COPE HEALTH SOLUTIONS

Key Contracting Considerations for Global Risk Arrangements

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To successfully move from fee-for-service to global risk, health plans and providers need a new contracting playbook. At a high level, the ground rules for value-based contracting should include:

- Providers should take the time to establish clarity on what they want and, whenever possible, provide their payer partners with 1-to-3 year deal points frameworks to react to rather than waiting for the plan to provide an agreement.
- Designing agreements to create wins for both sides.
- Giving providers more control and direct impact on care and costs because they are closer to the patients.
- Seeking over time to reduce costs, both medical and premium expenses and improving benefit offerings across all lines of business.
- Understanding this is a long game.

Of course, contracting requires a great deal more granularity than these general principles. Global risk contracts that support population health management must address a wide range of financial, data, infrastructure, services and other considerations. A solid framework that identifies all key areas and issues, such as the one outlined below, is essential.

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Assessing readiness for global risk

To negotiate with confidence on financial matters, providers must first determine their readiness for delegation and network adequacy, especially primary care physicians (PCPs). The three main infrastructure and capability issues for providers taking on global risk:

MSO Infrastructure
By taking on services, providers can negotiate a higher premium while having more direct control over costs. However, payers have economies of scale with these services, so they won't be willing to give up much premium. Understanding what services the provider takes on will be key in negotiating a higher premium.

Providers need to gauge their abilities to take on delegation, either through in-house capabilities or by outsourcing responsibilities to a managed services organization (MSO). The evaluation should be based on each specific function, from claims processing to care management, and the full range of requirements for the function, including auditing and collecting and reporting performance metrics.

Clearly, having the right data and analytics that provide timely and useful information for decision-making is a cornerstone of success with delegated functions. Access to complete and accurate data also is a necessity for delivering required reports on key performance indicators and benchmarking. In fact, plans will levy penalties for non-compliance, so providers must understand the data submission requirements and have the data analytics platform to meet them.

Network
Network management starts with ensuring network adequacy, and provider organizations can do so by leasing the plan's network or directly contracting with physician groups and other provider practices. Managing populations and costs demands physician commitment and engagement across the network, supported by competencies and resources for managing the network.

One key is establishing processes and accountability to minimize leakage, or referrals and care for members delivered outside of the network. As part of this service, it's important to understand member utilization and behavior. Provider organizations also could measure and share tiered performance metrics to encourage in-network referrals to top performers.

PCP Affiliation
Plans assign members, both voluntary and attributed, to PCPs. Most patients also view their primary care doctor as the starting point for any medical and health needs. The PCP's role in population health management cannot be overstated. To set themselves up for success, provider organizations need to develop a clear picture of their network.
They need to know each PCP's panel size and percent of patients that are fee-for-service. It's important to have the right staffing for the panel size. Other considerations:

- The level of the PCP's engagement with the provider organization will influence the doctor's willingness to take on population health management and risk.
- The PCP practices' sophistication of infrastructure and technological capabilities for managing populations is also critical.

Financial negotiations

Once providers have a firm idea of what delegated responsibilities they want to take on, they are ready to begin negotiating on financial matters. There are four primary financial categories for contracting for global risk:

1. Lines of business/products
Providers and payers need to start by determining which line(s) of business they will jointly agree to move to global risk. Contracts will differ based on product and benefit design as well as whether they cover individuals or are employer-based with family and individual deductions. As for products, Medicare Advantage plans alone can be preferred provider organizations, health maintenance organizations or private fee-for-service, mirroring traditional Medicare.

In all cases, the move to global risk means providers must understand and assess:

- Current membership attribution and utilization.
- Underwriting logic because they will be responsible for appropriate care regardless of the costs.
- Risk adjustment logic, which rests on the population's demographics and diagnoses to predict future expenditures.
- All pass-through costs, including taxes, sequestration, and re-insurance.

2. Covered Services
To gain more direct control over both care and costs, providers are accepting responsibility for services, such as credentialing, claims and utilization management, traditionally provided by payers. Decisions at this stage may include carve-outs, vendor-provided services and reinsurance.

Plans and providers need to agree on any carve-outs such as certain drugs or transplant services. Payers may keep the responsibility for these carve-outs and providers avoid the administrative and management burden related to those areas.

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For vendor-supplied services such as behavioral health, providers can accept the third-party cost or leave these services with the payer, especially if the payer has an existing long-term vendor contract. As for reinsurance, plans will offer it as a purchase add-on with an administrative fee to mitigate catastrophic claims, but providers could shop around to find a lower-cost option. It's often a question of cost versus convenience.

3. Membership Attribution/Assignment
While the LOB and product will help dictate the population, it's critical to clarify the specific membership attribution used by the payers. Typically, assignment is done by member choice. For some plans, when a member does not choose a PCP, members are automatically assigned to a provider based on an existing relationship determined by claims history. Voluntary plans also use claims data to attribute members to a PCP, but members can choose to stay with that provider or not—and the provider is still responsible for covering any out-of-network care and its costs.

Important questions about attribution to ask: How far back does the claims data go? Going forward, how frequently will plans run their attribution models and change risk pools?

Another major consideration is the health status of the members. How many are high-risk, high-cost? How many have chronic diseases? At the same time, what's the growth opportunity? Adding members typically means diluting risk. Is there any opportunity to work with the payer to grow the assigned members?

4. Cashflow
To budget appropriately, it's critical to understand the flow of money in and out. The beauty of capitation, from an accounting perspective, is that providers know exactly how much revenue they will receive every month.

Arriving at the payment amounts involves negotiating a number of important issues:

- Determining what is covered and finalizing the division of financial responsibility. The contract should clearly identify provider responsibilities and carve-outs, everything from sleep studies to primary care to home care and labs.
- Agreeing on retroactivity timeframes for all applicable reconciliations.
- Understanding retroactive utilization costs and setting sustainable premiums.
- Adding quality incentives, usually a percentage above the premium for meeting agreed-upon goals.
- Agreeing on a managed service organization fee for provider-delegated responsibilities, such as disease management and care coordination. The fees must be adequate to cover administrative costs.
- Resolving any restrictions on how funds can be deployed.

To drive behavior change that leads to improved quality and lower costs, payers and provider organizations should build in physician incentives. The potential gains, especially for PCPs, need to more than compensate for the added responsibilities and financial risk of value-based payments.

Finally, providers and payers need to agree on reserves. States generally set requirements. New York, for example, requires both payers and providers to put aside a certain percentage before approving an agreement.

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