



Accountable Care Academy 2020

As health centers continue to transition to value-based care and population health, more and more payer contracts include some form of risk (or financial burden for the services provided versus the amount of reimbursement expected in return). NACHC's Accountable Care Academy is a 4 part webinar series focused on the fundamental considerations for risk-based contracts and how to prepare health centers for participation in arrangements with risk. Each session will be led by Adam Falcone, Esq., of Feldesman, Tucker, Leifer, Fidell. Tools will accompany the webinars, including a glossary, checklists, and links to supplementary relevant resources, to reinforce key concepts.

Register Now! Next Three Webinars

6/17

General Considerations Under Federal Law/FQHC Payment Protections

<https://iweb.nachc.com/Conference/RegistrationProcessOverview.aspx?id=986>

7/15

VBP Contracting Safeguards

<https://iweb.nachc.com/Conference/RegistrationProcessOverview.aspx?id=987>

7/29

Field Representative Stories

<https://iweb.nachc.com/Conference/RegistrationProcessOverview.aspx?id=988>

#2

This webinar will discuss health center participation in and the legal considerations to be aware of when considering VBP contract arrangements. Payment protections under Medicare and Medicaid, including alternative payment methodologies (APMs), will also be included.

#3

This session will provide a deeper dive into the opportunities and challenges to be aware of when participating in VNP contracts and how to protect your organization. Attribution, benchmark calculations, capitation methodology, and minimizing down-size risk exposure are just a few of the topics discussed.

#4

An opportunity to hear from your peers from across the country as each describe their journey and experience preparing for and managing risk. There will be additional time to engage with the legal expert and your peers.



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THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.



HRSA Disclaimer

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Risk-based Payment Methodologies

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Adam J. Falcone

- Partner in FTLF's national health law practice.
- Counsels health centers, behavioral health providers, 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.
- Served as Policy Counsel for the Alliance of Community Health Plans, representing non-profit and provider-sponsored managed care organizations before Congress and the Executive Branch.
- 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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DISCLAIMER

These materials have been prepared by the attorneys of Feldesman Tucker Leifer Fidell LLP. The opinions expressed in these materials are solely their views and do not necessarily represent the opinions of the National Association of Community Health Centers (NACHC).

The materials are offered with the understanding that the authors are not engaged in rendering legal or other professional services. If legal advice or other expert assistance is required, the services of a competent professional should be sought.



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AGENDA

Risk Continuum in Payment Methodologies

HCP-LAN Framework for “Alternative Payment Models”

- Category 1 (FFS)
- Category 2 (Care Management Fees, P4P)
- Category 3 (Shared Savings/Shared Risk/Bundled Payments)
- Category 4 (Capitation)

National Medicaid Trends

- Managed Care Contractual Requirements
- State-Specific Examples (WA, OR and NY)

Concluding Thoughts



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“RISK” BY PAYMENT METHODOLOGY

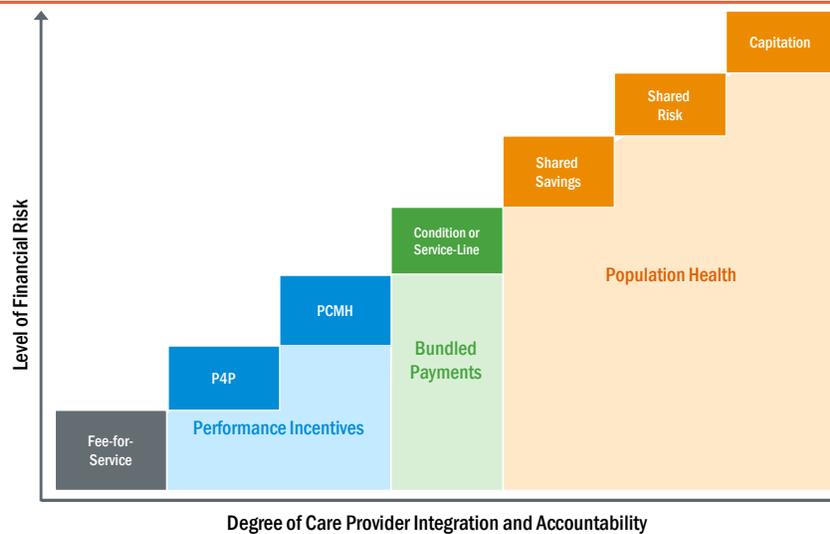
- The risk under any payment methodology is whether a provider is guaranteed payment to fully cover the provider’s costs.
- Spectrum of risk:
 - **Cost-Reimbursement:** provider is at risk only to the extent that certain costs will be disallowed (e.g., caps, non-reimbursed costs)
 - **FFS:** provider is at risk that the cost of furnishing a service exceeds a pre-established fee schedule for each service (i.e., “fee for service”)
 - **PPS:** provider is at risk that the cost of furnishing a bundle of services exceeds its prospective payment system (PPS) rate
 - **Capitation:** provider is at risk that the cost of furnishing a defined scope of services exceeds its monthly lump sum per patient (i.e., “capitation” payment)



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RISK BY TYPE OF PAYMENT MODEL



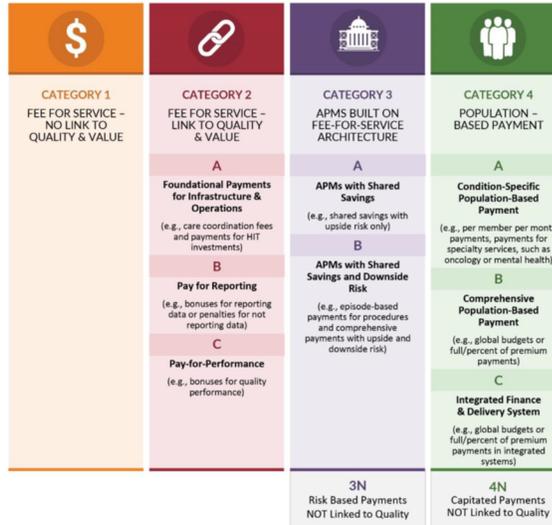
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ALTERNATIVE PAYMENT MODELS

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 value-based payment methodologies across all payer types (Medicare, Medicaid, and Commercial)



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HCP-LAN 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.
- FFS payments do not support investments, population health management tools, and increased access to care.
- FFS payments rewards providers for increasing volume of services, while population-based payments reward those that successfully manage all or much of an individual's care.



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HCP-LAN CATEGORY 2

Category 2: FFS payments linked to quality and value.

FFS payments are adjusted based on other factors, such as infrastructure investments, whether providers report quality data (pay-for-reporting), and/or performance on cost and quality metrics (pay-for-performance).

- **Category 2A (Foundational Payments):** Payments for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics.
- **Category 2B (Pay for Reporting):** Positive or negative payment incentives to report quality data.
- **Category 2C (Pay-For-Performance):** Payments that reward providers that perform well on quality metrics and/or penalize providers that do not perform well, thus providing a significant linkage between payment and quality.



HCP-LAN CATEGORY 3

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.

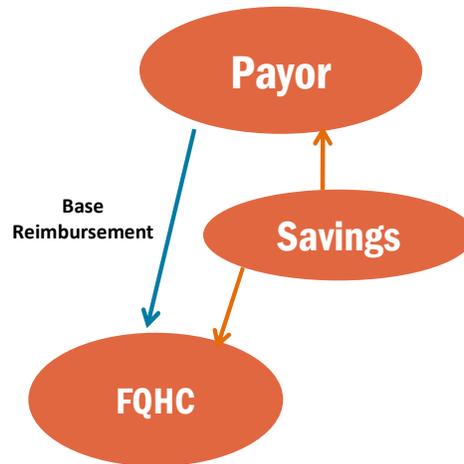
- **Category 3A (Shared Savings):** Providers must meet a total-cost-of-care target for some/all services for an attributed set of patients. If actual costs are below projections, providers may keep some savings if quality measures are met.
- **Category 3B:**
 - **Shared Savings and Downside Risk.** 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 if quality measures are met, or if actual costs are above projections, providers must compensate payors for a share of the losses.
 - **Bundled or episode-based payments.** A single payment to providers for all services needed to treat a given condition or to provide a given treatment. Providers receive an inclusive payment for a specific scope of services to treat an “episode of care” with a defined start and endpoint.

Note: *Must include link to quality to qualify as a Category 3 arrangement!*



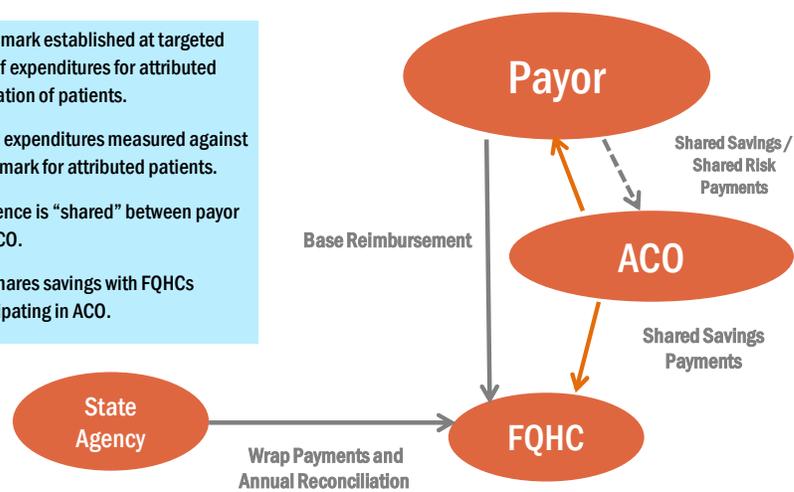
EXAMPLE: SHARED SAVINGS

- Benchmark established at targeted level of expenditures for attributed population of patients.
- Actual expenditures measured against benchmark for attributed population of patients.
- Difference is "shared" between payor and health center.



EXAMPLE: SHARED SAVINGS / DOWNSIDE RISK

- Benchmark established at targeted level of expenditures for attributed population of patients.
- Actual expenditures measured against benchmark for attributed patients.
- Difference is "shared" between payor and ACO.
- ACO shares savings with FQHCs participating in ACO.



ATTRIBUTION METHODOLOGIES

Attribution Methodology. The basis by which the payor attributes patients to a population under a shared savings or shared risk arrangement. Possible attribution methods might include populations based on an enrollee's:

- Geographic area (e.g., counties)
- Specific health diagnoses
- Receipt of services from a particular provider (e.g., patient/clients)
- Receipt of health home services
- Receipt of primary care services

Prospective Attribution. 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 year; and
- Include patients who have received services from the provider but who were actually assigned to a actually assigned to a different provider.



BENCHMARK METHODOLOGIES

Benchmark Methodology. The basis by which the payor establishes the benchmark under a VBP arrangement. Possible methods to establish the benchmark include:

- Percentage of Premium Revenue
- Medical Loss Ratio
- Claims Experience (projected forward)

Practice Pointers:

•Understand how the benchmark is set. If the benchmark is set too low, it will be impossible to generate savings under a shared savings arrangement (or you will more quickly incur downside losses under shared risk arrangement). Generally, you'll want the benchmark set as high as possible!

•Review which MCO expenditures count (such as incurred claims) against the benchmark. Generally, you'll want the "allowed spend" to be as low as possible to qualify for savings and avoid downside losses!



HCP-LAN CATEGORY 4

Category 4: Population-based payments.

Payments are structured to encourage providers to deliver coordinated, high-quality care within a defined budget.

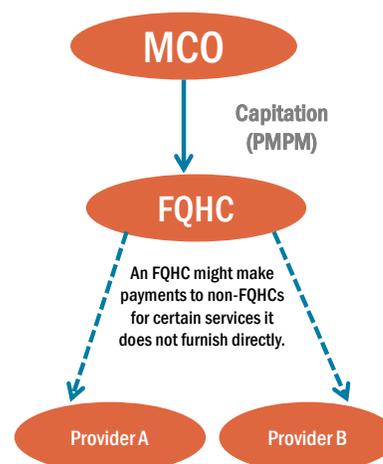
- **Category 4A (Condition-Specific Population-Based Payments):** Providers are accountable for quality and cost, receiving per-member per-month payments for a specific condition or defined scope of practice.
- **Category 4B (Comprehensive Population-Based Payments):** Providers are accountable for quality and cost, receiving per-member per-month (or percent of premium) payments for all of the individual's health care needs.
- **Category 4C (Integrated Finance & Delivery Systems):** Also involve comprehensive population-based payments but involve organizations that integrate financial and care delivery systems.

Note: Must include link to quality to qualify as a Category 4 arrangement!



EXAMPLE: CAPITATION PAYMENTS

- Under capitation, providers receive a prospective flat payment for each enrollee per month ("per member per month," or PMPM, payment)
 - **Primary care capitation:** Pays for primary care services covered under the contract
 - **Professional capitation:** Pays for a defined portion of physician services (*e.g.*, primary and specialty services)
 - **Full capitation:** Pays for broad scope of services covered under the contract (*e.g.*, hospital and physician services)



CAPITATION METHODOLOGY

Capitation Methodology. The basis by which the payor establishes the capitation amount (PMPM). Possible methods to establish the capitation amount include:

- Percentage of Premium Revenue
- Claims Experience (projected forward) for services subject to the capitation

Practice Pointers.

- Ensure the scope of services subject to the benchmark are appropriately and accurately defined.
- Consider whether the capitation amounts should be risk-adjusted (*e.g.*, aged/gender) or specific to particular subpopulations (*e.g.*, SSI).
- Consider whether the payor should make any adjustments to the capitation amount for retroactive changes in eligibility, individuals who seek care from other providers, or state adjustments to premiums.



NATIONAL MEDICAID TRENDS

- **Payment Reforms.** States are using MCO contracts as a vehicle to increase the number of providers paid under value-based payment arrangements. Such approaches include requiring managed care organizations (MCOs) to:
 - Adopt standardized VBP model to reimburse providers (Minnesota, Tennessee)
 - Make a specific percentage of provider payments through approved VBP arrangements (Arizona, Pennsylvania, South Carolina, New York State)
 - Participate in a multi-payer VBP alignment initiative (Tennessee)
 - Launch VBP pilot projects under state oversight (New Mexico, Minnesota)
- States may also adjust payments to MCOs based on quality metrics and efficiencies to drive health outcomes and advance integrated models.



STATE-SPECIFIC APM REQUIREMENTS

State	LAN Category in MCO Contract
Arizona	2C or higher
California	2, 3, & 4 in 2018
New York	3A or higher
South Carolina	2C or higher
Virginia	"Emphasis" on 3 and 4
Washington	2C or higher

Source: Bailit Health, "State Medicaid Approaches for Defining and Tracking Managed Care Organizations Implementation of Alternative Payment Models", February 2018.



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EXAMPLE: WASHINGTON STATE VBP REQUIREMENTS

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 payments in VBP arrangements in APM Categories 2C or higher that are directly conditioned on meeting quality and financial metrics)
- **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)
- **Challenge Pool Incentives** (Unearned VBP incentives from managed care premiums will be available to reward plans that meet exceptional standard of quality and patient experience based on subset of measures)

Washington's 1115 DSRIP (Medicaid Transformation Project) incentive funding is tied to specific performance metrics and APM Categories 2C and above



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EXAMPLE: OREGON VBP REQUIREMENTS

VBP Targets. Between 2020-2024, CCOs will be required to annually increase the level of payments that are in the form of VBP according to the following schedule:

- 2020: no less than **20%** of the CCO's payments to providers fall within LAN Category 2C (Pay for Performance) or higher;
- 2021: no less than **35%** of the CCO's payments to providers fall within LAN Category 2C (Pay for Performance) or higher;
- 2022: no less than **50%** of the CCO's payments to providers fall within LAN Category 2C (Pay for Performance) or higher;
- 2023: no less than **60%** of the CCO's payments to providers fall within LAN Category 2C (Pay for Performance) or higher and no less than **20%** of the CCO's payments to providers fall within LAN Category 3B (Shared Savings and Downside Risk) or higher;&
- 2024: no less than **70%** of the CCO's payments to providers fall within LAN Category 2C (Pay for Performance) or higher and no less than **25%** of the CCO's payments to providers fall within LAN Category 3B (Shared Savings and Downside Risk) or higher.

OHA, Contract Template, CCO 2.0, Exhibit H – Valued Base Payment, Secs. 1, 4.



EXAMPLE: OREGON VBP REQUIREMENTS

Care Delivery Area VBPs

- CCOs are required to develop VBPs that fall within LAN Category 2C (Pay for Performance) in the following care delivery areas: hospital care, maternity care, children's health care, behavioral health care, and oral health care according to the following schedule:
 - 2020: CCO shall develop two new, or expanded from an existing contract, VBPs.
 - 2021: CCO shall implement the two new or expanded VBPs developed in 2020.
 - 2022: CCO shall implement a new or expanded VBP in one more care delivery area. By the end of 2022: new or expanded VBPs in both hospital care and maternity care must be in place.
 - 2023 and 2024: CCO shall implement one new or expanded VBP each year in each of the remaining care delivery areas. By the end of 2024: new or expanded VBPs in all five care delivery areas must be in place.

OHA, Contract Template, CCO 2.0, Exhibit H – Valued Base Payment, Sec. 2.



EXAMPLE: OREGON VBP REQUIREMENTS

Patient-Centered Primary Care Home VBP

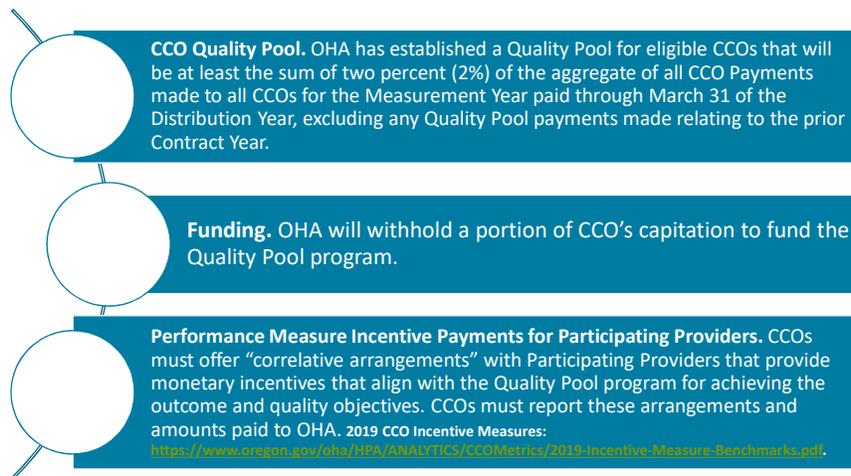
- CCOs are required to provide per-member-per-month (PMPM) payments to their Patient-Centered Primary Care Home (PCPCH) clinics.
- A Category 2A VBP (Foundational Payments for Infrastructure & Operations) is required as defined by the LAN Framework.
- CCOs are required to also vary their PMPMs such that higher-tier PCPCHs receive higher payments than lower-tier PCPCHs.
- The PMPMs must increase each year over the five-year contract and be meaningful amounts.
- Although OHA is not defining a specific minimum dollar amount, the payments should meaningfully support clinics' work to deliver patient-centered care.

OHA, Contract Template, CCO 2.0, Exhibit H – Valued Base Payment, Sec. 3.



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EXAMPLE: OREGON VBP REQUIREMENTS



OHA, Contract Template, CCO 2.0, Ex. B – Statement of Work – Part 10 , Sec. 3-5, Ex. C – Consideration – Section 1.a.



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EXAMPLE: NEW YORK STATE VBP REQUIREMENTS

New York State's Model Contract requires Medicaid Managed Care Organizations ("MCOs") to meet specific targets for VBP arrangements with providers.

- MCOs that fail to meet those targets are penalized.
- **Fully Capitated Plans (Including PACE)**
 - By April 2020, 80-90% of total MCO-provider payments (in terms of total dollars) must be in at least Level 3A VBP (shared savings) and at least 35% of total MCO-provider payments in Level 3B VBP (shared risk) or higher.
- **Not Fully Capitated Plans**
 - By April 2020, 80-90% of total MCO-provider payments (in terms of total dollars) in at least Level 3A VBP and at least 15% of total MCO-provider payments in Level 3B or higher.



KNOW YOUR VALUE!

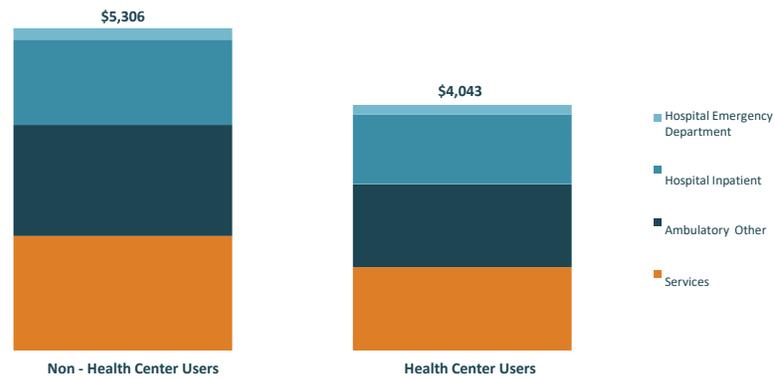
Health Centers are attractive partners for ACOs and payors engaging in value-based payment arrangements.

- Research shows that health centers reduce the rate of preventable hospitalizations, inpatient days, and Emergency Department (ED) use.
 - Medicaid beneficiaries who rely on health centers for usual care are 19% less likely to use the ED and 11% less likely to be hospitalized for ambulatory care sensitive (ACS) conditions compared to beneficiaries relying on other providers.
 - Counties with a health center have 25% fewer ED visits for ACS conditions than counties without a health center.
- Health centers save \$1,263 per person per year, lowering costs across the delivery system.
- The value of primary care delivered by FQHCs has been confirmed by studies showing that health center patients have lower overall total costs to Medicaid by successfully reducing avoidable specialty and hospital services.



RESEARCH FINDINGS

Health Centers Save \$1,263 (or 24%) Per Patient Per Year



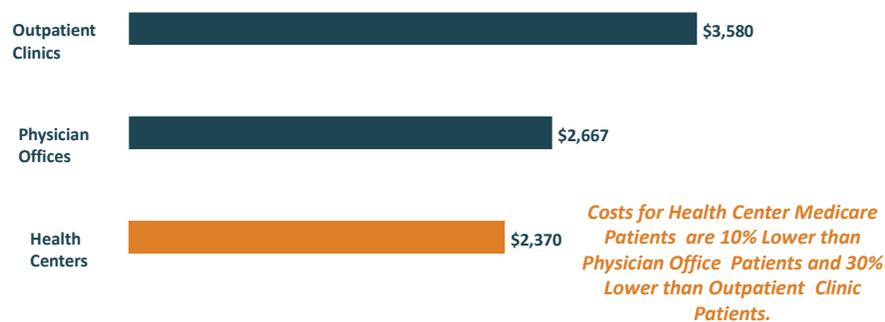
Source: NACHC analysis based on Ku et al. Using Primary Care to Bend the Curve: Estimating the Impact of a Health Center Expansion on Health Care Costs. GWU Department of Health Policy. Policy Research Brief No. 14. September 2009.



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RESEARCH FINDINGS

Health Centers are Associated with Lower Total Costs of Care for Medicare Patients Compared to Other Providers



Source: Mukamel, D.B., White, L.M., Nocon R.S., et al. Comparing the cost of caring for Medicare beneficiaries in federally funded health centers to other care settings. *Health Serv Res.* April 2016. 51(2): 625-644.



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