FEATURE

Right On Target
with **Direct Contracting**

Direct contracting with high-performance provider networks expected to raise the bar on quality of care

Written By Bruce Shutan

Targeted direct contracting, also known as a narrow or high-performance network, has garnered growing attention in recent years – and for good reason. The push for greater transparency on the price and quality of healthcare, as well as a market teeming with data-driven solutions, deserves the most credit alongside other considerations.

This more sophisticated model enables self-insured health plans to assert great control over the cost and quality of surgery, imaging, dialysis, physical therapy and other specialty medical services, observes Bud Brooks, president of Brooks Healthcare Solutions, LLC.

He points to a host of distribution or channel partners who play an important role in deploying direct contracts to multiple payers, other health plans and various groups that need access to preferred rates and contracts. What these partners in effect do is place those contracts into a host of different employers downstream that are their clients, he explains. The convenience of having them do all the work makes it particularly palatable. Also in the mix are convener clients such as Lantern, formerly SurgeryPlus, which acts as the TPA, although he says they're only doing the surgical benefit program and nothing else.

"They're not a benefits administrator in the classic sense," he says. "They're the ones who have the actual downstream employers, and they get the contracts and deploy them to the members of their clients.

Cristin Dickerson, M.D., founding partner of Green Imaging, lauds narrow networks and some of the non-traditional, direct primary care (DPC)-centric health plans that are emerging, noting how direct contracting arrangements are increasing markedly and moving upstream.

Cristin Dickerson

"Patients want to feel like they have a health plan, not all these silos with different numbers to call," she explains. "People of different socioeconomic levels use healthcare differently, "and so I think we have to answer their pain points."

SCALING BARRIERS

While believing that medical providers working directly with employers is always a good move, Employers Health Network (EHN) CEO Blake Allison says the challenge is overcoming a scale problem involving a limited set of employers of all sizes in aggregate, trying to work with a health system or providers. "How does a $10 billion organization in Houston that sees millions of lives do a direct deal for an employer that might have 500 lives? The two just don't add up," he says, noting the importance of creating a scale point that enables health plan sponsors and members to get the value they pay for.

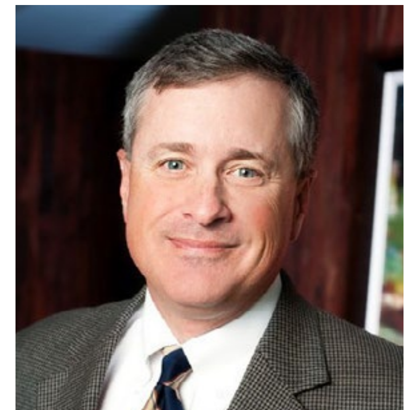
Employers are finding barriers to high-quality care, which is why they're paying an extra fee for concierge access to a primary care physician and urgent care for their employees, notes Tayebe Shah-Mirany, vice president of PsycHealth Care Management, LLC.

In her area of expertise, which is behavioral health, she recalls how the pandemic made coverage for mental health and substance use disorder all the rage with payers approving these services for the first time via telehealth.

"All of a sudden, you had a lot of organizations popping up nationwide that were part of a behavioral health network," without any care coordination or handholding, she says, concerned that the virtual deliverable was nothing more than watered-down care. Lawmakers have taken note of the role technology plays. In Illinois, where her firm is based, she reports that one of the nation's first state laws was passed banning the use of artificial intelligence for therapy in behavioral health.

With targeted direct contracting, the mission is to secure access to quality providers in a specialty network who know what they're doing and understand quality measures, such as following up after discharge. Behavioral health is top of mind for reinsurers who have told her these claims are among their most costly cases.

While telehealth can significantly widen access to behavioral health, Shah-Mirany says there are caveats to consider. "You would be shocked how many folks prefer brick and mortar to telehealth to really connect with someone in person," she says. "It's the same thing we're finding why employers are bringing people back to the office and why employees are being isolated in their workspace. They have nobody to talk to. This is what happened with Covid."


Bud Brooks

When it comes to vetting providers for targeted networks, Dickerson appreciates the philosophy of Nurse Deb Ault, president of Ault International Medical Management, who believes that great care, no matter what the price tag is up front, is going to be cheaper because it will avoid problems down the line.

A RESPONSE TO DILUTED VALUE

Two factors have accelerated the use of direct contracting in recent years, Allison opines. They include the realization that PPO networks

were diluting value over time and post-COVID price increases on the back end of inflation. Health systems also started to push back on reference-based pricing, which made it more difficult to access health systems. The way around that was to contract directly with providers. His company works exclusively with specific health systems in a market to build high-performance provider networks around directly held contracts.

Addressing why there's not more widespread adoption of directing contracting, Allison cites decades of muscle memory from familiar name-brand BUCA plans, creating a sense of comfort with their coverage options. Another is post-COVID employee sprawl. For example, if 20% of a 100-life group based in Orlando, Fla., now work remotely from Bozeman, Mont., Jackson Hole, Wyo. or other areas, it's not possible to cover everyone with a direct contract – though different options could be made available to employees outside headquarters as a workaround.

The site of care is as much about quality assurance as it is convenience. Multistate employers preferring to contract with one national organization to handle their employee behavioral health needs is short-sighted, according to Shah-Mirany. "They should find the best of breed within a state or metropolitan area if they want to ensure quality, outcomes, cost savings and oversight," she suggests. "All healthcare is indeed local – and it's important to work with organizations that understand the locality and the patient populations that reside there."

Shah-Mirany encourages self-insured employers to prioritize with their broker and TPA the importance of having employees access a cost-effective network of hands-on care in direct contracts rather than continue to pay an extraordinary access rate for a mediocre network featuring arms-length transactions.

MEMBER NAVIGATION

Patient engagement, of course, starts at open enrollment. "Most of our TPA partners on the high-performance, narrow network side require that there's a concierge program," Allison says. "The member needs additional support because healthcare is hard enough to navigate." Members also need to be incentivized to choose certain providers, he adds.

Tayebe Shah-Mirany

Care navigation is fundamental to the success of direct contracts, according to Brooks. "You've got to have somebody who can advocate with patients, explain to them the options and then gently convince them that the right thing to do is to go to see this surgeon at this facility because the quality of the doctor's experience level, where there will be zero out-of-pocket cost that the member will enjoy," he says.

Having the right navigation in place offers tremendous value. "I think consumerism has failed in healthcare because seeking any type of healthcare is stressful and it is complicated," Dickerson observes, noting the importance of examining how navigators are being paid so that incentives are aligned with ethics. Some are receiving a referral fee from the imaging center on top of a per-employee-per-month fee from the employer, she cautions.

Another issue she says to consider is how they're assuring quality and what tools they're using. "If a pre-auth is used to redirect to a higher quality, lower cost site of care, that's fantastic and what it should be doing, especially if there are no delays," she notes.

The most successful marketplace solutions are steeped in the education they provide – not so much the platforms themselves and IT talent behind their creation, Dickerson believes. "It helps to have subject matter experts in your health plan," she explains. "I can't tell you how often the HR person or broker calls me saying, 'we've got a patient with this problem. Can you help with this?' Having subject matter experts and physicians in your health plan is critical."

PHYSICIAN RESISTANCE

It's not surprising that the medical establishment's response to direct contracting has been largely lukewarm. Brooks believes it's difficult for providers to divest themselves from large health systems because they provide such a huge revenue pipeline. While a direct-contracting program with employers may result in slightly lower reimbursements, he says it's a much smoother, cleaner and seamless process for providers who don't have to put up with BUCA payer hassles.

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"They may be the only game in town, so therefore they're getting patients who they otherwise may or may not have ever seen, and there's no out-of-pocket expense to collect," he explains. "The cases are referred by a care navigator who has the authority to make the referral. Therefore, they don't have to worry about pre-authorization anymore."

In preparation for a Free Market Medical Association meeting in Houston, Dickerson noticed a resistance to direct-contracting alternatives. "I think people coming out of training programs are just so ingrained that they're going to work for a large hospital system, and they have so much debt that they hope these entities will assist them with that; it's hard for them to see another path," she laments.

On the other hand, she spots more doctors her age who are frustrated with the system, doing locums (temporary medical services to fill a staffing gap at a healthcare facility) to bypass the pressures of an office practice or embracing DPC, which is a means of direct contracting.

In spite of doctors' perceptions of the direct-contracting model, Dickerson says it's imperative that self-insured employers carefully read their contracts. "You've really got to look at how a TPA gets paid and be willing to pay more upfront so that they won't take kickbacks on the other side," she advises.

A TRACK RECORD OF RESPECTABILITY

Those who are best positioned to thrive in targeted direct contracting will be individuals who have been engaging with independent physician associations, value-based health systems and payers since the 1980s, Shah-Mirany believes.

"In order to be in a risk arrangement or HMO, you have to have all the tools in your organization to manage healthcare, almost like a mini-HMO system because you're taking on utilization responsibility, care coordination, responsibility, credentialing and the financial risk of ensuring care at the right time, right place and right cost," she says.

While direct contracting may dabble in case management, wellness and other areas, she notes that they're actually getting to what is driving the cost of care. "Those of us who've been doing this for a long time understand the wraparound services that are necessary to have good outcomes and quality," she says, noting that payers regularly audit the specialty network of behavioral health services her firm offers for quality, utilization and case management.

Her firm has peer review and credentialing committees, does primary source verification to confirm the accuracy of a clinician's credentials and checks each individual's malpractice history. "At the end of the day, you're looking for qualified folks with proper licensing and education," she says. "Once you're working with them, then you can start to discern where these people are falling on the continuum of quality and outcomes."

One major goal is to avoid the burn-and-churn cycle, wherein patients become dependent on their clinician. Rather, the mission is to teach patients the coping skills needed to stay sober and live their best possible life. Periodic check-ins with clinicians about their patients also help manage the quality of care being given.

When vetting providers, EHN will tap into national data from Leapfrog and the Centers for Medicare & Medicaid Services, as well as work with health systems that do value-based work, "and have as much data as we can get our hands on," Allison says, including a mechanism to remove poor-performing providers from their network.

Blake Allison

Targeted direct contracting is expected to continue trickling down market,

where smaller employers will be able to leverage the same high-quality care as their larger counterparts. What's so appealing about a group stop-loss captive for Dickerson is that her company doesn't have to onboard 50 small level-funded plans and do 50 different implementations. “We get the whole group. We can do one implementation,” she says. “It helps us provide access to smaller groups.”

Whether or not enough of her fellow physicians decide to take the plunge on this emerging care model, she’s sanguine about the future. “There are a lot of tremendous opportunities out there not just for holding down costs, but also for providing better access and giving people better care,” Dickerson observes. “And I think it’s critical that any new healthcare ecosystem basically gain back trust from patients because it’s not there right now.” ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 35 years.

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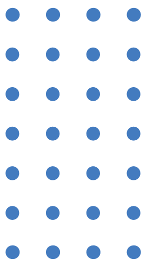

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