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

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
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
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

VALUE-BASED MODELS

Level of Provider Risk

Degree of Provider Integration & Accountability

Fee For Service

Quality Incentives

Performance Based Contracts

Shared Savings

Bundle / Episode Payments

Shared Risks

Global Payments

Capitation
The Provider Risk Continuum and Clinical Integration

THE RISK CONTINUUM ASSOCIATED WITH EXISTING AND PROPOSED REIMBURSEMENT STRUCTURES

- Physicians
- Medical groups
- Hospitals
- Other providers

- Consumers
- Employers
- Health plans
- Government payors

FINANCIAL RISK

CLINICAL INTEGRATION

FFS

Patient Centered Medical Home (PCMH)

Bundled Payment

Payment for Episodes of Care

CPC Initiative

Gain Sharing

Global Payment with Performance Risk and P4P

Global Payment with Financial Risk

P4P

† Global Payment with Financial Risk and P4P
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
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

Fully Insured Plan

Provider

DIRECT TO EMPLOYER ARRANGEMENT

Employer

Provider

TPA

TPA ARRANGEMENT

TPA Customers

Provider

LEGEND:

Contract

Funds Flow
Managed Care or Value-Based Variations

LEGEND:
- Contract
- Funds Flow
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)
Negotiation Strategy
# Negotiating in the Value World

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

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