Joint Venturing: Providers and Payers Pursue Accountable Care

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Today's Presenters

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Topics

- Without an ACO, what is the market telling us
- What are the opportunities to share risk with a managed care payer
  - By contracting
  - Using your captive
- What are the challenges presented by the PPACA MLR Rule

The problems with the MSSP ACO are many!

- Too complex
- Return too speculative
- Significant investment required
- The antitrust hurdle
- Legal issues of collaboration and integration may not be materially decreased
  - Federal: Stark, AKS, CMPs
  - State: Corporate practice, fee splitting, referral fees

We Are All in It Together – Plans and Providers

- Who knows what Congress did
- Available dollars going down (2014 may not be a panacea)
  - Rate controls (premium increases)
  - MLR regulation
  - The challenge of trickle down
- Plans and Providers aligned?
  - At least in the same leaky boat together

What We Want -

- (Payment) systems that promote quality
  - Clinical integration
- (Payment) systems that promote cost accountability
  - Cost control
  - Fair allocation of dollars paid
- (Payment) systems that promote quality improvement
  - Quality that translates to outcomes
  - Quality that requires improvement
  - Quality improvements that are sustained.

Within the Existing Legal Constraints

- Antitrust – Can't fix prices or overly exert real market power
- AKS – Can't pay for referrals (or based on value or volume of refunds)
- Stark – FMV is required when there are financial relationships
- CMP – Can't pay for direct care reductions, or to really induce consumers to change their habits
- Corp. Practice – Lay entities (in some places) can't practice medicine

How to Share Risks and Attack Costs

- Is there a Plan level provider ownership trend starting?
- Plans acquire providers
  - WellPoint acquires CareMore Health Group
    - Includes both Medicare Advantage Plans and clinics
  - Humana purchases Concentra
    - Urgent care centers – an alternative to ER services
    - Capital to be invested in expansion
  - Highmark buys West Penn Allegheny Health System
    - To attack a perceived market power problem
    - Financial commitment reported $475 million over four years
    - Pressure on UPMC to become an in-network provider
- Kaiser Model

Plans Joint Venture With Providers

- UNC Health – BCBS North Carolina
  - Build a primary care facility
  - To coordinate care "exclusively" for 5,000 BC Members
  - Practice run by providers
  - Claims, data by the Plan
- Joint ventures
  - Providers provide the care
  - Plans run the back office, provide capital for infrastructure
  - JV vehicle to do that

Plans Joint Venture With Providers (cont.)

- Horizon BCBS of New Jersey – Atlanticare
  - A Joint venture model
  - 50/50 Governance
  - Full mission statement, lofty goals
  - Agreed JV services: Claims processing, medical management, provider services, membership services

How to Evaluate These Ventures

- HFMA 1997 Discussion:
  - HMO Market penetration
  - Potential competitive response
  - Market demand
  - Reputation
  - Marketing ability
  - Organizational identity
  - Financial resources/access to capital
  - Managed care expertise
  - Risk contracting experience
  - IT

Provider Sponsored Plans

- From the 90's
- Are they an option again?
- Can they be joint ventured with Plans?
- See above for their issues
  - A challenging past
  - A few survive

How Some Attack Costs

- Pay less – A contracting approach
  - Case management
  - Bundling/editing bills
  - Carve outs (e.g., high cost drugs)
- Transaction friction
  - Not so efficient
  - Doesn't incentivize quality
  - Especially contract roll backs
  - Doesn't promote stability
  - Does nothing for care integration
- Even if you simply share savings

How Some Attack Costs (cont.)

- But legally protected (if the involved providers are not involved in price fixing)
- Safe harbors
  - Discounts [42 CRF 1001.952(h)]
  - Price reductions [42 CRF 1001.952(m),(t)]
- Not really a Stark problem at provider-plan level

The Discount Safe Harbor (1001.952(h))

- Remuneration does include a discount, unless
  - Cash payment (except rebates by checks)
  - Or is part of swapping arrangement
  - Applicable to one payor but not Federal program
  - Routine waiver or reduction in coinsurance or deductible
  - Services through a PSA
  - Some other bells and whistles

The Discount Safe Harbor (cont.)

- Buyer/seller rules
  - Buyer who reports costs
    - Earned based on purchase of same goods or services purchased within single fiscal year
    - Claimed within same year earned or following year
  - If buyer is an HMO, need not be reported
  - Variety of other rules

Note: No limit on scope or duration (over a year)

Note: No rule on how discounts may vary with volume or quality levels

The Price Reduction Safe Harbors

- 1001.952(m) – Price reductions to health plans
  - For reductions to HMOs, CMPs, dependent on their status (risk based, cost based; other)
  - Series of standards – for example
    - Contract not less than one year
    - Covered items and services specified
    - Can't shift burden of agreement to increase payments

Note: No limit on scope/duration, volume, other parameters.

The Price Reduction Safe Harbors (cont.)

- 1001.952(t) – Price reductions to eligible managed care organizations (EMCOs)
- HMO or CMP with risk or cost based contracts
- Part C plans receiving capitated payments
- Medicaid managed care plans
- Federally qualified HMOs
- Some others

Note: No limit on scope/duration, volume, other parameters.

1st Tier Rules

- Agreement in writing
- Specifies item and services
- At least a year
- Can't claim outside the agreement (with some limited exceptions)
- No swapping
- No shifting of burden

Downstream Rules

- Includes 1st Tier and Downstream contractors and between two downstreamers
- But, 1st Tier is not:
  - FQHC receiving supp. payments
  - Fed. Qualified HMO unless risk based payment contract
  - HMO compensation based on cost-based payments
- Like the 1st Tier rules

Beyond Simple Price Reductions, and Into Risk Sharing With EMCOs

- Capitation and % of premium arrangements
- Bonus pools/incentive [P4P] payment arrangements
- Bundled compensation arrangements
  - Multiple providers
  - Global rate
    - Procedure based (e.g., hip replacement)
    - Episode of care based

Addressing the Antitrust Risk

- Risk sharing
  - Sharing of substantial financial risk
    - Agreement to provide a complex or extended course of treatment, substantial coordination, complementary mix, for a fixed, predetermined payment, with variable costs
    - Capitation, % of premium, % of revenue
    - Significant financial incentives
      - Substantial withholds
      - Substantial rewards or penalties
  - Single entity treatment
  - How much is enough?

Addressing the Antitrust Risk (cont.)

- Clinical integration
  - The definition
    - Collaboration to the extent that interdependence is required
    - By both specialist and primary care providers
    - Requiring efficient and meaningful information exchange, with integrated IT, whereby utilization and claims information can be gathered, reviewed, analyzed
    - A high level of physician investment, economically and time
    - Agreement to comply with standards, benchmarks, with enforcement
  - Difficult to achieve—Can the network produce significant efficiencies and a necessity of joint contracting
  - Is there a real product there?

Move on to the AKS – Safe Harbors Help

- Price reductions offered by contractors with substantial financial risk to managed care organizations ("SFR") (1001.952 (u))
  - First tier rules
  - Downstream rules
- SFR alternatives
  - Capitation
  - % of premium
  - DRGs
  - Qualifying bonus or withhold programs
    - 20% non-institutional/10% hospital/nursing home threshold

Stark Safe Harbors

- Managed care (prepaid health plan) exceptions
  - 411.355(c) - Services furnished to enrollees of HMOs, CMPs Demonstration projects on a prepaid basis, MCOs contracting with a State
- Physician incentive plans
  - 411.357(d)(2) – For PIP plans between a physician and an entity or downstream contractor "the compensation may be determined in a manner (through a withhold, capitation, bonus or otherwise) that takes into account directly or indirectly, the volume or value of any referrals or other business generated between the parties" if:
    - No inducements to limit for specific individuals
    - If SFR, meets the rules (422.208, .210)
    - PIP is "any compensation between en entity (or downstream contractor) and a physician that may directly or indirectly reduce or limit services"

Stark Safe Harbors (cont.)

- Risk sharing arrangements
  - (411.357(n))
    - Withholds, bonuses, risk pools, or other risk sharing arrangements
    - Between MCOs or IPA and a physician, directly or indirectly through a subcontractor
    - Can't violate AKS
    - Pretty flexible

Physician Incentive Plan Rules (422.208)

- Apply to MA plans and any subcontracting arrangements
- Rules with respect to compensation arrangements that may limit services
- Basic requirements
  - No enrollee specific payments
  - Existence of SFR
    - Stop loss (aggregate or per patient) protection
    - Risk is based on use or cost of refunds in excess of risk threshold, *i.e.*, 25% of potential payments. Rules around panel size.
  - Potential payments = maximum payments possible
    - Excluding payments not based on referrals

And Don't Forget

- Other exceptions may help shape an arrangement
  - Employment
  - PSAs
  - Co-management arrangements
  - Indirect compensation arrangements

Where does this leave you?

1. Take insurance risk
   - Acquisition by a plan
   - Joint Venture with a plan
   - Create your own plan
   - Use your captive
2. Take contracting risk
   - Risk based contracts
   - Take advantage of AKS, Stark exceptions

MLR Impacts on Provider – Payor Risk Sharing Arrangements

- For purposes of PPACA, the medical loss ratio of an insurer is:

$$\frac{\text{Claims} + \text{Quality Improvement Measures}}{\text{Premiums} - (\text{Taxes} + \text{Fees})}$$

- PPACA Required Minimum MLRs
  - 85% for large groups
  - 80% for small businesses and individuals
- Insurers who have MLRs less than the ratios above must pay a rebate to policyholders

MLR Impacts on Provider -- Payor Risk Sharing Arrangements

- Benefit of risk sharing arrangements (fewer and lower claim costs) directly results in lower MLRs for health insurers
- A substantial number of health insurers are not meeting MLR
- Rebate could negate the benefit of the arrangement for the insurer

What Counts – What Doesn't

- What can be included in the numerator?
  - Capitation payments
  - Incentive and bonus payments made to providers
- What is not included in the numerator?
  - Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee

Impact on Payment Structures

- Because incentive and bonus payments can be counted in the numerator of MLR, insurers will likely favor these types of programs.
- Capitation models are also still favorable, however, the portion of the capitation payment associated with administrative costs likely cannot be included in numerator.

MLR Requirements and Medicare Advantage Plans

- 85% MLR requirement does not apply until 2014
- New regulations likely – open questions
  - What is in or out of the numerator?
  - How will incentive compensation programs be impacted?

Captive Reinsurance Arrangements

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Captive / Reinsurance Agreements

- Providers often have captive insurance companies for medical malpractice risks
- Providers can utilize their captives to take on insurance risk they control by entering into specific reinsurance agreements

Sample Reinsurance Transaction

- ABC Insurance develops an insurance product with a defined network
- Defined network providers enter into a reinsurance agreement with ABC Insurance Company, through their medical malpractice captive, XYZ Captive
- XYZ Captive agrees to reinsure 50 percent of the risk assumed by ABC Insurance through the PPO product, in return for 50 percent of premium, *i.e.* on a quota share basis

Benefits for Providers

- Obtain financial benefit of efficient care through receipt of premiums and low loss experience
- Financial benefit will incentivize efficient and coordinated care, which will create a better experience for the patients
- Increase of third-party risk helps XYZ Captive meet IRS definition of “insurance” for tax purposes

Benefits for Insurer

- Creation of new premium stream
- Better loss experience = greater profit
- Potential to transfer a portion of associated administrative costs to captive

Captive / Reinsurance Agreements – MLR Provisions

- Will MLR calculations be based on aggregate book of business of insurer or the specific PPO plan?
  - If aggregate book of business, captive may benefit if insurers' MLR is above 85% and the PPO plan's MLR is below 85%.
  - If based on only the PPO plan, captive may benefit in the case where insurer's MLR is below 85%, while the PPO plan's at 85% or above.

Captive / Reinsurance Agreements – Exit Provisions

- Protecting franchise upon exit from reinsurance agreement
- Termination may result in competition for network of providers from underwriting insurer
  - This risk can be mitigated with the standard non-compete clause in the reinsurance agreement

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