Design and Contracting Considerations for Plans & Networks for a Value Driven Healthcare Industry

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Historically, the healthcare industry has moved cyclically through periods of significant change in response to various drivers followed by periods of relative calm and consolidation - only to begin the cycle anew when conditions change again.

Driven by steady cost increases combined with various aspects of public policy, the healthcare industry is once again in a state of increasing instability as the revolutionary transition from activity-based to value-based care gets underway in earnest. Concurrently individual consumers are being more directly exposed to the cost of their health care in an effort to expand traditional (in other industries) market discipline on pricing.

Traditional health Plan designs and operational approaches designed to reimburse network Providers at varying negotiated levels based on activity are having to evolve to accommodate new concepts of what it means to perform and provide value to Plan sponsors, employees, and their Plan administrators.

For Employers, health Plans, and administrators the two sided question becomes:

What should Employers look for in Plan and network design and therefore what should Payers/TPAs offer and deliver?

Health benefit Plan and associated Provider network design are foundational to meeting Plan sponsor objectives. Here are some key health Plan and network design considerations for Employers and Payers/administrators as they shift to increasingly value-based and consumer directed healthcare Plans for their employees and members.

1. Requirements

As a Plan sponsor what are your specific Plan objectives and how are they prioritized?

Design of the benefit Plan for an employee population and design and creation of the associated Provider network are two different but obviously tightly related issues. Both should be driven by specific and individual Plan sponsor objectives. Employers should be clear and specific when articulating their needs and priorities. Payers and TPAs should naturally be responsive to their current and prospective Employer-Customer needs when designing and delivering products and services. Areas for requirements and priority consideration should include:

Attract and retain a highly qualified and high performing workforce?

The priority of this requirement in terms of benefit design can vary by factors including industry type, competition for employees in each location, and the current and near term health of the macro economy. Your employee acquisition and retention priorities and requirements may differ by employee level within the organization or by specific skill sets.

The relative importance of employee acquisition and retention for any population or subset will drive the investment Employers are willing to make in minimizing out of pocket cost, minimizing hassle, and maximizing access, service, and quality of care for the employees. As a consequence it will also drive the specifics of Plan and network design as well as operational performance requirements.

Balance Cost, Quality, Service, and Access?

This is a given. The question is, what balance for which populations? Higher quality and better service and access don't necessarily involve more cost but realistically they usually do. Clearly defining the level of overall investment you are willing to make and the balance you are trying to achieve will be critical to decisions on narrow or wide networks and formularies, Provider selection for network inclusion, level and form of employee cost sharing, and emphasis on value-based Provider contracting. Payers and administrators should consider offering multiple product designs to support various sponsor definitions of "best balance".

Shift to value-based contracting?

To what extent do you want your Plan to engage in pay for performance (value-driven) Provider contracting? Conceptually value based contracts provide tighter control over the balance of cost, quality, service, and access objectives described above. But there are real world tradeoffs. Generally these approaches work better with more narrow networks that better support tighter clinical integration. And depending on the specific Plan designs, there is a risk Patients may perceive that some services are being withheld in the interest of cost savings. There are also service level risks in that these are new approaches and administrative operations – processes and systems – are not yet stable.

Overall the industry is moving inexorably to value based care and contracting. But does your organization want to be a pioneer, early leader, or a follower in this regard?

Access as a design objective priority?

Access to Providers – defined as locality, breadth of Provider types, number of Providers from which to choose, and availability for appointments – is of key concern to all of us as Patients and Plan members. So it is worth special attention in defining your access requirements as a Plan sponsor. By definition, wider access means more Providers in a network which means less ability to steer volumes of Patients to those Providers which means less price negotiating power for those paying the bills. Employers must clearly understand:

► How their concentrations of employees match geographically to Provider locations. Are there enough Providers within reasonable distance? Are there rivers people won't cross? Are there parts of town where people prefer not to go?

► Are you a local Employer or a regional or national one? Do you need to consider multiple local healthcare market dynamics in determining network requirements?

► Are there significantly better branded and preferred Providers where your employees are? How important is it to honor those preferences?

► Do your employees and their families' demographics suggest that certain types of Providers must be readily accessible? How about cultural/language compatibility?

► Does your type of industry suggest that certain types of Providers must be readily accessible?

► Patient exposure to cost?

Patient exposure to cost through co-pays, deductibles, and premium contributions are key features of any benefit Plan. They comprise the major tool to influence Patients' selection of Providers and services. What is the total level of cost burden you are willing to place upon individual employees to achieve the selection and steerage objectives you prefer? And related, what level of cost sharing is necessary given your population demographics to influence behavior to the extent you are looking for? Finally, what overall level of cost sharing when combined with the Employer contribution will support the total healthcare program cost (and presumably value) you wish to be available to your population?

2. Transition to value based accountable and integrated care

Definitions

There is clear risk in these discussions of getting lost in the word salad and terminology. Let's define "value" as the buyer's definition of performance objectives for and best balance between cost, quality, access, and service. "Accountable" means that Providers are rewarded for achieving those objectives and balance across a population. "Integrated" refers to the level of both clinical and administrative coordination between Providers and across Providers, Payers, Sponsors, and Patients.

Value vs. Activity

A critical question is the extent to which the Plan pushes value-based versus activity based Provider reimbursement. Providers are generally very suspicious of being paid based on value. They are not used to it. Most will have to change their business models and practice patterns. They can see that the whole concept is designed to decrease their Patients' individual need for services. They don't trust that Payers will be able to make up that decrease in need with additional Patient volume to sustain – let alone grow - revenue. They don't trust the validity of metrics and methods that will be used to pay them. And they may even need to make investments in new systems and technology to support new clinical processes and performance reporting.

In short, many Providers are currently hesitant. If you push value-based design there may resistance by desired Providers to participation in your network. Since generally facilities are better able to manage the transition than smaller Provider practices some Plans are focusing value based reimbursement initiatives on facilities first leaving physicians on a fee for service schedule for now.

To the extent that you emphasize value-based reimbursement in the Plan and network design and contracting you need to Plan for using new approaches including bundling, shared savings, and/or partial or full capitation. You need to consider how to set baselines against which to evaluate performance. You need to define, measure and report performance metrics. You need to work out how reimbursements for populations or episodes of care will be allocated across multiple Providers that contribute to value. None of this is simple at the beginning. Expect to invest considerable effort and resources in moving along this path.

Scope of value-based focus

It is generally accepted that a key approach to improving care quality while managing cost is the integration of clinical care for a Patient across multiple Providers. Plan and network contracting design should at least emphasize this integration at an episode level. Design features that shift financial risk to Providers and directly relate reimbursement to quality outcomes such as bundling nicely dovetail with an episode of care focus.

An additional and broader consideration is the notion of designing and contracting to encourage the management and integration of care for the entire population of employees and dependents longitudinally across time. Integrating wellness initiatives, primary care, chronic disease management, acute care, and post-acute and long term care from both a population and an individual perspective is projected to be very effective at cost and quality management.

This will be achieved mainly through clinical coordination supported by effective information sharing across all the Providers in this spectrum. Plan, network, and contracting design should encourage this integration through targeted Provider selection, and strategic incentive alignment using financial risk shifting pay for performance driven approaches such as shared savings, capitation, etc. Support for proven common care protocols and state of the art concepts such as Patient centered medical homes is also key.

3. Balancing Access, Cost, and Quality through Plan and network design

Wide or Narrow

As stated previously, greater access generally means wider networks, more Providers, less pricing leverage and therefore higher total cost. Narrow or "high performing" networks if properly designed are arguably more likely to produce a good balance of cost and quality. They are more likely to be price competitive in exchange for volume – particularly in competitive Provider markets. And fewer Providers (but enough of each type) make it easier to coordinate and integrate care for Patients who receive all their care in network.

But other factors are also at play.

For one, history tells us that all other things being equal, consumers prefer wider networks with more choice and greater capacity. Thus the historic popularity of PPOs. As long as cost sharing was relatively low and Patient steerage incentives to use the lowest cost Providers in the network were mild, Patients enjoyed perceived easy access to a wide number of Providers.

So the challenge is to tailor network design to meet Plan sponsor balanced and prioritized objectives. Increased cost sharing has not surprisingly demonstrably increased consumer tolerance for less choice in Providers. But that doesn't mean they are happy about it. Factors that could potentially drive increasing acceptance of tighter networks include greater price transparency and better quality. Patients want to know in advance of service their total out of pocket expense. Real and clearly communicated healthcare quality – expressed in metrics that really matter to Patients – can buy a lot of acceptance of less choice and potentially somewhat lower service levels.

On the other hand a PPO or something like it can be designed such that in some sense it is a narrow network within a wider choice wrapper. You might consider a three tiered option using a narrow/high performance network core, a wraparound PPO, and a separate out-of-network benefit. If properly designed it can arguably find that sweet spot of Patient acceptance where there are strong cost sharing financial incentives to use the "truly" preferred Providers at its core while offering an "out" to access other Providers with less financial support if it is really important to the individual.

Centers of Excellence

Also an option is the inclusion of Centers of Excellence (COE's) in a network. Contracting with COE's to care for specific conditions or procedures can be both cost effective in terms of quality outcomes – even if travel cost is included) and attractive to employees – just in case they are needed. Employees and members like the idea of branded world class care for serious conditions. COE's can be either included in the main network or carved out and contracted by the Employer directly.

Reasonable Access

While working on network design be sensitive to "reasonable access" requirements and regulations at federal and state level as they evolve. The National Association of Insurance Commissioners is recommending sweeping new standards to address complaints from consumers about limited access to doctors and hospitals in health Plans sold under the Affordable Care Act. Even in PPO type designs the preferred/narrow part of the network should offer reasonable access by regulator definition.

Price Contracting

Price contracting is another key consideration. The traditional discounts off fee schedules is increasingly viewed as meaningless. It results in price being disconnected from true cost and at least to some extent value. In markets with significant Provider competition there is some competitive check on fee schedules. But in many markets where competition is lacking scheduled rates can rise unreasonably distorting investment priority signals to Providers in the process. Best practice today is to move to some form of reference pricing. Many Plans are defaulting to percent of Medicare fee schedules as a reasonable approach that rationally ties price to cost of delivery.

Finally, remember again that each healthcare market has its own characteristics. Sponsors and their payers and TPAs have an advantage in Provider competitive markets. High quality but narrow networks (or narrow preferred portions of PPO type networks) can be designed with excellent quality and decent access for reasonable cost in metro areas with multiple Provider systems in place for example. In non-competitive markets it may make more sense to consider COE type alternatives involving medical travel to Providers willing to offer high value and service in return for Patient flow.

Health Plan and network design and Provider contracting is a complex undertaking. Especially in an environment rapidly transitioning toward value-based care. While not a complete checklist of every possible issue, consideration of the topics described above will provide a solid foundation for success.

About the Authors

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Arlington Healthcare Group helps healthcare enterprises optimize their growth while achieving their financial, quality, service level, and compliance operational performance objectives.

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