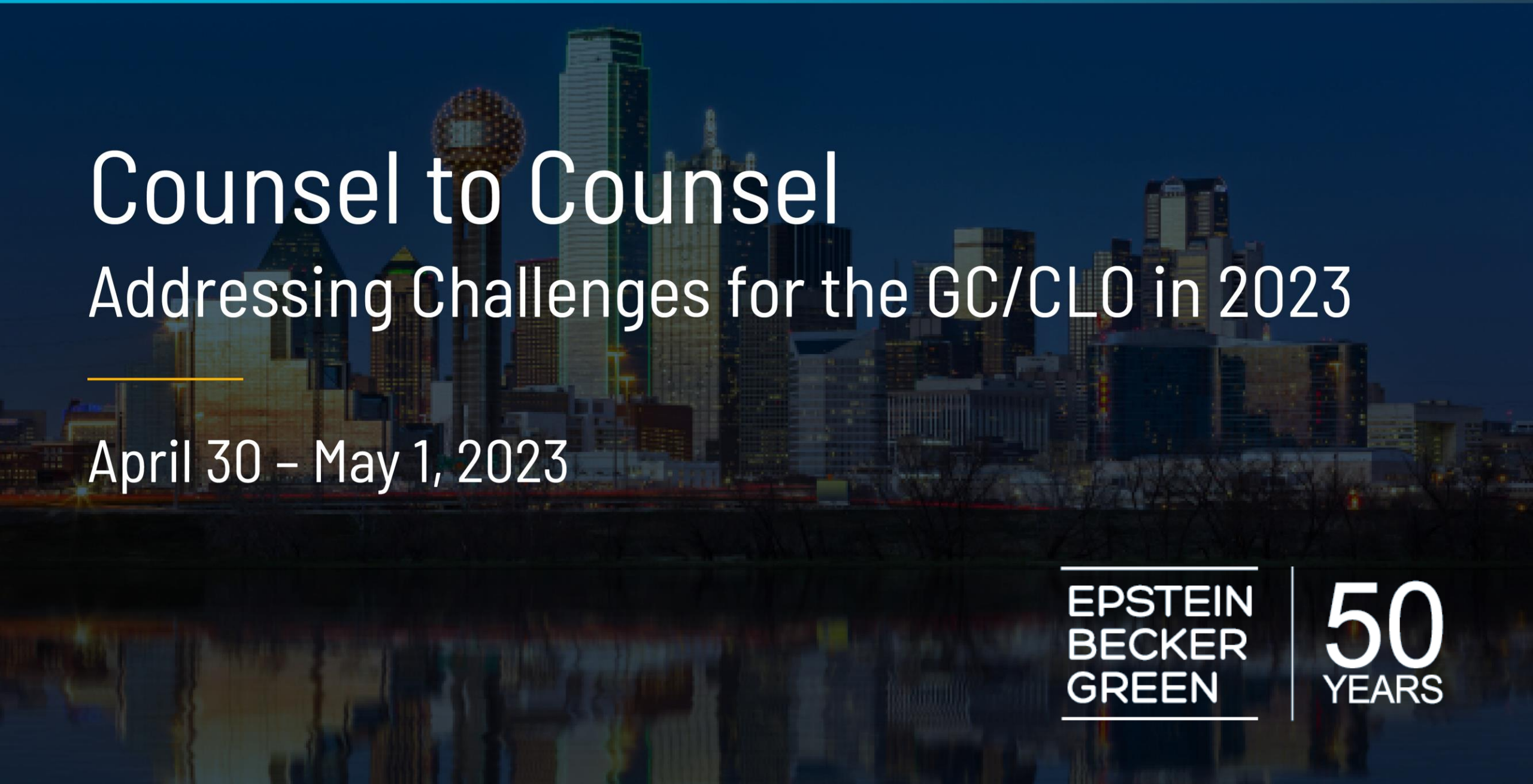
GENERAL COUNSEL ROUNDTABLE



# Counsel to Counsel

## Addressing Challenges for the GC/CLO in 2023

April 30 – May 1, 2023

EPSTEIN BECKER GREEN | 50 YEARS

# What GCs Need to Know About Value-Based Care and Putting It into Action

# What GCs Need to Know About Value-Based Care and Putting It into Action

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Epstein Becker Green

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# Agenda

1. Assessing whether value-based care is a good business strategy for your organization
2. Evaluating structuring options for value-based payment arrangements
3. Identifying and managing regulatory requirements and risks
4. Key issues and strategies for contract drafting and negotiations
5. Dispute resolution and management for value-based arrangements

# What is the correct definition of “Value Based Care”?

A. A vague term that alludes to providers having some exposure and accountability for cost and quality of care

B. Euphemistic term; roughly translates to “your revenue will be lower”

C. An oft foretold phenomenon that is imminent but has yet to occur; most likely to occur sometime between next Thursday and the end of the universe

D. An accretive business strategy that can be financially beneficial but is nevertheless difficult

E. All of the above

**ANSWER**

# Are You A Good Candidate For Value-Based Payment Arrangements?

## Opportunity Size

1. Assessment of attributable patient volume by payer category for next 5+ years
2. Projection of profit opportunity, revenue and cash flow
3. Medicare FFS trends/opportunities

## Primary/Plurality Care Capability

1. Reach of employed primary care and plurality specialists
2. Reach of affiliated (CIN?) providers
3. Telehealth and integrated EMR capability
4. Urgent care footprint

## Environmental

1. Current state and growth in payer mix
2. Government policy evolutions in the future
3. Potential disintermediation of physician referrers by other players
4. Motivations of payers, employers, and physician players

## Strategic Inputs

1. Risk appetite
2. Vertical Integration plans
3. MSSP / ACO Reach participation
4. Expected investments toward "value-based capabilities"

## Feasibility Validation

- **System-specific financial pro forma**
- **Capital and risk assessment**
- **Capabilities / readiness assessment**
- **Sensitivity analysis**

## These inform your dominant strategy….

- ? Risk-Capable Health System
- ? Center of Excellence
- ? Facilities Supplier
- ? Safety Net

# Competencies Assessment

Provider will need strengthen existing capabilities and build new ones to power a scalable and differentiated business model

| Capabilities | Current State Maturity (1-10) | |
|---|---|---|
| Payer Relationships | | Limited to single state experience |
| Tested and Productized Care Model | | Care model is in place, but likely needs documentation, refinement, and system engineering |
| Patient/Provider Workflow Management | | Patient and provider experience work may be needed to minimize friction in the practice of the care model; may need common EHR |
| Risk Pricing/Actuarial | | Advanced analytics, pricing and risk management tools needed for some options |
| Broad Provider Performance Data | | Performance data limited to state experience |
| Consumer Analytics | | Would love to see data enhancement and predictive analytics from Parent could be more aggressively applied |
| Physician Performance Analytics | | In addition to data foundation, need grouping tools and data linkages to synthesize a virtual ACO |
| Scalable Care Coordination / Case Mgt | | Need to scale up for most care models |
| Downstream Physician Contracting | | Need to scale regionally |
| Physician Digital Assets | | Existing foundation may need to be enhanced |
| Consumer Digital Assets | | Existing digital assets are likely quite adequate |

# Business Lines of Focus

1. Medicare Advantage
2. ACA individual / Marketplaces
3. Medicaid
4. ACA small group
5. Small group narrow network self-insured
6. Public sector employers
7. Commercial large group
8. ACO REACH/MSSP

- **Which business lines or financial classes have you done value-based arrangements in?**
- **Why did you start with those?**

# Varieties of VBC

- Shared Savings
- Bundled Payments (e.g BPCI or case rates)
- Sub-capitation by service line
- Global capitation
- “Pay-vider” JVs
- ACO-REACH / MSSP

- **Which varieties have you pursued?**
- **Why did you start with those?**

# Risk Bearing Entities

- PC
- Health system parent
- MSO
- JV LLC
- Captive
- JV Insurance Company
- CIN
- IPA

- **These are not mutually exclusive**
- **Which ones have you used?**
- **What drove your decision?**

# Structural Comparisons

| | Care Coordination and Quality Fee | Integrated Primary Care Sub Cap AMH | Gain/Loss Share | Global Capitation |
|---|---|---|---|---|
| **Target Populations** | All | Co-Morbid IDD and SMI | All | SMI/IDD |
| **Target Providers** | PCPs, Multi-Specialty Practices, FQHCs, Other Agencies(?) | Multi-Specialty Practices, Integrated PCP Practices | Large Volume Psych Practices, Multi-Specialty Practices, Integrated PCP Practices | Multi-Specialty Practices, Health Systems, ACOs |
| **Structure** | Provider care coordination fee | Condition-specific limited capitation | Payer/provider contract with gain share agreement | Condition-specific global capitation |
| **Service Scope** | •Maintenance care<br>•Medication mgt<br>•HEDIS/ access measures<br>•Admission/readmission | •All primary care svcs<br>•Integrated BH<br>•Medication mgt<br>•All HEDIS measures<br>•Care coordination | •Comprehensive | •Comprehensive |
| **Fixed PMPM** | $10-12 | $60-80 | $20-$30 PMPM | $200/$2,000 PMPM |
| **Target Threshold** | NA | NA | 90% of expected | 95% of expected |
| **Gain Payout** | NA | NA | 100% of savings; no limit | Unlimited |
| **Loss Payout** | NA | NA | 100% of loss up to $75K PMPY stop loss | Unlimited |
| **Attribution Model** | Claim triggered algorithm; provider led | Claim triggered algorithm; provider led | Retro-claim; prospective assigned DX/zip if NA | Retro-claim; prospective assigned DX/zip if NA |
| **Util Mgt** | Client | Shared | Shared | Provider |
| **Claim Admin** | Client | Client | Client | Provider |
| **EHR Integration** | Optional | Mandatory | Mandatory | Optional |
| **Risk Adjusted** | No | Yes(CDPS Rx) | Yes(CDPS Rx) | Yes(CDPS Rx) |

# Identifying and Managing Regulatory Requirements and Risks

## Structuring/Development Risks

- State Insurance/HMO regulation of risk delegation/assumption
- State UR and management services delegation requirements
- Medicaid state-specific requirements
- CPoM
- CMS PIP regulations
- FCA/AKS/CMP/Stark
- CMS program requirements for ACO REACH/MSSP
- Others?

## Operational Risks

- Risk adjustment FCA perils
- OIG/DOJ focus on marketing and UM
- Revenue accounting/auditing
- CMS PIP regulation compliance
- State Insurance/HMO compliance
- State UR and management services delegation requirements
- Medicaid state-specific and CMS program oversight requirements
- Others?

# Key Issues and Strategies for Contract Drafting and Negotiations

## Key Terms

- Assigned Risk Cohort
- Exclusions – Member/Cost
- Attribution Methodology and Process
- Shared Savings/Risk vs. Capitation
- Quality
- Risk Corridors and/or Stop-Loss
- Data sharing – Up Front/Ongoing
- Risk on Outpatient Medication Costs
- Risk Adjustment

- Baseline
- Trend
- Benchmark
- Program Governance
- Revenue recognition
- Term
- Termination
- Assignment
- Government Policy Changes
- Dispute resolution

# Dispute Resolution & Management for Value-Based Arrangements

## Common Causes of Disputes in Value-Based Arrangements

- Technical problems in data exchange, payment, or other operations
- Higher/lower numbers or risk in attribution than expected
- Regulatory/government payor changes
- Government investigations
- Actuarial disputes on benchmarking and risk adjustment
- Settlement calculation disputes
- Governance/strategy disputes
- Compliance disputes

- **What are the major problems you have experienced in operating value-based arrangements?**

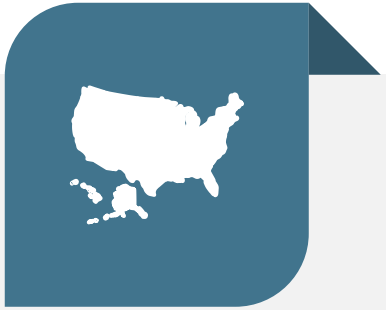
# Dispute Resolution & Management for Value-Based Arrangements

## Techniques for Avoiding and Efficiently Managing Disputes

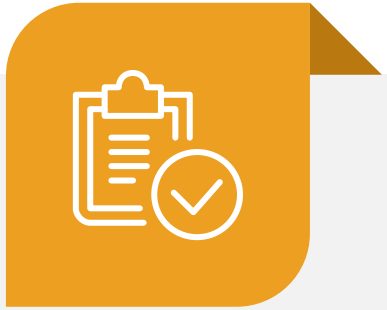
- Phased implementation
- Experienced staff and engaged leadership
- Clear governance process with participation from clinical, operational, finance, and compliance
- Strong and experienced compliance, especially in risk adjustment and marketing
- Carefully drafted finance provisions
- Pre-execution finance team meeting for cash-flow and settlement walk-through
- Clear language on material adverse events
- ADR process with actuarial dispute resolution

- **What are the major problems you have experienced in operating value-based arrangements?**

# Resources



EBG's 50-state survey on the regulation of value-based payment arrangements



Checklist of key contract terms for value-based arrangements

Model actuarial dispute resolution provision for value-base arrangements