The Transition to Value-Based Health Care

Shaping the Future: The Role of Payors in Value-Based Health Care

June 19, 2017

Bill Knowlton
william.knowlton@ropesgray.com
+1 617 951 7496

Michael Lampert
michael.lampert@ropesgray.com
+1 617 951 7095

Katie M. Sullivan
katie.sullivan@ropesgray.com
+1 617 951 7328
Agenda

• Introduction
• VBHC Programs Overview
• Legal Considerations
• Design & Implementation
• Ropes & Gray Resources
• Questions
Introduction

What is Value-Based Health Care ("VBHC")?

## Introduction

### A Tale of Two Approaches to VBHC

<table>
<thead>
<tr>
<th>Description</th>
<th>Episode-Based</th>
<th>Population-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Providers accept accountability for all care provided during a defined clinical event, such as a hip or knee replacement.</td>
<td>Providers receive bonuses/penalties based on comparison between population’s fee-for-service spending and benchmark costs over a defined period.</td>
</tr>
<tr>
<td><strong>Advantages</strong></td>
<td>Encourages collaboration among providers Responsibility limited to episode-related costs</td>
<td>Targets a broad range of patients Promotes collaboration at primary care level</td>
</tr>
<tr>
<td><strong>Disadvantages</strong></td>
<td>Difficult to exclude costs of co-morbidities Some episodes may be impossible to define</td>
<td>Providers not accountable for patient-level outcomes Continued cost reduction may not be sustainable</td>
</tr>
</tbody>
</table>
Introduction

VBHC Considerations for Payors

- MLR vs Admin Spend
- MEDICATION MANAGEMENT SERVICES
- PROVIDER NETWORK SUPPORT
- Medical Device Bundles
- DATA ANALYTICS AND CONSULTING
Agenda

• Introduction
• VBHC Programs Overview
• Legal Considerations
• Design & Implementation
• Ropes & Gray Resources
• Questions
## VBHC Programs Overview

### Government Payors - Medicare

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Medicare ACOs</th>
<th>BPCI</th>
<th>CJR/EPMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population-Based</td>
<td>Episode-Based</td>
<td></td>
<td>Episode-Based</td>
</tr>
<tr>
<td>Mandatory?</td>
<td>Voluntary</td>
<td>Voluntary</td>
<td>Mandatory*</td>
</tr>
<tr>
<td>Participant Type(s)</td>
<td>Medicare Providers</td>
<td>Acute Care Hospitals, SNF, Physician Groups, HHAs, IRF, LTCH</td>
<td>Acute Care Hospitals</td>
</tr>
<tr>
<td>Risk-Sharing?</td>
<td>Required, except for Track 1</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>Payment Method</td>
<td>FFS with retrospective reconciliation</td>
<td>FFS with retrospective reconciliation or global cap</td>
<td>FFS with retrospective reconciliation</td>
</tr>
</tbody>
</table>
## VBHC Programs Overview

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Comprehensive Primary Care+</th>
<th>Part D Enhanced MTM</th>
<th>Medicare Advantage VBID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory?</td>
<td>Voluntary</td>
<td>Voluntary</td>
<td>Voluntary</td>
</tr>
<tr>
<td>Participant Type(s)</td>
<td>Private Payors and Primary Care Physicians</td>
<td>Part D Sponsors</td>
<td>Medicare Advantage (“MA”) and MA-Part D Plans</td>
</tr>
<tr>
<td>Risk-Sharing?</td>
<td>Required</td>
<td>None (may spend more on MTM items/services)</td>
<td>None (may modify services or cost sharing)</td>
</tr>
<tr>
<td>Payment Method</td>
<td>FFS + PMPM care management fee + at risk incentive payment</td>
<td>Standard Part D reimbursement</td>
<td>Standard Medicare Advantage reimbursement</td>
</tr>
</tbody>
</table>
## VBHC Programs Overview

### Government Payors - Medicaid

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Arkansas</th>
<th>Massachusetts</th>
<th>Ohio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payor Types</td>
<td>Episode-Based</td>
<td>Population-Based</td>
<td>Episode-Based</td>
</tr>
<tr>
<td></td>
<td>State Medicaid and Private Payor</td>
<td>MassHealth-contracted MCOs</td>
<td>Ohio Medicaid MCOs; input from private payors</td>
</tr>
<tr>
<td>Providers</td>
<td>Varies by episode</td>
<td>ACOs that include PCPs; certain hospitals receive additional funds</td>
<td>Varies by episode type; participation mandatory</td>
</tr>
<tr>
<td>Risk-Sharing?</td>
<td>Required reconciliation at end of performance period</td>
<td>Yes – extent varies among participation options</td>
<td>Yes for highest cost episodes</td>
</tr>
<tr>
<td>Payment Method</td>
<td>Fee for services with reconciliation against price benchmark</td>
<td>PMPM capitation or FFS with shared savings/losses</td>
<td>Fee for service with retrospective gain/risk sharing</td>
</tr>
</tbody>
</table>
## VBHC Programs Overview

### Commercial/Private Payors

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>BCBS MA AQC</th>
<th>Humana</th>
<th>Walmart, GE, Boeing, Lowes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population-Based</td>
<td>Population-Based</td>
<td>Episode-Based</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Providers</th>
<th>BCBS MA AQC</th>
<th>Humana</th>
<th>Walmart, GE, Boeing, Lowes</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA provider groups that include PCPs that participate in POS/HMO</td>
<td>Integrated provider networks in NY, IN, PA, CO</td>
<td>Hospitals providing specified surgical procedures</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk-Sharing?</th>
<th>BCBS MA AQC</th>
<th>Humana</th>
<th>Walmart, GE, Boeing, Lowes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optional</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Method</th>
<th>BCBS MA AQC</th>
<th>Humana</th>
<th>Walmart, GE, Boeing, Lowes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modified 5-year global budget with quality incentive payments</td>
<td>Fee for service with gain/risk sharing for performance on quality and health outcomes</td>
<td>Fixed global payment for each procedure, including non-hospital services</td>
<td></td>
</tr>
</tbody>
</table>
## VBHC Programs Overview

### International VBHC

<table>
<thead>
<tr>
<th>Country</th>
<th>Be Healthy Together</th>
<th>Gesundes Kinzigtal</th>
<th>Bundled Care Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td>Population-Based</td>
<td>Population-Based</td>
<td>Episode-Based</td>
</tr>
<tr>
<td>Germany</td>
<td>Multispecialty physician practice and contracted providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Netherlands</td>
<td>Primary Care Providers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Risk-Sharing?    | Yes – risk/reward for specific pathways and outcomes | Managed care JV receives a global prepayment from state | Yes – for independent care groups |
| Payment Method   | Capitated rate; 2.5% of provider income tied to regional performance | Fee for service with additional payments for value-added services | Capitated payments for chronic disease management bundles |
Agenda

• Introduction
• VBHC Programs Overview
• Legal Considerations
• Design & Implementation
• Ropes & Gray Resources
• Questions
Legal Considerations

Medical Loss Ratio ("MLR") Requirements

\[
MLR = \frac{Health\ Care\ Claims + Quality\ Improvement\ Expenses}{Premiums - Taxes,\ Licensing\ &\ Regulatory\ Fees}
\]

Allowable Expense Categories

- Improve outcomes: quality reporting, care management/coordination, care compliance
- Readmissions prevention, including patient education and counseling
- Patient safety and reduction of medical errors
- Implement wellness and health promotion activities

Requirements for All Expenses

- Must be designed to improve care quality
- The desired positive outcomes must be objectively verifiable and calculable
- The spending should be directed towards enrollees or a population that includes enrollees
- Grounded in evidence based medicine, widely accepted clinical best practices or criteria
The Anti-Kickback Statute ("AKS")

| Scope | Prohibits the knowing and willful solicitation, receipt, offer or payment of any remuneration in return for either referrals of federal health care program business or recommending items or services reimbursed by a federal health care program |
| Managed Care Safe Harbor | Protects price reductions by first tier contractors offered to qualified managed care plans; would not cover services offered by a payor to providers; also requires contractor to have “substantial financial risk” which is narrowly defined |
| Personal Services Safe Harbor | Protects certain personal or management services; however, requires compensation to be at fair market value, which is difficult to determine when “value” is determined by outcomes and is therefore not set in advance (and may change over time) |
| Advisory Opinions | HHS-OIG endorsed safeguards include objective and verifiable cost savings and quality measures, no inappropriate reductions in services, and periodic reviews |
Legal Considerations

Responses to FY 2017 HHS-OIG Safe Harbor Solicitation

• Suggests modification of existing warranty, discount and personal services safe harbors

• Also recommends modifying managed care safe harbor to protect VBHC relationships with PBMS

• Requests development of a new, VBHC-specific safe harbor
Legal Considerations

Civil Monetary Penalties Law (“CMPL”)

Gainsharing

• Prohibits hospitals from knowingly making a direct or indirect payment to a physician to reduce or limit *medically necessary* services
• Penalty is $2,000 for each individual that receives such a payment
• HHS-OIG has recognized that gainsharing arrangements may implicate the fraud and abuse laws, particularly the Stark Law, even if the gainsharing actually improves quality or reduces waste

Beneficiary Inducement

• Prohibits the offer of or transfer to a federal health care program beneficiary any remuneration that the person knows is likely to influence the beneficiary’s selection of a provider or supplier of reimbursable items or services
• Penalty is up to $10,000 for each wrongful act
• Exception: “remuneration” does not include items or services that promote access to care and that pose a low risk of harm
State Laws

- Insurance Licensure
- Risk-Bearing Provider Organizations
- Network Adequacy
- ACO Certification
Agenda

- Introduction
- VBHC Programs Overview
- Legal Considerations
  - Design & Implementation
- Ropes & Gray Resources
- Questions
Design & Implementation

- Target Population Identification
- Performance Measures
- Provider Incentives
- Operational Challenges
- Continuous Improvement
- Care Transformation
Design & Implementation

Target Population

Performance Measures

Provider Incentives

Continuous Improvement

Operational Challenges

Care Transformation

• Will the VBHC initiative be population-based, episode-based, or both?

• What are the basic characteristics of the beneficiary population?

• How will patients be assigned to providers?

• Are the relevant providers ready to accept changes to their practice?

• Are risk adjustment and stratification methods sufficient?

• Are past costs capable of being benchmarked?
• Will quality measures be outcomes-based or process-based, or both?
• Is there relevant benchmarking data available?
• How will data be submitted and analyzed?
• Are measures consistent with VBHC initiatives that are already underway?
• Are measures sufficiently sourced and backed by reliable clinical evidence?
• Are the proposed cost savings realistic and sustainable?
• What will be the form of financial incentives – shared savings, performance/quality bonus, retained capitation payments?
• Are there non-financial practice supports available?
• Will supports offset the possibility of financial risk and the costs of care reorganization?
• What supports are available to providers?
• Does the VBHC initiative offer meaningful alignment that emphasizes outcomes, rather than short-term cost reduction?
• How will quality metrics be maintained over the life of the initiative?
• Is there a method established at the outset to modify or change metrics without disrupting established care coordination?
• What happens if improvement plateaus during later years?
• Is there a forum for provider engagement on quality measures?
Design & Implementation

Target Population
Performance Measures
Provider Incentives
Continuous Improvement

Operational Challenges

- Are other relevant payor programs aligned with respect to quality measurements and incentives?
- Are network providers capable of re-organizing care pathways to include high quality providers that may be part of other integrated systems?
- Are all participants aware of compliance requirements applicable to the program (and how it differs from routine compliance requirements)?
- Is there an adequate capital commitment to administrative costs such as HIT improvements and changes to model contracts and forms?
Design & Implementation

• Introduction
• VBHC Programs Overview
• Legal Considerations
• Design & Implementation
• Ropes & Gray Resources
• Questions
INDUSTRY SEGMENTS

DIGITAL HEALTH/TECH SOLUTION

PROVIDERS

PHARMA

MEDICAL DEVICE

PAYORS

TOPICS

MSSP AND DEMONSTRATION PROJECTS

MACRA

MEDICAID

PRIVATE PAYORS

ALTERNATIVE PAYMENT MODELS

IPAS AND OTHER PROVIDER RISK-BEARING ORGANIZATIONS (RBOS)

ANTITRUST

FRAUD & ABUSE / COMPLIANCE

https://www.ropesgray.com/Value-Based-Health-Care-Initiative
Ropes & Gray Resources

**Resources & Tools**

We compile and produce resources to help you navigate the transition to value-based care.

**CONTACT OUR TEAM for Research materials**

**Complimentary offerings**
- CLE Presentations
  - CLE Presentations on value-base health care topics
- Research Binders
  - Electronic collection of information related to CMS Innovation Models, including general overview, participation requirements, FAQs and more

**Offerings at a fixed fee**
- State Survey of RBO Laws
  - A time-saving tool that allows you to look up and compare RBO-related laws and regulations for across the country
- Hotline/Help Desk
  - Monthly bank of hours dedicated to counseling on value-based payment models
- Template Agreements
  - Provider participation agreements, management and administration services agreements for value-based payment models

**Insights & Analysis**
Ropes & Gray regularly examines trends, developments and issues in value-based health care to provide guidance on this rapidly evolving topic.

- Experts Tout Value-Based Contracts, RWE, Patent Reform As Pricing Fixes (June 16, 2017)
- Video - Value-based health care: fraud & abuse (June 13, 2017)
- Video - Value-based health care: issues for pharmaceutical companies (June 9, 2017)
- Video - Value-based health care: data & technology (June 2, 2017)

https://www.ropesgray.com/Value-Based-Health-Care-Initiative
Agenda

• Introduction
• VBHC Programs Overview
• Legal Considerations
• Design & Implementation
• Ropes & Gray Resources
• Questions
Questions?

Bill Knowlton  
+1 617 951 7496  
William.Knowlton@ropesgray.com

Michael B. Lampert  
+1 617 951 7095  
Michael.Lampert@ropesgray.com

Katie M. Sullivan  
+1 617 951 7328  
Katie.Sullivan@ropesgray.com