



— 2017 UT SYSTEM — LEGAL CONFERENCE

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Session 4b

Value-Based Care – Contracting and Legal Issues

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September 28, 2017 1:30-2:30 pm

Value-Based Care – Contracting and Legal Issues

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Agenda

- Introductions
- Background on Managed Care Arrangements
- Key Managed Care Contracting Terms
- Contracting for New Methods of Reimbursement
 - The Big Picture
 - Value-Based Purchasing
 - Bundled Payment Arrangements
 - ACO Arrangements
- Examples of Payer/Provider Collaborations
- Consumerism

Managed Care Arrangements

- Contracts are the basis for most healthcare revenue
 - Group and Individual Products
 - Self-funded ERISA and Governmental Products
 - Medicare Advantage
 - Medicaid Managed Care
 - TRICARE
- ACA Exchange Products are Texas-regulated insurance products

Key Contract Terms—Scope

- What products?
 - Group and Individual Products
 - Self-funded ERISA and Governmental Products
 - Medicare Advantage
 - Medicaid Managed Care
 - TRICARE
- What parties?
 - Affiliates of Managed Care Organization?
 - Affiliates of Provider?
 - Acquisitions by Managed Care Organization?
 - Acquisitions by Provider?

What Products?

- Texas “silent PPO” law
- Tex. Ins. Code Chapter 1458
- Provider must grant authority by “lines of business”
 - Individual and group PPO plans
 - Individual and group EPO plans
 - Individual and group HMO plans
 - Medicare Advantage plans
 - Medicaid managed care
 - CHIP

What Parties?

- Acquisitions by payers
 - Assignment language
 - Definition of “affiliate”
 - Is Chapter 1458 Implicated?
- Acquisitions by providers
 - Addition of service locations
 - Addition of individual providers to group
- Bottom line: Contract issues driven by structure of acquisition versus terms of contract

Key Contract Terms: Payment

- Offset
 - If individual plans permit offset, providers may be bound to this unless contract says otherwise...
 - Quality Ins. Care, Inc. v. Health Care Serv. Corp., No. 09-20188 (5th Cir. 2011)
 - Offset Process
 - Notice
 - Opportunity to Dispute or Repay
 - “Close the Books” Period
- Audits
 - Types of Audits
 - Audits by contingency recovery contractors
 - Audit Processes and Limits

Key Contract Terms: Payment

- Prompt Payment
 - Don't assume the Texas Prompt Pay Act will apply
 - Clear time to pay claim in the contract
- Continuation of Care
 - If contract terminates vs. if MCO is insolvent...
- Policies
 - Review beforehand!
 - Process for changes to policies...
 - Contract controls in the event of a conflict
 - Is termination an adequate remedy?

Key Contract Terms: Regulatory Requirements

- State managed care compilation (not frequently updated)
- <http://www.ncsl.org/research/health/managed-care-state-laws.aspx>
- Managed Medicaid contract and Provider Manual requirements**
- http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp8/8_1.pdf
- Duals demonstration—template contract
- <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TexasContract.pdf>
- Medicare Advantage template—model contract
- http://www.cms.gov/medicare/medicare-advantage/medicareadvantageapps/downloads/model_contract_amendment_10_05_12.pdf

Status of Exchange Markets

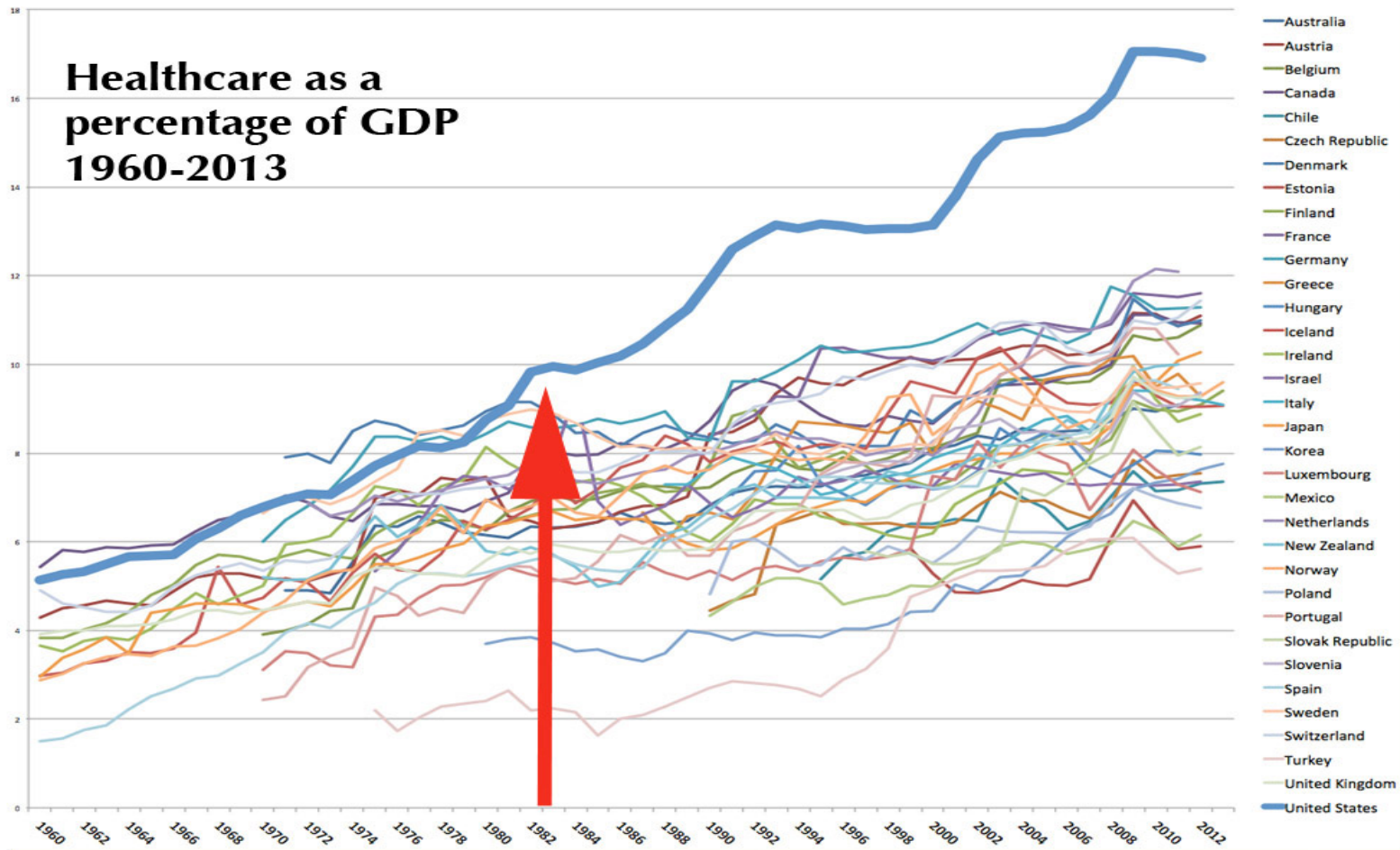
- States exchanges will continue
 - Premium tax credits can be used for eligible non-group policies, on or off exchange
 - Through 2019, tax credits are only advance payable for on-exchange policies
- Insurers continue to pull out
 - Humana's announced in February that it would no longer offer health insurance coverage in the state exchanges for 2018
 - Aetna exited in August of last year from 11 of the 15 states where it provided coverage.
- Insurers have until August 16, 2017 to decide if they will withdraw from of the exchanges for 2018

Near Term Considerations

- Plan withdrawals likely to continue and may be sudden and unexpected
- Statutory, regulatory requirements and enforcement likely to be uneven and subject to congressional and public pressure



The Big Picture



Value-Based Purchasing: What is it?

- Value-based purchasing is a payer-driven strategy to measure, report, and reward quality or value in health care delivery
- Value-based purchasing takes into consideration access, price, quality, and efficiency
 - Provider reporting of data and metrics
 - High performing providers benefit from
 - Improved reputations through public reporting
 - Enhanced payments for meeting benchmarks
 - Increased market share?



Value-Based Purchasing: An Example

- Plan will pay incentive payment to health system Provider if certain quality metrics are met (A1c control) for assigned patients with diabetes
- Threshold Issues
 - Assigning and identifying targeted patients
 - Setting incentive payment terms
 - Describing quality metrics
 - Outlining reporting requirements and reporting frequency



Value-Based Purchasing: Potential Issues

- Does the arrangement operate as an inducement to limit/reduce medically necessary services?
- Does Provider need physicians to achieve the metrics?
- If so, downstream contracts may be needed. Consider:
 - Payment terms
 - Data reporting terms
 - Stark/kickback compliance
 - Stacking analysis of all compensation arrangements between Provider and downstream physician

Value-Based Purchasing—Practical Tips

- For Plan:
 - Is Plan prepared to confirm eligibility for the patient population?
 - What level of involvement does Plan want with downstream contracts?
 - How will Plan determine savings? How will it share methodology and data with Provider?
- For Provider:
 - Is Provider prepared to track and report the required data?
 - Does Provider need appropriate protections for:
 - Data
 - Audits
 - Review of savings calculations

Ascension Approach to Value-based Care

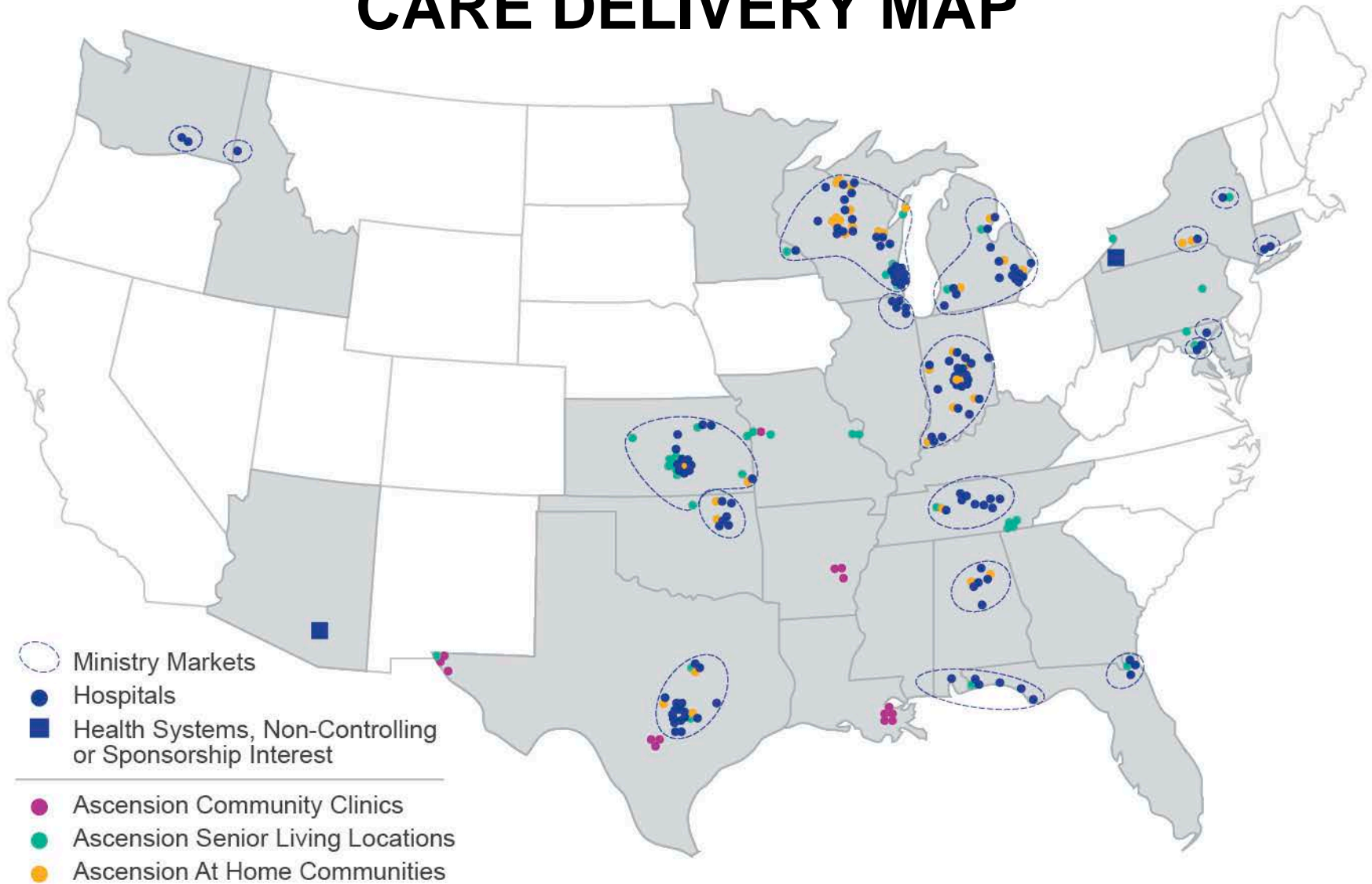
OUR VISION

We envision a strong, vibrant Catholic health ministry in the United States which will lead to **the transformation of healthcare.**

We will ensure service that is committed to health and well-being for our communities while meeting the needs of individuals throughout their lives.

We will expand the role of laity, in both leadership and sponsorship, to ensure a Catholic health ministry in the future.

CARE DELIVERY MAP



FACILITIES AND STAFF *(as of July 8, 2016)*

Sites of Care	2,500
Acute Care Hospitals	111
Rehabilitation Hospitals	6
Behavioral Health Hospitals	9
Long-Term Acute Care Hospitals	2
Joint Venture Hospitals (<i><50% ownership</i>)	13
Available Beds	22,416
Associates	150,000



CONTINUUM OF CARE SITES

HOSPITALS BY TYPE

Acute Care Hospitals	111
Rehabilitation Hospitals	6
Behavioral Health Hospitals	9
Long-Term Acute Care Hospitals	2
TOTAL	128
Hospitals Not Majority Owned – Joint Venture or Management Agreement	13

SENIOR CARE AND LIVING FACILITIES

Assisted Living	15
Continuum of Care Retirement Communities	8
Independent Living	2
Long Term Acute Care/Skilled Nursing	23
Multi-Service Line Communities	7
Other Senior Living (HUD, Other)	2
PACE Programs	3

POST ACUTE SERVICE SITES

Durable Medical Equipment	15
Home Health Services	42
Hospice Services	16
Outpatient Rehabilitation Centers	148

AMBULATORY CARE AND DIAGNOSTICS

Ambulatory Surgery Centers	66
Occupational Health Programs	55
On-Site Employer Clinics	76
Free-Standing Imaging Sites	110
Retail Lab Collection Sites	155
Primary Care Clinics	565
Retail Care Clinics	12
Retail Pharmacy Sites	45
Sleep Centers	31
Specialty Clinics	613
Virtual Care Programs	70

EMERGENCY SERVICES

Free-Standing ER and Urgent Care Sites	74
Emergency Medical Services (EMS)	21

COMMUNITY SERVICES

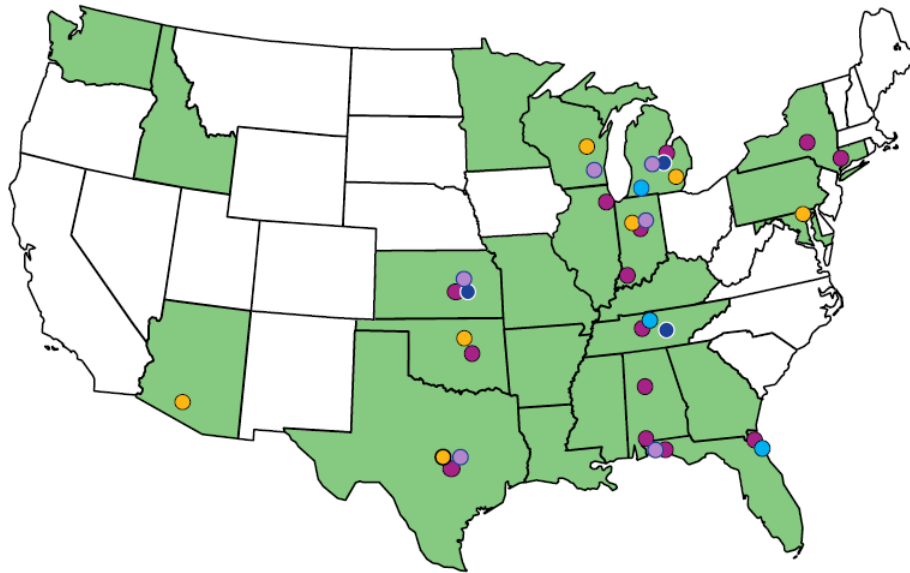
Community Health Centers	16
Dispensary of Hope Sites	9
Mobile Clinical Services	26
Wellness Centers	23
Community/Social Programs	157



**2,500
Sites of Care**



CURRENT VALUE-BASED HEALTHCARE DELIVERY



Map Key:

- 7 Wholly/Partially Owned Health Plans
- 14 MSSP ACOs in 12 Ministry Markets
- 6 Ministry Markets Participating in CJR Bundled Payments (16 hospitals)
- 3 Ministry Markets Participating in CMMI Bundled Payments
- 3 PACE Programs

OTHER SYSTEM MEASURES

>7,000 Employed Providers

2.6M Covered Lives Under Value-Based Contractual Arrangements

Our Value-Based Care Philosophy

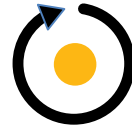


Prioritize clinically integrated systems of care to accelerate personalized care and move from an episodic to managed care delivery model

Standardize capabilities

High-quality, affordable, personalized care

Low-cost infrastructure



Transition from fee for service to fee for value

Evaluate and take measured steps toward managing total cost of care (i.e., full provider risk)

Define and implement a contracting strategy by market and population



Infrastructure build-out to support value-based care

Invest in key enablement capabilities to mitigate execution risk

Clinical transformation through physician engagement and practice/operations management



Partner with others to strengthen system capabilities

Meaningful partnerships with:

Payors

Providers

Others

Clinically Integrated Systems of Care

- Networks of physicians and caregivers working together with other healthcare organizations
- A systematic approach to high-quality, safe and valued care



Bundled Payment Arrangements

- Bundled payments are payments to providers based on expected costs for clinically-defined episodes of care
- Middle ground between FFS and capitation
- Many other names
 - Episode-based payment/episode-of-care payment
 - Case rate/evidence-based case rate
 - Global bundled payment/global payment
 - Package pricing/package pricing
- ACA created the Center for Medicare and Medicaid Innovation, which developed Medicare's Bundled Payments for Care Initiative (BPCI)

Bundled Payments: Structural Decisions

- What is the episode of care?
 - Health intervention or diagnosis
 - Set of services
 - Period of time
 - Patient eligibility criteria
- What providers will participate in the episode of care?
 - Healthcare facility
 - Surgeons
 - Anesthesia
 - Other



Bundled Payments: Structural Decisions

- How will the payment be structured?
 - Fixed payment for episode of care
 - Fixed payment for episode of care + shared savings incentive
- Variable payment(s) based on performance metric(s)
 - Length of stay
 - Readmissions
 - Other complications



Bundled Payments: Potential Issues

- Contractual Structure
 - Amend existing FFS structure
 - New arrangement
 - Contracts with downstream providers
 - Terms unique to the bundled payment
 - Data reporting
 - Audit
 - Recoupment
- Antitrust
 - Is the payment financial integration?
 - If not, is there clinical integration?

Bundled Payments: Potential Issues

- Insurance Laws Governing Risk
- Fraud and Abuse
 - No inducement to limit medically necessary services
 - Stark
 - State and federal kickback statutes

Bundled Payments—Practical Tips

- Upfront planning will help “upscale” number of arrangements
- Consider compliance responsibilities
 - Hospital Leadership
 - Finance and Accounting
 - Beneficiary Incentives
 - Patient Engagement
 - Data Use Guidelines
 - Fraud and Abuse Waivers (if applicable)



ACO Arrangements

- A healthcare organization that takes quality- or risk-based reimbursement for an assigned group of patients
 - Built around a coordinated group of providers with one or more hospitals and a strong primary care component
 - Accountable to patients and third-party payers for quality and efficiency of care
- Medicare Shared Savings Program
 - Voluntary
 - Shared savings only or shared savings/shared risk tracks
 - Quality measurements in four areas: (1) patient experience, (2) care coordination/patient safety, (3) preventive health, and (4) at-risk population

Payer/Provider Collaboration: ACO Arrangements

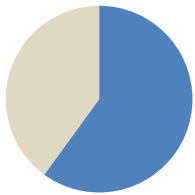
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Payer/Provider Collaboration: Joint Venture Health Plans

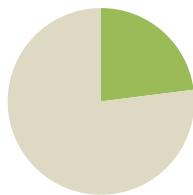
- 13% of U.S. health systems offer health plans in one or more markets (commercial, MA, managed Medicaid)
- Old version:
 - “Narrow” or “high performance” network with provider partner in top (lowest) cost-sharing tier
 - Provider partner accepts larger discount on services from plan partner
- New version:
 - Payer/Provider joint ownership
 - Shared Payer/Provider risk for certain product
- Market alternative to ACOs

Healthcare is Now a Retail Good

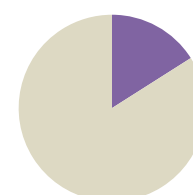
Few Providers Have Put Consumer-Centric Strategies into Action, according to First Annual Kaufman Hall and Cadent Consulting Group Report



In the healthcare industry, **66 percent** believe consumerism is a priority



Only **23 percent** have the insights needed to take action



Only **16 percent** have the capabilities to implement strategies based on those insights

New Consumer Landscape

As trends shift to meet consumer demand and we transition to value based care, **Ascension is responding** to new points of value differentiation among our competitors:

1. A strong, identifiable brand
2. Easy and consistent access to care
3. Convenience throughout the process
4. Customer satisfaction
5. IT connectivity
6. Consistent quality
7. Service
8. Price

Source: Kenneth Kaufman, Healthcare management consultant and
Chair of Kaufman Hall

Impact of Consumerism

- Demand for transparency in pricing
- Demand for customer service
- Demand for customer-focused experience

