Health Plan Contracting & Relationship Development:

9 Bases To Cover To Hit A Home Run With Health Plans

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Agenda

I. 9 Steps Of Impactful Relationship Development & Successful Contracting With Health Plans

II. Questions & Discussion

Optimizing Health Plan Relationships Is Critical For Sustainability For Many Health And Human Service Organizations

1. Payers – federal and state governments, the military, and employers – are increasingly adopting managed care models to finance and deliver their health care benefits. Over 75% of Americans with any type of insurance have their health benefits managed by some type of health plan, accountable care organizations, and specialty benefit management company.

2. The use of health plans by payers is increasing. More complex populations are moving to managed care plans. And more services are being covered by managed care plans.

3. For provider organizations, a larger and larger proportion of service reimbursement is now dependent on relationships with health plans. But health plans expectations of their relationships with provider organizations is changing. For health plans, the “ideal” service delivery model has medical, behavioral, and social needs addressed together in a system that has seamless consumer services, integrated data at the consumer level, and alignment of financial incentives.

4. Optimization includes establishing relationships with health plans that lead to new contracts, increased rates, increased referrals, and new opportunities for value-based reimbursement models.

I. 9 Steps Of Impactful Relationship Development & Successful Contracting With Health Plans

The *OPEN MINDS* Approach To Health Plan Relationship Optimization – A Nine-Step Process

Step 1: Setting Strategic Objectives For Health Plan Contracting

Strategic Objectives

- Position For New Growth Opportunities In The Expanding California Health Plan Market
- Revenue Diversification Through New Payer Contracts
- Establish Strategic Relationships With Targeted Health Plans For Sustainability And Future Opportunities
- Identify And Market Existing Service Lines That Leverage Current Capacity, Capabilities, And Quality Outcomes

Step 2: Assessment Of Managed Care Readiness & Value-Based Contracting Competency

Organizational Managed Care Readiness

1. Clinical operations
2. Customer-centric intake and admissions
3. Marketing and business development
4. Revenue cycle management
5. Leadership and human resources
6. Information technology
7. Metrics management
8. Quality management
9. Margin management

Health plan readiness means having the right operational systems and capabilities to deliver services under a managed care contract especially now in the growing performance-based and value-based reimbursement (VBR) marketplace.

Value-Based Reimbursement Preparedness

1. Provider Network Management
   - Strategies to enhance provider networks
2. Clinical Management & Clinical Performance Optimization
   - Data analyzed to drive clinical decision making
3. Consumer Access, Service Engagement
   - Processes to empower consumers and create engagement
4. Financial Management
   - Revenue cycle management and accounting procedures to support contracts
5. Technology & Reporting Infrastructure
   - Data leveraged to gain insight
6. Leadership & Governance
   - Alignment of strategy with infrastructure and resources

Value-based reimbursement preparedness means having the right operational systems and capabilities to deliver services in the growing performance-based and VBR marketplace.

Step 3: Development Of A Health Plan Partnership Concept Statement – Pitch Deck

Payer Partnership Concept Statement

What Is A Payer Pitch Deck?

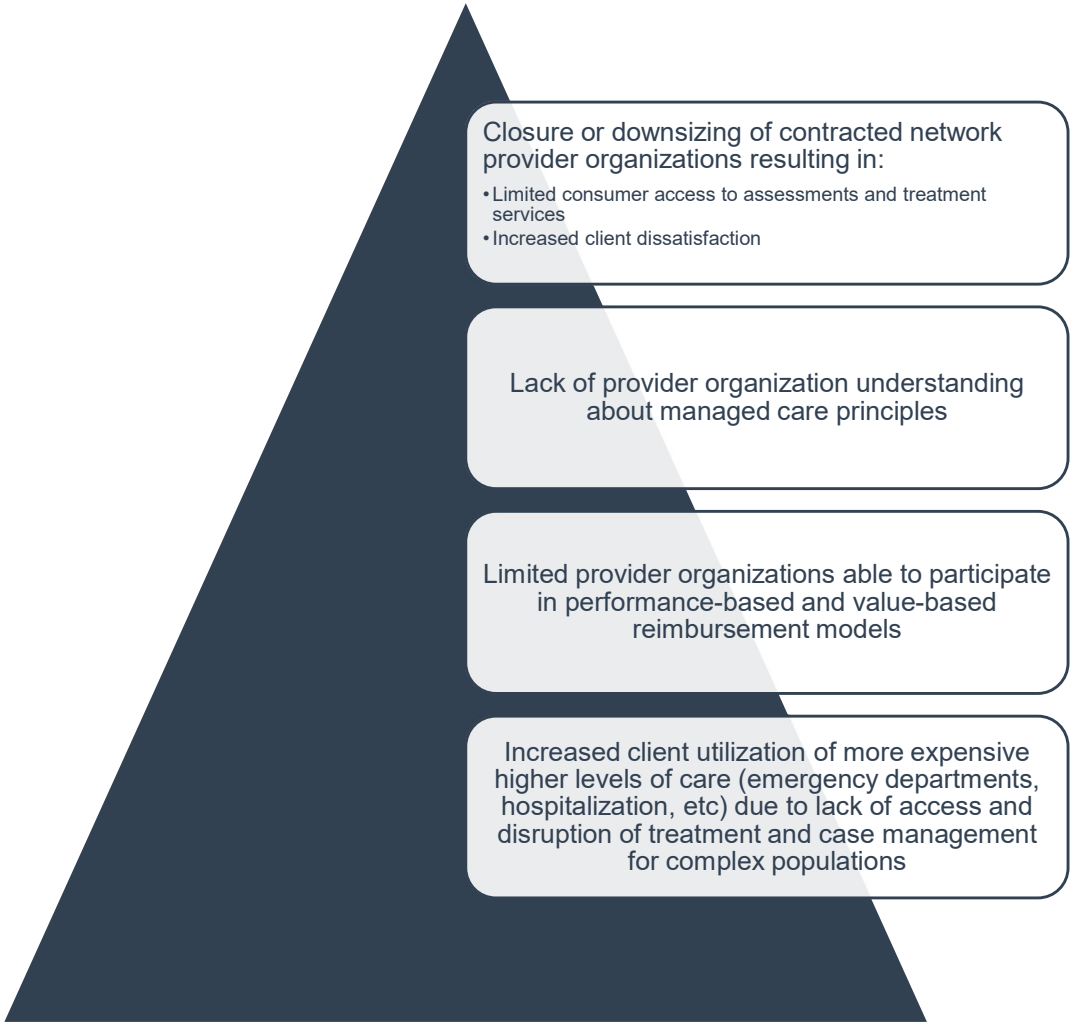
- A Payer Pitch Deck is a tool used to get the immediate attention of payer managers to schedule an introductory meeting:
  - Introduction
  - Rate negotiations
  - Contract expansion
  - New service line development
- Health plan managers often share these pitch decks internally with other plan managers - contracts, provider network, clinical, and provider relations - for feedback
- It's a brief snapshot of the services your organization offers that demonstrates your value proposition and outlines your proposed services solutions to the plans
  - Provides a concise overall description of your organization
  - Demonstrates that leadership understands the market and payer needs and that you have solutions to address payer service delivery, coordinated care, performance, and cost savings goals

Preparing For Pitch Deck Development

Know Your Competition In The Changing Marketplace

- Create a list of your main competitors in your geographic service area
- Conduct a brief assessment of your competitors — noting any changes in programming or capacity
- Competitors may have closed, downsized services, or have limited capacity due to the pandemic creating new business development opportunities for growth or expansion
- Contact local health plan or government payers and inquire about new provider network service needs due to competition changes in the market

Understand Payer Concerns As A Result of The Pandemic



Organization & Service Line Review

Your Pitch Deck Should Address Health Plan Needs

Payers are looking for provider organizations that are positioned for new growth opportunities and can align payer-provider organization goals and expectations to deliver services that address provider network service gaps.

Health plans are looking for:

- Solutions that address cost savings and quality of care for in serving “complex populations”
- Customized treatment, care coordination, and consumer engagement
- Shared risk arrangements – VBR approaches
- Outcome and performance data

Components Of A Payer Pitch Deck

- ✓ Introduction to your organization, including a statement about your interest in partnership/contracting and your unique positioning in your market
- ✓ Brief organization description: mission, vision, values, key executives, and clinical leadership
- ✓ Description of programs and services
- ✓ Specialty services and program innovations
- ✓ Populations served
- ✓ Outcomes data: clinical, client satisfaction, intake/admission (timely access to care, low no show rates, reduced hospital readmissions, emergency department visits, HEDIS)
- ✓ Value-based contracting management capabilities: customer-centric intake/admissions process, revenue cycle management, performance data tracking and reporting, account management, referral network development, etc.
- ✓ Highlights of unique program capacity or clinical capabilities

Organization Overview

The organization overview is an at-a-glance outline of the organization demographics, for example:

- Type of provider organization: adult, youth, outpatient, residential, etc.
- Profit status: for-profit / non-profit
- Number of years in business
- Accreditation and certifications: i.e., JACHO
- Annual number of members served
- Number of locations by state or county
- Core program competencies: residential treatment, foster care, non-public school, outpatient, foster care/adoption, etc.
- Evidence-based practices
- Mission, vision, and values

Service Lines

- **Service Line Description** — designed to easily inform the payer of your current programs and services
- Neither the pitch deck nor the service line description are designed to sell your programs but rather to get a conversation started with an updated overview of your organization – post pandemic
- Short descriptions and bullet points are sufficient
- **Example** - Outpatient mental health services:
  - Individual, group, and family mental health services for children, adolescents and adults by licensed mental health professionals
  - 24-hour assessment and intake
  - Psychiatry – assessment, medication management, and prescribing
  - Case management and linkage to community-based social supports

Outcomes Tracking & Reporting

In this era of managed care and alternative payment models, its important to demonstrate that your organization has the ability and procedures in place to track and report outcomes

High priority outcomes include:
• **Client clinical outcomes** – Treatment; Recidivism; Long-term success in community-based settings • **Satisfaction survey outcomes** – Client; Family; Referral source; Payers • **Intake/assessment/admission** - No show rates; Conversion rates • **HEDIS** - Timely access to care; Reduced hospital readmissions and emergency department visits; Customer satisfaction

Program, Care Coordination & Service Delivery Innovations

Highlighting program, care coordination, and service delivery innovations illustrates your organization's ability to stay competitive, positioned for new growth opportunities, and leverage strategic payer partnerships that bring “network value” to the health plans

- Telehealth and virtual consultation
- Integrated and whole person care approaches
- 24/7 call center for intake and admissions
- Strategic alliances with complimentary provider organizations in the market for scale and coordination of services: behavioral health/SUD and primary medical care
- Consumer access: website portals, virtual assessment
- Crisis and social support services for clients in the community to ensure early intervention and prevention of hospitalization

Step 4: Building The Health Plan Playbook

Identify & Prioritize Target Payers For Outreach & Engagement

1. Analyze the payers, health plans, managed behavioral health organizations, ACOs, and large employers operating in your service area. The goal of the analysis is to select the best targets for payer outreach
2. Identify the external market factors that are driving payer (health plan, MCO, MBHO) provider network service needs and contracts with specialty provider organizations
3. Create a payer profile to be used to facilitate payer interviews and network needs assessments

External Market Drivers

CalAIM Initiative

Health Plan Expansion In CA

Payer Focus on Whole Person /Integrated Care

Hybrid Virtual Consultation Platforms

Step 5: Conducting The Initial Health Plan Interviews

Health Plan Outreach & Engagement

1. Schedule a web meeting with targeted payers and determine their needs:
   - Contracts
   - Provider Network
   - Provider Relations
   - Business Development
2. Present the payer partnership pitch deck
   - Use the pitch deck as a meeting facilitation guide
3. Identify payer service needs and available contracting and partnership opportunities

What To Ask?

1. Are there any provider network needs/gaps/deficits or new service priorities in my geographic catchment area?
2. Do you have current plans for provider network expansion to meet new service delivery needs?
3. What are your preferred provider models and requirements?
4. Are there any new value-based purchasing initiatives?
5. Is there interest in developing new service lines to meet new member service needs?
6. **How do I get the contracting process started?**

Be Brief!
Be Brilliant!
Be Gone!

Step 6: Refining & Implementing The Health Plan Playbook Strategy

Strategy Implementation

- Compile targeted program descriptions
- Leverage indicated evidenced-based practices to demonstrate quality
- Package program outcome data for each marketable service line
- Develop digital marketing tools and update your website for referral development

Now is the time to redefine your health plan strategy playbook, using the insights and market intelligence revealed during the payer needs assessment.

The next step is contract negotiations.

Step 7:
Contract Development & Negotiation

Contract Development & Negotiations

1. **Establish A Single Point Of Contact –** for coordination of all aspects of contract development:
   - Application
   - Contract Completion
   - Credentialing
   - Implementation (operational facility/clinician)

2. **Contract Negotiations –** Be prepared:
   - Rate negotiations
   - Establish plan specific performance measures
   - Identifying opportunities to bundle services to create coordinated continuums of care to target complex populations under alternative payment models such as case rates

Enhanced Fee-For-Service Rates

Counter proposals for rate negotiations should highlight the organization's ability to coordinate services and intensive case management as part of a value-added continuum-of-care approach to achieve health plan clinical and cost savings goals for target populations

Contract Language & Measures Negotiation & Finalization

3. **Define the following:**
   - Specific metrics to focus on (either for FFS, to become a preferred provider, or as Metric for a VBR arrangement)
   - Methodology for measurement of the metrics
   - Populations and plans covered under the arrangement (i.e. Medicare, Medicaid, Commercial, etc.)
   - Data sharing – timeframes and process
   - Resolution process for data discrepancies between provider data and payer data on metrics
   - Value-based payment arrangement

Step 8:
Health Plan Proposal Development

Health Plan Proposal Development

1. Develop unsolicited proposal development aimed at targeted health plans for new contract and service line development.
2. Proposal highlights will include your organizations evidence-based practices (Trauma-Informed), infrastructure investments (telehealth), consumer and community testimonials and endorsements (customer satisfaction surveys), demonstrated outcome measures (reduced inpatient hospitalization), proposed rates, and reimbursement models (value-based reimbursement).
3. The proposal should address the specific pain points of the payer, your service delivery solution, and demonstrate your organization's ability to meet the clinical, fiscal, and coordinated care needs of the targeted health plan under a performance-based contract.

Develop An Unsolicited Proposal With A Proposed Reimbursement Model, Rates, and Performance Measures For Interested Payers

Step 9: Implementing, Managing & Optimizing New Health Plan Contracts

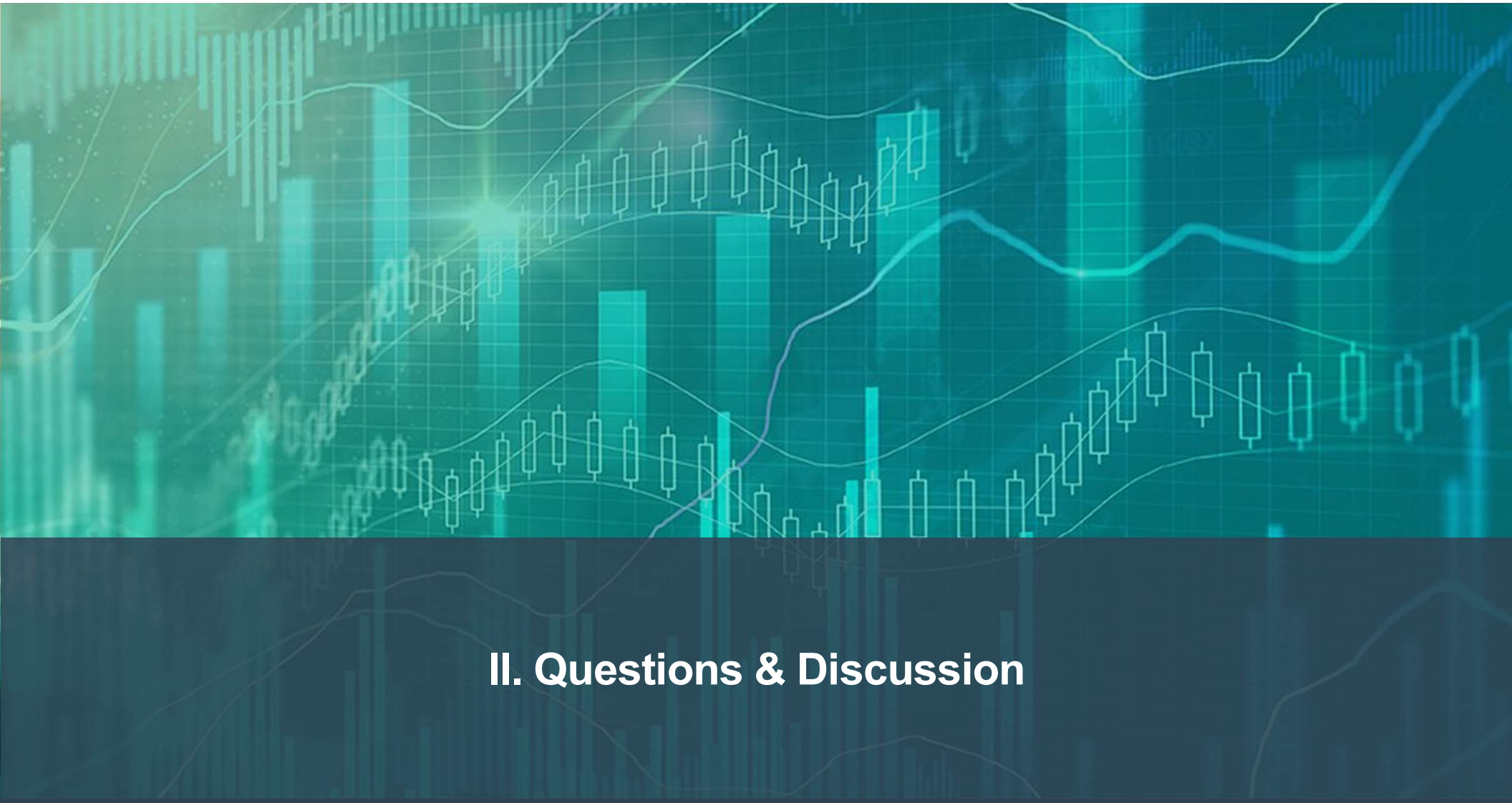
Health Plan Contract Optimization

1. Develop an implementation process to ensure your key organizational systems (i.e. intake/admissions, case management, program service delivery and data reporting, etc.) are prepared to meet new contract requirements.
2. Develop key roles, such as the payer account manager, and marketing and referral development strategies to get new referrals flowing — as well as performance monitoring and improvement.

Payer Account Manager
• Part of the marketing/business development team • Work with a dedicated group of payers and referral sources to help achieve payer goals and ensure customer satisfaction • Responsible for payer customer service and development of new contracts and service lines

The Payer Account Manager adds network value to your organization as the single point of contact with health plan managers:

- Contracts
- Provider Network
- Care Managers
- Credentialing
- Provider Relations
- Clinical Services



II. Questions & Discussion

Turning Market Intelligence Into Business Advantage

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