MANAGED CARE PARTNERING

From UR Ethics to UR Strategy

Presented by: Cade C. Saurage and Debra Nussbaum

Today's Speakers

- Cade Saurage – 17 years of managed healthcare experience; 10 years focused on behavioral health; entire career dedicated to building relationships with insurance companies and the people who represent them; Friends on the front lines, associates in the middle and partners up top.

- Debra Nussbaum - recruited out of Columbia University while finishing PhD in 1992 to start a managed care division for Empire Blue Cross and Blue Shield; Currently works for Optum National with focus on establishing and maintaining programs aimed at measuring and improving treatment outcomes.

Managed Care & the Provider

- Do I stay or do I go? (in-network vs out of network)
- How can I secure a fair per diem rate in-network?
- How do I get referrals from Insurance Companies?
- How do I become a preferred provider?
- Will I stop being denied if I go in-network?
- What happens if I decide I want to go back OON?
- Will I be able to sustain if I stay OON?
- Why do insurance companies seem to be even more difficult now that I have gone in-network?
- Who should I file a complaint with so it doesn't fall on deaf ears?

Trending. . .

- CD Inpatient: 180 days to 90 days to 45 days to 30 days to day by day
- More facilities > more patients > greater cost > more denials
- 3rd Party Doctor Groups (different from IRO) = hired hands
- Healthcare Exchange BOOM…….Healthcare Exchange withdrawal
- Affordable Healthcare Policy claims going unpaid…..who suffers?
- Chart audits / ROI for benefits / delayed payment / lawsuits
- Third-party services being scrutinized by payers
- Policy Changes (High Deductible, PPO to EPO, PPO to HMO, Employer Group incentives)
- UR: Standard (once simple) healthcare protocol became BUSINESS
- Pay-for-performance, self-management programs, partnership opportunities through managed care pilot programs aimed at cost-control
- Big Employer groups starting their own managed care divisions


Insurance
Self Pay


Self Pay
Insurance

The Faces of your Facility

- Who is the face of your facility at NAATP?
- Who is the face of your facility with your referral sources?
- Who is the face of your facility with your patients and their families?
- Who is the face of your facility with 90% of your overall revenue?

Are you assembling the right UR team?

Are you assembling an A-Team?

The A-Team

Combines the art of storytelling with the truth

Knows medical necessity better than the state

Works well with treatment team

Has a willingness to challenge determinations

Has a competitive streak and likes to win

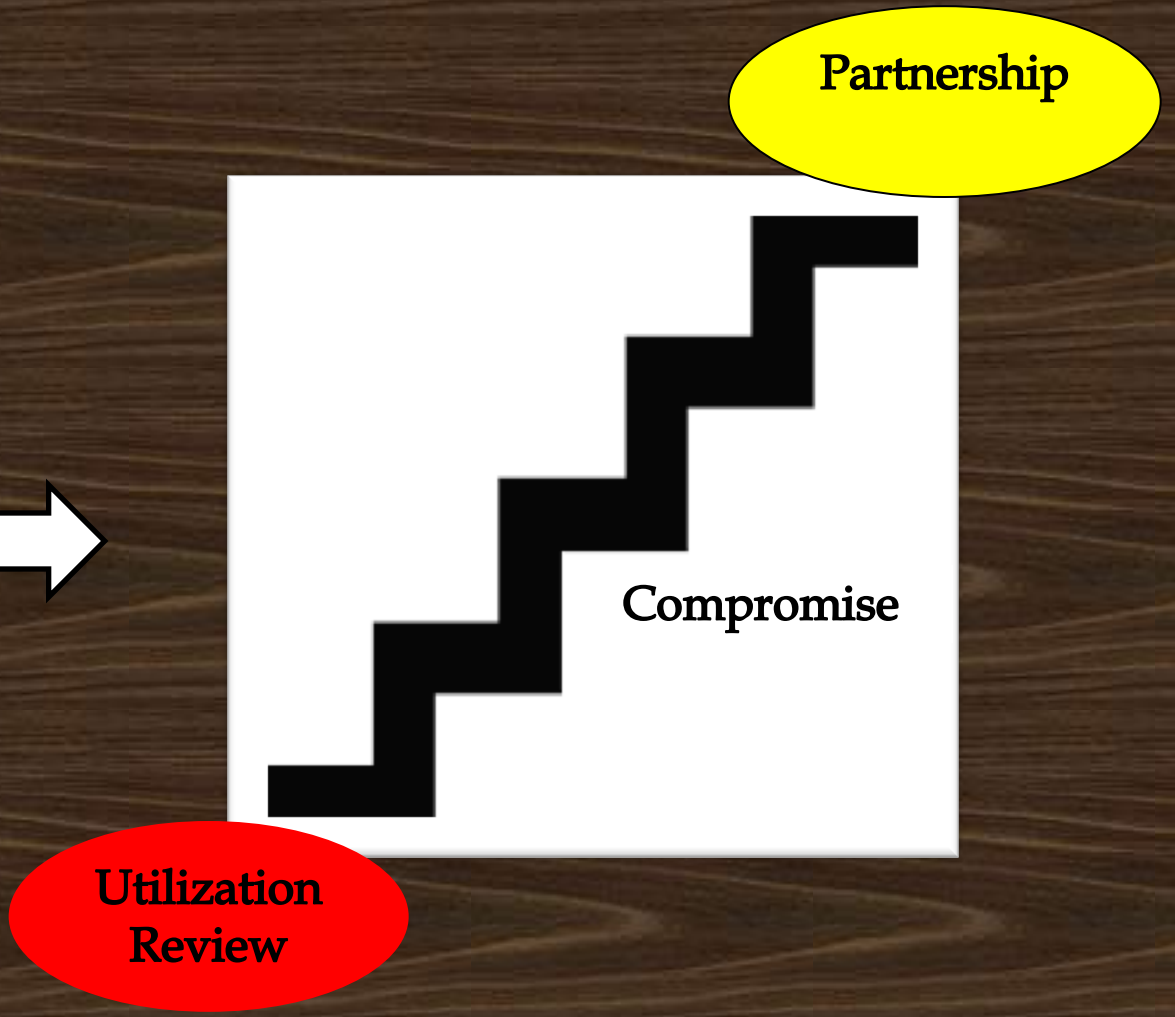
Makes few mistakes and keeps good notes

Has strong relationship skills and even stronger drive

Believes in rehabilitation and the provider they represent

Starts relationships, builds profiles, follows the ladder

UR: Strategic Accounts



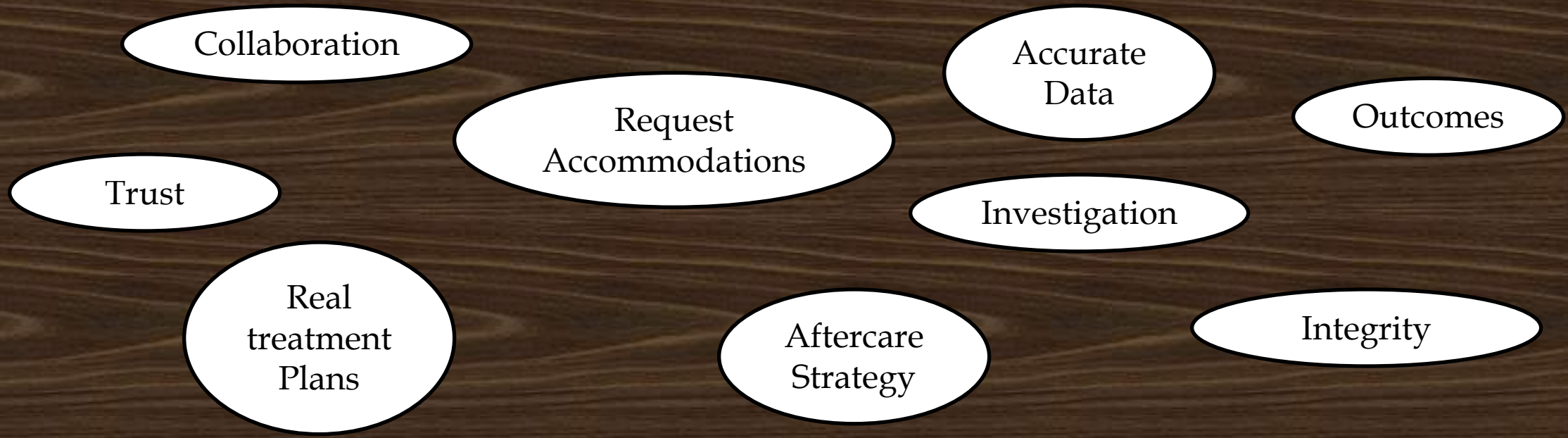
The A-Team Leader

Supervises UR & Drives Partnerships
Maintaining Ethics above everything else

- Knows the rules of the game better than anyone.
- Knows medical necessity criteria, Parity and NCQA regulation.
- Has ability to complain without being confrontational.
- Has ability to sell without being a salesman.
- Works effectively with ALL departments.
- Creates reports, studies and uses data.
- Has support from leadership and time to get it all done.

IMPORTANCE OF ETHICAL PRACTICES

- If you paint an inaccurate picture and a chart audit returns conflicting evidence, a black eye is given to our industry as a whole.
- Trust is established on the front end. Impressions of the provider come from 'the reviewer' AND 'the review'.



Managed Care Organization Relationships

- Book of Business – If you don't have one, start one
- (Even UR staff needs a book of business)
- (Everyone Insurance company employee needs a profile. They have one on you.)
- Begin on the phone with a GOAL of face to face
- (Harder to say NO to someone you know. Harder to get to know someone on the phone)
- Outcome Studies and Score Cards – MCOs love data
- (MCO's keep data)
- Provider Relations / Medical / Clinical / UM / Appeals

MCO Professionals

- The Diplomat

The Ambassador of Change


Who is putting out your fires?

Successful Offensives

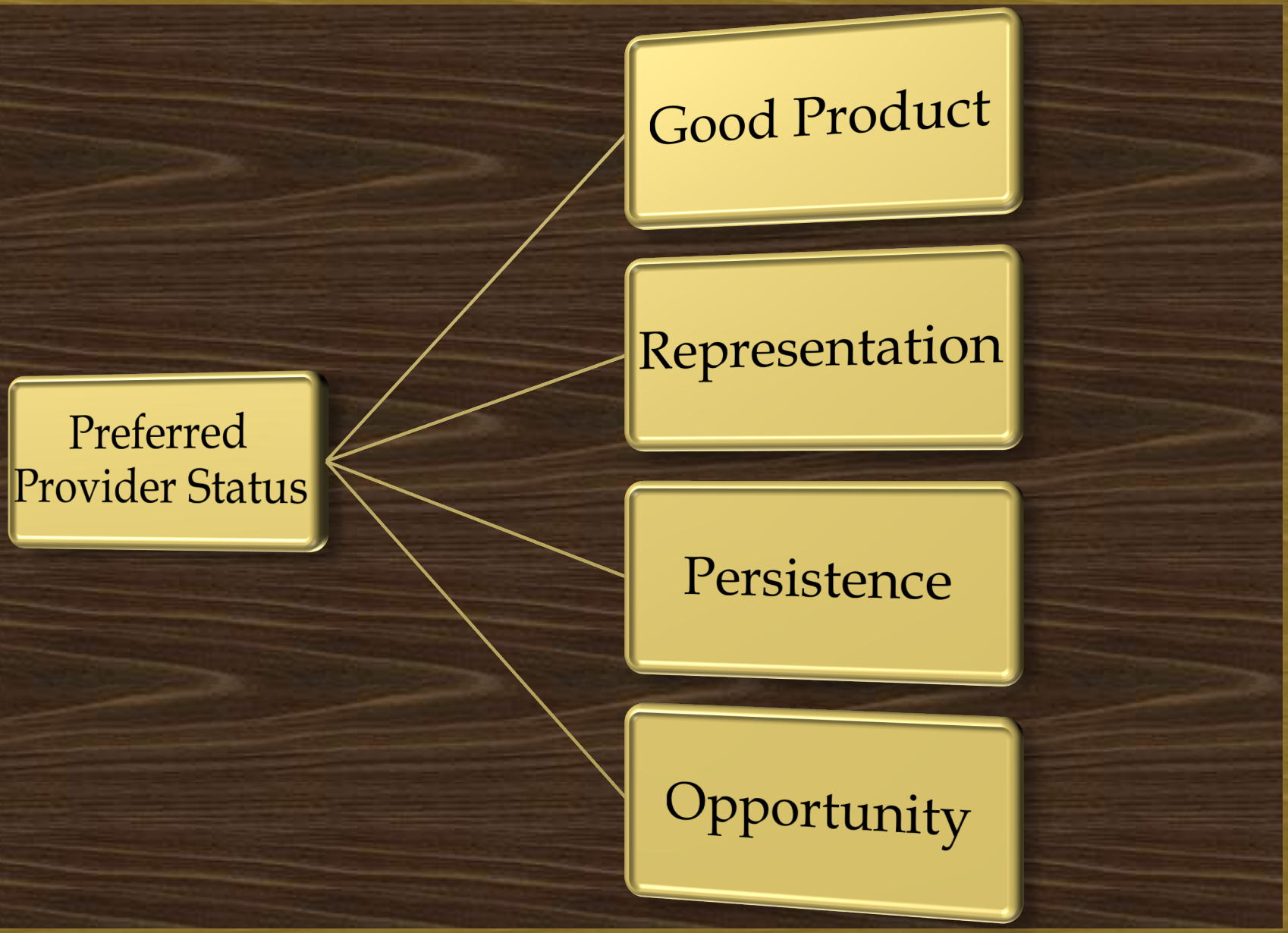
- Global Problem: New Anthem guidelines will state that PHP level of care can not be boarded at the facility……per Dr. PK
- Solution: Identified every negative consequence including financial burden and orchestrated both corporate site visits and conference calls with each regional medical director to introduce new action plan.
- Local Problem: Sudden blanket denials of both IPR & PHP levels of care, regardless of acuity, by a usually supportive payer.
- Solution: Collaborated with other providers, created a chart of denials by region, by level of care, and finally by MCO reviewer ultimately identifying that new hires were all semi-trained by ONE infamous personality. Collected denial data and went to contacts with proof.

True or False?

1. Managed Care Organizations are fully-staffed, well-oiled machines who have extremely organized processes from top to bottom.

2. The squeaky wheel always gets the grease.

Just kidding Deb


Preferred Provider Status
Good Product
Representation
Persistence
Opportunity

10 Points to PONDER

(Before you write or report)

1. 80 / 20 Rule – How much progress? Struggle?
2. Be Descriptive and support with evidence.
3. Document Quality vs. Quantity
4. Use 'Powerful' words to describe. Make reader uncomfortable.
5. Make reader sympathetic, empathetic for patient.
6. Never cause reader to oppose patient.
7. Put yourself in Insurance' Shoes.
8. Creative treatment – What MUST be done before discharge?
9. Turn **UP** the notes as treatment extends.
10. Better your craft by learning Criteria

The REVIEW

Drive Perception

- Tone of Voice – Drive the review
- Big Punch - Open with most significant
- Paint picture / Tell Story / Find an angle / Elaborate
- Bring it home (Why will they fail at a lower level)

MCO / Reviewer Relationship

- Build Profile of each reviewer (likes, dislikes, something personal to ask about on future call)
- Each review must be tailored to style, personality and tenure of insurance reviewer
- Create database of profiles, team and team lead contact names assigned to your program.

Medical Necessity Criteria

- Verbally establish the criteria being used on each call
- Keep copy of criteria accessible during reviews and **Quote criteria**

Case Preparation

- Take notes during review to use on next call – show organization
- Accommodate **EVERY** request from the Insurance reviewer.

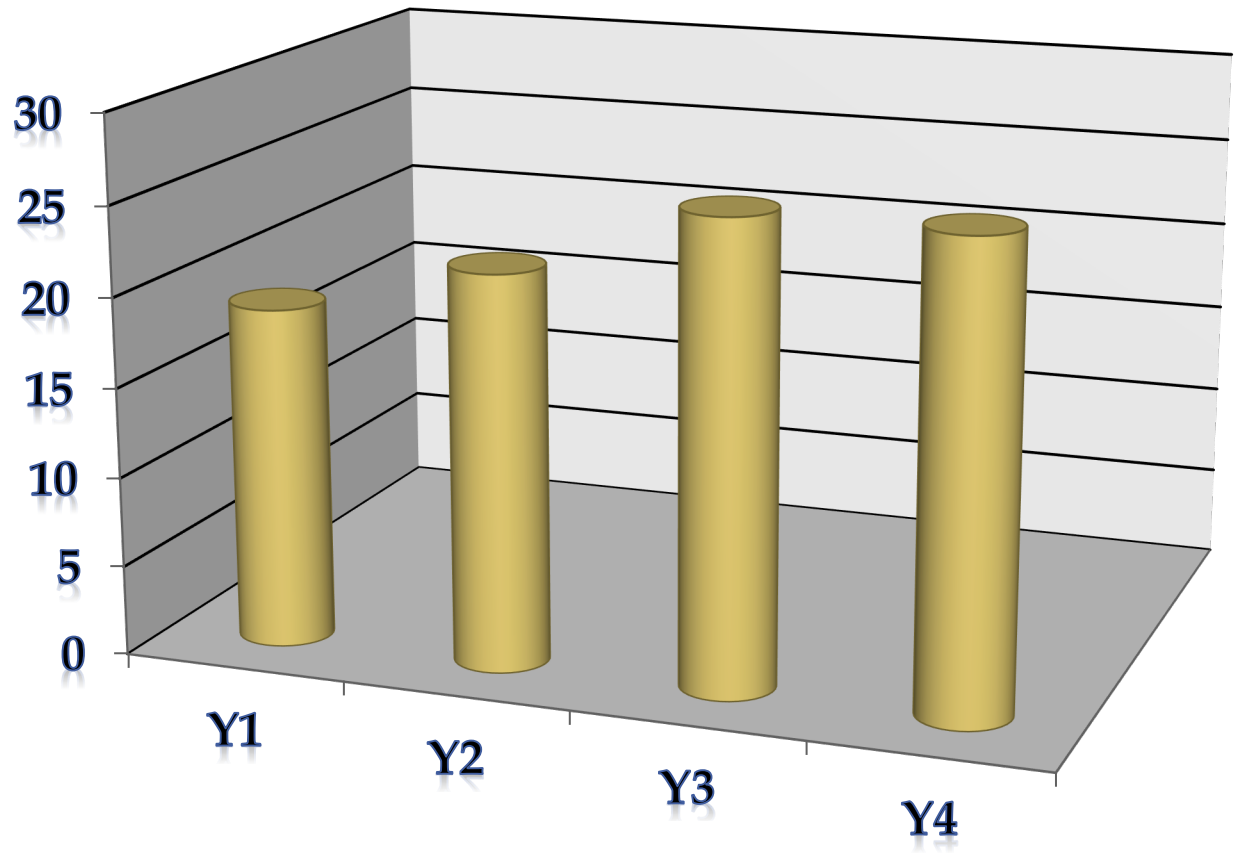
Closing

- Decide on standard (written) appeal or expedited (verbal) appeal…*AKA* D2D (Doc-to-doc) and inquire with Insurance reviewer how many appeals will be allowed before exhausted.

DOC-TO-DOC

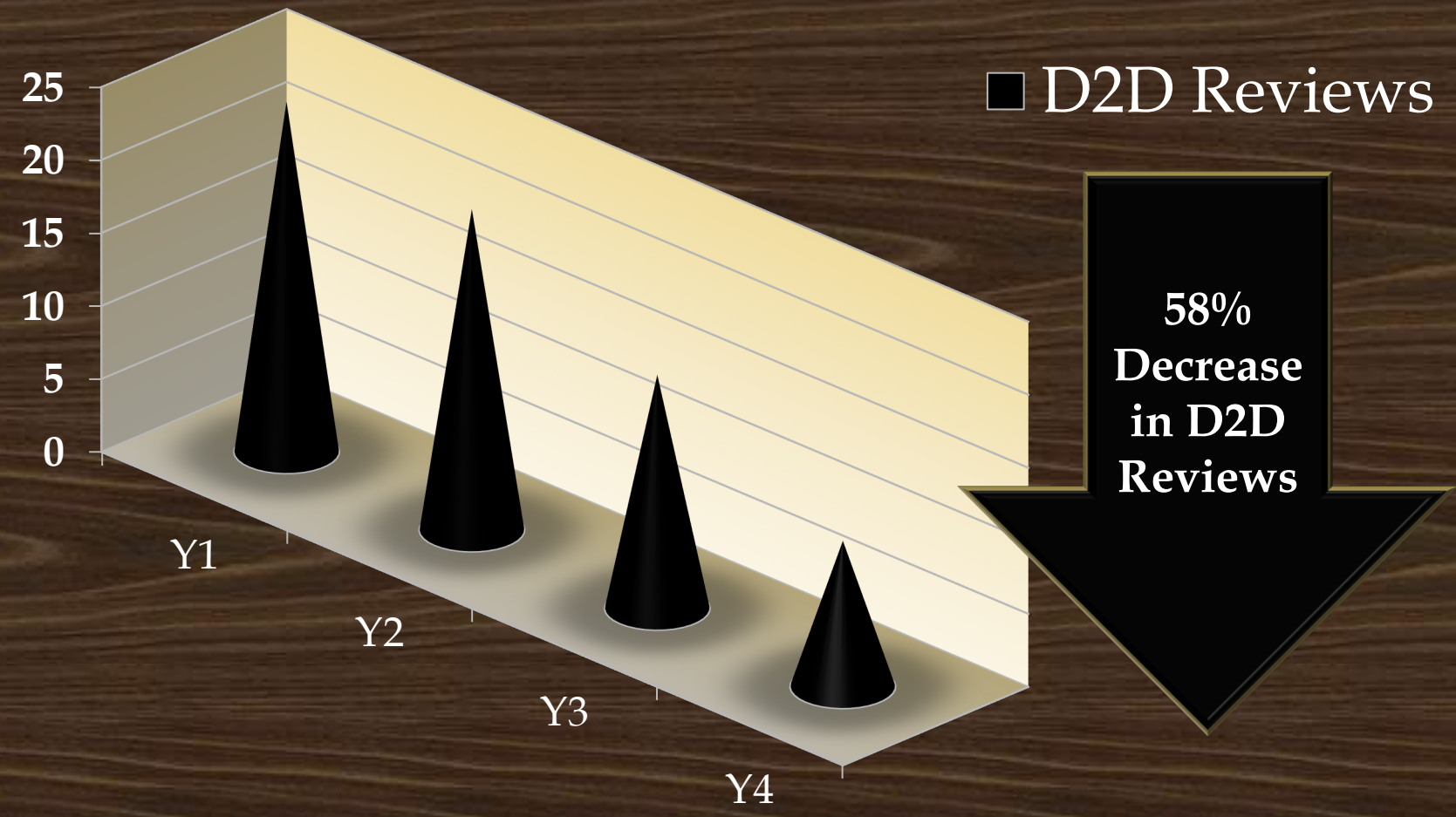
D2D / Verbal Appeals / Higher Level Review

Know your Reviewer / Know your Doctor
Build your case: Tell a story or take an angle
Drive Perception
Identify Criteria
Control Conversation
Start strong – Determination made quickly
Document reasons for denial for future use
Negotiate to salvage
Never break a promise



AVERAGE DAYS AUTHED

26.9% Increase in Total Days authorized


25
20
15
10
5
0
Y1
Y2
Y3
Y4
D2D Reviews
58% Decrease in D2D Reviews

Without Data, you are just another person with an opinion.

~ W. Edwards Deming

Optum
Formerly known as United Behavioral Health (UBH)

Debra Nussbaum, PhD, LCSW

Sr. Director, Behavioral Health

May 21, 2018

Transformation begins with relationships

PROVIDERS

4/5
U.S. hospitals

EMPLOYERS

4/5
of Fortune 100

HEALTH PLANS

300
health plans

LIFE SCIENCES

90+
organizations around the globe

GOVERNMENTS

34
States, DC and many federal entities

CONSUMERS

115 million
empowered consumers

OPTUM®

As of Q2, 2017

Achieving population health management

POPULATION HEALTH SERVICES

Prevention and Well-being	Care Management	Behavioral Health/ EAP	Network Solutions	Pharmacy Care	Care Delivery	Financial Services

66% increase
in care gaps closed for a Fortune 500 employer

35+ million people
access Optum Behavioral Health services

Largest
Health Savings Account provider in the United States

2016 Company of the Year
for Population Health Management by Frost & Sullivan

OPTUM®

Connecting people to top-quality care

Continuously drive the behavioral health network to higher levels of performance.

THE NATION'S LARGEST PERFORMANCE-TIERED NETWORK[1]

190,000

PROVIDERS NATIONALLY[2]

127,000 of them EAP

PREFERRED PROVIDER NETWORKS

$110

average savings per episode versus non-preferred practitioners (outpatient)[3]

15%–20%

lower readmission rates from our higher-performing facilities[4]

$2,330

average savings per episode versus non-preferred facilities (inpatient)[5]

"Optum is leading the pack in the transition of its network to value-based reimbursement (VBR)." — Monica E. Oss, Open Minds

1. Based on an Optum competitive study through a national third-party research firm, September 2017. 2. Optum analysis: D. Adler and M. Hart, 09/15/17. 3. Savings reflect the difference in mean paid per admission between preferred and non-preferred practitioners. D. Adler, SVP Network Services, and C. Mao, VP Clinical Network Affordability, 12/4/15. 4. Optum practitioner analysis; Source: Adler and Mao, March 2015. 5. Savings reflect the difference in mean paid per admission between preferred and non-preferred facilities. Mao, 8/18/17.

OPTUM®

Optum believes in lasting recovery through advancing care and empowering consumers

Advancing Care

- Substance Use Disorder (SUD) is a chronic, complex condition.
- Recovery is a long-term process. We believe people have a better chance of achieving long-term recovery by engaging in evidence-based care in their local community. This creates a strong and readily accessible support system.
- There is no standard program that works for all people, but we support science-based care that has shown evidence of better outcomes including whole-person, integrated care with the expertise to recognize and treat and/or coordinate co-morbid medical and behavioral conditions.

Empowering consumers

- We believe that lasting recovery from SUD requires broad choices for interventions, treatment, and support services that effectively target the stages of change, including relapse, for each individual's recovery journey.

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Introducing Achievements in Clinical Excellence Substance Use Disorder

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ACE SUD necessary?

To guide and reward facilities for delivering services more effectively and efficiently

ACE helps facilities reach these goals by:

Providing unbiased, risk-adjusted data that is quantified and compared against regional benchmarks

Identifying variations in practice patterns, which drive increased costs and poor clinical outcomes

Collaborate with facilities to achieve and maintain Preferred status

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ACE is condition-specific*

ACE breaks out facility evaluations into four condition-specific categories, with additional condition-specific categories possibly added in the future. This will allow for a truer "*apples-to-apples*" comparison of performance.

Mental Health (excluding Eating Disorder and Autism)	25 TO QUALIFY
Alcohol SUD	25 TO QUALIFY
Opioids and other SUD	25 TO QUALIFY
Eating Disorders	10 TO QUALIFY

*A facility must be in-network and have a minimum number of qualified admissions for a two year look back period to the facility's acute and/or intermediate LOCs, for the condition category being evaluated.

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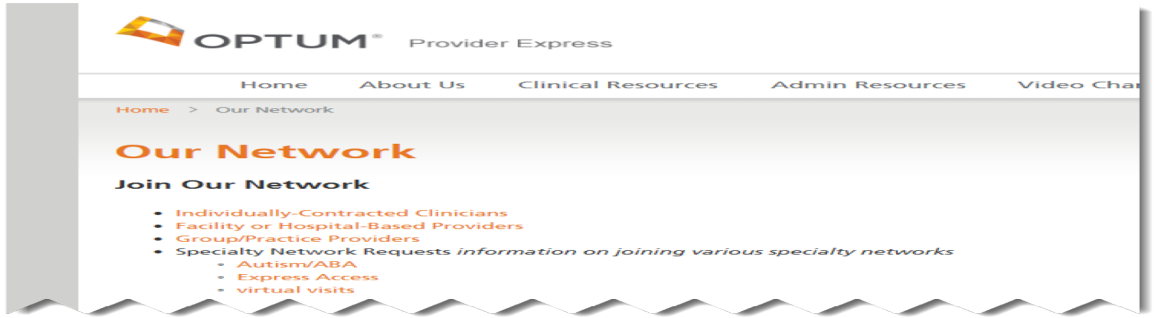
Becoming an Optum Network Provider



- Specialized SUD Network Vetting Committee formed in 2016 to review all requests
  - Co-chaired by Optum's Chief Medical Officer
  - Includes Eight Behavioral Medical Directors Board Certified in Addiction Medicine
- An *External Review Board* of nationally recognized SUD leaders assembled in 2018
- Initial Review Criteria include :
  - SUD specialty and Geo access needs
  - Local SUD Level of Care availability and needs
  - Program under review is founded upon Evidenced-Base Care
- Claims-based historical analysis outcome measure: including elements of effectiveness and efficiency
  - Average length of stay, Step-down patterns, and Comprehensive Discharge Planning
  - Benefit request denial rates and re-admission rates
  - Average Episode of Care Cost

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What Optum Customers Expect

Network Access	Access to a network provider when the member requires care. This process is called geo access review. Geo access is reviewed regularly and provided quarterly and annually to customers. Review includes: Diagnostic utilization, level of care, INN vs OON, % of network exceptions, state of care.
Highest Quality Specialty Services	Access to specialists. Providers that treat special populations or circumstances. These are the situations that inspired Optum's ACE programs and the recruitment/development of specialty services.
Effective care	Demonstrating quarterly and annually that Optum's network of clinicians, programs and facilities are providing quality services with superior treatment outcomes. Tiering the behavioral network and providing customers transparency to recognize programs with superior treatment outcomes.
Cost efficient care	Optum's contracts with network providers must align to customer benefit plans and industry standards. Cost of care must be transparent to the members and to the customers. Benefit plans have less in network cost share and must offer value.

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Industry Trends

What's coming….

Alternative Payment Models	Benefit Plan Design Changes	Reimbursement Methodology Changes	Customer Specific Networks
Bundled payments	Parity Compliant	Parity compliant	Parity compliant
DRGs	Eliminating out of network benefits (EPO)	Adopting policies that determine level of in and out of network program reimbursement	Similar to medical COEs
Reimbursement tiers	Broad limits on out of network services	Bundled, programmatic payments for standard services that should be part of a treatment program	Providers and programs within a defined geo access area
Case rates	Defined, limited networks		
Risk Sharing			

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Thank You