Payers can be partners in patient care, not adversaries. Psychologists and insurers are finding new ways to work more effectively as teams collaborating to improve patients’ well-being.

The APA Practice Organization’s Legal and Regulatory Affairs office is leading the way by building collaborative relationships with insurers. That collaboration allows the Practice Organization to rapidly solve practitioners’ problems such as insurance audits, reimbursements or customer service issues. “In the past, we’ve taken more of a confrontational approach to working with insurers, and we’ll do that if it’s necessary,” says Shirley Ann Higuchi, JD, associate executive director of Legal and Regulatory Affairs.

In addition to the Practice Organization engaging insurers, these companies and organizations seek to collaborate with psychologists. Insurers now view psychologists as experts on assessment, measurement, collaboration and patient engagement and satisfaction, she says. The result? New opportunities for psychologists.

Better care, lower costs

Why is collaborating with psychologists so important to insurers? Costs are one reason. “When people look at cost data for behavioral health within large insurance companies like Aetna, they see that behavioral health accounts for about three percent of costs,” says Mark Friedlander, MD, MBA, chief medical officer at Aetna Behavioral Health. “In some worlds, that’s kind of a rounding error.”

Yet that figure is misleading. “When you factor in the impact that behavioral conditions have on medical costs, it’s way, way more,” he says. Additionally, just five percent of commercially insured individuals drive 45 percent of the costs.
How could psychologists drive those costs down and improve patient care? For one, they could take on those five percent of patients and collaborate with multiple specialists to get them healthy. Many behavioral health providers, however, seem more comfortable working with 75 percent of patients who account for just 20 percent of costs than the more challenging patients, says Friedlander. Because uncoordinated care is a major source of wasted health-care dollars, he adds, psychologists must also become comfortable with team-based care. As payment shifts from fee-for-service to pay-for-performance, psychologists need to embrace what Friedlander calls “measurement-based behavioral health practice,” tracking outcomes and demonstrating what interventions work best.

**Measurement tools**

The Affordable Care Act and parity legislation are driving this new emphasis on measurement, says psychologist Bruce Bobbitt, PhD, formerly a senior vice president of behavioral health quality management with Optum prior to his retirement. “For insurers, especially in certain areas like Medicare, there’s a tremendous focus on quality measures,” says Bobbitt.

Take Star Ratings, for example. The federal government uses a series of quality metrics to assign Star Ratings to Medicare Advantage programs, then bases reimbursement on the number of stars received. “Study these measures, because in the Medicare space, health plans are going to be driven by improving their Star Ratings,” Bobbitt urges psychologists. While the current behavioral measures don’t reflect the kinds of things most psychologists see on a daily basis, he adds, that means there’s an opportunity to find metrics that better fit individual practitioners.

Another measurement tool psychologists will be asked to use is the Patient Health Questionnaire, or PHQ 9, says Bobbitt. The National Committee for Quality Assurance is including the PHQ 9 in a number of the behavioral health measures that insurance companies track and must improve. Insurers, says Bobbitt, “are going to be campaigning for people to use it to demonstrate that they’re able to move these scores.”

Psychologists should also familiarize themselves with the Healthcare Effectiveness Data and Information Set, or HEDIS®. Optum, for example, has a program designed to improve its HEDIS® score when it comes to seven-day follow-ups post-hospitalization.

**Going beyond traditional behavioral health services, the company uses peers to help prevent relapses in subscribers with serious substance use problems.**

**A case study**

Anthem is using innovative strategies to achieve the so-called “triple aim” of enhancing patients’ experience of care, improving population health and reducing costs, says Lawrence Grab, MBA, staff vice president of behavioral health utilization management at Anthem Blue Cross Blue Shield.

Going beyond traditional behavioral health services, the company uses peers to help prevent relapses in subscribers with serious substance use problems, for example. It also offers online psychotherapy to members and is exploring computerized cognitive-behavioral therapy and apps that would help subscribers, providers and Anthem case managers manage bipolar disorder and other conditions. So the integration of behavioral and medical services is being emphasized.

When it comes to integration, Anthem is using change management strategies and developing learning collaboratives to ensure optimal collaboration. “It’s one thing to say, ‘I have a behavioral health provider in my primary care practice,’ but are they being used effectively? Probably not,” says Grab. Anthem is also re-engineering reimbursement for behavioral health providers so that psychologists and others can participate in value-based contracting and the other opportunities their medical colleagues enjoy.

These innovative approaches are paying off. When Anthem developed a program to provide intensive in-home services, for example, health care utilization decreased. More important, participants had a 38 percent lower readmissions rate than other members a year later.

**A practitioner’s perspective**

Springfield Psychological in Springfield, Pennsylvania, is one practice that already views payers as partners, says Chief Executive Officer Vincent J. Bellwoar, PhD. This large, multidisciplinary practice’s goal is to reduce costs by keeping people healthy, he says.

Achieving that goal has meant getting a seat at the table...
“The more your practice can bring in data about what you do, the more likely they are to be impressed.”

What insurers want is data, says Bellwoar. “The more your practice can bring in data about what you do, the more likely they are to be impressed,” he says. Being big, covering lots of geographic territory and expanding treatment access also get payers’ attention.

The result? “Aetna has been a good friend of ours,” says Bellwoar, explaining that his was one of four practices to pilot the company’s value-based contracting. This year, the practice further improved its relationship with Aetna by meeting such metrics as tracking outcomes, making timely referrals to psychiatrists and following up with patients who leave treatment prematurely.

“What’s good for patients is also good for psychologists,” adds Bellwoar.

Referring to incentives for providers who lower costs, he says, “I just don’t want all that going to medical; I want some of that coming to our folks, too. If I help a depressed man who’s just had a heart attack by providing interventions in a primary care physician office and these interventions reduce overall medical costs, I want a share of some of those savings.”

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