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Trends in Managed Care Contracting

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The Network Value Principle
Why enter into contracts?

- Trade discounts for volume to build preferred partners – 'steerage'
- Networks became broad so carrots turned into sticks
- Fee-for-service payment creates adverse incentives, unit pricing is opaque and total cost of care measurement is elusive

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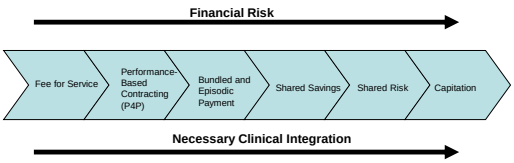
The Move Away from Fee for Service
The Journey to Risk



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Performance, Utilization Risk at the Core of Accountable Care

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Which Model will Prevail?
Population Health vs. Consumerism

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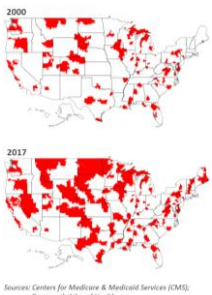
Consolidation will continue.



Sources: Centers for Medicare & Medicaid Services (CMS); Dartmouth Atlas of Healthcare

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Everybody wants more and better data.

- Data sharing between payers and providers creates a more complete picture
  - Risk profile of patients
  - Outstanding gaps in care
  - Social determinants of health
- Collaboration creates better outcomes
- Opportunity to reduce administrative burdens

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Unit cost increases will moderate.

- Utilization is important but does not account for the majority of inflation
- Cost shifting onto a smaller base cannot be sustained
- Trend increasingly must be earned
- Unit cost increases are baked into total cost of care calculations

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Site of service will matter as much as the rate.

- Payers are pushing for lower cost settings
  - Imaging
  - Outpatient Surgery
  - Infusion
- Controlled movement now or lost opportunity later
- Some health care services might not be worth keeping in-house

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The move to transparency is waning.

- Fatigue among consumers trying to get actionable data
- Provider systems discourage fragmented care
- Out of pocket maximums still incent you to care until you don't anymore
- Health care events are unforeseen and for most people, non-repeating

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Contracted pricing regarding network composition will keep everyone honest.

- Narrow networks trade discounts for steerage
  - ACOs are the new HMOs
  - Benefits define steerage
- Tiered networks steer to (or away from) providers due to higher price or lower quality
- Administrative burden reduction has economic value

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Long term deals will be harder to get.

- Arguments over trend are ongoing
- The future is uncertain
- Upside risk and downside risk are not even close to the same thing
- Do not take responsibility for things you cannot control

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Projecting reimbursement will become even more challenging.

- Total cost of care value contracts will continue to grow
- Reconciliations over multiple years may become the norm
- Everybody follows CMS and the federal government is hard to follow
- Large systems will look for reimbursement diversity

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The Imperative is to Lower Costs

- End of life care is a large cost driver and Medicare and Medicaid shortfalls promote cost shifting
- Unit costs must keep track with general inflation
- Providers must do less with less
- Healthcare needs a strong dose of market reality
  - The strong players must be allowed to win
  - Only competition lowers costs
  - Inefficiencies need to be driven out
  - Consumers should get a better product

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Managed Care Must Play A Strong Role

- Liaison between the Patient, Payer and the Provider - and between Finance and Clinical Operations
- Should be an advocate for the consumer
- Forward-looking to see where the market is going