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# Managed Care and Value-Based Contracting: Primer & Trends

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# Today’s Presenter

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# Agenda

01 PROVIDER RISK AND VBC MODELS

02 ANATOMY OF MANAGED CARE AGREEMENTS

03 KEY AND EMERGING ISSUES

04 NEGOTIATION STRATEGY

# The Path to Health Care Sustainability

Incentives must be aligned to promote behavior

Clinical integration and care coordination drive quality

Quality promotes health and is a means to efficiency

*Quality and efficiency through coordination and incentive alignment can lead to a better system.*

# Why Is Risk a Good Thing?

**FOR THE INDUSTRY:**
It matches the *power of the pen* with accountability for resource allocation.

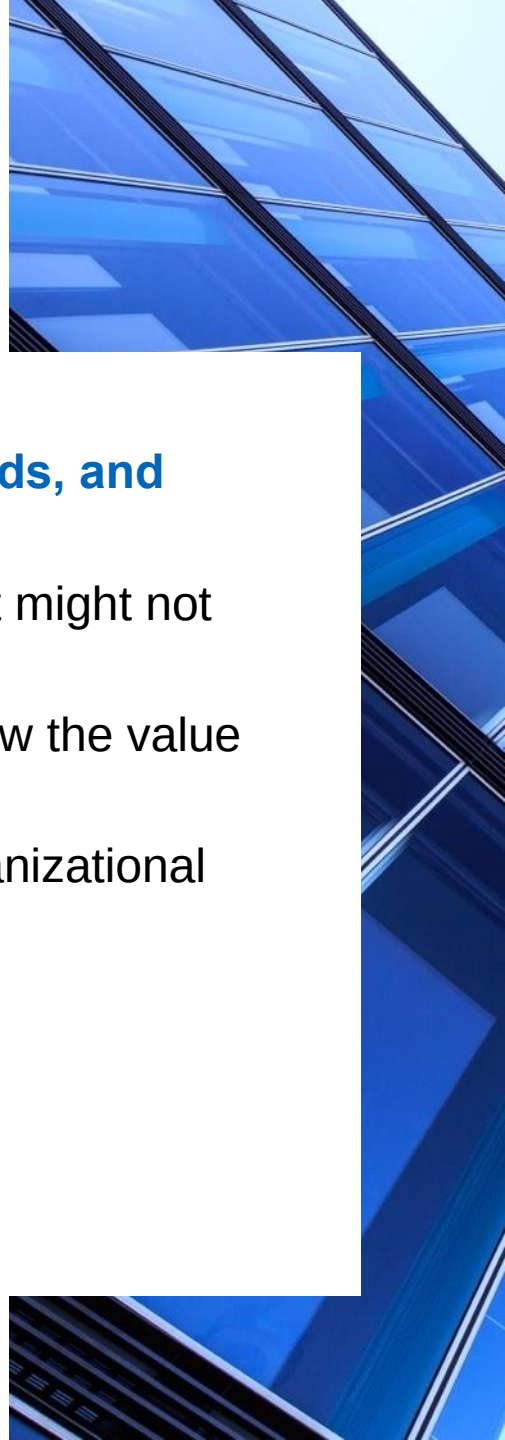
**FOR PROVIDERS AND MANAGEMENT:**
It provides control over the spend and access to information.

**FOR PATIENTS:**
It creates an opportunity for a more collaborative approach to health care.

**FOR HEALTH PLANS:**
It spreads risk and incentivizes good care for their members.

**However, there are a lot of "ifs, ands, and buts" that must be considered.**

- Theoretical beneficiaries to the left might not realize it
- There is significant variation on how the value proposition is delivered
- Often the risk is too high, and organizational capabilities too low



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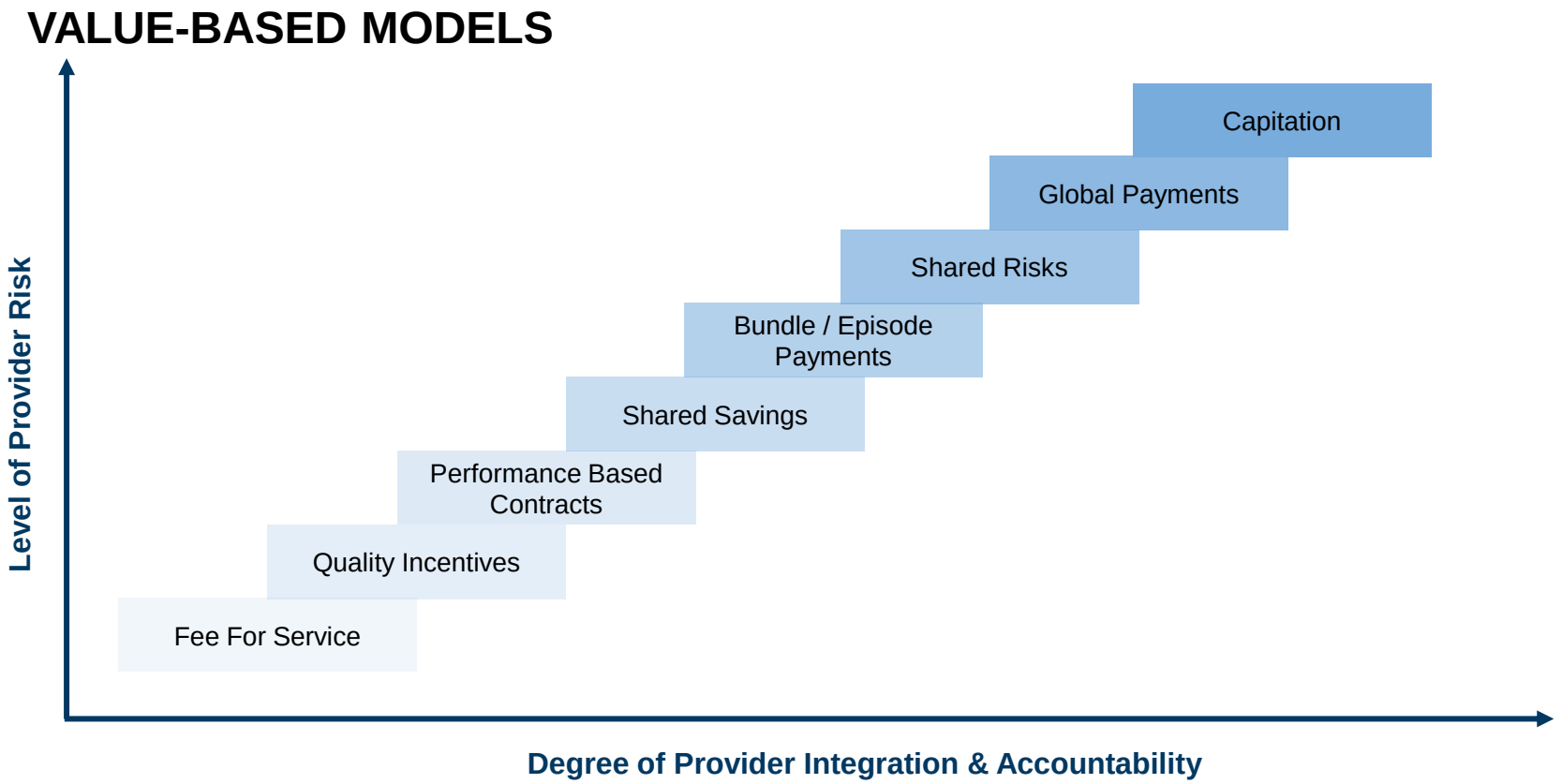
# What's Provider Risk and VBC Models?

# Provider Risk Overview

- What is Value Based Care?
- What is Provider Risk?
- Why Providers Take on Risk?
- Risk bearing providers can participate in several network manager structures:
  - Here are some common terms:
  - Independent Physician Association (IPA)
  - Physician Hospital Organization (PHO)
  - Clinically Integrated Network (CIN)
  - Risk Bearing Entity (RBE)
  - Accountable Care Organization (ACO)

# Providers in Value Based Care Models



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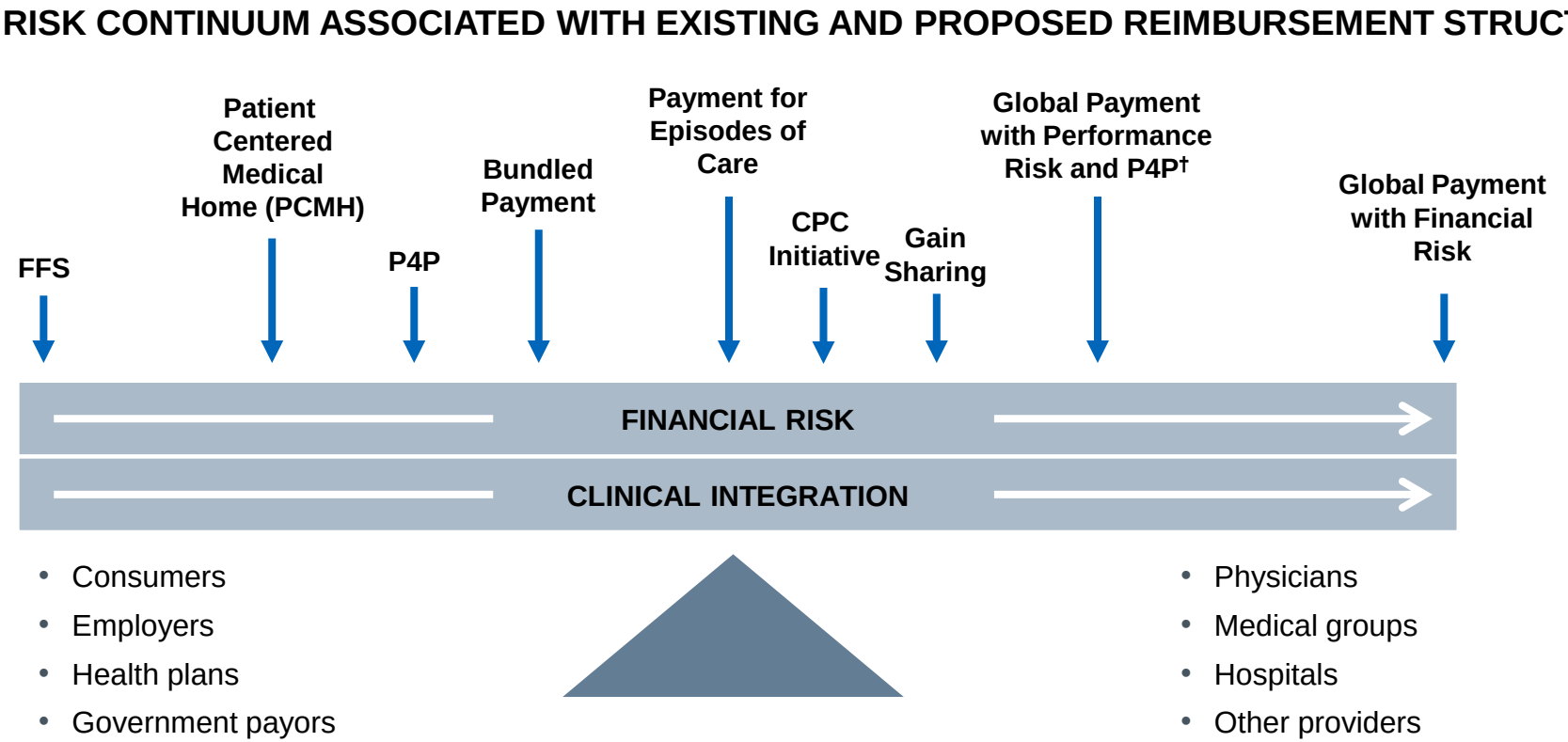
# The Provider Risk Continuum and Clinical Integration

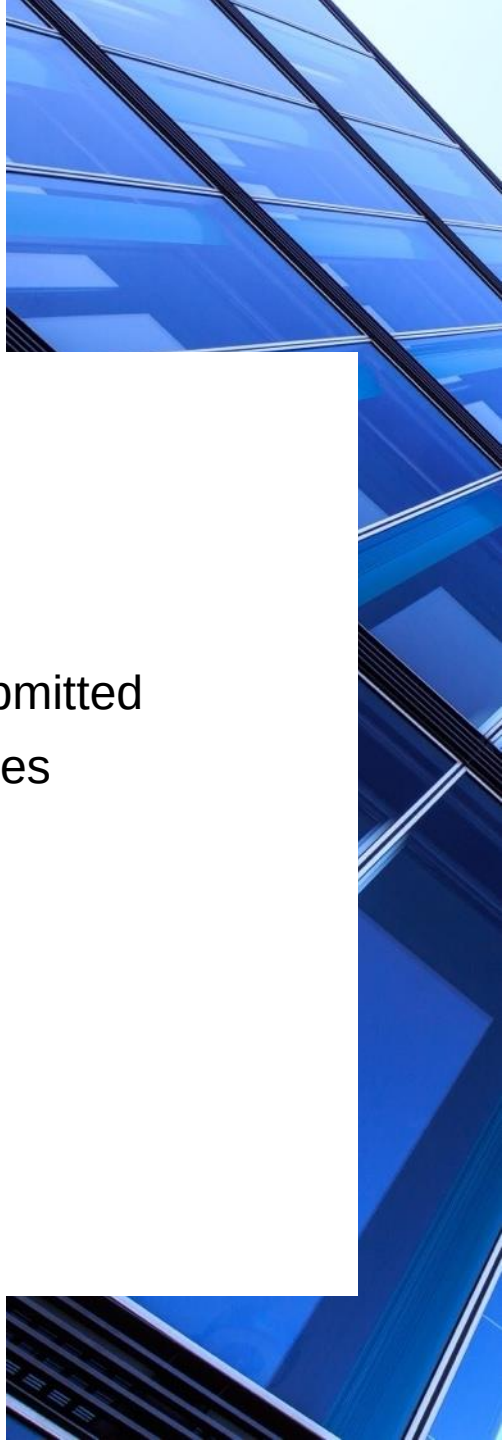


# Legal Considerations

- Federal Anti-Kickback Statute (AKS (42 USC 1320a-7b)
  - Several managed care safe harbors
  - Value based safe harbors
- Federal Antitrust Law
  - DOJ withdrew 2011 Statement of Antitrust Enforcement Policy regarding accountable care organizations participating in the Medicare Shared Savings Program (Feb. 2023)
- Medicare marketing guidelines
- Federal beneficiary inducement prohibition
- Risk bearing entity and provider network licenses and certificates
  - Example: Provider Network Registration in Texas
- Other State law

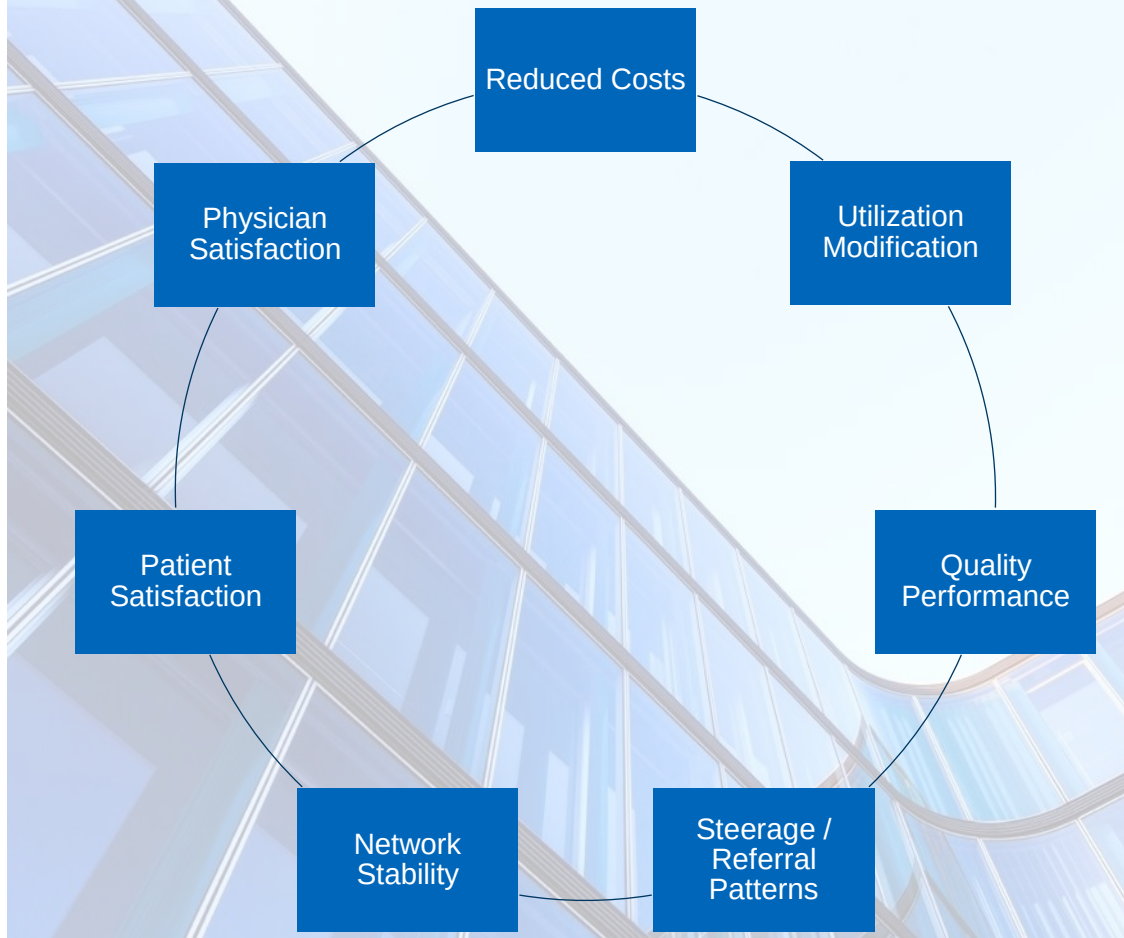
# Managing Audits and Compliance

- Need to have a compliance program
- Audits by Medicare, Medicaid, OIG, or state agency
- Standard Health Plan audits (Health Plan auditing the RBO)
- MSSP has specific compliance requirements, can audit clinical quality reporting data submitted
- MA plans can be audited for HCC coding accuracy as can delegated and capitated entities



# Goals of Value Based Arrangements

- Start with clear identification of goals
- Goals must be embedded into payment methodology
  - Aligned incentives
  - Measurable progress against triple aim



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# Anatomy of Managed Care Agreements

# Anatomy of Managed Care Agreements

## UNDERSTANDING MANAGED CARE STRUCTURE VARIATIONS

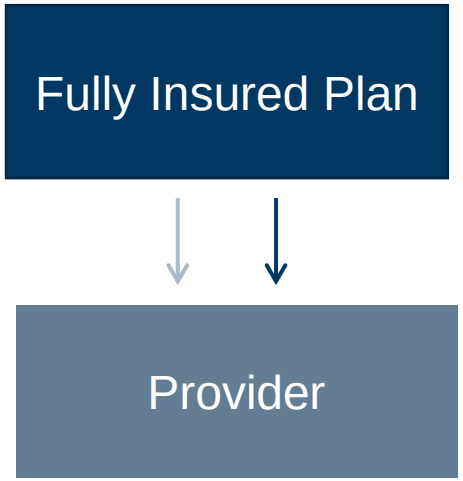
- Fully Insured Payor-Provider Model
- Direct to Employer Model
- Third Party Administrator (TPA) Model
- Network Manager Models

## WHO IS THE ULTIMATE PAYOR?

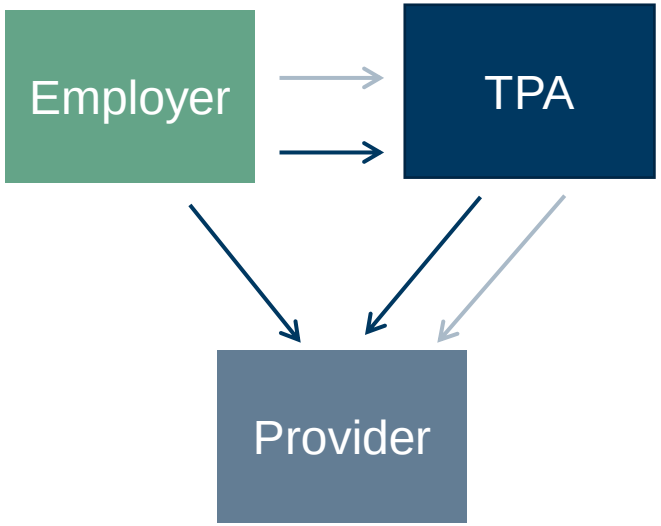
- Fully insured commercial health plan
  - State insurance laws
- Medicare Advantage
  - 42 C.F.R. 422 and Medicare Managed Care Manual
- Medicaid Managed Care Organization
  - State Medicaid Rules + 42 C.F.R. 422 (dual eligible)
- TPA for Self-Insured Employer Plans
  - ERISA
- Other?

# Anatomy of Managed Care Agreements

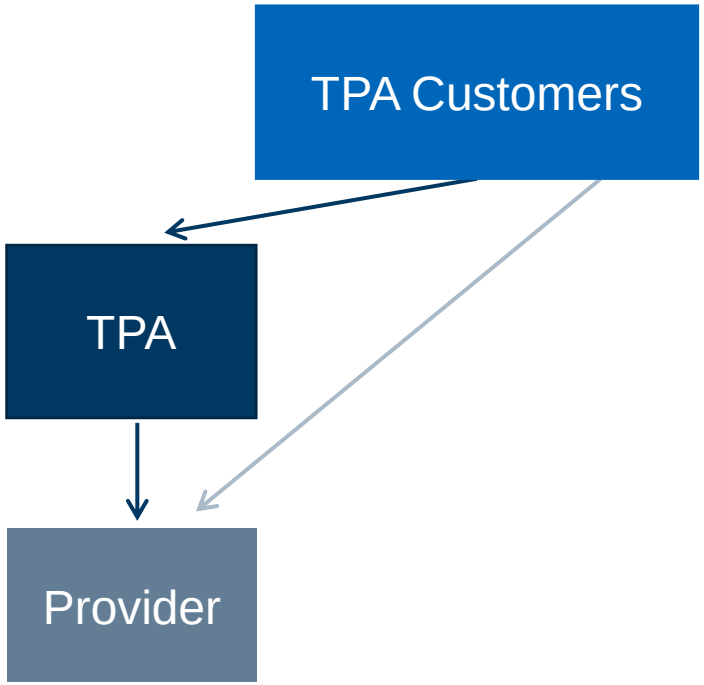
## FULLY INSURED ARRANGEMENT




## DIRECT TO EMPLOYER ARRANGEMENT




## TPA ARRANGEMENT

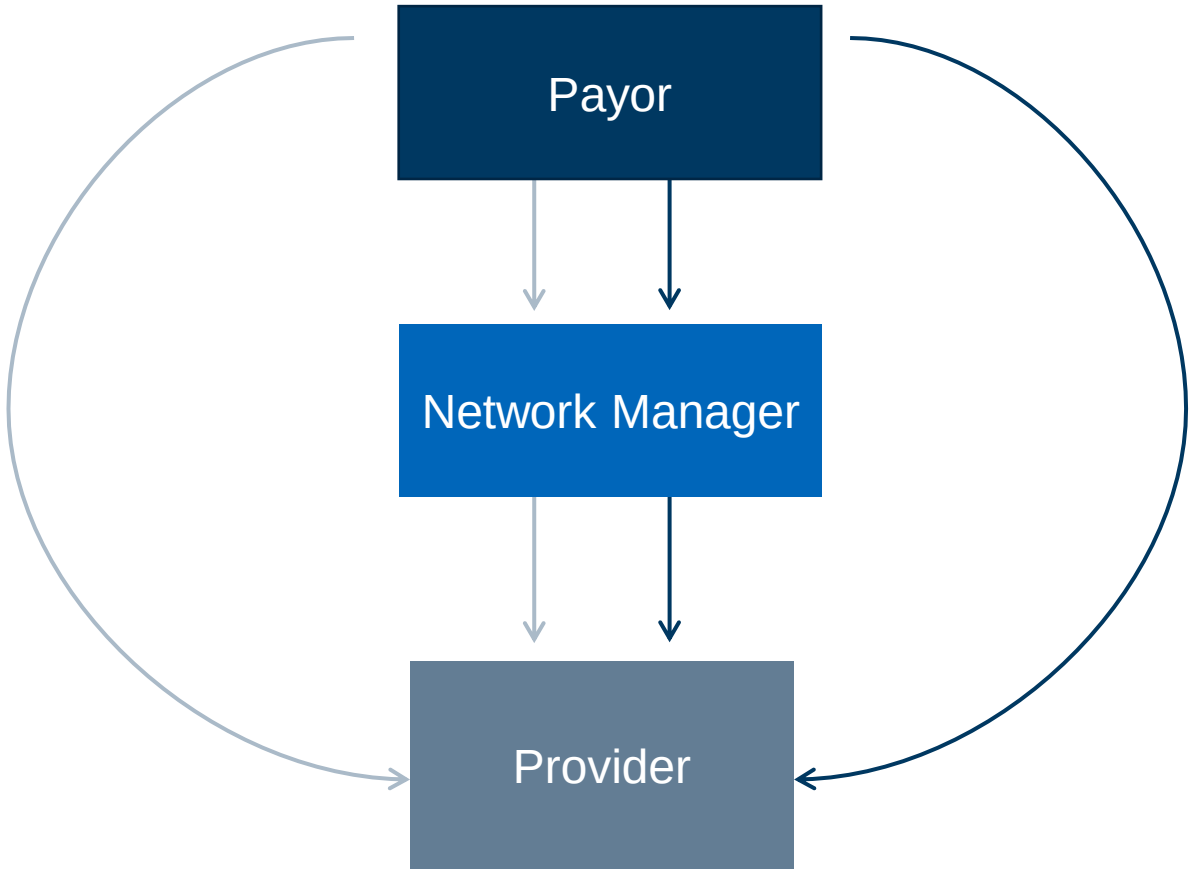



**LEGEND:**

Contract

Funds Flow

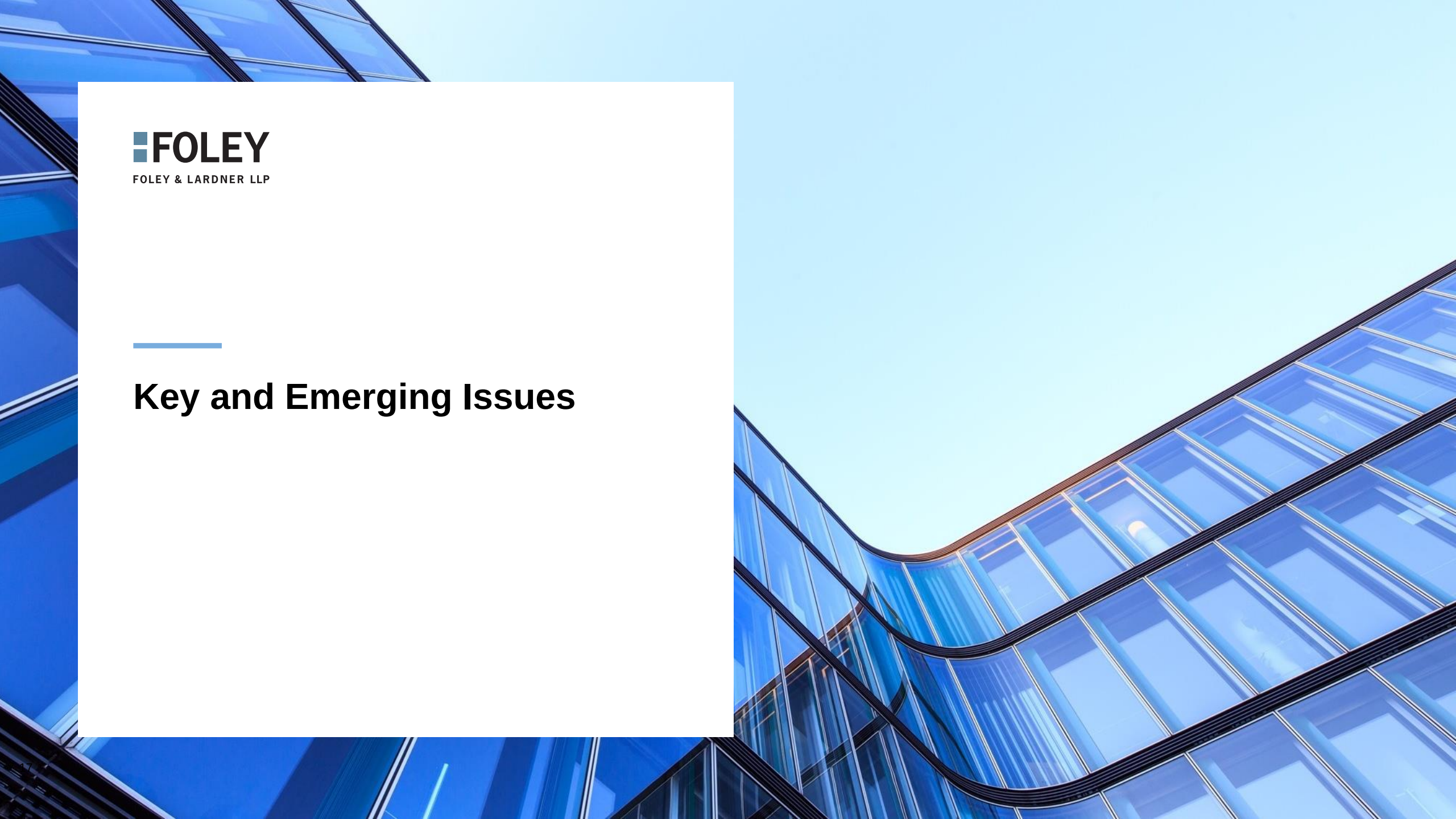
# Managed Care or Value-Based Variations




**LEGEND:**

Contract

Funds Flow



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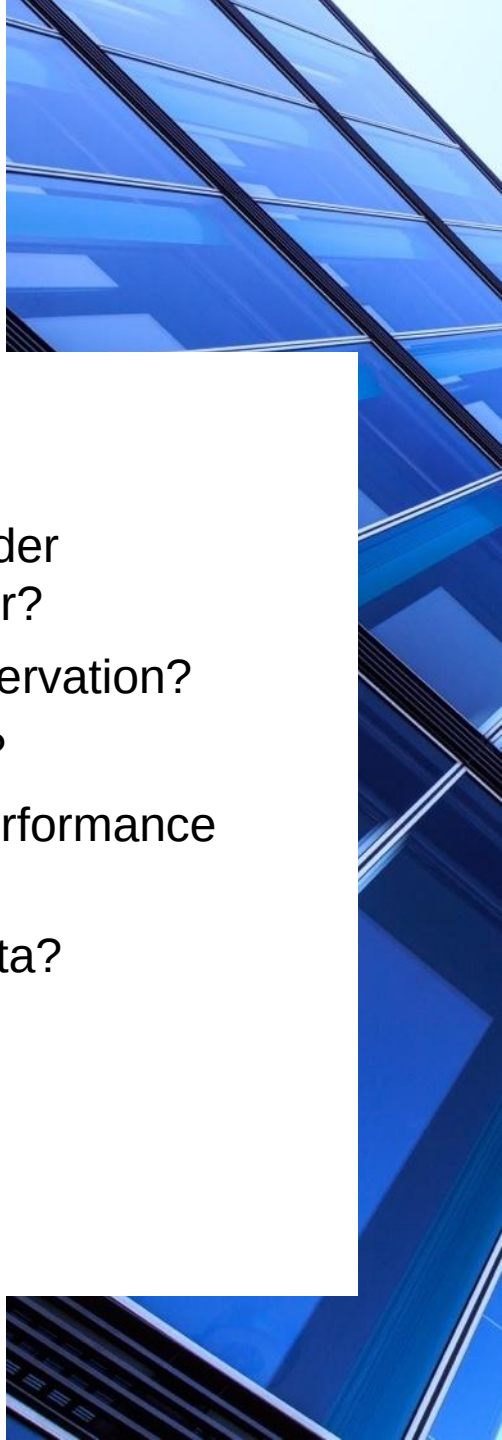
# Key and Emerging Issues

# Key and Emerging Issues in Managed Care Contracting



## EMERGING ISSUES:

- Alternative payment models
- Site neutrality
- Prepayment review and denials without basis
- Class action lawsuits
- Self-insured ERISA plans refusal to pay negotiated rates

## WATCH OUT FOR:

- Penalties or automatic payment reduction
- Plan ability to change rates
- Provider responsibility for downstream referrals
- Non-solicitation or non-competition
- Fraud set-ups

## NOVEL ISSUES:

- Vendor vs. provider contracting paper?
- Payment for observation?
- Limits on audits?
- Publication of performance data?
- Ownership of data?

# Provider-Led Marketing and Outreach Under MA and CMMI Programs

- What are the business objectives?
- Are you a regulated person: providers vs. broker, agent or TMPO?
- Communication vs. Marketing?
  - Educational activities for providers/staff or patients
  - Plan announcements
  - Sales events
  - Promotion of some or all MA plans offered in the geography
- MSSP & other CMMI programs have specific marketing rules and requirements
  - Restricted and preferred language

# Emerging CMMI Programs

CMS Innovation Center's strategic plan includes:

- **All Medicare fee-for-service beneficiaries** will be in a care relationship with accountability for quality and total cost of care by 2030.
- **The vast majority of Medicaid beneficiaries** will be in a care relationship with accountability for quality and total cost of care by 2030.

Recent Models Announced / Applications Under Review:

- Making Care Primary Model (MCP)
- Guiding an Improved Dementia Experience Model (GUIDE)
- States Advancing All-Payer Health Equity Approaches & Development Model (AHEAD)
- Innovation in Behavioral Health Model (IBH)
- Transforming Maternal Health Model (TMaH)

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# Negotiation Strategy

# Negotiating in the Value World

| | |
|---|---|
| Determine why it's important for your organization | • How and why do value models fit in with your vision?<br>• If it's market-facing that's perfectly fine! Business doesn't always have to be perfectly noble.<br>• Make sure you know the value proposition. |
| Establish tone and baseline reasoning | • Approach should be collaborative—what's in the best interest of all parties?<br>• Focus on what will drive long term success vs. how to get the better of the other party.<br>• Establish the value of accountability matching up with clinical decision making. |
| Be diligent and appropriately address language issues | • Everything may be theoretically negotiable, but everything is also about market power.<br>• Make sure you understand the other side's interests.<br>• Make your points and try to make the language fair. |
| Get the data and do the analysis | • Don't back off of this—you can do without it but not as effectively.<br>• Make sure you know what to analyze and how. You don't need predictive analytics.<br>• You need clinical analysts and good math people. |

# Negotiation Strategy

1. **GET THE DATA**
   Insist on getting historical access data on proposed membership. It won't include cost outside of possibly getting certain PMPM figures.
2. **ANALYSIS**
   Estimate utilization using the data and develop a robust financial analysis to support the strategy and negotiations

3. **PREPARE THE VALUE PROPOSITION**
   - **Quality and outcomes:** Articulate what you do that may be unique and what evidence is there that helps people get better and stay well.
   - **Network adequacy:** It's depth that matters vs. geographic coverage. You'll need both, but depth trumps breadth every time. You need providers to cover all services that are willing to play along.
   - **Affordability and cost:** Don't share actual costs information for the organization, rather prove what effective treatment and high quality bring to the patient and payor.

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# QUESTIONS?

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