How To Build Value-Based Payer Partnerships: An *OPEN MINDS* Executive Seminar On Best Practices In Marketing, Negotiating & Contracting With Health Plans

Part III: Best Practices in Contracting With Health Plans

The 2020 *OPEN MINDS* Performance Management Institute
Wednesday, February 12, 2019 | 1:00pm – 4:00pm

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Value Based Care for Behavioral Health
Powered by carelogic

Practical Contracting Guidance For Providers

- Specific contracting areas include:
- Type and Level of Risk
- Data Sharing
- Patient Population
- Consumer Engagement
- Service Requirements
- Quality Metrics/Performance Evaluation
- Provider Network Requirements
- Financial Structures
- Return on Investment
- Confidentiality Requirements

Category 1:
Fee-for-service, with no link to quality or value

Category 2:
Fee-for-service, with links to quality or value

Category 3:
Alternative payment models built on fee-for-service architecture

Category 4:
Population-based payment

Contract Considerations

Providers and payers should consider including contractual language around the following:

- Shared care planning, including descriptions of who is on the care team, whether there are dedicated case managers, and the role of individuals on the team
- Description of beneficiary cost-sharing and specifics on how that information is communicated
- Shared decision-making and engagement tools
- In any model where providers are at risk for cost, standards for informed consent, including written description of treatment options
- Full patient access to health records on a secure platform
- Patient access to comparative provider quality information
- Identification and collection process for Patient-Reported Outcomes Measures (PROMs)
- Processes for assessing individual capacity for self-activation, barriers to activation, and support to overcome barriers.

What To Expect When Doing Business With MCOs

MCOs will …

Have more rigorous service authorization procedures and controls

Have their own network contract requirements and standards

Institute performance and quality metrics

Encourage a higher level of technology sophistication

Expect key leadership competencies

Guidance For Providers New To A Managed Care Environment

Update technology capabilities to better integrate with MCO systems and share information

Consider alliances and partnerships with other providers to share investment costs

Conduct managed care “readiness assessment”

Affiliate with a larger entity who can perform managed care functions on your behalf

Develop business cases on the value of your services

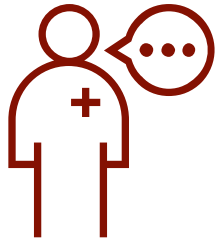
Build competencies

Forge partnerships with MCOs

What Can You Do Together With Health Plans?

Develop
ideas
to improve general
service delivery
for your clients and our
members

Co-design incentive-
driven programs
to help individuals reach
their goals (from a “paid services”
model toward an “outcomes” model)



Increase
the dialogue
between MCOs and
providers to maintain
alignment on
program goals

Most Commonly Used Performance Measures Of Specialty Provider Organizations

- Follow-up after hospitalization for mental illness
- Emergency room utilization
- Readmission rates
- Patient or consumer satisfaction
- Use of evidence-based care protocols
- Access to care measures
- Diabetes screening for people with Schizophrenia using an antipsychotic
- Antidepressant medication management
- Community Tenure
- Depression monitoring via PHQ-9
- Patient Reported Outcomes
- Involvement of family/significant other
- Initiation/ engagement of alcohol and other drugs
- Diabetes care – blood sugar controlled
- Adherence to antipsychotic medication for people with schizophrenia
- Use of depression screening and follow-up
- Risk adjusted ALOS

Access the online OPEN MINDS Value-Based Reimbursement Assessment free of charge, complements of Qualifacts at VBCforBH.com.

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