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Managing the Transition to Value-Based Alternative Payment Models for Healthcare Providers and Payors; Navigating State Regulations and Overcoming New Challenges

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Today's faculty features:

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Strafford Webinar
April 12, 2017

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Historical Perspective: Evolution of Insurance Industry Regulation

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- Traditional role of state insurance departments
  - Regulation of traditional indemnity health insurance companies, including PPOs
  - Regulation of HMO-type health plans

Historical Perspective: Evolution of Insurance Industry Regulation (cont'd)

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- State regulation has expanded since the 1990s to cover new forms of Risk-Bearing Organizations (RBOs), including capitated medical groups and IPAs, and more recently other new types of Alternative Payment Models (APMs)
  - Expanded regulations originally resulted from insolvencies of financial risk-bearing intermediary entities and large physician practices in the 1990s
  - New regulatory challenges presented by current shift towards value-based purchasing

APMs Come in Many Shapes and Sizes

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- Direct contractual arrangements between health plans and providers, and between CMS and Accountable Care Organizations (ACOs), with full spectrum of financial risk:
  - Upside shared savings “risk” only;
  - Upside and downside financial risk only for the services that the provider is licensed to provide or arrange for (from withholds to capitation); or
  - Global financial risk for the provider’s own services as well as the services of other providers.

APMs Come in Many Shapes and Sizes (cont'd)

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- Global capitated financial risk assumed by risk-bearing entities that are not licensed to provide health care services, which assume upside and downside financial risk for such services (e.g., ACOs, PHOs, third-party administrators (TPAs) and other intermediary RBOs)

- Direct primary care physician (PCP) arrangement with enrolled patients (a form of concierge care but also includes a full range primary care physician services, not just amenities)

Characteristics of APMs that May Impact Regulatory Burden

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- Whether the payor is an HMO or the federal government (CMS) (otherwise, regulatory limitations on shifting substantial financial risk);
- Whether the risk-bearing entity is a licensed health care provider or affiliated with a licensed provider or a state-licensed RBO;
- Whether a provider is taking on financial risk only for its own licensed services or also for health care services rendered by other types of licensed providers; and
- Whether the provider or third-party entity is marketing and selling health benefits directly to employers, union trust funds, or individuals, other than on a fee-for-service (FFS) basis.

State Regulation of Alternative Payment Models ("APMs") Varies Widely

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- **Examples of States with Relatively Minimal Insurance/HMO Regulation of APMs (to be discussed in presentation)**
  - Alabama
  - Florida
  - Minnesota
  - Wyoming

State Regulation of Alternative Payment Models ("APMs") Varies Widely

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- **Examples of State Regulatory Approaches (to be discussed in presentation)**
  - California
  - Massachusetts
  - New York
  - New Jersey
  - Colorado
  - Texas
  - Tennessee

State Regulation of Alternative Payment Models ("APMs") Varies Widely (cont'd)

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- **Examples of Innovative Approaches for Encouraging Adoption of APMs (to be discussed in presentation)**
  - New Hampshire
  - Rhode Island
  - Maryland
  - Vermont
  - Oregon

State Regulation of Alternative Payment Models ("APMs") Varies Widely (cont'd)

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- **Examples of States with Pending APM Legislation (to be discussed in presentation)**
  - Washington
  - New Jersey

State Regulation of Alternative Payment Models ("APMs") Varies Widely (cont'd)

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- **Examples of Direct Primary Care Initiatives (to be discussed in presentation)**
  - Arizona
  - California
  - Colorado
  - Maryland
  - Washington

States with Relatively Minimal Insurance/HMO Regulation of APMs

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- In these states, it is generally sufficient if the health plan retains ultimate liability for the cost of the health care provided, rather than shifting all financial risk to the unlicensed intermediary organization

States with Relatively Minimal Insurance/HMO Regulation of APMs

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- Alabama
  - If the individual enrollees have a contract with a licensed health insurer/HMO (and not the intermediary organization), the intermediary organization is not required to be licensed to assume capitated risk under contract with that licensed health insurer/HMO.
  - No restrictions on risk-based arrangements between an HMO/insurer and a licensed provider.

- Florida
  - Sufficient if HMO retains ultimate financial risk and responsibility to ensure that health care services are provided and paid for.
  - The Florida Office of Insurance may require review of any contract for administrative/management services or contract with a provider other than an individual physician. FLA. STAT. § 641.234(1).

States with Relatively Minimal Insurance/HMO Regulation of APMs

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- Minnesota
  - An intermediary organization providing services to/for a licensed health insurer/HMO may assume capitated risk; health plan retains ultimate financial responsibility.
  - HMOs may not enter into risk-based contracts with licensed hospitals which would require the hospital to bear risk for services being rendered by providers that are not affiliated with the hospital. MINN. STAT. § 62D.115(9b)

- Wyoming
  - No specific license is required to assume capitated risk from a licensed insurer/HMO for the provision of health care services.
  - No restrictions on risk-based arrangements between an HMO/insurer and a licensed provider.

California

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- Leads the nation in strictly regulating RBOs
- "Knox-Keene Health Care Service Plan" Regulation
  - The Knox-Keene Health Care Service Plan Act of 1975 requires licensure for any entity that assumes global financial risk for the provision of both physician and other health professional services and hospital services (and effectively prohibits prepaid or periodic charge arrangements that do not involve a licensed Knox-Keene Plan or CMS)
  - The California Department of Managed Health Care (DMHC) regulates all such arrangements in California (including behavioral health, dental, vision, and chiropractic specialty plans)
  - Indemnity insurers (including PPOs) are separately regulated by the California Department of Insurance (CDI), but DMHC takes the lead if point-of-service or other mixed HMO/PPO plan

California (cont'd)

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- Restricted Knox-Keene Plans
  - Originally called "Knox-Keene Plans With Waivers" because must meet same regulatory requirements as full-service Knox-Keene Plans (HMOs) except marketing and enrollment
  - Licensees may assume global risk by accepting both institutional and professional risk-based capitation payments as subcontractors to unrestricted "full-service" Knox-Keene Plans
  - Solvency and other health care service plan requirements still apply; time-consuming and costly to license and operate
  - An ACO with a financial downside contract (not just an MSSP "shared savings" contract) with CMS must have a Restricted Knox-Keene Plan license. (Note that Restricted Knox-Keene Plan may not contract directly with self-funded employer plan or union trust fund on a capitated basis)
  - May not be at risk just for limited services such as primary care and/or other physicians services only

California (cont'd)

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- Other Medical Group/IPA Regulation
  - Applies to medical groups and IPAs operating under capitated payment agreements for physician services only
  - Regulated indirectly by DMHC's Financial Solvency Standards Board (FSSB); may require Knox-Keene Plans to take corrective action against RBOs that do not continuously meet minimum financial solvency (tangible net equity or "TNE") standards

California (cont'd)

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- Due to California's strict prohibition against the corporate practice of medicine, hospitals generally may not employ or otherwise contract with physicians to provide patient care services in California (limited exception for hospital-based-physicians)
  - Therefore, hospitals may not assume capitated or other substantial financial risk for the cost of physician services (just as physicians may not be capitated for inpatient hospital services) unless the hospital has a restricted Knox-Keene license
  - However, hospitals and IPAs or medical groups may enter into limited financial risk-sharing ("risk pool") arrangements
  - DMHC has long prohibited downside risk arrangements that may require physicians to pay for losses out-of-pocket (such losses may be reasonably offset/amortized against future physician capitation)

California (cont'd)

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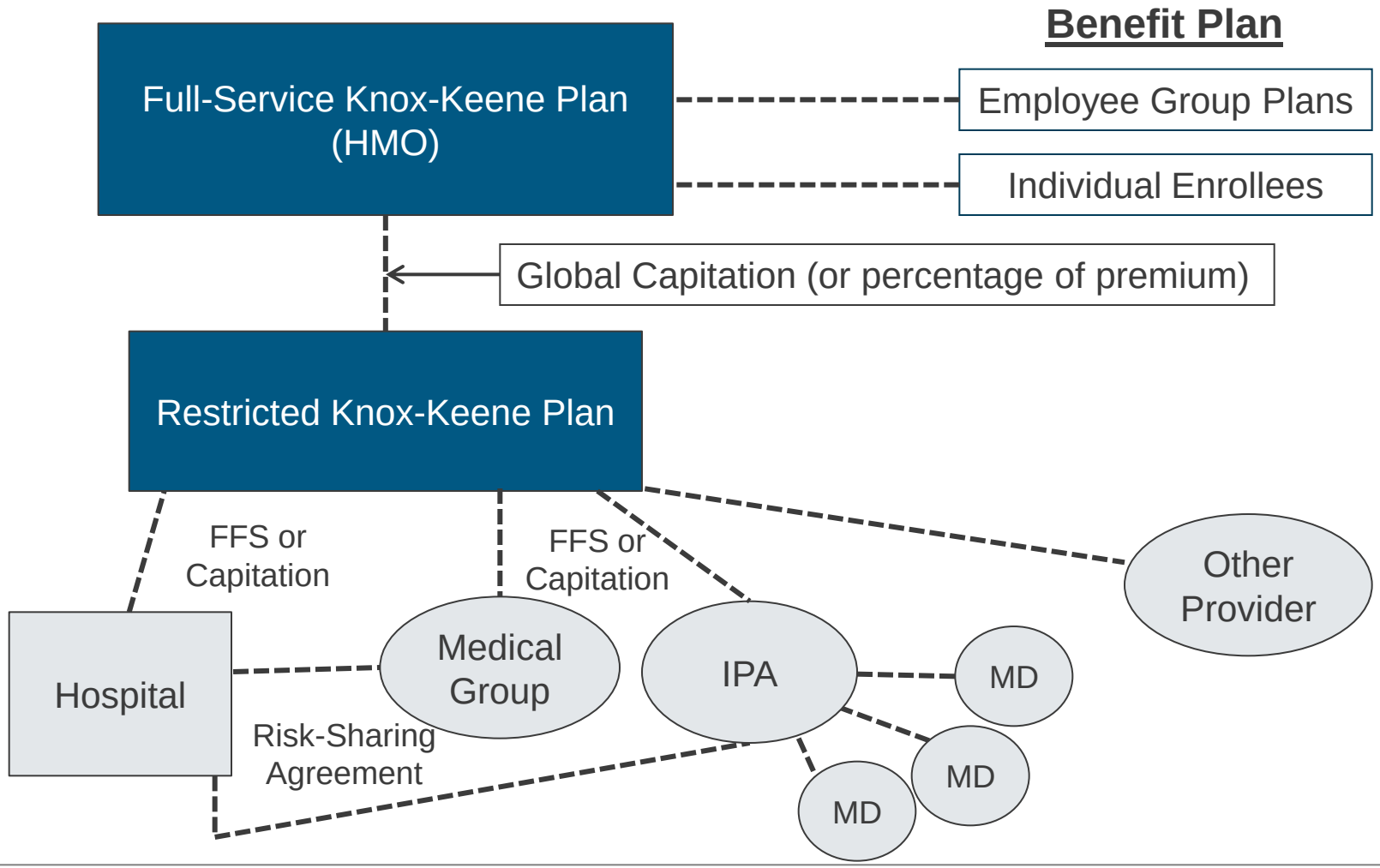

Massachusetts

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- Annual risk certification for “significant” downside risk arrangements
  - Certification classifies provider as a risk bearing provider organization (“RBPO”)
  - Application materials
    - Financial statements
    - List of all APM contracted carriers and payers
    - Actuarial certification
  - RBPO must demonstrate that its APMs are not expected to threaten its financial solvency
- Risk Certificate Waiver also available if provider can demonstrate that APMs do not contain significant downside risk.

New York

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- Risk-sharing arrangements must be approved by New York State Department of Financial Services ("DFS")
  - A health care provider may not enter into a financial risk transfer agreement with an insurer unless it is approved by DFS.
  - A lay entity assuming capitated risk is defined as an "intermediary entity" and also must obtain approval from DFS.
  - Assumption of capitated risk by a health care provider and/or intermediary entity subjects such provider or entity to financial requirements (*e.g.,* posting of financial security deposit).

New Jersey

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- Organized Delivery Systems
  - Entities that contract or arrange to provide comprehensive or limited health care services to health insurers.
  - May include preferred provider organizations, physician-hospital organizations, IPAs, and intermediary entities that hold risk arrangements on behalf of providers.
  - Excludes licensed providers and provider organizations that are comprised solely of providers and perform only services for which its members are licensed.

New Jersey (cont'd)

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- Licensure or Certification for Organized Delivery Systems
  - If an Organized Delivery System is compensated on a basis that includes the assumption of financial risk, it must be licensed.
  - Exception for *de minimis* financial risk, which instead requires certification.

Colorado

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- Providers Contracting with Insurers/HMOs
  - Provider networks and individual providers that enter into risk-bearing arrangements directly with insurers/HMOs do not require licensure by the Colorado Division of Insurance.
  - Risk-bearing arrangements may include both upside and downside risk.
  - No notification, application, registration or licensure requirements.

Colorado (cont'd)

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- Providers Contracting with Consumers/Employers
  - Providers and provider networks that enter into direct contracts with consumers or their representative(s) (*e.g.,* employers) to assume or share risk in the provision of health care services are engaging in the business of insurance and must obtain a license.
  - If services are limited to a particular health specialty, a narrower form of licensure for a "Limited Service Licensed Provider Network" is available.

Texas

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- Provider Risk Contracting
  - Providers may contract on a risk basis with insurers/HMOs for their own services without a license.
  - But may NOT contract on a risk basis for other providers' services unless they participate in a HMO delivery network.

Texas (cont'd)

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- Risk Contracting by Lay Entities
  - Non-provider intermediary entities that share risk with insurers/HMOs must obtain a license as a health care plan, limited health care service plan or a single health care service plan, depending on the services provided.
- Texas also licenses entities that operate similar to ACOs as Health Care Collaboratives ("HCCs").

Tennessee

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- HMO statute expressly permits HMOs and provider organizations to enter into arrangements for the provision of health care services on a prepayment basis or other risk-sharing basis.

Tennessee (cont'd)

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- No direct financial or reporting obligations for risk-sharing arrangements.
- Indirect regulation of APMs through HMO statute
  - HMOs must ensure that provider organizations obtain aggregate or per-patient stop-loss protection insurance coverage to cover risk-based payment arrangements.

Innovative Approaches for Encouraging Adoption of APMs: New Hampshire

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- Delivery System Reform Incentive Payment ("DSRIP") Section 1115 Waiver Program
  - Current target: at least 50% of Medicaid managed care patients covered under APMs by 2020.
  - Prior to April 1, 2017, submit to CMS the APM framework and plan for shifting Medicaid provider payments to APMs.

Innovative Approaches for Encouraging Adoption of APMs: New Hampshire (cont'd)

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- New Hampshire State Innovation Models ("SIM") Initiative
  - Formed a Payor Collaborative (includes private payors) and a Payment Reform work group.
  - Goal: to influence payers and purchasers towards innovative payment methods that will also impact the commercial market.

Innovative Approaches for Encouraging Adoption of APMs: Rhode Island

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- Health Insurers Required to Adopt APMs
- Office of Health Insurance Commissioner ("OHIC") Regulation 2
  - Applies to health insurers exceeding a specified threshold of covered lives
  - 2016-2017 AMP Plan: Reduce FFS payments and replace with APMs
    - Applicable health insurers are required to direct 6% of medical payments through non-fee-for-service models in 2017 and 10% in 2018
    - Applicable health insurers are required to direct 40% of medical payments through quality and efficiency based payment models in 2017 and 50% in 2018
- What lies ahead
  - OHIC to determine minimum downside risk threshold

Innovative Approaches for Encouraging Adoption of APMs: Maryland

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- Maryland All-Payer Model
  - Beginning in 2014, Maryland converted its fee-for-service hospital payment system to a global budget alternative payment structure.
  - Almost all hospital inpatient services are paid on the basis of an annual revenue budget, which is set in advance.
  - Goal is to incentivize Maryland hospitals to ensure efficiency, patient adherence to treatment plans and high quality clinical care.
    - Efforts to prevent readmissions through increased post-discharge support for transition to home or post-acute setting
    - ED case management
    - Proactive management of chronic conditions
    - Collaboration and partnerships among providers
    - Health information exchange

Innovative Approaches for Encouraging Adoption of APMs: Vermont

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- New All Payer ACO
  - ACO aims to have payors incentivize health care value and quality under a single alternative payment structure for the majority of providers in the state.
  - Participating payors include Medicare, Medicaid, and commercial health insurers.
  - Participation by insurers and providers is voluntary.
  - ACO qualifies as an Advanced APM under CMS's Medicare Quality Payment Program, allowing physicians to qualify for incentive payments

Innovative Approaches for Encouraging Adoption of APMs: Oregon

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- Medicaid APMs
  - Alternative Payment and Advanced Care Model
    - Collaboration between Oregon Primary Care Association, participating Federally Qualified Health Centers (FQHCs), and state Medicaid agency
    - Capitated PMPM payment for primary care services only, subject to annual reconciliation if needed
    - FQHCs report on quality metrics
    - Efforts to track non-traditional patient engagement / "touches" (e.g., phone calls, e-visits, clinical transitions, transportation assistance, support group participation, etc.)
  - Hospital Transformation Performance Program
    - Hospitals to earn incentive payments by meeting performance objectives

Pending APM Legislation

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- Washington
  - HB 1520 – 2017-18: allows APM for critical access hospitals
    - House: passed
    - Senate: in committee
- New Jersey
  - S2724/A4334: requires APMs register with Department of Health and expands provider referral allowances if beneficial interest related to APM
    - Senate amendment: 1/23/2017

Direct Primary Care ("DPC"): Overview

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- **DPC: "Concierge medicine for the masses"**
  - Covers only specified PCP services, not specialist or hospital or other health care services, for an annual or biannual flat fee or per member per month (PMPM)
  - Intended to bypass adverse third party payor (health plan, insurer) financial and other contractual impact on physician revenue and overhead
  - Cost containment: removes volume services incentive
  - Claims of better delivery of care compared to traditional FFS
  - Covered by some employee-benefit plans
    - Qliance in Washington

Direct Primary Care: States Defining DPC Outside of Insurance Regulation

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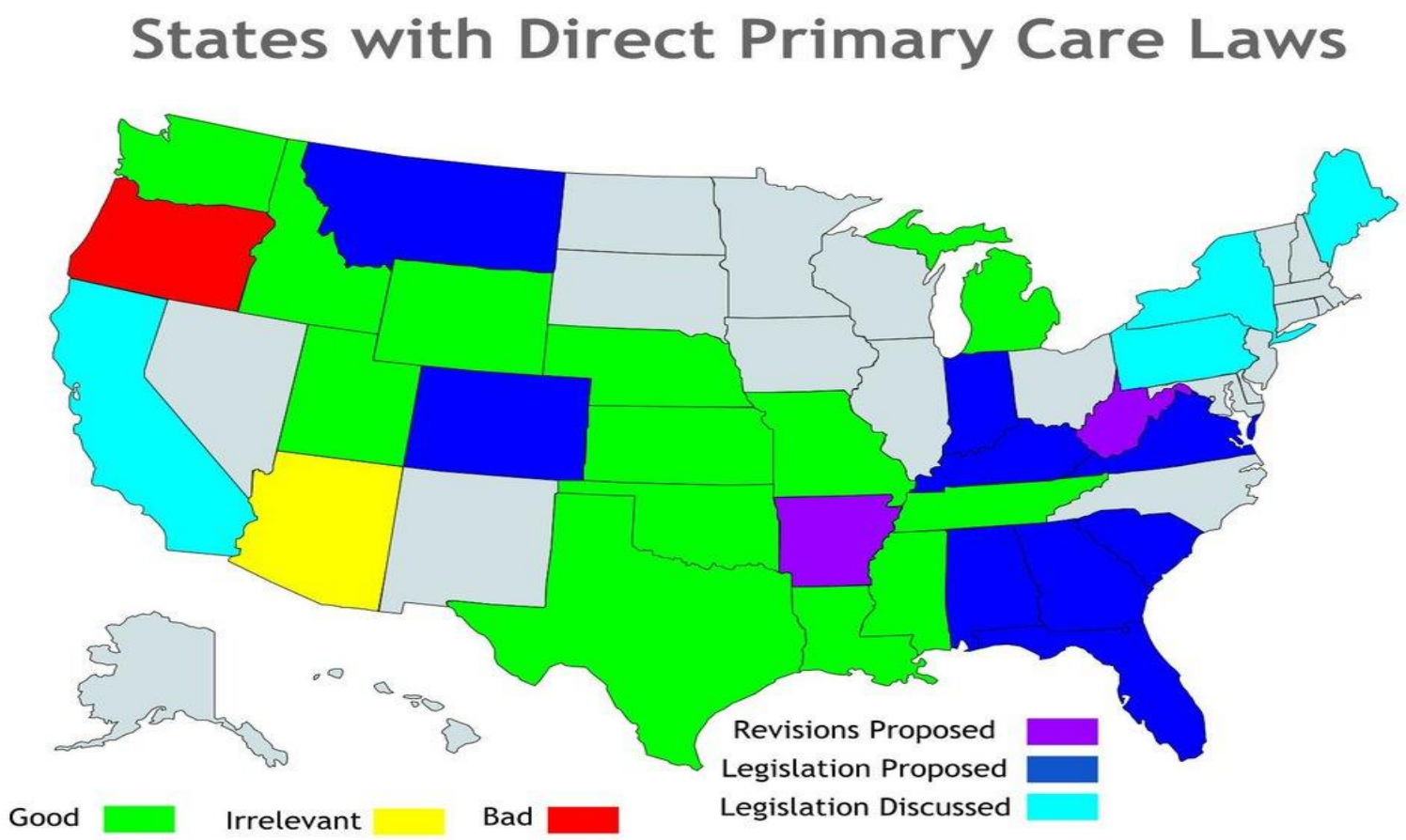

http://www.dpcfrontier.com/states/

DPC: State Regulatory Approaches

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Examples:

- **Arizona: DPC ≠ Health Plan/Insurance**
  - DPC exempted from insurance regulation
  - Micro-regulation:
    - Provider plan requirements
    - Mandated insurance disclaimer language
    - Required patient guidance materials

DPC: State Regulatory Approaches (cont'd)

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- **California: DPCs Effectively Prohibited (if patient payments cover any medical services vs. just amenities)**
  - Department of Managed Health Care interprets this as prepaid or periodic payment in return for providing or arranging for health care services
  - Therefore, requires a Knox-Keene License and none is available for just PCP services
  - Ongoing attempts to legislate but health plan lobby is strong

DPC: State Regulatory Approaches

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- **Colorado: Legislation Pending**
  - HB17-1115: Proposes DPC arrangement parameters
    - DPC exempt from insurance and the practice of underwriting regulations
    - Agreement specification
    - Provider qualifications

DPC: State Regulatory Approaches (cont'd)

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- **Maryland: Proceed with Caution**
  - Unauthorized business of insurance
    - Retainer fees for unlimited office services beyond physician's capabilities
    - No limitation of number of patients
    - Physician carries substantial financial risk for services rendered by other providers
- **Washington: DPC ≠ Health Plan/Insurance Expressly Permitted**

DPC Restrictions and Trends

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- **Many states still view DPC as a type of prepaid health plan**
- **Medicare prohibition on additional payments to PCPs for Medicare Services**
- **Conflicting Regulation**
  - Internal Revenue Code: Prohibits DPC payments under HSA
    - Considered “second health plan”
    - Not “qualified medical expense”
  - **ACA:** DCP is not an insurance plan
  - Proposals to lift bans
    - Update § 213(d) of the IRC to recognize DPC payments as qualified medical expenses

Best Practices for Managing Regulatory Challenges

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- Providers in an insurance world: dealing with comprehensive regulatory regimes
  - Prospective analysis
  - State-by-state nature of insurance regulation
- Navigating uncertain regulatory landscapes and new regulations
  - Handling ambiguity
  - Industry practices
  - Relationships with regulators
  - Staying up to date

Best Practices for Managing Regulatory Challenges

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- Creative alternative structures
  - Use of capitated “friendly physician” model
  - Direct FFS contracts with self-funded plans, with withholds and/or financial targets

Looking Ahead

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- Ever-shifting regulatory environment
- NAIC Model Act?
- Potential for changes at the federal level

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Thank You

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