MANAGED CARE AND CONTRACT NEGOTIATIONS

HFMA MA-RI
NEW TO HEALTH CARE

November 19, 2021 – Presented by Dianne Dobbins

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AGENDA

- Massachusetts Landscape
- Types of Managed Care Contracts
- Contracting Organizational Structure
- Negotiation Process and Stages
- A Few Tips

Acronyms

ACO - Accountable Care Organization	**IPA** – Independent Physician Association
ACU - Accountable Care Unit	**MCO** - Managed Care Organization
AHA - American Hospital Association	**MHA** - Massachusetts Health & Hospital Assoc
APC - Ambulatory Payment Categories	**PAF** - Payment on Account Factor
APM - Alternative Payment Model	**PHO** – Physician Hospital Organization
ASO - Administrative Services Only	**PMPM** - Per Member Per Month
CHIA - Center for Health Information & Analysis	**P4P** - Pay for Performance
DOI - Division of Insurance	**P4R** - Pay for Reporting
HPC - Health Policy Commission	**TME** - Total Medical Expenses

Massachusetts Landscape

Massachusetts – National Leader

- Massachusetts ranked #1 in the Commonwealth Fund's scorecard on state health system performance in the category of Access and Affordability and #2 Overall.[1]
- The United Health Foundation, a nationally recognized organization dedicated to improving health and health care, ranked Massachusetts #1 among all states in Clinical Care and #2 in Health Outcomes.[2]

Sources:

[1] Radley DC, Collins SR, Baumgartner JC. 2020 Scorecard on state health system performance. The Commonwealth Fund; https://scorecard.commonwealthfund.org/

[2] United Health Foundation. 2020 America's Health Rankings Annual Report.; https://www.americashealthrankings.org/

Massachusetts – Challenges

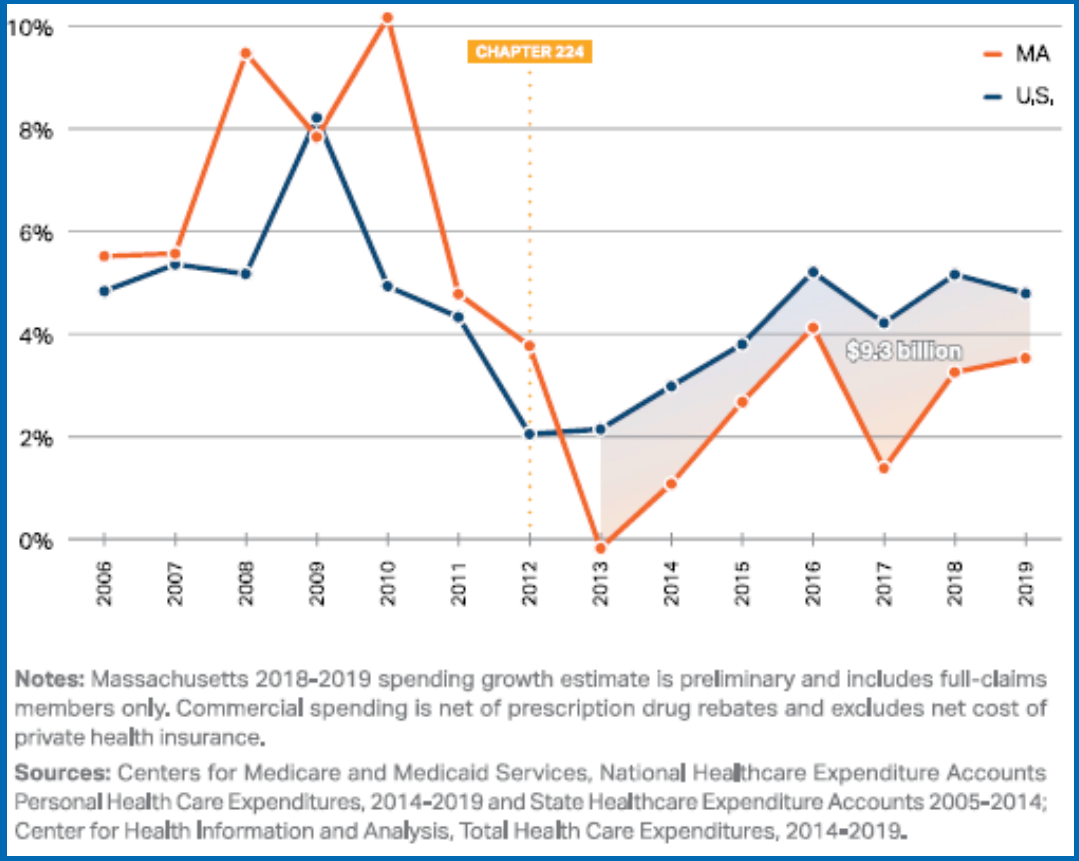
HPC 2021 Annual Report, September 2021:

"While the Commonwealth has been a leader in health coverage and innovation, cost containment, affordability and health equity continued to be challenges."

Massachusetts – Spending Rate Below National Average

HPC 2021 Annual Cost Trends Report, September 2021:

"In the commercial health insurance sector, per member spending growth rates…continued to be below the national average. Cumulatively from 2013 to 2019, these lower growth rates amount to commercial spending that was $9.3 billion lower than would have been the case if growth rates matched the national average."



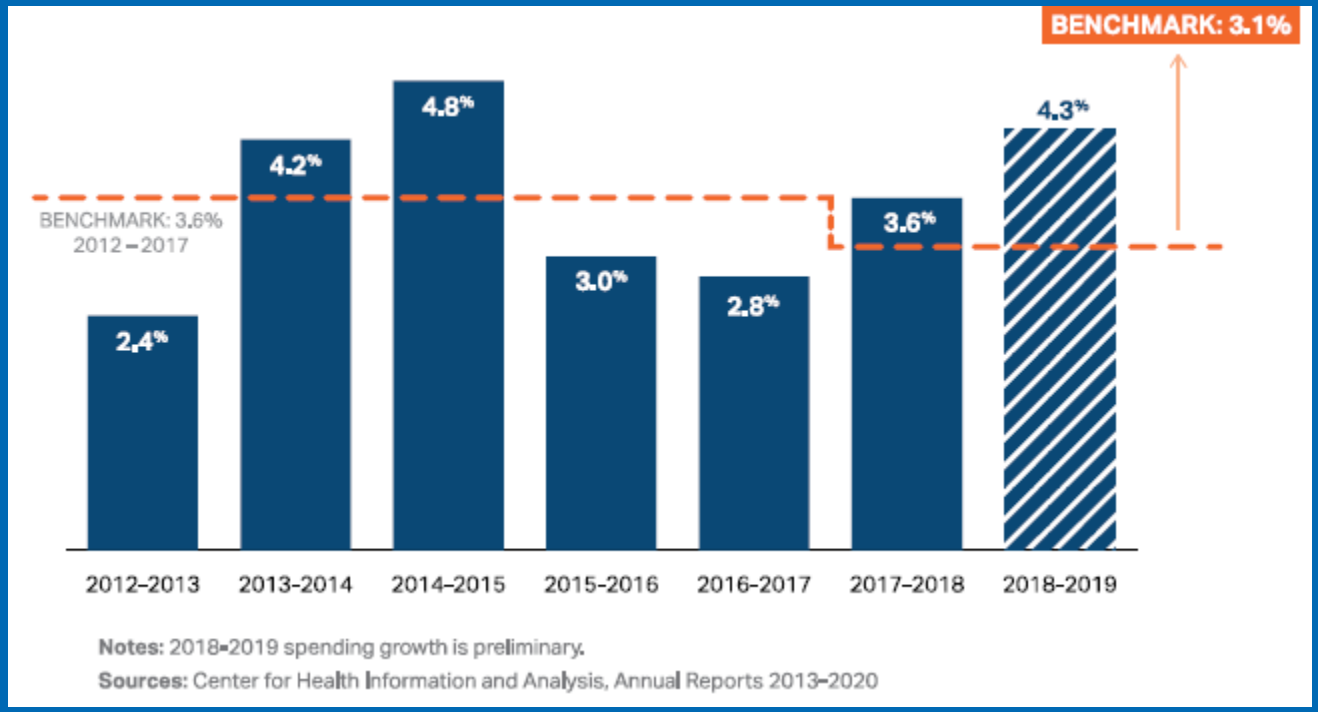
Notes: Massachusetts 2018-2019 spending growth estimate is preliminary and includes full-claims members only. Commercial spending is net of prescription drug rebates and excludes net cost of private health insurance.

Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures, 2014-2019 and State Healthcare Expenditure Accounts 2005-2014; Center for Health Information and Analysis, Total Health Care Expenditures, 2014-2019.

Massachusetts – Statewide Benchmark

HPC 2021 Annual Cost Trends Report, September 2021:

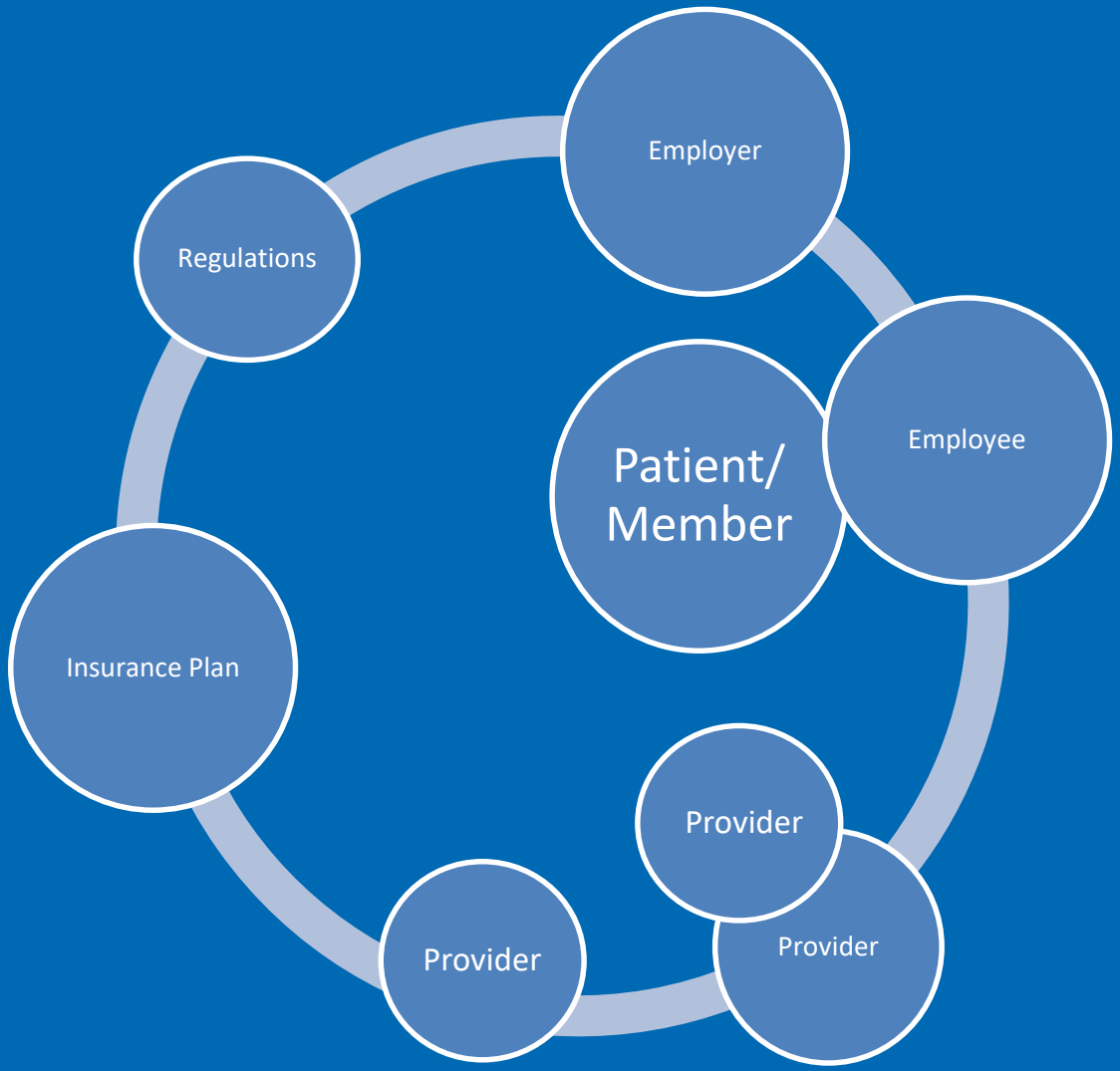
- Benchmark for annual growth in health care expenditures. The benchmark is comprised of all health care expenditures, cost and utilization including pharmacy



Massachusetts – Regulations

- Massachusetts State Law - Governs DOI fully-insured products; ERISA plans (self-insured/ASO) not subjected to state regulations
- MSL Chapter 176O *(letter "O", not number "0")* – Health Insurance Consumer Protections
- What about administrative simplification? HPC acknowledges in its 2019 annual report that:
  - *"…administrative complexity is endemic in the U.S. health care system. It is one of the principal reasons that U.S. health care spending exceeds that of other high-income counters and is a source of significant pain – both financial and non-financial – to patients and providers alike."*
  - *"The Commonwealth should be a national leader by requiring greater standardization of common administrative tasks across payers….and should facilitate efforts….to identify and reduce other drivers of valueless administrative complexity."*

Resulting Challenges – Common/Competing Interests



Types of Managed Care Contracts

Sample Contracting Entities/Services

- Performance network contracts
- Hospital contracts
- Medical Group contracts
- Behavioral Health
- Urgent Care
- Home Care
- Transplant
- Misc. – Atrius, CVS, Individual contracts, Children's Hospital and some vendor contracts related to contract performance or government regulations

Types of Managed Care Contracts

Alternative Payment Method/ Value Base Care

- Fee for Service - FFS
- Pay for Reporting – P4R
- Pay for Performance – P4P
- Shared Savings – one sided (surplus opportunity)
- Bundled payments
- Shared Risk – two sided (surplus/deficit potential)
  - Budgeted Capitation – PMPM budget set
  - Quality components
- Full Risk or Capitation – PMPM cash payment

Increasing Risk

Accountable Care Organizations (ACO) – Medicare & Medicaid

- CMS offers providers the opportunity to develop one of various types of ACOs (e.g., Medicare Shared Savings Program, Next Generation ACO, etc)
- MassHealth also has several different ACO model options (e.g., Accountable Care Partnership, Primary Care ACO, MCO-Administered ACO)
- These programs are important innovations for moving payment system away from volume and toward value and outcomes
- ACOs are alternative payment models that:
  - Promote accountability for a patient population
  - Coordinate items and services for Medicare FFS beneficiaries
  - Encourage investment in high quality and efficient services

POLLING QUESTION

Which of the following is NOT considered a value-based or an alternative payment model:

A) ACOs
B) Fee-for-service payments
C) Quality Pay-for-Performance

Shared Financial Risk

- How does a risk sharing arrangement work?
  - A budget is set: historical cost or a benchmark
  - Market increase trend (e.g. 3.1%) is applied to bring budget to current year
  - Health status is adjusted so budget reflects the current burden of care of the individual population of patients
  - Other adjustments: benefits, member cost share, etc.
  - Some adjustments are made along the way – new members or members leave
  - Expenses are “charged” against the budget
  - Quality score adjustment, if applicable
  - At year-end there is a surplus or a deficit with applied risk %

A Contracting Network

Framework for Managed Care and Negotiations

Clinical and Financial Integration

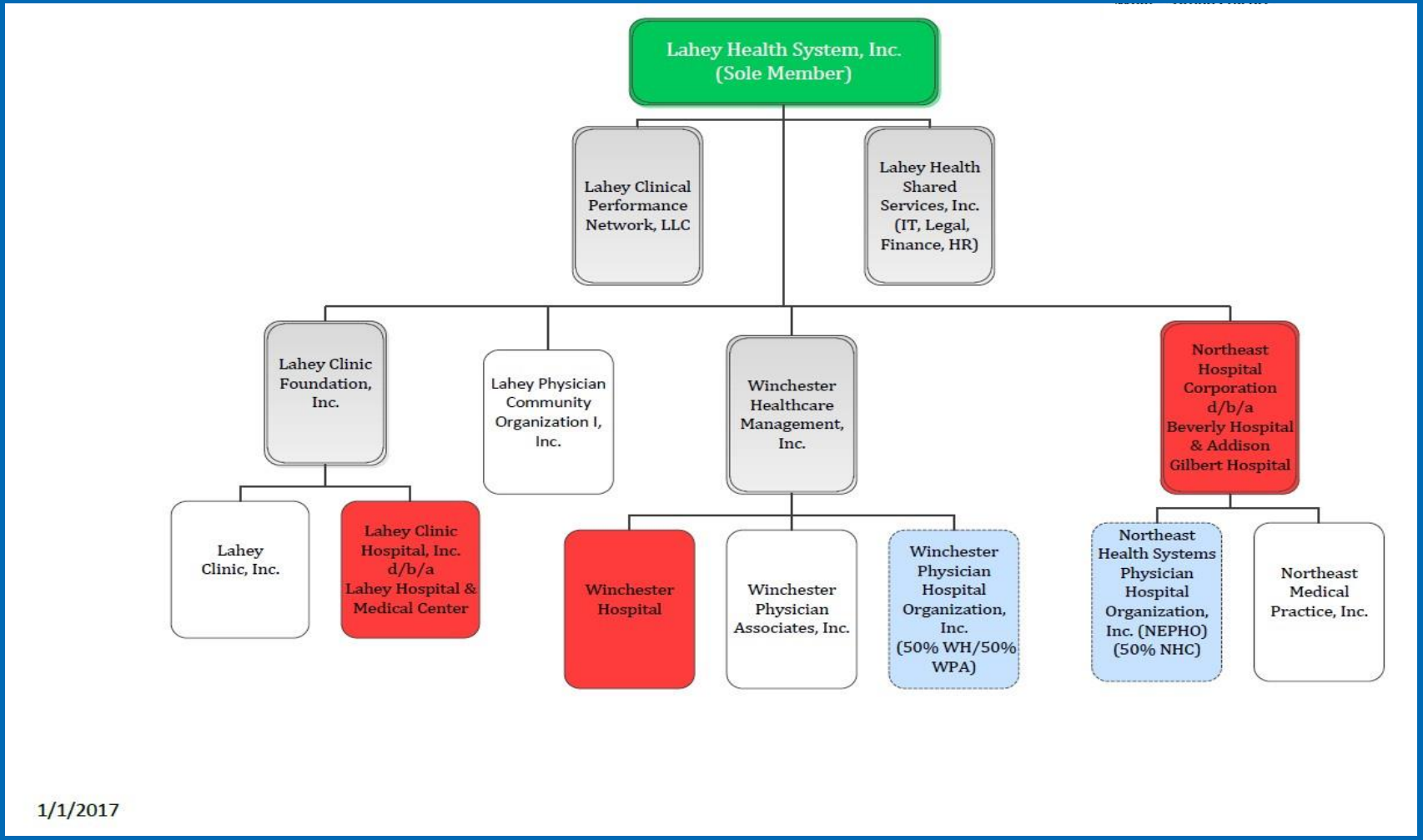
How do a group of private providers contract together?

- They need an alternative payment mechanism or model
  - Risk
  - Individual compensation of the physicians impacted by the performance of the integrated group—financial integration
  - Evidence-based care standards applied to assigned patients and measured on aggregate basis – clinical integration
- If this is not in place – a contract must be "messengered," or offered to the individual physician without negotiation
- Owned medical groups and hospitals are integrated

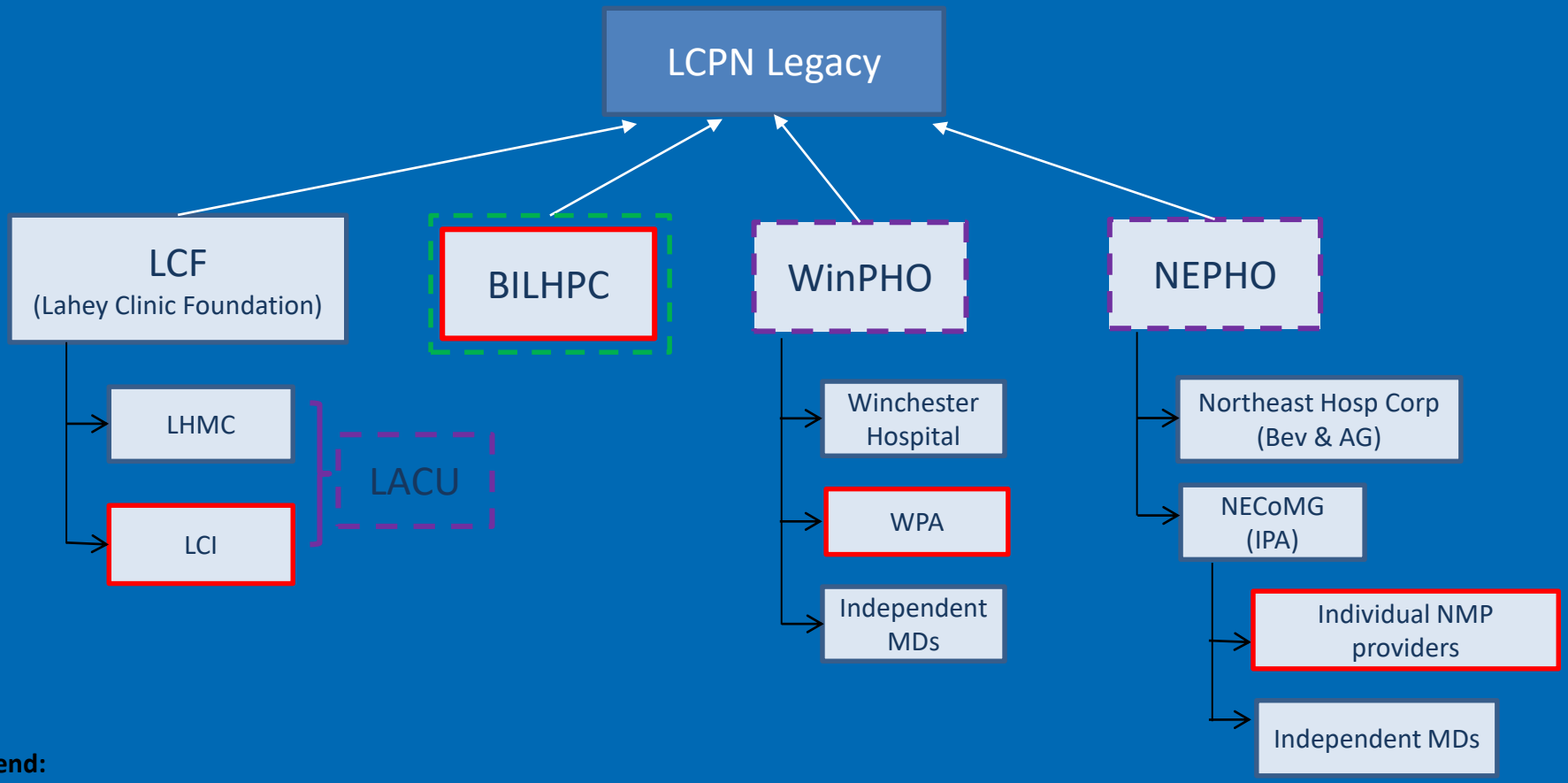
Former LHS Organization Structure

An example of how a contracting network fits into a health care system

Chart of Corporations



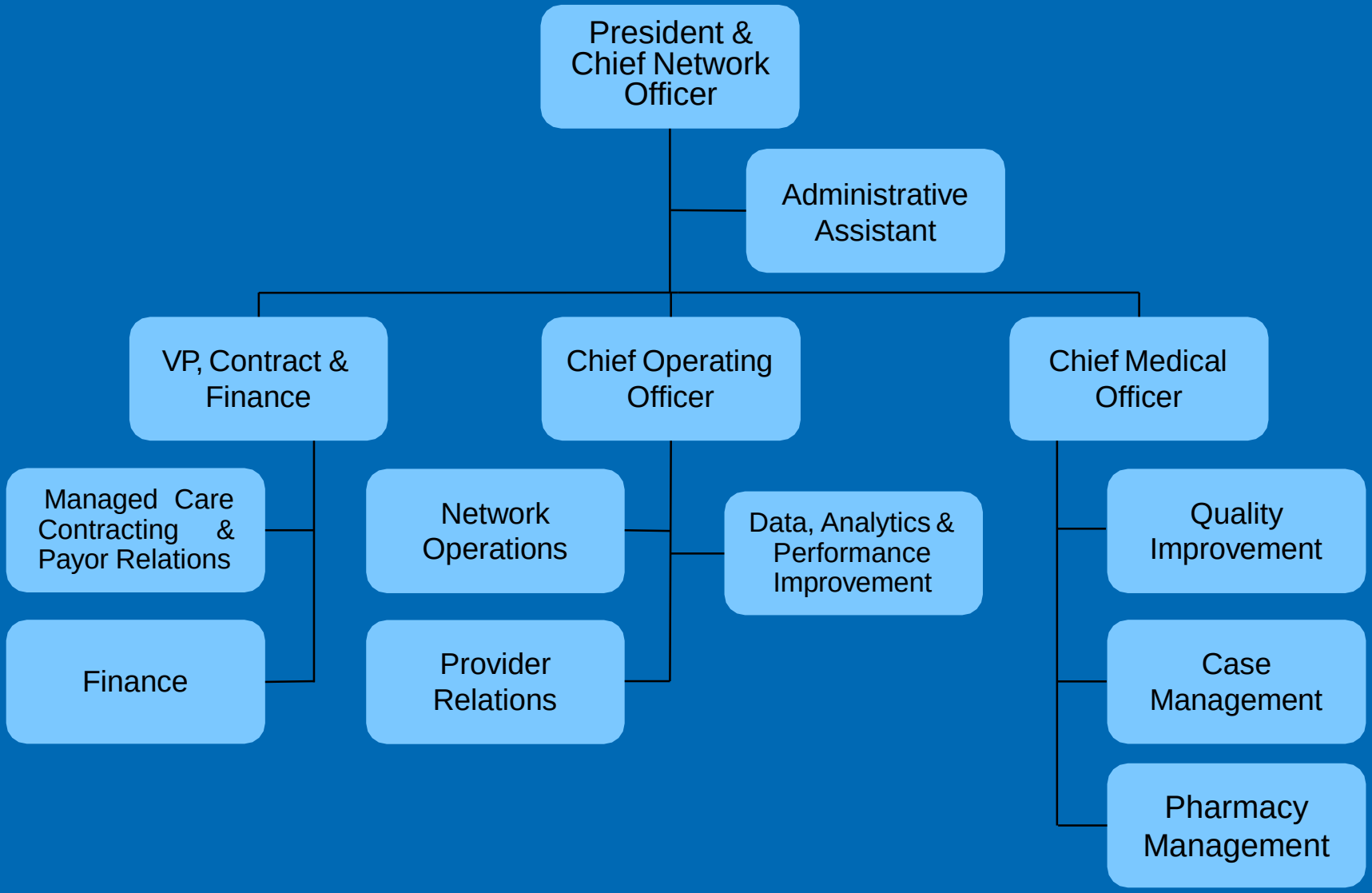
Lahey Clinical Performance Network (LCPN) Organizational Structure



Legend:

White arrow → = LCPN Participation Agreement
Dashed purple outline = Risk Unit
Dashed green outline = BILHPC providers are assigned to either LACU, NEPHO or WinPHO
Red outline = Employed provider by tax id

Sample Performance Network Organizational Chart



Accountability to Board of Directors

Sample Subcommittees of the Board

Quality Care and Value*	**Strategy**
Funds Flow*	**Finance**
Managed Care Contracting*	**Physician Review**

* Representational standing committees

Contracting Process

Ongoing Relationship Building

- While negotiations last for a limited time, Contracting teams maintain ongoing relationships with their payer counterparts
- Both sides need to develop ***trust***
- ***Integrity*** is critical to a successful negotiation and ongoing relationship
  - Point out errors even if they don't benefit your organization
  - Don't ever lie – you will get caught and lose your credibility
  - Don't say something is a "deal breaker" or a "final offer" unless it really is
- Negotiating styles will vary and will work as long as there is mutual ***respect***

Major Phases in a Negotiation . . . And After

- Preparation – single most important part of a negotiation
- Kick Off
- Proposal/Counterproposal(s)
- Financial Terms & Analysis
- Written Contract Language
- Thorough Legal Review
- Formal Acceptance and Approval
- Implementation
  - In-Service
- Ongoing Troubleshooting
  - Claims/Patient Financial Services
  - Case Management and Utilization Management
  - Enrollment

Example of a Contract Approval Process

- A strategy is proposed by the contracting/management team and vetted by the Board Contracts & Finance (C&F) Committee
- The recommended strategy is brought by C&F to the Board for approval
- Negotiation updates are given to the C&F Committee
- “Completed” negotiations are presented and the C&F Committee makes a recommendation to accept or deny the proposed contract terms to the Board
- Board votes to accept or deny the recommendation of the C&F Committee

Aligned Incentives Within a Contract

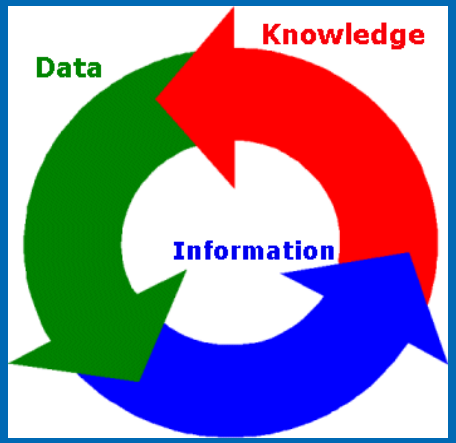
One of the toughest challenges during a negotiation

- Many internal stakeholders with different incentives need to be balanced in a successful contract
  - Hospitals
    - Tertiary and community
  - Physicians
    - Salaried or independent
    - Primary care and specialists
  - What is the risk tolerance among the stakeholders?
- Within a fee schedule, all specialties are represented, some are paid better than others
- Ancillary contracts are usually non-negotiable with many payers

Preparation – The Most Important Piece

Gather and carefully review all the data you can:

- External data
  - Publically available data: relative price (hospital and physicians), enrollment
  - Comparisons across payers, comparisons across providers
- Internal data
  - Margin by payer
  - Physician fee schedules as a percent of Medicare
  - Denials by payer
  - Mid-contract policy changes and their financial impact
  - Value the proposals
  - Exchange baseline data with payer
- Competitive Intelligence
  - Network and talk to others in the marketplace



Financial Terms and Analysis - Reimbursement

- Inpatient - PAF, Per Diems, DRGs
- Outpatient - PAF, Fee Schedules, Case Rates, Per Visit, APCs, etc.
  - Lesser of
  - Observation
- Physician Reimbursement – Fee Schedules, Capitation
- Risk Sharing:
  - Budget build – historical expenses, percent of premium, trends/adjustments
  - Percent of risk to be shared, minimum number of risk members
- Quality component – lump sum, compounding rate increases, PMPM amts
- Pharmacy risk – particularly troubling in recent times
- Infrastructure payments (on PMPM or lump sum basis) – to pay for operations and programs related to performance improvement
- Withhold – percentage of FFS claims held aside to offset potential deficits
- Reinsurance – to mitigate high risk

After Preparation is Complete . . .

- Kick-off Meeting
  - All parties at the table to explain what their goals are
  - A chance to talk about the challenges the parties are facing and what each thinks the future holds
- Initial proposal: it doesn't matter which party starts
  - If the parties listen carefully, the counterproposals reflect the issues that have been discussed and the gaps between proposals start to close
- There can be many counterproposals
  - Try to set deadlines - though sometimes it's hard to get the other side to stick to them
  - Set regularly scheduled meetings so that the negotiations progress well

Contract Terms

- Thorough review of the written contract document is a critical part of negotiations
  - Don’t fall into the trap that once the financial terms are agreed to the negotiations are complete
  - A well negotiated financial deal can be seriously undermined by unfavorable contract language
    - Policy manual changes, limited networks, tiered networks, all product contracts
    - Evergreen vs. hard term
    - Beware of terms that cannot be operationalized
    - Silent PPOs

- Provide examples for clarity whenever possible
- Legal review by an attorney that understands managed care financing and risk contracting
  - Business risk vs. legal risk

And Lastly . . .

- Formal Acceptance and Approval
- Implementation of the contract
  - Communicate contract terms to your organization
  - Consider doing an In-Service education program
- Ongoing Troubleshooting
  - Claims/Patient Financial Services
  - Case Management and Utilization Management – payment denials after record review
  - Enrollment
  - Recredentialing

POLLING QUESTION

A well negotiated financial deal can be undermined by unfavorable contract language.

True or False?

Tips

Tips

- Go into a negotiation with a “gain/gain” mind set. What can you gain for your organization? What will the other party gain for their organization?
- Document ‘version control’ is important
  - Maintain past iterations for reference
  - The “compare” functionality in Word will be your friend
- Join internal cross-departmental teams to enhance your subject matter knowledge
- Get to know and use your resources
  - CHIA, DOI, HFMA, HPC, MHA/AHA
- Remember - you will likely cross paths again!

Appendix

Shared Savings Program Participation Options

Applicable to ACOs in agreement periods beginning on July 1, 2019, and in subsequent years

The Medicare Shared Savings Program offers different participation options (tracks) that allow ACOs to assume various levels of risk. The below table summarizes the characteristics of the participation options under the BASIC track and ENHANCED track for agreement periods beginning on July 1, 2019, and in subsequent years.

Table 1. Comparison of BASIC track and ENHANCED track characteristics

Characteristic	BASIC Track's Glide Path				ENHANCED Track (risk/reward)
	Level A & Level B (one-sided model)	Level C (risk/reward)	Level D (risk/reward)	Level E (risk/reward)	
Shared Savings (once MSR met or exceeded)	1st dollar savings at a rate up to 40% based on quality performance; not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 75% based on quality performance, not to exceed 20% of updated benchmark
Shared Losses (once MLR met or exceeded)	N/A	1st dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped at 2% of updated benchmark	1st dollar losses at a rate of 30%, not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program capped at 1 percentage point higher than the benchmark nominal risk amount (e.g., 8% of ACO participant revenue in 2019 – 2020), capped at 4% of updated benchmark)	1st dollar losses at a rate of 1 minus final sharing rate, with minimum shared loss rate of 40% and maximum of 75%, not to exceed 15% of updated benchmark

Comparison of BASIC track and ENHANCED track

MEDICARE SHARED SAVINGS PROGRAM

Characteristic	BASIC Track's Glide Path				ENHANCED Track (risk/reward)
	Level A & Level B (one-sided model)	Level C (risk/reward)	Level D (risk/reward)	Level E (risk/reward)	
Annual choice of beneficiary assignment methodology?	Yes	Yes	Yes	Yes	Yes
Annual election to enter higher risk?	Yes, but new low revenue ACOs may elect an additional year under Level B if they commit to completing the remainder of their agreement under Level E	Yes	No; ACO will automatically transition to Level E at the start of the next performance year, except for July 1, 2019 starters that elect to enter at Level D	No; maximum level of risk / reward under the BASIC track	No; highest level of risk/reward under Shared Savings Program
Advanced APM status under the Quality Payment Program?	No	No	No	Yes	Yes
Beneficiary Incentive Program	No	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years	Yes, ACOs may establish an approved program starting July 1, 2019, or in subsequent years
Expanded Telehealth Services	N/A	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years	Yes, available to ACOs electing prospective assignment methodology for performance year 2020, and subsequent years
SNF 3-Day Rule Waiver	N/A	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years	Yes, ACOs may apply to start on July 1, 2019, and in subsequent years

MassHealth ACO Overview

- The Massachusetts Medicaid program, MassHealth, introduced accountable care organizations (ACOs) in March 2018.
- An ACO is a group of doctors, hospitals, and other health care providers that work together with the goals of delivering better care to members, improving the population's health, and controlling costs. An ACO is accountable both for the **health** of its members and for the **cost** of the care its members receive.
- MassHealth's introduction of ACOs represents a significant shift from the way MassHealth typically has partnered with health care providers. In this new model, MassHealth contracts with ACOs to deliver physical health care, mental health care, addiction treatment, and long-term services and supports (LTSS) to a defined group of MassHealth members.
- The ACOs are responsible for coordinating these services across providers, following a member- centered plan, with primary care providers (PCPs) playing an enhanced central role in the coordination. MassHealth ACOs also may be able to offer some non-medical services associated with better health outcomes, such as housing supports and nutritional programs.

Source:

Center for Health Law and Economics, UMass Medical School: What to Know About ACOs: An Introduction to MassHealth ACOs, July 2018, Robert Seifert and Kelly Anthoula Love

MassHealth ACOs

TABLE 1. CHARACTERISTICS OF THE THREE MASSHEALTH ACO TYPES

ACO MODEL	STRUCTURE	PAYMENT AND SAVINGS/LOSSES	PROVIDER NETWORK	NUMBER OF PARTICIPATING ACOs	ACO PLAN NAMES AND PARTNER ORGANIZATIONS
Accountable Care Partnership Plan	Provider-led ACO partnered with a single MCO.	Per member per month capitation from MassHealth; savings if aggregate cap payments exceed TCOC, subject to quality measures.	Uses network based on partner MCO for medical and behavioral health services.	13	
Primary Care ACO	Provider-led ACO contracting directly with MassHealth.	Fee-for-service payments from MassHealth, with savings or losses assessed at year's end by comparing TCOC and budget target, and adjusted for quality performance.	Uses MassHealth's network and narrower referral circles not requiring a PCP referral for medical services, and the Massachusetts Behavioral Health Partnership (MBHP) network for behavioral health services.	3	• **Community Care Cooperative (C3)** • **Partners HealthCare Choice** • **Steward Health Choice**
MCO-Administered ACO	Provider-led ACO contracting with one or more MCOs.	Capitation payments from MassHealth to MCO; MCO pays ACO according to MassHealth-approved arrangement that includes shared savings and losses, adjusted for quality performance.	Uses network of contracting MCO.	1	• **Lahey MassHealth ACO**

- **Be Healthy Partnership (HNE):** Health New England with Baystate Health Care Alliance
- **Berkshire Fallon Health Collaborative:** Fallon Health with Health Collaborative of the Berkshires
- **BMC HealthNet Plan Community Alliance:** BMC HealthNet Plan with Boston ACO
- **BMC HealthNet Plan Mercy Alliance:** BMC HealthNet Plan with Mercy Health ACO
- **BMC HealthNet Plan Signature Alliance:** BMC HealthNet Plan with Signature Healthcare
- **BMC HealthNet Plan Southcoast Alliance:** BMC HealthNet Plan with Southcoast Health
- **Fallon 365 Care:** Fallon Health with Reliant Medical Group
- **My Care Family (NHP):** Neighborhood Health Plan (NHP) with Merrimack Valley ACO
- **Tufts Health Together with Atrius Health:** Tufts Health Public Plans with Atrius Health
- **Tufts Health Together with BIDCO:** Tufts Health Public Plans with Beth Israel Deaconess Care Organization (BIDCO)
- **Tufts Health Together with Boston Children's ACO:** Tufts Health Public Plans with Boston Children's ACO
- **Tufts Health Together with CHA:** Tufts Health Public Plans with Cambridge Health Alliance (CHA)
- **Wellforce Care Plan (Fallon):** Fallon Health

Source:

Center for Health Law and Economics, UMass Medical School: What to Know About ACOs: An Introduction to MassHealth ACOs, July 2018, Robert Seifert and Kelly Anthoula Love

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