6 practices for effective managed care contracting

When considering managed care contracts with health plans, provider organizations should use six practices, the first of which is to assess readiness to assume risk.

Healthcare finance leaders can expect to see significant use of value-based approaches to healthcare delivery and payment. In addition to approaches advanced by the Centers for Medicare & Medicaid Services (CMS), commercial health plans are initiating value- and risk-based approaches to varying degrees and depth in diverse markets. A non-negotiable element of this new value equation for insurers and providers is the need for an unremitting focus on improving quality, access, and efficiency.

Commercial arrangements vary significantly on the provider risk-assumption spectrum. Some carry zero risk through upside-only payments for meeting performance targets; others require providers to assume full financial risk for patient care in exchange for a per-enrollee capitated payment.

Assumption of risk by hospitals and health systems has been slow. A recent survey of large hospital systems found that only 16 percent of respondents derive 10 percent or more of net patient revenue from risk-based contracts, while two-thirds of respondents estimated deriving 1 percent or less of revenue from risk contracts.6

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Readiness and capabilities are key factors in the speed of change for both providers and health plans.

**Key Practices for Effective Contracts**
Described here are six practices that provider organizations should use in their assessment of any contract, whether risk-based or fee-for-service with pay-for-performance components.

*Assess the organization’s ability to meet contract requirements.* The first approach is to engage in extensive conversations in executive suites and boardrooms to answer two basic questions:

> At what level of risk are we able to participate in contracting arrangements now?
> At what level do we want to participate in the future?

Financial success for organizations will depend on bringing required capabilities to the arrangements. Lack of such ability represents strategic, operational, or financial risk. Although every value-based contract is unique, core requirements of participating organizations typically include:

> Patient access to the appropriate services in the right setting
> An organized process for care coordination across the defined continuum, including planning, outreach, and referral-, case-, and disease-management programs
> IT systems and point-of-service tools to allow for use of evidence-based protocols, identification of care gaps, evaluation and measurement of interventions to identify best practices, and assistance to all stakeholders in understanding payment and savings provided under alternative contracts and care models

For example, in assessing ability to meet these contracting requirements, organization leaders must determine whether they will need to hire clinical experts to supplement organizational expertise in care coordination models. If additional clinicians are needed, the timeline required to hire staff could diminish the amount and slow the timing of potential shared savings.

Similarly, actuarial expertise in new contract models and data analytics may need to be developed internally or outsourced.

Healthcare organizations can use quantitative criteria to objectively identify their comparative readiness to deliver value. Readiness areas include level of team-based care coordination, patient centricity, physician engagement, and clinical and economic alignment of care providers; strength of health information systems, network design, financial position, and health plan relations; and operational efficiency.

*Identify the terms proposed by the health plan and the associated costs before examining rates.* Developing or acquiring the capabilities to participate successfully in value-based contracts is costly, so managed care staff should focus first on what the health plan is asking of the organization. Evaluating the rates first and ignoring contract requirement costs is a common practice that leads to unrealistic revenue expectations. Contracting rates can be evaluated later, informed by a detailed analysis of participation requirements and associated costs.

Examples of insurer program “asks” include the following provisions:

> The requirement that provider practices achieve Level III recognition from the National Committee for Quality Assurance, or similar recognition from a nationally recognized quality agency, within 24 months following program implementation
> The requirement that a dedicated care coordination and care management function be created within the organization to manage responsibilities, including coordination of care among specialists, hospitals, nursing homes, case managers, and provider registry management
> Mandatory provider participation in health education and intervention activities developed by the insurer

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Managed care staff must take care to identify all expenses related to such requirements. Staffing, program development or redesign, training, IT infrastructure procurement and deployment, financial analysis, and certification costs can be significant, potentially offsetting revenues under the contract terms. Moreover, if these capabilities are nascent or non-existent for the organization, the time required to achieve proficiency also may affect potential revenues, depending on specified performance periods.

Contracts typically have a section called “provider obligations” or “program requirements.” These sections may be separate exhibits or appendices and usually contain only summary provisions of the requirements. The actual detailed obligations and the insurer’s rights to modify those obligations “at will” reside in provider manuals or policies that are part of the contract by reference, but not within the formal contract. If these documents are not furnished by the health plan, the provider should request them.

Because providers have multiple contracts with different participation requirements, it is imperative for them to identify detailed obligations of each contract and develop strategies to accommodate such requirements as efficiently as possible. Some providers choose to incorporate all requirements in their capabilities-development initiatives, even if some of the requirements aren’t necessary for some of their health plan contracts. Other providers develop a list of requirements that they consider to be “best practice” and try to obtain agreement on this list with health plans (described below in the discussion of “one standard of care”).

Educate clinicians on incentive-linked coding requirements. Managed care staff should initiate this effort by asking health plans to provide specifications related to all quality metrics used in shared-savings or shared-risk contracts. This information should include how metrics are calculated, inclusions and exclusions from calculations, codes to be used, time periods covered, and other data (see the sidebar on page 4). Also important is information regarding how and when the health plan is allowed to update the specifications.

These specifications enable contracting staff to understand how the health plan calculates rates based on the metrics for which it holds the provider organization accountable, and the organization’s ability to perform at a desired level. Health plans that are fully committed to improving quality will furnish this information, recognizing that their success is linked to that of the provider. Interoperability and meaningful data exchange between the health plan and the organization, while challenging, are required to align all parties.

Employed physicians referring patients to the hospital’s network should be educated about the coding requirements and quality metrics that are linked to incentives.

Employed physicians and other clinicians referring patients to the hospital’s network then should be educated about the coding requirements—and specifically quality metrics that are linked to incentives. Most of the metrics use CPT/HCPCS codes and diagnosis codes that typically are used for claims purposes.

Medicare’s physicians quality reporting program requires that, for billing purposes, physicians use CMS measurement codes specific to each measure to indicate whether the action described by the measure was taken. Ambulatory surgery centers, for example, are required to report quality data using measurement codes on five measures or face Medicare payment reductions.

c. These measurement codes typically begin with a G or end with an F.
These codes—which are used across all health plans, not just with Medicare—are challenging for hospitals and physicians for three reasons:

- The codes garner no payment results.
- Documentation of the codes takes time and can be cumbersome, making the process costly for physician practices.
- Some billing systems don’t allow measurement codes to be entered at all, because no dollars are associated with them.

However, measurement codes drive the metrics that drive the incentives for value-based contacts, so physicians and coding staff must understand the coding requirements and code accurately.

Obtain and compare necessary data. Hospitals should, as a matter of course, obtain cost and quality data from commercial health plans and government payers to assess participation in a contract or to select episodes of care based on the organization’s current performance and ability to reduce costs and improve quality. Data also are required for monitoring performance as the organization and affiliated providers deliver care and receive payments. Obtaining cost and quality data is not always simple, however, and once obtained, analytics competence is essential.

Hospitals may seek to partner with health plans and self-insured employers, which typically are willing to share historical data. Hospitals should validate the accuracy of the data and assess the likelihood of meeting performance benchmarks.

Managed care staff also should run the organization’s own data for contract metrics on a regular basis and compare these data with health plan reports. Such health plan reports typically are provided only at the end of each performance year and may not present sufficient information to understand required process changes. Additionally, health plans usually provide summary data by

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**Understanding Quality Components and Metrics**

Quality metrics are an essential consideration in shared-savings or shared-risk contracts. Information about these metrics typically is located in an appendix, addendum, or exhibit. The provider organization should be familiar with and understand the specific measures. For each metric, organizations should ask:

- How is this metric calculated?
- What data are used? (Are claims data used?)
- What time periods are used?
- Are the data normalized?
- What data are excluded?
- If codes are used (e.g., ICD-10, HCPCS, CPT), how are code updates handled? When are code changes made?
- Are the data auditable?
- Is there an appeal mechanism if the payer’s data report is inconsistent with the provider’s data?
- When calculating the quality scores, are the scores derived from the payer’s entire patient population or just those segments covered under the specific agreement?

It also is important for the organization to ask whether metrics are negotiable. The organization should request that metrics be changed only as mutually agreed upon and in advance of adoption and use (exceptions may be government programs or measures such as HEDIS).

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organizations need patient-level detail to audit health plan results and ensure they understand the metrics and calculations. Details would include—by metric—numbers and names of patients included, numbers and names of patients excluded, and criteria for a given patient that resulted in the patient score.

Robust analytic tools are available for contract modeling and should be used. Frequent review of the organization’s own data enables managed care staff and clinicians to gauge their current performance and identify where early efforts can be made to improve future quality scores.

**Aim for one care standard across contracts.** Hospital systems commonly have many contracts covering their patient populations. The standard-of-care-related metrics in these contracts often vary because, unless the specific metrics are mandated by state or federal regulations, health plans may have differing standards on how patient care is delivered under specific arrangements.

For example, patient access, equipment certification requirements, patient notification requirements, or even quality metrics may differ among health plans, and may or may not be relevant to a provider’s given population. Nonuniform and nonrelevant standards present operational problems for hospital systems. Metric measurement is based on sample size, so providers must understand how their patient populations will be accounted for in specific measures proposed by health plans, and the potential implications.

When negotiating a contract, a hospital should try to get the health plan to remove or revise metrics that are not relevant for the hospital’s patient population, programs, and market dynamics. These metrics should be replaced with metrics that will move the needle on desired patient outcomes. For example, providers with strong specialty practices would want metrics specific to those specialties.

Both the hospital and health plan should identify key executives to discuss the unique aspects of the organization’s patient population. The goal is to identify and agree on standards of care that will best meet common goals on improved quality and reduced costs, and the implications for any incentives or penalties. Organizations have different leadership structures, but participation of leaders in positions such as chief medical officer, chief nursing officer, COO, accountable care organization or physician–hospital organization executive, and quality staff should be considered.

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**Treat the contract as a living document.** Ongoing consultation, communication, and education for clinicians and their support staff by the organization’s contracting staff better ensure success under the terms of contracts. Different staff members will need to understand different elements of contractual goals, based on their position. Consider the following examples:

- Revenue cycle staff will need to know contractual fee schedules, fee schedule update timelines, precertification requirements, appeal rules, and claims submission rules.
- Credentialing staff will need to know health plans’ credentialing process requirements, notification formats, and timelines.
- Financial staff will need to know chargemaster increase and notification provisions, reconciliation processes, and timelines.

Department-by-department identification and fulfillment of education needs are recommended.

Metrics must be vetted by the clinical staff, who must have confidence in the metrics to be motivated to meet performance targets. These staff members can provide valuable feedback about what works and what doesn’t work and
should be encouraged to communicate their concerns about metrics and care standards to the contracting staff. Adjustments may be necessary.

Common Goals and a Common Experience
Health plans and providers should recognize through the contract negotiation process that they have common goals. Both need to succeed with their respective credentialing organizations and in terms of Triple Aim goals. Their models and programs, as reflected in contractual arrangements, must support the consistent delivery of coordinated care using standardized and achievable measures. Both parties require timely, accurate, and actionable data to measure success and to develop appropriate programs and interventions that will achieve desired outcomes.

Transparency, communication, and input ensure fairness to both parties and sustainable arrangements into the future.

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