NATIONAL ASSOCIATION OF Community Health Centers®

Accountable Care Academy 2020

As health centers continue to transition to value-based care and population health, more and more payer contracts include some form of risk (or financial burden for the services provided versus the amount of reimbursement expected in return). NACHC's Accountable Care Academy is a 4 part webinar series focused on the fundamental considerations for risk-based contracts and how to prepare health centers for participation in arrangements with risk. Each session will be led by Adam Falcone, Esq., of Feldesman, Tucker, Leifer, Fidell. Tools will accompany the webinars, including a glossary, checklists, and links to supplementary relevant resources, to reinforce key concepts.

1

Register Now!

Final Webinar in the 2020 Accountable Care Academy Series: Field Representative Stories

An opportunity to hear from your peers from across the country as each describe their journey and experience preparing for and managing risk. The field representatives will represent both geographic diversity and contracting diversity, with one that contracts mostly for P4P incentives (and some foundational payments), one that contracts for shared savings, and the third that contracts on a primary care capitation basis with P4P. There will be additional time to engage with the legal expert and your peers. Speakers include:

- Henry Tuttle, CEO of Health Center Partners of Southern California
- Meghann Hardesty, Executive Director, Community Health IPA (of New York State)
- Rene Cabral-Daniels, CEO of Cenevia (formerly Community Care Network of Viriginia)

https://iweb.nachc.com/Conference/RegistrationProcessOverview.aspx?Id=988

2

HRSA Disclaimer

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3

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VBP Contracting Safeguards

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4

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- Partner in FTLF's national health law practice.
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- 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.

5

DISCLAIMER

These materials have been prepared by the attorneys of Feldesman Tucker Leifer Fidell LLP. The opinions expressed in these materials are solely their views and do not necessarily represent the opinions of the National Association of Community Health Centers (NACHC).

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6

AGENDA

Value-Based Contracting Safeguards

- Care Management Programs
- Pay-For-Performance Programs
- Minimizing Down-side Risk Exposures
- Attribution Methodologies
- Benchmark Calculation for Shared Savings/Shared Risk
- Capitation Methodologies
- Term and Termination Rights
- Amendment and Amendment Rights
- HIPAA / Part 2 Confidentiality Considerations

7

CARE MANAGEMENT PROGRAMS

"Primary care medical home" (PCMH) model:

- Each patient has a relationship with a PCP who serves as patient's first contact
- PCMH programs encourage PCPs to provide care management and other enabling services
- Recent years have also seen rise in "disease management" programs in which PCP is required to implement plan of care addressing chronic condition
- Some payors will offer a modest per-member-per-month fee for care management services when the health center is otherwise paid on fee-for-service basis
- Payors will usually define the activities that the health center is expected to do as care management in earning the fees.

8

VBP: PAY-FOR-PERFORMANCE PROGRAMS

P4P Programs. A health center is not placed at financial risk to participate in APM Category 2C (P4P) VBP incentive arrangements.

- Even if the health center 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, health centers should affirmatively request participation in an MCO's P4P Program to maximize overall reimbursement.

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

9

PAY-FOR-PERFORMANCE PROGRAMS

- **Performance Measures.** To facilitate participation in multiple VBP arrangements, health centers should seek performance measures that have standard definitions and methodologies for calculating scores (*e.g.*, HEDIS measures).
  - Ideally, the Medicaid measurement sets and incentives would align with those used by Medicare and commercial payers.
  - Health centers 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.

10

PAY-FOR-PERFORMANCE PROGRAMS

Practice Pointers:

- A health center's terms of participation in P4P programs 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 health center's consent.

11

MINIMIZING DOWNSIDE RISK EXPOSURES

Downside Risk VBP Arrangements. A health center is placed at financial risk to participate in APM Category 3B (upside and downside shared savings) VBP incentive arrangements.

Health centers should generally exercise caution in entering such arrangements as they could result in significant risk to the organization's financial health.

Health centers participating in downside risk arrangements should have:

•Experience in managing downside financial risk

•Have secured access to claims data or reports to manage downside risk

•Procured "stop-loss insurance coverage" to protect against high-cost claims

12

MINIMIZING DOWNSIDE RISK EXPOSURES

(continued)

Practice Pointers. When negotiating the terms of participation in any VBP arrangement that involves downside financial risk, the FQHC should add language that limits or mitigates any such downside risk.

- If the FQHC accepts significant financial risk, the FQHC should negotiate language that limits financial losses to a percentage of total payments or the benchmark, consistent with the Medicaid and Medicare Physician Incentive Program (PIP) regulations.
- If the FQHC participates in a shared risk arrangement for the total costs of care, the FQHC 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.

13

ATTRIBUTION METHODOLOGIES

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

- Geographic area (e.g., counties/zip codes)
- Specific health diagnoses (e.g., chronic conditions, substance abuse disorder, etc.)
- Receipt of services from a particular provider (e.g., patient/clients)
- Receipt of health home services
- Assignment of Primary Care Provider (PCP)

14

ATTRIBUTION METHODOLOGIES

Prospective Attribution Based on Past Claims. If attribution of patients is prospective using claims data, health centers should recognize that the population of patients attributed to the provider may:

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

15

ATTRIBUTION METHODOLOGIES

(continued)

Practice Pointers. To avoid surprises related to the attributed patient population, a health center should:

•Request that the MCO generate a list of attributed patients based on prior year's data so that the health center can learn how many and which patients would have been attributed to the health center under a VBP arrangement.

•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.

•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 health center against the health center's own records within 60 days of receipt of the patient rosters.

16

BENCHMARK METHODOLOGIES

Benchmark Methodology. The basis by which the payor establishes the benchmark under a VBP arrangement. Possible methods to establish the benchmark include:

- Percentage of Premium Revenue
- Medical Loss Ratio (MLR)
- Per-Member Per-Month Claims Experience (projected forward)

Practice Pointers:

•Understand how the benchmark is set. If the benchmark is set too low, it will be impossible to generate savings under a shared savings arrangement (or you will more quickly incur downside losses under shared risk arrangement). Generally, you'll want the benchmark set as high as possible!

•Review which MCO expenditures count (such as incurred claims) against the benchmark. Generally, you'll want the "allowed spend" to be as low as possible to qualify for savings and avoid downside losses!

17

BENCHMARK METHODOLOGIES

(Continued)

Practice Pointers. To appropriately establish the benchmark, a health center should:

- Request that the MCO apply the methodology to attributed patients based on prior year's data so that the health center understands how claims experience compares against the proposed benchmark.
- Negotiate a provision that requires the MCO to provide monthly or quarterly reports during the performance year on how expenditures for the attributed population compares against the benchmark.

18

CAPITATION METHODOLOGY

Capitation Methodology. The basis by which the MCO establishes the capitation amount. Possible methods to establish the capitation amount include:

- Percentage of Premium Revenue
- Per-Member Per-Month Amount for services subject to the capitation

Practice Pointers.

•Ensure the scope of services subject to the benchmark are appropriately and accurately defined (see example in next slide).

•Consider whether the capitation amounts should be risk-adjusted (*e.g.,* aged/gender) or specific to particular subpopulations (*e.g,*. SSI).

•Require advance notice if the MCO has the right to make adjustments to the capitation amount for retroactive changes in eligibility, individuals who seek care from other providers, or state adjustments to premiums.

19

EXAMPLE: PARTIAL CAPITATION

How does the contract define the scope of services? A recent contract defined primary care services to include the following:

TYPE	DESCRIPTION	CPT CODE
Office visits	New and established patients	99201-99205; 99211-99215
Hospital Inpatient	Observation, initial hospital care, subsequent hospital care/discharge	99217-99220; 99221-99223; 99231-99233;
Consultation	Outpatient and inpatient	99241-99245; 99251-99255; 99261-99263;
Emergency Department	Between hours of 5pm and 8am	99281-99285
Critical Care / Neonatal Intensive Care		99291-99292; 99295-99297
Intermediate Care Facility / Skilled Nursing Facility		99321-99333; 99341-99350
Preventive Medical Services	New Patients – Initial history and examination; Established Patients – Interval History and Examination	99391-99397
Newborn Care		99431-99440
Administrative Services	Arterial Puncture, withdrawal of blood; Initial (new patient) visit for surgical procedure; services after office hours; services between 10pm and 8am; Hem – Phlebotomy; Therapeutic; prolonger services; case management services; case plan oversight services	36600; 99025; 99050; 99052; 99195-99199; 99354-99359; 99361-99373; 99374-99380
Injections	IV Fluids; Allergy	90780; 95115-95170;
Special Services	Burn treatment; anoscopy; catheterization, urethra; irrigation, endocervical polyp removal; removal of foreign body (eye); EKG and interpretation; pulmonary function; urinalysis; pregnancy test; occult blood; hematocrit; hemoglobin; strep screen; cocci skin test; TB skin test	16000; 46600; 53670-53675; 57150; 57500; 65205; 93000-93014; 93040-93042; 94010-94060; 94640; 94760-94762; 81000-81002; 81025; 82270; 82947-82948; 83002; 85013-85014; 85018; 85651-85652; 86403; 86490; 86580-86585;
Miscellaneous	Treadmill; Holter monitoring; ambulatory BP monitoring (including interpretation)	93015-93018; 93224-93237; 93784
Minor surgical and other miscellaneous procedures	Surgical procedures; debridement; biopsy; excision; evacuation; repair; cryotherapy; arthrocentesis; minor casting; sigmoidoscopy; circumcision; vasectomy; proctosigmoidoscopy; IUD removal	Various
Auditory System	Removal of foreign body; removal of cerumen impaction	69200-69210; 92551; 92552; 92567
Radiology		70010-79999
Immunizations		

20

ACCESS TO DATA AND REPORTS

- Health centers 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 health center's terms of participation in VBP arrangements should contain language that requires the MCO to furnish to the health center 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 health center is entitled to receive and the frequency in which the MCO must provide the data to the health center.
- If the MCO fails to meet its data sharing obligations, the health center should be held harmless from any loss of revenue arising from unearned payment withholds or downside financial risk.

21

EXAMPLE: SAMPLE REPORTS

REPORT NAME	DATA	FREQUENCY
Attribution	Attributed Medicaid Members with demographic and contact Information	Monthly
Emergency Department Utilization Overview	Overview of emergent and non-emergent utilization that will include a Summary Report and Member Level Detail Report for members with 3+ non-emergent ED visits.	Monthly
Inpatient Utilization Overview	Overview of inpatient utilization that will include a Summary Report and Member Detail Report for members with the greatest number of inpatient admissions, and a Readmission Report.	Monthly
Quality Threshold Targets	A report that tracks the quality threshold targets.	Monthly
Performance Measures	A report that tracks performance measures; includes current rate (numerator and denominator) as compared to benchmark and previous time period.	Quarterly
Budget Tracking Report (Financial Reporting)	Shows at service category level, budget, actual performance and variance to the budget.	Quarterly - by the 15th of the second month following the end of the quarter
Claims Data	Member-level claims data	Monthly
IBNR	IBNR for Attributed Members	Monthly

22

VBP CONTRACT TERM

- Health centers 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 health center is committing to participate in the VBP arrangement.
- **Practice 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 health center can re-negotiate any problematic terms of participation in VBP arrangements.
  - In any VBP arrangement, health centers 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.

23

TERMINATION OF VBP ARRANGEMENTS

- **Termination Rights.** If participation in a VBP arrangement involves financial risk, the health center may wish to include contract language that permits the health center to terminate its participation in the VBP arrangement if the health center 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 health center 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 or does not provide agreed upon data or reports.
  - **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.

24

VBP CONTRACT AMENDMENTS

VBP 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 health center to reject the proposed amendment without altering the current terms of the VBP arrangement.

•If the amendments clause permits the MCO to unilaterally amend the terms of participation in a VBP arrangement, then the health center should have the right to terminate its participation in the VBP arrangement altogether.

25

SIDEBAR: 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 result in disclosures of all the 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.

26

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