The road map of Value Based Purchasing: Magellan Behavioral Health of Pennsylvania
Magellan Health attendees

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VBP.....What’s in it for me?

**Providers**
- Additional TA
- Consistency
- Learning collaborative
- Data – system level
- Comparative outcomes
- Reduced UM
- Published preferred provider status
- Reimbursement – aligned with performance

**Payers**
- Data based decision making for reimbursement and incentives.
- Quality of Programs
- Best performing providers
- Improved provider engagement tools

**Consumers**
- Enough information to choose the best provider for their needs. Includes cost and quality information.

**Quality** + **Cost** = **Value**
Value-based purchasing

Key Components

• **Defining Value** through data analytics that are transparent and standardized to equitable measure
• Early and ongoing **provider engagement**
• **Transparency** through sharing provider performance
• **Payment alignment** by reimbursing based on performance and incentives are aligned with measurements of value
• **Informed choice** Consumers, customers and payers have the right information to make informed decisions about choice of care, network and contracting (providers as consumers and payers)
**Value-based purchasing – Present State**

Key Components to Magellan’s Value Based Purchasing Model

- **Defined Value**: The use of data, algorithms, standardized equitable measures and actionable information to identify and define provider value.
- **Provider Engagement**: Early and ongoing engagement through data and an understanding of what is being measured, why and how it's being measured.
- **Transparency**: Public reporting to drive performance improvement and consumer transparency for selection of highest quality providers.
- **Payment Alignment**: Reimbursement is based upon performance and incentives are aligned with definition of value.
- **Informed Choice**: Consumers, customers and payers have the right information to make informed decisions about choice of care, network and contracting.
- **High Performance Networks**: Care Coordination, Member Facing Provider Profiles, Member Outcomes Data.
Clinical Delivery Transformation is at the Heart of Success

We couple our VBP strategy with tactical provider support to ensure success

The WHAT

1) Engaging providers,
2) Digging in deep to understand the market and provider readiness
3) Developing the alternative payment methodologies that will be supported by the provider community
4) Implementing the models to achieve value (cost/quality) across the continuum of care.

The Magellan HOW

1) Provider Engagement
2) Provider Readiness
3) Magellan Operational Support: Provider relations, education, support, technical assistance
4) Individual and Provider Group collaborative support approaches
### VBP-Then and Now

<table>
<thead>
<tr>
<th>Category</th>
<th>Then</th>
<th>Now</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Value Definition</strong></td>
<td>Did not include cost in the determination of value.</td>
<td>Cost/Quality=Value</td>
</tr>
<tr>
<td><strong>Provider Engagement</strong></td>
<td>Providers were engaged in performance improvement programs that focused on key metrics at the provider vs. system level.</td>
<td>Early and ongoing engagement through data and an understanding of what is being measured, why and how it’s being measured</td>
</tr>
<tr>
<td><strong>Transparency</strong></td>
<td>Public/Consumer reporting that was limited to certain providers not all providers.</td>
<td>Public/Consumer reporting that allows for comparison of provider performance</td>
</tr>
<tr>
<td><strong>Payment Alignment</strong></td>
<td>Payment was performance based on certain metrics for certain providers.</td>
<td>Payment is aligned with performance across all providers within level of care service. Allows for higher reimbursement to shift to higher performing providers.</td>
</tr>
<tr>
<td><strong>Informed Choice</strong></td>
<td>Little or no data was supplied externally in which decisions could be made regarding choice of care, network and contracting</td>
<td>Consumers, customers and payers have the right information to make informed decisions about choice of care, network and contracting.</td>
</tr>
</tbody>
</table>
Mile markers along the route of value-based purchasing

- Commitment
- Informed Choice
- Payment Alignment and redesign
- Transparency
- Provider Engagement
- Defining, assessing and measuring value.
# EVOLUTION OF VBP AT MAGELLAN

## History and Experience

<table>
<thead>
<tr>
<th></th>
<th>Defined Value Cost/Quality</th>
<th>Provider Engagement</th>
<th>Transparency</th>
<th>Payment Alignment</th>
<th>Informed Choice</th>
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</thead>
<tbody>
<tr>
<td><strong>Pay for Performance</strong></td>
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<tr>
<td><strong>Incentives</strong></td>
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<td>x</td>
<td>x</td>
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<tr>
<td><strong>Children’s Quality Collaborative (CQC)</strong></td>
<td>Missing Cost</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reward for Quality (R4Q)</strong></td>
<td>Missing Cost</td>
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<tr>
<td><strong>Partners in Care</strong></td>
<td></td>
<td>x</td>
<td>x</td>
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</table>

Temporary Rate increases not aligned across loc or available to all providers.
**PIT STOP 1: Reward for Quality (R4Q)**

**The opportunity:**
Establish a pilot program that allowed for increasing transparency with outcomes data and increasing provider awareness of standardized metrics.

**The approach:**
Prospective providers were identified based upon a review of specific quality metrics, audit history, and provider performance. Based on this review and analysis, a group of providers were identified for individual discussions.
R4Q-Approach Continued

Each level of care had certain indicators that were assessed-claims based as well as multiple tiers of benchmarks to measure the attainment of goals. Quarterly performance reviews:

- Admissions to higher levels of care
- Readmission to same or higher level of care
- Average length of stay
- Ambulatory follow-up rates
- Various clinical best practice measures based upon available data
## R4Q-The Pay for Performance Component

### Year One: Rate Structure

<table>
<thead>
<tr>
<th>Tier #</th>
<th>Definition</th>
<th>Rate Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold #1</td>
<td>All three standards met at the Gold level</td>
<td>3.5%</td>
</tr>
<tr>
<td>Gold #2</td>
<td>Two standards met at the Gold level and one standard met at the Silver level</td>
<td>3.0%</td>
</tr>
<tr>
<td>Silver #1</td>
<td>All three standards met at the Silver level or two Silver and one Gold</td>
<td>2.0%</td>
</tr>
<tr>
<td>Silver #2</td>
<td>Two out of three standards met at the Gold or Silver level</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

### Year Two: Rate Structure

<table>
<thead>
<tr>
<th>Tier #</th>
<th>Definition</th>
<th>Rate Increase</th>
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</thead>
<tbody>
<tr>
<td>5</td>
<td>All four standards met at Gold</td>
<td>5.0%</td>
</tr>
<tr>
<td>4</td>
<td>Three standards met at Gold and one standard met at Silver</td>
<td>4.0%</td>
</tr>
<tr>
<td>3</td>
<td>All four standards met at Silver or three Silver standards and one Gold standard are met</td>
<td>3.5%</td>
</tr>
<tr>
<td>2</td>
<td>Three of the four standards are met at any level</td>
<td>3.0%</td>
</tr>
<tr>
<td>1</td>
<td>Two of the four standards are met at any level</td>
<td>2.5%</td>
</tr>
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R4Q Results and Outcomes

The R4Q program has proven to be a valuable tool in achieving

- Increased Access
- Overall transparency and accountability with outcomes data
- Continuity of Care
- Increased quality

Providers that participated in the R4Q program performed better

- Lower readmission rates
- Lower Average Length of Stay (ALOS)
- Lower acute admission rates
- Increased 7 day follow up rates (AFU)
R4Q-Pit Stop Pick Up’s
Building the car while driving

Quality Metrics
Provider engagement
Transparency
PIT STOP 2: Children’s Quality Collaborative (CQC)

The Opportunity:

Ensure that Behavioral Health Rehabilitative Services (BHRS) were being appropriately utilized:

- Increase program efficiencies
- Increase quality and effectiveness of program services
- Improve consumer outcomes
- Develop and implement a payment system that pays for quality

Program Objectives:

- Increase capacity in BHRS services
- To develop strategies to improve the BHRS program
- Identify and share ways to increase effectiveness of services
- Identify and share ways to improve the quality of treatment provided
- Ensure utilization remains stable and service completion improves
CQC-The approach continued

The approach:

Identification of providers for participation in CQC included:

• Number of members served.
• Authorization patterns were in the middle to upper range for BSC, MT and TSS.
• Clinical leadership that was responsive to new partnership approaches to managing BHRS.
• Physical space and IT system capabilities to accommodate the requirement for the CANS administration.

Provider Requirements

• Participate in a monthly program management meeting to review the performance indicator report package and discuss opportunities for program improvements
• Participate in monthly individual meeting for clinical case review, specific report follow-up and other quality management activities
• Participate fully in the Child & Adolescent Needs Strengths assessment (CANS) Outcomes project
CQC-The approach continued

Magellan Requirements

• Eliminate requirement for clinical authorization for BHRS
• Provide system to providers utilize CANS
• Provide a rate increase for mobile therapy
• Coordinate Monthly Program Management Meeting
• Conduct monthly individual site visits

CQC evolved through the years

• Started with monthly group meetings regarding clinical practices and performance on program metrics.
• In the final stages of the program the frequency of group meetings decreased to quarterly, supplemented by clinical site visits.
CQC-The Pay for Performance & Incentive Component

- Providers were offered a rate increase for MT services to support their additional administration time for the CANS, as well as computers if needed for the CANS administration.
- No clinical review for authorization requests
- No requests for additional information
- No feedback forms
- No denials of service
- Packets submitted to Magellan
- Authorizations entered as required for compliance with the Kirk T reporting and to develop performance indicator reports
CQC-The Results and Outcomes

- Greater opportunities for real-time collaboration with BHRS providers for members in crisis and/or for members who may require a higher level of care.
- Reduce and streamline administrative processes.
- More opportunities for collaboration and joint treatment planning; inclusive of BHRS providers, Magellan, and other involved systems.
- Increased focus on treatment planning, progress notes, continuity of care, crisis planning, and discharge planning.
- Evidence of review/use of CANS in treatment planning.
- Utilization remained within target
CQC-Pit Stop Pick Up’s
Building the car while driving

Provider engagement
• Programmatic Management allowed both Magellan and the provider to step back and see the “big picture” and make improvements to the overall program
• The Quality Management initiatives were only possible through the relationships developed between the providers and Magellan
• Regular case reviews have improved clinical consistency within and among providers

Transparency
The Opportunity:
Magellan’s performance on Readmission within 30 Days of Inpatient Psychiatric Discharge identified the need to further analyze performance and develop interventions to improve those rates, through a formal RCA process.

The Approach:
Developed a provider collaborative aimed to increase provider involvement and accountability for performance on key metrics (including 30-day readmission rates), quality measures (such as audit scores, timeliness of coordination with community-based providers, timeliness of referrals, etc.) and to allow for ongoing best practice discussion.
50% of facilities demonstrated decreased (improved) readmission rates from 2010 compared to 2013.

The 2010 baseline of 14.34% across all Magellan providers was used to compare performance over the next 3 years; 2011 = 14.07%, 2012 = 14.30% and 2013 (claims not complete) = 13.90%.

Half of the involved facilities improved, it was not enough improvement to off-set those which did not.
Provider Engagement

✓ Providers are engaged into performance improvement program

Value

Specific key indicators of performance have been established

Transparency

✓ Individual facility performance metric benchmarks have been established
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WHAT’S SO HARD?
The delicate balance: Key Ingredients

Structure with Flexibility

QUALITY DATA

FINANCIAL DATA

No plug and play

Grassroots

County Influence

Defining an episode of care

Differing Budgets

Regional Priorities

Defining a service vs. a level of care

Clinical
+ Quality
+ Network
+ Finance
Why is this model right?

- Extensive experience with P4P programs coupled with a highly effective national strategy aligned to county and state priorities allows us to build a solid foundation that leads to the best outcomes for members.
- Engages providers to move toward delivering care that meets “value” criteria so that when a service or level of care is needed, it will be the right service, the right amount at the right time.

Why these services?

- Key to impacting the overall delivery system.
- Impacts and informs next steps for other levels of care.
- Various opportunities to engage providers to deliver services at the right time, in the right amount AND in a cost effective manner.
- Community Tenure is a shared outcome of each service.
Magellan Behavioral Health of Pennsylvania
Roadmap-2016

**Facility Incentive Program**
- Reduces unwarranted variation in practice patterns to decrease gap between cost and quality in our facility provider network
- Aligns reimbursement with performance

**Assertive Community Treatment**
- Performance based program focused on Assertive Community Treatment Providers and reimburses based upon community tenure metrics and effectiveness of evidenced based service delivery

**Family Based Services**
- Performance based program focused on Treatment Providers Family Based Service Providers and increased community tenure/decreased out of home placement
The Magellan Facility Incentive Program (MFIP)-
building on the successes of Partners In Care (MHIP PIC)

MHIP PIC Achievements

✓ Providers are engaged into performance improvement program
✓ Specific key indicators of performance have been established
✓ Individual facility performance metric benchmarks have been established

MFIP

• Program expands to all MH IP providers
• Providers are accountable for their overall performance
• Payment is aligned with the achievement and maintenance of VALUE score
MFIP – The Basics

The program is built upon a proprietary algorithm that allows the stratification of providers based upon a composite score of value (cost and quality metrics).
MFIP-The Scorecard

Inpatient scorecards
  • Basis for MFIP
  • Reviewed quarterly

Measures
  • Case-mix adjusted cost
  • Case-mix adjusted readmission
  • 7-day follow-up rate
  • 30-day follow-up rate
  • Percent of claims received electronically

Weights emphasize focus key metrics in the program
*The Facility Incentive model framework does not address specific financial reward amounts by Tier rather; it creates a structure for rewards and reimbursement to be aligned with performance.
Hitting all of the mile markers along the road

Commitment

Value = cost/quality

Payment Alignment

Provider Engagement

Informed Choice

Transparency
Pennsylvania Assertive Community Treatment

Leveraging experience, lessons learned and our national strategy.

- **Scorecard**
- **Performance based program**
- **Focused community tenure**
- **Measures of value built upon outcome expectation of the practice.**
- **Built upon provider partnerships**
  - Developed over time
Defining value takes time- It not as clear as an algorithm.
**Family Based Service** includes member outcomes tool scores & reimbursement is aligned with performance.

**Out Patient**

Performance based program focused on traditional Out Patient Services Level of Care. Possible metrics include: Availability, retention, treatment record reviews and administrative data.

**Non Hospital D&A**

Performance based program focused on non hospital D&A residential. Case mix adjusted algorithm will allows for equitable comparison of providers.
Now that the wheels are in motion.....

Future state-the bigger picture

- OP and D&A
- Addition of levels of care and/or services
- State Initiatives/ICP
- Certified Community Behavioral Health Clinics
- FBS
- High Performing Networks
- MFIP
- Centers of Excellence
- ACT
- Member Level Outcomes
- TRIPLE AIM
- State Initiatives/ICP
- ICP
Key Take Aways

• **Commitment** is Key
• Barriers are surmountable
• Joint efforts across QI/clinical/network/finance
• Great is the enemy of good – but improvements can be made
• Involve providers early and often
• Never assume everyone is on the same page (rinse, lather, repeat)
• Value-based purchasing is not a destination
• One size DOES NOT fit all!
In closing

The road map to VBP is guaranteed to be difficult terrain and the directions won’t always be clear.

Key pit stops in the journey will include:

• New and evolving measures of value

• Increasing focus on member and system transformation outcomes

• Expansion of VBP models across the continuum of care
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