Jennifer Nolty (00:00:00):

Good afternoon and good morning to those of you joining from times other than the East Coast, and those of you who are not observing Eastern or daylight savings time. My name is Jennifer Nolty and I am the director of PCA and Network Relations with NACHC and like to thank you for joining us today for our webinar on the Legal Considerations, ACO, Academy for Legal Considerations and Risk. And the objectives for today's webinar is you will be able to explain the antitrust safety zones that permit negotiating managed care contracts, review key provisions found in your participation agreements and understand what defines risk especially upside and downside and what to look for in various ACO contracts.

Jennifer Nolty (00:00:58):

We have presenting today and then again, please do not forget a week today at the same time, Adam Falcone from Feldesman Tucker Leifer Fidell, he will be available for the office hours. So please make sure to put that on your calendar, we will send out a couple of reminders, but he will be yours to ask questions next Thursday from 12:00 to 1:00 PM, Eastern Daylight Time. Again, I'd like to thank Adam for putting together this presentation.

Jennifer Nolty (00:01:39):

There's a lot of great information for those of you who may have heard Adam's presentations on this subject or these subjects before, there's a couple of new pieces in here. Some familiar items, but I really cannot stress that these are subjects that you cannot hear too often. Here, you will always walk away with something. And I really appreciate the time that Adam has taken to put this together and appreciate the time that you have taken to join us. So, without further ado, I'm going to turn it over to Adam Falcone.

Adam Falcone (00:02:19):

Thank you, Jen, for that very kind introduction and welcome everybody to today's webinar. I've been excited to today's webinar. I probably was too excited because I ended up having more slides than you can possibly fit into a webinar hour, but I basically made a decision along the way that since we have the office hours next week for an hour, at the same time, next Thursday, that it would be okay to include more slides than I would typically do. And then in the office hour next week, if there are slides that I don't get to or you have specific questions that I don't cover in today's webinar that you want me to drill down further, we'll have that whole hour to dedicate to that, to those topics. So again, thank you and welcome.

Adam Falcone (00:03:08):

Let me skip over the introductory slides. I think you know me and my experience and the law firm. I'm going to tell you what I'm going to cover today first. So, there's three areas I'm going to address. First, I'm going to talk about participating in accountable care organizations, including the Medicare Shared Savings Program in particular as well as how to look at some of the terms that you might encounter in an ACO Participation Agreement. Second, I'm going to discuss forming ACOs and how Federal Antitrust Law applies and their relevance safety zones. Many of you is considering or have formed clinically integrated networks, financial integrated networks, so I'll talk to you about what those terms mean, and what they allow you to do in regards to joint negotiation with MCO's.

Adam Falcone (00:03:58):

And then the third topic I'll cover today are payment methodology and risk sharing, particularly downside risk that you might take on either individually as a health center or I see from the participants today, some of you are from health center networks. What the network might take on as well as far as downside risk and special considerations that would apply to FQHCs who take downside risk either directly or indirectly through a health center network, controlled network, IPA or ACO and what terms you'd want to see in your contracts to protect yourself and the ACO from that potential downside risk.

Adam Falcone (00:04:39):

So let's dive in first to ACO just to sort of level set the conversation here. An ACO is not an MCO, it's not a managed care organization. It is intended to be a provider led and organized entity that is accountable for the cost and quality of care for a defined population. The Medicare rules in some States have defined the basic features of an ACO and typically they define it as a collection of certain providers who are working together in a particular-defined community, so there's local accountability, and that it's structured as such as a separate legal entity from the individual providers.

Adam Falcone (00:05:18):

It's not supposed to be controlled by any managed care organization, though some MCOs do provide sort of back office or management services to ACOs and communities. Some insurers have created their own ACOs, though when you look closely to see how they've structured the governance of the ACO, it's governed by the providers that are in ACO, not by the managed care entity. I encourage you to think about the opportunity for FQHCs to participate in ACOs because FQHCs are extremely well-positioned to participate and to form ACOs and they offer an incredible amount of value to ACOs based on the lower cost of care for attributed populations who are seen by health centers.

Adam Falcone (00:06:09):

NACHC has on its website a number of studies that illustrate the value that health centers bring because the research literature shows that patients who are cared for by FQHCs, by health centers have lower total cost of care than providers that are not health centers, that are not FQHCs and when you look at the value that they provide, it's considerable.

Adam Falcone (00:06:34):

Here, there's a slide that shows NACHC data, NACHC analysis showing the lower cost of care as high as 24% for health center patients as compared to non-health center patients. Because we're going to talk about Medicare in particular, I thought I'd show you some data related to the Medicare program where you can see that health center patients have lower cost of care for about 10% than physician offices and 30% lower costs of care than outpatient clinics typically run by hospitals. And why is that important?

Adam Falcone (00:07:05):

Well, health centers that receive invitations to participate in a Medicare ACO should recognize that they're delivering value back to that ACO, really simply by participating in that ACO because now the health centers' Medicare patients are going to be attributed to that ACO and you can run the numbers if your patients typically have lower cost of care between 10 and 30%, then basically, you're helping that ACO by reducing its total cost of care for the attributed population. But you certainly should make sure that you're getting something in return for the fact that your patient will now be attributed to that ACO, and that ACO is likely to be able to drive a profit from your participation.

Adam Falcone (00:07:48):

To level set the conversation, for those of you are not familiar with the Medicare Shared Savings Program, the MSSP, as it's known in short is Medicare's ACO Program. It applies just to those Medicare enrollees who are enrolled in the traditional Medicare program, so this is not managed care, this is not Medicare managed care, the Medicare Advantage Program, this does not apply to PACE, the programs of all-inclusive care for the elderly. These are the traditional Medicare beneficiaries, who would be assigned to an ACO based on the plurality where they receive the majority of their primary care services and primary care providers can only be participants in one Medicare ACO.

Adam Falcone (00:08:30):

Why is that? Because those primary care providers are how attribution decisions are made in the Medicare ACO program. If you think about it, it wouldn't be possible for a primary care provider to participate in multiple Medicare ACOs because then the Medicare program wouldn't know how to attribute patients to which ACO when they attribute patients to if a primary care provider participated in multiple Medicare ACOs and that's why there's a rule that says primary care providers can only participate in one Medicare ACO.

Adam Falcone (00:09:04):

The first question I get typically is how does that affect FQHC reimbursement? It doesn't. Any provider that participates in the Medicare Shared Savings Program continues to get paid by the Medicare program just as they normally would for any patient who is in a traditional fee for service Medicare program. And so FQHCs continue to file claims to their Medicare administrative contractor just as they normally would and would get paid their full PPS rate, the various encounter rate, regardless of whether they participate in a Medicare ACO or not. And that's why it's sort of a nice, easy way to get into the Medicare program to get into ACO world through the Medicare Shared Savings Program, because it doesn't interfere with your base reimbursement. And then if you're helpful and successful with the ACO in lowering the total costs of care, you might receive additional funds through a payment on your shared savings.

Adam Falcone (00:09:58):

One quick other note about attribution, based on a fairly recent change, many health centers struggled to participate in a Medicare ACO program because attributions decisions had to be based on physicians, on physician services to their enrollees, and many actuates, these particularly those enrolled providers, have a lot of care delivered through mid-levels, particularly nurse practitioners. So as a result, it took Federal Law change in Congress to actually change the law that applies to attributions decisions in the Medicare Shared Savings Program and there was a change, so that now on any service delivered by an FQHC is viewed as primary care, regardless of whether it's delivered by a physician or a nurse practitioner, and now, that individual can be attributed to a Medicare ACO. So that was a great win that occurred through some very good lobbying efforts by the National Association of Community Health Centers to make that change.

Adam Falcone (00:10:57):

For those of you who like to see the bio graphics of how the system works in the Medicare Shared Savings Program. We have Medicare at the top, who is the payer. They contract with ACOs around the country and then these ACOs in turn contract with various types of providers under what's called a Participation Agreement. And then some of these ACOs have downside risk, which I call shared risk and

some of these ACOs have just, at least initially, upside opportunity to earn money for Medicare called Shared Savings. If the ACO is successful than an additional payment will be made for Medicare to the ACO and then the ACO has the opportunity to share and distribute that payment to the various providers participating in the ACO under some payment methodology that they've all agreed to. As you can see, all the providers in the ACO continue to get paid from Medicare directly under the Fee for Service Program.

Adam Falcone (00:11:56):

The way the system works in the Medicare Shared Savings Program is that CMS recently changed the various amounts of risk for the ACOs, they called it their pathways to success program, and they're shifting away from three-year agreements with each of the ACOs to basically a five-year agreement. In the past, ACOs could essentially stay an upside only shared savings arrangements for three years, I think twice.

Adam Falcone (00:12:25):

Now, CMS has changed the rules of the game, so that any ACO that begins in the program, they will have a five-year contract, and they can only be in that one-sided risk model for one or two years and then CMS on increases the amount of downside risk for the remainder for the balance of the years up to five years. That's called the Basic Track. And then in the Enhanced Track, it's also a five-year agreement to help the ACOs in that track actually take downside risk beginning with year one and through all five years.

Adam Falcone (00:12:58):

So when I talk about downside risk and upside risk, you have to recognize that these ACOs are being evaluated against how well they do, against what bending is anticipated for the attributed population. So, CMS creates a benchmark, which is their estimate for how much it would cost to take care of all those beneficiaries that had been attributed to the ACO in the absence of that ACO existing, and then at the end of a performance year, the CMS measures what the actual costs were for the attributed population. And if it costs less than the estimate in the benchmark, then it's viewed as a savings to the Medicare program and CMS return some of those savings, dollars to the ACO. If there's a loss that costs more than the benchmark, then that's considered a loss and under a downside risk arrangement, then the ACO has to pay a portion back to the Medicare program, because it costs more than the benchmark.

Adam Falcone (00:13:58):

And as you can imagine, the more upside gain an ACO is entitled to, the more downside risk an ACO is willing to take, the more upside gain is available. So as you can see from the differences between the basic track and the enhanced track, because there's more downside risk under the enhanced track, there's more upside gain. So for those ACOs that are in the enhanced track that are willing to take more downside risk, the Medicare program is actually willing to share up to 75% of the savings with those ACOs as opposed to those ACOs in the basic track where the upside gain, the shared savings back to those ACOs is only at a maximum of 50% because those in the basic track are not taking as much downside risk.

Adam Falcone (00:14:47):

So, if you're offered the contract to participate in the Medicare ACO, I've listed here are some questions that you would want to ask yourself to understand about that ACO's participation. So you, of course,

would want to know whether the ACO is in the basic or enhanced tracks and most of the ACOs in the Medicare Shared Savings Program are actually in the basic track, very few are willing to take that downside risk from the first year. You'd want to know whether that ACO, if it's been around for some time, has been successful in generating savings and want to know when their agreement with CMS expires.

Adam Falcone (00:15:24):

You want to know how the ACO intends to share risk. Some of the ACOs that have been in the Medicare program have been hospital-owned and led and they might share a lower percentage of savings with primary care providers as opposed to an ACO that's controlled or led by primary care providers or physicians or FQHCs, who are much more willing to share the savings from Medicare with the primary care providers and FQHCs. So, you'd want to understand their track record and methodology for distributing any shared savings payment.

Adam Falcone (00:15:56):

And because primary care is so critical for resulting in shared savings, as you know, you'd really want to know how the ACO is investing in primary care or the patient shared medical home model, so that it would allow the ACO to be successful in managing the total cost of care. So, how is the ACO preventing avoidable hospitalizations or how is the ACO involved in identifying the highest cost, highest risk patient and allowing more funds to be delivered to the health center or the primary care provider to do greater outreach to avoid ER visits for those patients, do more care for those who have more higher complex conditions, those who might have co-morbidities when they have a primary care, physical health condition and a behavioral health condition that is working to make them a very high cost patient. And what data is the ACO willing to share back with the FQHC to allow the FQHC to be more successful in taking care of those high-risk, high-cost patients.

Adam Falcone (00:16:59):

One thing to think is what can you do to learn more about who has ultimate control and ownership of an ACO when you're offered an opportunity to participate and I always suggest that you request the network operating agreement for the bylaws to see who actually have control of the ACO because even if you're offered a seat on the ACO's governing board body, it could be that the ACO actually is controlled or owned by another entity, a hospital or a health plan and sometimes those hospitals or health plans actually have basically reserved powers and can trump the decision of the ACO's governing body on certain types of decisions. So, the hospital or MCO might have the ability to negate a decision by the governing board or a distribution of any savings might have to go to their owners for final approval. So, it's helpful to know who has ultimate control and ownership of an ACO and to see whether you do have an opportunity to influence the ACO's decisions.

Adam Falcone (00:18:06):

For any kind of ACO agreement that you might receive, the threshold questions you want to know, is this ACO just participating in the Medicare Shared Savings Program and obviously what track or is that ACO also involved with non-Medicare ACO programs? There are a number of networks and ACOs that do business with State Medicaid programs directly or contract with commercial payers under ACO arrangements directly, and so you might be offered an agreement to participate in an ACO and that ACO may have multiple product lines. One might be the Medicare Shared Savings Program, but it may also have product lines involved in the Medicaid program or with private commercial payers.

Adam Falcone (00:18:50):

And one of the questions you always want to know is the ACO intending to negotiate for my base reimbursement, rates that I received or do I continue to hold my individual contracts with a particular payer for the rates I've previously negotiated. Another concern about ACO is always about leakage. Many ACOs want to ensure that patients in the ACO or attributed to the ACO only see providers that are also participants on the ACO, so that they can better coordinate and manage the care. So you may want to ask the ACO, what specialists, what hospitals are providers in the ACO because typically, you'll be expected to refer patients to those hospitals and you will likely want to make sure that your existing referral arrangement allow for you to continue making referrals to your existing hospitals and specialty providers to see your patients. If not, you might have to structure some new referral agreements to other types of providers.

Adam Falcone (00:19:49):

I also have some of these checklist questions that you'd want to understand about how payment is made to you under the ACO Participation Agreement, whether you were made Fee-For-Service or PPS or whether it's tied to the total cost of care, are you taking downside risk individually at a health center or is it just for upside savings, shared savings arrangement, is it a pay for performance kind of contract, you definitely want to look at the details for how payment amounts are going to affect your reimbursement and what investments the ACO is making.

Adam Falcone (00:20:23):

FQHCs also should look at whether you have to be exclusive to that ACO or whether you can participate in another network or contract on your own with third party payers under value-based payment arrangements or under different types of contracts. It can get very complicated quickly. I know some ACOs that are only in the Medicare program and so a health center will contract and be exclusive to that ACO for purposes of the Medicare program, but then the health center will turn around and contract either individually or with other ACOs for participation in commercial, accountable care programs and commercial programs and that's permitted, because that's a separate line of business. And so the health center is specific to one ACO for the Medicare line of business and then free to contract individually or through other ACOs for non-Medicare Accountable Care contracts.

Adam Falcone (00:21:17):

Look at the other terms of the contract, how disputes are settled, how long the term is of the contract, whether you can terminate and get out if it's not good for you. Whether the ACO allows an accommodation for you to obtain malpractice coverage under the Federal Tort Claims Act, whether the ACO is willing to indemnify the health center for losses or claims that arise outside the ACO's negligence or intentional conduct related to their contract and then what costs are the ACO willing to shoulder for any kind of interoperability or IT cost that the ACO demands from you in participating in the ACO?

Adam Falcone (00:21:59):

All right. That was my brief summary of how to participate and what concerns to be concerned about in participating in ACOs. We'll come back to some other key contract terms under Part Three of today's webinar. Next, let's turn to forming ACOs and when you form an ACO, you're moving away from just a contractual relationship where you may have with other types of providers into one where you actually have an ownership or control of a new separate legal entity. I would like to point out that health centers

have lots of affiliation agreements that they have with other parties, with teaching hospitals, with hospitals, with specialty providers, and that's a contractual relationship between two or more parties.

Adam Falcone (00:22:44):

When you own or control a new legal entity, now you typically have multiple parties sitting around the table, who now have control or ownership of an entity in common, and so you've created a new legal entity that in turn contracts with MCOs typically under potentially Accountable Care arrangements. And why would you want to do that? Well, many of you want to protect the health center entity from potential liability and so the number one reason for why you would want to form a new legal entity for contracting, particularly for downside contract arrangements where you might be at risk for the total cost of care is in order to protect the health center or the health centers, if there's multiple ones, from any downside risk, because now that legal entity, that new legal entity would be incurring that downside risk, and the health center is protected from the downside risk in the event that there is any liability that results from a contract where you don't do so well, it is owned and that liability goes to the ACO and doesn't upset the health centers' finances.

Adam Falcone (00:23:50):

Now, many of you might consider entering or forming a new legal entity like an ACO because you want to be engaging in joint contracting. You'd want to be jointly negotiating the payment terms with that MCO. So, I always have to point out as a former antitrust attorney at the DOJ, that when providers come together and try to do things together where they are jointly negotiating, it can raise issues under the antitrust laws even though from your perspective, you might be joining or forming the ACO in order to do more work collaboratively. Collaboratively is only so good, they'd only goes so far, because from the antitrust perspective, if you are now providers or are providers that are now undermining competition, by now collaborating in negotiations with an MCO from an antitrust perspective, it can undermine the competition that is supposed to result in lower payment rates from payers to each of the providers.

Adam Falcone (00:24:52):

The antitrust laws are really focused on promoting competition between different providers and are structured in ways to disallow or prohibit anything that would be viewed as anticompetitive. So when providers or any type of entity decides to negotiate jointly or set prices jointly, that's viewed as anticompetitive. When providers come together and they carve up a marketplace and decide what services each of them will render for different geographic areas that they might cover, that's viewed as an anticompetitive activity and it's subject to enforcement by the Federal Trade Commission and the U.S. Department of Justice with Antitrust Commission, Antitrust Division.

Adam Falcone (00:25:34):

So antitrust laws have various standards that apply. The easiest way to understand them are the Per-Se, a legal standard that applies to any time at organizations or firms engage in price fixing or market allocation. Those are viewed as automatically Per-Se illegal and violations of the antitrust law. But most of the time that you get together with another provider and want to form a network, that's considered joint activity in a network. And for those types of efforts, those are not viewed typically as Per-Se illegal, instead, the antitrust enforcement agencies use a rule of reason standard, which is a balancing act, where they look at the good things that will come out of the collaboration, whether it's likely to result in lower cost and higher quality that's considered efficiencies that benefit consumers, which are typically the health plans or employers or consumers who buy and pay for health insurance on their own. And

they look at whether the price agreements by the providers in the network are necessary to achieve those outcomes, all the good things that might come out.

Adam Falcone (00:26:43):

Now, unfortunately, a reasonable test like that is subject to the DOJ and FTC weighing in on a particular arrangement and many providers complained that wasn't very good. It didn't give a very bright line rule for what would be permitted and what would not be and so after a number of years of complaining, in 1996, the agencies jointly issued enforcement statements, policies that established certain antitrust safety zones, so that it was clear to providers when they could work together, when they could jointly recommend changes to payers about how they dealt with different types of policies like referral policies or authorization policies, when they could jointly negotiate with payers, and those are covered by the Enforcement Policy Statements in Health Care from 1996. There's been no changes to those policy statements, except that since that time, the antitrust enforcement agencies have developed a new safety zone for ACOs that are participants in the Medicare Shared Savings Program. And I'll explain what that safety zone is in a moment.

Adam Falcone (00:27:48):

So, for those of you that want to jointly contract as part of a IPA or an ACO, there's different pathways to do that legally, and so you don't have to do all of the pathways, you can just choose one that makes sense for your particular group of providers. So the starting question is sometimes some health centers come together and they're in disparate parts of a State where they're not competitors with each other. There is no overlap in service areas between them, and in that kind of situation, they're non-competitors. The network is not composed of any competitors and providers that want to form a network where there's no competitive nature between them, they can do so and they can jointly negotiate with a payer because there's no loss to competition by them. And there's multiple opinions by the DOJ and FTC that networks that are not composed of competitors can jointly negotiate with MCOs, because there's no effect on competition.

Adam Falcone (00:28:44):

Where the providers are competitors, then the network might need to be financially integrated. And I'll explain what that term means. Those networks that are can't rise to the level of financial integration might pursue a network that's clinically integrated where they meet the definition which I'll explain in a moment of what clinical integration is and showed or demonstrate to the FTC or DOJ, that there are significant efficiencies, lower cost of care and better quality for those providers in a clinically integrated network. And lastly, those ACOs that are in the Medicare program also going to pass, there's a safety zone for them and they can jointly negotiate with private payers, if they're enrolled in the Medicare ACO program.

Adam Falcone (00:29:30):

The FTC and DOJ as part of those enforcement statements did create a special safety zone automatically for physicians that were forming networks and I think the safety zone is illustrative because you can see what is required of these physicians that are participating in these networks in order to be covered by the safety zone. So the way this works is that the FTC and DOJ said, "Okay, so if there's any physician, a group of physicians and they're in a joint venture because they formed an ACO or an IPA, some kind of physician provider network, then we won't subject it to what's called that rule of reason standard. Well, if the IPA or provider network meets the market share limitations below."

Adam Falcone (00:30:15):

So if it's a network of physicians, and they don't have more than 30% market share, and these physicians in that network can contract with payers either through the network or individually or through other organizations, then those physicians can have up to 30% market share in those communities. If the physicians in the network can only contract with payers through that ACO or IPA or provider network, that's considered an exclusive network, and then that IPA can't have more than 20% market share.

Adam Falcone (00:30:46):

So as you can see, the FTC or DOJ said that an exclusive network can only have a maximum of 20% market share, while a non-exclusive network could have up to 30%. They don't want these networks to be too powerful. They don't want these networks to have the ability to dictate prices to payers and that's why they want to make sure they only have a small percentage of the market share, so that an MCO can always contract with other providers if they can't contract to reach agreement with this provider network that meets this financial integration safety zone.

Adam Falcone (00:31:19):

If you're not a physician network, which you are not because you're an FQHC because you're a health center, then the DOJ and FTC created a policy statement, Statement Nine that applies to these so called multi provider networks. So, different types of entities that come together that are not physicians that come together and want to form a network. And unfortunately, the FTC and DOJ said these would be evaluated under the so-called Rule of Reason Standard, but will not be viewed as Per-Se violations, so long as there are significant efficiencies that result, that benefit MCOs or consumers and that the price agreements that these networks are negotiating are reasonably necessary to realize those efficiencies.

Adam Falcone (00:32:02):

So what kind of substantial financial risk is likely to result in efficiency? The DOJ and FTC gave examples of what it was what it would look like if there was substantial financial risk shared. Now, that's considered financial integration. So, a network that is paid by capitation or global fee, that is considered substantial financial risk sharing, because now that network has a very, very strong incentive to manage the total cost of care the money that they receive in furnishing all the services that are delivered by the network. And the FTC and DOJ said if you're uncertain whether your financial arrangement with the payer constitutes financial risk sharing then please write us and we'll give you a business review decision or an advisory opinion to let you know whether it is sufficient to be substantial financial risk sharing.

Adam Falcone (00:32:53):

A number of health center networks have come to me and asked whether they can jointly negotiate incentive payments such as upside only or downside risk payment arrangements for managing the total cost of care or whether they can directly negotiate pay for performance incentives earned. These are networks that don't negotiate based reimbursement because many of these are networks where the health centers retain and negotiate their individual contracts with payers and so the network is only interested in negotiating the incentive payment.

Adam Falcone (00:33:26):

So how would that be analyzed under the legal structure of Statement Nine? The question is whether these network members are sharing substantial financial risk under the arrangement with the payer.

And so if the answer is that these financial incentives that the networks want to negotiate are based on group performance and the accurate as a whole, so not the health centers individually, but as a whole to achieve those cost containment goals, cost of care goals, clinical goals for pay for performance. If the answer is yes, then the network can jointly negotiate those payments incentive, because that would be considered a financially integrated network in regard to the network contract with the ACO. And so the analysis would allow these networks to jointly negotiate the term of these payment incentives.

Adam Falcone (00:34:14):

If, however, the answer is that the MCO is awarding payments based on individual performance of the health centers, regardless of whether they are paying those incentives to the network or to the health center individually, that would not constitute substantial financial risk, because now, the health centers are earning them basically based on individual performance and there's no incentive for the health centers to collectively work together through the network to work together to achieve the clinical benchmark or the cost benchmarks that have been established by the MCO. You must have performance, you must have group performance, you have must have the MCO making decisions on whether to award those extra dollars, their payment incentives based on group performance as a whole. That is key.

Adam Falcone (00:35:01):

If you're not financially integrated, the enforcement agencies also created an exception for the clinical integration where networks that had active and ongoing programs to evaluate and modify the clinical practice patterns and those providers in the network, those could possibly be clinically integrated network. And over the years, probably over the last 20 years, the FTC and DOJ have issued various advisory opinions to let ACOs know or IPAs know whether they are sufficiently clinically integrated to allow them to negotiate fee for service contract with a particular payer.

Adam Falcone (00:35:41):

The last and most recent ACO safety zone has to do with the Medicare Shared Savings ACO safety zone, which I also said is a little bit counterintuitive, because it applies to these Medicare ACOs, but it allows these ACOs to negotiate Fee-For-Service contract with private commercial payers. Again, there's a threshold for how much market share that particular ACO can have in a community and the ACO has to evaluate how much market share they have and it needs to be less than 30%. Market share to fall within the safety zone that the enforcement agency has created for the Medicare Shared Savings ACO.

Adam Falcone (00:36:23):

Alright, that was my quick summary of antitrust law and in the last 20 minutes, I will now go into Part Three to talk about payment methodologies and downside risk arrangements between health centers or between health center control networks and payers. So, one thing to point out at the start is that there are various ways that health centers currently contract under risk arrangements, even though we don't really call them risk. The only non-risk payment method for a health center is a way where they get reimbursed dollar for dollar for all the costs they have with no caps or screens or disallowances. That's really the non-risk payment methodology, but very few health centers have that.

Adam Falcone (00:37:08):

There's a few states that still have cost-based reimbursement to health centers where the health centers submit cost reports, that would say, a very small minority of states. Most reimbursement to

providers and to health centers is on other payment methods, Fee-For-Service, PPS, capitation. Fee-For-Service involves some financial risk, too, because even though you're getting paid under an established fee schedule, you're only getting paid a set amount for each service that you render, and so if your cost for delivering that service exceeds your fee schedule rate, you're taking downside risk and you're basically in the red, because your costs that are exceeding the pre-negotiated fee schedule service rate. So, there's still risk even in a Fee-For-Service world, even though we don't talk about Fee-For-Service as a risk arrangement.

Adam Falcone (00:37:55):

The same is true for PPS. You get paid a bundled and counter rate for a visit and if the cost of delivering services on average for a visit, exceeds your PPS rate in Medicaid or Medicare, then you'll have downside risk. Your costs are exceeding the payment amount and so you're not being paid full for your costs and you have downside risk even though it's a PPS system, the difference is that you're getting paid a bundled rate, but it still exposes you to risk if your costs exceed the PPS payment amount.

Adam Falcone (00:38:27):

Capitation, of course, is more risk for a broader scope of services that you could incur some downside risk for. So, let me talk about capitation a little bit more, because more and more health centers are looking to capitation methodology because there are certain advantages from getting paid under capitation. As you know, you can build into the capitation rate, the payment or costs for delivering non-clinical and enabling services, so those that get extra money to do care management, care coordination, translation or transportation can be built into your capitated payment methodology.

Adam Falcone (00:39:04):

Some health centers like getting paid under a capitated method, because now there's a predictable revenue stream each month regardless of the amount of utilization, regardless of the number of visits and health centers can also be more creative in how they deliver services to patients that don't necessarily generate a billable encounter. So they may be able to take more advantage of using Telehealth to deliver services, they might be able to deliver services through some community health workers or nurses that wouldn't necessarily result in a billable visit and payment. And there's fewer disputes, of course, because you're not getting paid Fee-For-Service, there's fewer disputes for each claim to get paid. You may have disputes related to the capitation amount and the population that's being attributed to you, but you no longer would have the dispute that you typically do under a fee-for-service claims based system.

Adam Falcone (00:39:56):

The disadvantage, of course, is that it's unpredictable, how much utilization, how many visits you might have, so you have to manage that downside risk, and some payers don't like capitation for primary care providers, because they view it as a disincentive for those providers to provide visits. They want to see providers be incentivized to provide more visits because the MCO recognizes that primary care is a high value service that leads to typically lower utilization of ER services and lower utilization of avoidable hospital visit, the more primary care there is. And as the data that I showed earlier in the presentation today, health centers deliver high value typically more preventative care, and help those patients avoid hospitalization, and so many payers want to avoid a payment methodology that can be viewed as an incentive to reduce those visits.

Adam Falcone (00:40:53):

There's different types of capitation methodologies. There's global capitation that typically covers a very broad scope of services and there's partial capitation, which is a narrow set of services. So, you might have professional capitation, which would pay a health center for all physician type services, typically both primary and specialty care or you can have an arrangement with a payer that's just primary care cap, where the health center gets paid a PMPM just for the primary care services they provide within their four walls. Under these capitation methodologies, you don't get any more. If you have more services that you deliver, you get paid a fixed PMPM that doesn't vary on the number of services that are furnished to patients.

Adam Falcone (00:41:37):

For those of you that like those graphs, here, you can see a payer that pays a capitated amount under a professional cap arrangement for all physician services to that FQHC and the FQHC will need maybe delivering all of the primary care services directly through its own physicians and might have to contract with the specialty care services of physicians for delivering a set of services for specialty services, because they're getting paid a capitation rate that includes the specialty services for the enrollees for the attributed population that is assigned to them and so, the FQHC might actually have to go out and contract with specialty providers, so that they are now paying those specialists for those specialty services that are being delivered to the FQHC patients.

Adam Falcone (00:42:28):

If you are paid under a risk-based approach, there are key provisions you'd want to make sure that you have in your contract with the MCO. One of the most important which might not be intuitive, unless you've done this before, is that if you're paid under any kind of risk-based mechanism, it will be incredibly important for you to make sure you get the access to the claims data that you need from the MCO. If you don't have that MCO claims data about where those patients are accessing care, whether they're getting care in emergency rooms or getting hospitalizations, you won't be able to typically design interventions to address those highest cost, high utilizers of care.

Adam Falcone (00:43:08):

The same is true for pay-for-performance programs or incentive programs that you might have, you typically want to know which patients aren't getting their primary care or their recommended primary care services so that you can reach out to them. So you'll be relying typically on the MCO's data to inform you about which patients you want to design your systems around and reach out to make sure that patients are getting those primary care services. So in your contract with the MCO, you'd want to make sure that you specify exactly what data the MCO has to turn over to you, the frequency that they're turning over to you to map data and what should happen in the event that the MCO does actually fails to turn over the data as they promised to under the contract.

Adam Falcone (00:43:57):

If you have a pay-for-performance program, under your contract with the MCO or as part of your ACO agreement, you want to make sure that there's clear language that indicates exactly what population of patients is attributed to you and whether you are responsible for what patients and what definitions apply to calculating your scores on any performance measures. Certainly, the MCO should be able to shift the game or change the game midstream and change performance measures that they're

evaluating or the methodology they used to establish or their performance scores under those performance measures.

Adam Falcone (00:44:37):

If you are considering being placed at financial risk, so a downside risk mechanism with an ACO or with a payer or downside risk where a health center is going to be imposed penalties if they did not achieve the pay-for-performance metrics, I urge you to exercise great caution in entering these risk of arrangements directly with payers because then the health center is basically at risk for when things go wrong. So, you want to be very careful in entering these arrangements and you want to be thinking about ways you can structure the arrangement to limit or minimize how much downside risk you have. So you might be wanting to think about a ceiling or a maximum penalty that the ACO could hold you accountable for or if you were taking a risk arrangement directly with a payer, how much risk, the highest amount of risk you would be encountering under downside risk with that particular payer.

Adam Falcone (00:45:31):

Sometimes you can get quite creative where the amount of payments or downside losses are a percentage of total payments that you might receive or that's established under the benchmark or sometimes you can allow losses that you have in year one or early years to be paid back by gains in subsequent years, in years two and three. So you might expect going into the arrangement that there's going to be a loss the first year as you get used to and develop your systems internally, but you want to be able to pay those losses back in subsequent years gain.

Adam Falcone (00:46:05):

Attribution is a very tricky topic in any kind of value based or accountable care arrangement, because you want to make sure that you're only being held accountable for the patients essentially that you're willing to take risks for. So there are various methodologies that MCOs attribute risk to ACOs in the health centers. Sometimes it's defined by accounting, so you might be attributed all the patients in a particular count, sometimes with just specific health diagnoses. Those patients that might have particular chronic conditions, multiple chronic conditions that might be attributed to a particular health center or an ACO, because there's a health home that is a definition that defines what patients are attributed based on a diagnosis of those patients.

Adam Falcone (00:46:51):

Sometimes it's just patients that you've seen because they're defined as those that receive health services from a particular provider. Other times, the dominant method really in attribution is by primary care, and so a patient that is basically assigned a primary care provider is assigned or attributed to the ACO or the network. But you have to be very careful here, because let's say you had a patient that was default enrolled to you at the health center and that patient never showed up because they were accessing care at their ER or going to another primary care provider for services, regardless of that fact or the fact that they had been attributed to you as their primary care provider. That patient still may be attributed to you under the ACOs or the MCOs attribution methodology because you were lifted as the PCP for that particular patient. So even though they haven't visited you at any time, you could still be responsible for their quality outcomes and for their clinical outcomes and for their total cost of care.

Adam Falcone (00:47:54):

And you as a health center may not want to be responsible for that patient because you haven't seen that patient, you haven't engaged that patient and you might feel like you don't have the ability or the resources to identify and reach out to that patient who is sort of outside your scope of care. So, you always want to be careful about the attribution system to make sure that you're taking that risk just for the patients that you want to under the attribution methodology.

Adam Falcone (00:48:20):

So as a way to do this, think about asking the MCO to generate a list of patients that they would attribute to you based on their existing attribution methodology, so that you can compare that to what patients you think as your current patients, the health funder, and require the MCO to update these list regularly, so that you always have a current list of the patients who have been attributed to you under the MCO's attribution methodology. You may even want to have a mechanism where you can push back at the MCO, so that if an MPC is attributing new patients and you don't think that it is consistent with the distribution methodology that you can appeal or reject patients that they've attributed to you and enlisted on some sort of attribution list or a patient roster.

Adam Falcone (00:49:10):

There are various ways the MCO use to establish a benchmark in their value-based payment arrangement, so some of them just simply downstream a percentage of their premium. So they might say, okay, 85% of our premium dollars, we're going to attribute to you. Others might try to attribute patients based on a percentage of premium revenue medical loss ratio like 80% of our premium dollars will go to you or will be listed as the benchmark. Others might just come up with an amount based on claims experience, what they expect the cost is for a particular population.

Adam Falcone (00:49:47):

And the game here, essentially for setting a benchmark that you would be subject to is to think about the fact that you would always want the benchmark to be set as high as possible, because that's how the MCO is going to evaluate whether you generate any savings. So, if you're in a shared savings or shared risk arrangement, you always want to make sure that the MCO have all the possible costs in that particular benchmark, that it's set as high as possible. They want that benchmark to include not just the amount that it receives from the Medicaid program from the Medicaid agency or the Medicare program, you want to make sure it includes GME payments, you want to make sure it includes an FQHC wraparound payments, any type of one-time life event like deliveries in the hospital, you want that benchmark set as high as possible.

Adam Falcone (00:50:33):

In contrast, the amount that counts against that benchmark that you're evaluated on as the total spend, you want that to be as low as possible in order to qualify for savings. They typically don't want these amounts to include what the MCO spends on administrative services contracts or what they pay out to various vendors to manage authorization decisions or if the MCO uses vendors for quality improvement, you don't want those costs to count. You don't want it to include typically provider bonuses or other incentives or shared savings, because you want those kept out of whether you achieve and how well you do against the benchmark. You want to make sure typically outliers, patients who have claims, for example, in excess of $100,000 are not included in the allowed spend that you're measured against the benchmark. You want this to be as low as possible, so that you can qualify for savings.

Adam Falcone (00:51:31):

So again, consider asking the MCO to apply the methodology to the attributed patients that would be attributed patients based on last year's data, so you can see how your claims experience would measure up against the attributed benchmark that the MCO is suggesting. You can see how well you do. For example, add an ACO also in the controlled network basically told was told by an MCO that the ACO already does really well against their benchmark and so the MCO wanted to set a benchmark very, very low something on the order of 75% a premium payment, because the MCO knew that already, the health center controlled network was likely to achieve that benchmark.

Adam Falcone (00:52:17):

And if the MCO sets that benchmark that low, the ACO is never going to be able to probably get much lower than that and would never qualify for shared savings against that benchmark and therefore would lose out on the opportunity to earn additional dollars. So, consider always asking the MCO to run the attribution and the cost based on prior years' data to see how well you do against that benchmark, so that you have a baseline to evaluate the MCs benchmark proposal. The MCO has this data, so you only need that data to evaluate the MCO's offer.

Adam Falcone (00:52:52):

Same kind of thought would be also true for any capitation methodology that the MCO offers you. You want to make sure that you understand basically your claims experience to see whether you would have enough money under that capitation methodology to pay for all the costs, all the claims that you'd be responsible for paying for the attributed patient population, and certainly there's many sophisticated ways to adjust these capitation rates based on the population that served. You may want to understand what specific subpopulations, with the SSI populations or particular classes of populations. You may want your capitation adjusted for based on age or gender.

Adam Falcone (00:53:33):

Some folks are able to even adjust capitation rates based on social determinants of health, so if they see a population that has greater needs, the capitation rate adjusts to reflect that amount. And also, if the MCO continues to pay any claims on a fee for service basis for patients that are attributed to you, and they want to offset these from capitation amount they pay to you, you certainly want to make sure that you have advance notice of that kind of charge back and get claims level data, so that you can evaluate these claims paid by the MCO to see whether they really should be paid at your capitation dollars to that kind of leakage.

Adam Falcone (00:54:13):

As you know, FQHCs have special entitlements under Federal Law in regard to wraparound payments. The Medicaid agencies are not allowed to consider any financial incentives that a health center receives in calculating supplemental wraparound payments. In other words, you get to receive your PPS rates and be made whole for your PPS for each visit, and then you're entitled to keep all the financial incentives, both positive and negative, outside of that PPS wraparound determination.

Adam Falcone (00:54:43):

So, as a practice pointer, I would strongly recommend that in your contract of any Medicaid MCO, either individually or through an IPA that you have the MCO distinguished between the compensation that is

being paid for the FQHC services as compensation as opposed to just keep that separate from any of the payment amounts that are being received by the health center for bonuses or incentive payments, even if it was a paid on under a capitated basis, because you'll want to have a document that you can show your Medicaid agency, so that it is clear that the MCO incentives are separate amounts that don't involve your payment for the underlying payment for your delivery of health center services. So, I've started writing these as separate provisions in the contract, so that it's not ambiguous, but it's very clear incentive separate from the underlying payments for services from a health center to a health center.

Adam Falcone (00:55:42):

More recently than 2001, because that guidance was kind of old, more recently in 2016, the CMS said that health centers are entitled to their statutorily mandated payment levels, PPS as well and any kind of value-based payment arrangements must also to keep in mind any grant funding requirements. So, for example, your Section 330 Requirements and your grant funding may have special rules attached to how you spend those dollars, and that is, of course true.

Adam Falcone (00:56:13):

As many of you know, you're under special restrictions on how you spend your Section 230 grant revenue. You cannot use your grant funds to pay for costs that relate to any service outside of your approved scope of project. So, you cannot use your grant funds to pay for specialty and hospital services that is outside your approved scope of project. Now, even when you provide services on a prepaid capitation basis, your grant funds still can only be used for delivering services under your approved project scope. You can, however, create a reserve, Section 330 regulations allow you to. You can use your grant funds to create a reserve where it's required by the State to conduct a prepaid healthcare plan. So if you're a health center that has created an MCO, you can use your grant funds to establish that reserve.

Adam Falcone (00:57:09):

Can you take downside financial risk? That's always the hottest question from health centers. You can take some downside financial risk, so long as you're not using grant funds to pay for services outside that scope, your scope of project. So if you're taking some downside risk for total cost of care and that downside risk involves hospital and specialty services, you may not use your Section 330 dollars to offset those costs.

Adam Falcone (00:57:38):

Can you use your program income? Program income is revenue that you generate by operating a health center, so your third party payers. It's allowable under some circumstances to use a reasonable amount of your program income, so long as it's for accomplishing purposes of your approved scope of project. So if you're trying to reduce total cost of care for your population of patients in your service area and some of that involve taking some downside risk and an upside gain as well for managing the total cost of care for your patients and a reasonable amount of downside risk would be permitted.

Adam Falcone (00:58:17):

As you know that if you participate in Medicare managed care, there are similar protections available to you or to wraparound and you can contract with IPAs as well. Any financial incentives you earn are outside the calculation that Medicare uses to determine wraparound payments. All right, I seem to have managed to get through all my slides just in the nick of time. Office Hours will be available next week at

the same time to go into some greater detail, answer any questions that you might have about the material I discussed on today's webinar. Jen, you want to just close for us.

Jennifer Nolty (00:58:56):

Great. Thank you so much, Adam. I really appreciate your time and all the great information that you shared. And again, don't forget next week, this time, Legal Considerations and Risk. Adam will be there on line and talk either via chat, email. We will also have the option to have the phone line open, so please, we will send out a couple of reminders in the next couple of days, but please feel free to be on the call, especially right at noon Eastern Time which would be 9:00 AM in the West. So, really want to utilize Adams brain trust and his information that he can provide to you. And please call in, email, etc.

Jennifer Nolty (00:59:57):

Again, thank you for being on today's webinar. We will have survey. A link to that survey will be popping up at the end or no. I'm sorry. It will be sent this afternoon and then a reminder will also be sent out in the next few days. So, also I just wanted to let you know that our third and final webinar for the ACO Academy right before the end of the summer will take place in two weeks and that one is on Staff Engagement in Achieving the Quadruple Aim, and that will be held on June 13, from 12:00 to 1:00 Eastern time again, followed by Office Hours on Tuesday, June 25, from 12:00 until 1:00.

Jennifer Nolty (01:00:46):

So again, thank you again, Adam, thank you all for joining us and have a great afternoon.