Behavioral Healthcare in an Evolving Healthcare Environment

Dan Mendelson, CEO, Avalere Health
Healthcare Environment is Changing

1. **Evolving Payer Landscape**
   Managed markets orienting around coverage expansion

2. **Consolidating Provider Environment**
   Providers increasingly integrating, at risk for quality

3. **Increased Consumer Accountability**
   Access to information and financial burden growing
Plan Perspective: Downside and Upside

- Fiscal Pressure
  - Rate review, MLRs
  - ACA Taxes, Federal rate pressure
  - Increased underwriting risk

- Expansion Markets
  - Medicaid, Exchanges
  - Medicare, Duals

- Quality Based Payments
  - Demand for proof of claims
25 States Are Poised Not to Expand Medicaid in 2014 – Resulting in 5.3M New Beneficiaries Enrolled

State Commitment to Expand Medicaid Eligibility in 2014

- Will Expand (23 + DC)
- Leaning Yes (2)
- Leaning No (6)
- Will Not Expand (19)

Source: Avalere State Reform Insights, Updated May 24, 2013

*Considering a premium assistance model for expansion using exchange plans for some or all beneficiaries
If 25 States Forgo Expansion, 3.4M More Individuals Will Remain Uninsured, Putting Pressure on Hospitals

Source: Avalere Estimates as of May 24, 2013

DSH= Disproportional Share Hospital.

Expected Enrollees Impacted by Medicaid Expansion Decisions

<table>
<thead>
<tr>
<th>Number of Enrollees (in millions)</th>
<th>All States Expand</th>
<th>25 States + DC Expand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exchanges &amp; Other Private Coverage</td>
<td>10.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Medicaid</td>
<td>5.5</td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td>3.4</td>
<td></td>
</tr>
</tbody>
</table>

As a result of DSH cuts, hospitals in non-expansion states will face additional cost pressures.
States That Do Expand Will Face a Significant Influx of New Medicaid Enrollees

Percent Increase in Medicaid Enrollment as Compared to Baseline Coverage, 2022

*AR & IA will offer premium assistance to some Medicaid beneficiaries; thus, new Medicaid enrollment is low as some of these individuals are captured in exchange enrollment.

Source: Avalere Enrollment Model, May 2013, Scenario 3 (assumes 25 states opt out of the Medicaid expansion)
Newly Eligible Population Will Be Non-Disabled Adults, but Will Still Have Significant Health Needs

- **Mostly Adults**: 60% of current Medicaid beneficiaries are under 18 compared to just 11% of new enrollees

- **Fewer Minorities**: Half of new enrollees are white, compared to 37% of current beneficiaries

- **Better Health**: Adult eligibles are in slightly better health compared to current enrollees that include many disabled beneficiaries
  - 77% of new enrollees report good to excellent health compared to 62.5% of current enrollees

- **Fewer Diagnoses**: New adult enrollees have a lower incidence of common chronic conditions than current adults enrollees age 18-64
  - But they may be underdiagnosed due to lack of access to services

- **Mental Health Needs**: Rates of serious mental illness are higher among new Medicaid eligibles than current enrollees—12% compared to 9% among current beneficiaries

New eligibles defined as low-income (<138% FPL) uninsured.

Figures from the 2010 Medical Expenditure Panel Survey (MEPS). Avalere’s analysis uses an algorithm that categorizes individuals based on the type of coverage that they had for the most months during the year. If a given individual had multiple sources of coverage for the same number of months, they are placed into a coverage group based on a hierarchy. The algorithm ranks Medicare above Medicaid.
Medicaid Will Increasingly Rely on Managed Care

Medicaid Non-Dual Enrollment (in millions), 2008-2018

Will facilitate increased and aggressive use of specialty pharmacy, particularly for high cost medications

Source: Avalere Analysis using Avalere Enrollment Model, scenario 1
FFS = Fee-for-service
MCO = Managed Care Organization
Compressed Timeline for Launch of Exchanges

- **HHS Deadline to Approve State-Based Exchanges** January 1
- **State Partnership Blueprint Deadline** February 15
- **Final Rules** February - March
- **QHP Application & Product/Rate Filing Deadlines** (Varies by State) April - May
- **QHP Certification & Product/Rate Approvals** May - July
- **Consumer Education & Outreach Activities** May - September
- **HHS Activity**
- **State Activity**
- **QHP Activity**

**2013**

- Exchange Open Enrollment Begins
  - **October 1 to March 31, 2014**

- **Exchange Coverage Begins January 1, 2014**

**HHS Deadline for Partnership States to Apply for State-Based Exchange Status in 2015**
  - **November 18**

QHP = Qualified Health Plan
About Half of Population Under Federal Exchanges


*UT announced that it will not pursue a state-run individual exchange but continues to request HHS certify its existing small group exchange, Avenue H.

**OH and VA have indicated they will perform plan management functions and QHP certifications.
Exchange Enrollees Have Unique Health Profile

Characteristics of Subsidized Exchange Enrollees Compared to ESI Population**

- Slightly younger than those with employer coverage
- Worse reported self-health than individuals with employer coverage
  - Over 89% still report good to excellent health
- Lower incidence of common chronic conditions than adults with employer coverage
  - May have undiagnosed conditions
- Spend less per capita, than individuals with employer coverage

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* Avalere Enrollment Model, February 2013, Moderate Scenario (assumes that 17 states opt out of the Medicaid expansion).
** All data for non-elderly individuals. Exchange enrollees defined as moderate-income (138-400% FPL) uninsured. Figures from the 2009 Medical Expenditure Panel Survey (MEPS).
### Plans in Exchanges Bound by Rules

<table>
<thead>
<tr>
<th>Essential Health Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Plans in the individual and small group markets are required to cover ten categories of essential health benefits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actuarial Value (AV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Level of cost sharing is indicated by metal tiers in the exchange: Bronze - 60%; Silver - 70%; Gold - 80%; Platinum - 90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out of Pocket (OOP) Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>- OOP cap is tied to annual HSA limits (~$6,500 for an individual in 2014)</td>
</tr>
<tr>
<td>- AV calculator allows plans to establish separate OOP limits for drugs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deductible Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Deductibles in the small group market limited to $2,000 (individuals) and $4,000 (families)</td>
</tr>
<tr>
<td>- Plans may establish separate deductibles for drugs</td>
</tr>
</tbody>
</table>

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**Actuarial Value** = A measure of a benefit generosity that is expressed as percent of expenses paid by the insurer

**HSA** = Health Savings Account

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Behavioral Health Services Protected Somewhat Under ACA

1. **Minimum Essential Benefits**
   - Applies to all individual and small group plans

<table>
<thead>
<tr>
<th>Ambulatory patient services</th>
<th>Prescription drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services</td>
<td>Rehabilitative and habilitative services and devices</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Laboratory services</td>
</tr>
<tr>
<td>Maternity and newborn care</td>
<td>Preventive and wellness services &amp; chronic disease management</td>
</tr>
<tr>
<td>Mental health and substance abuse services</td>
<td>Pediatric services (including oral and vision care)</td>
</tr>
</tbody>
</table>

2. **Out-of-Pocket Limits (OOP)**
   - Applies to all plans – OOP cap is tied to annual HSA limits (~$6,000 for an individual)

3. **Actuarial Value**

<table>
<thead>
<tr>
<th>Bronze</th>
<th>Plan covers 60% of healthcare costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Silver</td>
<td>70% of healthcare costs</td>
</tr>
<tr>
<td>Gold</td>
<td>80% of healthcare costs</td>
</tr>
<tr>
<td>Platinum</td>
<td>90% of healthcare costs</td>
</tr>
</tbody>
</table>

4. **Extends Mental Health Parity to Individual and Small Group Plans**

HSA = Health Savings Account
Actuarial Value = A measure of a benefit generosity that is expressed as percent of expenses paid by the insurer
Potential Issues with Rx Coverage Under Exchanges

- **Coverage ≠ Access:** EHB only addresses formulary coverage
  - Protections do not restrict the use of utilization management, tiering, or high cost-sharing

- **Medical Benefit Drugs Not Protected:** EHB formulary standards do not extend to physician-administered drugs
  - Plans will deploy specialty pharmacies and other mechanisms to manage medical benefit products

- **Coverage for New Formulations at Plan Discretion:** EHB counts only distinct chemical entities
  - Coverage for extended releases, combination products, alternate dosage forms, and multi-source drugs will be decided by health plans
Essential Health Benefit Benchmark Varies by State

Number of Drugs Covered by Benchmark Plan

Source: Based on data released by CMS on state selected benchmark plans, February 20, 2013, available at http://cciio.cms.gov/resources/data/ehb.html. Maximum potential drug count is 1032; totals may double-count drugs that are categorized in more than one USP class.
States Will Need to Manage “Churn” Between Medicaid and the Exchange

Problems Created by “Churn”

- Disrupts to continuity of care & medication adherence
- Creates possible gaps in coverage
- Discourages insurer investment in longer-term wellness
- Increases administrative burden to states

Financial Alignment Demonstration Allows Unprecedented Flexibility to Improve Quality and Lower Costs for Duals

In 2008, duals accounted for 20% of the Medicare population but 31% of Medicare spending, and 15% of the Medicaid population but 39% of Medicaid spending.”

CMS’ Goals for the Demonstration

1. Create incentives for States to invest in delivery system reform and care management
2. Develop, test and validate fully integrated delivery system and care coordination models that can be replicated in other States
3. Evaluate potential for future changes

Demonstration Flexibilities

- **Payment:** States share in savings; reduce cost shifting
- **Administrative Alignment:** Unified enrollment, appeals, auditing and marketing rules
- **Benefit Design:** Allow plans to offer supplemental benefits
- **Enrollment:** Allow passive enrollment, a departure from current Medicare policy

*Kaiser Family Foundation. Medicare’s Role for Dual Eligible Beneficiaries. April 2012; Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2008, Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on FY2008 MSIS and CMS Form 64; and Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006*
2.2 of the 9 Million Duals Are Eligible for the Demonstrations

In the 6 states with signed MOUs*, 985,000 duals are eligible for the demonstration. In the remaining states, 1.2 million duals are eligible for enrollment in the demonstration.

*WA has only signed an MOU for the Managed Fee for Service (MFFS) component of its demonstration. WA is also planning to implement a capitated demonstration. In total, 27,000 beneficiaries will be in the capitated demonstration, 21,000 in the MFFS and the remaining 58,000 will be enrolled in a third strategy using capitated and MFFS payments. MOU= Memorandum of Understanding
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ACA Intended Shift to Value Based Purchasing

Old Paradigm
- Siloed payment system with separate payments at each site of care
- Payments based on service rather than quality and/or outcome
- Limited coordination or shared risk among providers
- CMS constrained in testing and new payment models

New Paradigm
- Value-Based Purchasing
- Accountable Care Organizations, Medical Homes
- Bundled Payments
- Link payments and outcomes
- Encourage care coordination and primary care; allow providers to share in savings

CMS: Centers for Medicare and Medicaid Services
ACA: Affordable Care Act
States with Medicare ACOs

Source: CMS Accountable Care Organizations website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO/
Note: MSSP and Pioneer ACOs often serve Medicare beneficiaries in more than one state. Since the numbers embedded in the map capture this, they do not add up to equal the number of ACO entities approved by CMS for 2012.
467 Providers in 218 Markets* Will Participate in Bundled Payment Demonstration

*Market is defined as county
## Hospital Financial Incentives Evolving

<table>
<thead>
<tr>
<th>Program</th>
<th>FY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Adjustment for Readmissions</td>
<td>3%</td>
</tr>
<tr>
<td>Hospital Value-Based Purchasing</td>
<td>1.5%</td>
</tr>
<tr>
<td>Payment Adjustment for HACs</td>
<td>1%</td>
</tr>
<tr>
<td>Hospital Inpatient Quality Reporting Program (P4R)</td>
<td>2%</td>
</tr>
<tr>
<td>Meaningful Use</td>
<td>33% reduction in 3/4th of market basket update</td>
</tr>
<tr>
<td><strong>Possible Maximum Payment Reduction</strong></td>
<td>&gt;7.5%</td>
</tr>
</tbody>
</table>

*Payment reductions are calculated from base DRG
**Payment reductions are calculated from market basket update
^Additional meaningful use penalties are at the discretion of the Secretary
Financial Incentives Change Under Bundling

Providers at-risk for all cost of care during the episode timeframe

*Potential Strategies*

- Attention to quality based payments
- Reduce readmissions
- Use lower cost settings and reduce LOS in high-cost settings
- Standardize care management
- Aggressive control of input costs

**Average Episode Cost: $30,000**

*For Illustrative Purposes Only*

- Acute Inpatient, 30%
- Readmission, 15%
- Post-Acute Care, 30%
- Physician Services, 15%
- Hospital Outpatient, 5%
- Other Part B, 5%
# New Hospital Economics Will Affect Purchasing

![Vantage Care Positioning System](image)

## Top Discharge Destinations from Hospital A

<table>
<thead>
<tr>
<th>Destination</th>
<th>Type</th>
<th>Discharges</th>
<th>% of Hospital A’s Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUMMIT HOME HEALTH</td>
<td>HHA</td>
<td>141</td>
<td>2.81</td>
</tr>
<tr>
<td>Coventry Meadows</td>
<td>SNF</td>
<td>139</td>
<td>2.77</td>
</tr>
<tr>
<td>Your SNF</td>
<td>SNF</td>
<td>138</td>
<td>2.75</td>
</tr>
<tr>
<td>REHABILITATION HOSPITAL OF FORT WAYNE GENERAL PAR</td>
<td>IRF</td>
<td>118</td>
<td>2.35</td>
</tr>
<tr>
<td>TRANSITIONAL CARE UNIT OF ST JOSEPH</td>
<td>SNF</td>
<td>76</td>
<td>1.52</td>
</tr>
<tr>
<td>PEABODY RETIREMENT COMMUNITY</td>
<td>SNF</td>
<td>57</td>
<td>1.14</td>
</tr>
<tr>
<td>SELECT SPECIALTY HOSPITAL-FORT WAYNE</td>
<td>LTACH</td>
<td>56</td>
<td>1.12</td>
</tr>
<tr>
<td>PARKVIEW HOME HEALTH &amp; HOSPICE</td>
<td>HHA</td>
<td>48</td>
<td>0.96</td>
</tr>
<tr>
<td>KINGSTON CARE CENTER OF FORT WAYNE</td>
<td>SNF</td>
<td>40</td>
<td>0.8</td>
</tr>
<tr>
<td>HEARTLAND HOME CARE</td>
<td>HHA</td>
<td>32</td>
<td>0.64</td>
</tr>
</tbody>
</table>

**Discharge Destination Settings for Hospital A (n=1,725)**

- **SNF**: 65.7%
- **HHA**: 21.0%
- **IRF**: 3.7%
- **LTACH**: 2.0%
- **Other IP**: 7.6%

Source: Vantage Care Positioning System
# Healthcare Environment is Changing

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Consumerism: Information and Incentives

Consumer choice in health insurance expands with exchanges and changes in employer markets

Plans, providers and employers driving consumers to take greater roles in their care decisions

Individuals with insurance are facing higher deductibles and co-pays

Individuals seek better information about the value of healthcare choices
... But Cost Sharing CanImplicitly Discriminate

Enrollment-Weighted Average Cost Sharing Among Five-Tier PDPs Using One Coinsurance Tier, 2011-2012*

About 54 percent of five-tier plans use one coinsurance tier in 2011.

• Typical tier structure:
  » Tier 1: Preferred generics
  » Tier 2: Non-preferred generics
  » Tier 3: Preferred brands
  » Tier 4: Non-preferred brands
  » Tier 5: Specialty / Injectable drugs

Source: Avalere Health analysis using DataFrame®, a proprietary database of Medicare Part D plan features. 2012 plan data were released in November 2011.

* These graphics display the enrollment-weighted average cost sharing for the most typical cost-sharing arrangement for each tier. 2012 cost-sharing values are weighted by September 2011 enrollment. 2011 cost-sharing values are weighted by August 2010 enrollment.
... And Can Raise Quality Concerns

- Avalere analysis of pharmacy transaction data 2007-2009:
  - 6% of cancer patients with co-pays of $100 or less abandoned their initial prescriptions for oral anti-cancer drugs
  - 25% of those with cost-sharing greater than $500 abandoned

Budget Wrangling = Ongoing Funding Challenges

- American Taxpayer Relief Act Enacted
- Sequestration in Effect
- House and Senate Budget Resolutions Passed
- President’s FY2014 Budget Released
- FY2014 Appropriations Bills Considered
- FY 2013 Continuing Resolution Ends
- Debt Ceiling May Need to Be Raised
- SGR Fix Expires

January 2013
March 1, 2013
March 2013
April 10, 2013
May-Sept 2013
Sept. 30, 2013
Fall 2013
Dec. 31, 2013
## Current Environment Poses Risks and Opportunities

<table>
<thead>
<tr>
<th>Risks</th>
<th>Opportunities</th>
</tr>
</thead>
</table>
| ♦ Cost pressures on plans and state budgets will impact providers  
  ‣ More Medicaid managed care, including duals demos  
  ‣ Exchange plans will use UM and offer limited networks  
  ‣ Exchange coverage entails cost-sharing for low-income patients  
  ‣ Federal budget pressures | ♦ Medicaid and exchange expansion could reduce uncompensated care  
  ♦ ACA Essential Health Benefits (EHB) expands access to mental health and SA services and drugs  
  ♦ Duals demos could improve integration of care across programs for those with mental health needs  
  ♦ Value-based payment could provide opportunities to partner with other providers to deliver comprehensive, efficient care |