology

### Technical Blueprint For IT Functionality in Practice Changes



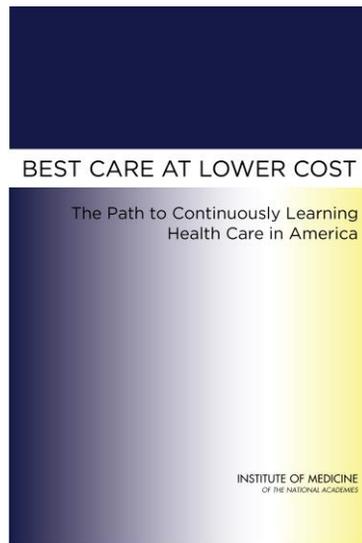
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## New Institute of Medicine Study Addressing the Importance of Practice-Based Data Systems

Recent IOM study, "Best Care at a Lower Cost": The Path to Continuously Learning Health Care in America,

- Large randomized clinical trial are not practical and too costly to implement.
- Digital records present a tremendous opportunity to generate information and facilitate practice based learning
- Multiple new sources for data., personal electronic records, self management web sites, apps, or dedicated mobile devices.
- Provider- patient interface becomes the critical source of data for care decisions, research and ensuring the quality of the data.

Promotes the use of practice-based data in real time to facilitate practice decision and increase knowledge



## “Learning Systems”

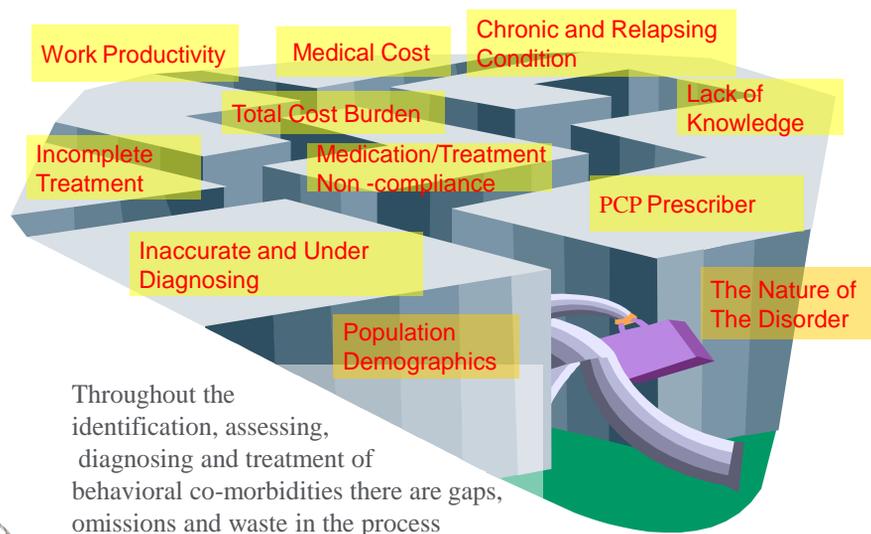
- **Is an organized provider organization that is able to utilize research evidence and practice-based data to create information that improves learning, clinical decision making and effectiveness of care.**
- **Funded or sponsored by grants, provider organizations and health plans**
- **Using data analytics and six sigma methodologies**



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## The Management Maze Medical Patients with Behavioral Co-Morbidities



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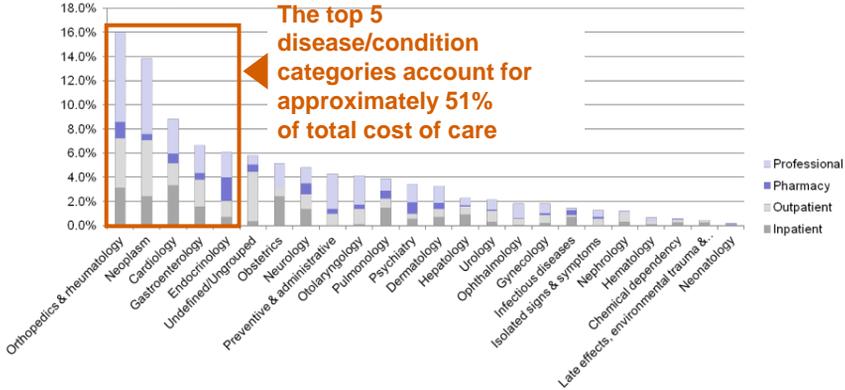
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## Cost Distribution by Major Practice Category

### Cost & Utilization Distribution by Claim Type

Commercial Population

October, 2009 – September 30, 2010



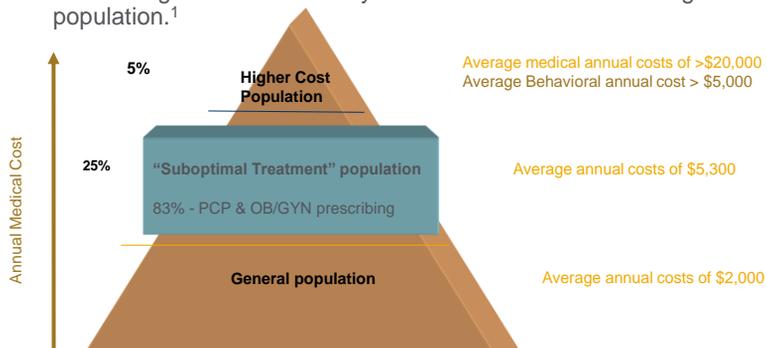
Major Practice Categories (MPCs) are based on the diagnosis on claims data. They do not represent specific provider specialties. For example, claims submitted by family practice providers for treating diabetes cases would be placed in the Endocrinology MPC.



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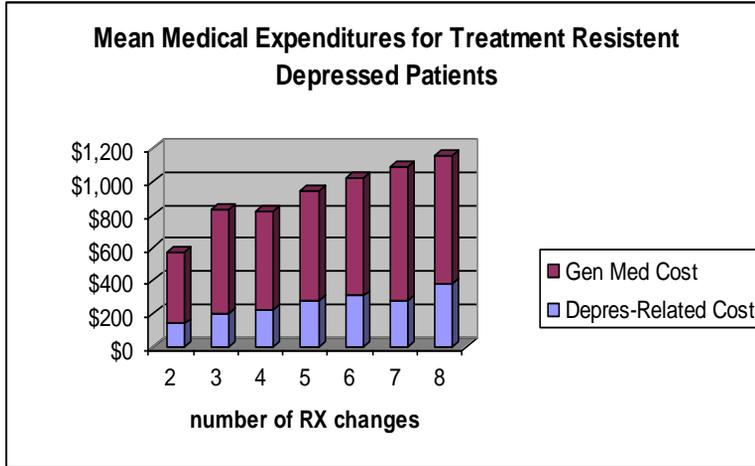
## Behavioral Health Opportunities Through Integration

- Medical populations that are either sub-threshold to medical screens or not addressed completely by medical management touch points.
  - Poor health outcomes, medication waste, increased ER visits and lab/imaging testing, increased risk of relapse, and decreased productivity
  - Generating 2.5 times more a year in medical costs than the general population.<sup>1</sup>



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## Cost Impact of Treatment Resistant Depression



Russell, March 2004, J Clin. Psych.



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## Psychotropic Medication

Psychotropic medications account for the largest component of drug expenditures, at **23%**<sup>7</sup>

- Consumer use continues to grow annually
- Over **75%** of psychotropic drugs are prescribed by primary care providers (PCPs)<sup>7</sup>
- Studies indicate that only **8-22%** of all Major Depressive Disorder cases receive recommended guideline-level treatment<sup>8</sup>
- Up to **70%** of people do not take their psychotropic medication as prescribed<sup>7</sup>



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## Behavioral Presentation in the Medical Setting

- The top 10% of medical service utilizers account for:
  - 29% of all PC visits ;52% of specialty visits
  - 40% of inpatient days; 26% of all prescriptions
- 50% are psychologically distressed
  - Depressed 40.3%; anxiety 21.8%
  - Somatization 20.2%; panic 11.8%
  - Alcohol 5% (Katon et al. 1990)



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## Co-Morbid Behavioral Conditions in PCP Practice

• **Hidden medical costs** driven by undiagnosed and under-treated behavioral health conditions

Medical Costs per Diseased Member per Month<sup>6</sup>

Chronic Medical Condition	With Behavioral Condition	Without Behavioral Condition
Arthritis	\$871.88	\$564.76
Asthma	\$861.99	\$470.05
Cancer (Malignant)	\$1,180.96	\$1,018.45
Chronic Pain	\$1,210.56	\$884.70
COPD	\$1,219.33	\$807.64
Coronary Artery	\$1,305.00	\$958.34
Diabetes Mellitus	\$1,110.27	\$828.18
Heart Failure	\$2,242.85	\$1,888.11
Hypertension	\$880.33	\$588.04
Ischemic Stroke	\$1,461.57	\$1,254.68

Across these 10 chronic medical conditions, depression and anxiety are **undiagnosed 85% of the**

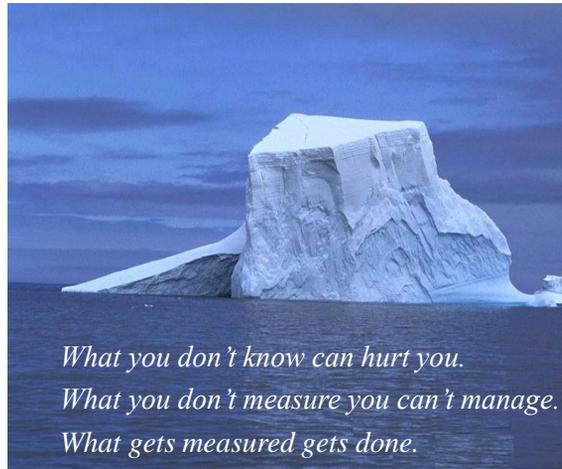
**time<sup>6</sup>**

Chronic Medical Condition	% Treated For Depression or Anxiety	Expected Depression or Anxiety Prevalence	% Missed
Arthritis	7.1%	32.3%	77.9%
Hypertension	5.5%	30.5%	82.0%
Chronic Pain	5.9%	61.2%	90.4%
Diabetes Mellitus	5.2%	30.8%	83.2%
Asthma	6.8%	60.5%	88.8%
COPD	8.0%	39.3%	79.6%
Coronary Artery Disease	5.7%	48.2%	88.1%
Cancer (Malignant)	5.7%	39.8%	85.7%
Congestive Heart Failure	7.0%	43.8%	84.1%
Ischemic Stroke	7.7%	52.4%	85.2%
<b>Average</b>	<b>6.1%</b>	<b>38.9%</b>	<b>84.3%</b>



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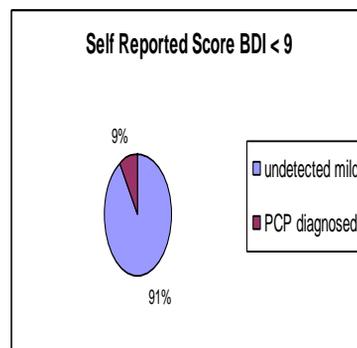
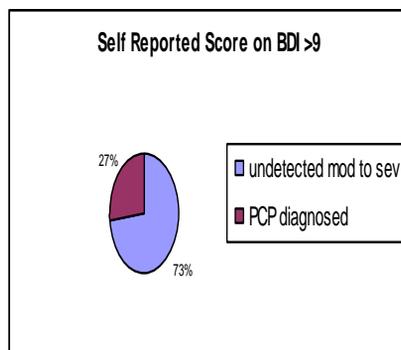
## Tip of the Ice Berg



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## Undetected Diagnosis

Based on 508 patients with depression studied  
(Callahan – 2002 – *J Fam Pract.*)

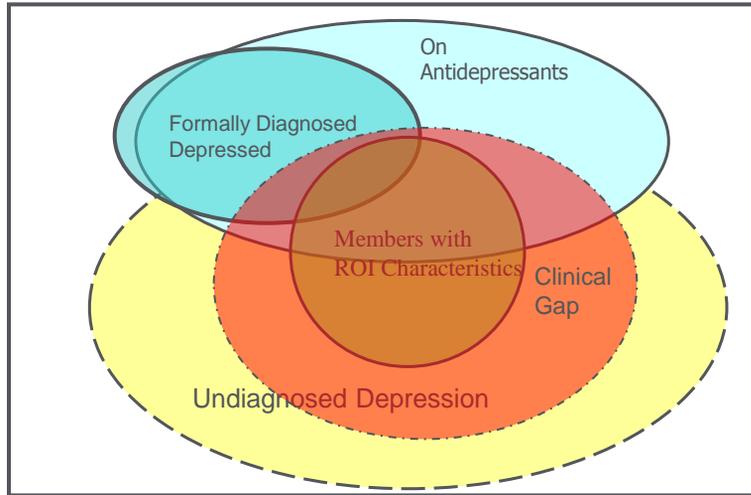


When patient's self report and PCP diagnosis fail to match, the PCP orders lab test. PCP more likely to diagnose when the level of severity is high



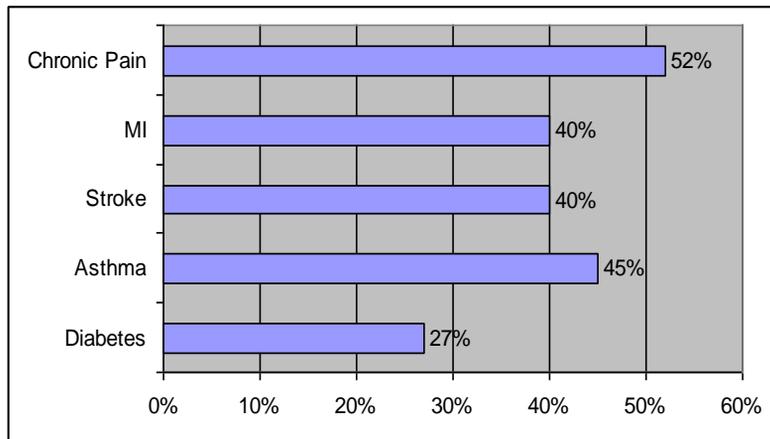
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### Population Defined by Depression Disease Management



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### Prevalence of Depression in Medical Illness



Pincus, HA; (2001) *J Clin. Psych*; Schatzberg, A, (2004) *J Clin Psych*

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## Medical Behavioral Health Challenge

- Noncompliance with a short-term medication regimen
  - Patients **do not fill** their prescriptions **30 to 35 percent** of the time
  - Patients **stop** taking medications after several days **25 percent** of the time
  - Patients **do not complete** a 10-day course of treatment **75 to 80 percent** of the time
- Noncompliance with a long-term medication regimen
  - Patients **do not comply** with long-term treatments **50 percent** of the time
  - Compliance problems increase with the duration of an illness
- Noncompliance with lifestyle changes
  - Patients **do not follow** modest dietary recommendations **70 percent** of the time
  - Patients **do not stop** using tobacco products **90 to 95 percent** of the time after being advised to do so

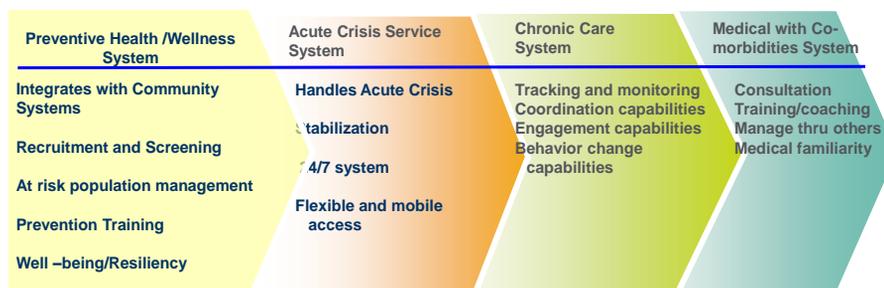


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## Behavioral Health Functional System Structure

- Functional systems are necessary components of care delivery. How they are organized, structure and provided may differ in the future.



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# Medical with Co-Morbidities System

<b>Workforce</b>	<ul style="list-style-type: none"> <li>Must have a psychiatrist</li> <li>Must have case manager function</li> <li>Must have care coordination function</li> <li>Medical/behavioral experienced</li> </ul>
<b>Capabilities</b>	<ul style="list-style-type: none"> <li>Bilingual capabilities, (speaks medical)</li> <li>Quick response to medical physician request</li> <li>Early detection and intervention systems</li> <li>Consultation/training/wellness coaching</li> </ul>
<b>Performance Measurement</b>	<ul style="list-style-type: none"> <li>Performance based on HEDIS and PCQRI measurements</li> <li>Hospitalization/ER rates</li> <li>Treatment adherence</li> <li>Medical cost offsets</li> </ul>
<b>Payment systems</b>	<ul style="list-style-type: none"> <li>Variable payments systems depending of medical payment structure</li> <li>Fee 4 Service based on FTE need</li> <li>Case rates</li> <li>PMPM to capitation</li> <li>F4</li> </ul>



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# Acute Crisis Service System

<b>Quick Easy Access</b>	<ul style="list-style-type: none"> <li>24/7 on call system</li> <li>Capable of emergent, ( 4 hour) and urgent, ( 24 hour) access</li> <li>No waiting list</li> <li>Technology capable</li> </ul>
<b>Skilled Work Force</b>	<ul style="list-style-type: none"> <li>Access to prescribers</li> <li>High engagement skills</li> <li>Highly skilled in comprehensive assessment and triage</li> <li>Multidisciplinary teams and case management</li> </ul>
<b>Access to Systems of Care</b>	<ul style="list-style-type: none"> <li>Formal and/or accountable linkages to different levels of care</li> <li>Able to influence ERs and hospital care</li> <li>System includes alternative and community level resources</li> </ul>
<b>Pay for Performance</b>	<ul style="list-style-type: none"> <li>F4F with performance bonus based on reduced readmission to inpatient and ER</li> <li>Population based — case mix adjusted bundled payments</li> <li>Easier systems for creating new payment methodologies</li> <li>Shared saving based on admission avoidance</li> <li>Capitation arrangements</li> </ul>

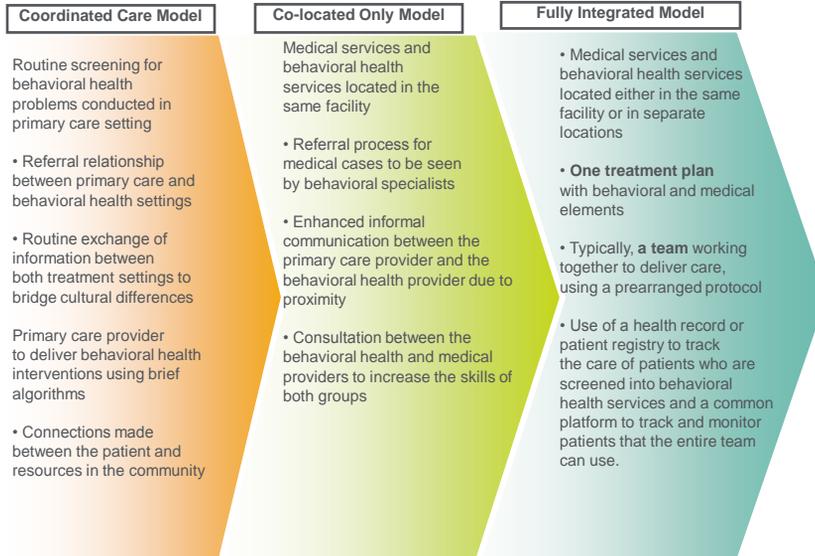


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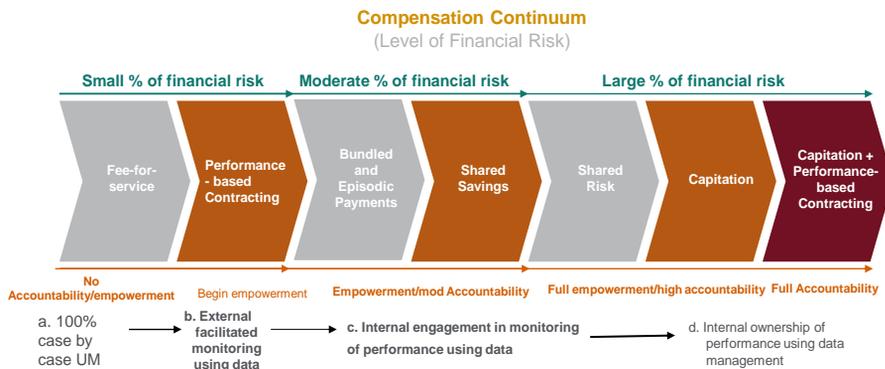
## The Integration Continuum

Source: Adapted from Blount 2003



## Transforming Provider Empowerment/Accountability

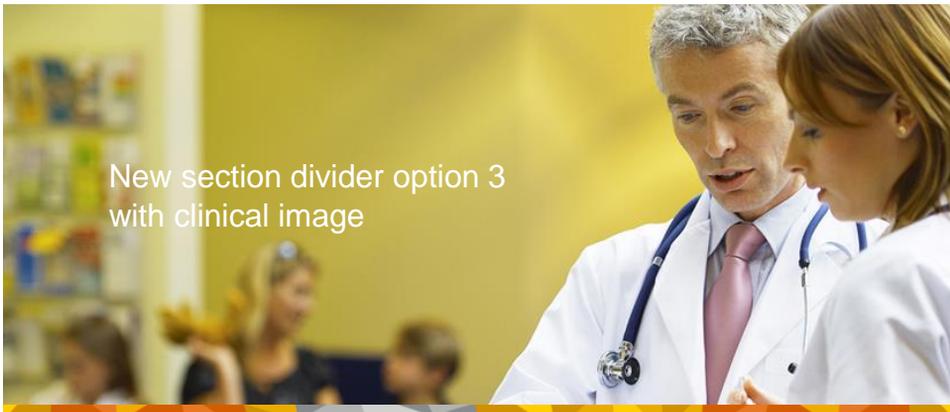
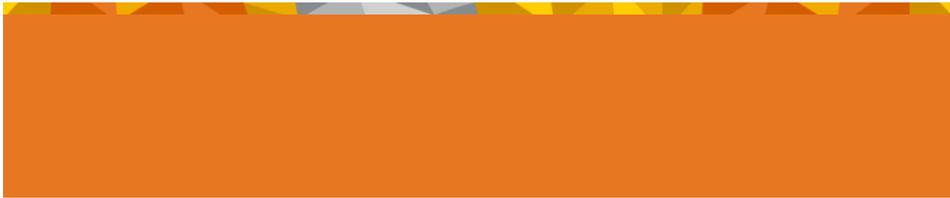
In selected provider arrangements, we will be transitioning and supporting financial risk, accountability and utilization management practices.





# Thank You!

Rhonda J Robinson Beale, M.D.  
Chief Medical Officer, External Affairs



New section divider option 3  
with clinical image