Marketing To Managed Care: Succeeding In Providing Behavioral Health Services For Commercial Insurance & Managed Care Plans

Monica E. Oss, Chief Executive Officer, OPEN MINDS
Session Agenda

1. Why Health Plans Matter For Most Behavioral Health Provider Organizations
2. Trends in Health Plan Contracting
3. Marketing To Health Plan -- A Three-Tiered Approach
4. Organizational Capabilities Required To Succeed In Managed Care Contracting
5. How To Improve Organizational Positioning & The Process For Marketing To Payers
I. Why Health Plans Matter For Most Specialist Provider Organizations
**The policy focus is covering more people with the same total budget...**

- **Payer preference for coordinated care** – medical, behavioral, and social.
- **More managed care across all payers**
- **Blurring of role of payer and provider**
- **Payment reform:** more value-based purchasing – risk-based and P4P
- **More competition** – with rise of ‘mega’ providers
- **Technology changing nature of service and of competition**
- **Environmental drivers with impact on market positioning and sustainability of health and human service organizations...**
The Expansion Of Use Of Managed Care Models – More Enrollment & New Populations

Increasing use of managed care financing and service delivery models

- Commercial
- Medicaid
- Medicare
- Dual eligible

New populations

- Complex disabilities
- Long-term care
<table>
<thead>
<tr>
<th>Health Care Payer Type</th>
<th>% Managed Care: 1995</th>
<th>% Managed Care: 2010</th>
<th>% Managed Care: 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer-sponsored insurance</td>
<td>73.0%</td>
<td>99.0%</td>
<td>99.0%</td>
</tr>
<tr>
<td>Medicare</td>
<td>0.0%</td>
<td>24.0%</td>
<td>27.0%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>29.4%</td>
<td>71.5%</td>
<td>74.2%</td>
</tr>
</tbody>
</table>
With More Consumers With Coverage, There Are More Consumer Choices

- Consumers have a new and more complex role – with more financial responsibility (11.4% of total budget)
  - Rising coinsurance, copayments, and deductibles
  - Increasing use of consumer-directed health plans
- “Penalties” for lack of consumer coverage
- “Penalties” for lack of participation in health management
- “Safety net” taking on a whole new meaning in states with Medicaid expansion
Key Concerns Of Provider Organization Executive Teams About Managed Care

- Rates
- Administrative requirements – authorization, documentation, billing
- Reporting requirements
- “Narrow” networks
- Gain sharing models
- Performance-based contracting
Payer Focus: Reducing Health Care Costs Of 5% Of Consumers

5% of U.S. population account for half (49%) of health care spending

$11,487 per person

50% of population account for only 3% of spending

$664 per person
### Comorbid Chronic Physical & Behavioral Disorders Increase Annual Medicaid Costs by 75%

<table>
<thead>
<tr>
<th>Condition</th>
<th>No Behavioral Health Disorder</th>
<th>With Mental Illness And/Or Addiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma/COPD</td>
<td>$8,000</td>
<td>$24,598</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>$9,488</td>
<td>$24,927</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>$8,788</td>
<td>$24,443</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$9,498</td>
<td>$36,730</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$15,691</td>
<td>$35,840</td>
</tr>
</tbody>
</table>

The additional healthcare costs incurred by people with chronic medical conditions and comorbid mental conditions were estimated to be $293 billion in 2012.

Total private insurer medical costs for children with autism is 3 to 7 times greater than for those children without autism.
Emerging Service Delivery System Model – A Framework For Integration

- Expanded managed care models – increasing use for SMI, I/DD, and LTC
- Accountable care organizations (ACOs)
- Medical homes and health homes
- Disease management programs
For The 95%: Primary Care-Focused Models
Spend Less Via Consumer Engagement

- Management via primary care within ACOs and medical homes
- Specialist role is secondary
- Focus on prevention and wellness
- Consumer self-care and consumer convenience is key
- Web presence (optimization, reputation, etc.) critical for consumer referrals
- Health information exchange requirement

- Primary care relationships with clearly defined specialty service
- Consumer ‘experience’ (and preference) critical
- Web presence key referral mechanism
- Health information exchange capabilities

Services for 95% of consumers via primary care-directed models
For the 5%: Intensive Coordinated Care Models
Spend Less By Investing More

• Coordination of medical, behavioral, and social service needs by specialty groups within larger system
  – Specialty care management programs
  – Specialty medical homes and health homes
  – Waiver-based HCB programs
  – PACE programs
  – “Vertical” HMO models

• Assumption of performance risk (with or without financial risk)

- Cross-specialty and cross-system care coordination capability
- EHR system and HIE with real-time care management metrics
- Performance-based contracting and risk-based contracting capabilities

Specialty coordinated care systems for ‘high needs’ consumers – the new ‘carve out’ model
II. Trends in Health Plan Contracting
The internet has created more venues for fee transparency

Health plans facilitating consumer choice – essential with higher consumer financial contributions
Fee Schedule Look-up

This action allows participating providers to look up contracted rates for CPT and HCPC codes for a specific physician/healthcare professional name and product. If you are unable to view the Fee Schedule Look-up screen, please contact your organization's Password Owner for access. The ability to look up Anesthesia contracted rates is not available online.

Three Steps to Check Fee Schedule Lookup
To get started, login to UnitedHealthcare Online and select Fee Schedule Lookup from the Claims & Payments drop down menu.
1. Complete Required Information.
2. View Search Results.

Fee Schedule Search (required fields are marked with an asterisk.)
1. Select the Corporate Tax ID Owner. If there is only one Corporate Tax ID Owner, it will be pre-populated.
2. Select the Physician/Provider Name. If there is only one Physician/Provider Name, it will be pre-populated.
3. Select the Physician/Provider Name. If there is only one Physician/Provider Name, it will be pre-populated.
4. Enter the Provider Zip Code.
5. Answer the question: Are you the PCP/Acting PCP for this service? by clicking the Yes or No radio button.
6. Answer the question: Is service related to Mental Health? by clicking the Yes or No radio button.
7. Click on the Member Information Look-up link (see search specific information below).
8. Enter the Member Zip Code. This information will be pre-populated after the Member Information Look-up has been completed.
9. Enter the Date of Birth using the mm/dd/yyyy format. This information will be pre-populated after the Member Information Look-up has been completed.
10. Select the Gender; Male or Female radio button. This information will be pre-populated after the Member Information Look-up has been completed.
11. Select the Place of Service from the drop-down menu.
12. Enter the Date to Check using the mm/dd/yyyy format or by clicking the Calendar icon. Today's date is the default date.
13. Enter the Diagnosis Code or click on the magnifying glass icon.
14. Enter the CPT or HCPC code or click on the magnifying glass icon.
Members can compare clinicians by cost (actual out-of-pocket expenses) as well as clinical performance ratings on quality and efficiency.

Optum Provider Rating System

Preferred clinicians “star-rated” for quality can earn a second star rating for meeting cost-efficiency standards.

“This looks a lot like picking a flight…it is already feeling familiar.”

“Ratings matter.”

— Consumer Testing Responses
Many initiatives to measure and report on “performance”
Launched in August 2011

Find & Compare...

Doctors, Hospitals, Plans and Suppliers

- Get contact information for hospitals, doctors, nursing homes, home health agencies, dialysis facilities, and drug and health plans.

- Compare information about the quality of care and services these providers and plans offer.

- Get helpful tips on what to look for when comparing and choosing a provider or plan.

Select a compare tool from the left to get started
Graph 14 of 22 How often the home health team taught patients (or their family caregivers) about their drugs.

CMS Home Health Rating System

This information comes from the Home Health Outcome and Assessment Information Set (OASIS) C during the time period July 2010 – June 2011.

How often the home health team taught patients (or their family caregivers) about their drugs.

- Average for all Reporting Agencies in The United States: 87%
- Average for all Reporting Agencies in Pennsylvania: 90%
- ABINGTON MEMORIAL HOSPITAL HOME CARE: 100%
- ABRAMSON HOME CARE: 97%
- AMEDISYS HOME HEALTH: 82%
These results are from patients who had overnight hospital stays from January 2010 through December 2010.

If patients were given medicine that they had not taken before, the survey asked how often staff explained about the medicine. “Explained” means that hospital staff told what the medicine was for and what side effects it might have before they gave it to the patient.

Bars below tell the percent of patients who reported that staff “always” explained about medicines before giving it to them.

How often did staff explain about medicines before giving them to patients?

- Average for all Reporting Hospitals in The United States: 61%
- Average for all Reporting Hospitals in Pennsylvania: 59%
- HAHNEMANN UNIVERSITY HOSPITAL: 69%
- THOMAS JEFFERSON UNIVERSITY HOSPITAL: 61%
- VIRTUA MEMORIAL HOSPITAL OF BURLINGTON COUNTY: 60%
<table>
<thead>
<tr>
<th>Nursing Home Rating System</th>
<th>ANGELA JANE PAVILION</th>
<th>BETHANY VILLAGE RETIREMENT CENTER</th>
<th>CHESTNUT HILL LODGE HEALTH AND REHAB CTR</th>
</tr>
</thead>
<tbody>
<tr>
<td>8450 ROOSEVELT BLVD</td>
<td>5225 WILSON LANE</td>
<td>8888 STENTON AVENUE</td>
<td></td>
</tr>
<tr>
<td>PHILADELPHIA, PA 19152</td>
<td>MECHANICSBURG, PA 17055</td>
<td>WYNDMOOR, PA 19088</td>
<td></td>
</tr>
<tr>
<td>(215) 708-1200</td>
<td>(717) 766-0279</td>
<td>(215) 886-2100</td>
<td></td>
</tr>
<tr>
<td>Mapping &amp; Directions</td>
<td>Mapping &amp; Directions</td>
<td>Mapping &amp; Directions</td>
<td></td>
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<tr>
<td>----------------------------</td>
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<td>-----------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Overall Rating</strong></td>
<td>★★★★★★</td>
<td>★★★★☆</td>
<td>★☆</td>
</tr>
<tr>
<td>5 out of 5 stars</td>
<td>3 out of 5 stars</td>
<td>1 out of 5 stars</td>
<td></td>
</tr>
<tr>
<td><strong>Health Inspections</strong></td>
<td>★★★★★★</td>
<td>★★★★☆</td>
<td>★☆</td>
</tr>
<tr>
<td>5 out of 5 stars</td>
<td>2 out of 5 stars</td>
<td>1 out of 5 stars</td>
<td></td>
</tr>
<tr>
<td><strong>Nursing Home Staffing</strong></td>
<td>★★★★☆</td>
<td>★★★☆</td>
<td>★★★☆</td>
</tr>
<tr>
<td>4 out of 5 stars</td>
<td>3 out of 5 stars</td>
<td>3 out of 5 stars</td>
<td></td>
</tr>
<tr>
<td><strong>Quality Measures</strong></td>
<td>★★★★★★</td>
<td>★★★★★★</td>
<td>★★★★★★</td>
</tr>
<tr>
<td>4 out of 5 stars</td>
<td>5 out of 5 stars</td>
<td>3 out of 5 stars</td>
<td></td>
</tr>
<tr>
<td><strong>Fire Safety Inspections</strong></td>
<td>6 Fire Safety Deficiencies</td>
<td>7 Fire Safety Deficiencies</td>
<td>9 Fire Safety Deficiencies</td>
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<tr>
<td><strong>Penalties and Denials of Payment Against the Nursing Home</strong></td>
<td>0 Civil Money Penalties</td>
<td>1 Civil Money Penalties</td>
<td>0 Civil Money Penalties</td>
</tr>
<tr>
<td>0 Payment Denials</td>
<td>0 Payment Denials</td>
<td>0 Payment Denials</td>
<td></td>
</tr>
<tr>
<td><strong>Complaints and Incidents</strong></td>
<td>1 Complaints</td>
<td>1 Complaints</td>
<td>7 Complaints</td>
</tr>
<tr>
<td>What is this?</td>
<td>0 Incidents</td>
<td>1 Incidents</td>
<td>0 Incidents</td>
</tr>
<tr>
<td><strong>Nursing Home Characteristics</strong></td>
<td>Medicare</td>
<td>Medicare and Medicaid</td>
<td>Medicare and Medicaid</td>
</tr>
<tr>
<td>Program Participation</td>
<td>Medicare</td>
<td>Medicare and Medicaid</td>
<td>Medicare and Medicaid</td>
</tr>
<tr>
<td>Number of Certified Beds</td>
<td>49 Certified Beds</td>
<td>69 Certified Beds</td>
<td>200 Certified Beds</td>
</tr>
<tr>
<td>Type of Ownership</td>
<td>For profit - Partnership</td>
<td>Non profit - Corporation</td>
<td>For profit - Corporation</td>
</tr>
<tr>
<td>Continuing Care Retirement Community</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Resident &amp; Family Councils</td>
<td>Resident &amp; Family Councils</td>
<td>Resident &amp; Family Councils</td>
<td>Resident Council Only</td>
</tr>
<tr>
<td>Located in a Hospital</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
Cenpatico™
Improving Lives

7 Day ACCESS to Care
* Standard is 90%

June | July | August

ACCESS to Intake Agency and Pharmacy as of 4/1/2010

- Adult Access to Intake Agency: 0.966
- Youth Access to Intake Agency: 0.968
- Adult Access to Pharmacies: 0.987
- Youth Access to Pharmacies: 0.987

30-day Readmission Rates
* Standard is 12.5%

AzCA | CBI | Corazon | CPLC | EMPACT | HAI | Horizon | Pinal | Providence | SWBH | SMMHC

FY10Q2 | FY10Q3 | FY10Q4 | FY11Q1
More Value-Based Purchasing

1. Increase transparency of performance
   – Increase ‘pressure’ for improvement
   – Facilitate consumer-directed care
2. Link professional, service provider organization, and care manager reimbursement to desired performance
   – Improved access to care
   – Increase care integration and coordination
   – Person-centered planning and recovery focus
3. Control costs of care
   – Financial incentives to help consumers become and remain healthy for longer periods of time
   – Increase lower-cost interventions for ‘not yet seriously ill’ population
   – Reduce unnecessary use of high-cost services
More Organizations Are “Rating” Performance In Health & Human Services

<table>
<thead>
<tr>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Quality Initiatives</td>
</tr>
<tr>
<td>National Committee for Quality Assurance (NCQA)</td>
</tr>
<tr>
<td>National Quality Forum (NQF)</td>
</tr>
<tr>
<td>Substance Abuse and Mental Health Services Administration (SAMHSA)</td>
</tr>
<tr>
<td>The Joint Commission</td>
</tr>
<tr>
<td>Center For Excellence in Assisted Living</td>
</tr>
<tr>
<td>Payer and care management organizations (states, counties, HMOs, MCOs, PPOs, ACOs, etc.)</td>
</tr>
<tr>
<td>Consumer-driven open-source rating organizations</td>
</tr>
</tbody>
</table>
From Pay For Volume To Pay For Value

- FFS
- Case Rate & Bundled Rates
- Capitation & Subcapitation
- Pay-For-Performance: P4P
Optum: Platinum Benefits – Great Effort Has Its Rewards

Streamlined Clinical Reviews
- Efficient, streamlined review process requiring far fewer phone calls
- Always-available, online secured website for initial and discharge reviews
- Optum intervention on an “as needed” basis

Ease of Claims Access
- Designated contact for claims assistance and resolution

Increased Transparency and Improved Access
- Assigned Regional Medical Director for immediate resolution of issues
- Assigned team of Optum staff including Facility Practice Specialist and Facility Performance Manager
- Monthly review of effectiveness and efficiency data in order to share data trends

Marketing on Provider Behalf
- Optum will work in collaboration with your current marketing efforts to promote your Platinum achievement
- Recognition on Provider Express
- Certificate of achievement to display in the facility
- Specially targeted messaging to area clinicians promoting a facility’s Platinum status
Optum Provider Network Changes

Network Referrals Geared by Provider Performance

We have three distinct approaches to steering members toward high-performing providers:

**Provider Tiering**
- Encourage use of in-network preferred providers, facilities or places of service
  - No changes to network; preserves choice
  - Requires high level of consumer engagement and understanding of benefit plan
  - Provides consumers with information and/or transparency tools (cost and quality) which enable more informed decisions

**Specialty Networks**
- High-performing network-specific population or specific modality
  - Requires specific criteria (e.g., certified suboxone providers)
  - Network typically created from a subset of our broader Choice Network

**Centers for Excellence**
- Superior performing providers that advance evidence-based practices, targeted at high-cost, high-risk populations
  - Practice based on experts and research regarding best practices
  - Requires specific criteria for participation and ongoing system sustainability

Cost and quality ratings available online at LiveandWorkWell

Disability, EAP, Peer Support, Substance Use Disorder, Autism

Eating disorders
Transition of the Model

Optum Provider Contracting Changes

In selected provider arrangements, we will be transitioning and supporting financial risk, accountability and utilization management practices.

Compensation Continuum
(Level of Financial Risk)

- Small % of financial risk: Fee-for-service
- Moderate % of financial risk: Performance-based Contracting, Bundled and Episodic Payments
- Large % of financial risk: Shared Savings, Shared Risk, Capitation, Capitation + Performance-based Contracting

No Accountability → Moderate Accountability → Full Accountability

a. 100% case by case UM
b. Utilization stats review supplemented by case review
c. Data management and system Modifications to achieve targets
d. Internal ownership of performance using data management

Basic Q and U measurements → Max quality process and outcomes driven measurements

Passive involvement → Provider engaged → Provider active in management → Assumes accountability
**Pay for Performance**

- Reward providers for increased collaboration, outcome-based results, and improved cost-efficiencies.
- Nearly 10% of our total spending on network-based health care services is tied to performance-based incentive contracts.

**Member Transparency**

- Preferred clinicians “star-rated” for quality can earn a second star rating for meeting cost-efficiency standards.
- Seeking formal accreditation for our provider performance programs through NCQA Physician Quality Accreditation program (survey to be held in July 2013).
# Cigna Pay-for-Performance: Current & Future State

<table>
<thead>
<tr>
<th>Contracting</th>
<th>Current State</th>
<th>Future State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Fee-for-Service</td>
<td>• Reimbursement for Quality</td>
</tr>
<tr>
<td></td>
<td>• Some Case-Rate</td>
<td>• Greater Case-Rate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Metrics</th>
<th>Current State</th>
<th>Future State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities and Individual Practitioners:</td>
<td>• Clinical metrics</td>
<td>• Clinical metrics</td>
</tr>
<tr>
<td></td>
<td>• Cost metrics</td>
<td>• JCAHO (facilities only)</td>
</tr>
<tr>
<td></td>
<td>Note: metrics for discussion purposes not rewards</td>
<td>• Cost metrics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Satisfaction metrics</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rewards*</th>
<th>Current State</th>
<th>Future State</th>
</tr>
</thead>
<tbody>
<tr>
<td>n/a</td>
<td></td>
<td>• Rate escalation at the time of contract renewal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased referrals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enhanced service level from Cigna</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reduction or elimination of UM necessity</td>
</tr>
</tbody>
</table>

*Rewards will vary based on contracts and applicability

Reason for change...

- Collaboration to achieve the Triple-Aim: improved quality, affordability, and patient satisfaction
- Increased market demand for lower cost/ higher quality products and services
- Evolution of reimbursement strategies from other payers including Medicare
- Demand from customers for high-quality care and transparency into cost and quality
<table>
<thead>
<tr>
<th>Provider Incentives</th>
<th>Alternative Payment Arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pay for Performance (P4P),</td>
<td>• Case Rates</td>
</tr>
<tr>
<td>• Reward for Quality (R4Q)</td>
<td>• Episode of Care Reimbursement</td>
</tr>
<tr>
<td>• Performance Incentive Funds</td>
<td>• Monthly “Global Budget Payments”</td>
</tr>
<tr>
<td></td>
<td>• Sub-Capitation / Risk arrangement</td>
</tr>
</tbody>
</table>
# Magellan - P4P Pennsylvania Case Example

## Measurement:

<table>
<thead>
<tr>
<th>Providers</th>
<th>Baseline from 1/1/08 - 9/30/09</th>
<th>Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 hr LOC</td>
<td>90 day Re-Admission Rates</td>
<td>ALOS</td>
</tr>
<tr>
<td>RTF - JCAHO</td>
<td>9.38%</td>
<td>226.93</td>
</tr>
<tr>
<td></td>
<td>Silver - 7%</td>
<td>Silver - 7 m. or 210 days</td>
</tr>
<tr>
<td>RTF Non-JCAHO</td>
<td>6.90%</td>
<td>208.8</td>
</tr>
<tr>
<td></td>
<td>Silver - 7%</td>
<td>Silver - 7 m. or 210 days</td>
</tr>
<tr>
<td>RTF Non-JCAHO</td>
<td>13.89%</td>
<td>264.48</td>
</tr>
<tr>
<td></td>
<td>Silver - 13%</td>
<td>Silver - 7 m. or 210 days</td>
</tr>
<tr>
<td>Drug &amp; Alcohol / Rehab</td>
<td>8.76.%</td>
<td>29.06</td>
</tr>
<tr>
<td></td>
<td>Silver - 7.0%</td>
<td>Silver - 23 days</td>
</tr>
</tbody>
</table>

## Community Based LOC

<table>
<thead>
<tr>
<th>AIP Admission Rates</th>
<th>ALOS</th>
<th>AIP Admission Rates</th>
<th>ALOS</th>
<th>Clinical Best Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive Case Management</td>
<td>3.13%</td>
<td>412 Days</td>
<td>Gold - 1%</td>
<td>Gold - 10 months</td>
</tr>
<tr>
<td></td>
<td>Silver - 2%</td>
<td>Silver - 12 months</td>
<td>Silver- Evidence of coordination with AIP/Crisis Res Staff regarding treatment/discharge from AIP or Crisis Residential.</td>
<td></td>
</tr>
<tr>
<td>Step by Step</td>
<td>1.99%</td>
<td>No available report for this level of care</td>
<td>Gold - 1%</td>
<td>Gold - 10 months</td>
</tr>
<tr>
<td></td>
<td>Silver - 2%</td>
<td>Silver - 12 months</td>
<td>Silver- Evidence of use of the CHI at intake, 6 months and discharge.</td>
<td></td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>40.66%</td>
<td>No available report for this level of care</td>
<td>Gold - 15%</td>
<td>Gold - 120 School days</td>
</tr>
<tr>
<td></td>
<td>Silver - 20%</td>
<td>Silver - 140 School days</td>
<td>Silver- Evidence of use of the CHI at intake, 6 months and discharge.</td>
<td></td>
</tr>
</tbody>
</table>
Provider Engagement – Magellan Facility Incentive Program (MFIP)

Collaboration with facility providers to increase quality, improve efficiencies and lower the overall cost of care by engaging them in a transparent relationship built upon timely, accurate and actionable data about the facilities provision of quality care.

TIER 1
- "PREFERRED PARTNER IN CARE"
  - Regional Centers of Excellence
  - Assume more risk for overall patient care including costs

TIER 2
- "PARTNER IN CARE"
  - Facility improving and maintaining improvement
  - As quality increases “touch points” decrease

TIER 3
- "EARLY ENGAGEMENT"
  - Facility is new to program
  - More touch points/management

PROFILE
TIER
SCORECARD
QUALITY BENCHMARK
INCENTIVES
III. Marketing To Health Plans – A Three-Tiered Approach To Contracting
<table>
<thead>
<tr>
<th></th>
<th>Six Market Scenarios In Health &amp; Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Third-party payer reimbursed with no consumer selection - “narrow network”</td>
</tr>
<tr>
<td>2.</td>
<td>Charitable payer reimbursed with no consumer selection - “grant-funded programs”</td>
</tr>
<tr>
<td>3.</td>
<td>Third-party payer reimbursed with consumer selection</td>
</tr>
<tr>
<td>4.</td>
<td>Charitable payer reimbursed with consumer selection</td>
</tr>
<tr>
<td>5.</td>
<td>Third-party payer partial reimbursement with consumer selection and partial payment</td>
</tr>
<tr>
<td>6.</td>
<td>Consumer self-pay</td>
</tr>
</tbody>
</table>
Use push strategies to gain endorsement of a payer or health plan – and promote services to through their referral mechanisms.

Use pull strategies to market directly to the consumer.

Three levels in strategy: payers, referral sources, and consumers.
The Payer Marketing Challenge – Improving Positioning Of Relationships

- The fee-for-service payer network contract
- Being ‘preferred’ within a payer network
- Gaining ‘exclusivity’ within a payer system
The Fee-for-service Payer Network Contract

- Most fundamental of all business relationships for provider organizations in health and human services
- Often need to begin with privileging professionals individually, rather than being privileged at the organization level
- Difficult market position but often necessary
- No assurance of volume and no likelihood of referrals
- Often ‘commodity’ positioning
- Should be a “win-win-win” for all parties involved
- Should be approached carefully and with “eyes wide open”
Contracting Preparation Checklist: Administrative

- What systems are in place to secure and execute contracts with health plans -- and communicate those provisions to key staff?
- Are your internal administrative systems in place to assist and support the professional staff working with a health plan (intake, benefit verification, utilization management and billing systems)
- What systems are in place to track health plan authorizations, review managed care clinical criteria, and product appropriate service documentation?
- How much of your health plan revenue is being written off because there are no clinical or administrative systems in place to track utilization of authorized services?
Contracting Preparation Checklist: Financial

- Who are the largest health plans and payers in your market? Do you have a contract/relationship with those organizations?

- What are your unit costs and will contracting with a specific health plans cover those costs?

- What is your policy regarding copayments and deductibles? Are they being collected? What role does repayment play in the “recovery process”?

- How much revenue is your organization writing off because of no contract or being “out of network”?
Contracting Preparation Checklist: Clinical

- Does your organization have a “program” model? Can your team provide data on the performance of that model?
- Does your organization “individualize” the client’s treatment?
- Does your organization have the services available that a health plan would be interested in? (i.e. intensive outpatient, in-home crisis stabilization)
- Does most of your professional staff have professional degrees and licenses?
- Does your organization have “room” to accept the rapid stabilization, brief solution focused therapy philosophy -- and reconcile this philosophy with your mission?
- Are the attitudes of your professional staff ready for creating programs that meet the needs of health plans?
- Are your professional staff members “open” to new ideas and clinical approaches?
Contracting Process

1. Solicitation
2. Application and contract review (includes credentialing process by the payer)
3. Rate negotiations
4. Rate and contract language finalization (signatures)
5. Implementation (operational-facility/clinician)
Contracting Process: Solicitation

- Identify major payers and health plans operating in your geographical area – and research covered lives, major clients, employers served
- Initiate contact with personnel responsible for contracting (provider relations, facility contracting)
- Send introductory information regarding services your organization offers
• Health plans interested in contracting with facility providers utilize a facility application to credential the facility (JCAHO, State License, malpractice insurance requirements, program descriptions)

• Health plans interested in contracting with individual professionals mainly use the CAQH web site for their credentialing and have standardized “take it or leave it” contracts for individuals and/or groups
Contracting Process: Application & Contract Review

• A sample contract is sent to the prospective provider organization for their legal review (usually the most time consuming art of the process for facility contracts)

• Facility fill out the application, attach the appropriate licenses, accreditations, malpractice insurance, and program descriptions to the health plan

• Some health plans may require on-site review of your organization
Contracting Process: Rate Negotiations

- Rate negotiations take place between the health plan and the provider organization.
- For individual services delivered by individual clinicians, most payers only offer fixed fee schedule.
- For programmatic services, health plans have a limited range of acceptable rates (most rates are per diem).
  - Areas of contention created in what is included in the per diem (physician fees, drug screens, aftercare sessions, assessments).
Provider organizations make proposed language changes for the contract and sends them to the health plan for review and modification and/or acceptance of language changes [NOTE: this is not the case with individual professional services]

The health plan sends counter proposed language changes to facility

Once language is settled, rates are confirmed via letter to the respective organizations
Contracting Process: Implementation

- Communication to the appropriate departments regarding the provisions of the contract is initiated.
- The signed, executed agreement is sent to the person responsible for contract management.
- Conduct training in-services to review the health plan’s administrative and clinical policies.
- Develop administrative and clinical tools to assist line staff in effective management of the contract.
Having preferential referrals due to some market differentiation

Need a demonstrable value proposition—almost always involving P4P or value-based payment
Gaining ‘Exclusivity’ Within A Payer System

• Having a financial relationship (most often with significant financial risk) that gives you exclusivity by geography and/or consumer type

• Your organization is the ‘narrow network’
1. Market mapping
2. Solution-focused sales and payer strategy (playbook) development
3. Developing a service with the payer value proposition in mind
4. Concept sale, program development, and contracting
5. Consumer pull through
6. Managing to the performance metrics – to assure renewed and additional contract
## Payer Profiles

Last updated: April 1, 2013

### Government Insurers

<table>
<thead>
<tr>
<th>Payer</th>
<th>Total Enrollment (CA)</th>
<th>Enrollment, San Diego</th>
<th>Enrollment, Imperial</th>
<th>Enrollment, Orange</th>
<th>Enrollment, San Bernardino</th>
<th>Enrollment, Riverside</th>
<th>Headquarters Street Address</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>5,000,188</td>
<td>178,563</td>
<td>2,466</td>
<td>189,292</td>
<td>123,223</td>
<td>152,309</td>
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<tr>
<td>MediCal</td>
<td>7,339,984</td>
<td>453,494</td>
<td>55,519</td>
<td>469,970</td>
<td>494,988</td>
<td>410,932</td>
<td>101 Capitol Ave., MS 4400</td>
<td>San Francisco</td>
</tr>
</tbody>
</table>

Medicare Advantage:

<table>
<thead>
<tr>
<th>Payer</th>
<th>Total Enrollment (CA)</th>
<th>Enrollment, San Diego</th>
<th>Enrollment, Imperial</th>
<th>Enrollment, Orange</th>
<th>Enrollment, San Bernardino</th>
<th>Enrollment, Riverside</th>
<th>Headquarters Street Address</th>
<th>City</th>
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</thead>
<tbody>
<tr>
<td>Aetna Health Of California, Inc.</td>
<td>25,452</td>
<td>1,864</td>
<td>2,410</td>
<td>5,837</td>
<td>6,813 P.O. Box 10160</td>
<td>Van Nuys</td>
<td></td>
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<tr>
<td>Anthem Blue Cross Life And Health Ins Company</td>
<td>37,375</td>
<td>4,688</td>
<td>204</td>
<td>7,457</td>
<td>116</td>
<td>2,080 50 Beale Street</td>
<td>San Francisco</td>
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<tr>
<td>Blue Cross Of California</td>
<td>12,251</td>
<td>1,746</td>
<td>16</td>
<td>945</td>
<td>4,200</td>
<td>2,463 50 Beale Street</td>
<td>San Francisco</td>
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<tr>
<td>California Physicians' Service</td>
<td>66,727</td>
<td>569</td>
<td>118</td>
<td>18,134</td>
<td>4,422</td>
<td>2,522 50 Beale Street</td>
<td>San Francisco</td>
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<tr>
<td>Care1st Health Plan</td>
<td>30,369</td>
<td>7,288</td>
<td>1,075</td>
<td>445</td>
<td>219-001 Potter's Grande Drive</td>
<td>Monterey Park</td>
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<tr>
<td>Caremore Health Plan</td>
<td>51,262</td>
<td>27</td>
<td>3,201</td>
<td>3,635</td>
<td>12900 Park Place Drive, Suite 150</td>
<td>Carlsbad</td>
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<td>Central Health Plan Of California, Inc.</td>
<td>12,311</td>
<td>748</td>
<td>1,330</td>
<td>31,540</td>
<td>31,540</td>
<td>31 1540 Bridgegate Drive</td>
<td>Diamond Bar</td>
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<tr>
<td>Citizens Choice Healthplan</td>
<td>14,388</td>
<td>1,113</td>
<td>1,543</td>
<td>3,271</td>
<td>4,928</td>
<td>3171 17315 Steubelaker Road, Suite 200</td>
<td>Carlsbad</td>
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<tr>
<td>Community Health Group</td>
<td>1,221</td>
<td>1,221</td>
<td>1,221</td>
<td>740 Bay Blvd</td>
<td>740 Bay Blvd</td>
<td>740 Bay Blvd</td>
<td></td>
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<tr>
<td>Easy Choice Health Plan Inc.</td>
<td>53,767</td>
<td>1,543</td>
<td>500</td>
<td>7,569</td>
<td>3,200</td>
<td>7,634 180 East Drive, Suite 100</td>
<td>Long Beach</td>
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<tr>
<td>Health Net Of California</td>
<td>138,335</td>
<td>12,390</td>
<td>31</td>
<td>12,330</td>
<td>10,884</td>
<td>14,731 32833 Burbank Boulevard, Suite 63</td>
<td>Woodland Hills</td>
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<td>Humana Health Plan Of California, Inc.</td>
<td>20,961</td>
<td>2,329</td>
<td>1,439</td>
<td>1,449</td>
<td>1,449</td>
<td>1,449 5421 Avenida Encinas, Suite N</td>
<td>Carlsbad</td>
<td></td>
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<tr>
<td>iHop Health Access</td>
<td>9,452</td>
<td></td>
<td>5,034</td>
<td>4,397</td>
<td>4,397</td>
<td>4,397 3231 East Dundon Road, Suite 400</td>
<td>San Bernardino</td>
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<tr>
<td>Inter Valley Health Plans, Inc.</td>
<td>20,191</td>
<td>17</td>
<td>6,859</td>
<td>8,230</td>
<td>200 South Park Avenue, Suite 300</td>
<td>Pomona</td>
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<td>Kaiser Foundation Hr, Inc.</td>
<td>881,902</td>
<td>70,539</td>
<td>102</td>
<td>47,975</td>
<td>41,118</td>
<td>40,828 300 Lakeshore Drive, 13th Floor</td>
<td>Oakland</td>
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<tr>
<td>Molina Healthcare Of California</td>
<td>7,469</td>
<td>1,364</td>
<td>15</td>
<td>1,357</td>
<td>1,357</td>
<td>705 200 Orange Grove, Suite 100</td>
<td>Long Beach</td>
<td></td>
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<tr>
<td>Orange County Health Authority</td>
<td>14,646</td>
<td>14,624</td>
<td>14,624</td>
<td>14,624</td>
<td></td>
<td>505 City Parkway West</td>
<td>Orange</td>
<td></td>
</tr>
</tbody>
</table>

Blue Shading indicates plan with enrollment ≥ 1000 - threshold to complete demographic research for this plan

Note: Medicare Advantage Enrollment data does not include numbers <10 in each county according to Health Plan

Some Medicare Advantage plans are under same plan name/entity but have a different contract number with CMS, therefore under separate columns (Plan ID included in the last column)
1. Solution-focused sales is focused on understanding the needs of the customer – and developing a solution (rather than ‘selling’ the services currently offered)

2. Meeting with payers to identify problems and concerns

3. Developing ‘services’ that address those payer problems
### Payer Strategy Playbook Example

#### Magellan – San Diego Region

<table>
<thead>
<tr>
<th>Network Manager</th>
<th>Wiley, San Diego Network Manager; <a href="mailto:jwiley@macepanhealth.com">jwiley@macepanhealth.com</a> 1-800-430-0335 Option #4, Direct Line 619-326-9274 <a href="mailto:CaliforniaProvider@macepanhealth.com">CaliforniaProvider@macepanhealth.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Manager</td>
<td>To be assigned</td>
</tr>
</tbody>
</table>

#### Facility/Organization Network Application Process Flow
- Begin with a phone call to Network Representative 1-800-430-0335 Option #4
- Complete the application sent by the representative
- Complete and submit the California Provider Specialty Information Form online: [https://www.macepanprovider.com/mpblueShieldCA/do/DisplayProviderSpecialtyInfo](https://www.macepanprovider.com/mpblueShieldCA/do/DisplayProviderSpecialtyInfo)
- Go to the Council for Affordable Quality Healthcare (CAQH) website and authorize Magellan to access your Universal Credentialing Data Source information

#### Key Market Intelligence
- Care Management Team is located in San Diego.
- Blue Shield is their primary and largest account in California. They work with Western Health Advantage but they are mostly in the Sacramento area. In the Southern California market they have a few EAP customers, but most of what you would see is Shield.
- Shield has one core management group and five or six others. They have some members in the Medical and Specialty perspective, and they have relatively few in the Medical Group or Specialty perspective. They are unique, referrals may be few.
- Generally open to case rates, but generally don’t do capitation based contracting because Blue Shield (their major CA customer) has an open network.
- However, they are working with Shield on the Healthcare Exchanges and, since that population is likely to be a bit different, they’re possibly open to other kinds of contracting. They don’t delegate credentialing.

#### Provider Web Portal Address
- [https://www.macepanprovider.com/MHS/MGU/Provnet/](https://www.macepanprovider.com/MHS/MGU/Provnet/)
- [https://www.macepanprovider.com/MacepanProvider/do/LoadHome](https://www.macepanprovider.com/MacepanProvider/do/LoadHome)

#### Member Web Portal Address
- [https://www.macepanassst.com/default.aspx](https://www.macepanassst.com/default.aspx)

#### Electronic Copies Included
- Network Manual
- Facility/Organization Application Form
- Level of Care/Medical Necessity Guidelines for Residential Substance Use Tx. and for Residential Eating Disorder Tx.
- Facility/Organization Site Visit Guidelines & Checklists
- FAQs
Developing A Service With The Payer Value Proposition In Mind

• Concept development
  – Service description
  – Cost/benefit or ROI analysis
• Proposal development
• Contracting
IV. From Contract To Revenue – Pull Through Consumer Marketing
Most Health Plan Contracts Do Not Equal Revenue

• Marketing to referral sources and consumers essential to getting financial yield from contracts
• Consumer awareness and responsiveness to inquiries is key
• Developing and maintaining and managing relationships with referral sources
• Common communication vehicles
  – Telephone
  – Online – website, social media, email
  – In-person referral representative activities
  – Advertising campaigns for brand building
  – Community relations events for awareness
Consumer Marketing: If Consumers Have A Choice – Will They Choose You?

• Consider the consumer’s perspective and what they would define as quality:
  – Communication (courtesy, respect, listening, explaining)
  – Responsiveness of staff
  – “Outcome” of treatment
  – Ease of access to your services
  – Do you deliver on your unique selling proposition?

• Why would consumer’s choose your services over another type of intervention?

• What are consumer’s telling others about their experience?
Internet = Relationships
Why Internet Is Important For You

- Google searches per month = 90 billion
- Health care is Google’s #1 legitimate vertical
- 60% of U.S. adults search for health on Google, Bing, or websites
Consumer Marketing Is All About Endorsement & The Internet

Endorsement – whether on-line or interpersonal – is critical factor
Internet (and social media) is preferred communication vehicle
### Behavioral Health Searches = Revenue

<table>
<thead>
<tr>
<th>Program</th>
<th>Substance Abuse</th>
<th>Eating Disorders</th>
<th>Depression</th>
<th>Autism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Searches</td>
<td>400,000</td>
<td>50,000</td>
<td>25,000</td>
<td>40,000</td>
</tr>
<tr>
<td>New Patients</td>
<td>4,000</td>
<td>500</td>
<td>250</td>
<td>400</td>
</tr>
<tr>
<td>Revenue/Patient</td>
<td>$ 10,000</td>
<td>$ 30,000</td>
<td>$ 30,000</td>
<td>$ 30,000</td>
</tr>
<tr>
<td>New Revenue/Month</td>
<td>$ 40 million</td>
<td>$ 15 million</td>
<td>$ 7.5 million</td>
<td>$ 12 million</td>
</tr>
</tbody>
</table>
Who Gets Behavioral Health Search Revenue?

Google search for "residential treatment depression"

- Residential Treatment | TimberlineKnolls.com
- Women's Depression Center
- Treatments For Depression | Mdd-Add-On-Treatment.com
- Scholarly articles for residential treatment depression
- Depression Residential Treatment Centers, Depression Treatment
- Mental Health Residential Treatment Centers
- Treatment for Depression

Ads 10 - 15%

Ads - Why these ads?

1. Depression Rehab Retreat
2. What is TMS Therapy?
3. Depression Treatment
4. Depression Treatment Help
5. Are You Depressed?
6. Depression Treatment
7. Depression Research Study

40 - 45%

12%

10%
New Patient Revenue Per Month

Ads ~ $700,000 - $1 million

$3.3 million

$900,000

$700,000
“Open Source” Relationships
Online = Reputation

• “Open source” is a computer term for software that anyone can use - open to all
• Reputations are made on-line
• Not all bad -- lots of positive, lots of great interesting comments
• Need to form your online brand
• Ignore = invalidate
• Engage
  – Listen
  – Learn - great feedback loop
  – Communicate
mental health New York

1. Washington Square Institute
   Category: Counseling & Mental Health
   Neighbourhoods: Chelsea, Midtown West
   41 E 11 Univ Pl
   New York, NY 10001
   (212) 477-2600

2. Jewish Board of Family & Children's Services
   Category: Counseling & Mental Health
   Neighbourhood: Midtown West
   120 W 57th St
   New York, NY 10019
   (212) 552-9100

3. Barbara Haynes, PhD
   Category: Counseling & Mental Health
   Neighbourhood: Midtown West
   10 W 34th St
   New York, NY 10001
   (718) 762-4178

4. Ryan William F Community Health Center Annex
   Category: Medical Centers
   Neighbourhood: Manhattan Valley
   160 W 100th St
   New York, NY 10025
   (212) 789-7200

The Loss and Bereavement Program for Children and Adolescents offers bereavement groups for youth ages 5-18. Groups are led by two mental health professionals who support an effective grieving process. The bereavement

...
CRM provides a holistic view of the customer across multiple channels including the website, call center, marketing campaigns, and referral development so that the organization can better market, sell, and service their customers and accounts of all types.
Six-Step Plan For Internet-Integrated Consumer Marketing

1. The right services with the right positioning at the right price
2. Address pull through issues with payers and referrals sources – appropriate relationships established and maintained
3. Marketing materials (print and on-line) convey the right message to consumers
4. Make sure consumers in need find you – web content planning, web site design, and web search optimization
5. Maintain brand, reputation, and relationship with referral sources and consumers – stakeholder engagement plan and team
6. Plan to build customer web functionality that integrates with service -- the emerging CRM/EHR linkage
IV. Organizational Competencies For Success With Health Plan Contracts
## Administrative Capabilities For A Managed Care Environment

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marketing and contracting functions – payer contracting, referral development, and consumer choice</td>
</tr>
<tr>
<td>Systems to facilitate administrative processes of FFS managed care and value-based purchasing – preauthorization, clinical criteria, documentation</td>
</tr>
<tr>
<td>Revenue cycle management - billing and collections for both payer and consumer</td>
</tr>
<tr>
<td>Development of services that are customer-preferred in terms of value – both payer and consumer</td>
</tr>
<tr>
<td>Medical Home Core Functional Requirements</td>
</tr>
<tr>
<td>------------------------------------------</td>
</tr>
<tr>
<td>1. Comprehensive care management - Clinical treatment planning and utilization management system – with care tracking and automated clinical decision support tools across all chronic disease states</td>
</tr>
<tr>
<td>2. Care coordination and health promotion - Infrastructure and resources to locate and coordinate both health-related services and non-health social services</td>
</tr>
<tr>
<td>3. Comprehensive transitional care from inpatient to other settings– If not going to provide all services, must have provider relations and network management</td>
</tr>
<tr>
<td>4. Support for patients, their families and authorized representatives. Member and customer service functions – with systematic approach to consumer engagement and improving the consumer experience</td>
</tr>
<tr>
<td>5. Referral to primary care, specialty care, and community and social support services</td>
</tr>
<tr>
<td>6. Robust health record keeping and the ability to do health information exchange as feasible and appropriate</td>
</tr>
<tr>
<td>Care Management Organizational Competencies For Risk-Based Contracts</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>1. Financial management systems</td>
</tr>
<tr>
<td>2. Legal and risk management requirements – risk reserves, licensure, reinsurance</td>
</tr>
<tr>
<td>3. Provider network management capability – if not going to provide all services</td>
</tr>
<tr>
<td>4. Claims management and payment system – if not going to provide all services</td>
</tr>
<tr>
<td>4. Eligibility determination and beneficiary management capabilities</td>
</tr>
<tr>
<td>5. Accreditation and licensure</td>
</tr>
<tr>
<td>6. Client satisfaction measurement and customer experience management</td>
</tr>
<tr>
<td>7. Performance management system with metrics-based financial management and business process management</td>
</tr>
</tbody>
</table>
Some Closing Thoughts. . .

1. Make sure the contract is a win-win-win: win-for the facility/individual clinician, win for the client and yes, a win for the managed care organization (because they have just enhanced their network by adding your organization).

2. Make sure the benefits of having this agreement outweigh the costs (low market penetration, onerous clinical/administrative requirements, low rates of reimbursement).

3. If the reimbursement rates are not covering your costs, don’t use the “make it up in volume” argument to justify contracting with that MCO.

4. Be willing to walk away from the contract if it does not meet any of your organization’s criteria.

5. Sometimes, it is better not to have a contract than to have one that will not allow a win-win-win scenario.
The market intelligence to navigate.
The management expertise to succeed.

www.openminds.com
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