Payer Contract Negotiations
Navigating the Transition To Value-Based Payment Models

Health Education and Learning Program Webinar
Small Rural Hospital Transition Project
National Rural Health Resource Center
April 24, 2015
Agenda

• Pressures on traditional fee-for-service contracting
• Commercial payer value-based purchasing initiatives
• Non-price contract terms
• Networking
• Direct contracting
Triple Aim
Three Dimensions of Value
Bringing Value to Healthcare

Sick Care → Population Health
Sick Care

Diagnose and treat presenting illness or injury

Population Health

Address preventive and chronic care needs of specific population
Sick Care

Risk Resides With *Payer*

Population Health

Risk Resides With *Provider*
Population Health Payment Models

- Narrow Networks – Tiered Benefits Plans
- Enhanced Fee Schedule – Care Management
- Pay-for-Performance
- Shared Savings Programs
- Bundled Payments
- Centers of Excellence
- Global Budgets
“Our goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018.”

“Our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018.”

• HHS Secretary Sylvia Burwell (January 30, 2015)
Fee-For-Service Tiered Pricing

Tiered Pricing is Part of Current Provider Network Strategy

<table>
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<tr>
<th>Total Payers</th>
<th>Yes 68%</th>
<th>No 24%</th>
<th>Don't know 9%</th>
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Anticipate Offering Tiered Pricing in Next 2-3 Years

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<th></th>
<th>Yes 48%</th>
<th>No 33%</th>
<th>Don't know 19%</th>
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SOURCE: McKesson Health Solutions, The State of Value-Based Reimbursement and the Transition From Volume to Value in 2014
Fee-for-Services Care Management

• Tied to patient-centered medical home initiatives
• Physician supported and payer-provided care managers
• Follow Medicare’s lead?
  – Transitional care management
  – Chronic care management
Value-Based Payment Models

SOURCE: McKesson Health Solutions, The State of Value-Based Reimbursement and the Transition From Volume to Value in 2014
What About Commercial Payers?

P4P Piggy-Back

• Medicare hospital P4P programs
  – Readmission penalty
  – Value-based payments
  – HAC/Never-event penalty

• Medicare physician P4P programs
  – PQRS reporting
  – Value modifier
  – MIPS
Non-Price Contract Terms

• Timely filing
  – Exceptions and extensions
• Prompt payment
  – Definition of clean claim
• Amendments
  – Deemed acceptance
• Termination
  – “Without cause” used to extract concessions
Non-Price Contract Terms

• Eligibility and preauthorization
  – Method for requesting and timeframe for response
  – Provider no fault provision

• Provider manual

• Credentialing process

• Grievance procedures
Network Contracting

• Four options
  – Single signature
  – Messenger model (represented negotiations/individual contracts)
  – Supported negotiation (individual negotiations/individual contracts)
  – Centralized support
Single Signature

- Network offers interested providers opportunity to participate
  - Terms of participation specified by contract between network and each individual provider
- Providers directly accountable to network (compliance, enforcement)
- Network negotiates with payer terms on which network providers will serve payer’s covered lives
- Network and payer enter into network provider agreement
  - Network directly accountable to payer
  - Each provider bills and collects on individual basis
Antitrust Concerns

• No issue if payer requests or voluntarily agrees to negotiate with network agreement
  – Effectively waives any antitrust claim

• If payer objects, may still pursue single signature contract if network demonstrates clinical or financial integration
  – Clinical integration = enforced shared protocols + care coordination
  – Financial integration = share financial risk
Messenger Model

• Network negotiates directly with payers
  – Non-price terms
  – Price terms
• Once agreement reached, payer circulates revised contract to individual providers
• Individual providers may negotiate additional terms and/or sign contract
• Network not party to any payer contract; individual providers solely responsible for performance under payer contract
Supported Negotiations

- Network develops and circulates to individual providers analysis of standard contract provisions
  - Explanation + proposed revision
  - Provider free to use in any way provider sees fit
- Individual providers responsible for direct negotiations with payers
- Network not a party to any payer contract; individual providers solely responsible for performance
Centralized Support Services

• Alternative to full single signature contract

• Network contracts with payer to deliver centralized care coordination and/or wellness and preventive care services for covered lives
  – Scope of services, quality measures, etc., defined in network-payer contract
  – Network paid by payer on flat rate or PMPM basis

• Provider contracting options
  – Network contracts with identified providers to furnish specified services
  – Payer incorporates into contract with individual providers
Direct Contracting

• Provider’s self-insured employee health plan
  – Training ground for clinical integration
  – P4P payments, shared savings arrangements
  – Narrow network

• Other employers’ self-insured plans
  – Wellness and prevention PMPM
  – Primary care global budget
  – Shared savings/global budget
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