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Contracting Guidance for High-Need, High-Cost Populations

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This document is intended to provide guidance for payers and providers as they engage in contract negotiations. This guidance is geared toward organizations that contract exclusively for high-need, high-cost (HNHC) populations and those that contract for broader populations with segmented HNHC groups. The recommendations below are tailored to the level of contracted risk.

There are 10 critical elements of an ideal contract process. They include: Type & Level of Risk, Data Sharing, Patient Population, Consumer Engagement, Service Requirements, Quality Metrics/Performance Evaluation, Provider Network Requirements, Financial Structures, Return on Investment, and Confidentiality Requirements. While a number of these elements have pre- and post-contracting considerations, one element listed here — Return on Investment (ROI) — is primarily conducted in the pre-contracting phase.

For more recommendations on contracting for the HNHC population, please read the companion report, Best Practices in Care Management Contracting for the High-Need, High-Cost Population, which features insights and recommendations from 11 interviewed organizations.

Contracting Recommendations

Type & Level of Risk

There are four categories of reimbursement that providers and payers may consider in their contracting strategies. They are:

Category 1: Fee-for-service, with no link to quality or value

All payments made on a per-visit/per-procedure basis; no financial incentive to reduce volume or improve quality.

Category 2: Fee-for-service, with links to quality or value

At least a portion of payments are based on quality and/or efficiency of care delivery.

Examples include:

- Foundational payments for infrastructure and reporting, such as per-member/per-month (PMPM) care coordination fees; and
- Pay-for-performance, such as bonuses for quality performance.

Category 3: Alternative payment models (APMs) built on fee-for-service architecture

Some payment is linked to effective management of populations or care episodes.

Examples include:

- APMs with shared savings only, such as an upside-only Accountable Care Organization (ACO); and
- APMs with upside and downside risk, such as episode-based (bundled) payments or Medicare Shared Savings Program Track 1+.

Category 4: Population-based payment

Payment isn't directly triggered by service delivery, and providers are responsible for patient care over a contracted duration.

Examples include:

- Globally capitated payments.

Provider considerations:

- Is the organization ready to assume risk, or will it be soon?
- Does the organization plan to contract for a primarily HNHC population or a broader mix of individuals?

- How does the HNHC program align with organizational strategy on risk-based payment?
- Can the organization afford to internally subsidize the HNHC program if savings are not achieved in the first few contractual years?

Payer considerations:

- What is the comfort level with service delegation?
- How much experience does the organization have administering different risk models? While some models such as episodes of care may prove effective at managing expenditures for HNHC beneficiaries, in practice few payers have the payment infrastructure to adequately support these arrangements.

Payer and provider considerations:

- Since payers will always need to ensure that beneficiaries receive adequate care management, provider contracting should be fair, equitable, effective, and reflect the level of service the provider is capable of successfully offering.
- Risk-sharing models should accomplish enough downside and upside to motivate real engagement in the process, as well as change.
- Identification of provider-subcontracted services, such as mental health or pain management, is critical for fee-for-service-based arrangements (i.e., Categories 1-3), as these services will typically be paid at higher specialist rates.
- As contractual risk increases, payers and providers should identify and include underlying mechanisms that will mitigate any potential for unintended consequences, such as stinting on care or cherry-picking patients.

*Note: categories as defined by the Health Care Payment Learning and Action Network. https://hcp-lan.org/groups/apm-refresh-white-paper/

Data Sharing

Data on a patient population is often needed prior to developing a risk-based contract to set accurate payments. Therefore, it is important to specify what data is required prior to contracting versus what is needed to operationalize the contract. If necessary, enter into a confidentiality or non-disclosure agreement regarding the data exchanged before a contract is executed.

Pre-contracting considerations:

Provider

- Is the organization pursuing a Category 3 or 4 alternative payment model? If so, has the organization secured access to a minimum of 12 months and a recommended 18 months of retrospective claims data on potential beneficiaries; and
- Have adequate resources been lined up, such as data analytics and actuarial support, to ensure sufficient analysis on the projected cost of the population?

Payer

- Ensure that the provider is able to safely house and analyze beneficiary data. Does the provider have:
  - » A secure claims data warehouse?
  - » A common file platform?
  - » The ability to format and scrub data?
  - » The capability to develop registries and use predictive analytics to identify and segment the HNHC population (especially important for Category 3 and 4 models)?
  - » Tools to internally monitor performance, such as scorecards?

Contract considerations:

- Assuming the considerations above are met, contracts should include secured access to the following payer data:
  - » Monthly retrospective claims data;
  - » Daily hospital census data;
  - » Supplemental health information, such as behavioral health data (as available); and
  - » Enrollment of HNHC individuals in supplemental care/disease management programs.
- Under the Health Insurance Portability and Accountability Act (HIPAA), the contract must include specifications about how the data will be securely transferred and handled. The contract should follow federal data use agreement guidelines in terms of how the provider will house and access protected health information (PHI) and personally identifiable information (PII).

Patient Population

Contracting for the HNHC patient population is a multi-step process that requires prior identification of the patient population (especially important for organizations that primarily contract for HNHC-eligible individuals), as well as post-contracting population segmentation.

Pre-contracting considerations:

- For providers that contract exclusively for the HNHC population, identification of the population must happen prior to contracting, and may be done by the provider organization with payer claims data or by the payer (see "Data Sharing" above). Some patient types may be excluded from the contracted population due to factors such as:
  - » Age;
  - » Co-morbidities;
  - » Specific patient history; and
  - » Recurrent episodes.
- Patient identification directly informs pricing negotiations, particularly in Categories 3 and 4 models. It may also play a role in establishing PMPM care management fees in Category 2 models.
- Providers that engage in whole population contracting typically do not employ sophisticated HNHC patient identification prior to contracting.

Contract considerations:

- The contract should clearly state which populations, if any, are excluded. For example, children with special healthcare needs or individuals with specific disease states may be carved out.
- The contract should also include a description of how the population will be segmented for care management, and activities applicable to each segment.
- Any carve-out populations should be carefully considered by both parties, and a plan should be put into place for management of these individuals.

Post-contracting considerations:

- Providers should conduct additional internal analysis on the contracted population to further segment into sub-groups for targeted intervention. Segmentation typically combines data from a variety of sources, including administrative claims data and internal provider data such as EHR records.*

*For best practices in segmentation, please reference Population Segmentation and Targeting of Health Care Resources: Findings from a Literature Review, published by Mathematica Policy Research. Available at: https://www.mathematica-mpr.com/our-publications-and-findings/publications/population-segmentation-and-targeting-of-health-care-resources-findings-from-a-literature-review

Consumer Engagement

Providers and payers must think about how they can provide relevant information and resources to individuals and caregivers to promote trust and engagement. They should consider including contractual language around the following:

- Shared care planning, including descriptions of who is on the care team, whether there are dedicated case managers, and the role of individuals on the team (also see "Service Requirements");
- Description of beneficiary cost-sharing and specifics on how that information is communicated;
- Shared decision-making and engagement tools;
- In any model where providers are at risk for cost, standards for informed consent, including written description of treatment options;
- Full patient access to health records on a secure platform;
- Patient access to comparative provider quality information;
- Identification and collection process for Patient-Reported Outcomes Measures (PROMs); and
- Processes for assessing individual capacity for self-activation, barriers to activation, and support to overcome barriers.

Service Requirements

Service requirement definitions, including scope of services and division of responsibility, are some of the most essential elements of any contract.

Contract considerations

- Providers should have input into the contractual benefit design structure. Contracts should clearly state which services will be provided by the provider versus the payer. As most payers have at least some capabilities for care management of HNHC individuals, there may be some division of clinical responsibility for certain aspects of patient care.
- Division of clinical responsibility is especially important in Category 2 models, in which providers are paid a set PMPM for provision of services. Lack of clarity on responsibility division may result in underpayment for services, which could unfortunately prompt curtailing of necessary services for HNHC beneficiaries. However, division of responsibility is also important for more advanced risk models as well.
- Contracts should include the following:
  - » Delegation of core services;
  - » Mental health (services are optimally integrated as opposed to carved out);
  - » Terms of partnership between plan and provider on chronic and rare diseases; specific diseases should be referenced (lists are typically kept by payers); and
  - » Structure of care management services to be provided:
    - Program and care team structure
    - Authority for final care management decision-making.
- The level of shared clinical responsibility will vary significantly by payer/provider capabilities and by level of risk assumed by providers:
  - » **Category 1 and 2 models:** Significant involvement by payers, but variation depending on line of business. Medicaid beneficiaries and dual-eligible/special needs plan participants more likely to receive payer-directed and administered care management across areas such as transitions of care and medication management.
  - » **Category 3 and 4 models:** Less involvement by payers, with total-cost-of-care models delegating virtually all care management responsibilities to providers. Payers may still retain certain aspects of care management, such as 24/7 telephonic help lines, under Category 3 APMs.

Quality Metrics / Performance Evaluation

Quality metrics and performance evaluation should include a well-curated set of metrics that are relatively straightforward to collect and ideally applicable across multiple payers.

Contract considerations

- The contract should specify a set of quality measures that are directly related to HNHC patient management. These measures would ideally be non-payer-specific to minimize provider reporting burden. Good quality measures should:
  - » Focus on metrics that are meaningful to the person, providers, and payers;
  - » Limit reporting to a manageable number of metrics; and
  - » Minimize the burden of collecting data that isn't easily accessible.
- There are several potential sources for quality metrics, including the Healthcare Effectiveness Data and Information Set (HEDIS), the Center for Medicare and Medicaid Services (CMS) programs, International Consortium for Health Outcomes Measurement, specialty societies, and patient advocacy programs. Contracts would also ideally include PROMs (see "Consumer Engagement").

Financial Structures

Ensuring that the patient is cared for in a financially responsible way should be the primary goal of any contract. Also, explicitly defining the Division of Financial Responsibility (DOFR) will promote synergies and reduce duplication in services between payer and provider. Specific terms will vary by contract and population type, but the following are components that should be considered for most contracts.

Contract considerations

Category 2:

- Defined dollar amount per patient, payment frequency (monthly, yearly) for care coordination/care management services, in addition to payment for fee-for-service encounters; and
- Underlying methodology for payment calculation; should be based on historical spending patterns, geographic location, and informed by provider assessments of expected cost.

Category 3 and 4:

- Attribution and payment methodology, based on historical claims and/or Medical Loss Ratio (MLR)-based (depending on model);
- Stop-loss and/or reinsurance thresholds (based on the size of the population and organization's financial reserves);
- Risk corridors (based on organization's financial reserves and comfort level with risk); and
- Risk adjustment for population case severity.

Other considerations:

- Organizations should factor in scope of service costs, including non-discretionary cost increases.
- Identification of a ramp-up period is key. How long will it take to achieve desired outcomes for contracted services? Organizations should develop appropriate ramp-up models that factor in the number of patients as well as expected time for quantifiable health impacts, which will in turn inform contracted outcomes metrics.

Confidentiality Requirements

Confidentiality requirements should follow standard protocol for any contract containing PHI or PII. See "Data Sharing" above for more detail on confidentiality in data storage and transfer. Also see HIPAA Title II for guidance.

Return on Investment

ROI forecasting is an important activity that should be undertaken independently by providers and payers prior to entering into any contract.

Contract considerations:

Payer and provider:

- Payers and providers should engage resources such as actuarial, finance, and data analytics to model projected ROI.

Provider:

- For providers entering into Category 3 and 4 models, predicting how long it will take an organization to break even on infrastructure/program investment is key. This will also help inform negotiations on contract cycle length.
- For providers pursuing Category 4 models, recommended contract duration is three to five years. In some instances, contract duration may only be two years.
- ROI is also important for providers in Category 2 models that rely on PMPM/PMPY to finance HNHC care and disease management programs. Understanding what funding is needed to offset fixed program investments and ongoing expenses is critical to ensure long-term sustainability and access to care for all beneficiaries.

Payer:

- For payers, ROI forecasting should involve ongoing assessment of patient outcomes relative to provider payment, especially in the case of shared responsibility for services.

Glossary of Terms and Acronyms

DOFR: Division of Financial Responsibility. Term used to identify the formal breakdown of financial responsibilities between parties — in this instance, payer and provider.

HIPAA: Health Insurance Portability and Accountability Act of 1996. Contains five sections. Title II requires national standards for electronic health care transactions and requires organizations to implement specific security standards for accessing and storing data.

Leakage: When patients seek treatment outside a contracted network. Typically used in reference to closed-network systems.

MLR: Medical Loss Ratio. A contractual specification that requires insurers to put a certain ratio of every dollar toward medical claims and quality improvement activities, as opposed to administrative expenses.

PHI: Protected Health Information. Any information about health status, provision of health care, or payment for health care that can be linked to an individual. Includes 18 specific identifiers specified under HIPAA such as name, social security number, and medical record number.

PII: Personally Identifiable Information. Any information that can be used on its own or with other information to identify an individual. While PII is not definitively linked to one category of information or technology and is assessed on a case-by-case basis, specific examples of identifiers include name, address, social security number, and date of birth.

PMPM/PMPY: Per Member/Per Month or Per Member/Per Year. Typically refers to a fixed payment from an insurer to a provider for a patient.

PROM: Patient-Reported Outcomes Measures. Measures that are based on patient reports of how they feel and what they are able to do. While PROMs are receiving greater recognition and acceptance within the health care sector, they are still not in widespread practice.

Reinsurance: Also referred to as stop-loss coverage, reinsurance is insurance that is purchased by a payer to cover expenses/losses above a certain dollar amount. Reinsurance usually kicks in once the insurance has paid the agreed-upon amount and will cover the delta between the insurer's payment and the total cost.

Risk adjustment: A statistical process undertaken by an insurer to adjust payments to a provider based on factors such as health status and health expenditures for a particular group of beneficiaries.

Risk corridors: A range in which a provider or payer is responsible for financial gains or losses. Losses or gains are limited beyond the allowable amount. Often used in fee-for-service-based (Category 3) risk arrangements.

ROI: Return on investment. A measurement of the gain or loss created by an investment in relation to the amount of money invested.

Tertiary/quaternary care: Highly specialized consultative care, usually provided upon referral from a primary or secondary provider. Usually associated with a large specialized treatment facility and/or academic medical center.

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