

VALUE-BASED CONTRACTING FROM A
POSITION OF **STRENGTH!**



September 23, 2018

Adam J. Falcone, Esq.
Partner

PRESENTER: ADAM J. FALCONE



Contact information

afalcone@ftlf.com

202.466.8960

- Partner in FTLF's national health law practice.
- Counsels health centers, behavioral health providers, and provider networks on a wide range of health law issues, including fraud and abuse, reimbursement and payment, and antitrust and competition matters.
- Began his legal career in Washington, D.C. as a trial attorney in the Antitrust Division's Health Care Task Force at the U.S. Department of Justice.
- Served as Policy Counsel for the Alliance of Community Health Plans, representing non-profit and provider-sponsored managed care organizations before Congress and the Executive Branch.
- Received a B.A from Brandeis University, an M.P.H. from Boston University School of Public Health, and a J.D., cum laude, from Boston University School of Law.

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- This presentation is provided for general informational and educational purposes only and does not constitute legal advice or opinions.
- The information is not intended to create, and the receipt does not constitute, an attorney-client relationship between attorney and participant.
- For legal advice, you should consult a *qualified* attorney.

AGENDA

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- MCO Incentives

Questions and Comments – ANYTIME!

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- Participating in VBP Contracts
- Structuring VBP Arrangements
- Antitrust Risks
- Negotiating Rates
- Negotiating Value-Based Payments

Questions and Comments – ANYTIME!

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- Level 1 VBP Arrangements Protections
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- Level 1/2/3 VBP Arrangements Protections
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Questions and Comments – ANYTIME!

PART 1

Value-Based Contracting

VBP ARRANGEMENTS – NEW YORK STATE

Types				
	Total Care for General Population (TCGP)	Total Care for Special Need Populations	Care Bundles	Integrated Primary Care (IPC)
Definition	Party(ies) contracted with the MCO assumes responsibility for the total care of its attributed population	Total Care for the Total Sub-pop <ul style="list-style-type: none"> •HIV/AIDS •MLTC •HARP 	Episodes in which all costs related to the episode across the care continuum are measured <ul style="list-style-type: none"> •Maternity Bundle 	Patient Centered Medical Home or Advanced Primary Care, includes: <ul style="list-style-type: none"> •Care management •Practice transformation •Savings from downstream costs •Chronic Bundle (includes 14 chronic conditions related to physical and behavioral health related)
Contracting Parties	IPA/ACO, Large Health Systems, FQHCs, and Physician Groups	IPA/ACO, FQHCs and Physician Groups	IPA/ACO, FQHCs, Physician Groups and Hospitals	IPA/ACO, Large Health Systems, FQHCs, and Physician Groups

NYS LEVELS OF VALUE BASED PAYMENTS

Level 0 VBP*	Level 1 VBP	Level 2 VBP	Level 3 VBP (feasible after experience with Level 2; requires mature contractors)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/IPC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)
FFS Payments	FFS Payments	FFS Payments	Prospective total budget payments
No Risk Sharing	↑ Upside Risk Only	↑↓ Upside & Downside Risk	↑↓ Upside & Downside Risk

- Goal of ≥80-90% of total MCO-provider payments (in terms of total dollars) to be captured in Level 1 VBPs at end of DY5
- Aim of ≥ 50% of total costs captured in VBPs in Level 2 VBPs or higher

NYS VBP EXPENDITURE GOALS BY YEAR

April 1, 2018

- At least 10% of total MCO expenditures in Level 1 or above.

April 1, 2019

- At least 50% of total MCO expenditure in Level 1 or above of which at least 15% of which are in Level 2 or higher.

April 1, 2020

- 80-90% of total MCO expenditures in Level 1 or higher of which At least 35% of total payments contracted through Level 2 VBPs or higher for fully capitated plans and 15% contracted in Level 2 or higher for not fully capitated plans.

NEW YORK STATE MEDICAID MCO INCENTIVES

VBP incentives for MCOs are designed to encourage not only higher value, but also to encourage increased (and earlier) adoption of VBP contracting. These include:

- **Stimulus Adjustments**
 - Increased capitation premium to MCOs that achieve VBP at higher levels
- **Penalty Adjustments**
 - Downward adjustment to premium for lack of movement to VBP
- **Efficiency Adjustments**
 - Rewards efficiency in delivery of care in VBP arrangements
- **Quality Adjustments**
 - Incorporates new VBP measures into current quality incentive program

NEW YORK STATE MEDICAID MCO INCENTIVES

Penalty Adjustments

- Levied on the value of the margin between the VBP threshold and the plan's contracted amount
- Begins in Rate Year 2018-19 and becomes more stringent over time
 - SFY 18-19: 0.5% penalty if 10% VBP Level 1 not met
 - SFY 19-20: 1% penalty if 50% VBP Level 1 or 15% Level 2 not met
 - SFY 20-21: 1% penalty if 80% VBP Level 1 or 35% Level 2 not met

PART 2

Contracting Strategies

FORMATION OF NEW LEGAL ENTITY

Two or more parties may establish a new legal entity to conduct activities under shared ownership or control.

The benefits of forming a new legal entity include:

- Shielding each partner from liability for debts, obligations and other liabilities of the network and other partners
- Partners retain control over their own organizational operations because shared control only extends to network's joint activities
- Partners maintain their independence and autonomy while working together
- Partners can pool resources to make joint investments in information technology, clinical or financial expertise, or equipment

PROVIDER NETWORKS

Many terms have been given to describe different types of provider-led entities:

- Independent Practice Association (IPA)
- Management Services Organization (MSO)
- Administrative Services Organizations (ASO)
- Clinically Integrated Network (CIN)
- Accountable Care Organization (ACO)
- Group Purchasing Organization (GPO)

Note: Some of these terms may only be used when approved by regulatory agencies.

FUNCTIONS OF PROVIDER NETWORKS

Shared Support Services

- ✓ IT Support for Electronic Health Record (EHR)
- ✓ Health Information Exchange (HIE)
- ✓ Credentialing practitioners; exclusion/debarment background checks
- ✓ Third-Party Billing

Managed Care Contracting

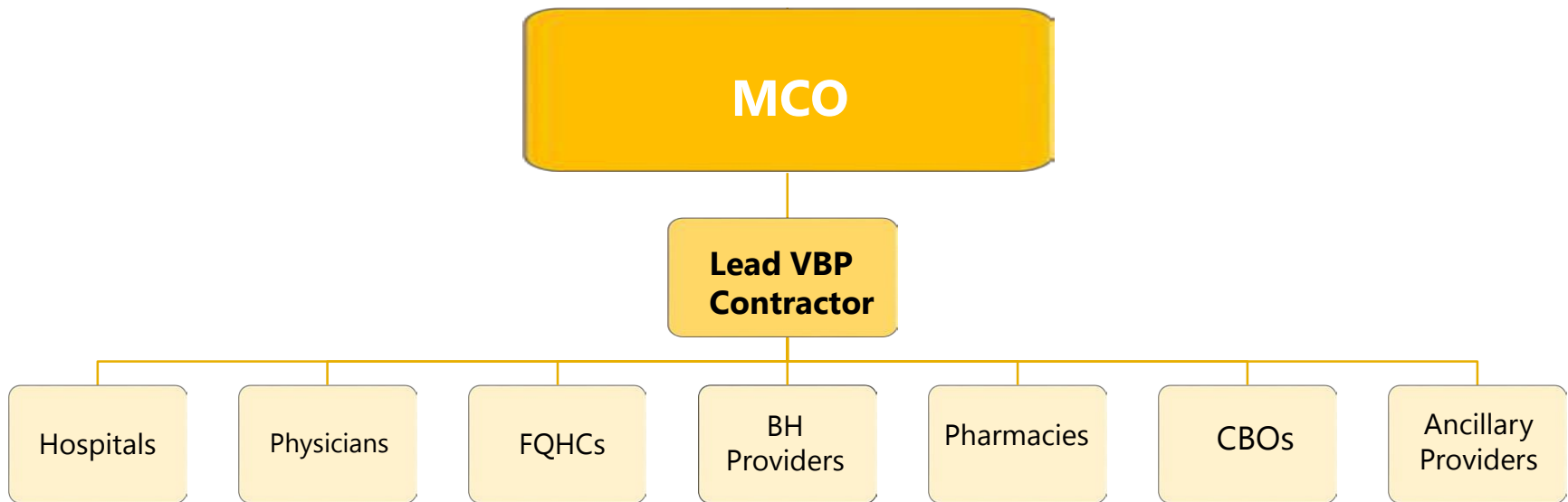
- ✓ Marketing network of health care providers/agencies
- ✓ Facilitating managed care contracting
- ✓ Negotiating contracts

PARTICIPATING IN VBP CONTRACTS

- Participation in a joint venture or integrated provider network can allow you to contract under a VBP arrangement, manage total costs of care, and improve performance on quality metrics.
 - **Lead VBP Contractor:** Typically larger provider system experienced and capable of contracting with an MCO
 - **Provider Partners:** Typically smaller or downstream providers that will contract with the Lead VBP Contractor.
 - **Community Based Organization (CBOs):** CBOs are uniquely positioned to address root causes of poor health.

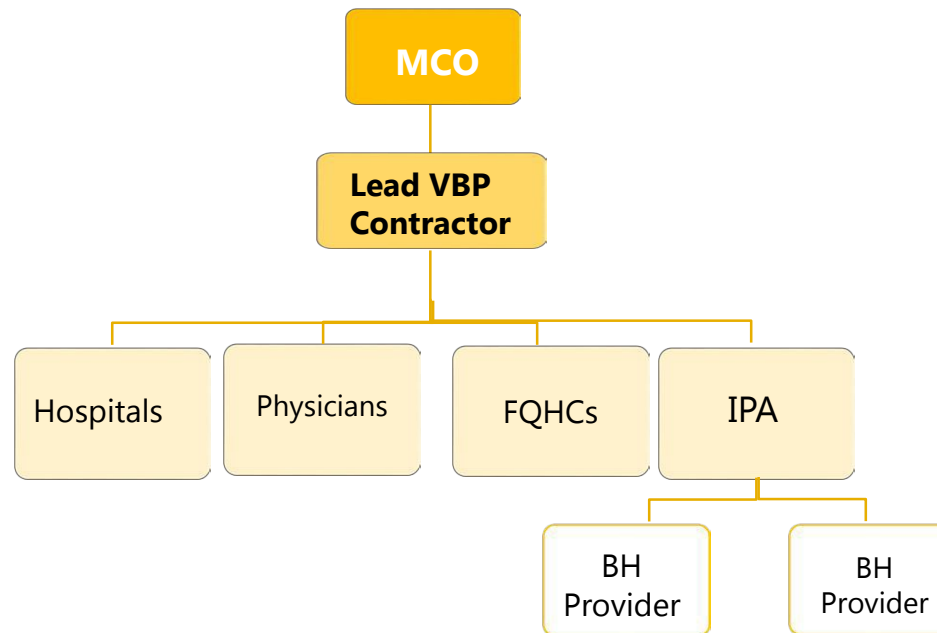
STRUCTURING VBP ARRANGEMENTS

Example 1



STRUCTURING VBP ARRANGEMENTS

Example 2



CAUTION: ANTITRUST RISKS

Stu's Views

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Give me
one good reason
we shouldn't
promote
teamwork.

The
government
calls it
"antitrust".



In general, providers must make independent, unilateral decisions on contractual terms and negotiate separately in order to comply with state and federal antitrust laws.



ANTITRUST LEGAL STANDARDS

Per-Se Illegal (*e.g.*, price-fixing, market allocation)

“Rule of Reason” test determines whether lawful if:

- The joint activity of the network is likely to produce significant efficiencies that benefit consumers and
- Price agreements by the network providers are reasonably necessary to realize those efficiencies.

Antitrust “Safety Zones”

- DOJ/FTC Statements of Enforcement Policy in Health Care (1996)
 - <http://www.ftc.gov/bc/healthcare/industryguide/policy/statement8.htm>
- Medicare Shared Savings Program (MSSP)

NEGOTIATING MANAGED CARE CONTRACTS

- Can a provider network negotiate fee-for-service (i.e., non-risk) contracts with MCOs?
 - **Generally, no as it would constitute price-fixing.**
- But the answer can change:
 - If the network is not composed of competitors (or potential competitors)
 - If the network is “financially integrated” (see next slide)
 - If the network is “clinically integrated” and the joint negotiation is necessary to make the clinically integrated activities work
 - If the network participates as an ACO in the Medicare Shared Savings Program (MSSP)

HEALTH CARE ENFORCEMENT POLICY

Statement 9: Multiprovider Networks

Examples of “**substantial financial risk-sharing**” include:

- capitation payments
- global fee arrangements
- fee withholds
- cost or utilization based bonuses or penalties for participants, as a group, to achieve specified cost-containment goals
- a fixed, predetermined payment to provide a complex or extended course of treatment that requires the substantial coordination of care by different types of providers offering a complementary mix of services

Tip: The Enforcement Agencies encourage multiprovider networks which are uncertain whether their proposed arrangements constitute substantial financial risk sharing to take advantage of the Agencies' expedited business review and advisory opinion procedures.

BASE REIMBURSEMENT RATES

- Can provider networks negotiate base reimbursement rates?
 - Fee-for-service (“FFS”) schedules
- Legal Test:
 - Do the network members share “substantial financial risk”?
 - No, because the network participants do not share financial risk for the services priced through the network.
 - Are the network members “clinically integrated”?
 - Analyze extent of integration under DOJ/FTC standards.
- **Conclusion: Until the network satisfies the test for clinical integration it cannot negotiate base reimbursement rates.**

NON-INTEGRATED NETWORKS

Non-integrated provider networks do not meet legal standards for financial or clinical integration


Non-integrated provider networks may *facilitate* (but not negotiate) contracts involving base reimbursement rates if they carefully comply with the “Messenger Model”

MESSENGER MODEL

Provider Network, as the messenger, transmits proposed rates to each provider in network



Each provider determines whether to accept (or reject) MCO's payment terms



Provider Network communicates each provider's decision back to MCO

VALUE-BASED PAYMENT METHODOLOGIES

Do federal antitrust laws permit provider networks to jointly negotiate value-based payments?

Level 0 VBP*	Level 1 VBP	Level 2 VBP	Level 3 VBP
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient	FFS with risk sharing (upside available only when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)
<ul style="list-style-type: none"> Providers share risk jointly to earn bonus payments based on group performance Providers do not share risk for FFS payments 	<ul style="list-style-type: none"> Providers share risk jointly to earn shared savings payments based on network performance Providers do not share risk for FFS payments 	<ul style="list-style-type: none"> Providers share risk jointly to earn shared savings payments or owe shared risk payments to MCO based on network performance Providers do not share risk for FFS payments 	<ul style="list-style-type: none"> Network agrees to furnish services under capitated rate Providers can receive FFS payments from network for individual services
Upside Risk Only	↑ Upside Risk Only	↑↓ Upside & Downside Risk	↑↓ Upside & Downside Risk

VALUE-BASED PAYMENT METHODOLOGIES

Legal Test: Do the network members share “substantial financial risk” under value-based payment methodologies?

- Providers jointly share financial risk for bonus payments (Level 0), shared savings payments (Level 1), shared risk payments (Level 2) and capitation payments (Level 3) based on group/network performance, i.e., the value-based components of VBP methodologies.
- Providers do not share financial risk for FFS payments, i.e., the non-value-based component of the VBP methodologies.

Conclusion: The network may negotiate the value-based components of VBP methodologies where those components involve sharing financial risk based on overall network performance. Networks may not negotiate FFS payments.

COMBINATION APPROACH?

Base Reimbursement

Messenger Model

- Network members accept FFS/APM rates offered by MCO (without engaging in any negotiation).
- No downside risk because NYS currently mandates payment levels for behavioral health services to Medicaid enrollees.

Payment Incentives

Financial Risk-Sharing

- Network negotiates incentives (e.g., bonus payments, shared savings, shared risk) with MCO
- Value-based payments won or lost on group performance
- Network distributes value-based payments, if any, to providers, pursuant to methodology agreed by the members of the network.

PART 3

VBP Contract Terms

ACCESS TO CLAIMS INFORMATION

Behavioral health agencies need timely, accurate and usable data to be successful in VBP arrangements.

- Timely receipt of patient health information related to emergency room visits, hospitalizations, and physical health care is essential for performing well on P4P incentives and managing the total costs of care of the attributed population.

Practice Pointers. A provider's terms of participation in VBP arrangements should contain language that requires the MCO to furnish to the provider the necessary claims information related to a patient's use of services (or provide access to integrated databases), patient risk scores, and prior authorization requests on a real-time basis.

- Ideally, the contract would specify the type of data that the provider is entitled to receive, the timeliness of such data, and the frequency in which the MCO must provide the data to the provider.
- If the MCO fails to meet its data sharing obligations, the provider should be held harmless from any loss of revenue arising from unearned payment withholds or downside financial risk.

PATIENT CONFIDENTIALITY LAWS

- A Covered Entity may disclose protected health information (“PHI”) for the treatment activities of any health care provider (including providers not covered by the Privacy Rule).
 - Covered Entities include health care providers who transmit health information in an electronic form as well as health plans (e.g., health insurers, state Medicaid programs)
 - “Treatment” generally means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.
 - Note: Disclosures for treatment purposes do not need to abide by the “Minimum Necessary Standard” and can disclose all of a patient’s PHI.
- Generally, 42 CFR Part 2 restricts disclosure and use of substance use disorder records which are maintained in connection with the performance of a federally-assisted Part 2 program.
 - Unlike HIPAA, patient consent is required even for disclosures for the purposes of treatment.

PERFORMANCE MEASURES

- To facilitate participation in multiple VBP arrangements, providers should seek performance measures that have standard definitions and methodologies for calculating scores (*e.g.*, HEDIS measures). Ideally, the Medicaid measure sets and incentives would align with those used by Medicare and commercial payers.
- Providers should be familiar with the performance measures applicable to MCOs (particularly Medicaid MCOs), understand the financial rewards available to MCOs (if any), prioritize internal operations to score high on those performance measures, and leverage those results for favorable VBP arrangements with MCOs.

Practice Pointers:

- A provider's terms of participation in VBP arrangements should contain clear language regarding the population of patients subject to the performance measures, the definitions and methodology for calculating scores, and the financial rewards available.
- The MCO should not be permitted to change the performance measures (or methodology) after they have been established for any given performance year, at least without the provider's consent.

NYS BEHAVIORAL HEALTH CLINICAL MEASURES

- In 2018, NYS included the following BH measures in the Medicaid measure set:
 - Adherence to mood stabilizers for individuals with bipolar disorder
 - Antidepressant medication management
 - Initiation and engagement of alcohol and other drug dependence treatment
 - Initiation of pharmacotherapy upon new episode of opioid dependence
 - Preventive care and screening for clinical depression and follow-up plan
 - Use of alcohol abuse or dependence pharmacotherapy

LEVEL 1 VBP ARRANGEMENTS

Why not? A provider (or VBP Lead Contractor) is not placed at financial risk to participate in Level 1 (upside only) VBP incentive arrangements.

- Even if the provider does not qualify for incentive payments, participation in those arrangements may “kick-start” internal delivery changes and partnerships with other providers to qualify for future payments.

Practice Pointers. During negotiation of contracts (and contract amendments!) with MCOs, providers should affirmatively request participation in an MCO’s VBP arrangements to maximize overall reimbursement.

- If an MCO is not willing to permit participation in VBP arrangements at the point of contracting, a provider should seek language that entitles the provider to participation at a future date, upon meeting eligibility requirements, or otherwise.

LEVEL 2 VBP ARRANGEMENTS

- **Downside Risk.** A provider (or VBP Lead Contractor) is placed at financial risk to participate in Level 2 (upside and downside shared savings) VBP incentive arrangements. Providers should generally exercise caution in entering such arrangements as they could result in significant risk to the organization's financial health.
- **Practice Pointers.** When negotiating the terms of participation in any VBP arrangement that involve financial penalties or downside financial risk, the provider (or VBP Lead Contractor) should add language that limits or mitigates any such penalties or downside risk.
 - If the contract imposes a financial penalty on the provider, the provider should negotiate language that creates a ceiling on the penalty as a fixed dollar amount or percentage of total payments received from the MCO.
 - If the provider enters a downside shared risk arrangement, the provider should negotiate language that limits financial losses to a percentage of total payments or the benchmark.
 - If the provider is participating in a VBP arrangement that involves financial penalties, the provider should negotiate a provision that allows financial losses incurred in one year to be paid back to the MCO by financial gains earned in subsequent years.

LEVEL 1/2/3 VBP ARRANGEMENTS

Who's In? Who's Out?

Attribution Methodology: The basis by which the MCO attributes patients to a population under a VBP arrangement. Possible attribution methods might include populations based on an enrollee's:

- Geographic area (e.g., counties);
- Specified behavioral health conditions;
- Receipt of services from a behavioral health agency (e.g., clients); or
- Receipt of primary care services.

If attribution of patients is prospective, providers should recognize that the population of patients attributed to the provider may:

- Include patients who have not visited the provider during the current performance year; and
- Include patients who have received services from the provider but who were actually assigned to a different provider.

LEVEL 1/2/3 VBP ARRANGEMENTS

(continued)

Practice Pointers. To avoid surprises related to the attributed patient population, a provider (or Lead VBP Contractor) should:

- Request that the MCO generate a list of attributed patients based on prior year's data so that the provider can learn how many and which patients would have been attributed to the provider under a VBP arrangement.
- The provider should negotiate a provision that requires the MCO to provide a list of the attributed patient population at least 90 days prior to the start of the performance period for the VBP arrangement.
- The provider should negotiate a provision that requires the MCO to provide monthly or quarterly patient rosters of attributed patients for the current performance year as well as the right to confirm or reject individuals attributed to the provider against the provider's own records within 60 days of receipt of the patient rosters.

CONTRACT TERM

- Providers (or Lead VBP Contractors) should be aware that there may be a separate contract term that applies to VBP arrangements.
- In practical terms, the contract term reflects the amount of time that the provider is committing to participate in the VBP arrangement.
- **Provider Pointer.** When initially contracting with an MCO, it may be desirable for the term of the VBP arrangement to be shorter (e.g., one year)– possibly without automatic renewal-- so that the provider can re-negotiate any problematic terms of participation in VBP arrangements.
 - In any VBP arrangement, providers should seek contract language that permits them to receive payment of any earned payment incentives for completed performance periods prior to termination of the participation agreement, even if the payment incentives have not been distributed prior to termination.

TERMINATION

- If participation in a VBP arrangement involves financial risk, the provider (or Lead VBP Contractor) may wish to include contract language that permits the provider to terminate its participation in the VBP arrangement if the provider is incurring (or is likely to incur) financial penalties under the arrangement.
- Contracts can typically be terminated “for cause” or “without cause”.
 - **For cause.** The situations that constitute cause will be listed in the contract, e.g., breaches of material terms of the contract.
 - **Practice Pointer:** The provider may want to add other circumstances that would permit participation in the VBP arrangement to be terminated for cause, e.g., the MCO modifies the performance measures or methodologies.
 - **Without cause.** In some contracts, a party may also terminate without cause after providing written notice to the other party.
 - **Practice Pointer:** Contracts that contain termination without cause provisions mean that, from a practical perspective, the term of the contract is the notice period. This may be a desirable mechanism to exit the VBP arrangement if necessary.

AMENDMENTS

- Amendment provisions are particularly crucial in VBP arrangements because the clinical, operational, and financial environments in which the parties operate are subject to constant change.

Practice Pointer. Determine whether there is a specific amendments clause that applies to participation in VBP arrangements.

- Any amendments clause to VBP arrangements should offer the right to the provider to opt-out but if the amendments clause permits the MCO to amend unilaterally the terms of participation in a VBP arrangement, then the provider should negotiate language that permits the provider to terminate its participation in the VBP arrangement.

QUESTIONS?

Adam J. Falcone, Esq.

FELDESMAN TUCKER LEIFER FIDELL LLP
1129 20th Street, N.W.
Suite 401
Washington, DC 20036
(202) 466-8960
afalcone@ftlf.com