Value-based and Hot Contract Issues

PAYER PERSPECTIVE

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Value-based Contracts

- New England Journal of Medicine survey of Health Leaders November 8, 2018:
  - 46% of respondents say value-based contracts significantly improve care quality
  - 42% say value-based contracts lower the cost of care

- Unifies Payer and Provider goals
- Beware of unequitable obligations or distribution of risk and reward

Value-based Contracts - Quality

- Quality based payments
  - Typically based on HEDIS metrics
    - Health Effectiveness Data and Information Set - industry standard quality performance indicators
  - Negotiate the targets
    - Based on national or regional performance
    - Year over Year improvement
  - Hierarchy Conditions Code (HCC) gap closure

Value-based Contracts – Shared Savings/Risk

- Percent of Premium
- PMPM Medical Cost Targets (MCT)
- Combination of Shared Savings and Quality
- Savings subject to Quality scores

Value-based Contracts - Cautions

- Watch for terms that allow the Payer to pass CMS penalties or paybacks on to the Provider
- CMS risk adjustment data validation (RADV) audits performed to validate the accuracy of payer diagnosis data which is the basis for member risk adjustment scores and determines the CMS payments to MA plans

Medicare Advantage Contract Payer Tactics

- Payers tend to quote CMS regulations as "required" when it favors them and not when it favors the Provider

- Attempt to pass their Medicare Advantage Organization (MAO) CMS obligations on to the Provider

Medicare Advantage Contract Payer Tactics – Payers Avoid Specific Terms

- Medically Necessary - watch for definitions that include terms related to cost as this should be based on defined medical criteria
  - …not more costly than alternative service
- Inpatient or next level of care authorizations
  - Most payers will follow NCQA (National Committee for Quality Assurance) time requirements or refer to CMS requirements (72 hours for expedited request, 14 days for non-urgent)
  - Provider should request quicker response such as 24 hours

Medicare Advantage Contract Payer Tactics – Payers Avoid Specific Terms

- Peer to Peer Review (P2P)
  - Limiting to the "attending" physician - specify P2P can be done by any provider familiar with the patient's clinical status
  - Set timeframe prior to issuance of a denial

CMS Regulations Additional Hit List used by MA plan Payer

- Third party payment obligations
  - Payers may try to limit your option to bill 3rd parties or to collect full payment
- Post termination requirements
  - Provider is not obligated to the extent the MA plan is
- Claim adjudication policies
  - Watch for policies more not consistent with CMS

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Additional Resources: HFM Magazine: Oct 1, 2018

A Blueprint for Building a 'Risk Ready' Healthcare Organization

7 Considerations in the Financial Modeling of Value-Based Payment Arrangements

CMS Medicare Managed Care Manual
https://www.cms.gov/Medicare/Medicare.html