Measurement & Reporting From The Payer Perspective: A Look At Trends In Performance Requirements Among HMOs, MBHOs, ACOs, States, & Counties

Steven E. Ramsland, Ed.D. Senior Associate, OPEN MINDS
2013 Performance Management Institute
Thursday, February 14, 2013/11:15 am
Agenda

I. Current Trends In Performance Measurement
II. How Payer Performance Systems are Impacting Policy
III. Implications for Provider Organizations: The views of two leading MBHOs
I. Current Trends In Performance Measurement
Drivers Of Performance Measurement & Performance-Based Contracting

1. Payers (public and private) want to get the most from available dollars

2. Increased interest in transparency of performance of health care systems, provider organizations and professionals
   - Increase ‘pressure’ for improvement
   - Facilitate consumer-directed care
<table>
<thead>
<tr>
<th>More Organizations Are “Rating” Performance In Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Quality Initiatives</td>
</tr>
<tr>
<td>National Committee for Quality Assurance (NCQA)</td>
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<td>National Quality Forum (NQF)</td>
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<tr>
<td>Substance Abuse and Mental Health Services Administration (SAMHSA)</td>
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<tr>
<td>The Joint Commission</td>
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<tr>
<td>Center For Excellence in Assisted Living</td>
</tr>
<tr>
<td>Care management organizations (HMOs, MCOs, PPOs, ACOs, etc.)</td>
</tr>
<tr>
<td>Consumer–driven open–source rating organizations</td>
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</table>
Current CMS Quality Initiatives

• Medicare Quality Care Finder
• Star Quality Rating System
• Physician Quality Reporting System
Launched in August 2011

Find & Compare...

Doctors, Hospitals, Plans and Suppliers

- Get contact information for hospitals, doctors, nursing homes, home health agencies, dialysis facilities, and drug and health plans.

- Compare information about the quality of care and services these providers and plans offer.

- Get helpful tips on what to look for when comparing and choosing a provider or plan.

Select a compare tool from the left to get started

Additional Resources
- Medigap Policy Search
- Long-Term Care Planning
- Formulary Finder
- Medicare Supplier Directory

Contact Medicare
- 1-800-MEDICARE (1-800-633-4227)
- 1-877-486-2048 (TTY)

Learn about the Affordable Care Act
Measures In Medicare Quality Care Finder: Hospital Compare

1. Process of care measures
2. Outcome of care measures
   ◦ Hospital readmission rate compared to national average
   ◦ Hospital mortality rate compared to national average
3. Use of medical imaging
4. Patients' hospital experiences
   ◦ Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
5. Patient safety measures
   ◦ Serious complications and deaths
   ◦ Hospital acquired conditions
6. Medicare payment and volume
Medicare Quality Care Finder – Comparing Three Hospitals In Louisiana

Bars below tell the percent of patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.

Were patients given information about what to do during their recovery at home?

- Average for all Reporting Hospitals in The United States: 82%
- Average for all Reporting Hospitals in Louisiana: 82%
- BATON ROUGE GENERAL MEDICAL CENTER: 76%
- EARL K LONG MEDICAL CENTER: 80%
- WOMANS HOSPITAL: 87%
## Your Selected Nursing Homes

<table>
<thead>
<tr>
<th>Nursing Home</th>
<th>Mapping &amp; Directions</th>
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| ANGELA JANE PAVILION | 810 ROOSEVELT BLVD  
Philadelphia, PA 19152  
(215) 708-1200 |
| Mapping & Directions |
| BETHANY VILLAGE RETIREMENT CENTER | 5225 WILSON LANE  
MECHANICSBURG, PA 17055  
(717) 766-8279 |
| Mapping & Directions |
| CHESTNUT HILL LODGE HEALTH AND REHAB CTR | 8833 STENTON AVENUE  
WYNDMOOR, PA 19033  
(215) 836-2700 |
| Mapping & Directions |

### Overall Rating

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<tr>
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### Health Inspections

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### Nursing Home Staffing

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### Quality Measures

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### Fire Safety Inspections

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### Penalties and Denials of Payment Against the Nursing Home

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### Complaints and Incidents

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## Nursing Home Characteristics

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<td>Medicare and Medicaid</td>
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<td>Non profit - Corporation</td>
<td>For profit - Corporation</td>
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<tr>
<td>Located in a Hospital</td>
<td>No</td>
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</table>
Medicare Star Quality Rating System

- The Medicare Star Quality Rating System was enacted with federal health care reform to improve the quality of care provided by private Medicare plans.
- The system compares how well Medicare Advantage plans perform based on 50 quality measures assessed across five categories:
  - Staying healthy
  - Managing chronic conditions
  - Customer services
  - Pharmacy services
  - Member satisfaction
Examples Of Measures In Medicare Star Quality Rating System

- Performance measures that are derived from plan and beneficiary information collected in administrative data and data from three surveys:
  - Healthcare Effectiveness Data and Information Set (HEDIS)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - Health Outcomes Survey (HOS) – and administrative data
### Geisinger Gold Classic 3 $0 Deductible Rx (HMO) (H3954-100-0)

- **Organization:** Geisinger Gold

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<td>Retail Annual: $139.90</td>
<td>$13.90</td>
<td>Annual Drug Deductible: $0</td>
<td>Doctor Choice: Plan Doctors Only</td>
<td>All Your Drugs on Formulary: N/A</td>
<td>$2,100</td>
<td>4.5 out of 5 stars</td>
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<td>Rest of 2012: $139.00*</td>
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<td>In-Network</td>
<td>No Gap Coverage</td>
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<td>D V H</td>
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<td>Drug Copay/Coinsurance: $1.10 - $3.30</td>
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### FreedomBlue PPO HD Rx (PPO) (H3916-025-0)

- **Organization:** Highmark Inc.

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<tbody>
<tr>
<td>Retail Annual: $0.00</td>
<td>$0.00</td>
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<td>Doctor Choice: Any Doctor</td>
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<td>Out of Pocket Spending Limit: $2,700 In-Network</td>
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<td>D V H</td>
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### Advantra Elite (PPO) (H5522-008-0)

- **Organization:** HealthAmerica

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<td>Retail Annual: $0.00</td>
<td>$0.00</td>
<td>Annual Drug Deductible: $0</td>
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<td>In-Network</td>
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<td>Drug Copay/Coinsurance: $1.10 - $3.30</td>
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</table>
Physician Quality Reporting System

- PQRS is a Congressionally created mandate for physicians to provide quality data to CMS
- The program is voluntary – but provides incentive payments to eligible physicians (EPs) and other professionals who satisfactorily report data on quality measures for covered services
- CMS provides a 1% incentive payment in 2011 and 0.5 percent incentive payments in 2012 – 2014 for successfully reporting PQRS measures
- Penalties will begin in 2015 for those who do not satisfactorily submit quality data
- CMS proposes to include 198 measures individual EPs can report in 2011
  - Claims–based reporting measures
  - Registry–based reporting measures
  - New individual measures
  - EHR–based reporting measures
Examples Of Measures In Physician Reporting System: Major Depressive Disorder

• Antidepressant Medication During Acute Phase for Patients with MDD – Percentage of patients aged 18 years and older diagnosed with new episode of MDD and documented as treated with antidepressant medication during the entire 84-day (12-week) acute treatment phase

• Diagnostic Evaluation – Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who met the DSM–IV criteria during the visit in which the new diagnosis or recurrent episode was identified during the measurement period

• Suicide Risk Assessment – Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period
Examples Of Measures In Physician Reporting System: Substance Use Disorders

• Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence – Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period

• Screening for Depression Among Patients with Substance Abuse or Dependence – Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period
### NCQA Quality Initiatives

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Health Plan Report Card

### NCQA Accreditation Programs

- Health plan and new health plans
- Managed behavioral healthcare organizations
- Disease management programs
- Wellness and health promotion programs
- Accountable care organizations
- Patient–centered medical homes (recognized practice)
NCQA’s HEDIS Measures

- HEDIS is a tool used by more than 90 percent of America's health plans to measure performance
- Creates a standard data set when comparing performance of health plans
- 75 measures across 8 domains of care

### HEDIS Measures Relevant To Behavioral Health

<table>
<thead>
<tr>
<th>Measure</th>
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<tbody>
<tr>
<td>Antidepressant medication management</td>
</tr>
<tr>
<td>Follow-up care for children prescribed attention-deficit/hyperactivity disorder medication</td>
</tr>
<tr>
<td>Initiation and engagement of alcohol and other drug dependence treatment</td>
</tr>
</tbody>
</table>
Use of antipsychotic medications

The percentage of members 25–64 years of age with a diagnosis of schizophrenia who remained on an antipsychotic medication for at least 80% of their treatment period.

An average of 65.7% of the individuals maintained continuous treatment with an antipsychotic for at least 80% of the time. The range across the states was 48.3% to 84.6%.

Follow-up after hospitalization at seven and 30 days

The percentage of members 25–64 years of age with a diagnosis of schizophrenia who had an outpatient visit, intensive outpatient encounter, or partial hospitalization following discharge from a hospitalization for schizophrenia.

An average of 36% of individuals received follow-up care at seven days and 69.7% received follow-up care at 30 days. The range across the states was 8.3% to 66.1% for seven days, and 25.6% to 88.5% for 30 days.

Cardiovascular screening

The percentage of members 25–64 years of age who were diagnosed with schizophrenia or bipolar disorder and prescribed any antipsychotic medication, and who received a cardiovascular health screening during the measurement year.

An average of 43.9% of individuals received cardiovascular health screening. The range across the states was 6.9% to 63.3%. 

New HEDIS® Measures for SMI Consumers
Diabetes monitoring

Definition:
The percentage of members 25–64 years of age who were diagnosed with schizophrenia and with diabetes, and received both an LDL–C test and an HbA1c test during the measurement year.

Field Test Result:
An average of 57.3% of individuals received LDL–C test and an HbA1c test. The range across the states was 9.1% to 81.6%.

Cardiovascular monitoring

Definition:
The percentage of members 25–64 years of age with a diagnosis of schizophrenia and a diagnosis of cardiovascular disease, who received a cardiovascular health monitoring test during the measurement year.

Field Test Result:
An average of 54.5% of individuals received cardiovascular health monitoring test. The range across the states was 11.7% to 85.7%.

Diabetes screening

Definition:
The percentage of members 25–64 years of age with a diagnosis of schizophrenia or a diagnosis of bipolar disorder, who were prescribed any antipsychotic medication and received a diabetes screening test during the measurement year.

Field Test Result:
An average of 12.1% of individuals received diabetes screening test. The range across the states was 2.3% to 28.2%.
NCQA’s Health Plan Report Card compares the performance of NCQA–accredited health plans across the country based on HEDIS measures.

Categories Of Health Plan Ranking Criteria

- Access and Service
- Living with Illness
- Qualified Providers
- Staying Healthy
- Getting Better
Humana Health Benefit Plan of Louisiana: Health Plan Report Card

**General Information**

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<tr>
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<tr>
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<td>HMO</td>
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<tr>
<td>Address:</td>
<td>One Galleria Boulevard, Suite 1122, Metairie, LA, 70031</td>
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<tr>
<td>Number of members enrolled:</td>
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<td>Website:</td>
<td><a href="http://www.humana.com">www.humana.com</a></td>
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<tr>
<td>Other Names:</td>
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This health plan serves members in the following state(s):
Louisiana

For specific areas covered, please contact the plan directly.

**Accreditation Details**

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**Performance Results**

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**Accreditation Star Ratings**

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<tr>
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# Health Plan Report Card Comparison Function

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<th>Staying Healthy</th>
<th>Getting Better</th>
<th>Living with Illness</th>
<th>Overall Accreditation Status</th>
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<td>★★★★</td>
<td>★★★★★</td>
<td>★★★★</td>
<td>Commendable</td>
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<tr>
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National Quality Forum

• The National Quality Forum (NQF) is a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting.

• The NQF represents over 375 organizations:
  ◦ Public and private purchasers
  ◦ Health care professionals
  ◦ Provider organizations
  ◦ Organizations involved in health care research or quality improvement
  ◦ Health plans
  ◦ Accrediting bodies
NQF–Endorsed Standard Development Process

- NQF uses its formal consensus development process to evaluate and endorse consensus standards which includes:
  - Performance measures
  - Best practices
  - Frameworks
  - Reporting guidelines
- NQF uses this process to ensure the standards going forward are representative of the health care industry as a whole
NQF-Endorsed Behavioral Health Performance Measures

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NCQA)
- Medical Assistance With Smoking and Tobacco Use Cessation (NCQA)
- Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (AMA–PCPI)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (CMS)
- Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD) (NCQA)
- Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (NCQA)
- Cardiovascular health monitoring for people with cardiovascular disease and schizophrenia (SMC) (NCQA)
- Diabetes monitoring for people with diabetes and schizophrenia (NCQA)
- Follow-Up After Hospitalization for Schizophrenia (7– and 30–day) (NCQA)
- Follow-Up After Hospitalization for Mental Illness (NCQA)
Joint Commission Performance Measures For Behavioral Health

- Hours of physical restraint use
- Hours of seclusion
- Multiple antipsychotic medications at discharge – overall rate
- Multiple antipsychotic medications at discharge with appropriate justification – overall rate
- Post discharge continuing care plan – overall rate
- Post discharge continuing care plan transmitted – overall rate
Center For Excellence In Assisted Living (CEAL)

- Non-profit collaborative of 11 national organizations, has published recommendations for nine domains for assessing person-centered home and community-based services (HCBS) attributes and assisted living indicators
- The project was undertaken with Commonwealth Fund support and the recommendations have been submitted to the Centers for Medicare and Medicaid Services (CMS), which is in the process of identifying person-centered attributes and indicators for its Medicaid HCBS programs
CEAL Performance Measurement Domains

1. Core values and philosophy reflect personhood; respect and dignity; autonomy, choice and independence; and privacy
2. Relationships and sense of community reflect and support belonging
3. Governance/ownership values, policies, and practices incorporate and operationalize person-centered principles
4. Leadership systems demonstrate understanding of person-centered principles and support staff empowerment
5. Workforce practices for staff and volunteers support person-centered principles
6. Meaningful life and engagement is supported by soliciting resident preferences and offering them relevant choices
7. Service delivery and schedules support resident preferences
8. Environment, or the facility spaces and visitor policies
9. Accountability on the part of the facility to use resident and staff feedback in quality improvement processes
mental health New York
Browse Category: Counseling & Mental Health

1. Washington Square Institute
   Category: Counseling & Mental Health
   Neighborhoods: Chelsea, Midtown West
   Reviews: 6
   Address: 41 E 11 Univ Pl
   New York, NY 10001
   Phone: (212) 477-2600
   are expected to take part in in order to improve your idea about mental health. Of course you have to pay to sit there.) and seemingly focused on the benefit of the limited group of people, which could be called their...

2. Jewish Board of Family & Children's Services
   Category: Counseling & Mental Health
   Neighborhood: Midtown West
   Reviews: 1
   Address: 120 W 57th St
   New York, NY 10019
   Phone: (212) 582-9100
   The Loss and Bereavement Program for Children and Adolescents offers bereavement groups for youth ages 5-18. Groups are led by two mental health professionals who support an effective grieving process. The bereavement

3. Barbara Haynes, PhD
   Category: Counseling & Mental Health
   Neighborhood: Midtown West
   Reviews: 1
   Address: 19 W 34th St
   New York, NY 10001
   Phone: (718) 762-4178
   forty-five minute mental health session on MY time! The tiny minute office, a rental, smell of eggs, cheese and coffee as well as donuts. Ayia, it was as equal for having a date who constantly texted or check his cell

4. Ryan William F Community Health Center Annex
   Category: Medical Centers
   Neighborhood: Manhattan Valley
   Reviews: 3
   Address: 180 W 100th St
   New York, NY 10025
   Phone: (212) 769-7200
   The F Community Health Center is a great place for medical professionals who want to help their community.
II. How Payer Performance Systems Are Impacting Policy
Impact Of Performance Systems

• With better performance measurement:
  ◦ Payers able to move systems to P4P and risk-based contracting. Policy focus moving from lowest cost per unit to ‘value’ of service
  ◦ Providers are redesigning service delivery models to improve outcomes, reduce costs, and appeal to consumers
  ◦ Consumers are better able to choose providers based on performance
Objectives Of P4P In Behavioral Health

• Link reimbursement to desired outcomes and quality improvements
  ◦ Improved access to care
  ◦ Increase care integration and coordination
  ◦ Person–centered planning and recovery focus

• Control costs of care
  ◦ Financial incentives to help consumers become and remain healthy for longer periods of time
  ◦ Increase lower–cost interventions for ‘not yet seriously ill’ population
  ◦ Reduce unnecessary use of high–cost services
Missouri Health Home Payment & Performance Measures: Capitated Care Management

• The Missouri CMHC health homes receive $78.74 per member per month
• Pay–for–performance funding based on CMHC performance against six benchmarks
  1. Completion rate of metabolic screenings
  2. Enrollment and outreach percentage of clients in The Disease Management 3700 Project (DM 3700)*
  3. Completion rate for CPS adult and youth status reports
  4. Completion rate for Mental Health Statistics Improvement Program (MHSIP) adult consumer surveys
  5. Cyber access patient history utilizations
  6. CMHC behavioral pharmacy management (BPM) benchmark report
64+ measures with financial penalty or incentive:

1. **Readmission rate** Rate of mental health inpatient readmission by children and adults and overall at 7, 30, and 90 days. Monitor to the following:
   - 7-day readmission for children and adults
   - 30-day readmission by children and adults 15% or less
   - 90-day readmission by children and adults 25% or less

2. **Community Tenure** The average time between mental health hospitalizations shall not fall below 60 days for children and adults.

3. **Involuntary Hospitalization** The percent of involuntary admissions for mental health treatment to 24-hour inpatient settings shall not exceed 15% of all children admissions and 10% of all adult admissions.

4. **Service Array** At least 6% of mental health service expenditures will be used in the provision of integrated services and supports, including natural supports, consumer run programs, and services delivered in the home of the enrollee.
New York City Social Impact Bond Program

- In August 2012, NYC awarded a P4P contract to non-profit MDRC for the Rikers Adolescent Behavioral Learning Experience (ABLE) project for incarcerated youth.
- 4 year contract; $2.4M per year; 3000 youth annually
- Goal: reduce recidivism by at least 10%
- Social Impact Bond Financing: private investors (Goldman Sachs) loan $; philanthropy provides loan guarantee; NYC pays MDRC based on outcomes; MDRC repays investors with interest. If MDRC misses outcomes, NYC pays $0.
III. How Payer Performance Systems Are Impacting Providers
Provider Impact

- Payers are increasingly aligning provider performance with compensation
  - “Pure” FFS is decreasing
  - Cost–related contract funding is decreasing
- Consumers are increasingly choosing providers based on performance and cost
- Providers must excel at delivering cost–effective, desirable, evidence–based practices AND also accurately measure and report their performance
Provider Impact

The fundamental questions to answer in this marketplace are –

• How will provider organizations perform under these pressures? How will they deliver on both contractual and consumer expectations?
• How will they remain profitable under the possibility of poor performance and the diminished returns that will come with that kind of performance?
Provider Impact

The ability to demonstrate value-based care will be a key differentiator in the near future. Sharpen your organization’s approach to metrics-based management by proactively incorporating common public measures.

Metrics-based management enables providers to:
• Track clinical and financial performance
• Increase productivity
• Reduce variability of service
• Gather customer satisfaction data
• Measure critical operations components ⇒ Good management decisions
• Strengthen relationship with payers and consumers
Measurement & Reporting from the MBHO Perspective

Tim McIntyre
Sr. Director, Provider Profiling
Magellan Health Services

Mary Wesson
Vice President, Provider Performance
Behavioral Network Services
OptumHealth
Improving Health Care Quality
Tim McIntyre, LCSW
Does Pay for Performance Work?

- The Centers for Medicare and Medicaid Services believes strongly that pay for performance is the best mechanism to tie care to improvements in consumer wellness and outcomes.
- Today there is almost nothing that ties a provider to providing care that is evidence based, safe and effective beyond the individual characteristics of the facility or clinician.
- Evidence remains mixed that pay for performance in the BH space will drive widespread adoption by providers and will lead to better consumer outcomes.
- Some of the difficulty in measuring the impact of pay for performance in the BH space is that the number of studies have been relatively small to date and the data has been very difficult to capture as BH outcomes are often somewhat objective and take time to mature.
- What we do know from work done in the medical space as well as studies in organizational psychology is what you measure, by the virtue of measurement alone, begins to change-participants (provider and consumer alike) move from passive participants to active change agents.
- Systems that measure performance tend, by the very nature of measuring that performance, to implement activities that improve the outcomes.
- Damberg (April 2009, Health Affairs) found that provider organizations make changes in response to financial incentives, but those changes did not always lead to better quality and much work remained to be done to assure improvements were meaningful.
Challenges in Implementing Performance Programs

• Financial incentives are often too small to be meaningful to the provider – base pay has to be sufficiently attractive to make a performance bonus really feel like a bonus.

• Without changes to fee for service structures, performance bonuses don’t do much to address providing more services for the sole purpose of achieving higher payments.

• Misalignment of payment systems – providers are still generally paid more for doing more.

• Metrics are often hard to capture – not easily collected from claims.

• Member outcomes are difficult to quantify and low member participation complicates clear conclusions on provider effectiveness.

• Major contracting changes tax all parts of the system and provider organizations are often not prepared for changes to compensation such as claims withholds, bonus payments, capitation and different fee schedules for achieving performance levels.

• No strong ongoing support for or within provider groups and facilities for what kinds of changes would produce the desired outcomes – lack of coaching and mentoring.

• Implementation of parity changes the authorization process and creates a change in metrics as well as our ability to steer consumers to the best practitioners.
Targets of Performance Based Programs

- **Outcomes** – assure reduction in symptoms, improvement in functioning, better work performance and productivity, reduced absence from work
- **Process** – assure certain kinds of things are provided and that care meets evidence based practice
- **Wrap around** – assure that additional programs or services are offered to consumers – especially disease management and community based services
- **Financial** – assure that care is provided efficiently – making the best use of the benefits that are available to the member
- **Willingness to participate in a program of performance improvement**
- **Medical offset** – assure that BH results in medical savings – less depression in primary care, better compliance with diabetes care, reduction in asthma, fewer ER visits for pain
Potential Data Elements

- Hospital readmission rates (inpatient and outpatient providers)
- Case mix adjusted utilization (inpatient and outpatient)
- Coordination of care and med-psych integration
- Use of adjunctive or alternative services – e-health, ABA services
- Use of electronic medical records
- Clinical outcomes – symptom reduction, improvements in work functioning
- Diversions from inpatient care
- Use of ER services
- Medication assisted treatment for substance abuse (suboxone and other anti-craving medications)
Hallmarks of a Strong Program

- Alignment between payer of the care and the delivery system on goals, measurement and incentives
- Sufficient resources exist to coach and mentor performance improvements
- Financial resources are properly reserved and planned for through contracting mechanism
- Non financial incentives are well formed and rigorously supported and implemented throughout the organization
- Transparency and close to real time feedback
- Scorecards that can easily be understood by consumers that influence their behavior – incentives may also be helpful
- Scorecards available to providers to monitor their own results (at a minimum) and ideally to own over time those results with real financial accountability
- Measurement tools that have strong validity, reliability and clinical utility for the payer, provider and consumer
## Building Performance Based Relationships

<table>
<thead>
<tr>
<th>Meet and Listen</th>
<th>Work Together</th>
<th>Capture and Export Learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Select provider partners for initial contracting focus</td>
<td>• Establish routine feedback mechanism</td>
<td>• Develop scorecard that becomes basis for evaluating broader network performance</td>
</tr>
<tr>
<td>• Review current performance and ascertain plans for sustained performance or performance improvement</td>
<td>• Reach agreement on partnership parameters</td>
<td>• Develop contracting mechanisms – bonus structures, withholds, renewal escalators, shared savings, capitation and mixed models</td>
</tr>
<tr>
<td>• Develop contracting relationships and strategic partnerships</td>
<td>• Measure performance to benchmarked criteria</td>
<td>• Communicate – transparency with consumers and providers is essential</td>
</tr>
<tr>
<td>• Capture provider feedback on strategic partnership</td>
<td>• Provider shares insights into protocols supporting performance</td>
<td>• Listen to what consumer and providers tell you about the program – learn and evolve</td>
</tr>
</tbody>
</table>
**OUR EXPECTATIONS**
- Adherence to clinical best practice standards
- Performance within benchmarked quality metrics
- Provider Engagement to drive high quality and reasonable cost
- Shift in overall payment structure without driving higher costs

**OUR COMMITMENTS**
- Regular communication and collaboration to assure care delivery to consumers
- Regular reporting on performance to benchmarked quality metrics - transparency
- Relaxing of UM requirements
- Focused efforts on patient steering to partner providers

Partnership
## Our Expectations

<table>
<thead>
<tr>
<th>Goals</th>
<th>In Practice</th>
</tr>
</thead>
</table>
| Adherence to Clinical Best Practices | • Routine communication and coaching on Best Practices  
• Shared road maps with ongoing guidance  
• Continual engagement, monitoring and coaching  
| Performance within Quality Benchmarks | • Establish mutually agreed upon benchmark for each partnership  
• Ongoing reporting – high levels of transparency  
• Establish agreed upon process for expanding scorecard metrics  
| Provider Engagement | • Align provider incentives  
• Deliver on commitments for payment, reporting and support  
• Providers move to full accountability for performance rather than passive recipient of rating  
| Shifts in Payment Structures without adding trend | • Contracting methods that move from pure fee for services to performance bonuses and withholds, shared savings and full risk  
• Non financial incentives such as less admin burden, more patients, public recognition  
|
Our Commitments

Goals

Regular Communications
- Establish agreed upon meeting schedule
- Establish key contacts for communications between meetings
- Frequent Reporting with full transparency on performance

Performance to Benchmarks
- Establish benchmark and goals for each partner
- Reach agreement with facility on reporting package (measuring period, specifications, source of truth)
- Establish agreed upon process for expanding scorecard metrics

Relaxing UM
- Prepare document detailing proposed UM relaxing
- Analyze impact at each facility
- Establish criteria for phasing UM in and out

Driving volume
- Document potential levers for driving volume
- Analyze and Quantify potential steerage for each partner facility

In Practice
Creating the Opportunity

- Aligned Goals
- Proper Incentives
- Engaged Providers, Consumers and MBHO

Optimal Clinical and Financial Outcomes
Influencing Member Choice

- Despite attempts by medical and behavioral payers to provide consumers with information that will help them make good choices about the providers they say (cost estimators, information on education, specialties), research shows that the key information consumers value is gaining a feeling for how the provider will be with them.
- Consumers often don’t understand or trust the information provided in a provider directory – generally feel more trust for referrals from family and friends.
- Distrust of provider cost information - some consumers feel that if a provider is more expensive he or she must be a better provider.
- Provider directories need to provide information on what a consumer can expect by way of cost and outcome, but should also provide a sense of what the provider is like.
- Consumers should be given the opportunity to provide feedback on their provider’s performance.
- Consumers should have an opportunity to compare providers and to understand the basis for the ratings that they are viewing.
Provider Search | View Provider Detail

At times a provider's information may change. If you find any errors, please let us know so we can update our directory.

EMPLOYEE ASSTNCE PLUS, LLC (Group)

9378 Olive Blvd. Ste. 317
Saint Louis, MO 63132-3224
314-994-9344
[www.stleaplc.com](http://www.stleaplc.com)
[schedule@stleaplc.com](mailto:schedule@stleaplc.com)

"Candies has always been a symbol of peace, love and harmony to me. However, there are times in everyone's life that peace, love and harmony seems to have vanished away. Maybe this is where I can help because..."  

Office Hours

<table>
<thead>
<tr>
<th>Morning</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
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<td>Afternoon</td>
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<td>Evening</td>
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Languages: English, Spanish

Ages Treated: Younger Child (0-5), Older Child (6-12), Adolescent (13-17), Adult (18-64), Geriatrics (65+)

Specialties: Eating Disorders, Grief/Bereavement, Marriage/Family Therapy, Mental Health, Substance Abuse

Was this review helpful to you?  Yes  No

"Dignissim tempor! Dapibus dapibus? Lundium risus purus parturient? Et, cum tortor! Ut eu vut! Vut cum. Sed sed auctor auctor, a elementum tincidunt mattis et amet utrices etiam etiam lorem adipiscing et!"

Was this review helpful to you?  Yes  No


Was this review helpful to you?  Yes  No

"Porta est, tempor in et cras. Velit dis turpis sit vel quis, velit tortor."

Was this review helpful to you?  Yes  No

"Ridiculus odio rhoncus aliquet, egestas placerat, enim magna, ut magna! Magna magna, augue nisi proin arcu, aenean, et porta nis! Habitasse urna mus integer, elementum magna odio platea! Nisi ridiculus odio in, amet, et porta urna augue, urna proin mattis, adipiscing montes tortor porta purus lectus dis dis?"

Was this review helpful to you?  Yes  No
<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Specialty</th>
<th>Location</th>
<th>Add Review</th>
<th>Attributes</th>
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</thead>
<tbody>
<tr>
<td>ERLING, SHANNON, PHD</td>
<td>Therapist</td>
<td>4144 Lindell Blvd Ste 140</td>
<td>Add Review</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Saint Louis, MO 63108-2931</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>314-996-810</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BUSH, DANIELLE N, MED</td>
<td>Therapist</td>
<td>4500 W Pine Blvd</td>
<td>Add Review</td>
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</tr>
<tr>
<td></td>
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<td>Saint Louis, MO 63108-2186</td>
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<td></td>
<td></td>
<td>314-3-7802</td>
<td></td>
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<tr>
<td>WARNER, KEVIN J, MSW</td>
<td>Social Worker</td>
<td>3909A Magnolia Ave</td>
<td>Add Review</td>
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<td>Saint Louis, MO 63110-4026</td>
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<td></td>
<td></td>
<td>314-229-6779</td>
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<td></td>
</tr>
<tr>
<td>MERZ, LAILA K, MSW</td>
<td>Social Worker</td>
<td>1129 Macklin Ave</td>
<td></td>
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<td></td>
<td></td>
<td>Saint Louis, MO 63110-1440</td>
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<tr>
<td></td>
<td></td>
<td>314-534-0200</td>
<td></td>
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</tr>
</tbody>
</table>
Tools for Providers

- Providers should be able to access all of the data the goes into the profile that we display about them
- Providers should be given the opportunity to own their data and drill down into that data to help them plan practice protocols and programs
- Providers should be given the opportunity to correct data inaccuracies and address any poor ratings they receive
- The goal over time is to move providers to full ownership for clinical and process improvements and share the financial risk and benefits
- Ideally providers bring additional quality programs for partnership consideration – two way street
- The best providers are given the opportunity for public recognition, preferential administrative processes, facilitated claims and the opportunity to develop new programs and services in partnership
Provider Dashboard

Selection of Provider Dashboard opens the dashboard application
Dashboard Details
Conclusion

- Pay for performance programs and changes to contracting and payment systems can work to improve key components of the consumer’s experience and care
- Providers must be active partners in creating and implementing programs
- The goals and metrics must be carefully developed and rigorously cultivated
- Transparency is critical – we are all in this together
- Fee for service as we know it will not continue indefinitely – multiple large and small scale pilots are ongoing throughout the healthcare system and all organizations must be ready for the change
- We all have the same goal – improve the quality, outcome and cost of the care for the consumers who seek our services
Steering the Course: Outcome Measurement, Pay for Performance, and Quality Care

OPEN MINDS Performance Management Institute
February 14, 2013
Background: About Optum

- Optum is a collection of companies, including United Behavioral Health (UBH), owned by UnitedHealth Group; UBH is the largest managed behavioral health company in the country.
- Optum owns and operates work/life, employee assistance (EAP), behavioral health, and disability support programs,
  - Serves 2,500 customers including commercial, state and county government employers, public sector entities, and health plans including United Healthcare
  - Covers more than 43 million members across USA (1 in 6 insured Americans)
- Counseling and treatment services provided through a national network managed out of 9 major call centers across the USA.
  - 110,000 clinicians
  - 5,000 facilities
Improving Outcome and Provider Measurement Programs: Why?

• It’s the *right thing to do* – for everyone!
• There are significant benefits to providers, facilities, and members
• Health care reform legislation
  – Changes in Federal regulations
  – Changes in state requirements
• The economics of the healthcare market
  – Public and private sectors are focusing on spending benefit dollars on *quality* outcomes
  – Consumers want and deserve access to the most effective providers
  – CMS has instituted its STAR rating system
  – Clinicians and facilities are under increased pressure to demonstrate accountability, transparency, and quality
Focus on Achieving the Triple Aim: Improved Quality of Care, Population Health, and Affordability*

These are the fundamental avenues of focus for improving care and outcomes, and enhancing employee health

**Triple Aim**

<table>
<thead>
<tr>
<th><strong>Payment Reform</strong></th>
<th><strong>Employee Responsibility/Incentives</strong></th>
<th><strong>Population Analysis</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Performance-based contracting and other more sophisticated reimbursement approaches as providers’ sophistication matures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Facilitates provider quality and accountability</td>
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<td></td>
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<tr>
<td>• Consumer Tools/Transparency</td>
<td></td>
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<tr>
<td>• Centers of Excellence</td>
<td></td>
<td></td>
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<tr>
<td>• Benefit tiering/high performing networks</td>
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<td></td>
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<tr>
<td>• Helps members make informed choices</td>
<td></td>
<td></td>
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<tr>
<td>• Sophisticated Analytics</td>
<td></td>
<td></td>
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<tr>
<td>• Intra-provider incentives</td>
<td></td>
<td></td>
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<tr>
<td>• Electronic Health Records that allow Provider Interoperability</td>
<td></td>
<td></td>
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<tr>
<td>• Consumer support tools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Facilitates total population management</td>
<td></td>
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</tr>
</tbody>
</table>

The Triple Aim: *Care, Health, and Cost*

- Fundamental drivers of the Triple Aim that directly affect provider practice behavior and the health care delivery system

**Key drivers…**

<table>
<thead>
<tr>
<th>Access</th>
<th>Payment Reform</th>
<th>Practice Performance Measurement</th>
<th>Transparency</th>
<th>Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Existing shortages of primary care and specialists</td>
<td>• Movement from volume based payments to performance-based contracting.</td>
<td>• Measure effectiveness and efficiency</td>
<td>• Process, clinical effectiveness and cost transparency</td>
<td>• Shared across multiple providers, settings and levels of care</td>
</tr>
<tr>
<td>• 30+ million new consumers being added to the system in 2014</td>
<td>• Bundling rates across discipline and levels of care</td>
<td>• Identify top performers within the system</td>
<td>• Info for Consumers</td>
<td>• Transparent designation</td>
</tr>
<tr>
<td>• Rethinking scope of practices for key practitioner types</td>
<td>• Shifting more financial accountability to providers</td>
<td>• Stratify the network, based on performance</td>
<td>• Info available to Competitors</td>
<td>• Wide scope of expectations beyond typical focus</td>
</tr>
<tr>
<td>• Use of emerging technologies to improve access</td>
<td></td>
<td>• Link performance measures with payment</td>
<td>• Benefit to high performing networks</td>
<td></td>
</tr>
</tbody>
</table>
Current Conditions Drive All of Us to Change

**Consumer**
- Needs to be informed
- Will make choices
- Needs to be active
- Financially engaged
- Part of the treatment decision-making team

**Practitioner**
- Changes practice to patient-centered
- Integrated approach
- Rated, based on performance
- Performance made public

**Managed Care**
- Partners and supports providers with data
- Facilitates providers’ “learning curve”
- Enhances support for consumers
- Pays providers differently
- Pays providers for quality

**Provider Practice**
- Uses data and information technology
- Accountable for outcome
- Population management
- Operates within a system of care as an owner
Responding to the Industry Conditions

We are building the infrastructure needed to support the system delivery changes and provider practices.

- Provider Engagement
  - Pay-for-performance arrangements
  - Transparent provider rating against best performers – measuring clinical and cost effectiveness

- Care System Facilitator
  - Leveraging Optum
  - Provider relationships
  - IT solutions

- Member Engagement
  - Online provider performance profiles
  - Peer-support approaches
  - Tools to enhance daily wellness
  - Enhanced social networking options

- Clinical Innovation
  - Tele-psychiatry
  - Peer-centered networks and solutions
  - Centers of Excellence
  - Specialty networks
  - Special Investigation Unit focused on Fraud, Waste and Abuse

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Current Provider Performance Initiatives

1. Facility Quality Measure (FQM)
2. Campaign for Excellence (CFE)
3. ALERT®
   Algorithms for Effective Reporting and Treatment
Facility Quality Measurement (FQM)
The History of FQM

With a commitment to Quality and Continuous Improvement, our facility based evaluation tool has been in development since 2005. Facilities have received scorecards since 2006, and we are now in our fourth generation of the program.

• Based on a quality improvement project
• Introduced in 2006, following two years of development
• FQM’s methodology was enhanced in 2008, providing qualifying facilities with a quarterly scorecard
• Revised benchmarks and improved case mix methodology to include more variables
• Added public sector data in January 2010
• Implemented stars for quality and efficiency to display on the member portal for provider search
Tiering Structure: Quality First

Quality (Clinical Effectiveness) + Cost (Efficiency) = Value

- A facility that achieves the quality criteria receives one star (★).
- A facility that achieves the quality criteria and meets the criteria for efficiency receives an additional star (★★).
- A facility can not receive an efficiency star unless they achieve the quality criteria.
- Facilities that achieve the two-star rating are considered Tier 1 facilities.
### Facility Scorecard

#### Tier # 1

**Facility Name**: United Behavioral Health / US Behavioral Health Plan, California  
**State**: Reporting Period: 19. 01OCT2011-30SEP2012

#### Facility Performance Summary

<table>
<thead>
<tr>
<th></th>
<th>Discharge</th>
<th>Average Quality Score</th>
<th>Efficiency Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>515</td>
<td>2.7</td>
<td></td>
</tr>
<tr>
<td>Medicare / Medicaid</td>
<td>60</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>Weighted / Combined Score</td>
<td>575</td>
<td>2.6</td>
<td>In Range</td>
</tr>
</tbody>
</table>

#### Tiering Criteria

<table>
<thead>
<tr>
<th>Tier #</th>
<th>Average Quality Score</th>
<th>Efficiency Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>≥ 2.0 and In Range</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>≥ 2.0 and Out Of Range</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1.1 - 2.0 and In Range</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>&lt; 1.1 and Not Considered</td>
<td></td>
</tr>
</tbody>
</table>

### Membership

#### Commercial Membership

**Average Quality Score**: Range: 1 to 3 (low to high)  

<table>
<thead>
<tr>
<th>Metric</th>
<th>30 Day Readmissions</th>
<th>Appts Scheduled</th>
<th>Appts Kept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Score</td>
<td>8.5% High (3)</td>
<td>36.0% High (3)</td>
<td>60.3% Med (2)</td>
</tr>
<tr>
<td>State</td>
<td>8.7% High (3)</td>
<td>30.4% High (3)</td>
<td>45.3% Med (2)</td>
</tr>
<tr>
<td>Book of Business</td>
<td>9.9% High (3)</td>
<td>76.1% Med (2)</td>
<td>57.7% Med (2)</td>
</tr>
</tbody>
</table>

#### Medicare and Medicaid Membership

**Average Quality Score**: Range: 1 to 3 (low to high)  

<table>
<thead>
<tr>
<th>Metric</th>
<th>30 Day Readmissions</th>
<th>180 Day Readmissions</th>
<th>Community Tenure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Score</td>
<td>11.7% High (3)</td>
<td>27.1% High (3)</td>
<td>138 Low (1)</td>
</tr>
<tr>
<td>State</td>
<td>11.3% High (3)</td>
<td>30.8% Med (2)</td>
<td>156 Low (1)</td>
</tr>
<tr>
<td>Book of Business</td>
<td>18.6% High (3)</td>
<td>40.5% Med (2)</td>
<td>157 Low (1)</td>
</tr>
</tbody>
</table>

#### Quality Metrics Benchmarks

<table>
<thead>
<tr>
<th>Metric</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Score</td>
<td>&gt; 80.0%</td>
<td>&gt; 60.0%</td>
<td>&gt; 36.0%</td>
</tr>
<tr>
<td>State</td>
<td>&gt; 80.0%</td>
<td>51.2% - 80.0%</td>
<td>&lt; 51.2%</td>
</tr>
<tr>
<td>UHN Book of Business</td>
<td>&gt; 80.0%</td>
<td>36.0% - 60.0%</td>
<td>&lt; 36.0%</td>
</tr>
</tbody>
</table>

### Combined Efficiency

#### Efficiency Score

**In Range**

- **Raw ALOS**
- **Case-Mix Adjusted ALOS**
- **ALOS Variation from Expected**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Expected ALOS</th>
<th>ALOS Variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Score</td>
<td>6.0</td>
<td>5.7</td>
</tr>
<tr>
<td>State</td>
<td>6.5</td>
<td>N/A</td>
</tr>
<tr>
<td>UHN Book of Business</td>
<td>6.3</td>
<td>N/A</td>
</tr>
</tbody>
</table>

#### Efficiency Metric Benchmark

- **ALOS Variation – In Range (High)**: <= 1
- **ALOS Variation – Out of Range (Low)**: > 1
## FQM Scorecard Detail

### Facility Scorecard

**United Behavioral Health / US Behavioral Health Plan, California**

**Tier # 1**

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Tier #</th>
<th>Average Quality Score</th>
<th>Efficiency Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>1</td>
<td>&gt; 2.0 and In Range</td>
<td></td>
</tr>
<tr>
<td>Medicare / Medicaid</td>
<td>2</td>
<td>&gt; 2.0 and Out of Range</td>
<td></td>
</tr>
<tr>
<td>Weighted / Combined Score</td>
<td>3</td>
<td>&lt; 1.1 and Not Considered</td>
<td></td>
</tr>
</tbody>
</table>

### Facility Performance Summary

<table>
<thead>
<tr>
<th></th>
<th>Discharge</th>
<th>Average Quality Score</th>
<th>Efficiency Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>515</td>
<td>2.7</td>
<td></td>
</tr>
<tr>
<td>Medicare / Medicaid</td>
<td>60</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>Weighted / Combined Score</td>
<td>575</td>
<td>2.6</td>
<td>In Range</td>
</tr>
</tbody>
</table>

### Membership

#### Commercial Membership

<table>
<thead>
<tr>
<th>Metric</th>
<th>Ranges: 1 to 3 (Low to High)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Score</td>
<td>High</td>
</tr>
<tr>
<td>State</td>
<td>High</td>
</tr>
<tr>
<td>Book of Business</td>
<td>High</td>
</tr>
</tbody>
</table>

### Medicare and Medicaid Membership

<table>
<thead>
<tr>
<th>Metric</th>
<th>Ranges: 1 to 3 (Low to High)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Score</td>
<td>High</td>
</tr>
<tr>
<td>State</td>
<td>High</td>
</tr>
<tr>
<td>Book of Business</td>
<td>High</td>
</tr>
</tbody>
</table>

### Efficiency

**Efficiency Score:** In Range

- Raw ALOS
- Expected ALOS (Case-Mix Adjusted)
- ALOS Variation from Expected

<table>
<thead>
<tr>
<th>Metric</th>
<th>Raw ALOS</th>
<th>Expected ALOS (Case-Mix Adjusted)</th>
<th>ALOS Variation from Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Score</td>
<td>6.0</td>
<td>5.7</td>
<td>0.3</td>
</tr>
<tr>
<td>State</td>
<td>6.5</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>URN Book of Business</td>
<td>6.3</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Efficiency Metric Benchmark**

- ALOS Variation - In Range (High) <= 1
- ALOS Variation - Out of Range (Low) > 1

---

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## Star Designations on Online Directory

### Facility Search Results

Your search results are listed below. You can change the sort order of the results by clicking on the Facility Name or Distance column header.

Note: It is possible that certain services or programs provided by the facility are not covered by OptumHealth Behavioral Solutions. Please contact OptumHealth Behavioral Solutions to confirm coverage of the service or program desired.

To learn more about our quality program - indicated with ★'s on this site, please click [here](#).

**Directory last updated on 07/26/2012**

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Distance</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Phone</th>
<th>Map</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234 Pretend St</td>
<td>10.3</td>
<td>1234 Pretend St</td>
<td>Anywhere</td>
<td>TX</td>
<td>33000</td>
<td>(555) 991-6044</td>
<td></td>
</tr>
<tr>
<td>111 Test Blvd</td>
<td>10.3</td>
<td>111 Test Blvd</td>
<td>Anywhere</td>
<td>TX</td>
<td>33000</td>
<td>(555) 434-4566</td>
<td></td>
</tr>
<tr>
<td>223 Medical Ctr Dr</td>
<td>11.8</td>
<td>223 Medical Ctr Dr</td>
<td>Anywhere</td>
<td>TX</td>
<td>33000</td>
<td>(555) 991-8500</td>
<td></td>
</tr>
<tr>
<td>123 Blvd</td>
<td>19.1</td>
<td>123 Blvd</td>
<td>Anywhere</td>
<td>TX</td>
<td>33000</td>
<td>(555) 474-8888</td>
<td></td>
</tr>
<tr>
<td>151 Peachford Rd</td>
<td>13.0</td>
<td>151 Peachford Rd</td>
<td>Anywhere</td>
<td>TX</td>
<td>33000</td>
<td>(555) 456-3200</td>
<td></td>
</tr>
<tr>
<td>303 Pkwy Dr NE</td>
<td>1.3</td>
<td>303 Pkwy Dr NE</td>
<td>Anywhere</td>
<td>TX</td>
<td>33000</td>
<td>(555) 265-4000</td>
<td></td>
</tr>
<tr>
<td>2701 N Decatur Rd</td>
<td>6.7</td>
<td>2701 N Decatur Rd</td>
<td>Anywhere</td>
<td>TX</td>
<td>33000</td>
<td>(555) 601-1000</td>
<td></td>
</tr>
<tr>
<td>3050 Austell Rd</td>
<td>14.4</td>
<td>3050 Austell Rd</td>
<td>Anywhere</td>
<td>TX</td>
<td>33000</td>
<td>(555) 732-6580</td>
<td></td>
</tr>
<tr>
<td>1821 Clifton Rd NE</td>
<td>4.9</td>
<td>1821 Clifton Rd NE</td>
<td>Anywhere</td>
<td>TX</td>
<td>33000</td>
<td>(555) 728-6200</td>
<td></td>
</tr>
</tbody>
</table>

**Total Record Results: 9**

1

★★ Quality and cost efficiency criteria met
★ Quality of care criteria met
We have released four iterations of the scorecard to facilities who qualify.

The number of facilities achieving Tier 1 status has increased.

The number of Tier 3 facilities has decreased.

More members have opportunities to receive treatment at Tier 1 facilities.

Members seen at Tier 1 facilities have lower overall treatment costs.

<table>
<thead>
<tr>
<th>Facilities</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 2013</td>
<td>925</td>
<td>43%</td>
<td>47%</td>
</tr>
<tr>
<td>May 2008</td>
<td>792</td>
<td>28%</td>
<td>51%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Jan 2013</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of tiered facilities</td>
<td>43%</td>
<td>47%</td>
<td>10%</td>
</tr>
<tr>
<td>Average cost per admission</td>
<td>$4,930</td>
<td>$5,559</td>
<td>$6,370</td>
</tr>
</tbody>
</table>

Quality Care = Cost Effective Care
Campaign for Excellence (CFE)
History of CFE

Optum established the Campaign for Excellence in response to requests from members and customers for increased transparency, value, and choice within behavioral health services. This program reinforces our shared belief that patient outcomes are the most important indicator of quality.

• In 2007, UBH assembled a National Advisory Council comprised of national behavioral health experts, consumers, network clinicians, and Health Plan and employer representatives to gather stakeholder input into a provider performance measure.

• Baseline clinical data reports were mailed in December 2007 to approximately 5,800 network clinicians in six states in order to obtain clinician input.

• Clinicians provided valuable input through an online survey.

• Recommendations from the network clinicians and the National Advisory Council formed the basis for the design of the Campaign for Excellence.
Campaign for Excellence (CFE)

• CFE measures individual clinician and group performance through a review of member outcomes derived from the ALERT® Wellness Assessments.
• Our clinician-level analysis accounts for variance in member severity.
• Outcomes data is shared with participating clinicians.
• Transparency to members is achieved via the online provider directory, helping inform their decisions related to behavioral health care.
• Clinicians and groups with superior outcomes are recognized and rewarded.
• This program drives cost-savings through referral to and reliance on clinicians and groups who have a proven track record of effective treatment.
• CFE guides performance-based contracting.
• Providers with single star ratings see double the number of patients per year (48 vs. 24).
• Nationally preferred solo clinicians cost $185 less per episode ($120 less for groups).
Quality Measure

Severity Adjusted Effect Size (SAES)

- SAES is the methodology that Optum uses to measure outcomes.
- This methodology was developed in consultation with external statisticians and approved by the Provider National Advisory Council.
- The outcomes measure is derived from member reports on the ALERT Wellness Assessment.
- Effect size is a common metric to measure treatment effectiveness.
- SAES adjusts the effect size measure for case mix differences.
Clinician’s View of CFE Outcome Measures

**Campaign For Excellence (CFE) Score**

**Clinical Effectiveness**
Clinical effectiveness is measured using a Severity Adjusted Effect Size (SAES) for change in Global Distress, the core scale of the UBH Wellness Assessments. Clinical effectiveness can be measured for clinicians with 10 or more members for whom a minimum of two Wellness Assessments were received AND whose baseline Global Distress score was within the clinical range. For more information on the methodology, [click here](#).

**Your Results**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Clinical Cases</td>
<td>12</td>
</tr>
<tr>
<td>Your SAES Lower Confidence Limit (LCL)</td>
<td>0.54</td>
</tr>
<tr>
<td>Your Mean SAES</td>
<td>0.76</td>
</tr>
<tr>
<td>Your SAES Upper Confidence Limit (UCL)</td>
<td>0.98</td>
</tr>
<tr>
<td>Your Effectiveness Designation</td>
<td>Effective</td>
</tr>
<tr>
<td>Your Network Tier</td>
<td>1</td>
</tr>
<tr>
<td>UBH Network Mean SAES</td>
<td>0.81</td>
</tr>
</tbody>
</table>

To view treatment episodes that make up your SAES, [click here](#).

**Network Tier Designation**

<table>
<thead>
<tr>
<th>Tier</th>
<th>Clinical Effectiveness</th>
<th>CFE Enrollment Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>Effective, LCL &gt;= 50</td>
<td>Participant</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Insufficient Data to Determine Effectiveness, LCL &lt; 50 and UCL &gt;= 50</td>
<td>Participant</td>
</tr>
<tr>
<td>Tier 3</td>
<td>No Designation, UCL &lt; 50</td>
<td>Participant</td>
</tr>
<tr>
<td></td>
<td>No Designation, Non CFE Enrollee</td>
<td>Non-Participant</td>
</tr>
</tbody>
</table>

To view the CFE Business Partner Rewards Program, [click here](#).
# Sample Detail Data for Individual Clinician

## Treatment Episodes that contributed to the Severity Adjusted Effective Size (SAES)

### Sample Data
- **Patient:** All
- **Adult/Youth:** All
- **Change Comparision:** All

<table>
<thead>
<tr>
<th>Patient</th>
<th>Adult/Youth</th>
<th>Last WA Date</th>
<th>Baseline Global Distress Score</th>
<th>Last Global Distress Score</th>
<th>Actual Change</th>
<th>Actual Change Compared to Expected Change</th>
<th>Episode SAES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 01</td>
<td>A</td>
<td>8/11/09</td>
<td>42</td>
<td>26</td>
<td>-16</td>
<td>As Expected</td>
<td>1.53</td>
</tr>
<tr>
<td>Patient 02</td>
<td>A</td>
<td>9/4/09</td>
<td>18.21</td>
<td>20.36</td>
<td>2.15</td>
<td>Worse than Expected</td>
<td>-0.35</td>
</tr>
<tr>
<td>Patient 03</td>
<td>A</td>
<td>9/10/09</td>
<td>21</td>
<td>19</td>
<td>-2</td>
<td>As Expected</td>
<td>0.28</td>
</tr>
<tr>
<td>Patient 04</td>
<td>A</td>
<td>11/5/09</td>
<td>37</td>
<td>28</td>
<td>-9</td>
<td>As Expected</td>
<td>0.37</td>
</tr>
<tr>
<td>Patient 05</td>
<td>A</td>
<td>11/17/09</td>
<td>15</td>
<td>13</td>
<td>-2</td>
<td>As Expected</td>
<td>0.86</td>
</tr>
<tr>
<td>Patient 06</td>
<td>A</td>
<td>3/19/10</td>
<td>17</td>
<td>8</td>
<td>-9</td>
<td>As Expected</td>
<td>1.26</td>
</tr>
<tr>
<td>Patient 07</td>
<td>A</td>
<td>12/17/10</td>
<td>20</td>
<td>8</td>
<td>-12</td>
<td>As Expected</td>
<td>1.7</td>
</tr>
<tr>
<td>Patient 08</td>
<td>A</td>
<td>3/4/11</td>
<td>21</td>
<td>13</td>
<td>-8</td>
<td>As Expected</td>
<td>0.75</td>
</tr>
<tr>
<td>Patient 09</td>
<td>A</td>
<td>4/11/11</td>
<td>25</td>
<td>24</td>
<td>-1</td>
<td>As Expected</td>
<td>0.4</td>
</tr>
<tr>
<td>Patient 10</td>
<td>Y</td>
<td>8/7/09</td>
<td>18</td>
<td>11</td>
<td>-7</td>
<td>As Expected</td>
<td>1.13</td>
</tr>
</tbody>
</table>
## Member Transparency

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Clinician Type</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>County</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXXX</td>
<td>Masters Level Clinician</td>
<td>Phoenix AZ</td>
<td>85028</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Masters Level Clinician</td>
<td>Phoenix AZ</td>
<td>85004</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Masters Level Clinician</td>
<td>Phoenix AZ</td>
<td>85013</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Masters Level Clinician</td>
<td>Phoenix AZ</td>
<td>85044</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Masters Level Clinician</td>
<td>Phoenix AZ</td>
<td>85014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Masters Level Clinician</td>
<td>Phoenix AZ</td>
<td>85020</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Masters Level Clinician</td>
<td>Phoenix AZ</td>
<td>85018</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Masters Level Clinician</td>
<td>Phoenix AZ</td>
<td>85028</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XXXX</td>
<td>Masters Level Clinician</td>
<td>Phoenix AZ</td>
<td>85014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### Clinician Search

OptumHealth Behavioral Solutions has a clinician recognition program called Campaign for Excellence (CFE). It is a voluntary program that clinicians in the OHNS network may choose to join. Group practices are also invited to join CFE.

The star designation in this directory is designed to show you those clinicians or group practices who joined the CFE and have achieved effective results based upon Wellness Assessment reports reflecting member symptom changes during treatment.

Clinicians or groups may not have a star because they: 1) are part of the CFE program but do not have enough information to rate their effectiveness, 2) have not volunteered for the CFE program, or 3) have volunteered for CFE but have not achieved effective results.

The star designation is intended only as a guide when choosing a clinician or group practitioner and should not be the sole factor in the selection of a treatment professional. As with all programs that evaluate performance based on analysis of a sample, there is a risk of error. For example, an error may occur in the claim data used in the evaluation, the calculation used in the evaluation, and/or the way the program determined that an individual clinician was responsible for the treatment of the patient’s condition. It is important that you consider many factors and information from as many sources as possible when selecting a clinician. You may wish to discuss designations with a clinician before choosing him/her or confer with your current physician for advice on selecting other clinicians. Please be aware that some geographical areas may not have a CFE-recognized clinician due to participation being voluntary.
ALERT Online
**ALERT Online – Empowering Clinicians**

ALERT Online is a powerful tool that empowers network clinicians to monitor their patients’ progress in treatment and their clinical effectiveness.

- **Interactive reports** are updated nightly on [www.providerexpress.com](http://www.providerexpress.com).
- **Clinician Aggregate Reports**
  - Mean change reported by their patients
  - Severity Adjusted Effect Size
  - Certificate of Clinical Effectiveness
- **Member-Specific Reports**
  - Progress reports tracking patients’ improvement
  - ALERT algorithms
  - Wellness Assessments Responses
- **Resource library and references** are available to providers.
  - FAQs
  - White Papers

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- Mean change reported by their patients
- Severity Adjusted Effect Size
- Certificate of Clinical Effectiveness

**Member-Specific Reports**

- Progress reports tracking patients’ improvement
- ALERT algorithms
- Wellness Assessments Responses

**Resource library and references** are available to providers.

- FAQs
- White Papers
Comparative Data

- By using the tabs *Global Distress, Workplace Presenteeism, Workplace Absenteeism,* and *Caregiver Strain* located in *Clinician Group*, clinicians are able to view comparative data showing the changes in global distress scores for their members, compared to our national data set.
Progress Reports

- In the **Member** tab, clinicians are able to access *Progress Reports*, which allow them to track their client’s scores across Wellness Assessments.
- Clinicians are encouraged to submit additional Wellness Assessments to track their client’s progress, in greater detail, over time.
Network Innovations

“A shift toward increased collaboration between payors and providers is driving innovation in outcome-based payment models and delivery system configuration.”

— Sam Ho, Chief Medical Officer, UnitedHealth Group
Network Innovation Strategy to Increase Value

• We are developing and implementing a suite of value-based incentive programs that reward care providers for improvements in quality and efficiency.

• We are supporting delivery systems as they become more integrated and accountable for cost, quality and experience outcomes.

• Alignment across our Network, Product and Clinical innovations allows us to increase value for customers and consumers.
Transition of the Model

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

Compensation Continuum

- Small % of financial risk
  - Fee-for-service
  - Performance-based Contracting
- Moderate % of financial risk
  - Bundled and Episodic Payments
  - Shared Savings
- Large % of financial risk
  - Shared Risk
  - Capitation
  - Capitation + Performance-based Contracting
- No Accountability
- Moderate Accountability
- Full Accountability
Nearly 10% of our total spending on network-based health care services across all OptumHealth Behavioral Solutions lines of business is tied to performance-based incentive contracts that reward providers for increased collaboration, outcome-based results, and improved cost-efficiencies.
## Performance-Based Contracting – At A Glance

Incentivizing provider performance leads to better outcomes for employees.

### Facility Participation Requirements

| Collects **HBIPS7** data for JCAHO and shares yearly results with OptumHealth  
Adheres to our utilization management process, Level of Care Guidelines and Coverage Determination Guidelines, including attending MD visits, pre-authorization requirements, and discharge planning  
Qualifies as an OptumHealth High-Volume provider  
Participates in periodic meetings with OptumHealth clinical operations staff to review data  
Submits claims electronically |

### Metrics

| Reduction in Average Length of Stay  
Reduction in 30 day Readmission rate to any inpatient LOC  
Improved results on ambulatory follow-up rates (7 days post inpatient discharge) |

### Performance Incentives

| Facility will earn escalator based sharing of savings if performance is within targeted range  
Facility will earn additional escalator through greater sharing of savings if performance exceeds range (up to a cap)  
Can earn return if only one measure is met as long as there are savings in total days |
Platinum: Embracing the Future

- To develop and promote transparency of metrics to outpatient and facility networks, based on quality and cost metrics
- To identify providers and facilities that provide the best quality and most cost-efficient care for our members
- To achieve transparency of cost and quality metrics for members (i.e., provide a star rating for cost/efficiency to members and internal customers)
- To utilize network tiering for preferential referral strategies
- To utilize reimbursement strategies (pay for performance, bundling, case-rates etc.) to strengthen the tier system
- To achieve accreditation for provider (clinicians and groups only) performance programs through the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF)
## Quality and Cost Metrics - Facilities

### FQM Current Metrics

#### Commercial
- 30-day Readmission Rate
- Follow-up scheduled to occur within 7 days of discharge, and actual occurrence of follow-up within 7 days
- Case-mix adjusted Average Length of Stay

#### Public Sector
- 30-day Readmission Rate
- 180-day Readmission Rate
- Community Tenure
- Case-mix adjusted Average Length of Stay

### Future Metrics - Quality
- 7-day Readmission Rate
- Risk-Adjusted 30-day Readmission Rate
- Follow-up after mental health hospitalization (HEDIS)
- Peer Review Rate

### Future Metrics - Cost
- Case-mix adjusted Average Length of Stay
- Spending per beneficiary
Quality and Cost Metrics - Individuals and Groups

**CFE Current Metrics**
- Severity Adjusted Effect Size from the Wellness Assessments

**Future Metrics**
- Severity Adjusted Effect Size from the Wellness Assessments
- Case-Mix Adjusted Average Number of Visits
- Average cost per episode (groups)
Members can compare clinicians by cost (actual out-of-pocket expenses) as well as clinical performance ratings on quality and efficiency.

Preferred clinicians “star-rated” for quality can earn a second star rating for meeting cost-efficiency standards.

“This looks a lot like picking a flight…it is already feeling familiar.”

“Ratings matter.”

— Consumer Testing Responses
Questions/Comments?
Thank You…

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Closing Thought

Great works are 1% inspiration and 99% perspiration…
Upcoming Education Events

2013 Planning & Innovation Institute
June 11–13, 2013 – New Orleans, Louisiana

2013 Executive Leadership Institute
September 11–13, 2013 – Gettysburg, Pennsylvania

2013 Technology & Informatics Institute

2014 Performance Management Institute
February 13–14, 2014 – Clearwater Beach, Florida
The **market intelligence** to navigate.
The **management expertise** to succeed.