



Coordinating Care— Moving Beyond Concepts & Operationalizing the New Healthcare Environment

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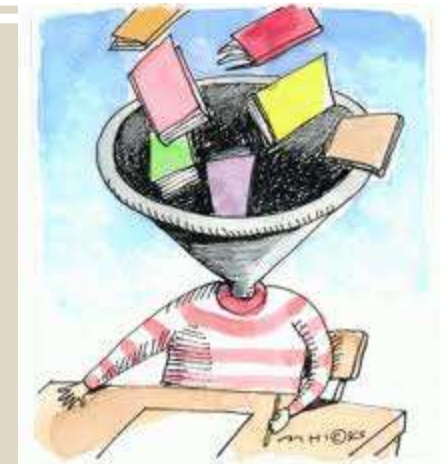
Feldesman Tucker Leifer Fidell LLP





What We'll Cover

- ❖ 6 Key Readiness Steps
- ❖ Legal Considerations in Forming Integrated Models of Care
- ❖ Evaluating and Developing ACOs
- ❖ State Activities to Facilitate Coordination





The New York Times

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HEALTH LAW STANDS

Roberts Joins Majority, Deeming Mandate a Tax

Ruling Affirms a Key Provision of Law; Victory for Obama

By THE NEW YORK TIMES
32 minutes ago

The Supreme Court on Thursday largely let stand President Obama's health care overhaul, in a striking victory for the president and Democrats, with the conservative chief justice, John G. Roberts Jr., affirming the central legislative pillar of Mr. Obama's term.

• A Reader's Guide to The Times's Coverage 9:35 AM ET



Brandon Hoffman for The New York Times

Supreme Court Decision

- Upholds majority of the Affordable Care Act including:
 - Coverage mandate
 - Health Insurance Exchanges, EHB
 - Prevention Services
 - **Demo programs: ACOs, Medicaid Health Homes, Dual-Eligibles**

The ACA came about in response to specific health system pressures...
...which will continue to exist regardless of whether the ACA falls or stands.

Care
Coordination





Are YOU ready?





What's waiting at the finish line – from a business planning perspective

- Shifts in revenue sources as more people become eligible and enroll in new insurance options
- Increased competition as health providers meet new value-based purchasing standards built on health system partnerships and accountability for clinical outcomes





The path to gold: 6 key elements

1. Estimate changes in payer mix
2. Get your clients enrolled
3. Know the value you bring to the healthcare system
4. Be accessible and convenient
5. Produce measurable outcomes
6. Connect with other providers





Some States See Profits in Expansion

“Several states have completed studies showing they will make a profit by participating in the Medicaid expansion, according to Deborah Bachrach, special counsel for health care transaction and policy with Manatt, Phelps & Phillips. “They’ve concluded they can’t afford not to expand,” she said.

One way states can save on coverage costs is by no longer having to pay for separate mental health and substance abuse programs, she said, noting that many people in these programs would be covered under expanded Medicaid.



Can you estimate what your new payer mix will be?

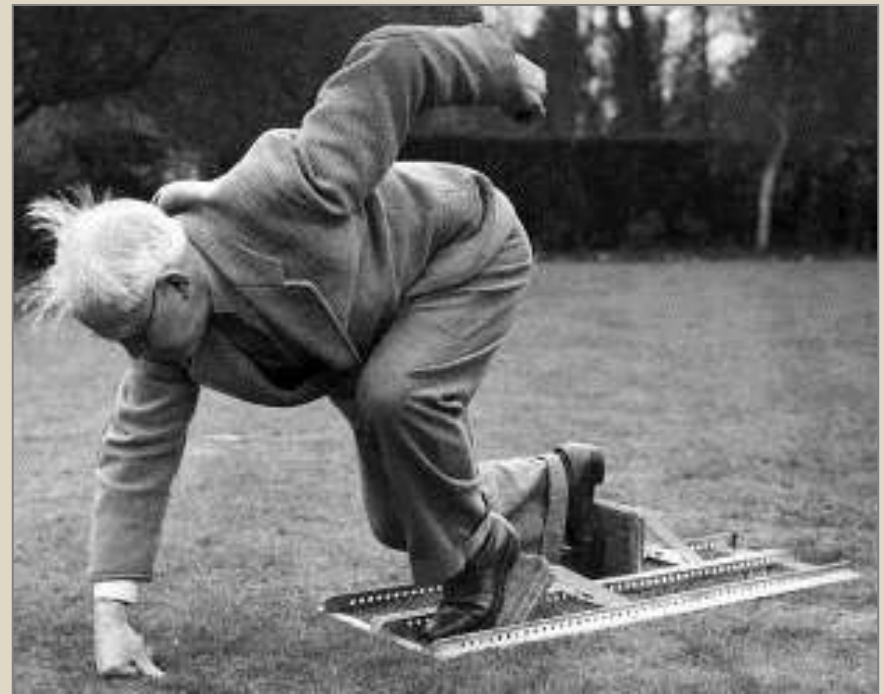
Are you ready to bill third-party payers?

Are your providers empanelled and properly licensed per insurance plan requirements?



Get set...

**Prepare for
increased
competition
(#3-6)**





Increased competition in MH/SUD

- Managed care
- Accountable Care Organizations
- New MH/SUD coverage under qualified health plans
- New parity requirements

Type of Plan	Must offer MH/SUD?	Parity applies?
Plans sold in Exchanges (Qualified Health Plans)		
Individual market (not sold in the Exchanges)	¹	
Small group market (not sold in the Exchanges)	¹	²
Large group market (not sold in the Exchanges)		³
Traditional Medicaid, fee-for-service		
Traditional Medicaid, managed care		³
Benchmark Medicaid for newly eligible, FFS		Partially ⁴
Benchmark Medicaid for newly eligible, mgd care		



The path to gold: 6 key elements

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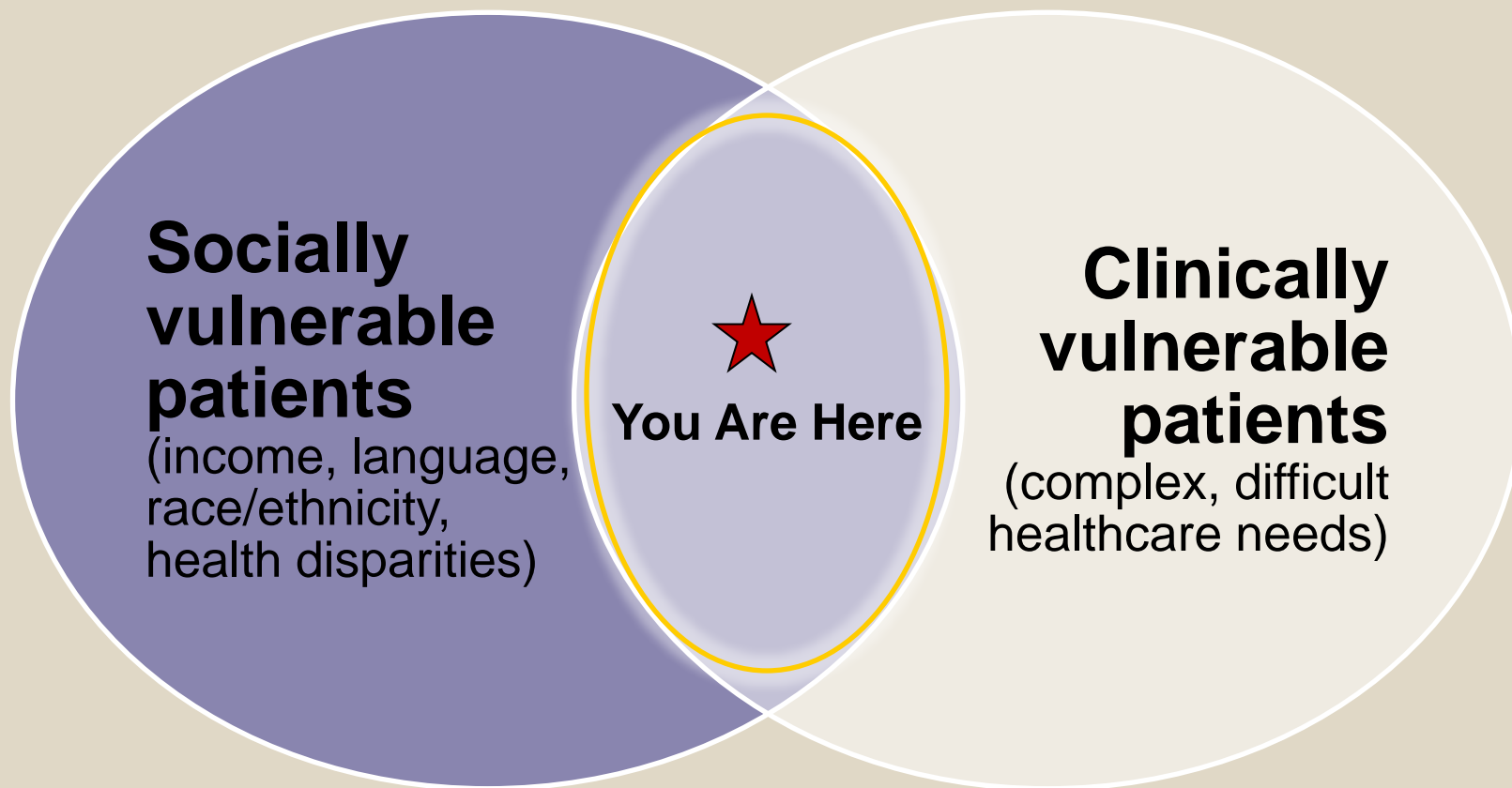


3. Know the value you bring to the table

- Payment reform = primarily shared-risk models with **responsibility on providers** to manage care and lower costs
- Individuals served by the safety net are some of the most costly and complex
- Community behavioral health organizations have **expertise and experience** in caring for these populations, making them valuable partners in the reformed healthcare ecosystem



Our niche: caring for complex, costly patients





Making the business case for your services

- Have a data-driven understanding of your service delivery
- Know the integrated care networks that are forming in your community
- Form referral relationships built on your ability to guarantee **timely access**, produce **good outcomes**, and be able to **report back** (#4, 5, 6)



4. Be accessible

- Important factor in getting referrals and handling increased caseloads
- Walk-in, same day, or rapid access intake models
 - Results include: elimination of no-shows, increased staff productivity, and higher client satisfaction





One-stop shopping

Accessibility, convenience, and integration across primary care, mental health, and substance abuse

- Simplify the consumer experience
- Co-location of services
- Telehealth
- Therapies for people with less severe conditions
- Marketing advantage



5. Produce measurable outcomes

- Episodic care
- Treat to target
- Solution-focused therapy
- Use of standardized tools to measure improvement in symptoms, functioning, resilience and recovery



Don't be afraid to embrace new approaches to treatment!



6. Connect with other providers

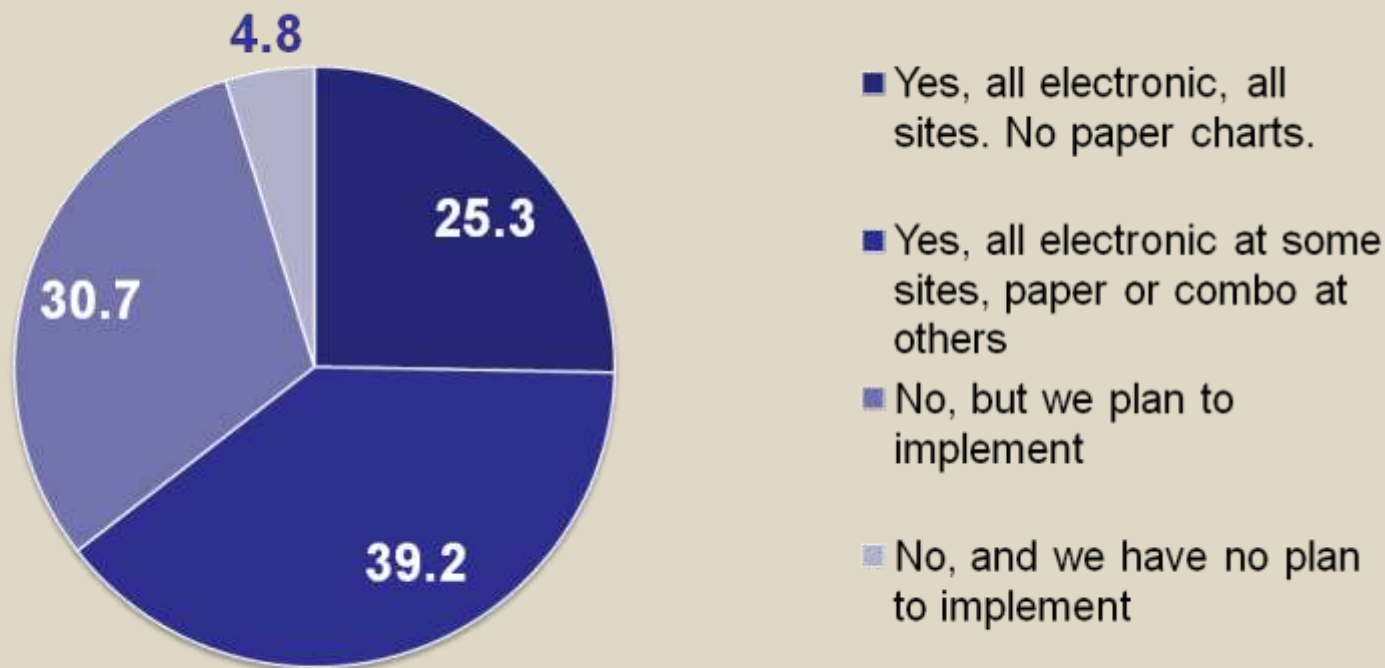
To be a valuable partner, specialists must demonstrate competency around:

- Timely consultations & referrals
- Timely, effective exchange of clinical data
- Effective participation in co-management situations
- Patient-centered care, enhanced care access, and high levels of care quality and safety
- Supporting the health home practice's work
- Electronic communication of health information



Electronic communication: Does your organization use an EHR?

EHR use among National Council members (%)





Within 2 years, what new strategic partnerships will you have developed?

Within 2 years, how will you be demonstrating the effectiveness of your services?



In a nutshell: **make yourself indispensable!**

- Know how to make the business case for your services – and why others should want you on the team!





The path to gold: a recap

1. Estimate changes in payer mix
2. Get your clients enrolled
3. Know the value you bring to the healthcare system
4. Be accessible and convenient
5. Produce measurable outcomes
6. Connect with other providers





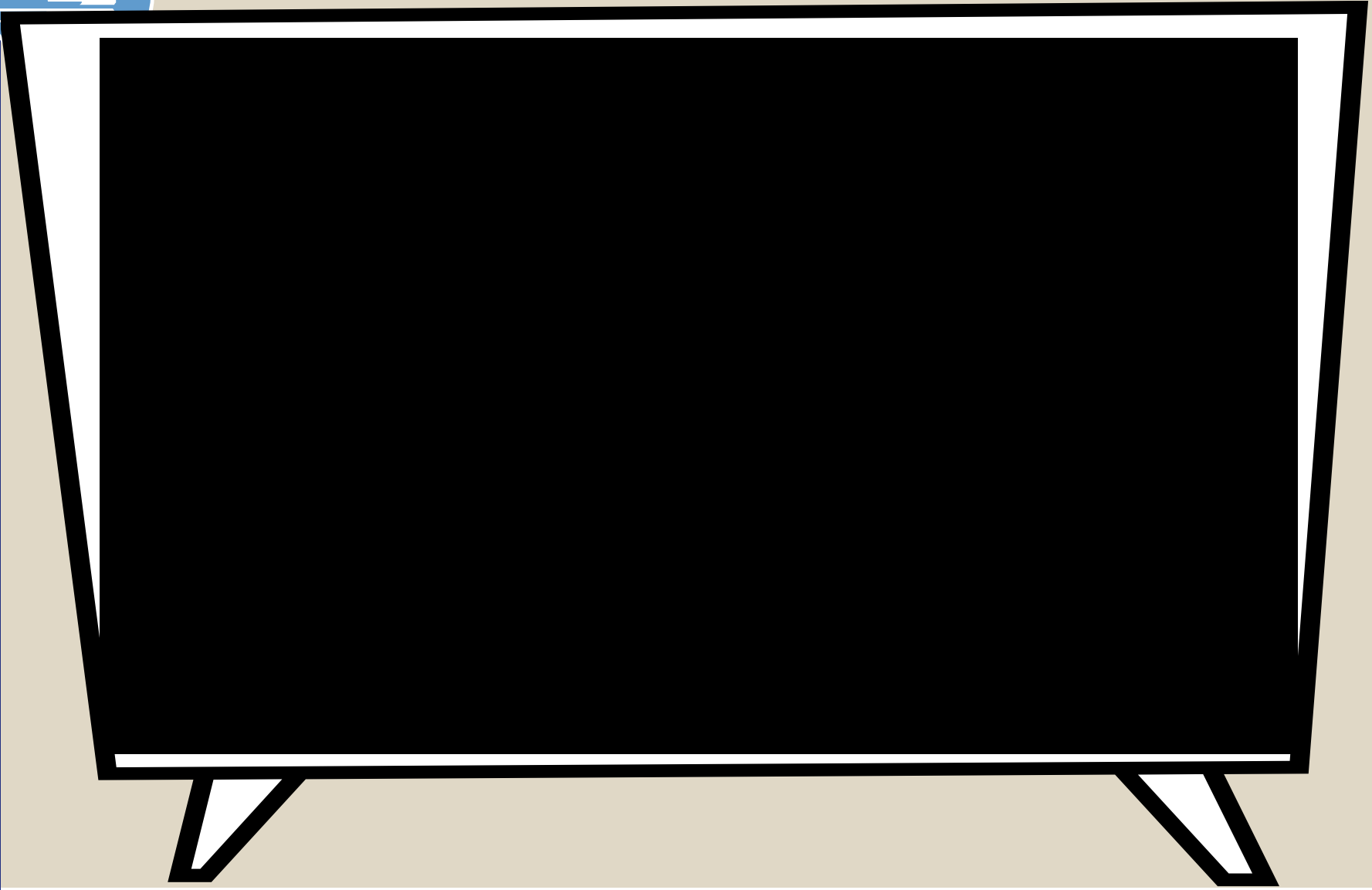
Go!





Legal Considerations in Forming Integrated Models of Care







Accountable Care Organizations

*“Networks of physicians and other providers that **could** work together to improve the quality of health care services and reduce costs for a defined patient population.”*

- Health Affairs, Robert Wood Johnson Foundation, Health Policy Brief, *Accountable Care Organizations. Under the health reform law, Medicare will be able to contract with these to provide care to enrollees. What are they and how will they work?* (July 27, 2010) (Emphasis added).



Basic Features of the ACO

- Combination of one or more hospitals, physician groups (primary care and specialty), and other providers
- Local accountability
- Financial incentives to meet quality benchmarks or cost-savings
- Shared governance structure
- Formal legal structure that allows organization to receive and distribute payments to participating providers
- Leadership and management structure that includes clinical and administrative systems
- Performance measurement



Antitrust Law

The Sherman Act (15 U.S.C. § 1)

- Purpose: To promote competition and protect consumers
- Prohibits anti-competitive activities (*i.e.*, agreements) among private, competing businesses, that unreasonably restrain competition
 - Price fixing
 - Market allocation
 - Concerted refusals to deal
 - Boycotts
- Enforced by U.S. Department of Justice (Antitrust Division) and Federal Trade Commission (FTC)



Potential Antitrust Exposures for Networks

- Agreements between a provider and one or more other providers not to compete with each other for patients, often by dividing up a geographic area.
- Agreements between a provider and one or more other providers to negotiate jointly with managed care organizations.
- Exclusive agreements between a provider and one hospital not to refer patients to any other hospital, thereby denying those other hospitals of any business.
- Affiliation agreements with other providers to develop joint reporting systems under which certain competitively sensitive information (e.g., price-related terms) may be shared, coordinated fee schedules, and/or patient tracking and referral systems (which could result in the allocation of patients)



Antitrust Legal Standards

- Per-Se Illegal (e.g., price-fixing, market allocation)
- “Rule of Reason” test determines whether lawful if:
 - The physicians' **integration** through the network is likely to produce significant efficiencies that benefit consumers and
 - Price agreements by the network physicians are reasonably necessary to realize those efficiencies.
- Antitrust “Safety Zone”
 - “The safety zone for integrated provider networks allows a network to negotiate and contract with third parties as a single entity on behalf of its participants and to engage in other activities typically considered anti-competitive, if the participants are sufficiently integrated.

Statement 8, DOJ/FTC Statements of Enforcement Policy in Health Care (1996)

- <http://www.ftc.gov/bc/healthcare/industryguide/policy/statement8.htm>



Financial Integration Safety Zone

- To satisfy the requirements of the integrated provider safety zone, participants must be financially integrated at a sufficient level” such that the following criteria must be met:
 - The participants share substantial financial risk, i.e., capitation payments, global fee arrangements, fee withholds, cost or utilization based bonuses or penalties; and
 - The participants demonstrate other indicia of financial integration, i.e., make substantial capital investments in the arrangement and/or execute a participating provider contract that provides for capitation.
- Market Share Limitations
 - If the collaboration is non-exclusive, it must be comprised of no more than 30% of the primary care or specialty physicians in the relevant market
 - If the collaboration is exclusive, it must be comprised of no more than 20% of the primary care or specialty physicians for the relevant market.



California Provider Networks

- No fewer than 285 Physician organizations in California furnish or arrange care for defined populations, publicly report data on their clinical and financial performance, and are often financed through partial or global capitation payments.
- Independent Practice Associations (152)
 - Hill Physicians Medical Group
 - Brown and Toland Medical Group
- Integrated medical groups / PHO (133)
 - Permanente Medical Groups (contracts with Kaiser hospitals)
 - Palo Alto Medical Foundation (contracts with Sutter hospitals)
 - Sharp Rees-Stealy Medical Group (contracts with Sharp hospitals)

Source: Integrated Healthcare Association, "Accountable Care Organizations in California: Lessons for the National Debate on Delivery System Reform," 2010.



California Provider Networks

- Payment to Provider Network
 - Professional services capitation (covers primary and specialty physician services)
 - Excludes hospital and pharmacy services
- Payment to individual physicians within network
 - Salary, with a bonus based on group and individual performance
 - Fee-for-service or sub-capitation



Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC)

- Eligible entity: Any provider organization
- Responsible for cost and quality of services, including services provided in the hospital setting
- Participating provider organizations:
 - Physician groups (PCPs and specialists)
 - Atrius Health (>400 PCPs)
 - Hampden County Physicians Associates (100 PCPs)
 - Integrated delivery systems (e.g., PHOs)



Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC)

- **Payments to Provider Network:**
 - Global budget (risk and inflation-adjusted on a yearly basis) based on total dollars spent on prior year
 - Supplemented by bonuses of up to 10 percent for improvements in quality, safety and patient experience.
- **Payments to participating providers in network:**
 - Network decides allocation and payment distribution among providers participating in the network
 - Not specified in the contract between BCBSMA and the network



Clinical Integration Safety Zone

- Joint contracting is allowed if network:
 - Has established “sufficient clinical integration”
 - Can demonstrate that joint price negotiations are reasonably necessary to achieve the substantial efficiencies arising from the clinical integration
- Clinical integration defined as a “network implementing an active and ongoing program to evaluate and, as necessary, to modify the practice patterns of the participating providers, and to create a high degree of interdependence and cooperation to control costs and ensure quality.”
 - *Statements of Antitrust Enforcement Policy in Health Care* (August 1996) at Statement 8, § B.1.



Elements of Clinical Integration

- Implementing utilization control mechanisms to control costs and assure quality of care
- Establishing information systems to gather aggregate and individual data in order to measure performance of the group and of the individual participating providers, and to ensure exchange of all relevant patient data.
- Monitoring patient satisfaction with the participating providers.
- Establishing reporting systems to provide payers with detailed reports on the costs and quantity of the services delivered, and on the collaboration's success in meeting its goals.
- Employing centralized staff
- Investing significant time and money in the development of necessary infrastructure, including practice standards and protocols and care management protocols, and actively monitoring the care provided through the collaboration.
- Monitoring the participating providers' compliance with network's standards and protocols, and taking remedial action against those individuals who fail to adhere to them.



FTC Advisory Opinion to MedSouth, Inc.

- Network was composed of competing primary and specialty care physicians
 - Sought to negotiate price and other terms and enter fee-for-service contracts with payers.
- Proposed to coordinate and integrate certain health care services by its members with a clinical resources management program that would include:
 - Web-based electronic clinical data record system
 - Clinical practice guidelines
 - Measurable performance goals
 - Centralized Medical Director
 - All network members would commit to participate in the network's programs and adhere to network's protocols.
- FTC approved the proposal on Feb. 19, 2002
 - <http://www.ftc.gov/bc/adops/medsouth.htm>
 - <http://www.ftc.gov/bc/adops/070618medsouth.pdf>



FTC Advisory Opinion to Greater Rochester IPA, Inc.

- Network composed of two hospitals and approximately 600 physicians
- Sought to negotiate price and other terms and enter fee-for-service contracts with payers.
- Proposed developing an internet-based health information system to identify high-cost, high-risk patients and facilitate the exchange of patient treatment information to better manage them.
 - Network would develop clinical practice guidelines, report information using the internet-based system, and then monitor physicians' compliance with those guidelines.
 - The network would also set performance targets, monitor performance using its own benchmarks, and take action when physicians failed to meet performance expectations.
- FTC approved the proposal on September 17, 2007
 - <http://www.ftc.gov/bc/adops/gripa.pdf>



FTC Advisory Opinion to Tri-State Health Partners, Inc.

- Network composed of more than 200 physicians and one hospital
- Sought to “clinically integrate” its members in order to contract jointly with payers on a fee-for-service basis
- Proposed a formal and stringent medical management program that includes protocol development and implementation, performance reporting, procedures for corrective action when necessary, and aggressive management of high-cost, high-risk patients.
- Plans to implement a web-based health information technology system to review episodes of care to determine where performance improvement will have the greatest financial and quality benefits.
- FTC approved the proposal on April 13, 2009
 - <http://www.ftc.gov/os/closings/staff/090413tristatealetter.pdf>



Key Lessons

- CBHOs should only allow a provider network to negotiate on the organization's behalf if the network is financially or clinically integrated.
- Clinical integration may not require financial risk-taking, but significant investment of resources for internal tracking and reporting will still be necessary.
- A clinically integrated provider network is likely to be positioned well for participation as an ACO.



Tax Exemption Legal Considerations

- Unlike for-profit entities, tax-exempt entities cannot distribute profits
 - IRC 501(c)(3) prohibits inurement of exempt organization's net earnings to private individuals and requires exempt organization to pursue charitable purposes with only incidental private benefit
- Consider tax status of other providers participating in ACO
 - Network members that are not charitable organizations should be charged at least cost.
 - May want to obtain IRS private letter ruling to confirm that participation will not affect tax status



Anti-Kickback Legal Considerations

- Financial arrangements (including capital investments and distributions) between referring providers in an ACO are likely to implicate the Federal Anti-Kickback Statute (“AKS”)
 - Prohibits willfully offering, paying, soliciting, or receiving remuneration as an inducement for the referral of Medicare or Medicaid business
- Current AKS safe harbors may not protect ACO arrangements, though falling outside of the safe harbor does not necessarily result in a violation
 - If payments are not intended to induce referrals, ACO arrangement will not result in violation
- Section 10606 of PPACA transforms AKS violations into a False Claim

» Continued...



Anti-Kickback Legal Considerations

- Even without requisite intent, best practice is to safe harbor arrangement if it involves remuneration.
 - Series of favorable OIG Advisory Opinions on “gainsharing” in which a hospital rewards physicians for efforts to reduce costs
- Under Section 3022 of the PPACA, the HHS Secretary has authority to waive certain provisions under the AKS to carry out ACO demonstrations
- Consult qualified counsel to minimize kickback exposures in collaborations between providers



False Claims Act Legal Considerations

- False Claims Act violations can result from misreporting data related to performance when it influence payments from Federal health care programs.
 - Misrepresentations will have legal consequences under the False Claims Act or Civil Monetary Penalties (CMP) Law
 - PPACA expanded False Claims Act and CMP liability
 - Overpayments must be returned within 60days to Medicare and Medicaid
 - Civil Monetary Penalties for a false statement or misrepresentation increases to \$50,000 per violation
- Establish a corporate compliance program to prevent misrepresentations and false claims (as well as to repay overpayments within 60 days) to reduce potential liability



Liability Considerations

- Reassess insurance coverage and ensure sufficient reserves to cover any potential losses
- If the ACO is not assuming risk for the clinical and financial outcomes of its providers, then the individual providers may be incurring the risk themselves, exposing them to significant financial losses.
- If the ACO is assuming full or partial risk for the clinical and financial outcomes of its providers, then it may need to meet certain state law requirements for risk-bearing entities.



Stark Law Considerations

- Federal physician self-referral law (Stark Law) prohibits physicians who have a financial relationship with an entity from referring to that entity the opportunity to furnish services that may have been paid for by Medicare
 - No intent requirement; strict liability unless exception applies
- Certain Stark exceptions may apply to ACOs
 - Prepaid plan enrollee exception
 - Risk-sharing arrangements exception
 - Proposed “Shared Savings Exception”

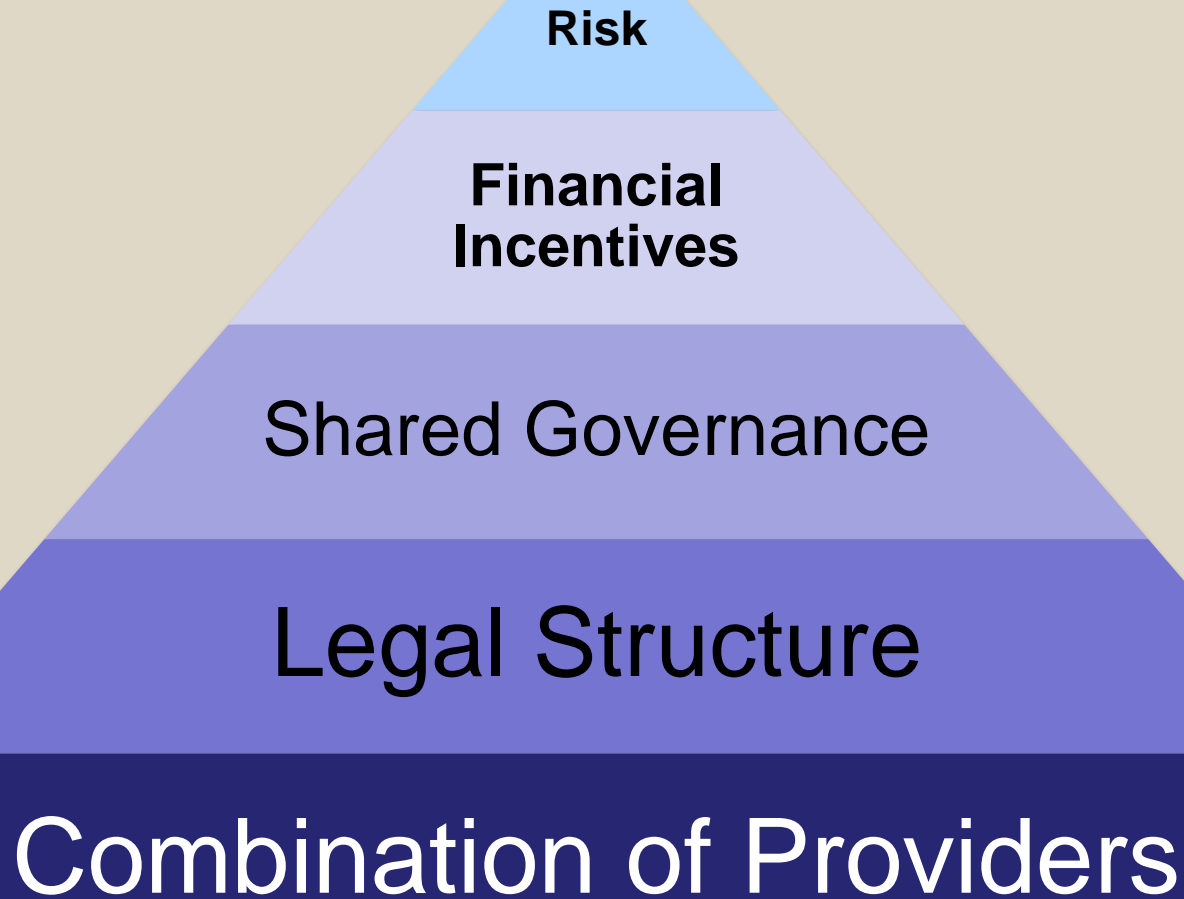


Evaluating and Developing ACOs





Key ACO Considerations



Combination of Providers





Legal Structure

Full Integration

- System owns hospitals and employs salaried physicians

Partial Integration

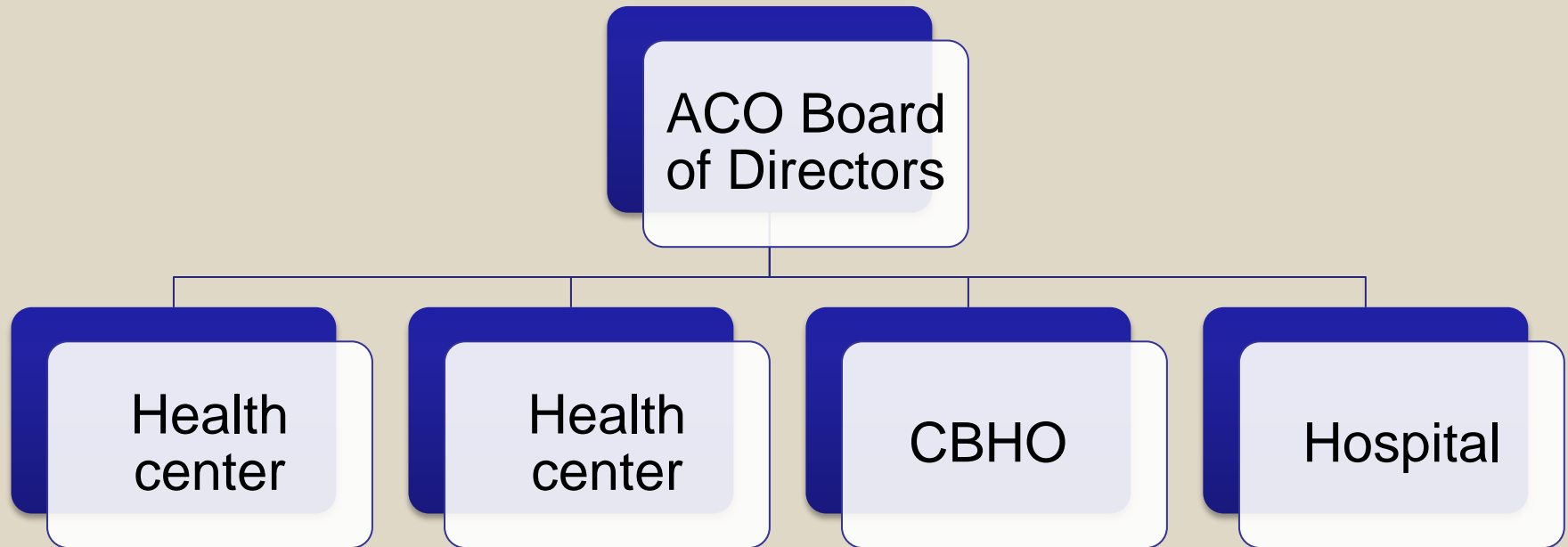
- Joint ownership or joint control of new legal entity (e.g., IPA, PHO)

Joint Venture

- Contractual relationships (e.g., affiliation)
- Joint governance committee



Shared Governance





Shared Governance

- Shared Savings Distributions
 - Who has the authority to determine the terms of the shared savings program?
 - Who has the authority to decide how shared savings are distributed to providers?
 - Who has the authority to decide how any losses are repaid?
- Amount of Capital Investment
 - What amount of capital investment is required to become a member of the ACO?
 - Will each member contribute the same amount of capital?
 - Will profit distributions be made in the same proportion as capital investments?

Financial Incentives



Secondary/Tertiary Care

- Fewer hospitalizations
- Fewer ER visits



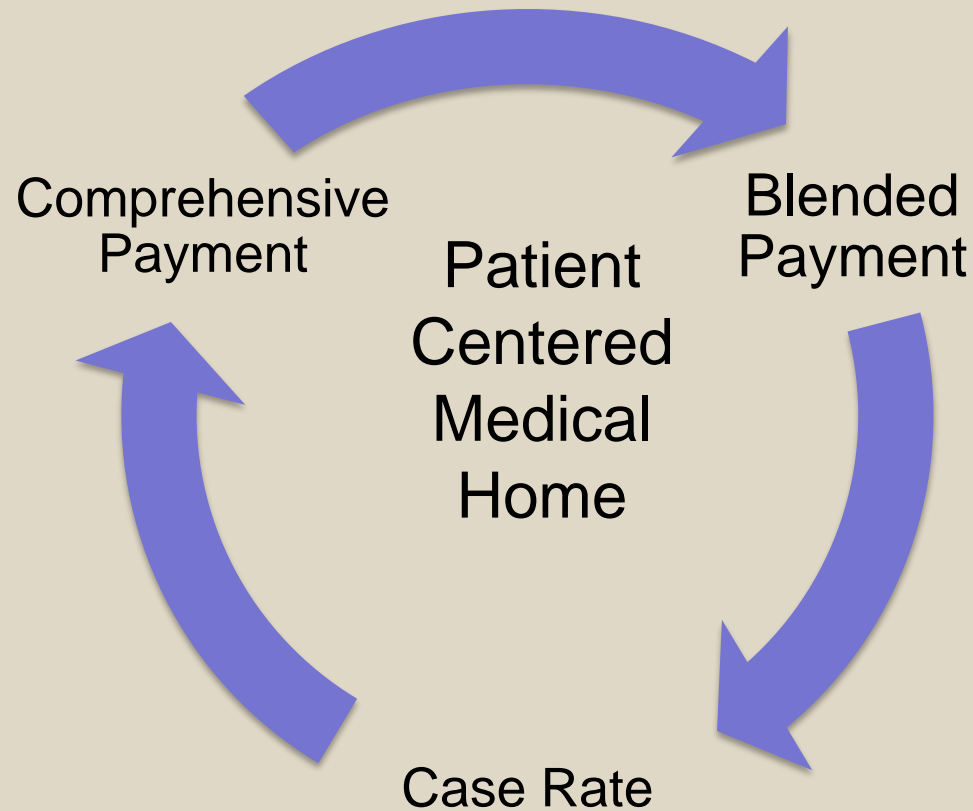
Primary Care

- Preventive care
- Chronic care
- Coordinated care

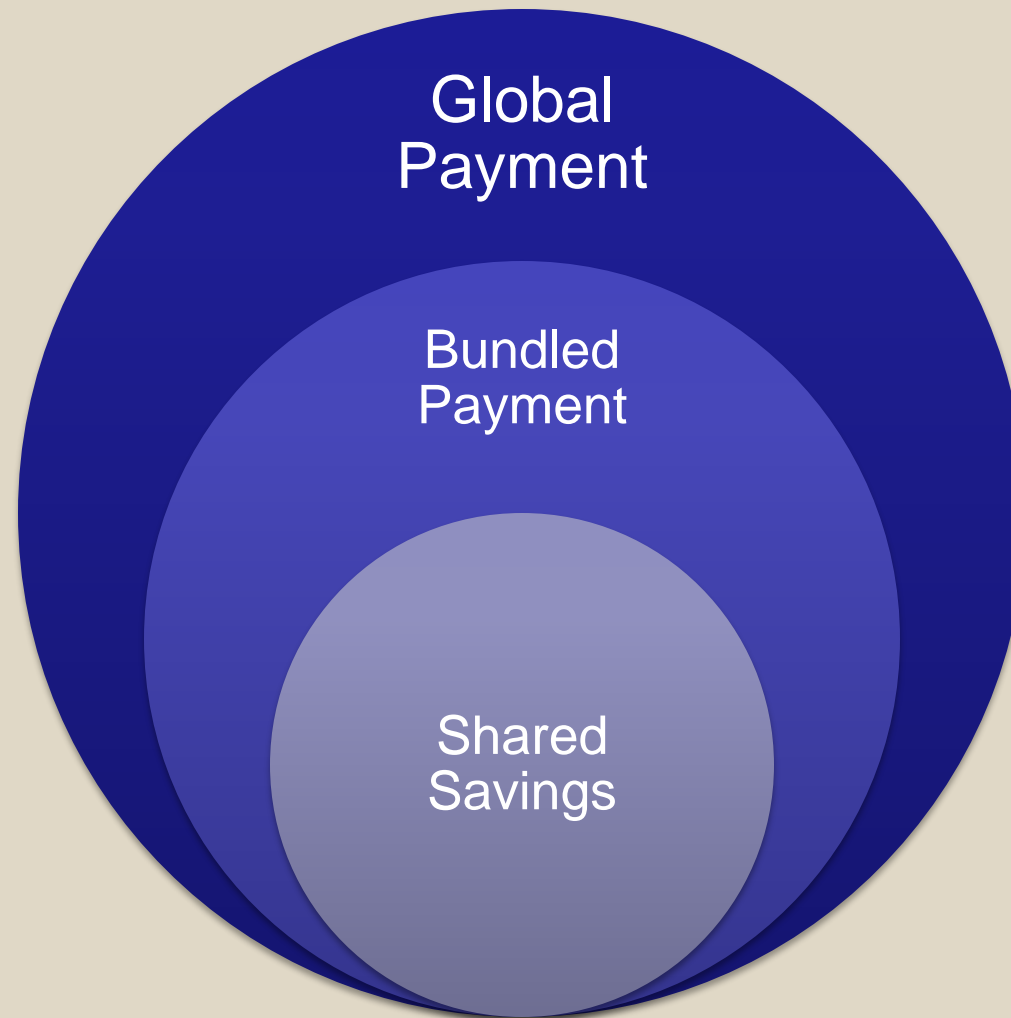




Financial Incentives

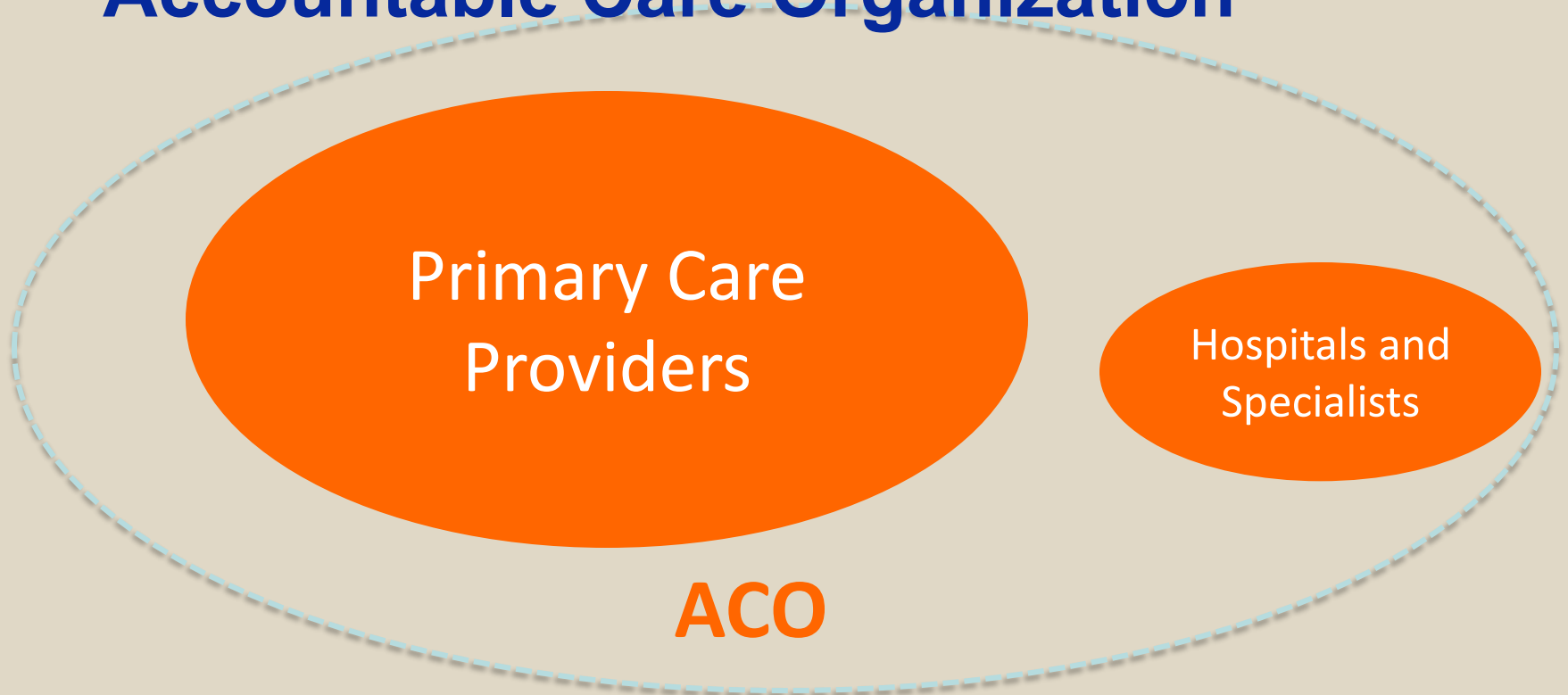


Risk





Accountable Care Organization





Accountable Care Organization

Primary Care
Providers

Hospitals and
Specialists

ACO

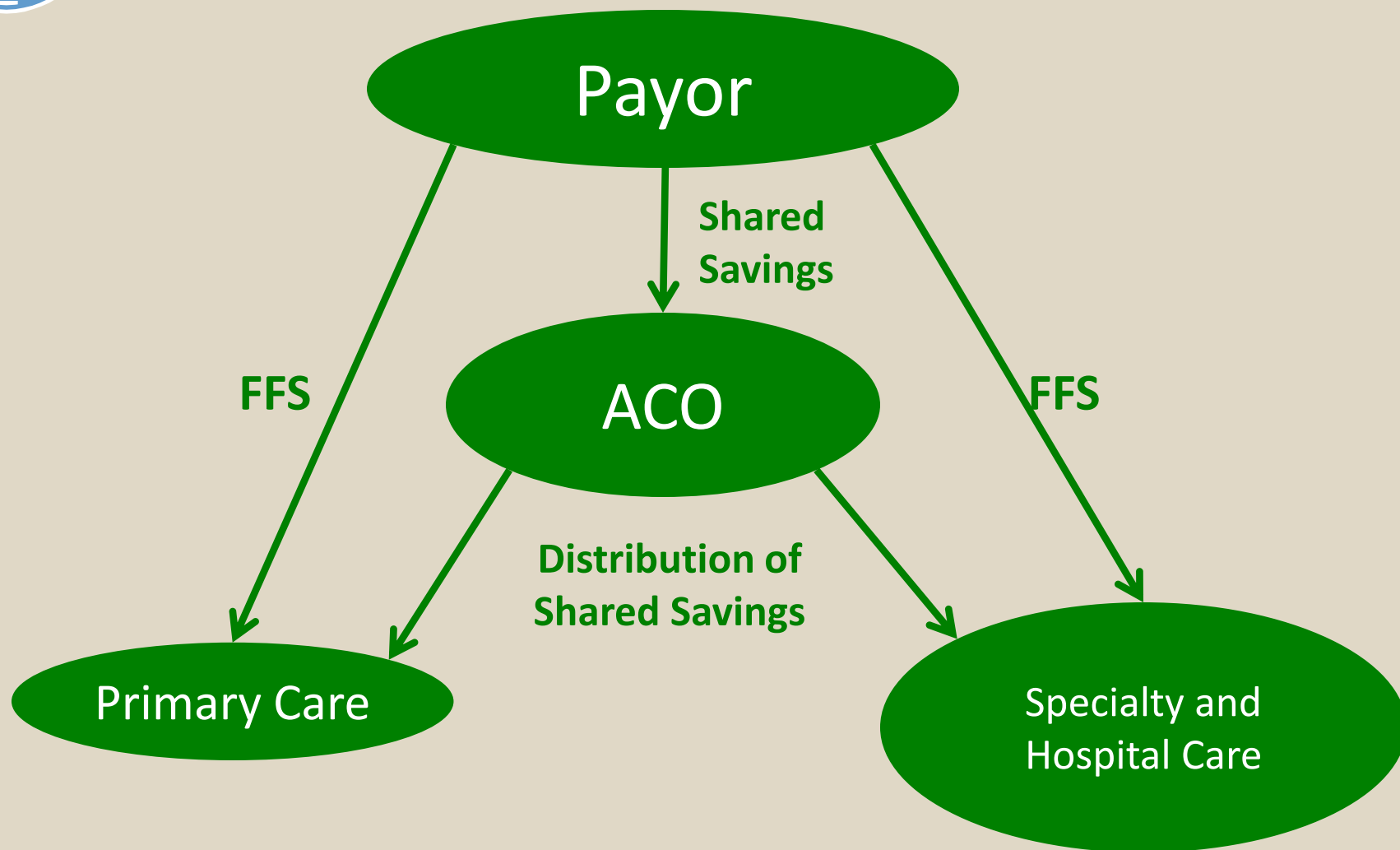
Some ACOs may feel more like this.



Shared Savings ACO Model

- Providers continue to be paid fee-for-service for services provided to patients.
- Providers eligible for bonus payments if savings are obtained.
 - Expenditure benchmarks based on historic trends, adjusted for patient mix
 - If expenditures are below particular benchmark, then the payor “shares savings” with the ACO.

ACO: Shared Savings Model





ACO: Shared Savings Model

Checklist of Key Questions

☐ Risk

- Upside only?
- Downside risk? How much?
- How will downside losses be paid for?

☐ Shared Savings

- How much of the savings will be shared (or retained by the ACO)?
- Who decides distribution of savings among participants?
- What have hospital/specialty partners contributed?

☐ Primary Care/PCMH

- What investments will ACO make in primary care?
- How much input on clinical pathways/guidelines?
- What quality metrics will be used?

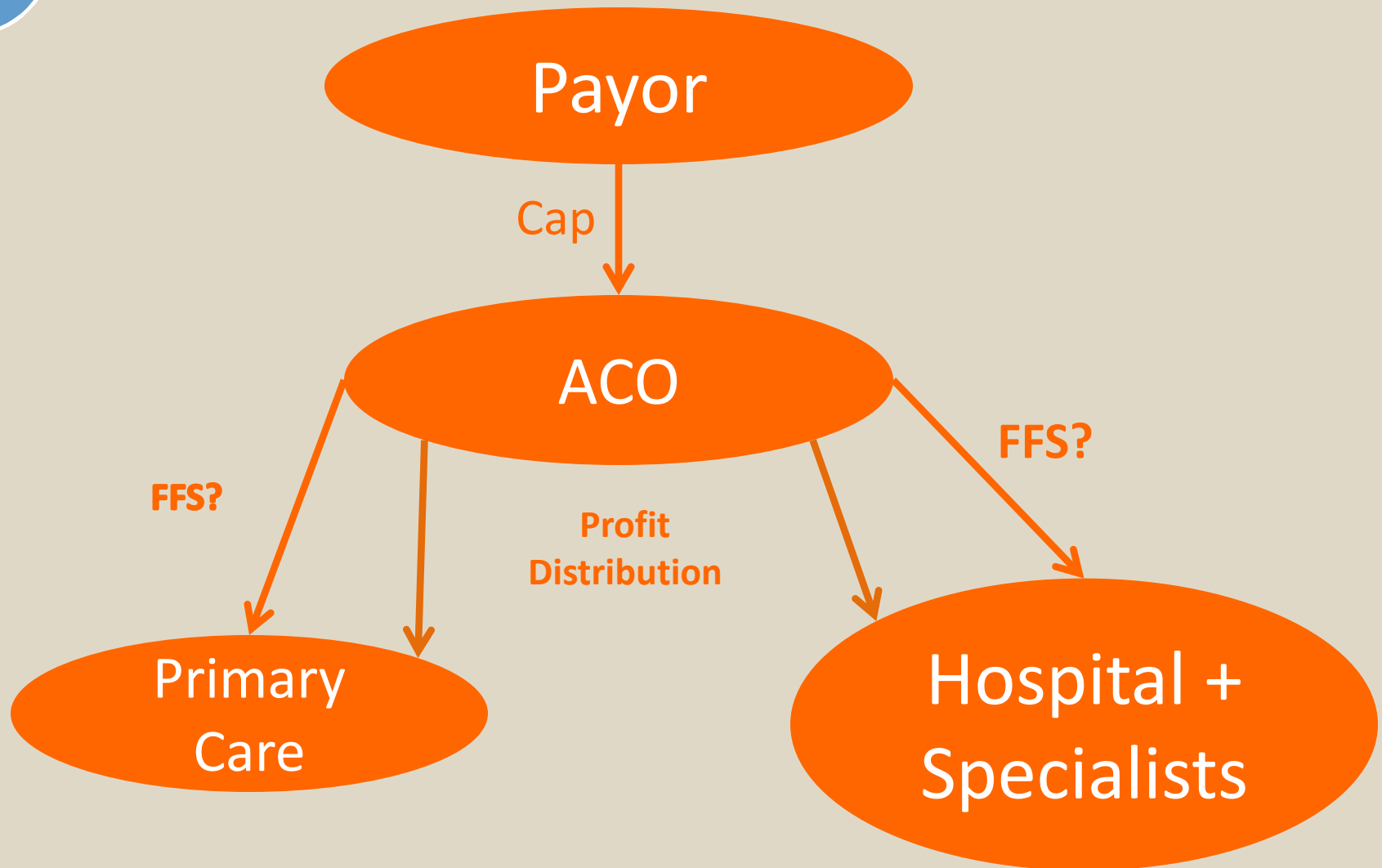




Global Payment ACO Model

- Global payment
 - ACO receives a set payment to furnish all or part of the care for a given population of patients over a defined period of time
 - ACO must be prepared to manage the risk associated with a limited budget for an undefined amount of possible services

ACO: Global Payment Model





ACO: Global Payment Model

Checklist of Key Questions

☐ Risk

- How will downside losses be paid for?
- What if ACO runs out of money?

☐ Profit Distribution

- How much of any profits will be shared?
- Who decides distribution of profits among participants?
- What have hospital/specialty partners contributed?

☐ Primary Care/PCMH

- What investments will ACO make in primary care?
- How much input on clinical pathways/guidelines?
- What quality metrics will be used?



State Activities to Facilitate Coordination

- ✓ Oregon's Medicaid Coordinated Care Organizations
- ✓ Lessons Learned from Early Adopters





Primary Care and Behavioral Health

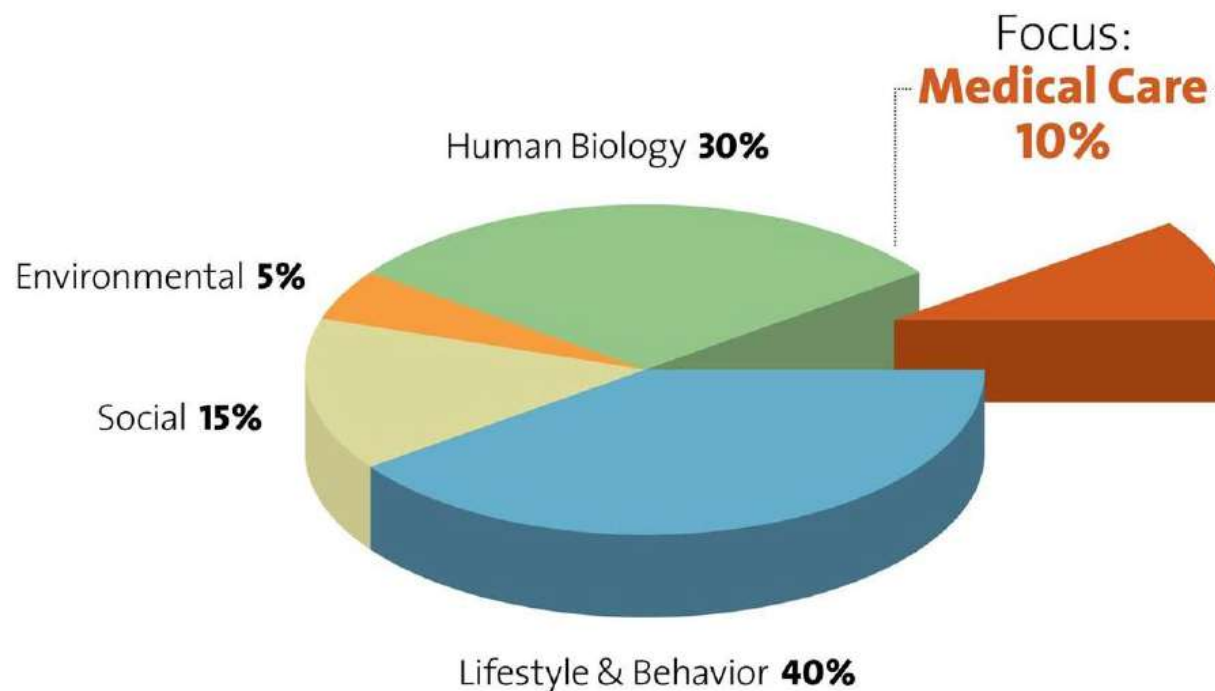
- Most PCPs do a good job of diagnosing and beginning treatment for depression (Annals of Internal Medicine, 9/07)
 - 1,131 patients in 45 primary care practices across 13 states
- PCPs did less well following up with treatment over time
- Lowest quality of care occurred among those with the most serious symptoms, including those with evidence of suicide or substance use

“Right now PCPs don’t have the tools necessary to decide which patients to treat and which to refer on to specialized MH care”



Morbidity and Mortality-SMI

- *Higher rates of modifiable risk factors:*
 - Smoking
 - Alcohol consumption
 - Poor nutrition / obesity
 - Lack of exercise
 - “Unsafe” sexual behavior
 - IV drug use
 - Residence in group care facilities and homeless shelters
- *Vulnerability due to higher rates of:*
 - Homelessness
 - Victimization / trauma
 - Unemployment
 - Poverty
 - Incarceration
 - Social isolation



Today's Oregon Health Plan

We haven't been doing anything to solve the problem of rising costs because we were dealing with 10% of the pie.

Source: Oregon Health Authority ppt, July 2012



Basic Principles



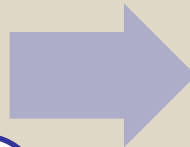
- Benefits and services are integrated
 - Physical health, MH, chemical dependency, and dental
 - Emphasis on innovation: EHRs, community health workers
- Enhanced provider accountability through outcomes
- State law says governance structure must include PCP and a MH/chemical dependency provider
- “Global Budget” with opportunity for growth over time



Oregon's CCOs

Current

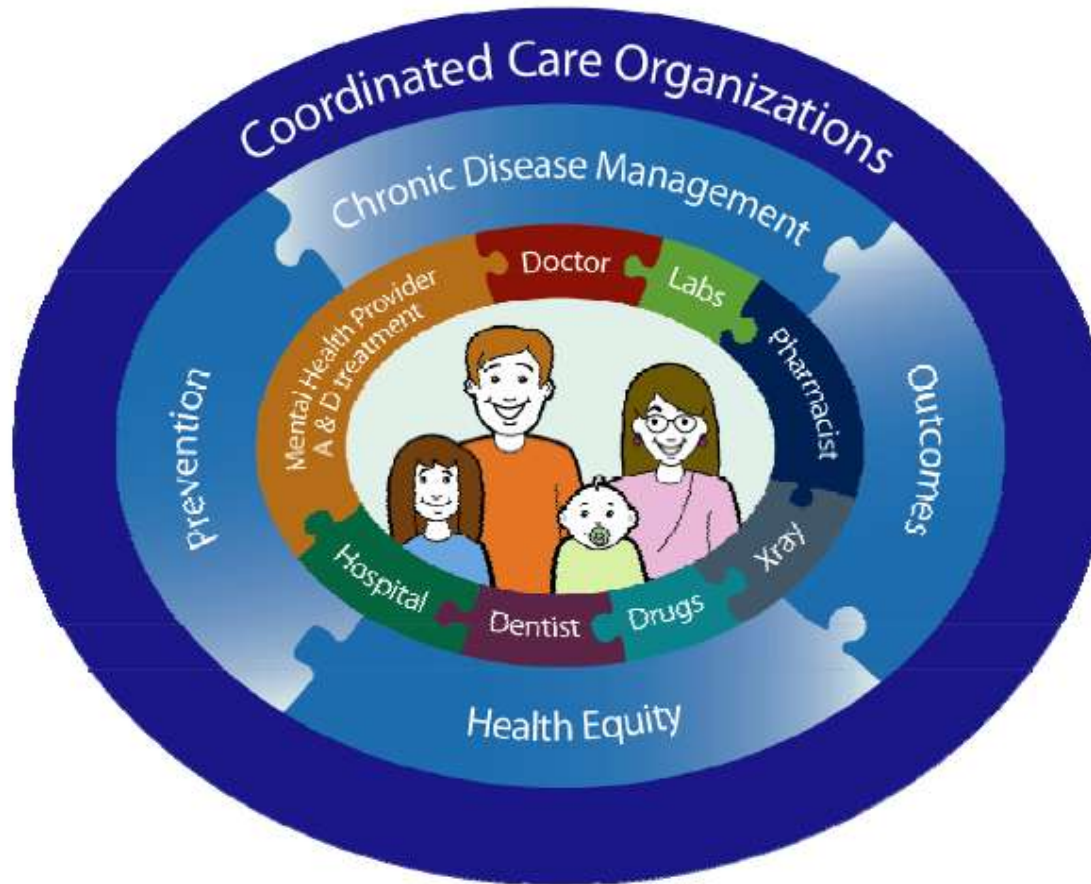
- FFS/"process" payments
- No bonuses for positive health outcomes
- Limited incentive for "whole health" approach



Global Payments

- Overall - 1 budget
- Health outcomes/metrics
- Locally driven
- Shared accountability and savings
- Opportunity for wellness approaches

And here's what this looks like



Source: Oregon Health Authority ppt, July 2012



Client Education & Transition

Most Current FFS Clients → **November 1**

Current FFS MH Clients → MH services transition to CCO as early as September (if available), rest of services transition as of Nov 1

Using transition plans, health coaches and targeted outreach to clients with “significant health needs”

New Clients → **Enrolled in a CCO**



Timeline and Agreements

- Reduced Medicaid spending by \$11B in 10 years
 - 2% reduction in OR spending in 2 years
- Feds providing \$1.9B in support at the beginning
- State and CCOs held to health outcomes/metrics
- Timeline: CCOs in the process of being launched (Aug/Sept)





So What Can we Learn from Early Adopters?



Focus on the Clients

- Who is *Eligible* & Who to *Enroll*?
- What information is needed for management of enrolled clients? Special assistance during transition?
- What's your plan to educate your staff about a new structure, so they in turn can educate clients?
- How can you prepare them for shift in culture?
Emphasis on prevention, health coaches, etc. and new connections with other providers



Focus on System Development & Administration

- What mechanisms are in place to facilitate cross-provider communication and data-sharing?
- How can you be at the planning table, both in proposal and implementation process?
- How much do your services cost and how does this fit into global payment structure?
- How do you address health care compliance issues?



Focus on Provider Practices

- What do you need to add to your service capacity?
- How will you systematically implement self-management training and support?
- How will you support clinical information system adoption and implementation?
- What supports are necessary for behavioral health staff to adopt and implement a whole-person orientation (e.g. prevention)?
- How do you collect, review, report quality measures? (what you *have to* report vs. what you *could review*)

Success in the New Healthcare Ecosystem

Mental Health & Substance Use Provider Readiness Assessment



JULY 2011

 NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

Partnering with Health Homes and Accountable Care Organizations

Considerations for Mental Health and Substance Use Providers



JANUARY 2011



Questions?

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