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NEGOTIATION STRATEGIES FOR MANAGED CARE CONTRACTS AND SUCCESSFUL VALUE-BASED PAYMENT ARRANGEMENTS

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TODAY'S PRESENTER

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Adam regularly speaks to groups across the country on managed care contracting and value-based payment methodologies, bringing strategic counsel to clients that are responding to changes in their local marketplace, negotiating participating provider agreements and seeking to establish provider networks.

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AGENDA

- **Negotiating Strategies for Managed Care Contracts**
  - Identifying Strengths and Leverage Points
  - Negotiating Tips & Scripts
- **Key Terms for Value-Based Payment Arrangements**
  - Pay-for-Performance Programs
  - Access to Data and Reports
  - Shared Savings / Shared Risk Programs

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Negotiating Strategies for Managed Care Contracts

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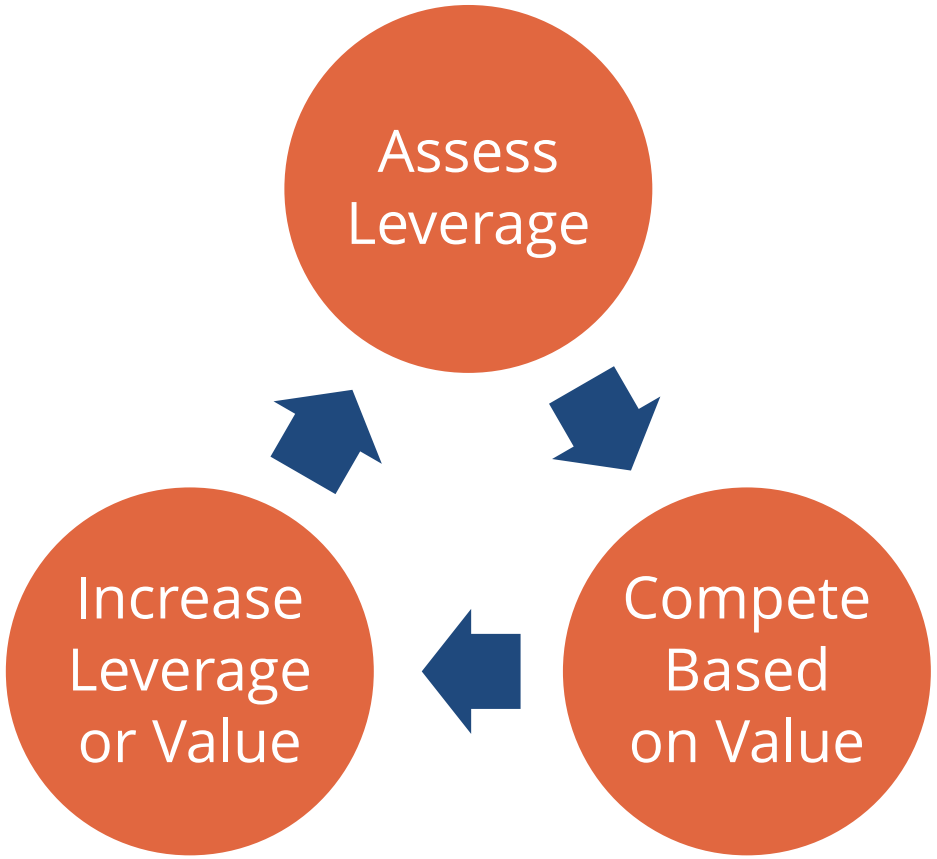
IDENTIFY YOUR STRENGTHS



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ASSESSING LEVERAGE: LEGAL

- **Possible Leverage Points:**
  - Participation: Is the MCO required to include me in its provider network?
  - Payment: Is the MCO required to pay me a specific rate?
- **Sources of Leverage:**
  - Federal Insurance Exchange / Marketplace rules (e.g., FQHC payment protections)
  - State insurance laws (e.g., prompt payment protections, commercial rate mandate for OMH/OASAS licensed entities)
  - MCO Contract with the State Medicaid Agency ("Model Contract")

- **Hint**: Key terms to look for: "provider network," "network adequacy," "network service," "payment," "FQHC", "network contracting requirements," and "minimum network standards."

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STATE INSURANCE EXCHANGES / MARKETPLACE PLANS

- **Payment Rates**. Federal law requires marketplace plans (QHPs) to pay FQHCs no less than Medicaid PPS rates for products offered on state insurance exchanges, regardless of whether the FQHC contracts with the MCO.

> PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.—If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offer or of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.

42 U.S.C. § 18022(g)

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STATE INSURANCE EXCHANGES / MARKETPLACES

- **Payment of FQHCs.** Federal regulation also requires marketplace plans (QHPs) to pay an FQHC at no less than its Medicaid PPS rate when the FQHC furnishes services to an enrollee of the QHP; however, the regulation permits the QHP and FQHC to agree to a rate below Medicaid PPS rates so long as the rate is not less than the generally applicable rate by the QHP to a similarly situated provider.

  - "If an item or service covered by a QHP is provided by a **federally-qualified health center** (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under **section 1902(bb) of the Act** for such item or service."
  - "Nothing in [the above] paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under **section 1902(bb) of the Act**, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section."

  45 C.F.R. § 156.235(e)

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NYS COMMERCIAL RATE MANDATE

- **OMH and OASAS Facilities**
  - Under the 2025 New York State Enacted Budget, and in accordance with Part AA of Chapter 57 of the Laws of 2024, effective on or after January 1, 2025, commercial insurers will be required to reimburse covered outpatient mental health and substance use disorder services provided by OMH and OASAS facilities participating in the plan's network at rates that are not less than the Medicaid rates for those services. See N.Y. Ins. §§ 3216(i)(31)(J), 3216(i)(35)(K), 3221(l)(5)(K), 3221(l)(7)(J).
  - Effective Date. "This act shall take effect January 1, 2025 and shall apply to policies and contracts issued, renewed, modified, altered, or amended on and after such date."
  - To assist with the implementation of this mandate, NYS has established a Commercial Billing for Behavioral Health (BH) Services webpage. This page provides rate and reimbursement information as well as interpretive support resources.

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NYS MODEL CONTRACT
PROVIDER NETWORK REQUIREMENTS

21.21(b) Federally Qualified Health Centers (FQHCs)

- In a county where Enrollment in the Contractor's MMC product is mandatory and/or the Contractor offers an FHPlus product, the Contractor shall contract with FQHCs operating in that county.
- The contract with the FQHC must be between the Contractor and the FQHC clinic, not between the Contractor and an individual practitioner at the clinic.

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ASSESSING LEVERAGE: MARKET POWER

- **Leverage Points:**
  - MCO has no alternative providers in market if it does not contract with me.
  - MCO cannot meet network adequacy requirements without me.

- **Understand Your Market:**
  - What organizations (if any) furnish similar services to me?
  - For each of my services, what percent of the market do I serve as compared to other organizations?

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ASSESSING LEVERAGE: TIMING

- **Leverage Points:**
  - MCO is establishing new provider network or product
  - MCO faces critical deadlines in order to enter marketplace by a certain date

- **Stay Informed:**
  - State timelines
  - Managed care entities
  - Your trade and professional associations
  - Your peers

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COMPETING ON VALUE

- Enhances your negotiating position because you can offer something of greater value than your competitors in the marketplace.
  - Sometimes referred to as “competitive advantage”

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HEALTH CENTER "VALUE"

- Research shows that health centers reduce the rate of preventable hospitalizations, inpatient days, and Emergency Department (ED) use, resulting in lower overall total costs of health center patients.
- Medicaid:
  - Health centers save 24% per Medicaid patient compared to other providers
  - Health centers saved Medicaid nearly $2,400 per patient in total annual health care spending.
  - The Health Center Program saved over $10.1 billion* in 2017 for Medicaid fee-for-service patients.
- Medicare:
  - Costs for health center Medicare patients are 10% lower than physician office patients and 30% lower than outpatient clinics.
  - Areas with high health center penetration have 10% ($926) lower Medicare spending per beneficiary.

See NACHC 2024 Chartbook, Figs. 6-3, 6-4, 6-7, 6-9

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INCREASE LEVERAGE OR VALUE

- Collaborations with other providers through joint ventures or integrated provider networks may increase leverage in the marketplace, enhance your value, or both, thereby improving your negotiation position.

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WHAT'S NEGOTIATION?

Reframe negotiation as discussion aimed at reaching agreement.

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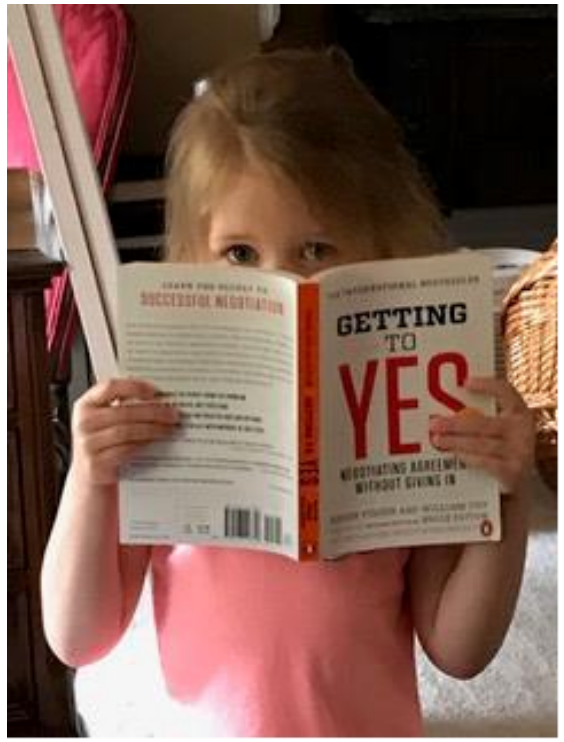
GETTING TO YES



- Fisher, Roger; Ury, William; Patton, Bruce (2011) [1981]. Getting to Yes: Negotiating Agreement Without Giving In (3rd ed.). New York: Penguin Books.

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NEGOTIATING LOGISTICS

Set the Stage for a Successful Negotiation

- Who will be negotiating?
  - A team?
  - An individual?
- How will issues be negotiated?
  - In writing?
  - By phone?
  - In person?

NEGOTIATING THE CONTRACT

Occurs when one or both parties get stuck in ensuring that they win on their positions, regardless of whether the overall goal is attained.

Occurs when parties take extreme positions with the expectation that they will have room to bargain down.

A common error is bargaining over positions.

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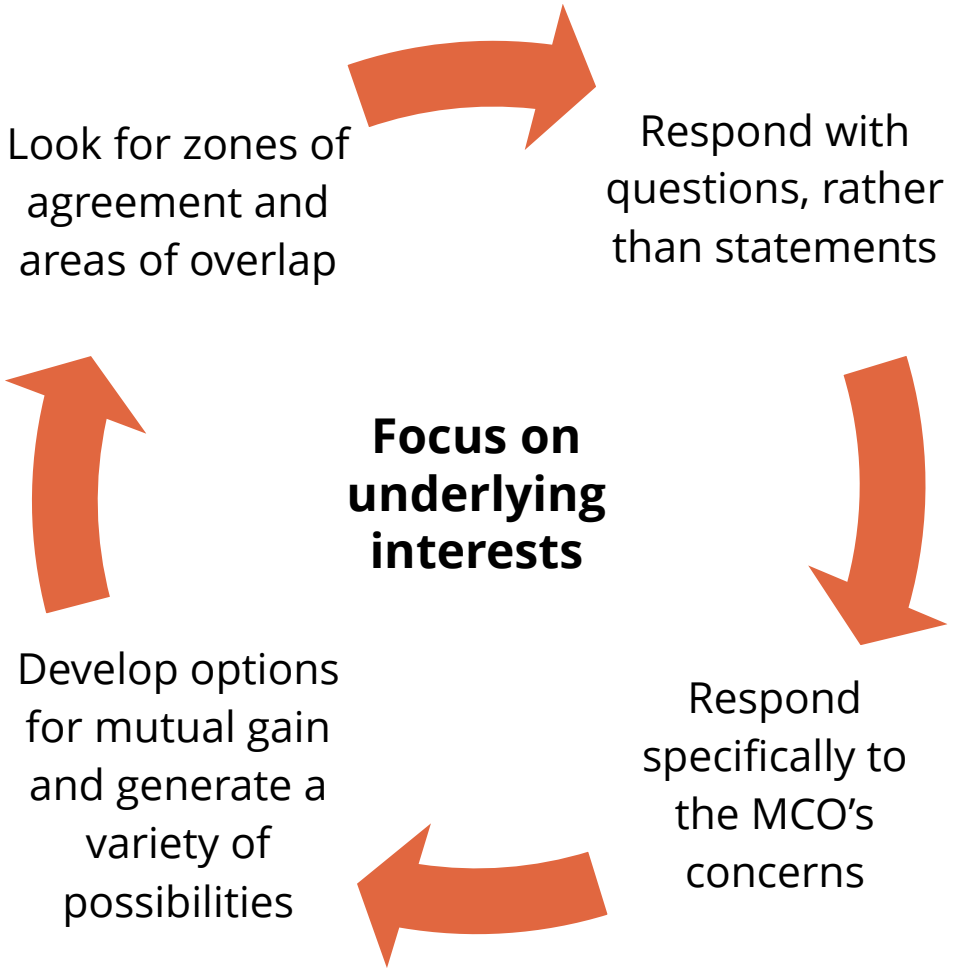
NEGOTIATING TIPS



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NEGOTIATION SCRIPTS

- Summarize your interpretation of the applicable contract provision.
  - *Is this your understanding of what the provision means?*
- Explain how the provision, as drafted, creates a problem or challenge for the health center.
  - *If X were to occur, then the impact on the health center would be . . .*
  - *It is unlikely that the health center could . . .*
- Ask questions to determine plan's intent:
  - *Did you really intend for the provision to have that effect?*
  - *Is that result what you had intended?*
  - *Had you anticipated that result?*
  - *What were you hoping to do or achieve from this provision?*

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NEGOTIATION STRATEGIES

- **Actively listen to the MCO's responses to your questions.**
  - Could any of the MCO's concerns be valid? Or are they based on incorrect assumptions or how they've "always done it"?
  - Address any incorrect assumptions (factual or legal) on their part.
  - Explain why "how they've always done it" might not be optimal or desirable in this situation.
  - Do any of the MCO's responses provide clues as to possible solutions or what the MCO might find acceptable?

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NEGOTIATION SCRIPTS

- **Float a possible solution, as potential questions:**
  - *Would it be OK if we added some language to clarify that…?*
  - *What if we replaced that with this?*
  - *What if there was an exception for [insert proposal]?*
  - *What if both parties had identical rights/protections?*
  - *Is there an objective standard that we could use instead?*
  - *Do you have any flexibility on [rates or other issue]?*

Key Value-Based Payment Terms

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HEALTH CENTERS INCREASINGLY PARTICIPATE IN NEW MODELS OF CARE

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Percent of health centers reporting…

The Commonwealth Fund

* Statistically significant difference compared to 2013 (p<.05).

Data: Commonwealth Fund 2013 and 2018 National Surveys of Federally Qualified Health Centers

Corinne Lewis et al., *Changes at Community Health Centers, and How Patients Are Benefiting: Results from the Commonwealth Fund National Survey of Federally Qualified Health Centers, 2013–2018* (Commonwealth Fund, Aug. 2019).

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PAY-FOR-PERFORMANCE PROGRAMS

- During negotiation of contracts (and contract amendments!) affirmatively request participation in a pay-for-performance (P4P) arrangements to maximize overall reimbursement
- To facilitate participation in multiple P4P arrangements, seek performance measures that have standard definitions and methodologies for calculating scores (*e.g.*, HEDIS measures)
- Health centers should:
  - Be familiar with the performance measures generally used by payors
  - Understand the financial rewards available to payors (if any)
  - Modify operations to score high on performance measures and
  - Leverage clinical performance for favorable P4P arrangements with payors

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PAY-FOR-PERFORMANCE PROGRAMS

- **Practice Pointers:**
  - Seek contract language that defines the patient population for the performance measures, describes the methodology for calculating scores, and sets forth the financial rewards available.
  - Seek contract language that excludes patients who have not received any services from a network provider within last twelve months from the patient population.
  - Do not agree to contract language that permits payors to change the performance measures (or methodology) after they have been established for any given performance year, without the provider's consent.

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ACCESS TO DATA

Access to Claims Data and Reports

- Timely, accurate, and usable data is essential for maximizing performance under value-based payment arrangements
  - Timely receipt of care gap reports and performance on clinical measures
  - Timely reports on performance on financial measures (e.g., MLR)
  - Claims information (e.g., emergency room visits, hospitalizations, and physical health care) related to the total costs of care of the attributed population
- Many contracts involving value-based payment arrangements are silent on the MCO's obligations to furnish data and reports or allow the MCO to decide which reports it will provide and when.

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ACCESS TO DATA AND REPORTS

Practice Pointers:

- Seek clear language that legally obligates the MCO to furnish data and reports that you deem necessary to do well under the value-based payment arrangement
  - Specify the type of data that the MCO will provide, the timeliness of such data, and the frequency in which the MCO will provide or update data in the contract
  - Identify the consequences in the event that the MCO's data and reporting obligations have not been met:
    - Will the MCO give full credit for impacted performance measures?
    - Will the health center be held harmless from any loss of revenue arising from downside financial risk?

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SHARED RISK / SHARED SAVINGS PROGRAMS

Practice Pointers:

- Review contract definitions for the benchmark and allowed expenses to ensure consistency with Medicaid/state contract and federal regulations
  - Ensure that benchmark's premium includes any one-time payments by a state Medicaid agency for certain life events (*e.g.*, deliveries) and additional payments to cover GME and, if applicable, FQHC wrap-around payments; fraud recoveries, prescription drug rebates, etc.
  - Exclude all claims for enrollees that hit re-insurance threshold (including those claims below the threshold)
- Negotiate a provision that requires the MCO to provide monthly or quarterly reports during the performance year on how expenditures for the attributed population compares against the benchmark
- Negotiate audit rights for MCO's calculations of any key benchmarks or performance against those benchmarks

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SHARED RISK / SHARED SAVINGS PROGRAMS

Practice Pointers:

- Do not agree to move from shared savings to shared risk in a specific time frame unless you are ready to assume downside risk
  - If the contract requires the provider to move from shared savings to shared risk within the term of the agreement, negotiate language that would permit the health center to delay that move if it has not generated savings over the last two performance years
  - If the contract involves a shared risk arrangement, seek contract language that limits financial losses to a percentage of total payments or the benchmark, or has a risk corridor that caps financial risk
  - Negotiate a provision that allows financial losses incurred in one year to be paid back to the payor financial gains earned in subsequent years

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FINAL THOUGHTS

- **Leverage Payment Protections and Health Center Value**
  - Seek supplemental (i.e., wrap-around) payments from CMS in the Medicare managed care program
  - Seek Medicaid PPS rates, or equivalent, for marketplace (exchange) plans per federal statutory entitlement
  - Seek Medicaid rates from commercial plans for OMH/OASAS licensed services per state law entitlement
  - Seek value-based payment arrangements in managed care contracts (i.e., primary care capitation, pay-for-performance programs, and shared savings/shared risk programs).
  - Use these slides to develop an internal checklist for reviewing contract terms for value-based payment arrangements

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