Structuring Commercial ACOs: Payor and Provider Perspectives
Evaluating Payment Models, Negotiating Contract Terms, Ensuring Federal and State Law Compliance

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Today’s faculty features:
Charles Buck, Partner, McDermott Will & Emery, Boston
J. Peter Rich, Partner, McDermott Will & Emery, Los Angeles

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Structuring Commercial ACOs: Payor and Provider Perspectives
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J. Peter Rich
McDermott Will & Emery, LLP
2049 Century Park East
38th Floor
Los Angeles, California 90067
(310) 551-9310
jprich@mwe.com

Charles Buck
McDermott Will & Emery, LLP
28 State Street
Boston, Massachusetts 02109
(617) 535-4151
cbuck@mwe.com
An overview of commercial accountable care arrangements, including key differences and similarities between commercial accountable care arrangements and Medicare Shared Savings Program ACOs and a discussion of various approaches that payors and providers have taken to implementing commercial accountable care arrangements
Topics Covered

- Discussion of opportunities for ACOs beyond traditional shared savings arrangements, including a discussion of where the market is likely to go relative to accountable care arrangements
- Summary of key terms of commercial accountable care arrangements and salient federal and state law issues.
The current culture of medicine which has been built into our health care systems for decades is experiencing a transformational change.

This transformational change requires strong partnerships between payors and providers to meet the new demands of the marketplace.

Historical Culture of Medicine
- Competitive
- Volume-based
- Individualistic

Evolving Culture
- Patient centered
- Quality
- Value-based
- Collaborative
Various Accountable Care Perspectives

- Payors:
  - Must bend cost curve
  - Increasing pressure to keep down premium cost increases from government regulators and customers
  - Medical Loss Ratio requirements incentivize delegation to provider organizations
  - Better aligned financial incentives
  - Better quality outcomes
Various Accountable Care Perspectives (cont’d)

- Hospitals and Other Health Facilities
  - Need to get in the game to avoid being locked out of market opportunities
  - Bearing significant additional costs but already paying for most EHR/HIT
  - Physician integration strategy
  - Risk of decreased volume and revenue
Physicians and Other Healthcare Professionals

- Do not want to be locked out of a particular network
- Some see more upside in accountable care models (including Medicare Advantage)
- Many unable/unwilling to finance cost of ACO formation
- Unlike Medicare ACOs, commercial accountable care arrangements require no separate “ACO” entity and patient can be “channeled” to the provider with managed care-type financial incentives and negotiated benchmarks
- Given governance role with minimal if any capital investment (most ACOs have a majority physician board)
Provider Concerns vs. Payor Concerns

- **Payor Concerns:**
  - Adequacy of ACO management
  - Accuracy and validation of actual savings and quality improvement
  - Providers may “game” the system to avoid shared losses or by using payor subsidies to compete with payor in the future
  - Could backfire by spurring concentration of provider market and thus higher costs
  - Long-term marginalization of payor role
  - ACO solvency

- **Provider Concerns:**
  - Being pushed towards assuming unmanageable downside risk
  - Insufficient payor support for care management
  - Lack of transparency
  - Just another payor product
  - Do not trust quality/cost measurements by payors
  - Concerned about “free rides”
  - Costly to implement
Overview of the ACO Concept

- **ACOs**: Group of providers that manage and coordinate patient care and accept responsibility for the quality and cost of care delivered to a defined population
  - Examples are physician groups, hospital systems, and integrated health systems
  - Patients attributed to ACO, generally based on ACO-participating primary care physician from whom patient receives plurality of primary care services

- **Goals of commercial accountable care contracting**
  - Limit the rate of medical cost growth
  - Maintain or increase quality performance

- **Provider motivation for entering into accountable care contracts**
  - Participation in preferred tiers or limited networks
  - Payment is moving in this direction (e.g., traditional Medicare)
Overview of the ACO Concept

Payment Approaches to Achieve Accountable Care

- Medicare ACO Programs (non-MA)
  - Pioneer ACO Program
  - Medicare Shared Savings Program ACOs

- Private Payors (including MA)
  - Shared savings with quality component
  - Shared savings and shared losses with quality component (Shared Risk)
  - Bundled payments with quality component
    - Procedure-based
    - Chronic conditions
Commercial Accountable Care Arrangement: What is it?

- May be payor-initiated or provider-initiated
- Likely to be an exclusive contract for defined populations between payor and one or more CINs
- Generally, financial rewards/penalties for reducing cost of care while maintaining or ideally improving quality, including the patient experience, and ensuring that care is delivered in the most appropriate setting
May be:

- Stand-alone accountable care arrangement negotiated between a clinically integrated provider network (“CIN”) of providers and a commercial payor (no separate ACO entity is required), or

- A CMS-contracted ACO (MSSP or Pioneer Innovation) may also enter into accountable care-type arrangements with commercial payors (may include Medicare Advantage Plans)¹

Sample ACO Arrangement Structure

(If You’ve Seen One Accountable Care Arrangement, You’ve Seen One Accountable Care Arrangement …)
Medicare ACOs, By the Numbers: Now 19 Pioneer ACOs (and declining), 350+ Shared Savings ACOs
Current ACO Market Trends

- As of Jan 2015, anticipated 600+ ACOs/Accountable Care Arrangements
  - Split roughly equally between those participating in government programs and commercial programs, with some participating in both
  - At least one in every state

- Currently projected to have over 18 million ACO-attributed covered lives

- Continued growth in Medicare MSSP ACOs
  - Medicare ACOs: Serve over 5.3 million beneficiaries
  - 2014: 123 New MSSP ACOs
  - $275 Million in Projected Savings from Key Participants in First Year of Pilot Program

- Even faster growth now occurring in Private Payor Commercial ACOs
Types of Accountable Care Payment/Pricing Models

- Shared savings/risk
- Bundled payments
- Reference pricing
- Capitation
Maintains FFS payment mechanisms with possibility of shared savings/shared losses based on:
- Comparison of PMPM claims costs for ACO’s attributed members to agreed-upon benchmark; and (usually)
- ACO’s quality performance

Additional funding streams that might be available
- Separate PMPM patient management fees?
- Initial start-up costs? Loans?
Goals of Shared Savings/Risk

**Control Medical Cost Growth**
- Move away from system that rewards volume
- Align provider/insurer goals

**Increase Quality**
- Financial rewards based on quality
- Encourage re-designed innovative care processes
ACO Shared Savings Financial Model

Projected Total Cost of Medical Care

- Actual Cost of Care for the Defined Population

Surplus (or Deficit)

- Based on Actuarial Analysis of Historical Data
- Paid to Providers on a FFS Basis
- Provider Bonus Available ONLY if Surplus Exists at Year End

Outpatient Ancillary

Outpatient Diagnostics

Other Outpatient

Hospital, SNF, Inpatient Rehab

Outpatient Retail Pharmacy

Different Provider Types May Participate in Pools On Different Basis
Bundled Payments

- Episode-based payment around a particular procedure.
  - Could still utilize FFS payments but impose a retroactive reconciliation
  - Could replace FFS payments with bundled payment

- Common procedures include knee and hip replacement, CABG.

- Providers assume the risk for any complications or additional specified services during the defined time period.

Pre-op (e.g. 3 days prior to procedure)  Procedure  Post-op (e.g. 90 days after procedure)
Reference Pricing

- Plan establishes a maximum payment amount for a specific procedure, with any additional costs borne by members.
- Generally used for non-urgent standardized services.
Spectrum of Possible Commercial Payor-ACO Risk Arrangements

- **“Risk Light”:** Simple shared savings based on medical claims expense with withhold upside
- **Risk Light Plus:** In addition to shared savings based on medical claims expense, include quality improvement initiatives – e.g., readmission rate for members assigned to ACO physicians
- **Shared risk:** Sharing of gains and losses based on medical expense target
- **Full risk:** Provider organization assumes full risk for members assigned to ACO-affiliated based PCPs; ACO may assume substantially all administrative functions
An Ideal ACO Physician Payment Model?

- **Primary Care**: Capitation (Risk Adjusted)
- **Emergency/Urgent Care**: FFS with higher copayment, patient education
- **Specialist Care**: Bundled Payments (Risk/Severity Adjusted)

Source: Goldsmith, J., “Accountable Care Organizations: The Case for Flexible Partnerships Between Health Plans and Providers” Health Affairs (January 2011)
Is it Easier to Innovate in the Commercial Market?

Yes

- More flexibility to customize based on provider(s)’ particular needs and circumstances

- Fewer legal/regulatory constraints (e.g., may channel patients using benefit differentials). Beneficiary stability and “leakage” are major barriers to MSSP ACO success. One recent study showed:
  - 20% of beneficiaries assigned to an ACO in 2010 were not in the same ACO in 2011.

1 See, Outpatient Care Patterns and Organizational Accountability in Medicare, Journal of the American Medical Association, published online April 21, 2014.
Yes (cont’d)

– Among beneficiaries assigned to an ACO in 2010 or 2011 only 2/3rds were assigned to same ACO in both years.

– 2/3rd of specialists visits for ACO beneficiaries were provided by non-ACO specialists

- Greater flexibility for experimentation

- Depending on # of covered lives included, potential to significantly alter provider incentives
Is it Easier to Innovate in the Commercial Market? (cont’d)

No

- Antitrust compliance standards for commercial ACOs are ambiguous and burdensome
  - Clinical integration standards are highly subjective
  - “Shared savings”-only does not constitute financial integration under historic guidance
  - By contrast, MSSP ACO participation provides relatively clear antitrust deemed “safe harbor”, for the MSSP ACO’s Commercial Contracts too

- MSSP ACOs may take advantage of powerful waivers of Stark law, federal anti-kickback statute, and CMP law
  - These laws otherwise pose meaningful limits on commercial ACOs
Commercial ACOs are Developing Nationwide

- **HMSA (BCBS Hawaii) HPH:** Performance on shared savings/losses also affects future payment increases
- **Providence Health & Services:** $30 M, two-year contract with public employee benefits board
- **Blue Shield California:** Two ACOs in Northern California
- **Anthem Blue Cross:** ACO pilot with Sharp HealthCare medical groups
- **BCBS Minnesota:** Shared savings contract with five providers
- **BCBS Illinois:** Shared savings contract with Advocate Health Care
- **Humana:** ACO pilot with Norton Healthcare
- **CIGNA:** Medical home contract with Piedmont Physicians Group
- **UnitedHealthcare:** ACO with Tucson Medical Center
- **Maine Health Management Coalition:** Multi-stakeholder group supporting ACO pilots
- **BCBS Massachusetts’s Alternative Quality Contract:** Annual global budget, quality incentives for participating providers
- **Aetna:** ACO pilot with Carilion Clinic

**Note:**

Performance on shared savings/losses also affects future payment increases.
A Pioneering Successful Commercial “Virtual ACO” Collaborative Model

Blue Shield of California, Catholic Healthcare West, Hill Physicians (2010-11)

- Initially created “virtual ACO” to manage the care of 40,000 CalPERS members; no new contracts. Used payor-provider committees.
- Goal: Keep plan health care costs flat in 2010
- Utilized existing benefit product
  - Blue Shield HMO benefit product
  - Members with existing primary care physicians affiliated with Hill Physicians
- Parties said biggest challenge centered around data creation, sharing, and access
- Results: First year resulted in better care and millions of dollars in savings
  - Zero percent premium increase for 2011
  - Statewide now
Early Movers: Aetna and Carilion Clinic

- The Aetna-Carilion relationship encompasses the following key areas:
  - co-branded commercial health care plans for businesses and individuals available later this year;
  - joint opportunities to better meet the personalized care needs of patients, including Medicaid beneficiaries in Virginia; and
  - new payment models that encourage providers to share accountability to improve patients’ health, including rewards for meeting quality targets and shared costs savings.
Early Movers: Norton Healthcare and Humana

- Focus of pilot:
  - the use of preventive screenings and tests (such as mammograms) and vaccinations
  - better coordination in the management of chronic illnesses (such as heart failure)
  - more effective treatment of common problems (such as back pain), appropriate utilization of generic drugs to lower costs
  - improved access to the appropriate level of care (such as primary care rather than emergency department treatment).
Examples of Other Commercial ACO Arrangements

- BCBSIL-Advocate (beg. 2010)
  - Advocate: 10 hospitals and 4,000 physicians
  - Roughly 380,000 members
  - Term: three years (recently extended through 2014)
  - Shared savings/shared losses based on comparison of attributed lives’ PMPM costs to benchmark
  - Positive results so far in controlling costs and managing admissions

- BCBST Bundled Payments (Launched Oct. 2012)
  - Total knee and hip replacements
  - Started with 4 orthopedic groups
Recent Examples of Current ACO Arrangements

Examples of Current ACO Initiatives

- HMSA-Hawaii Pacific Health (End of 2013)
  - 5-year shared risk contract
  - HMO and PPO commercial insurance market products
  - Patient management fees in addition to existing FFS payments
  - HPH performance is measured against cost trend in HMSA’s network
  - Quality affects overall percentage of savings or losses attributed to HPH
  - Particularly challenging to craft long-term innovative arrangements in an era of uncertainty in healthcare industry
It is Working?

- **BCBS of Michigan**
  - Patient-Centered Medical Home Program, a type of ACO, saved nearly $155 million over 3 years of operation
  - Correlated with a 3.5% higher quality measure, 5.1% higher preventative care measure, and $26.37 lower PMPM cost for adults
  - Savings result from managing claims costs more closely, which in part involves improved care coordination that reduces hospital readmission rates and the number of ER visits by beneficiaries

- **BCBS of Illinois** forming a new ACO with downside-risk payment model in which providers face penalties if they miss utilization and quality targets but get more of the shared savings (between 50% and 80%)
Major Growth Occurring

- Aetna expanding ACO contracts in Virginia, Kentucky, New York, and South Carolina, making Aetna the predominant player in ACOs in mid-Atlantic states

- Cigna entering into ACO contracts with ACOs in Arizona and Pennsylvania
  - Now in 66 ACO contracts in 26 states
  - The ACO contracts will bring in 27,000 doctors (including 12,500 PCPs) and 700,000 commercial customers
  - Cigna’s goal is to have 100 ACOs, with 1 million customers, in place by next year
UnitedHealth Group intends to expand ACO contracts to $50 billion over the next 5 years; will span employer-sponsored, Medicare, and Medicaid businesses

- United is currently in ACO contracts with 575 hospitals, 1100 medical groups, and 75,000 doctors, and these numbers will only grow

While major investor-owned hospital chains have generally avoided ACOs, Tenet’s acquisition of Vanguard suggests possible change

- Vanguard a leader of ACOs and the owner of Detroit Medical Center, a PACO
Shift toward Patient-Centered Care

- ACOs have begun investing in services, such as prevention and wellness programs, chronic disease management, and behavioral and mental health that were previously under-reimbursed or not reimbursed at all.

- The use of global budgets means providers must shift focus from volume of service to a more comprehensive view of health.
Patient Engagement Technologies

- Johnson & Johnson purchased HealthMedia, which creates coaching tools to help patients navigate the healthcare system, engage with providers, and learn what symptoms to watch for.

- Aetna invested in the mobile app iTriage, which allows patients to query their symptoms, find appropriate providers and care settings for their treatment, and determine what services are covered by their insurance.
  - Aetna found that with this information, patients are much more likely to seek appropriate care and choose an in-network provider.
Evidence Based Medicine

- BCBS of Massachusetts’ Alternative Quality Contract: high-tech radiology and imaging services are used significantly less often, while preventive care, such as cancer screening, has improved overall, compared to FFS payment models.

- Steward Health Care System, a PACO, found that one of three anesthetics was four times as expensive as the others; after reviewing the evidence, it uses that drug only where evidence supports its use over the other anesthetics.

- Partners HealthCare, started a Center for Drug Policy where physician leaders review therapies newly approved by the FDA and write clinical guidelines for use.
Despite concerns about integrating the technology with existing clinical care processes and concerns that the technology does not provide enough support for clinical analytics and decision-support tools, remote patient monitoring has been adopted or is being evaluated by over half of ACOs.

- Used to address readmissions and chronic care management and coordination.
Future Trends and Challenges

- Some suggest that many of the early ACO adopters are the systems that already performed well, so the real challenge will be transforming care permanently and widely over the next several years.

- ACOs are required to serve everyone who comes through their doors, but this may hinder their ability to specialize in coordinated care for chronic conditions.
Future Challenges and Questions for ACOs

- Will ACOs discourage the use of new technologies because the benefits have not yet been proven?
  - Will ACOs favor less expensive therapies over more costly alternatives with potential long-term benefits that are not yet clear when they first enter the market.

- Will ACOs incentivize the use of Part D therapies excluded from the ACO’s global budget over Part B therapies that aren’t excluded?

- How will cost concerns of ACOs change the way academic research is supported and subsidized?
Future Challenges and Questions for ACOs

- Will high-deductible plans work against ACOs?
  - Beneficiaries on high-deductible plans do not want to spend the money to see a doctor -- under-utilization hinders preventative care
  - Problematic because high-deductible plans are increasingly popular: from 1 million beneficiaries in 2005 to 13.5 million in 2012

- “Hitting the wall”: once an ACO achieves savings it will need to find new savings continuously in order to keep generating future bonus payments
  - The most successful ACOs will “hit the wall” first, possibly undermining the idea of rewarding accountable, cost-conscious care and turning it upside-down
Future Challenges and Questions for ACOs

“Leakage”: ACO beneficiaries going to non-ACO providers, where they may receive unnecessary treatment

- By statute, Medicare ACOs cannot effectively limit beneficiary utilization (e.g., can’t require higher cost-sharing/copays at non-ACO providers)
New Compensation Paradigms

- Can the market move away from rewarding more procedures?
  - Reward participants for reducing total health care costs
  - Reward PCP participants for size of patient network
  - Reward participants for adopting/using certain technology
  - Reward participants for dedicating staff to ACO activities
  - Reward participants for population health changes

- Be cognizant of difficulty involved in transitions

- Participant success is critical to long-term survival of ACO
1. Employer Opt-Out Rights

- The insurer will need to consider whether to provide any employer groups with an opt-out right. (Different insurers take different approaches).

- Payors try to avoid such opt-outs
2. Benefit Products Included

- The agreement will need to describe which benefit products are included in the calculation of shared savings/shared losses. To the extent Medicare Advantage or Medicaid managed care products are included, the use of federal funds may raise unique legal issues that could affect the structure of the arrangement (e.g., antikickback statute), particularly if not with an MSSP ACO.
3. Member Attribution

- Parties will need to have a detailed process for determining which members are in and which are out of the arrangement. Below is sample language:

  - Attribution Model. Members enrolled in Accountable Benefit Products will be attributed to Provider based on the member attribution procedure that Insurer utilizes across its entire network as described in Schedule [___] (the “Attribution Model”). Except as otherwise provided in this Agreement, for any month Members are enrolled in an Accountable Benefit Product and attributed to Provider, such members are referred to herein as “Attributed Members.” For any month Members are enrolled in an Accountable Benefit Product and attributed to Network Providers, such Members are referred to herein as “Network Members.” Insurer may from time to time modify the Attribution Model, provided that Insurer shall provide Provider with no fewer than thirty (30) days’ prior written notice of such changes.
4. Compensation Arrangement

- The agreement will need to contain a detailed description of how shared savings/shared losses are determined. There are a number of issues that the parties will need to consider:
  - Will the agreement be upside risk only or upside/downside risk or will it vary by product (e.g., HMO upside/downside and PPO upside only)?
  - What will the benchmark be for determining whether shared savings or losses exist?—Some possible benchmarks are (i) the medical cost trend for the rest of the insurer’s network or (ii) a predetermined percentage increase in the contracted provider’s medical costs.
  - Medicare Advantage Plan “clawback” for sequestration offsets?
4. Compensation Arrangement (cont’d)

- How will quality performance affect the shared savings/shared losses calculation?
  - Need to have quality as a factor in the compensation calculation to avoid creating the impression that the agreement is designed purely as a cost control measure. This is a liability issue for the insurer and must be included in any arrangement.
4. Compensation Arrangement (cont’d)

The relationship between quality performance and the calculation of shared savings/shared losses is important. There are a number of possible ways and quality could affect compensation:

(1) as a “gatekeeper” function where provider must meet minimum quality score to be eligible for shared savings;

(2) a higher quality score could mean an increased % of shared savings and lower % of shared losses that the provider is responsible for, on a sliding scale; or

(3) a combination of the two approaches described above where a minimum quality score must be met to be eligible for any shared savings but then a higher quality score will increase provider’s share of shared savings or decrease its share of shared losses.
ACO Payor–Provider Contract Terms

4. Compensation Arrangement (cont’d)

- Will shared savings and shared losses be measured from the first dollar or will there be a threshold applied to the cost target (1% up or down from target) to account for statistical “noise” to increase the odds that any shared savings or losses are due to provider’s efforts and not random statistical variation.

- Will there be a cap on the total amount of shared savings that can be earned or shared losses that can be incurred in a particular year?

- Will there be a risk adjustment methodology to account for the disease burden of a provider’s members? This could be particularly important if the provider’s performance is going to be measured against the rest of the insurer’s network.
5. Patient Management Fees

- The parties will need to determine whether the provider will be separately compensated for providing care coordination and patient management services. If an insurer chooses to make these payments, some considerations include:
  - Make sure the payments are described in a way that enables the insurer to receive positive Medical Loss Ratio (MLR) treatment (45 CFR Part 158) for the payments to either be considered an incurred claims expense or a quality improvement activity expense.
5. Patient Management Fees (cont’d)

- The parties will need to determine whether the patient management fees will need to be clawed back in the event the provider is found to have failed to provide the required services.
6. Term and Termination

- The parties may want to make it difficult for either party to unilaterally terminate the agreement. From the insurer’s perspective, this would prevent a provider from simply terminating the agreement if it becomes clear that the provider won’t be able to meet the cost trend benchmarks. Providers are likely to want to create easier pathways for early termination (e.g., triggered by changes to a plan’s benefit products).

- One option would be to create an escrow account whereby a party terminating the agreement prior to the end of the term would forfeit the amounts in the escrow account.
7. Post-termination

- The Parties also need to address what effect of early termination will be on shared savings/shared losses for in-progress plan years. One option would be to not calculate any shared savings or shared losses for the in-progress portion of a plan year. Another option would be to calculate the shared savings/shared losses based on the pro rata experience during the in-progress plan year, but this could raise complications (e.g., applying quality data from a partial year that were designed to be based on a year of data).
8. Information Technology Provisions

- ACO products and software; payor interface and system requirements
  - Provider system requirements and associated costs\(^3\)
- ACO and/or provider network eligibility to access and use payor or ACO IT applications
  - Provider use for non-ACO patients
- IT developed jointly by the participants? IT contributed by one party? Post-termination license?

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\(^3\) See, 42 C.F.R. 411.357(u) and (v) for Physician Self-Referral (“Stark”) Law exceptions for community-wide health information systems and electronic prescribing items and services.
9. Competition

- The commercial payor may request protections against the provider network or ACO competing against the payor. The scope of the competition restriction is important for ACO or providers to consider in relation to other commercial or governmental payor or ACO applications.

- The ACO may seek protection against the payor competing with the ACO or excluding the ACO provider network from other products

- Potential for illegal restraints of trade, tying arrangements, group boycotts, and market divisions exists.

4 See generally, 42 U.S.C. 18042(c)(3)(B) concerning ACA Section 1322 Consumer Operated and Oriented Plans (“CO-OPs”) and the governance requirements in relation to “insurance industry involvement and interference.”
10. HIPAA privacy and security standards/confidentiality

- Reasonable efforts to limit the requested information to the minimum necessary to accomplish the purpose of the intended use, disclosure or request. (But Payor-ACO BAA may be unnecessary since ACO is a Covered Entity…)

- Tracing the PHI, analyzing its uses and assuring appropriate for treatment, payment or health care operations

- State law provisions more restrictive re mental health, genetic testing and HIV/AIDS information; see also federal substance abuse treatment program requirements, 42 C.F.R. Part 2.
Miscellaneous Contract Provisions

- Lead-time issues/Lock-In Period
- Exclusivity
- Data Access & Collection
- Funding of care management (pmpm?)
- Compliance with applicable state HMO, Insurance, TPA, & managed care contracting laws (compliance certification? Insolvency?)
- Changes in Law
Dispute Resolution (require arbitrator with health insurance law/managed care experience? Use AHLA dispute Resolution? Payor should expressly prohibit class actions. See *Oxford Health Plan v. Sutter*, 569 U.S. ___, 133 S. Ct 2064 (2013) (Arbitrator may interpret arbitration agreement to permit class action unless expressly prohibited) and *Iskanian v. CLS Transportation Los Angeles, LLC*, (Calif. Supreme Ct. June 23, 2014) (Class action waivers in arbitration agreements are enforceable)
Salient Federal Law Issues Faced By Commercial ACOs (less so commercial payors except Medicare Advantage, e.g., risk adjustment controversy)

- Stark Law
  - EHR Subsidy Exception
  - Indirect Compensation Exception
  - Risk Sharing Exception (42 CFR 311.357(n))

- Anti-Kickback Statute
  - Managed care/MSSP exceptions may be available
  - If legitimate ACO, requisite intent to violate may be hard to establish
  - ACO should recapture costs prior to distribution (conservative position)

- CMP Law and Gainsharing
Unfair Competition/Antitrust Claims

- Antitrust laws apply to competitor joint conduct, even activities spurred by health reform
- Antitrust enforcement agencies have said that they will continue to vigorously enforce the antitrust laws
- Antitrust enforcement agencies provided guidance for MSSP-participating ACOs
- Traditional antitrust guidance and analysis continues to apply to clinically-integrated networks that are not MSSP-participating ACOs
Unfair Competition/Antitrust Claims (cont’d)

- Core concern about ACOs is limiting competition by allowing providers to aggregate and fix prices. Private Payors could be seen as co-conspirators or aiding and abetting unfair competition (See, e.g., “Most Favored Nation” pricing).
- Potential for direct liability too, through illegal restraints of trade, tying arrangements, group boycotts, and market divisions exists.
- MSSP ACOs deemed “clinically integrated,” for commercial contracting purposes as well.
Salient Federal Law Issues Faced By Commercial ACOs

- Internal Revenue Code Section 162(m)(6) limiting tax deduction for health insurer (and affiliate) employee to $500,000
  - Newly issued final regulations appear to except ACOs and other risk-based organizations that are not paid health insurance premiums.
KEY STATE LAW COMPLIANCE ISSUES

- Corporate Practice of Medicine
- HMO/Insurance/Managed Care Laws
Representative State Law Issues: Corporate Practice of Medicine

- Most states still have laws that prohibit, to varying degrees, the “corporate practice of medicine” ("CPOM"), which generally prevent unlicensed lay entities from employing physicians or otherwise contracting with physicians to furnish medical care.

- CPOM laws may limit the flexibility of payors, physicians and non-physicians to structure ownership and employment arrangements of an ACO unless licensed as a managed care organization or the hospital may employ physicians under state CPOM law.
Some states with strong CPOM laws (e.g., California, Nevada, and Texas) even prohibit hospitals from employing physicians, but have laws permitting nonprofit “medical foundations” to engage physicians (e.g., in medical group) indirectly to provide medical care or exempt entities with downstream risk-bearing organization license (e.g. California’s Restricted Knox-Keene Plans).

“Friendly Physician” or “Management” models in CPOM states require careful drafting to minimize regulatory risk.
State HMO/Insurance/Managed Care Licensing Laws

- **Provider insurance licensing**
  - Shared savings/risk: Shared risk could implicate state insurance licensing requirements for provider.

- **Underwriting vehicle**
  - Shared savings/risk:
    - Shared risk may be limited to HMO products
    - Member attribution may be challenging in PPO environment

- **Bundled payments:**
  - Greater patient flexibility to visit providers in PPO setting may raise certain challenges for implementation
Background

- National Association of Insurance Commissioners ("NAIC") determined in 1990s that a health care provider receiving capitated-type payments assumes insurance-type financial risk.

- In most states, capitation is permissible under state insurance/HMO law for state-licensed HMO’s “downstream” providers, within the scope of their medical/health licensure, for services provided to that HMO’s members.
Capitated or Other “Downside Risk” Payments?

- In a number of states (e.g., California, Colorado, Illinois, Massachusetts, New Jersey, New York, Ohio and Pennsylvania) an ACO may be prohibited from assuming capitated or other substantial financial risk, unless the ACO is licensed by the state to assume such financial risk or falls within an exception.

ACO that direct contracts with self-funded ERISA plan is not shielded from state insurance/HMO licensure and regulation by ERISA preemption, which applies only to plan itself. [See Hewlett-Packard Co. v. Barnes, 571 F. 2d 502 (9th Cir 1978)]

- Congress could preempt state insurance/HMO laws for Medicare capitation, but PPACA does not appear to do so.
Examples of representative state insurance/managed care laws that may apply to ACOs and other risk-bearing organizations include:

- California Knox-Keene Act: ACO requires “Limited” Knox-Keene Plan license to assume global downside risk for physician and hospital services.
- Florida’s Fiscal Intermediary Service Organization Law: Fla. Stat §621.316 (unless owned and controlled by a hospital and/or physicians).
- Massachusetts Divisions of Insurance regulation of Risk-Bearing Provider Organizations: 211 CMR 155.00.
Applicability of state insurance/HMO/managed care laws may depend on precise payment structure:

- Global capitation/percentage of premium
- Capitation only for services that capitating provider is licensed to provide (e.g., California)
- Risk corridors (10-15% or 50%?)
- FFS combined with withholds (10-15% or 50%+)
- FFS with upside shared savings bonus or bundled payments (likely not regulated)
In some states (such as California, Ohio, and New Jersey), providers that lack state health plan license generally may not capitate or assume substantial financial risk other than under contract with a licensed HMO, and then only for services within scope of provider’s licensure.

In those states, ACO may still engage in direct employer fee-for-service contracting as permitted by CPOM (including case rates and other bundled pricing) but prohibited from being paid on a capitated basis or otherwise assuming downside financial risk unless ACO holds the required state HMO, PPO or insurance license or subcontracts for its own licensed health care with an HMO services with an HMO.
Must review other state insurance/HMO/managed care laws carefully before structuring ACO

State AWP laws

ACA non-discrimination provision
- Scope of provision is currently unclear
- Additional regulatory action likely

Tiered network participation
- Excluded providers may object to exclusion
- Enrollees may object to inadequate access

Note: If ACO is not a licensed health plan and is delegated TPA functions (e.g., claims adjudication), ACO may be required to obtain a state third party administrator (TPA) license