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Value-Based Payments in Managed Care: The Legal Landscape

May 24, 2016

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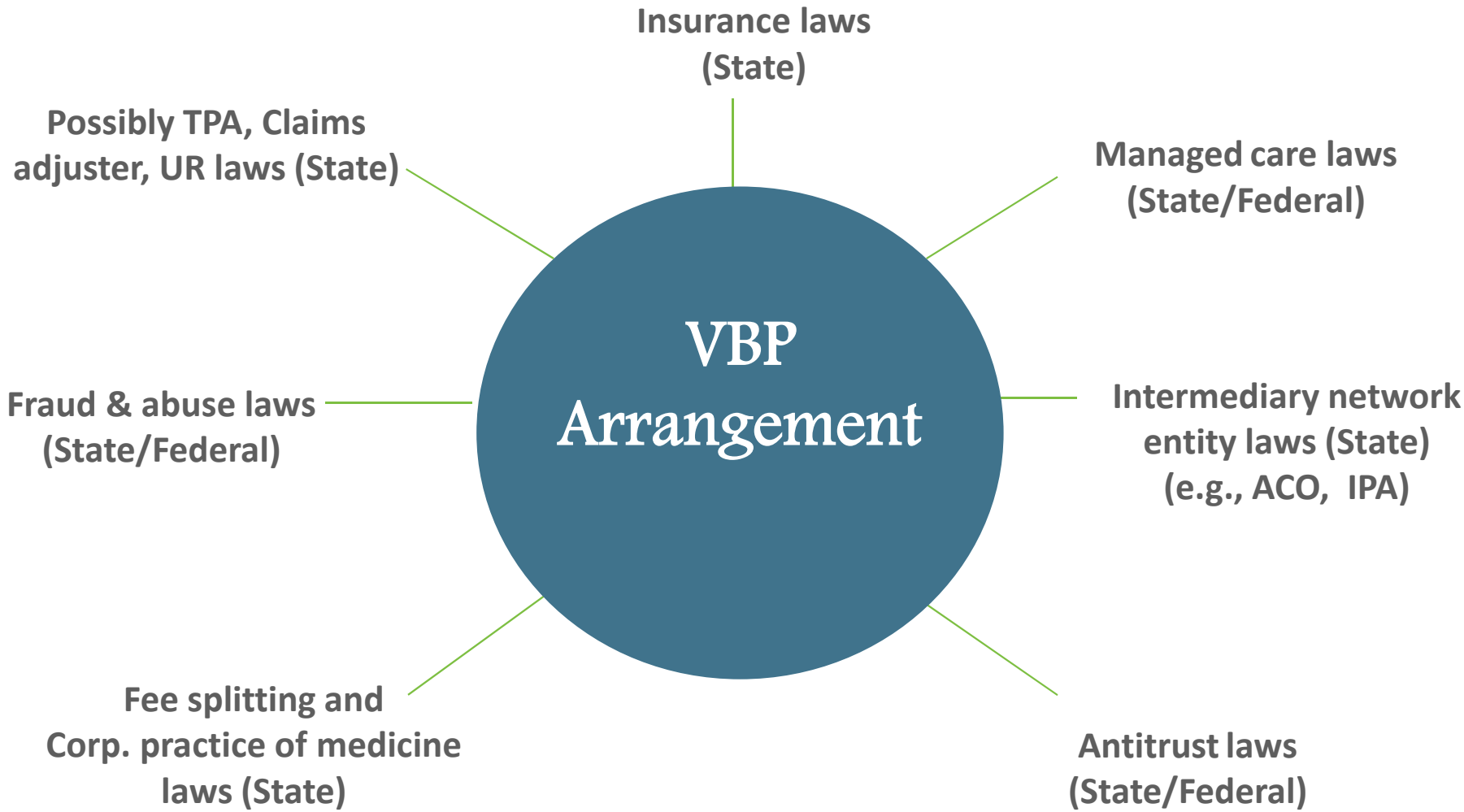
This presentation will cover:

1. Key variables impacting the legal analysis of a VBP arrangement
2. Laws that often apply to a VBP arrangement
3. Examples of legal analyses for two hypothetical VBP arrangements

VBP Legal Issues Vary Based on Type of Payor, Product, Provider and Payment

Payer	Product	Provider	Payment
• HMO • Insurer • QHP • TPA • PPO • Employer	• Medicare Advantage / Part D • Medicaid managed care • CHIP • FIDA/other dual products • MLTC • Commercial– fully insured exchange (individual or group) • Commercial– fully insured off exchange (individual or group) • Commercial – self insured(ASO)	• Licensed provider(s) – hospital, physician, etc. • Intermediary business entities --- ACO, IPA, etc. • Downstream providers • Other	• Quality only • Shared savings • Shared savings and shared losses • Bundled payment/episodic payment • Capitation • Percent of premium • For one service or multiple services (health care, admin) • For In-network only or also out of network

Some Laws That Often Apply to VBP Arrangements



Insurance Laws

At some point VBPs = the practice of insurance.

INSURANCE

FFS	QUALITY INCENTIVE	SHARED SAVINGS (UPSIDE ONLY)	SHARED SAVINGS & SHARED LOSS	BUNDLED PAYMENTS	CAPITATION OR PERCENT OF PREMIUM

Insurance Laws

- "Health insurance risk" is defined by NAIC as "*uncertainty regarding the possibility of loss caused by bodily injury or illness, including medical expenses*".
- Each state may define insurance somewhat differently, but bottom line is anyone that engages in the practice of insurance needs to be licensed and have reserves for such risk.
- Some states permit an insurance company to share risk for its health insurance products with providers or others under certain conditions (e.g., prior approval, reinsurance or other security to cover potential loss, etc.)
- The degree of regulation typically depends on the type of services that are subject to risk sharing (one service or all, in-network only or also out of network, etc.) or on the type of payment (e.g. prepaid capitation but not retrospective payments).
- MLR requirements (medical cost and quality improvements) may apply.

HMO Laws

- HMO are licensed by states to take health insurance risk.
- Many HMO laws address when risk can be “shared” with providers and others.
- Some state laws prohibit risk sharing with providers altogether, but more states allow it but regulate it , e.g., requiring approval and often security for such risk, such as reinsurance or stop loss or reserves.
- Like insurance laws, the degree of regulation depends degree of risk assumed -- one service versus multiple services; sub-population or entire population, in- network versus out-of-network services, etc.
- MLR requirements (medical cost and quality improvements) may apply.
- Changes in HMO (and other managed care type) laws are being driven by CMS’ VBP reform for traditional Medicare and Medicaid (e.g., MSSP ACOs, MIPS, CJR, final Medicaid managed care rule).

Medicaid Reform

Some states are adopting "VBP Roadmaps" in context of Medicaid managed care reform and requiring managed care plans to pay providers based on value.

For example, NY is requiring 80-90 percent of Medicaid managed care payments be value based by the end of 2019:

NEW YORK STATE | Department of Health | Medicaid Redesign Team

New York Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Value-Based Payment Roadmap

Options	Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level; requires mature PPS)
All care for total population	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Global capitation (with outcome-based component)
Integrated Primary Care	FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores	FFS (plus PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when outcome scores are sufficient)	FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for Primary Care Services (with outcome-based component)
Acute and Chronic Bundles	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on bundle of care (savings available when outcome scores are sufficient)	FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	Prospective Bundled Payment (with outcome-based component)
Total care for subpopulation	FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings based on subpopulation capitation (savings available when outcome scores are sufficient)	FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)	PMPM Capitated Payment for total care for subpopulation (with outcome-based component)

Intermediary Network Entity Laws

Non-HMO and non-insurance entities that arrange for health care services to be provided may also be regulated. For example:

- New York: ACOs, IPAs, Performing Provider Systems (PPS)
- New Jersey: Organized Delivery Systems (ODS)
- Connecticut: Preferred Provider Networks (PPNs)
- North Carolina: Intermediaries
- California: IPAs, risk based organizations (RBO)
- Oregon: Coordinated Care Organizations (CCO)

Antitrust Laws

- Relevant to VBP arrangements, e.g., when multiple providers negotiate VBP arrangements together.
- Federal and state laws may apply.
- Joint negotiation of reimbursement terms including VBPs may be permissible if the providers are "clinically or financially integrated".
- Otherwise providers may need to use a messenger model arrangement.
- VBPs can constitute financial integration if "substantial risk" is shared among providers.
- Government VBP programs often include antitrust waivers; Commercial programs typically do not.

Corporate Practice of Medicine and Fee Splitting Laws

- CPM laws/doctrines prohibit the practice of medicine and certain other health care services by general business entities.
- Fee splitting laws prohibit professionals (e.g., physicians) from splitting fees for professional services with non-professionals.
- "Friendly PC" models may be allowed but the rules differ by state and often involve foreign qualification and stock transfer agreement issues.
- Government VBP programs may include CPM and fee splitting waivers; Commercial programs typically do not.

Fraud and Abuse Laws

- Mainly affect government programs but state laws can apply to commercial programs; also Medicare may be a secondary payer and exchange subsidies
- Stark – physician self-referral law; FMV analysis
- Anti-Kickback Statute (AKS) – payment for referrals
- False Claims Act – can be based on violations of Stark or AKS
- CMP – payments to reduce medically necessary care
- Gainsharing between hospitals and physicians (OIG Advisory Opinions)
- Both federal and state laws
- Government VBP programs often include fraud and abuse type law waivers; Commercial programs typically do not.

Laws Related to Delegation of Plan Services

Additional regulatory requirements often apply when a managed care plan delegates administrative or management services (which is more likely to occur in downside risk sharing arrangements). For example:

Claims Payment:

- If a provider or management company pays claims on behalf of plan or employer, then a TPA license may be necessary in many states. Approval of the agreement may also be necessary.
- Some states require licensure for "claims adjusters"

Utilization Review:

- Reviewing claims submitted for medical necessity often requires state licensure. Approval of the agreement may also be necessary.

Credentialing:

- Credentialing providers on behalf of the plan may require approval of the agreement.

One Hypothetical VBP Arrangement

Payer	Product	Provider	Payment
• HMO	• Medicare Advantage / Part D	• Licensed provider(s) – hospital, physician, etc.	• Quality only
• Insurer	• Medicaid managed care	• Intermediary business entities --- ACO, IPA, etc.	• Shared savings only
• QHP	• CHIP	• Downstream providers	• Shared savings and shared losses
• TPA	• FIDA/other dual products	• Other	• Bundled payment/episodic payment
• PPO	• MLTC		• Capitation
• Employer	• Commercial– fully insured exchange (individual or group)		• Percent of premium
	• Commercial– fully insured off exchange (individual or group)		• For one service or multiple services (health care, admin)
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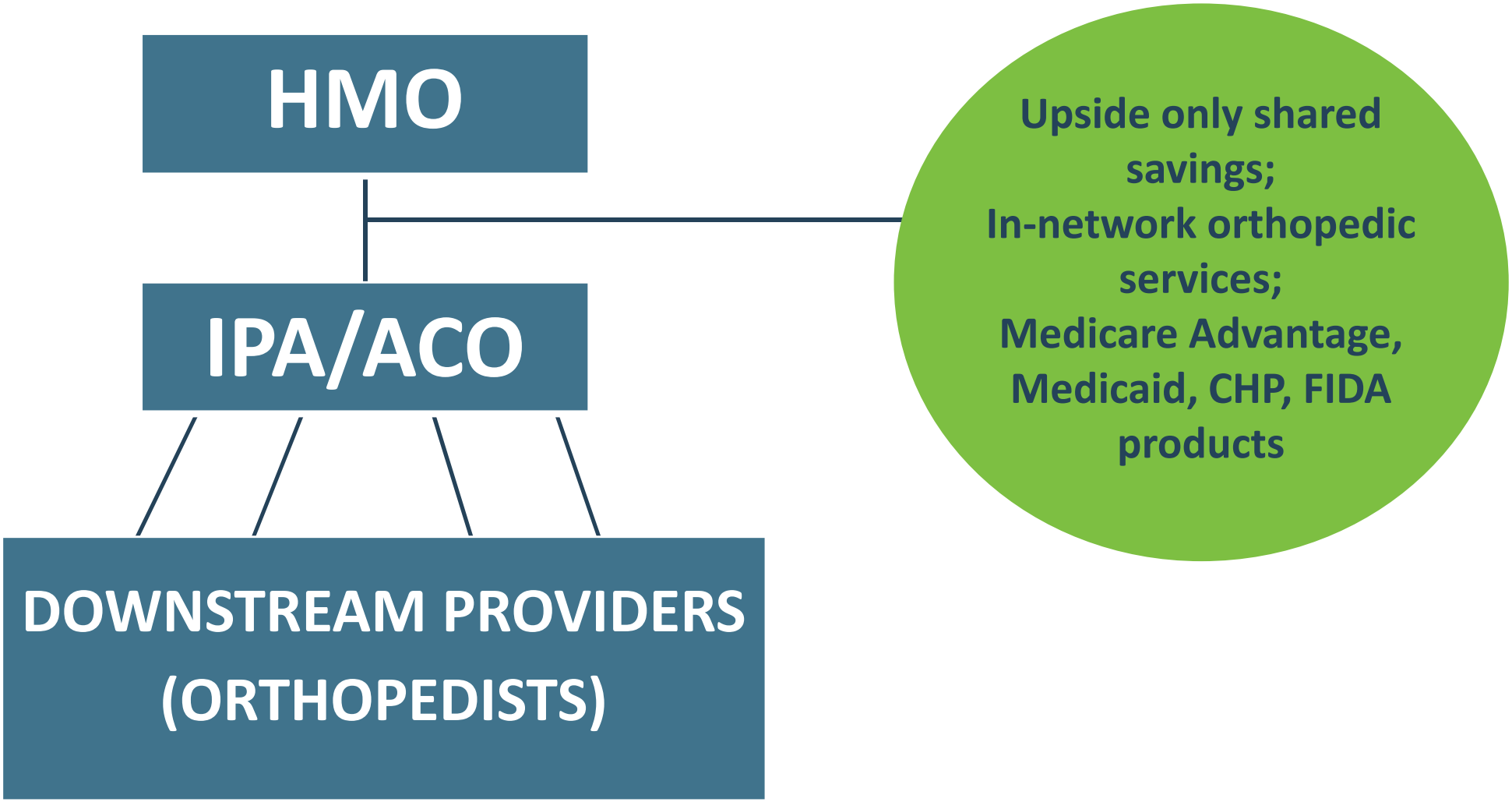
Same Example in a Diagram



Another Hypothetical VBP Arrangement

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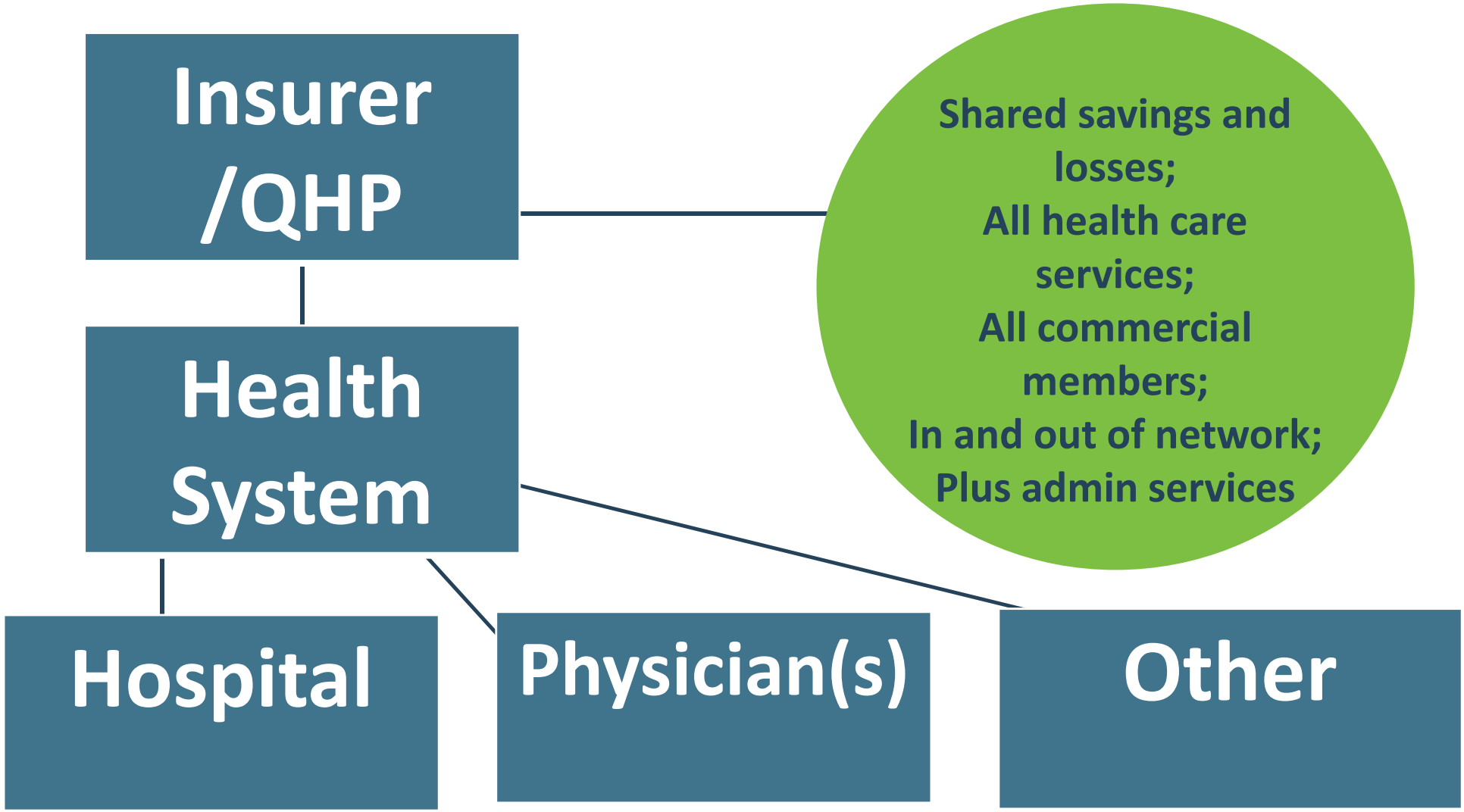

Questions?

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Upcoming Webinars

Value Based Payments Crash Course Series

- **VBP and Managed Care Contracting**
  May 31, 2016 at 2:00 – 2:15 p.m. ET
  Basil H. Kim

To register, please visit: http://www.ebglaw.com/events/

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