

## Draft Contracting Strategy Worksheet

### Behavioral Health Provider

The purpose of the worksheet is to apply what you have learned about contracting to create a mock contracting strategy for your organization. There are some terms that will not apply to your situation. For example, those listed under shared savings/risk would not apply to provider entities who are only negotiating a pay-for-performance contract. The terms in the second column are for illustrative purposes only. The user should review each and modify the strategy as appropriate to their individual circumstances.

TERM	CONTRACTING STRATEGY (sample for illustrative purposes only; modify for your organization)	TERM DOES NOT APPLY (note with an X)
<b>Term of Agreement</b>	Reset annually	
	Modification mid-year only by mutual consent	
	Termination mid-year only by mutual consent except for breach of contract	
<b>Information Exchange</b>		
Member rosters	Delivered electronically to my assigned/attributed members	
Inpatient authorizations	Delivered daily to each practice for my assigned/attributed members	
Care management	Sharing of care plans of my assigned/attributed members in the health plan's high-risk care management program.	
Performance on quality metrics that have financial implication	Access to performance on the health plan's provider portal that indicates overall score and allows drilldown to the member level; updated at least monthly.	
Total cost of care report (applies to shared savings or risk arrangements only)	Monthly report of MLR with a calculated incurred but not yet reported (IBNR)	
Utilization reports (applies to shared savings or risk arrangements or when one or more of these hospital utilization metrics are part of a pay-for-performance program),	Monthly report of ED utilization (separated by potentially avoidable or not), overall hospitalization rates, hospitalization rate for behavioral health conditions, all-cause 30-day rehospitalization rates for attributed members with segmentation for behavioral health conditions versus other conditions.	
High-cost member list (applies to shared savings or risk arrangements only).	List of my assigned/attributed members with a rolling 12-month total cost of care of more than \$100,000.	
Frequent ED utilizer list (applies to shared savings or risk	List of my assigned/attributed members with four or more ED visits in a rolling 12-month period.	

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# HEALTH MANAGEMENT ASSOCIATES

arrangements or where ED utilization is a pay-for-performance metric only.)		
Medication possession ratios (applies to shared savings or risk arrangements or where medication adherence is a pay-for-performance metric only.)	List of attributed members whose medication possession ratios are less than 80% for agreed upon high impact medications such as anti-depressants or psychotropic medications.	
Raw claims data (applies to shared savings or risk arrangements only).	At least monthly medical claims data, ideally with pricing, and daily pharmacy fill data.	
<b>Member Assignment</b>	Prospective based on member choice and attribution algorithm	
	Rolling 12-month retrospective claims analysis to prospectively adjust assignment based on plurality of ambulatory behavioral health visits with tie going to provider with latest visit.	
<b>Payment for Direct Services</b>	Fee-for-service reimbursement at Medicaid rates	
<b>Foundational Payments for Infrastructure, Operations and Care Coordination</b>	Per-member-per-month (PMPM) payment to cover these services; cost may be charged as an expense when calculating the savings pool if applicable.	
<b>Pay for Performance</b>		
Funding potential	1-2% of health plan premium	
Choice of metrics	Selection of 5-6 metrics from a list that is a subset of metrics which have financial implications for the health plan; may be efficiency as well as behavioral health-related HEDIS quality metrics; final metric selection based on mutual agreement.	
Data collection method	Ability for provider to submit supplementary data electronically to demonstrate compliance as allowed by NCQA;	
Performance targets	Credit for significant improvement (closing gap between historical performance and attainment target) with enhanced credit for reaching the attainment target.	
Payment methodology	Annual bonus when performance target is achieved	
Treatment of cost when calculating savings	Cost may not be charged as an expense when calculating savings.	

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<b>Shared Savings/Risk</b>		
Defined population	Assigned members for every month of assignment	
Minimum assigned membership	2,000	
Service exclusion	LTSS; pharmacy	
Setting the baseline (% premium vs. historical spend)	Medical loss ratio that is a 1% improvement over historical experience but never <88%	
Risk adjusted benchmark	Yes	
Trending the benchmark	Benchmark is increased proportional to increase in plan premium	
Claims run out period/IBNR	Six months with incurred-but-not- reported (IBNR) calculation using actuarially sound principles	
Minimal savings threshold	None	
Minimal loss ratio	Ideally 2% but not if requires a symmetrical minimal savings ratio	
High cost claimants	\$100,000-\$150,000 threshold with 100% coverage of claims coverage	
Shared Saving/Risk %	50%	
Quality gate to accessing the savings/risk pool	None	
Impact of payment of savings/risk pool on subsequent year's savings/risk pool	Not charged as an expense	
Risk Corridor	Shared Losses will be limited to the lessor of reserves or 3% of the amount funding the pool multiplied by the risk share. No shared savings corridor.	

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