Case Study:
Health Cooperative of Missouri

Scaling Community Access with a Direct Contract Administrator

<u>Details at a glance:</u>

Community Access Program: Health Cooperative of Missouri
Case Study Dates: 2019 – January 2022

Direct Contract Administration: Health2Business

Plan Funding: Self-funded
Industry: Any
Client Size: 2 employees and up
Third Party Administrator: Any
Vendor Stack: Any
Health Rosetta Benefit Advisor: Jason Swindle
Advisor Organization: TIG Advisors | Columbia, MO

This Case Study begins with healthcare providers who recognized that collectively they could offer a solution to employers in their region for affordable, sustainable access to their services. In 2019, some hospitals and providers in rural Central Missouri began collaborating in earnest to make their services available via direct contracts. The goal was to create a Community Access Program (CAP), an open, transparent, self-funding alternative to traditional networks like Cigna, Blue Cross, and Humana. Offering this Community Access Program to employers would make it possible for local, independent doctors to serve their communities in a meaningful and replicable way.

When we look at the number of direct contracts in place, or the number of Community Access Programs poised to serve employer health plans, challenges persist in the ability to scale these solutions. Over the last five years, the number of direct contracts has increased sharply, though most of these contracts have been implemented between a single employer and a single provider without the ability for other employers to join. Contract administration has been relegated to vendors with limited competency in the direct contracting arena. Insufficient provisioning for additional parties or infrastructure to permit scaling of contracts has, in turn, limited the potential growth of Community Access Programs, as the members of the Health Cooperative of Missouri discovered.

Key Players

Health Rosetta Benefit Advisor Jason Swindle was involved from the initial point where these hospitals and providers banded together to form the Health Cooperative of Missouri. Swindle represented local employers with self-funded health plans seeking ways to remove barriers to healthcare access and affordability for their employees. He was able to educate the providers in the Cooperative about the potential opportunity direct contracts could foster with employers. He helped lead one of the first employer groups into the Health Cooperative's CAP and contributed to the group's ability to participate without friction.

Orchestrating provider participation and communication while propelling the idea to fruition was stakeholder Jim Tune. Tune became the CEO of the Health Cooperative in 2019. In addition to leading the charge to bring these providers and services together to form a Community Access

Program, he was accountable to the Cooperative's board of directors comprised of regional providers and local hospital CEOs.

Lastly, the providers contributed time, energy, and thought, as they joined forces in trying to figure out how they could create a sustainable and beneficial service offering to their community.

These key players shared the question: *How do we make a scalable offering out of direct contracts so that Employers can include the contracts in their Health Plans?*

Employer Health Plan Decisions and Access

When it comes to Employer-sponsored health plans, Employers have four areas of responsibility. They must determine:

1. How to access healthcare
2. How claims will be paid
3. How to access prescription drugs/pharmacy
4. How to structure stoploss to manage large claim risk

The Missouri Cooperative providers sought to present employers a solution to the first decision point: how to access healthcare. Imagine if you will, the classic play toy, Mr. Potato Head. The foundation is the potato, with eyes, ears, noses, mouths, and all kinds of accessories that can be configured in any way desired. Bundling any combination makes Mr. Potato Head look and work the way the person holding the potato wants it to work.

When it comes to accessing healthcare, "access" is the potato – the foundation upon which everything else is built.
There are three ways – three different potato foundations - an employer can access healthcare

1. A traditional network of providers, historically the most prevalent solution
2. Reference-based pricing, a relatively new innovation where the employer pays a set a price for each health care service instead of negotiating prices with providers
3. Direct contracts

When employers contract directly with providers outside of established provider networks, the direct contract creates an access component that can be added to a health plan.

Direct contracts as a foundation for access are best when they encompass all services rendered by a hospital or provider, all services at a multi-specialty, an orthopedic group, etc. The direct contract should be a global contract, rendering a full arrangement that is outside existing networks. Other types of direct contracts not necessarily applicable to scaling Community Access Programs and outside the scope of this case study include bundled services and Direct Primary Care (DPC).

Self-funded employers can mix and match different proportions of the three foundational access points within their health plans. Any other "access" solution could be argued as a "bolt-on" to one of these three core ways that the employer is accessing healthcare.

By design, Community Access Programs fundamentally aim to change the core way in which employers access healthcare by connecting employers directly to providers and assigning employers the responsibility of payer. Stated another way, Community Access Programs give providers a more efficient way to offer their services to local employers in the community.

Scaling the Access

Frequently, direct contracts permit only a single employer to access the contract with the provider. These “closed contracts” exclude multiple employers from being able to join into the contract. Having anticipated this issue, a separate set of challenges persistently inhibited Missouri Health Cooperative’s effort to scale. In fact, there were many points over the course of two years when the Provider Stakeholders questioned whether their Community Access Program could truly function as originally envisioned.

In 2021, Health Cooperative of Missouri enlisted the help of a company that specializes in direct contracts. Health2Business (H2B) tackled four separate problems and implemented the solutions outlined below:

1. Difficult to identify

   The providers had difficulty discerning which employers were participating in the Community Access Program due to:
   a. Multiple Payer IDs
   b. Multiple TPAs
   c. TPAs simultaneously administering the Cooperative contracts and traditional network plans

   Scalable Solution #1: H2B implemented a single Payer ID designated exclusively for the purpose of Community Access Programs. Next, H2B introduced ID cards that removed TPA logos and served as the identification anchor point of the CAP. This new ID card made clear from registration to revenue cycle, which employer was accessing the direct contract. Establishing this front-end infrastructure enabled any TPA or Advisor with a health plan to engage with the Cooperative.

2. Different reimbursements off same rate schedules

   A lack of integrity in the management of the rate sheets resulted in identical claims being processed with different allowable amounts. Different administrators, different processes, and lack of front-end infrastructure were responsible for these errors.

   Scalable Solution #2: H2B routed all claims to their clearinghouse, where they assumed responsibility for repricing all claims associated with the direct contracts to the appropriate allowable. The claim was then passed to the TPA for plan adjudication and payment.

3. Administrative burden of information updates

   Providers moving to different organizations, as well as new providers joining the Coop, meant that TIN, NPI, and Provider Directory information was ever-changing. The challenge of managing these information updates was further exacerbated by needing to funnel the updates to six different TPAs.

   Scalable Solution #3: H2B assumed management of the front end of this administrative load and clearly defined the roles and responsibilities. Managing the TIN, NPI, provider roster and directory, and schedule information, housing the data, and subsequently passing “ready-to-adjudicate” claims to TPAs streamlined the process to ensure accurate claim adjudication.

4. Contract administration ambiguity

   With some TPAs administering the contracts in-house, while others outsourced to a reference-based pricing vendor or other vendor, it was not clear who was doing the administrative work or who was taking responsibility for the contract administration.

   Scalable Solution #4: Identifying and assigning a single Direct Contract Administration (DCA) firm to manage the contracts removed ambiguity and potential liability. H2B was selected to assume all responsibilities outlined in the contract and directly manage the administrative work associated with the contract.

New Ideas to apply to Community Access Programs

In addition to the solutions that the Health Cooperative of Missouri implemented in order to scale their Community Access Program, the process brought to light several new ideas that should be considered as others build and scale CAPs.

1. The most prevalent scalability problem with Direct Contracts and Community Access Programs right now is the re-bundling of direct contract access into third party administrators or reference-based pricing vendors so that the only way to access a contract is through a specific TPA or RBP vendor. When an employer desires to switch TPAs or vendors, they no longer have access to the contract.

   If we want Community Access Programs to scale and replicate, the direct contract needs to
   1) Be held independent of any other vendors - TPA, RBP, Stop-loss, or other
   2) Be accessible to all other vendors - TPA, RBP, Stop-loss, or other

2. From a provider perspective, the Community Access Program has to be administratively easy as it scales from 3 groups to 30 groups and beyond - or the providers will turn it off. Direct contracts need to be efficiently and appropriately administered in a way that facilitates seamless functionality and minimal burden for the providers. A direct contract administration firm provides the needed infrastructure that allows CAPs to scale in this way.

3. Independent and agnostic direct contract administrators that are not affiliated with other vendors (TPAs, repricers, etc.) are in the best interest of the Community Access Program and CAP participants. Stand-alone DCAs remove potential conflicts of interest among vendor services, clarify roles, maintain transparency, and ensure compliance.

Roles and Responsibilities in Scaling Community Access Programs

Each entity had a specific role to play when it came to successfully scaling the Health Cooperative of Missouri’s Community Access Program. To replicate this example, a clear understanding of the needed roles will improve collaboration.

The Benefit Advisor’s role is to bring employers to the table and show them the value of the Community Access Program. The advisor also provides strategic recommendations to employers for how their health plan should be architected and designed to best meet the specific needs of each company and workforce.

Employers' role in scaling Community Access Programs is to learn about the advantages of structuring their health plan in a way that allows them to participate in a CAP. Employers consult with Benefit Advisors to build a custom health plan and make important decisions pertaining to the plan, such as how to access healthcare.

The Provider Community needs to allow services to be purchased via a direct contract that is outside of traditional networks. Banding together to deploy services with the proper infrastructure will create the desired efficiencies and eliminate friction points for all Stakeholders providing, paying for, and receiving healthcare, as well as vendors and advisors.

Third-Party Administrators and Health Plan Administrators maintain their core competency as a claims payer, customer service center, and communication hub while integrating directly with the Direct Contract Administration firm.

Direct Contract Administrators provide the infrastructure that allows Community Access Programs to scale efficiently. They are primarily responsible for repricing claims associated with the direct contracts and delivering them to the TPA ready for plan adjudication. Direct Contract Administration is a new vendor class that upholds an independent, agnostic position to serve the financial best interest of the Employer health plan sponsor.

What's Possible

By January 1, 2022, the Health Cooperative of Missouri had resolved the persistent challenges that had prevented the viability and growth potential of their Community Access Program. The success of this plan is defined by these characteristics:

1) Providers truly want to participate in a scalable Community Access Program
2) Burdensome confusion around Payer ID has been eliminated
3) Direct contracts are provisioned to allow an infinite number of Employers to participate
4) Direct contracts are held independently while remaining accessible
5) Proper infrastructure exists for the seamless administration of the contracts
6) Roles and responsibilities are clearly defined

Establishing a Community Access Program where the above criteria are met results in a scalable and replicable CAP **able to serve all size employers across all sectors.** While this may seem insignificant, the implications could also prove to be revolutionary.

Another exciting possibility is the ability to productize a Community Access Program. Once the structure is in place, level-funded options can be launched for employers with as few as two members on the plan. Any vendors or any products can be included. The structure invites innovation around cost-containment strategies and other areas, providing for endless possibilities.

There also exists the likely generation of multiple *Health Rosetta Dividends*.* Employers who participate in Community Access Programs position their company to save hundreds of thousands of dollars that can be invest back into company benefits, the employees directly, and the business. Bringing the Provider community and the Employer community in alignment, working together, will mutually benefit providers, employers, employees, their families, and therefore, entire communities.

Until recently, many Community Access Programs have met with challenges that constrained their ability to add more employer participants. Now that a blueprint exists for how to successfully scale CAPs, changes can be adopted quickly. Scalable Community Access Programs are now poised for high-velocity impact.

*Per Health Rosetta: We have more than enough money to fund world class healthcare and all of the other key drivers of health and well-being but only if we stop squandering over $1 trillion every year on waste. With only $0.27 of every dollar ostensibly spent on clinicians and the U.S., spending 2-3x other countries, where is all of our healthcare money going? We have to understand that to achieve the Health Rosetta Dividend that can restore the American Dream by rebuilding hope, health and well-being in our communities. https://vimeo.com/452247640

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