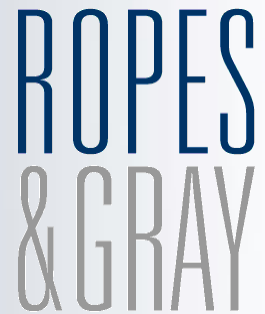


Behavioral Health Value Based Payment Readiness

Key Considerations for Participation in Independent Practice Associations (IPAs) and Behavioral Health Care Collaboratives (BHCCs)



June 1, 2017

Agenda

1. Strategic Importance of IPAs to Behavioral Health Value Based Payment and BHCC Formation
2. Background on IPAs
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4. Potential IPA/BHCC Structure
5. Key Decision Points
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 - Governance
 - Provider Participation
 - Operational Support
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Strategic Importance of IPAs

Behavioral Health Value Based Payment

- To help transform the health care delivery system under the Medicaid Redesign Team Waiver (April 2014), NYS is incentivizing the coordination and integration of providers by moving almost entirely to value-based payment (VBP) by 2020
 - This mandate includes behavioral health (BH) services
 - A key focus is population health, including the integration of BH and physical health services to achieve better health outcomes
- VBP places the development and contracting requirement on Medicaid Managed Care Organizations (MCOs), but the impact will be felt directly by providers
 - Reimbursement will be driven by contractual relationships with Medicaid MCOs, including Health and Recovery Plans (HARPs), rather than through traditional Medicaid fee-for-service payments
 - MCOs will use VBP methodologies that are designed to reward providers for better health outcomes and lower costs

Strategic Importance of IPAs

Behavioral Health Value Based Payment

NYS established 3 levels of VBP:

Level 1:

FFS with upside only shared savings arrangements

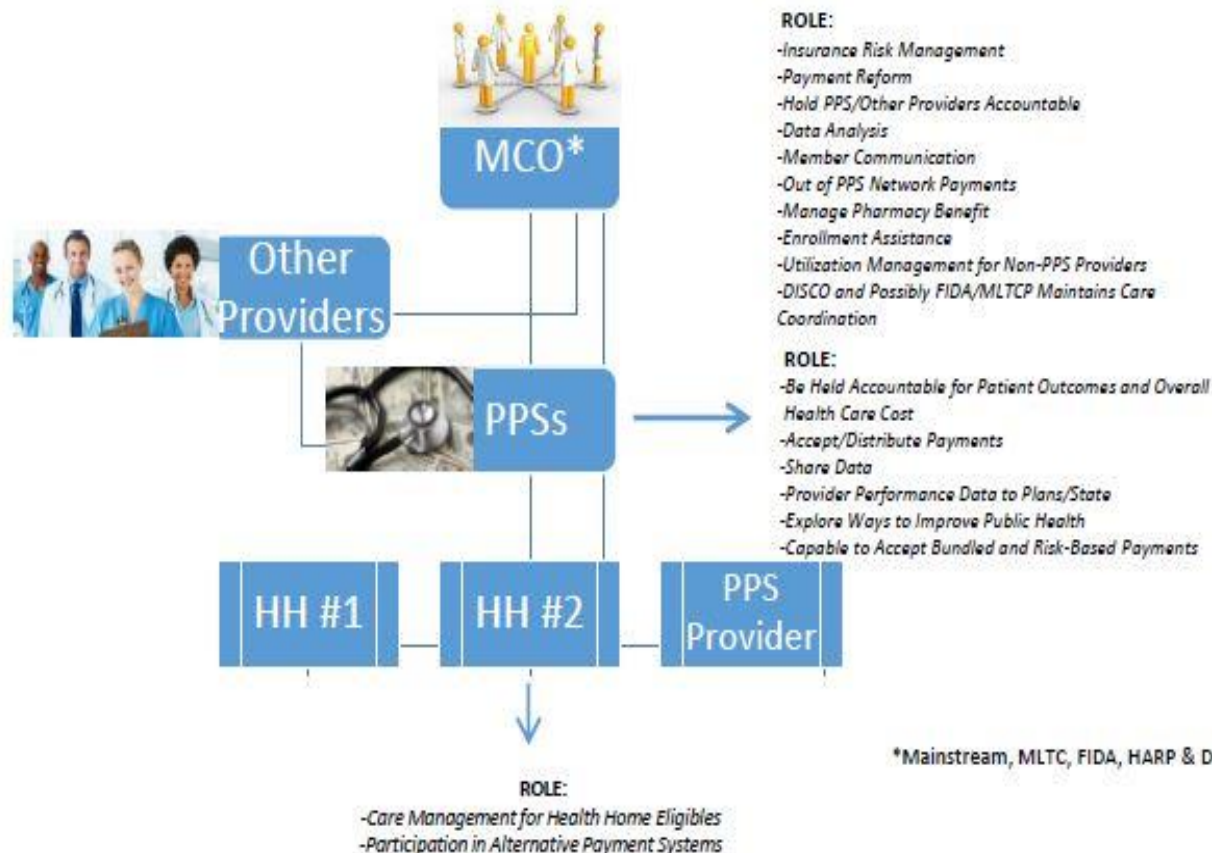
Level 2:

FFS with upside and downside risk sharing arrangements

Level 3:

PMPM and/or single bundled payments

How The Pieces Fit Together: MCO, PPS & HH



Source: Center for Health Care Strategies, The New York State DSRIP Program: A Model for Reforming the Medicaid Delivery System (Dec. 2014)

Strategic Importance of IPAs

Behavioral Health Value Based Payment

Phase I

Phase II

2015

2016

2017

2018

2020

PPSs initiate projects in DSRIP Project Plan

MCO and PPS combos submit growth plan for path to 90% VBP

MCO and PPS combos have at least one Level 1 VBP for PCMH/ APC and one other bundle or sub-population

50% of NYS Medicaid MCO payments through VBP

80-90% of NYS Medicaid MCO payments through VBP

Strategic Importance of IPAs

Behavioral Health Value Based Payment

- Given the transition to VBP, BH providers will find it increasingly difficult to operate independently
 - Inability to influence the spectrum of care to ensure appropriate clinical outcomes
 - Failure to achieve adequate recognition of value by MCOs, which will be reflected in rate setting
 - Lack of access to capital necessary to invest in the infrastructure to support VBP methodologies and clinical data reporting
- As a result, Providers have two primary responses:
 - **Corporate Transaction:** Pursue a strategic affiliation—such as a merger, sale, corporate consolidation or membership substitution—that will create scale through combined operations, but will result in a loss of provider independence
 - **Collaborate:** Preserve independence, but strategically collaborate with other independent BH (and non-BH) providers to pursue VBP arrangements

Strategic Importance of IPAs

Behavioral Health Value Based Payment

- Alphabet soup of provider collaborations
 - Performing Provider Systems (PPSs)
 - Accountable Care Organizations (ACOs)
 - Independent Practice Associations (IPAs)
 - Behavioral Health Care Collaboratives (BHCCs)
- **Regardless of the terminology, the concept is the same:** independent providers collaborating to improve health outcomes, manage costs and participate in VBP arrangements
- For BH VBP, OMH and OASAS are funding the development of BHCCs to achieve these purposes
 - BHCCs bear a strong resemblance to traditional IPAs
 - IPAs are one good way to achieve BHCC objectives

Strategic Importance of IPAs

Behavioral Health Value Based Payment

- DOH has recognized this construct as well in the VBP Roadmap, which permits an IPA to enter into VBP arrangements
- Similarly, OMH and OASAS have recognized that an IPA can serve as the BHCC lead agency



New York Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Value-Based Payment Roadmap

What New York State's Medicaid VBP plan is not:

An attempt to require MCOs to contract with PPSs for VBP Arrangements: MCOs are free to continue to build upon their existing direct provider contracts or IPA/ACO arrangements to achieve the VBP goals.

A requirement that only PPSs can enter Medicaid VBP Arrangements: all (groups of) providers that can deliver integrated care services, including, but not limited to Independent Practice Associations (IPAs), Accountable Care Organizations (ACOs) and PPSs, are intended to be able to enter into VBP arrangements

Excerpt: VBP Roadmap, page 5

BH VBP Readiness Program NOTIFICATION OF INTEREST FORM

Lead Agency

A lead agency must be OMH or OASAS licensed or certified community based organization, contracted with a participating Medicaid Managed Care Organization (MMCO). Where a BHCC is an IPA contracted with a participating MCO, the IPA will serve as lead agency. The lead agency will receive the planning and implementation funds and communicate with the State on behalf of the BHCC. They must also provide a Letter of Intent signed by the CEO/Executive Director with this Notification of Interest.

Excerpt: BH VBP Notification of Interest Form,
https://www.omh.ny.gov/omhweb/bho/notification_of_interest.pdf

A BHCC functioning as an IPA represents an established—and legally authorized—vehicle for VBP contracting

Background on IPAs

- **Definition:** An IPA is a special purpose legal entity that contracts directly with health care providers so that it may then contract with one or more MCOs to make the services of such providers available to enrollees of the MCOs (10 NYCRR § 98-1.2(w))
- An IPA may undertake two “special” functions under New York law that other legal entities cannot:
 1. It can negotiate and contract on behalf of its downstream providers with MCOs; and
 2. It can “bear risk” for health care costs without need for a separate insurance or MCO license

Background on IPAs

- **Contracting Function**

- Without forming an IPA, providers would have to contract individually with MCOs
- IPAs can “arrange for” the provision of health care services through a contracted provider network without violating New York restrictions against the corporate practice of medicine
- By negotiating collectively through an IPA, providers can jointly contract an ancillary function to financial and clinical integration activities

Background on IPAs

- **Risk-Bearing Function**

- IPAs are permitted to enter into risk sharing arrangements with MCOs, such as Level 2 or Level 3 VBP arrangements
- IPAs may also participate in other kinds of risk transfer arrangements with MCOs
- Depending on the type or “level” of risk, IPAs must meet certain state-mandated financial requirements before assuming risk (e.g., Part 98, DFS Regulation 164) and receive regulatory approval from DOH

Background on IPAs

- **Other Functions**

- IPAs can perform other downstream administrative services under contract with MCOs
- Delegation of administrative functions can help BH providers “control their own destiny” with MCOs and support larger VBP arrangements and payment methodologies
 - **Credentialing:** Above those obligations found in regulations, determines standards for participation as an eligible provider
 - **Purchasing:** Enables group purchasing of administrative infrastructure, such as data systems, care management tools and oversight staff
 - **Claims processing:** Dictates documentation and billing requirements

IPA Formation Requirements

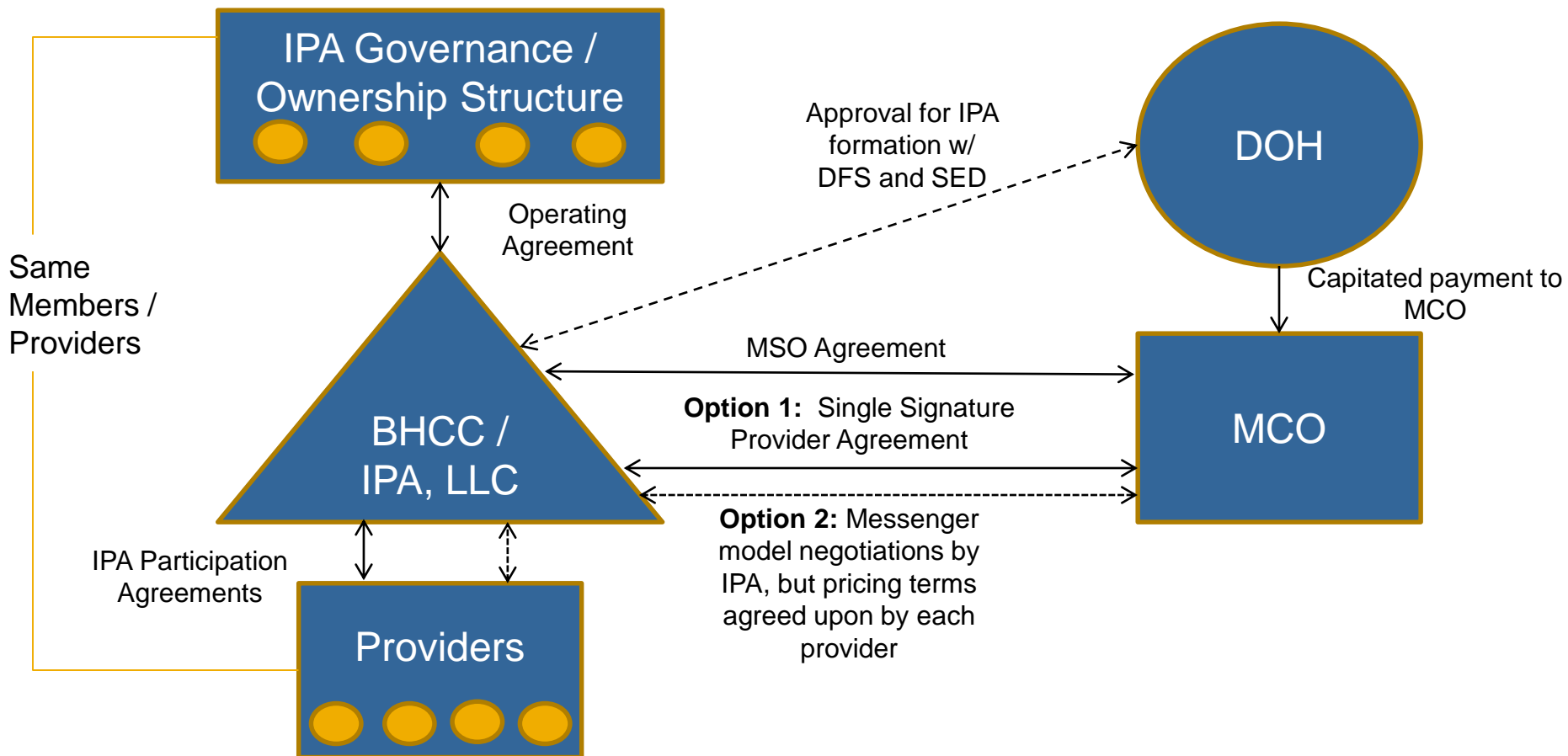
- The formation process is straightforward
 - IPAs may be formed as a corporation (general business or not-for-profit) or limited liability company
 - Formation of an IPA requires consent and approval from DOH, the State Education Department (SED) and the Department of Financial Services (DFS) prior to filing a certificate of incorporation with the Secretary of State
 - State approval is not materially affected by selection of business form
 - It normally takes six months to form an IPA—elongated timeframe in light of state resources
- IPAs do not require specific licensure
 - IPA providers, by contrast, must still be licensed to furnish specific services to enrollees (e.g., Article 31 and Article 32)
 - Other licensure may be needed for the IPA to perform certain delegated functions (e.g., Utilization Review)

IPA Formation Requirements

- Specific information must be provided as part of the certification process:
 - The name, address and telephone number of the IPA;
 - The IPA formation documents, including bylaws or operating agreement (if an LLC);
 - A list of the IPA board members and MCO affiliations of the board members;
 - The names, addresses and occupations of the members of the IPA;
 - A list of the health care and insurance affiliations of the members of the IPA;
 - A list of the types of providers that will be contracting through the IPA; and
 - A general description of the arrangements that the IPA expects to negotiate with MCOs
- “Independent Practice Association” or “IPA” must appear in the name of the entity

Potential IPA / BHCC Structure

A sponsored IPA contracts with MCOs on behalf of its members and performs select administrative services



Key Decision Points: Corporate Formation

- A key consideration is the legal form through which to operate the IPA, which includes three options:
 - Not-for-Profit Corporation
 - Limited Liability Company
 - Business Corporation
- Each one of these corporate forms has certain pros and cons when considering the potential legal implications in forming the IPA
- These legal implications can be divided into three broad categories:
 - Corporate Law
 - Tax Law
 - Securities Law

Key Decision Points: Governance

- IPA must create a governing document (management agreement or bylaws)
 - Will the IPA be limited to OMH/OASAS-licensed providers and services?
 - BHCCs contemplate that lead agencies and network providers will be OMH and OASAS-licensed
 - Affiliated providers may include other provider types
 - How will the governance of the IPA be structured?
 - Who will be part of the IPA?
 - **Closed** – participation is limited to those agencies who are part of provider group and members of the IPA
 - **Hybrid** – participation is guaranteed to those willing to sign on as members to the IPA, and some others
 - **Open** – participation is a combination of member providers and non-member providers

Key Decision Points: Governance

- IPA must create a governing document (cont'd.)
 - What powers will be reserved to the members?
 - Appointment and removal of governing body and members
 - Appointment and removal from committees
 - Admission of new providers/credentialing
 - Appointment and removal of officers/managerial employees
 - Changes in corporate purposes or significant new initiatives (e.g., movement from messenger model to joint contracting, new risk sharing vehicles)
 - Approval of major corporate actions, dues payments and distributions

Key Decision Points: Governance

- IPA must create a governing document (cont'd.)
 - Committee Participation
 - **Executive Committee** – depends on size and composition of governing body
 - **Finance Committee** – establishes budgets and dues, and analyzes risk sharing arrangements
 - **Clinical Quality Improvement Committee** – creates clinical protocols and enforces them; credentials new providers
 - **Contracting Committee** – solicits contracts and guides contracting process
 - **Innovation and Risk Sharing Arrangement Committee** – solicits demonstration projects and analyzes risk sharing arrangements
 - **Non-Member Participation** – participation on Committee by non-Member providers
 - Member capitalization and distribution of IPA proceeds
 - Pro rata capitalization and distribution
 - Distribution of BHCC funding
 - Distribution planning for risk sharing arrangements and general IPA revenue

Key Decision Points: IPA Participation Agreement

- Services performed by IPA for participating providers
 - MCO Contracting / Negotiation agent (messenger model or full integration)
 - Provision of technology and linkages
 - Referrals
 - Credentialing
 - Clinical integration program development and implementation
 - Financial integration/risk sharing contracts
 - Marketing, public relations and directory services
- Levels of Exclusivity
 - **Total** – Participating provider may not contract with any other IPA, physician hospital organization or other organization for MCO contracting purposes
 - **Right of First Opportunity (“ROFO”)** – No exclusivity with regard to IPAs, but participating provider must grant the IPA the first opportunity to pursue contracts with MCOs before using another IPA or negotiating directly
 - **Notification** – No exclusivity or ROFO, but participating provider must notify IPA of any other contract offers with MCOs
 - **None** – Participation is voluntary and open at all times

Key Decision Points: IPA Participation Agreement

- **Opt-out/Opt-in**
 - **Opt-out:** Participating Provider automatically participates in all Payor Contracts, but may opt-out upon notice to the IPA
 - **Opt-in:** Participating Provider must exercise the opt-in right in order to participate in a Payor Contract
 - Either case must be analyzed under state and federal antitrust law
- **Dues**
 - Dues must adequately capitalize the IPA for start-up activities
 - Should dues level vary based on level of integration or participation in IPA or should dues be uniform to ensure consistent participation?

Key Decision Points: Operational Support

- Depending on functions performed by IPA, it will need to be staffed and supported by providers

Initial and Start-Up

- IPA requires few independent resources in start-up stage
- Time devoted by staff to determine how best to leverage health home and related work to IPA functions (e.g., referrals and linkages, technology, care management models, common protocols)

Messenger Model

- Additional resources funded by provider dues are required to compile a network of participating providers available for messenger model contracting
- Individuals must be engaged to coordinate compliance messenger model contracting

Full Integration

- Significant staff and resources are required to, among other things, apply for a COPA/ACO, monitor adherence with clinical protocols, perform other quality assurance activities, assess compliance against risk sharing models and perform contracted functions with MCOs
- IPA must have a committed revenue stream or significant member commitment
- Solicitation of capital partnership is possible

Legal Considerations

- **Antitrust Law:** Joint contracting with MCOs by competing providers through an IPA may be considered illegal price fixing under federal and state antitrust laws unless:
 - **Clinical Integration:** There is sufficient clinical integration and the contracting parties are involved in a legitimate joint venture to produce significant efficiencies that benefit consumers and to which joint contracting is ancillary;
 - **Financial Integration:** There is substantial economic integration (e.g., sharing of substantial financial risk, such as capitation programs, significant withholding of reimbursement);
 - **Messenger Model:** Payor contracts are separately negotiated through the IPA acting as a “messenger”; and/or
 - **Certificate of Public Advantage (“COPA”)/State ACO:** A COPA or state ACO certificate of authority are developing processes by which providers may receive state action immunity

Legal Considerations: Clinical Integration

- Examples of clinical integration include a combination of:
 - Utilization review
 - Quality assurance
 - Evaluation of performance
 - Care coordination
 - Development and use of evidence-based protocols
 - Development and use of performance-based targets
 - Central data collection and analysis
 - Data gathering, analysis and distribution
 - Attendance at regular meetings
 - Significant capital investment
 - Training and education
 - Review of outliers
 - Common EMRs
 - Consequences for nonparticipation/outlier behavior: financial penalties, termination
- 1-2 years (or longer) to achieve clinical integration is typical; BHCCs are viewed as a vehicle for “clinical integration”

Legal Considerations: Financial Integration

- Financial Integration might include:
 - A MCO VBP agreement under which the IPA is subject to “downside” losses if cost savings or outcomes are not achieved
 - “Level 2” and “Level 3” payment models (*i.e.*, upside/downside) in the VBP Roadmap is consistent with the concept of Financial Integration
- VBP arrangements with financial integration require additional statutory and regulatory reviews by DOH and DFS to ensure IPAs are financially capable of the risk

Legal Considerations: Messenger Model

- Until substantial clinical and/or financial integration is achieved, a messenger model or modified messenger model could be used to promote contracting, while complying with antitrust laws
 - The key defining characteristic of a messenger model arrangement is that the messenger serves as a conduit used by providers participating in a network to make individual determinations about their prices and participation in a particular contract offered by a payor
 - The purpose of using the messenger model must be to reduce transaction costs in payor-provider contracting; it must not be used with the intent of increasing provider price leverage through collective negotiation strategies

Legal Considerations: Messenger Model

- **Traditional Messenger Model**
 - The messenger goes back and forth between the payor and providers to convey to providers any contract offer made by payor
 - Each provider makes a separate, independent and unilateral decision to accept or reject a payor's offer
- **Modified Messenger Model**
 - A messenger collects minimum fees or fee ranges from each individual network provider. Providers may then grant the messenger advance authority, on an individual basis, to agree to offers by payors who meet or exceed the price that the provider has designated as an acceptable price
 - The messenger then conveys the offer to the remaining providers whose minimum terms were not met for their individual determination whether to opt-in or opt-out of the proposed contract

Legal Considerations: NYS Programs to Lessen Antitrust Risk

- New York State has established two programs intended to protect collaborative arrangements, such as those that may be conducted through IPAs, from antitrust liability:
 - Accountable Care Organization (“ACO”) Certification
 - Codified at 10 N.Y. Comp. Codes R. & Regs. § 1003.1 *et seq.*
 - Certificates of Public Advantage (“COPAs”)
 - Codified at 10 N.Y. Comp. Codes R. & Regs. § 83-1.1 *et seq.*

Legal Considerations: NYS Programs to Lessen Antitrust Risk

ACO Certification

- An ACO is an organization of clinically integrated providers that provide, manage and coordinate care for a defined population
 - Includes shared governance, ability to negotiate, receive and distribute payments, and accountability for the quality, cost and delivery of health care to the ACO's patients
 - An IPA may become an ACO, or facilitate involvement by providers in an ACO
 - Note: Under the Next Generation Model and Medicare Shared Savings Program regulations, an IPA may not contract directly with an ACO

Legal Considerations: NYS Programs to Lessen Antitrust Risk

Certificates of Public Advantage

- A COPA is a document issued by the DOH signifying the approval of a “Cooperative Agreement” or planning process. A COPA may be issued for at least a two year period
 - Parties that have received a COPA are provided immunity from private claims under state antitrust laws and may negotiate and conduct business pursuant to a Cooperative Agreement or planning process
 - NYS intends that a COPA provide the parties with state action immunity under federal antitrust laws
 - Arrangements covered by a COPA are subject to active state supervision
- An IPA may request a COPA for certain arrangements and necessary activities to carry out the arrangement, *but* a COPA will not apply to any Medicare or non-governmental commercial transactions or activities carried out by an IPA
- COPAs have been pursued primarily by PPSs for DSRIP projects

Legal Considerations: NYS Programs to Lessen Antitrust Risk

COPA

- Certificate granted for a potentially large array of purposes, as defined in a “Cooperative Agreement” among the parties or in a planning process to develop a Cooperative Agreement
- Granted by DOH in consultation with the Attorney General
- Requires clinical integration
- Does not impose specific governance, leadership or financial requirements to receive a COPA
- Provides for potential state action immunity from antitrust laws only

ACO

- Certificate granted for “ACO” activities, which include shared savings or risk-based arrangements (e.g., “NextGen” ACOs)
- Granted by DOH in consultation with the Department of Financial Services
- Requires clinical integration
- Imposes specific governance, leadership and financial requirements to receive an ACO Certificate of Authority
- Provides for potential state action immunity from antitrust laws and exemption from other state legal restrictions that may implicate ACO activities (e.g., fee splitting, referrals)

Questions

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