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Update On Managed Care Trends Driving Opportunities in the California Health Plan Market

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Agenda

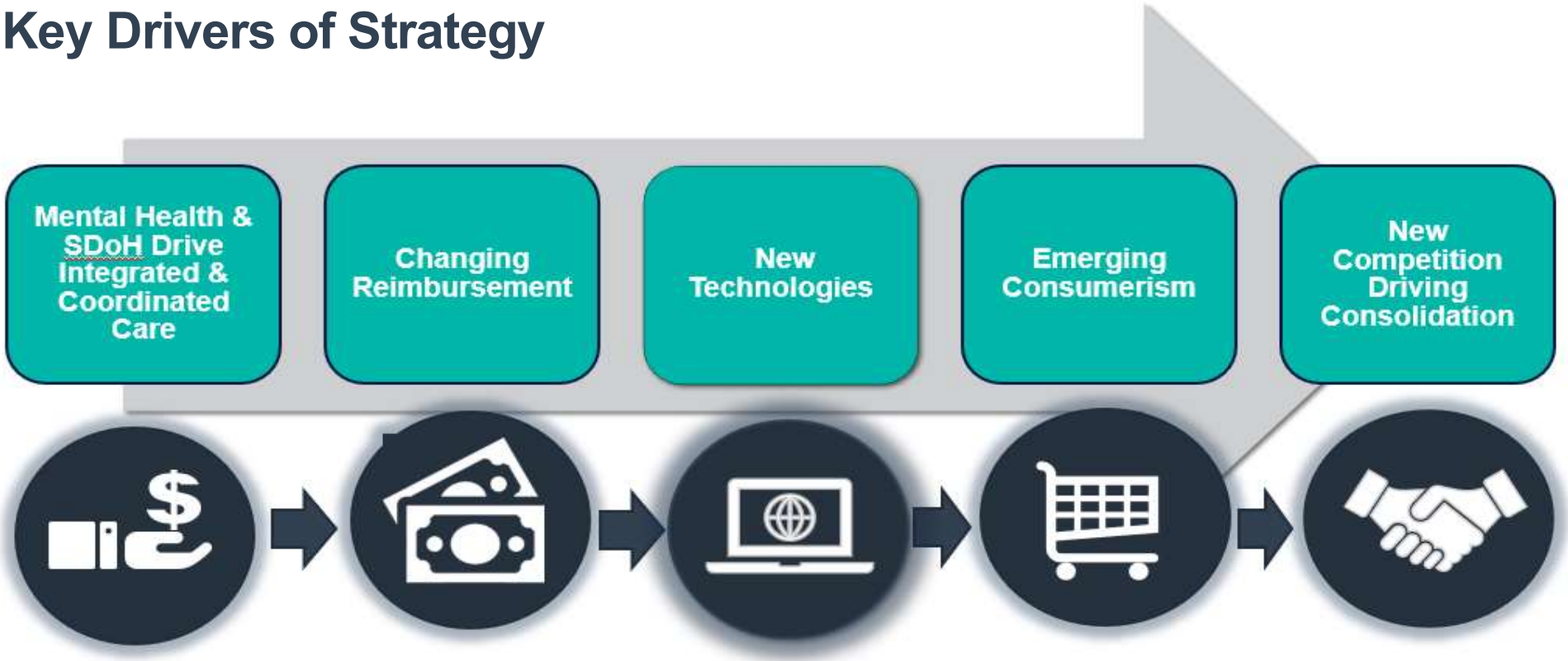
I. Behavioral Health Drivers Impacting Managed Care Strategy In California

II. Leadership Strategies For Creating Managed Care Opportunities

III. Questions & Discussion

I. Drivers Of The Movement To Managed Care In California

The National Behavioral Health Landscape – Key Drivers of Strategy



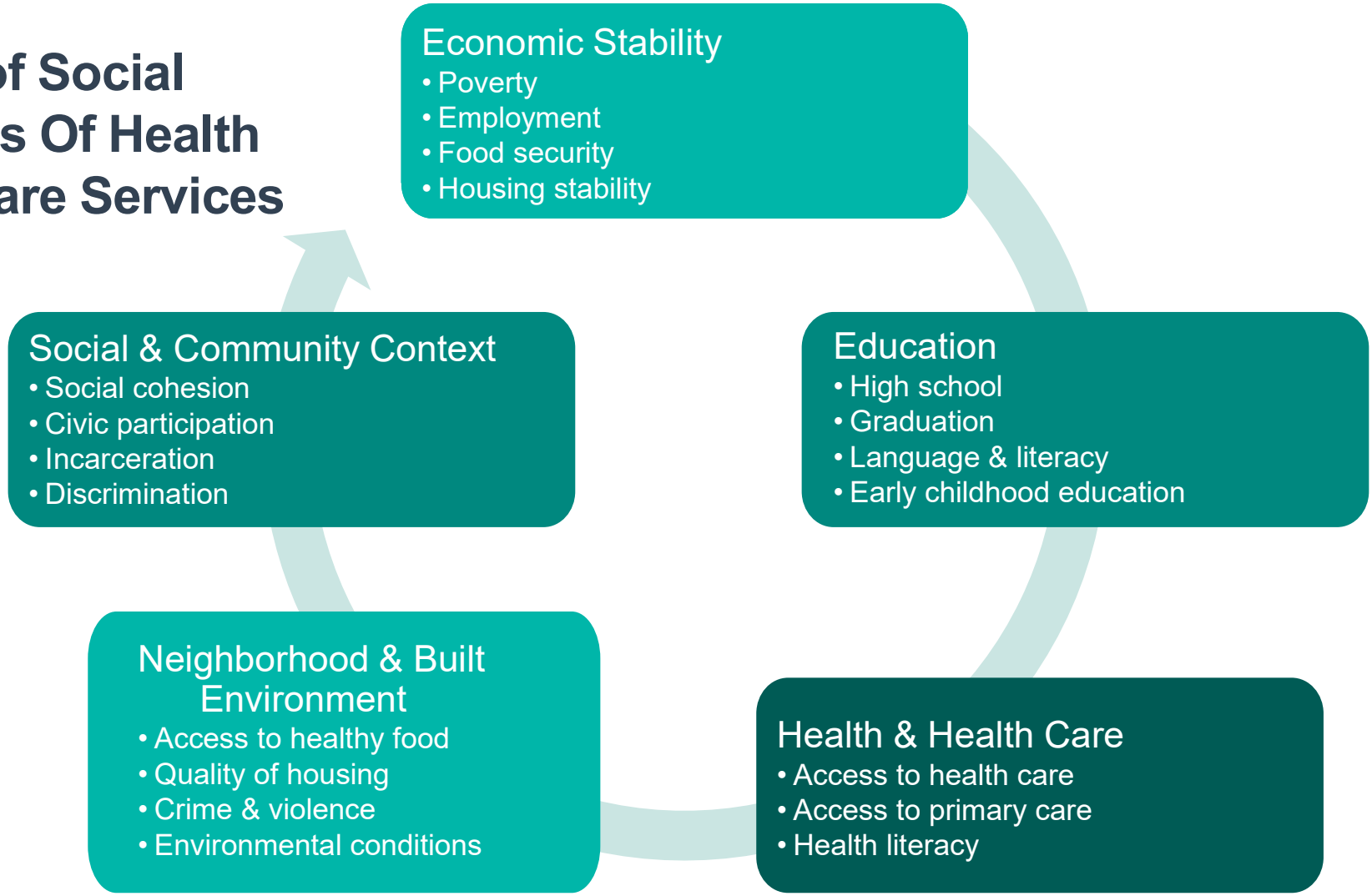
Added to these drivers is the economic recession and extended uncertainty related to COVID-19

Mental Health & Social Determinants Drive Integrated & Coordinated Care

1. All payers and health plans are interested in organizations that will coordinate care across multiple provider organizations to close service gaps and improve outcomes
2. Integrated care ensures that consumers with multiple chronic conditions are treated in a holistic manner
3. Social determinants of health are now a focus of payers in serving individuals with SPMI and other chronic conditions
4. Alternative payment methods support development of integrated services and coordinated care by removing fee-for-service funding restrictions

Key Driver #1: Mental Health & SDoH Drive Integrated & Coordinated Care

Integration of Social Determinants Of Health Into Healthcare Services



Payers & Health Plans Are Starting To Recognize The Importance Of Social Support Services

1. 80% of payers believe addressing SDoH is important and are using programs to identify and address SDoH
2. 70% of payers are integrating awareness of social determinants of health directly into clinical processes
3. Though their approaches are different, its clear that payers recognize the value in addressing SDoH:
   - 42% of payers integrate referrals to community-based social service programs and resources
   - 34% integrate consumer medical information with consumer financial, census, and geographic data
   - 31% offer a “social needs” assessment along with health risk assessments

Health Plans Are Covering Social Supports Through Pilot Programs, Donations & Bundled Payment Models

The Health Care Service Corporation (HCSC) and the Blue Cross Blue Shield (BCBS) Institute launched foodQ, a six-month food delivery pilot program
(see Blue Cross Launches Food Delivery Program to Address Social Determinants)

Humana Foundation Dedicating $7 Million To Address Social Determinants Of Health
(see Humana Foundation Dedicating 7 Million to Address Social Determinants of Health)

The American Medical Association (AMA) and UnitedHealthcare (UHC) announced a collaboration to support the creation of 23 new ICD-10 codes related to social determinants of health
(see AMA & United Healthcare Partner to Propose New ICD-10 Codes to Identify & Address Social determinants of Health)

Anthem is making a push to whole person care, as well as person-centered care
(see No Whole Person Care Without Person-Centered Organizations)

Health Net Community Solutions CA In Lieu of Services (ILOS)

1. Health Net is a managed care plan contracted with Department of Health Care Services (DHCS) to provide Medi-Cal covered services to Medi-Cal managed care beneficiaries.
2. ILOS are flexible wrap-around services that Health Net can provide and integrate in their population health strategies. ILOS will be integrated with case management for clients at medium to high risk for using ED, inpatient hospital, skilled nursing, etc services and address medical and social determinants of health needs.
3. ILOS will allow the Medi-Cal health plans to use a set of 14 non-medical ILOS that include: Housing Support, Transition Support, Post – Acute Support Services, At Home Support

Reimbursement On The Way…

Medicaid

- Medicaid is prohibited from covering social supports, like room and board housing costs, but can cover support services directly related to health
- In 2015, the Centers for Medicare & Medicaid Services (CMS), allowed coverage of “housing-related activities and services”, such as supporting consumers to maintain housing.
- States are using 1115 waivers to pilot new programs that allow them to support housing, non-emergency transportation, and food security

Medicare

- Starting in 2021, Medicare Advantage plans can cover new social support services, with the goal of keeping consumers in the community.
- Tools or services must be recommended by a licensed medical professional as part of a consumer’s care plan
- Services may include:
  1. Transportation services for health-related appointments, such as a physician office, a nutritionist, or a chronic condition education program
  2. Meal delivery and nutrition services
  3. Adult day care services
  4. Memory fitness programs
  5. Personal care services and home modifications to assist with activities of daily living, such as adding railings or supports in the bathroom

Remaking Primary Care – Merging With Care Coordination

1. Health plans with virtual primary care (Humana, Oscar)
2. Primary care at home (Wellcare, Humana)
3. Retail chains – 1,100 locations, offer specialist consults virtually, partnership with VA
4. Backward integration of primary care functions in health plans – Aetna, Kaiser, United/Optum, etc.
5. Specialist services provided via virtual care within primary care model
6. “Augmented intelligence” can support basic primary care functions –
   - “Assess, prescribe, refer”
   - “Care coordination, health education, health promotion”
7. Growing payer preference for "specialty" primary care (and specialty medical homes)

California Emerging Markets

- The Health Homes Program (HHP) is designed to serve eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions who may benefit from enhanced care management and coordination. The HHP coordinates the full range of physical health, behavioral health, and community-based long-term services and supports (LTSS) needed by eligible beneficiaries.
- The HHP provides six core services:
  - Comprehensive care management
  - Care coordination (physical health, behavioral health)
  - Health promotion
  - Comprehensive transitional care
  - Individual and family support
  - Referral to community, social support services, housing
- Started July 1, 2019 with case rate reimbursement

Key Driver #2: Changing Reimbursement

Of the 38 states with Medicaid managed care, 22 require the Medicaid health plans to implement VBR with provider organizations

- At least 11 states have Medicaid ACOs
- 81% of Medicaid health plans have pay-for performance fee-for service (P4P FFS) payments for behavioral health organizations
- 47% of Medicaid health plans have bundled payments for specific acute episodes

Nationally, specialty provider organizations with VBR revenue:

- 74% of primary care organizations
- 56% of behavioral health organizations
- 44% of child and family services organizations
- 4455of I/DD and LTSS organizations

HCP-LAN Model Of Value-Based Reimbursement

Category 1

Fee For Service – No Link To Quality & Value

Category 2

Fee For Service – Link To Quality & Value

A

Foundational Payments For Infrastructure & Operations
(e.g., care coordination fees and payments for HIT investments)

B

Pay For Reporting
(e.g., bonuses for reporting data or penalties for not reporting data)

C

Pay-For-Performance
(e.g., bonuses for quality performance)

Category 3

APMs Built On Fee-For-Service Architecture

A

APMs With Shared Savings
(e.g., shared savings with upside risk only)

B

APMs With Shared Savings & Downside Risk
(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

3N **Risk-Based Payments NOT Linked To Quality**

Category 4

Population-Based Payment

A

Condition-Specific Population-Based Payment
(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

B

Comprehensive Population-Based Payment
(e.g., global budgets or full/percent of premium payments)

C

Integrated Finance & Delivery System
(e.g., global budgets or premium/full percent of premium payments in integrated systems)

4N **Capitated Payments NOT Linked To Quality**

The Intersection Of Value-Based Reimbursement (VBR) & Social Determinants Of Health (SDOH)

VBR

- Ties reimbursement to quality and efficiency measures
  - Facilitates the achievement of the triple aim—improving population health, reducing the costs of health care and improving individual member outcomes
  - Supports provider engagement and payer/provider collaboration
  - Rewards provider performance on agreed upon measures of quality and utilization
  - Utilizes alternative payment mechanisms that facilitate greater provider freedom

SDOH

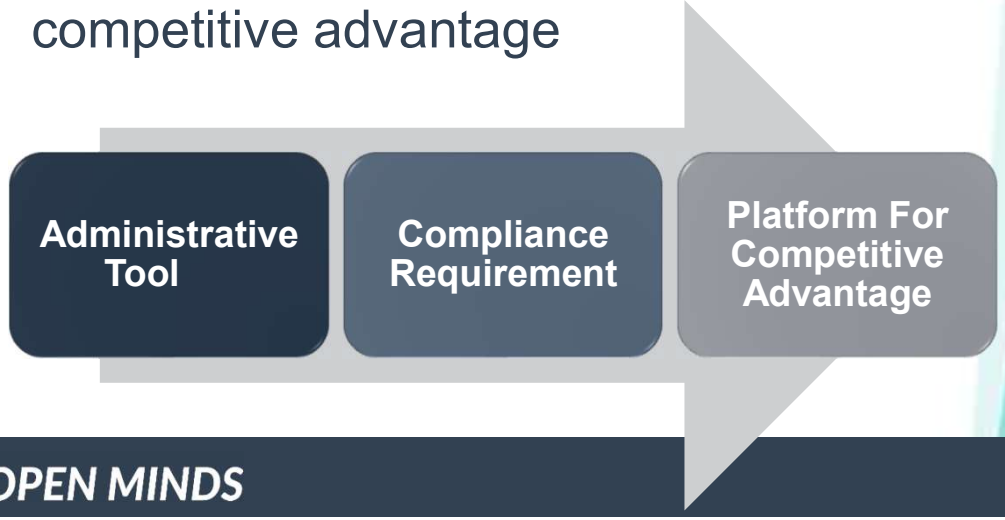
- Environmental factors that influence a population's health and functioning (e.g., socio-economic status, transportation, age)
  - Provides important details that can guide interventions to achieve VBR goals
  - Increases understanding of population needs
  - Moves VBR beyond easy-to-access measures to measures that hold greater meaning

Payer – Provider Solutions: Improving Quality Measures

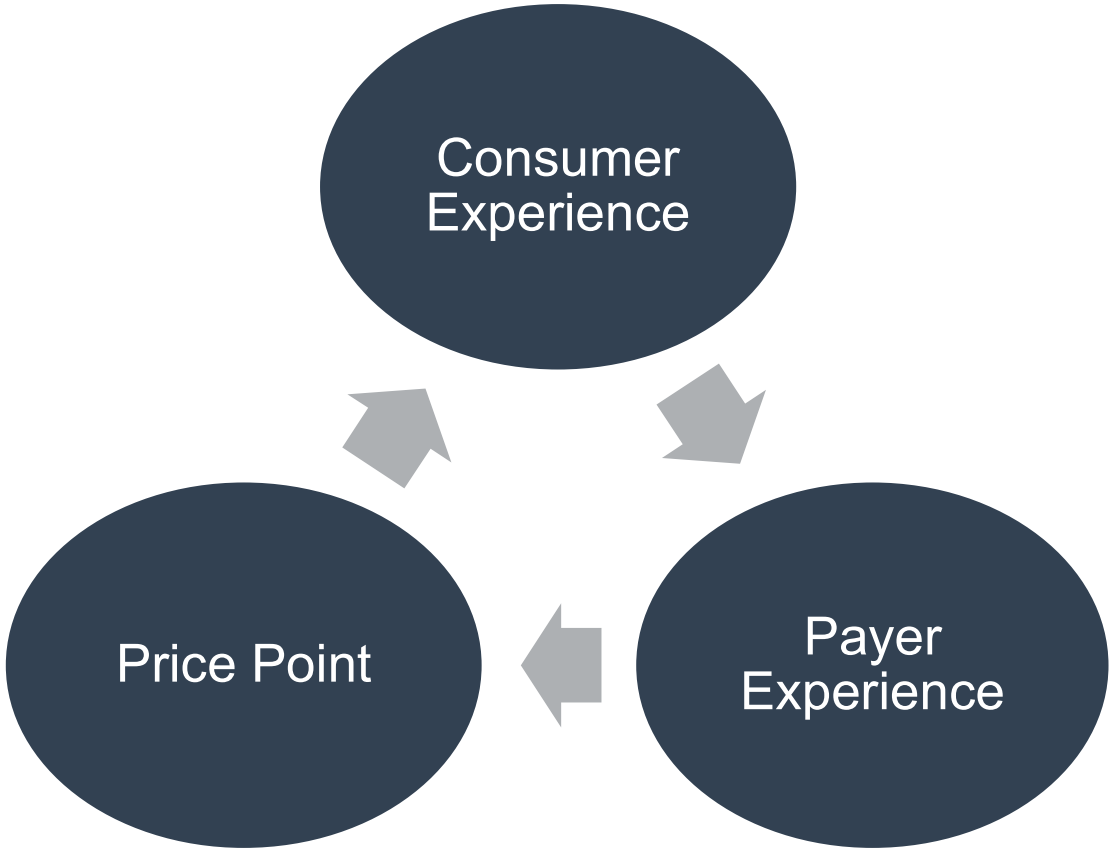
- **Problem:**
  - High utilization of inpatient psychiatric hospital readmissions for adults with severe mental illness
  - High outpatient “no show” rates to PCP and mental health treatment visits
  - Low HEDIS scores
- **Results:**
  - 69% reduction in psychiatric hospital readmissions
  - Initial outpatient visit to mental health treatment provider within 72 hours post hospital discharge
  - Significant improvement in CA Health Plan HEDIS scores
  - Improved client outcomes in outpatient treatment and resiliency in the community
- **Reimbursement Model**
  - Case Rate

Shifting Technologies

- In the last 10 years behavioral health technology has moved from a billing and compliance focus to a tool for competitive advantage
- Purchases of technology are no longer seen as the “cost of doing business”, but now align with strategies for creating competitive advantage



Key Driver #3: Shifting Technologies



The Pandemic Has Accelerated Technology Adoption By Customers.

How Have These Technology Investments Changed Competitive Advantage Of Services?

The New Consumer Expectations

- Easy and convenient on-line access – both on-line presence pre-service and for service selection
- On-demand services with real-time on-line scheduling
- Virtual care – both synchronous and asynchronous (telephone, text, email, video, etc.)
- AI-driven self-directed tools
- Single record via interoperability
- Customized service via CRM-like functionality
- Personalized care via decision support tools

The New Payer Expectations

- Hybrid service delivery capability – virtual and face-to-face (clinic and home) in integrated platform
- Interoperability and data sharing (and receiving) capabilities
- Standardized services via decision support tools with data-driven algorithms
- Measurable performance – both consumer and health system
- Auditable and transparent services (electronic visit verification, etc.)
- Ability to accept value-based contracts with downside financial risk

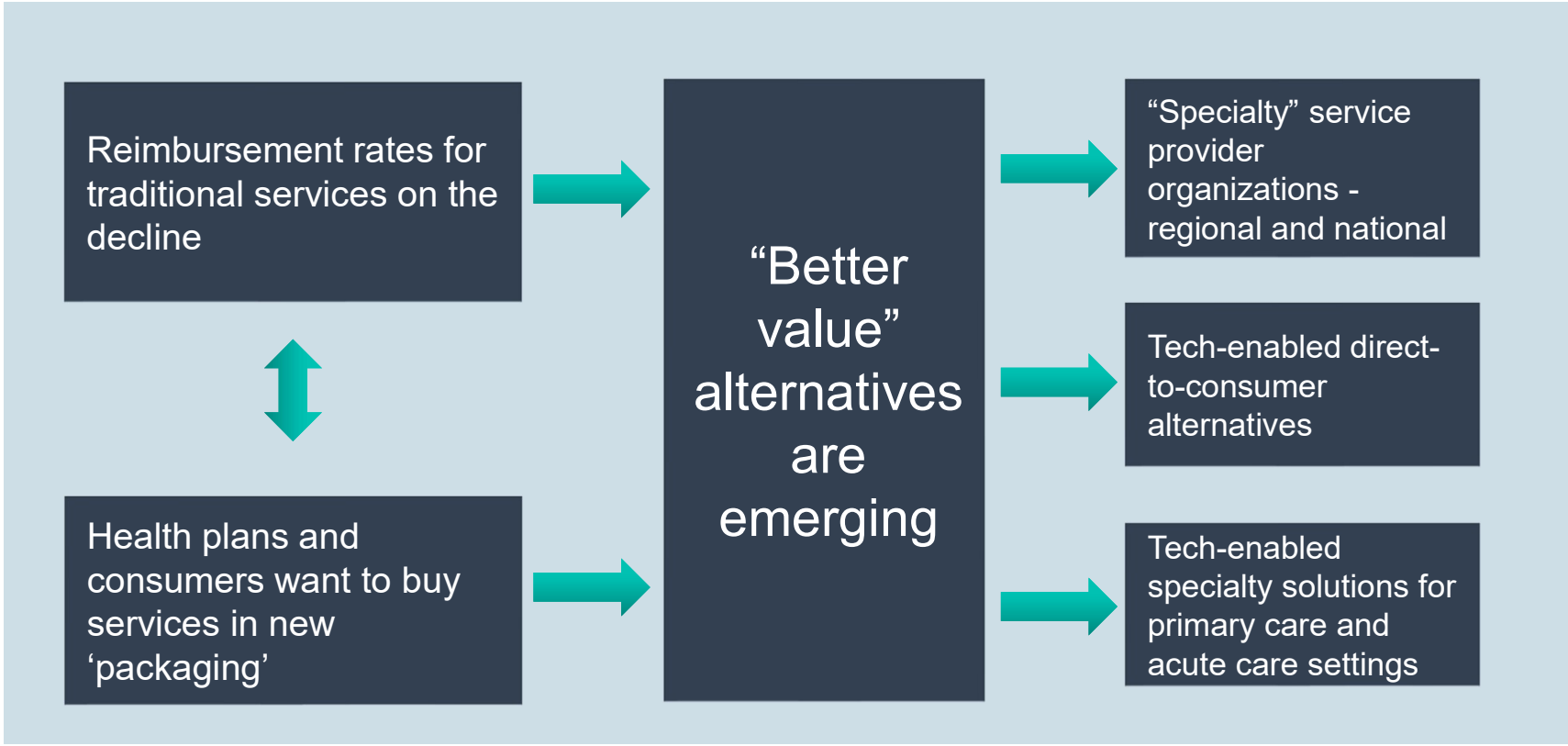
The New Price Point Drivers

- Scale changes amortization of overhead costs
- Automation of administrative functions
- Automated remote monitoring
- Route optimization for community-based workers
- Predictive analytics to reduce unnecessary spend
- More “acute” services in less expensive settings

Key Driver #4: Emerging Consumerism

1. **Consumer Engagement** - Process to help individuals take action to improve their health, make informed decisions, and engage effectively and efficiently with the health care system with the goal of improved health status, reduced costs, and better access
2. **Consumer Transparency** - Making available, in a reliable, and understandable manner, information on the health care system's quality, efficiency and consumer experience with care, which includes price and quality data with the goal of improved service quality and reduced costs
3. **Consumer Financial Participation** – Focus on the proportion of health care spending paid by the consumer with the goal of decreasing costs by increasing engagement and reducing unnecessary expenses
4. **Consumer Experience** - How consumers perceive their interaction with an organization, evaluated as useful, usable, and enjoyable - resulting in the consumer perception of an organization's brand with the goal improved consumer choice and level of engagement

The Changing Preferences Of Customers & New Market Options



Market Role For Specialist Provider Organizations Changing

Traditional FFS 'money makers' shrinking – targeted case management, traditional undifferentiated "residential" treatment, post-surgical SNF care, etc.

The "Cash Cow" Is Becoming The "Dog"

New Competition Driving Consolidation

1. “Consolidator companies” are putting pressure on fee-for-service rates by mergers/ acquisitions that increase size/scale of an organization
2. “Disruptor organizations” are offering new service models that are appealing to consumers, health plans, and payers
3. Key Drivers for For-Profit Mergers
   - Focus on implementing new technologies, consumerism and competitive positioning
   - Market expansion with a focus on the bottom-line and cash flow are key considerations
   - Private equity firms are seeking value-based care models and consolidation of “fragmented” markets
   - The average margin of acquiring companies was 12.8%

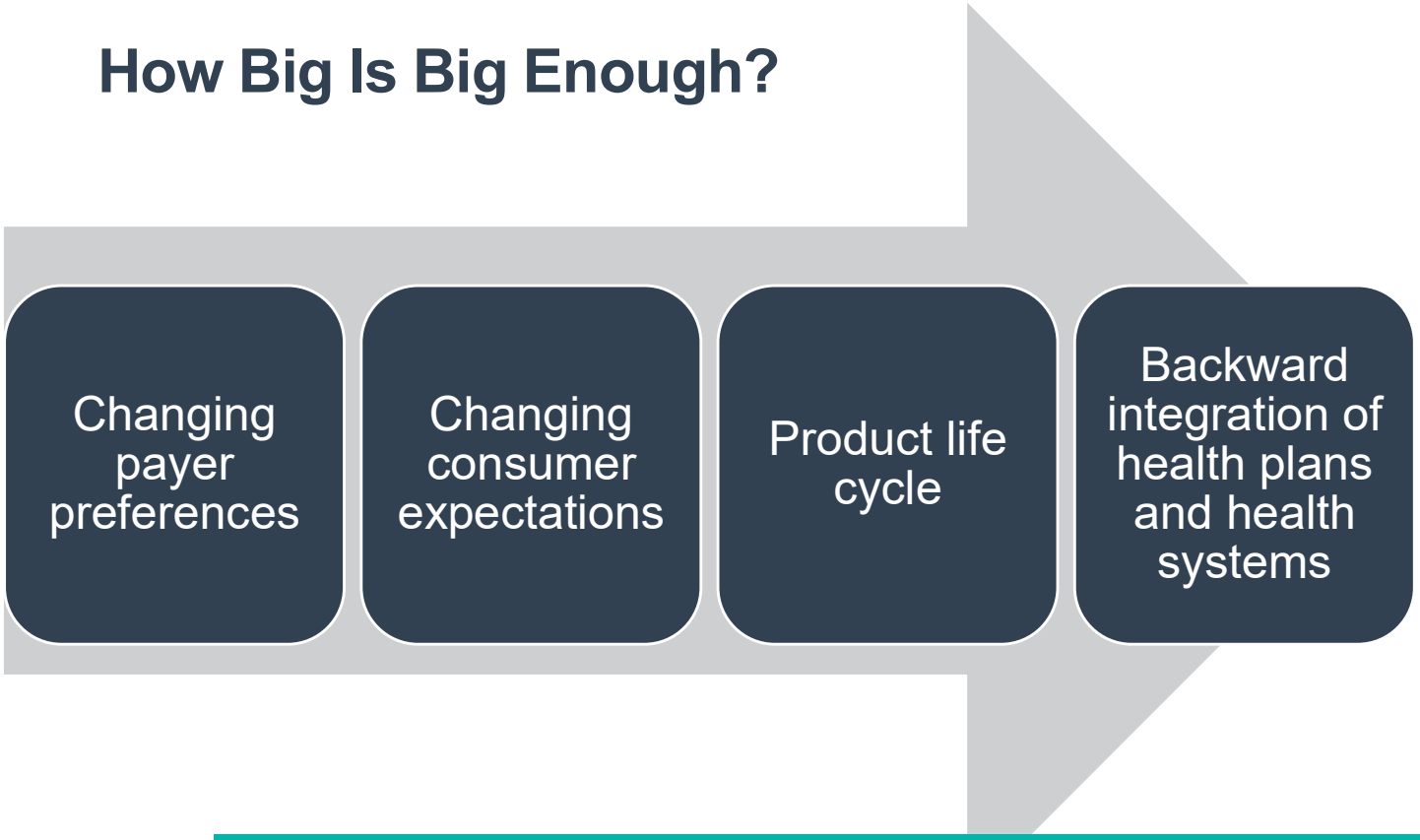
Key Driver #5: New Competition Driving Consolidation

Sustainability In A Changing Youth Services Market

- **Program Features**
  - Acute psychiatric stabilization of complex youth
  - Unlocked treatment setting
  - Seclusion and restraint free
  - Trauma informed
  - Coordinated transition to community treatment upon discharge
  - Provider-operated countywide clinic sites
  - Managed Care & VBR Ready
  - Case rate for outpatient services
- **Goal**
  - Reduced psychiatric hospital readmissions for children/adolescents with histories of frequent psychiatric hospital readmissions
  - Payer Mix Diversification:
- **Commercial Health Plan Contracts**
  - Kaiser Permanente
  - Beacon Health Options
  - Blue Shield/Magellan
  - Anthem Blue Cross

- Residential TX Provider Los Angeles County
- Psychiatric Hospital Diversion Program for Complex Youth

How Big Is Big Enough?



Behavioral health organizations need growth to achieve scale –
for investments, for market leverage, to attract talent, for competitive unit costs, and more

Scale is a tool that can yield these results. But size alone does not provide scale – many large organizations don't have scale because they have too many different programs that prevent leverage of their infrastructure or growth of their talent ratio

Private Equity Investments In The Complex Consumer Space Increasing

- CareGiver - I/DD
- ExpertCare - I/DD
- Suncoast New Options – I/DD
- Florida Autism Center - Autism
- Community Psychiatric – Mental Health
- Agape – Addiction Treatment
- Haven Behavioral - Mental Health
- InnerChange - Mental Health
- Walden Behavioral – Mental Health
- Sun Behavioral - Mental Health
- Sequel Youth & Family – Children's Residential
- Center For Autism & Related Disorders – Autism
- AdvoServ - I/DD
- BrightSpring - I/DD

California Advancing & Innovating Medi-Cal Initiative

What Is CalAIM?

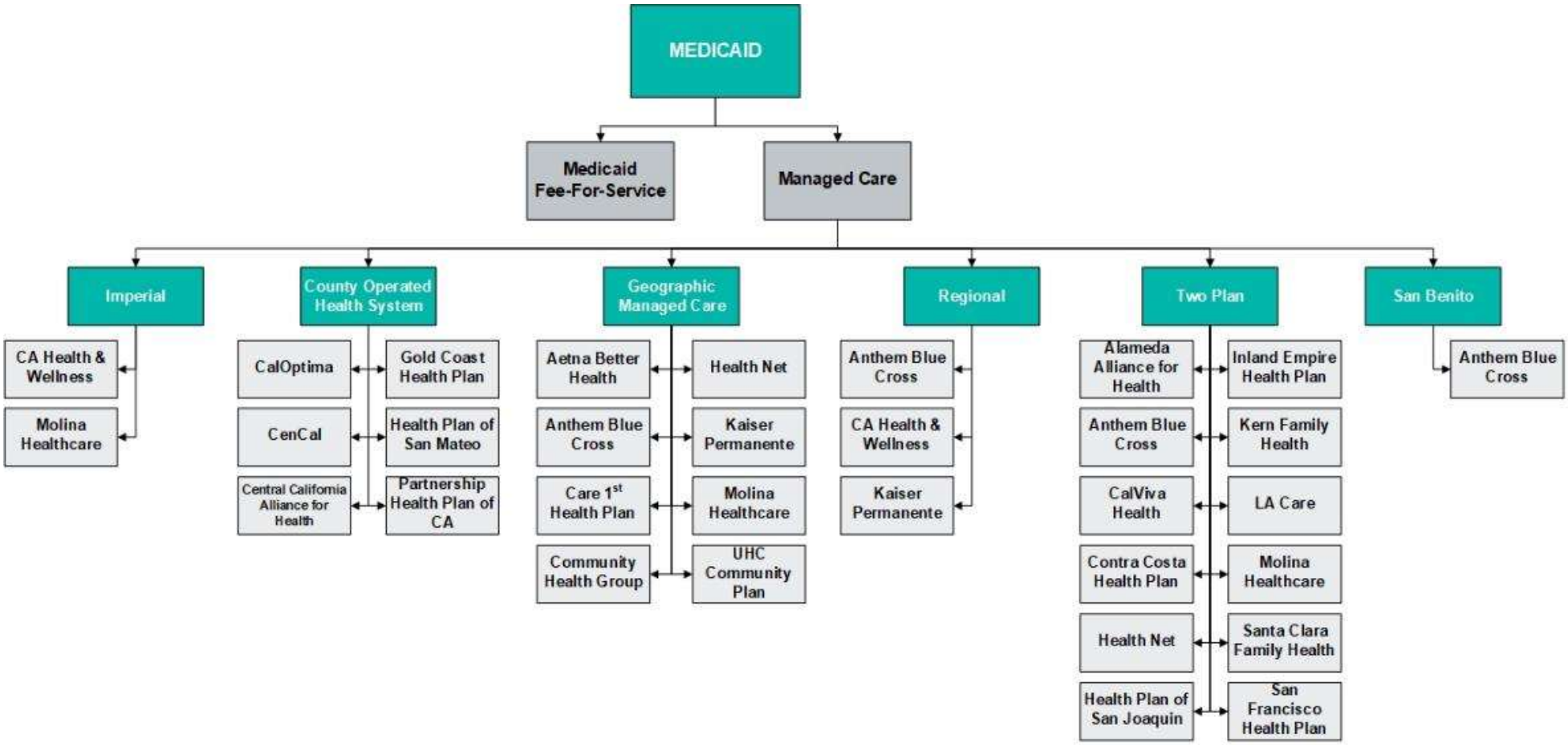
What Is CalAIM?

1. CalAIM initiative will implement broad reforms to the Medicaid delivery system, programs, and payment methodologies.
2. CalAIM is intended to reduce system complexity, increase flexibility, improve quality of care, and drive system transformation through the use of value-based initiatives and payment reform.
3. In the multi-year implementation, some of the provisions are slated to go live by January 1, 2022, and the final provisions are projected to go live by 2027.
4. The provisions of CalAIM are part of the state's renewal of its current 1115 and 1915(b) Medicaid waivers

CalAIM Goals

1. Standardization of managed care plan benefits so that all Medi-Cal managed care plans in the state provide the same benefit package.
2. Carve institutional long-term care into managed care plan benefits.
3. Carve pharmacy out of managed care plan responsibility.
4. Implementation of managed long-term services and supports (MLTSS) statewide to replace the current variety of 1915(b) Medicaid waiver plans, which have capped enrollment and are not statewide.

California Medicaid Managed Care Programs



CalAIM Reforms Are Driving Provider Organizations To Adopt Managed Care & Integrated Care Approaches

Key Reforms as of January 2021

1. Transition Medicaid fee-for-service (FFS) beneficiaries to managed care by January 1, 2022
2. Standardize the Medicaid benefit package across managed care plans by January 1, 2023
3. Revision of managed care plan contracts to integrate physical health, behavioral health, and oral health services by January 1, 2027.
   - A single contract will consolidate multiple Medicaid delivery systems: Medi-Cal managed care, county mental health plans, and Drug Medi-Cal Organized Delivery System (DMC-ODS).
4. Implement a single integrated behavioral health plan to administer specialty mental health and addiction treatment services in each county or region by 2027.
5. Transition behavioral health services from a cost-based payment methodology to outcomes and quality-based payment by July 1, 2022.

Key Reforms (continued)

1. Revise medical necessity criteria to standardize requirements by January 1, 2022
2. Require Medi-Cal managed care plans to develop and maintain a person-centered population health strategy for addressing member health and health-related social needs based on data-driven population-level assessment, and risk stratification and segmentation by January 1, 2023
3. Implement the enhanced care management (ECM) benefit for beneficiaries at risk of institutionalization to build on and replace the current Health Homes Program (HHP) and Whole Person Care (WPC) Pilots.
   - Medicaid managed care plans will partner with existing Health Homes, community-based care management entities (CB-CMEs), and Whole Person Care provider organizations by January 1, 2022.
4. Integrate a set of 14 nonmedical "in-lieu of services" (ILOS) as an alternative or substitute for covered Medi-Cal benefits over time. The ILOS will be integrated with care management for high-risk members by January 1, 2022.
5. Implement incentive payments to plans to invest in the delivery system and quality performance by January 1, 2022

CalAIM Provider Organization Growth Opportunities – ECM / ILOS 2022

1. ECM services will coordinate Medi-Cal services and provider organizations for physical health, behavioral health, oral health, and long-term services and supports.
    - ECM focuses on beneficiaries with mental health and addiction disorders and co-occurring physical health conditions who are at risk of being institutionalized.
2. Medi-Cal managed care plans will be required to contract with local provider organizations to deliver ECM
    - ECM contractors could be county departments, behavioral health provider organizations, and community-based provider organizations
3. ILOS will allow the Medi-Cal health plans to use a set of 14 non-medical ILOS listed by the state. The ILOS will be integrated with care management for high-risk members.

II. Leadership Strategies For Creating Managed Care Opportunities

Strategies Aimed At Managed Care Success

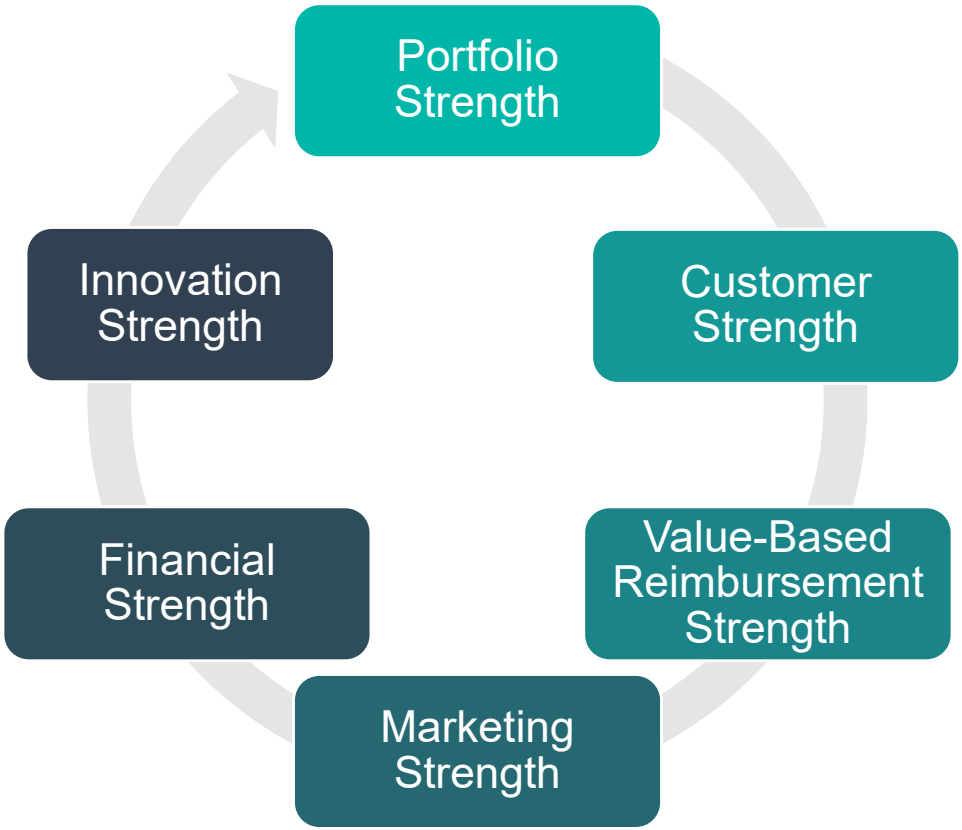
Strategies:

- Improve health plan payer contract performance
- Track key access measures
- Improve consumer experience
- Standardize clinical processes for consistent outcomes
- Improve revenue, margins and financial sustainability

Initiatives

- Develop integrated care approaches and programs
- Improve managed care functionality with optimized revenue cycle management
- Improve consumer access and engagement
- Service line development, diversification, and new revenue streams
- New technology investments
- Contracts and systems for value-based reimbursement
- Margin improvement with operational process reengineering and unit cost management

Organizational Strengths For Market-Based Success



1. Do you have the right services configured in the right way to meet the needs of payers and consumers?
2. Are you improving customer satisfaction?
3. Have you built the metrics-based structure for alternative payment methods based on successful outcomes?
4. Do you have a strong marketing plan?
5. Are you generating a net margin and building financial sustainability?
6. Do you encourage and incentivize innovation?

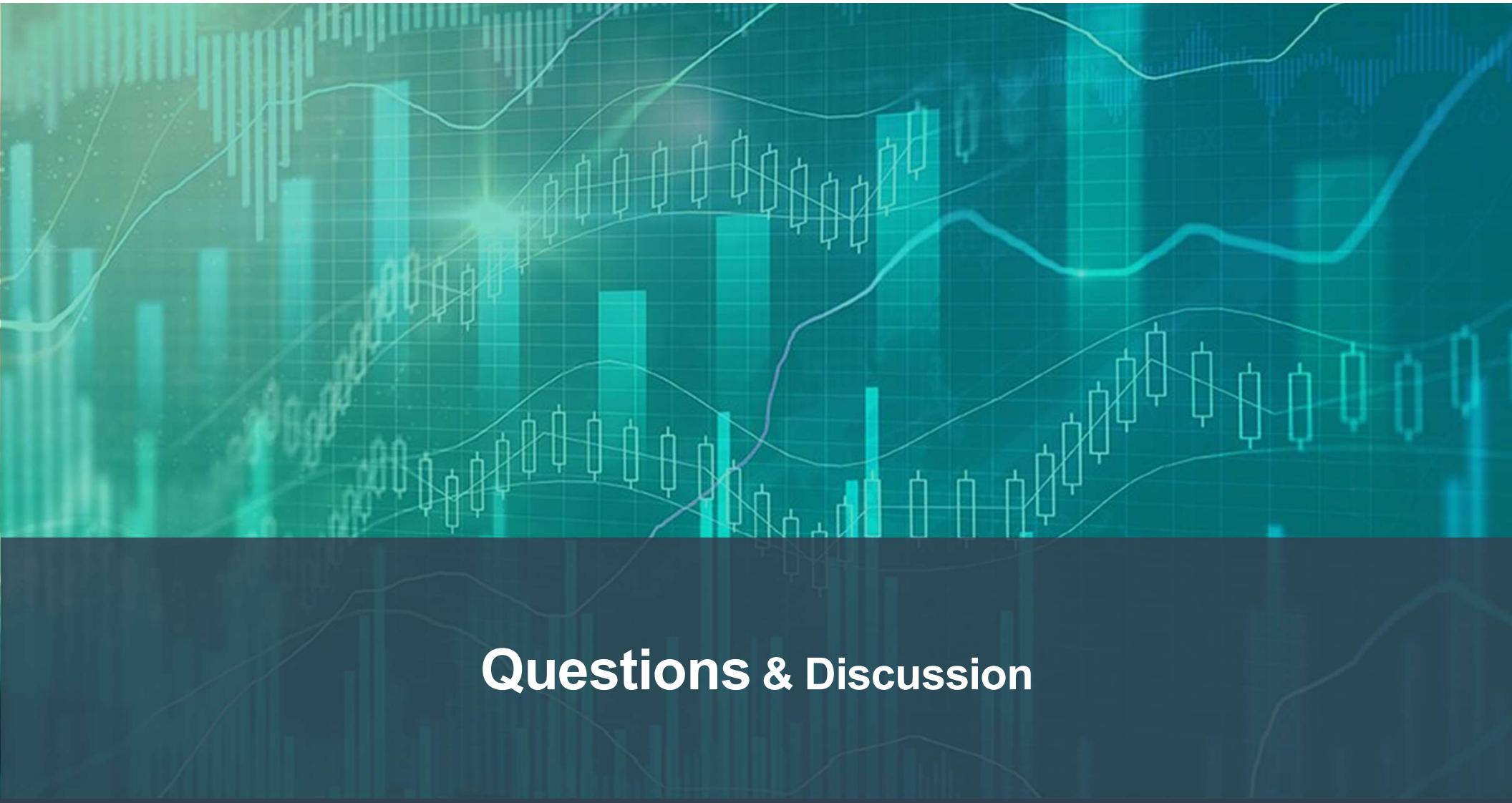
OPEN MINDS Performance Domains For Health & Human Service Provider Organizations

"High Performing" On Payer Contracts	The Speed & Cost Factors	The Consumer Experience	Clinically Cutting Edge	Financial Sustainability
• National health home measures • NCQA HEDIS measures • CMS STARS measures • Most common health plan contract measures • Specific health plan contract measures • Specific funder performance measures	• Unit cost • Search engine ranking and optimization • Online reputation • Inquiries • Inquiry response time • Inquiry conversion rates • Time to appointment • Service rates • Rate-value linkage	• Net promoter score • Customer satisfaction • Customer experience monitoring ("mystery shopper") results	• Consistency in "treatment model" – lack of unexplained variability • Current in clinical and service practices • Short time to evaluation and adoption of new treatment technology	• Revenue – by service line • Liquidity – current ratio, days cash outstanding, cash flow from operations, days of accounts receivable • Profitability – revenue growth and net operating profit margin, by service line • Leverage – debt to equity ratio

The New "Preferred Provider" In Behavioral Health Care

- Timely access to care
- Delivery of quality treatment services
- Coordination of client care and essential social supports
- Measurable and impactful service line clinical outcomes
- Focused customer service at multiple engagement points: payer, client, and referral source
- Aligned payer / provider goals – positioned for "repeat business"

A preferred provider organization understands payer goals and expectations



Questions & Discussion

Turning Market Intelligence Into Business Advantage

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