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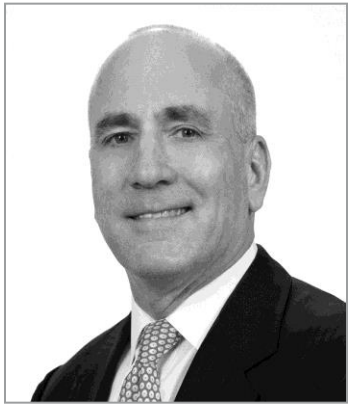
NORTON ROSE FULBRIGHT

The growth of population health within CINs and ACOs

Thursday, May 11, 2017

Speakers



Bernard Duco, *Of Counsel*

Bernie Duco joined Norton Rose Fulbright in 2014 after serving as Chief Legal Officer with the Memorial Hermann Health System. Bernie led the development of Memorial Hermann's Medicare certified Accountable Care Organization and was the lead legal advisor for MHMD – Memorial Hermann's clinically integrated physician group. Prior to joining Memorial Hermann, Bernie served as Senior Vice President and General Counsel for Mercy Health System in St. Louis. Having served for over 20 years as general counsel for large non-profit health systems, Bernie has broad corporate governance, transaction, and litigation management experience. Bernie received his JD from the University of Houston Law Center and his BA from Rice University. He is licensed to practice in Texas and Missouri.

Speakers

Denise Webb Glass, *Partner*

Denise Glass, a partner in the Health Care Transactional group of the Dallas location, joined in 1997. Her practice is devoted to operational, business and related regulatory issues affecting the health care services industry. Denise has broad experience in transactions involving physicians and hospitals, including compliance issues arising under the federal anti-kickback statute and the Stark law, formation, acquisition and disposition of health care entities, and joint venture arrangements.

She has significant experience in the development, organization and operation of various types of managed care and insurance-related entities, including accountable care organizations and clinically integrated networks. She provides advice on both commercial payor and government contracting and compliance matters, including issues related to participation in state managed Medicaid programs, the Medicare Advantage program and the Medicare Shared Savings Program.

Speakers

James Wiehl, *Head of Healthcare Transactions, St. Louis*

Jim Wiehl heads up the Firm's healthcare transactional practice across the United States. His broad corporate and regulatory healthcare practice includes handling all types of affiliations, mergers and acquisitions, development and implementation of accountable care organizations under the Affordable Care Act, including the utilization of waivers and deemed clinical integration status, complex outsource arrangements, managed care arrangements, antitrust consulting, Medicare and Medicaid regulatory consulting, investigations and corporate compliance and other health care regulatory consulting.

He has worked with a diverse group of health care clients including health care systems and academic medical centers, hospital, large specialty physician groups, health insurance companies, hospitalist companies and other health care providers.

Continuing education information

We have applied for 1.0 hour of California, Illinois, Indiana, Missouri and Texas CLE credit and 1.0 hour of New York transitional CLE credit. For attendees outside of these states, we will supply a certificate of attendance which may be used to apply for CLE credit in the applicable bar or other accrediting agencies.

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- Participate in the web seminar by phone and via the web.
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Administrative information

- Today's program will be conducted in a listen-only mode. To ask an online question at any time throughout the program, click on the question mark icon located on the toolbar in the bottom right side of your screen. Time permitting, we will answer your question during the session.
- Everything we say today is opinion. We are not dispensing legal advice, and listening does not establish an attorney-client relationship. This discussion is off the record. You may not quote the speakers without our express written permission. If the press is listening, you may contact us, and we may be able to speak on the record.

Presentations

1. AHCA update and population health overview	Jim Wiehl
2. Further risk assumption by your network	Bernie Duco
3. Trends in allocating risk downstream, concluding remarks	Denise Glass

AHCA update and population health overview

Jim Wiehl

House Bill American Health Care Act (AHCA) Overview:

- H.R. 1628
  - Passed by House on May 4, 2017
  - Republicans claim to “repeal & replace” ACA
  - Utilize FY 2017 budget reconciliation process
  - Vote: 217 to 213
    - 20 Republicans voted against bill

House Bill American Health Care Act (AHCA) Overview:

- MAJOR CHANGES:
  - Repeal ACA mandates, premium and cost sharing subsidies
  - Modify ACA Premium Tax Credits
    - Moving from ACA *income* based credits to *age* based credits
    - Phase-out of credits based upon incomes, at ranges between and $75,000 (600% of FPL) and $115,000
  - Impose late enrollment penalty on those who do not stay continuously covered

House Bill American Health Care Act (AHCA) Overview:

- MAJOR CHANGES (con't)
  - Establish Patient and State Stability Fund
    - Federal funding of $130 Billion over 9 years
    - Additional $8 Billion over 5 years for states electing community rating waivers
      - Assist to reduce premiums or out-of-pocket costs for individuals subject to higher premiums due to community rating
  - Repeal funding for Prevention & Public Health Fund
    - Provide funding to community health centers for 2017 of $422 million
  - Encourage use of HSAs

House Bill American Health Care Act (AHCA) Overview:

- MAJOR CHANGES (con't)
  - Limit Medicaid Expansion – only states that adopted as of March 1, 2017
    - And such states' enhanced expansion sunsets January 1, 2020
  - Add State Option to require work as a condition of eligibility for Medicaid adults
    - Excludes Disabled, Elderly and Pregnant Individuals
  - Repeal Medicare HI tax increase and other ACA revenue provisions
  - Prohibit Medicaid funding for Planned Parenthood Clinics for one year
  - Tax penalty for large employers that do not provide health benefit reduced to zero, effective 1-1-16

House Bill American Health Care Act (AHCA) Overview:

- What Remains - Generally
  - Requirement to provide dependent coverage up to age 26
  - Minimum MLR standards for all health plans
  - Requirements for health plans to report transparency data and provide standard, easy-to-read summary of benefits and coverage
  - Retain private market rules
  - Retain health insurance marketplaces, annual open enrollment periods and special enrollment periods
  - No change to Medicare benefit enhancements or provider/Medicare advantage plan savings

House Bill American Health Care Act (AHCA) Overview:

- What remains – particular to ACOs
  - Section 3022 of the ACA
    - Created ACOs
    - Added new Section 1899 to SSA
    - Neither Section cited by AHCA
  - So, ACOs and ACO waivers currently remain unaffected

SO, CURRENT STATUS IS…..

- ACOs and CINs remain in place, currently unaffected by HB 1628
- Accordingly FTC/DOJ Guidance on ACOs should remain unaffected
  - Deemed “Clinically Integrated“ Status
- Favorable IRS Guidance on ACOs regarding inurement and impermissible private benefit should likewise remain unaffected

Population Health Overview

- Transition from episodic, volume-based care to management of the health or condition of a population
- What is the population?
  - Community
  - Plan Members for whom the Health System has assumed risk (HMO model)
  - Patients for whom the Health System has assumed some form of financial risk for treatment
    - value-based arrangements
    - case rate/bundled arrangements

Population Health Overview

- Why the growth of population health?
  - The right thing to do
    - Right care at the right time for the best outcome
  - Managing population health is the means through which the Health System manages the financial risk it has assumed

Population Health Overview

- *Hypothesis:*
  - Like the concept of self-insurance with umbrella insurance for high risk events, aligning providers' clinical judgment and expertise with the first level of risk, through population health management (with other mechanisms for high risk events), should produce a more economical health delivery model in the United States

Further risk assumption by your network
Bernie Duco

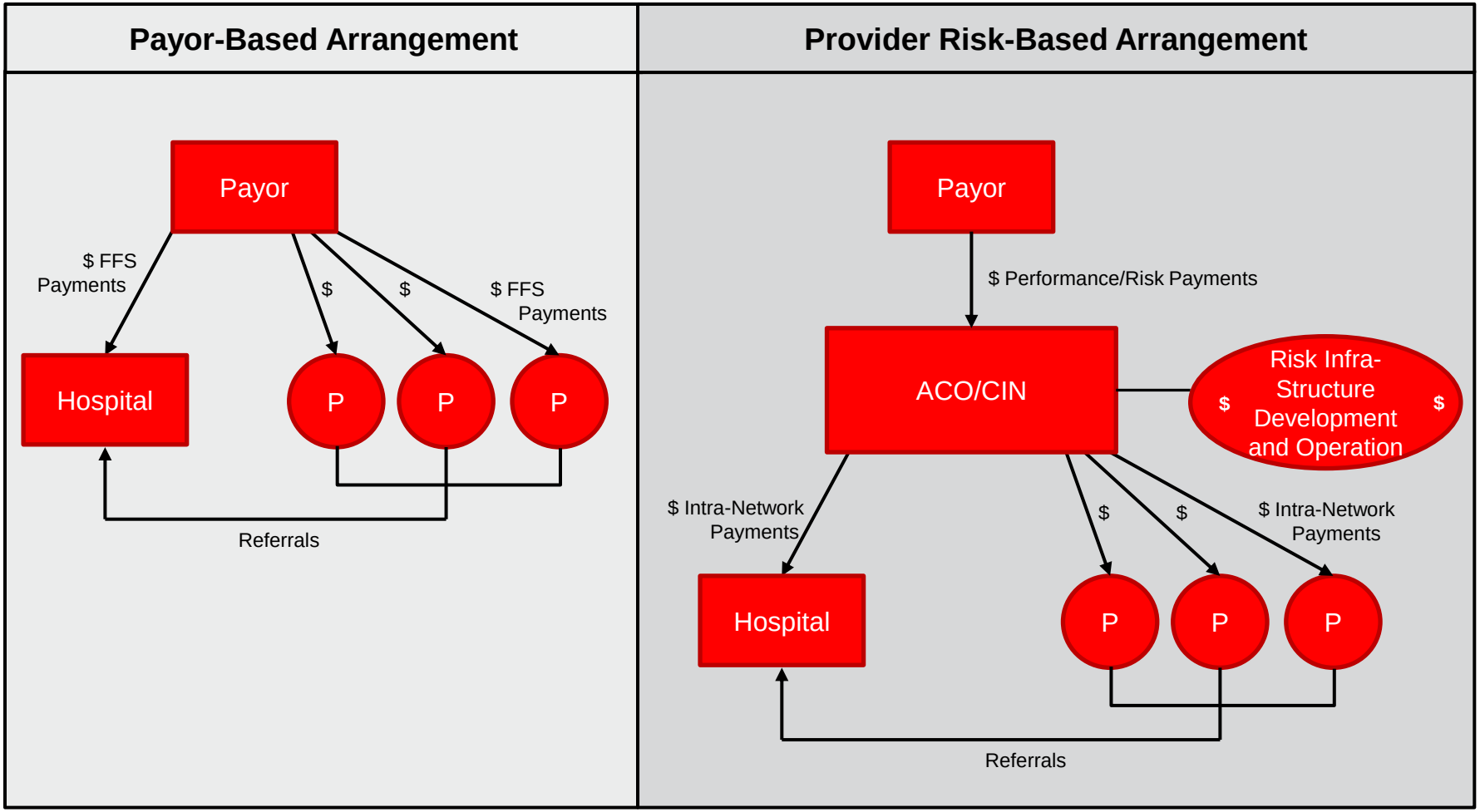
Network Provider Risk

- Arrangements under which health care providers, usually through integrated networks like CINs or ACOs, assume some degree of financial responsibility for the quality, efficiency, or outcome of the care they individually or collectively provide

Including Risk in Network Provider Arrangements

- No Legal or Regulatory Requirement To Do So
- Should Network Risk Be Included?
- If so, how?
  - Direct Allocation?
  - Performance-based Incentives?
- Conclusions:
  - Important to include Network Risk in Network Provider arrangements
  - Probably best through performance-based incentive arrangements
  - Essential for population management initiatives

Network Provider Risk Arrangements



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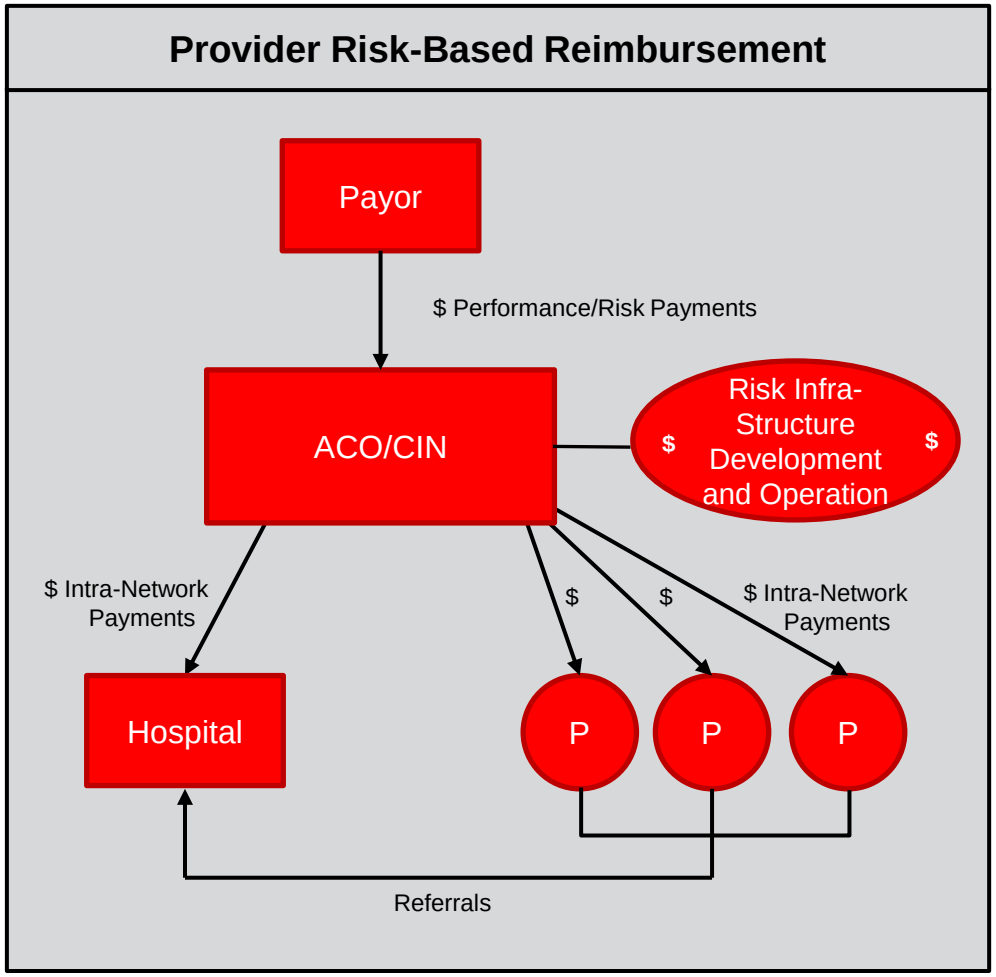
Network Provider Risk Arrangements



Intra-Network Payments

- Create aligned incentives to provide high quality, efficient, in-network care (population health management)
- Elements
  - In-Network utilization requirement
  - Use of bonuses/withholds and other mechanisms to reward appropriate care

ALL ARRANGEMENTS MUST BE STARK AND AKS COMPLIANT AND NOT CREATE PRIVATE INUREMENT OR IMPERMISSIBLE PRIVATE BENEFIT

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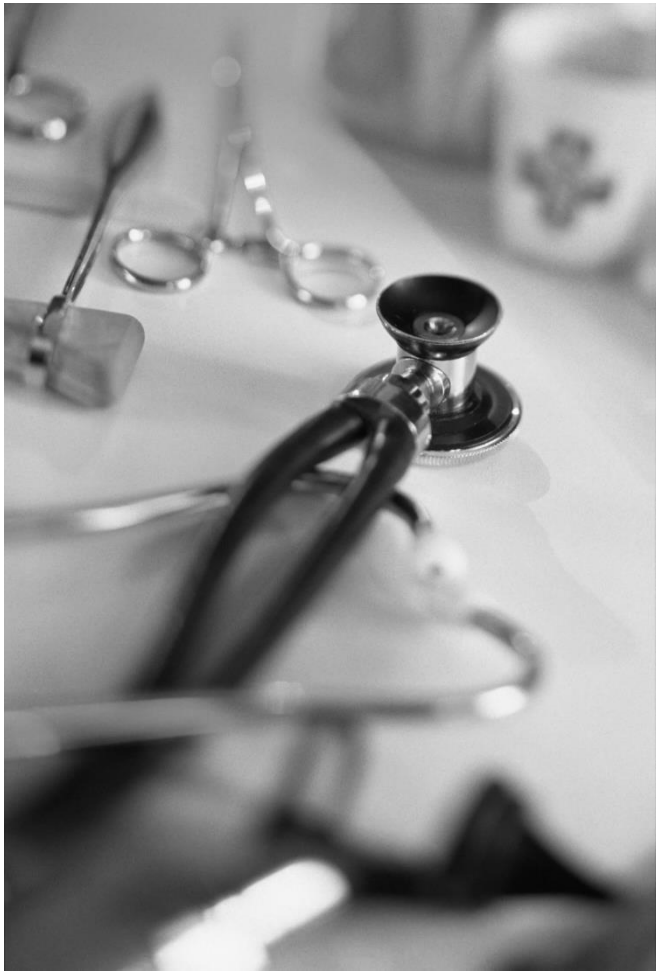
Network Provider Risk Arrangements

- Potentially Applicable Stark Exceptions
  - Personal Services Arrangement (General)
  - Personal Services Arrangement (Physician Incentive Plan Exception)
  - Bona Fide Employment
  - Risk Sharing Arrangement
  - Indirect Compensation Arrangement



Network Provider Risk Arrangements

- Available Stark Law exceptions allow providers to establish legally compliant arrangements containing provisions that will encourage high-quality, efficient care within the risk-bearing network
- Developing effective, straightforward incentive arrangements within the Stark law framework can be challenging
  - Arrangement Objectives
    - Changes in Practice Behaviors
    - Often Outcome rather than process focused
    - Disease, Service, or Network outcome measures
  - Fair Market Value Determination Requirement
- While some Network Provider Arrangements may not fall within an AKS safe harbor, those arrangements that meet a Stark exception should also not violate the AKS

Use of MSSP ACO Waivers for Network Provider Arrangements

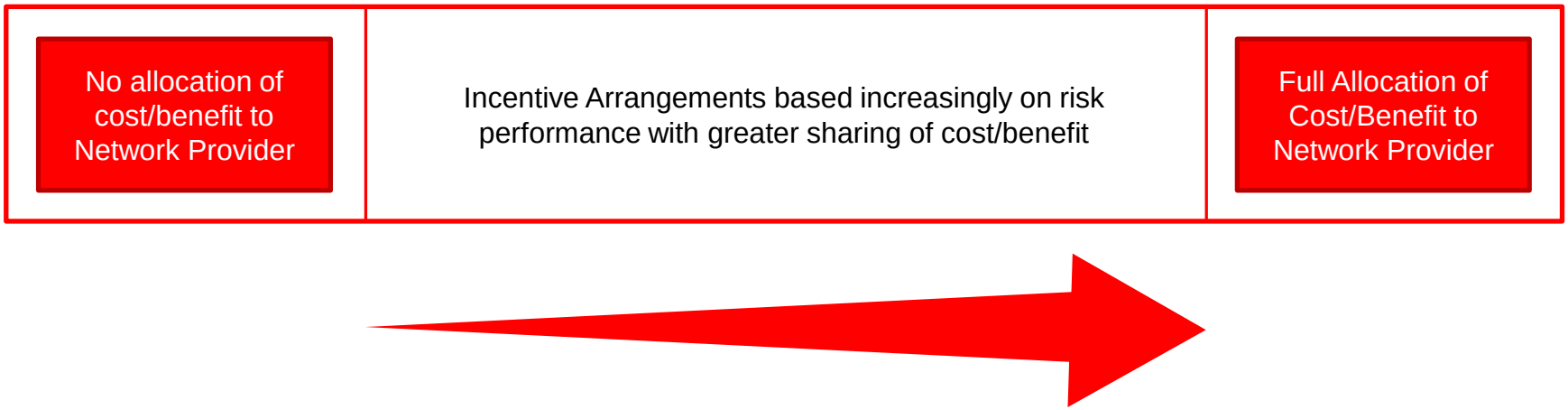
- Illustrative MSSP ACO “Start-Up Arrangements” include:
  - Creation of incentives for performance-based systems and the transition from a fee-for-service payment system to one of shared risk of losses (population health management)
  - Information Technology
    - Data reporting systems
    - Data analytics
  - Capital investments including loans, capital contributions, grants and withholds
- Commercial payer risk arrangements may be considered in developing Network provider arrangements that are eligible for MSSP waivers, but provider arrangements that are tied exclusively to commercially insured patients are ineligible for MSSP waivers

Use of MSSP ACO Waivers for Network Provider Arrangements

- Recommend placing arrangements under a waiver
  - clearly contemplated by CMS
  - provides greater flexibility in establishing incentive-based arrangements that reward performance, which can be challenging under the Stark Law
- Caution: MSSP Waivers do not waive applicable IRS rules
  - Network Provider Arrangements must be reasonable as regards the sharing of potential costs and benefits to avoid creating private inurement or impermissible private benefit

Allocation of the Cost/Benefit of Network Risk Arrangements to Network Providers

- Spectrum of Network Provider Financial Arrangements



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Allocation of the Cost/Benefit of Network Risk Arrangements to Network Providers

- Under what terms should risk cost/benefit be shared?
- Can Network Providers receive all of the benefit with none of the cost?
- What are the risk-related costs?
  - Credit Costs
    - LOC, Surety Bond or Escrow Account
    - Fee for Guarantee provided by ACO parent or Health System
  - Stop-Loss Premium
  - Network Reserve Fund Contributions
  - Repayment of unpaid losses accrued from prior performance periods
  - Exposure of Network assets to uninsured losses
  - Increased Network overhead related to assumption of risk/population health management

Including Risk in Network Provider Arrangements: A Proposed Model

- Network Providers are not directly responsible for risk-based losses
- Risk is included in Network Provider arrangements through performance-based incentives
- No distribution of risk proceeds until risk-related costs are covered

Including Risk in Network Provider Arrangements: A Proposed Model

- Any windfall gains from risk arrangements should be retained by the Network for future development or distributed to the Health System to the extent the System capitalized and supports the Network. This counter-balances the retention of uninsured risk loss by the Network
- Must be Stark and AKS compliant, or under MSSP Waiver
- Must not create private inurement or impermissible private benefit if a TE organization is involved in the Network

Trends in allocating risk downstream

Denise Glass

The shift to risk shifting

- HHS has set as a goal to have 50% of Medicare payments in alternative payment models (e.g., ACO's, bundled payments, and population-based payments) by the end of 2018.
  https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html
- Private Payers are following suit
  - - In 2015 United Health Group expected about a 20% increase in the concentration of value-based reimbursement to providers – growing from $36 billion to $43 billion.
    "United Health's $43 Billion Exit From Fee-For-Service Medicine," Forbes, January 23, 2015

What does CMS require under MSSP or Next Gen?

- Repayment mechanism
  - Percentage of payment limit
  - Form of security
- Still responsible for compliance with state insurance laws
  - "To participate in the Next Generation ACO Model, an ACO must demonstrate compliance with all applicable state licensure requirements regarding risk-bearing entities unless it provides a written attestation to CMS that it is exempt from such state laws."
  - "…CMS understands that most states do not have laws that specifically address provider organizations bearing substantial financial risk, distributing savings, or, in the case of certain Next Generation payment mechanisms, paying claims. Therefore, depending on the particular state laws and the discretion of state authorities, Next Generation ACOs may be subject to insurer or third-party administrator (TPA) licensure requirements. It is a Next Generation ACO's responsibility to determine and meet all applicable licensure requirements."

When risk becomes risky--various forms of risk-sharing arrangements

- Capitation (predetermined prospective payment on a per member basis or percent of premium)
- FFS payments with shared upside/downside based on achieving established cost/quality benchmarks
- Repayment of care coordination fees based on failure to achieve certain cost/quality thresholds
- Bundled payments

State Insurance Laws Concerns

- Insurance laws are state specific and vary widely
  - A provider risk arrangement that is allowed under the laws of one state may not be allowed under the laws of another
  - Ability to take risk may depend on the type of payor and/or product
  - Ability to take/shift risk may depend on who the payor is
- Caution: existing payers are whistleblowers-in-waiting for providers who engage in prohibited risk-based arrangements


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