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Negotiating Successful Value-Based Contracts: Legal Considerations

Tuesday, June 12, 2018

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Learning Objectives

- Differentiate between level and types of value based payment models as determined by risk categories and contract characteristics
- Understand contract terms and legal considerations
- Further refine your value proposition to bring to the negotiation table

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REVIEW: What is a Value Proposition?

- A positioning statement that explains what benefit you provide, for whom you provide the benefit, and how you do it uniquely well.
- It describes your target buyer, the problem you solve and why you are distinctly better than the alternative.
- Should show relevancy, quantified value and unique differentiation.

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REVIEW: How does this solve a problem for your payer?

- Your value proposition should be in the language of your payer.
- Assess your payer's pain points.
- Research payer's participation in any pilot projects in the past.

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REVIEW: Value Proposition Template: Example

- For (target customers)…
- Who are dissatisfied with (the current alternative)
- Our service is a (new model)
- That provides a (key problem-solving capability)
- Unlike (the current alternatives)

Presenter: Adam J. Falcone

- Partner in FTLF's national health law practice.
- Counsels health centers, behavioral health agencies, and provider networks on a wide range of health law issues, including fraud and abuse, reimbursement and payment, and antitrust and competition matters.
- 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.
- 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.

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Value-Based Payment Arrangements: OPPORTUNITY AND RISK

Alternative Payment Models

- Alternative Payment Model (APM) Framework provides a continuum of payment models.
- The Health Care Payment Learning & Action Network (HCP-LAN) was created to **drive alignment** in payment approaches across the public and private sectors of the U.S. health care system.
- The HCP-LAN created a **common framework** for adoption and measurement of VBP across all payer types (Medicare, Medicaid, and Commercial).

Alternative Payment Models

Category 1: FFS Payments Not Linked to Quality

- FFS payments are based on the number and units of service provided, without linkages to, or adjustments for, provider reporting of quality data, or performance on cost or quality data.

Alternative Payment Models

Category 2: FFS Payments Linked to Quality and Value

- FFS payments are adjusted based on other factors, such as infrastructure investments, reporting quality data (pay-for-reporting),and/or performance on cost and quality metrics (pay-for-performance).
- This may also include a penalty disincentive, i.e., a lower or withheld payment if providers do not produce quality indicators, or report events or procedures that are harmful and were avoidable.

Note: *Washington State Health Care Authority's definition of VBP starts with Category 2C, i.e., rewards for high performance on clinical quality measures.*

Alternative Payment Models

Category 3: Alternative Payment Models Based on FFS

- Payments are based on FFS, but provide mechanisms to more effectively manage services. Providers must meet quality metrics to share in cost savings, and payments are based on cost performance against a target.
- Models may include:
  - **Shared savings/shared risk**. Also referred to as "upside" or "downside" risk respectively, providers must meet a total-cost-of-care target for some/all services for an attributed set of patients. If actual costs are below projections, providers may keep some savings or may also be at risk for higher-than expected costs.
  - **Bundled or episode-based payments.** A single payment to providers for all services needed to treat a given condition (e.g., maternity care) or to provide a given treatment (e.g., hip replacement). Providers receive an inclusive payment for a specific scope of services to treat an "episode of care" with a defined start and endpoint (e.g., case rate for six months of SUD recovery services).
- Note: *Excludes* risk-based payments that do not take quality (and therefore value) into account.

Alternative Payment Models

Category 4: Population-Based Payments

- Payments are structured to encourage providers to deliver coordinated, high-quality care within a defined budget.
- Payments may cover a wide range of preventive, medical, and health improvement services.
- Examples include global or capitated per-member-per-month payment that reflects the total cost of care for treating a primary (typically chronic) condition, or for maintaining the health and managing the illness of an entire population.
- Note: *Excludes* population-based payments that do not take quality (and therefore value) into account.

VBP Expands in Public Programs

- **Value-Based Payment (VBP)** generally refers to activities that move away from traditional fee-for-service (FFS) payment system, which rewards volume, to alternative payment models that reward high-quality, cost-effective care.
  - Nearly 40% of state Medicaid directors surveyed in 2016 reported plans to expand VBP arrangements in 2017.
  - CMS aims to move 50% of Medicare FFS payments into alternative payment models by 2018.

VBP: Washington State Landscape

- Health Care Authority (HCA) has set a goal that 90% of state-financed payments to providers will be in APM Categories 2C-4B by 2021.
- Between 2017-2021, HCA is withholding a percentage of MCO's monthly premium based on performance in the following areas:
  - **Provider Incentives Target** (Percentage of premium payments that must be spent on incentives to providers in APM Categories 2c or higher)
  - **VBP Arrangements Target** (Percentage of provider payments that must be in the form of VBP arrangements in APM Categories 2c or higher)
  - **Quality Improvement Score** (Withholds that reward improvement and achievement of targets for seven quality measures)
  - **Washington's 1115 DSRIP (Medicaid Transformation Project)** - MCO Challenge Pool Incentives (Incentives are available through DSRIP to reward plans that meet VBP transformation targets, and any remaining funds redirected to reward MCO performance on a set of clinical quality metrics)

VBP Opportunity for Behavioral Health

- VBP should be a significant opportunity for providers of behavioral health services, given that:
  - Total spending per person for individuals with a behavioral health diagnosis is nearly four times higher than for those without.*
  - 20 percent of Medicaid enrollees who have a behavioral health diagnosis account for almost half of total Medicaid expenditures.*
  - Many people with serious behavioral health disorders have a substantial number of comorbid acute or chronic medical conditions.*

VBP Opportunity for Behavioral Health
(continued)

- **Practice Pointers.** As the locus of Medicaid's highest cost patients, behavioral health agencies should recognize their value to MCOs in managing the total costs of care and leverage HCA financial incentives with MCOs. Behavioral health agencies should:
  1) Educate MCOs on the business case for VBP arrangements for populations with a behavioral health diagnosis.
  2) Identify (and promote!) specific VBP arrangements in APM Categories 2C and higher that will achieve HCA targets / quality scores, assisting MCO to recover premium withholds.

*Medicaid and CHIP Payment and Access Commission. "Chapter 4: Behavioral Health in the Medicaid Program — People, Use, and Expenditures. Report to Congress on the Medicaid and CHIP." June 2015.

Contract Terms and Legal Protections: VALUE-BASED PAYMENT ARRANGEMENTS

Access To Claims Information

- Providers 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.

Access To Claims Information
(continued)

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

Applicability of 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 disclose all of a patient's PHI.

Applicability of Patient Confidentiality Laws
(continued)

- 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.

Performance Measures

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

Performance Measures

- **Practice Pointers:**
  - A provider's terms of participation in VBP arrangements 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 provider's consent.

Performance Measures

2018 Quality Measures in Apple Health Contracts

- To connect payment to quality of care and to value, HCA is withholding 1.5 percent of a MCO's monthly premium.
- 75% of that withhold can be earned back based on achieving targets for the following quality measures:

Blood sugar testing for people with diabetes	Staying on antidepressant medication (12 weeks)
Blood pressure control for people with diabetes	Staying on antidepressant medication (6 months)
Controlling high blood pressure	Well-child visits in the 3rd, 4th, 5th and 6th years of life
Immunization (child-combo 10)	Asthma medication management (ages 5-11)
Asthma medication management (ages 12-18)	

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Performance Measures

- The Washington State Common Measure Set is a set of measures that enables a common way of tracking important elements of health and health care performance.

- These measures are also embedded throughout the Medicaid Transformation Project Toolkit as performance metrics for the DSRIP/transformation projects.

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Performance Measures

Behavioral Health Measures from the Common Measure Set:

- Antidepressant medication management
- Follow-up after DC from ED for mental health
- Follow-up after DC from ED for alcohol/drug dependence
- Follow-up after hospitalization for mental illness
- Mental health treatment penetration
- Substance use disorder treatment penetration
- Outpatient ED visits
- Plan all-cause readmission rate (30 day)

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Incentive Payments (P4P Rewards/ Upside-Only)

- A provider is not placed at financial risk to participate in APM Category 2A (P4P rewards) and 3A (upside-only shared savings) VBP incentive arrangements.
  - Even if the provider 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, providers should affirmatively request participation in an MCO's VBP arrangements to maximize overall reimbursement.
  - If an MCO is not willing to permit participation in VBP arrangements at the point of contracting, a provider should seek language that entitles the provider to participation at a future date, upon meeting eligibility requirements, or otherwise.

Incentive Payments (P4P Penalties/ Downside Risk)

- A provider is placed at financial risk to participate in APM Category 2D (P4P rewards and penalties) and 3B (upside and downside shared savings) VBP incentive arrangements. Providers should generally exercise caution in entering such arrangements as they could result in significant risk to the organization's financial health.

Incentive Payments (P4P Penalties/ Downside Risk)
(continued)

- **Practice Pointers.** When negotiating the terms of participation in any VBP arrangement that involve financial penalties or downside financial risk, the provider should add language that limits or mitigates any such penalties or downside risk.
  - If the contract imposes a financial penalty on the provider, the provider should negotiate language that creates a ceiling on the penalty as a fixed dollar amount or percentage of total payments received from the MCO.
  - If the provider enters a downside shared risk arrangement, the provider should negotiate language that limits financial losses to a percentage of total payments or the benchmark.
  - If the provider is participating in a VBP arrangement that involves financial penalties, the provider 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.

Population-Based VBP Arrangements

Who's In? Who's Out?

- Attribution Methodology: The basis by which the MCO attributes patients to a population under a VBP arrangement. Possible attribution methods might include populations based on an enrollee's:
  - Geographic area (e.g., counties);
  - Specified behavioral health conditions;
  - Receipt of services from a behavioral health agency (e.g., clients); or
  - Receipt of primary care services.
- If attribution of patients is prospective, providers should recognize that the population of patients attributed to the provider may:
  - Include patients who have not visited the provider during the current performance year; and
  - Include patients who have received services from the provider but who were actually assigned to a different provider.

Population-Based VBP Arrangements (continued)

- **Practice Pointers.** To avoid surprises related to the attributed patient population, a provider should:
    - Request that the MCO generate a list of attributed patients based on prior year's data so that the provider can learn how many and which patients would have been attributed to the provider under a VBP arrangement.
    - The provider should 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.
    - The provider should 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 provider against the provider's own records within 60 days of receipt of the patient rosters.

Regulatory Penalty Provisions

- Some MCO contracts hold a provider liable for financial penalties assessed against the MCO by a regulatory agency. The financial penalties might result from the MCOs failure to meet clinical benchmarks, down-side risk arrangements, or non-compliance with VBP requirements.
- The provider can be held responsible if the financial penalty results from a provider's non-compliance with a requirement under the contract or provider manual. Under these provisions, providers will be liable even if:
  - MCO was unaware of the non-compliance, took no steps to monitor the provider or correct the provider's non-compliance.
  - Provider did not act negligently but made good faith efforts to comply.
- Providers do not have authority to appeal or dispute the regulatory agency's fines or penalties against the MCO.
- **Practice Pointer.** Providers should seek to remove these provisions from participation agreements with MCOs so as to avoid incurring liability for fines or penalties assessed against an MCO.

Contract Term

- Providers 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 provider is committing to participate in the VBP arrangement.
- **Provider 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 provider can re-negotiate any problematic terms of participation in VBP arrangements.
    - In any VBP arrangement, providers 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.

Termination

- If participation in a VBP arrangement involves financial risk, the provider may wish to include contract language that permits the provider to terminate its participation in the VBP arrangement if the provider is incurring (or is likely to incur) financial penalties under the arrangement.
- Contracts can typically be terminated “for cause” or “without cause”.

Termination
(continued)

- **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 provider 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.
- **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.

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.

- Types of amendment provisions include:
  - Immediate amendment: The provider has notice but no right to opt-out or consent. (Typically used only for regulatory or statutory changes)
  - Auto-amendment: Notice and right to opt-out. (Typically used for non-regulatory amendments)
  - Written amendment: Notice and Consent (signed by both parties).

- **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 provider to opt-out but if the amendments clause permits the MCO to amend unilaterally the terms of participation in a VBP arrangement, then the provider should negotiate language that permits the provider to terminate its participation in the VBP arrangement.

Questions?

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Next Steps

Next Webinar:

- Wrap-up Webinar: Celebrating Success
  - Tuesday, July 17, 2018
  - 11:30-1:00pm PT (1.5 hours)

Next Steps:

- By Friday, June 22, 2018:
  - Complete the VTA
  - Complete three slides outlining stretch project successes, lessons learned, a sustainability plan, and your value proposition – a template will be provided
  - Send to Joan Miller at JMiller@thewashingtoncouncil.org

3x3 Instructions

- **Accomplishments** - What lessons have you learned from planning for and implementing your stretch project that you intend to apply to future value-based payment practice transformation efforts?
- **Lessons Learned** - What lessons have you learned from planning for and implementing your stretch project that you intend to apply to future value-based payment practice transformation efforts?
- **Sustainability Plan** - What are your next steps for your stretch project and for your organization's transformation to value-based payment?
- **Your Value Proposition** –
  - What population(s) is your organization serving?
  - What is the benefit of your services to the community?
  - What makes your services unique and different?
  - How does this solve a problem for your payer?

Questions? Email Joan Miller
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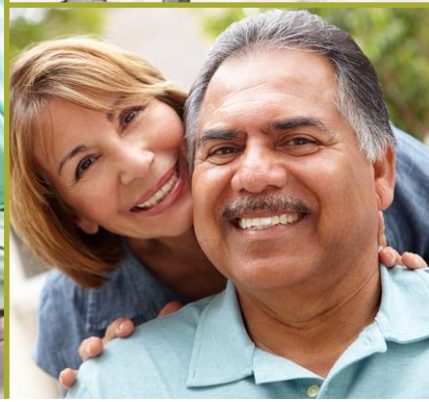
Thank you!



The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.