Payor Initiatives with Physicians and Payment Models In The Insurance Marketplace

A Changing Landscape

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Payment models that seek to reward physicians, hospitals and other health care providers for achieving certain quality and cost-saving goals, or "value-based purchasing" (VBP), are not new to the healthcare landscape, although they are more prevalent in certain regions of this Country. However, more recently, it appears that both payors[1] and providers[2] have been motivated, whether for opportunity or survival, to seek out or advance new or existing VBP payment models and other health care provider alignment strategies.

I. The Traditional HMO Model Initially Was Equated with VBP

Managed care is recognized as a system that integrates the financing and delivery of *medically appropriate* healthcare using a variety of cost containment techniques.[3] Historically, to accomplish these goals, an HMO's relationship with its network of contracted providers is intended to shift the focus of innovation from health care *delivery* to health care *financing* through the use of capitation, shared risk arrangements and risk pools. The cost containment mechanisms utilized by many HMOs were intended to *both* improve quality of care and lower healthcare spending. Still, the capitation payment models of the 1980's and 1990's were flawed in several respects and contributed to the backlash against the HMO business model. Early per member per month (PMPM) capitation payments did not adjust PMPMs for severity of conditions, did not link PMPM payments to quality incentives and did not adequately increase PMPM with inflation. Providers began to reject HMOs or sour on them due to concerns, whether real or perceived, that HMOs interfered with the providers' medical decision-making, compromised the physician-patient relationship and created excessive administrative burdens.

Unfortunately, the traditional HMO model of the 1980's and 1990's was not lowering health care spending or improving health care quality. Health insurance premiums continued to rise — to the chagrin of employers and consumers purchasing HMO coverage. And, many of the large capitated provider organizations that grew to meet the needs of HMO model expansion seemed to implode by the sheer weight of their rapid expansion and the lack of sufficiently advanced technology and data sharing to successfully coordinate care and predict financial exposure in capitation negotiations with HMOs and downstream providers.

II. Quality (Not Cost) Emerges as the Focal Point for Healthcare Improvement

As the traditional HMO model struggled, the health care industry turned their attention to "quality." In 1998, the Institute of Medicine (IOM) issued a seminal report identifying significant quality of care concerns in the healthcare industry.[4] The three systemic deficiencies cited by the IOM included overutilization of healthcare, underutilization of healthcare and misuse of healthcare based on the prevalence of medical errors and other patient safety concerns.[5] In helping to refocus the discussion of healthcare quality, the IOM report concluded:

- Quality of health care can be precisely defined and measured.
- Quality problems are serious and extensive.
- Deficiencies in quality of care is the problem, not managed care.
- Change is required in how we deliver healthcare.[6]

As a result, the IOM concluded that "major, systemic effort to overhaul how we deliver health care services, educate and train clinicians, and assess and improve quality" was needed.[7]

Facing continuing pressure from policymakers, purchasers, providers, consumers and regulators, HMOs and other types of commercial health plans also went through an evolution in their provider risk-sharing strategies to include quality programs and the opportunity for providers to earn financial rewards based upon meeting quality and efficiency benchmarks.[8]

III. ACA and MACRA – Government Payors Adopt and Experiment with Quality Payment Models

ACA established new payment models and new delivery system models available to providers participating in traditional Medicare and Medicaid. Under ACA, the Center for Medicare and Medicaid Services (CMS) implemented value-based incentive payment programs based on performance or improvement on certain measures (e.g., for heart failure, MI, pneumonia, surgical infection) or

the reduction in adverse events (i.e., lower payments for early readmissions). CMS also implemented bundled payment programs for certain episodes of care. The Medicare Shared Savings Program (MSSP) allows providers to organize into accountable care organizations (ACOs) to continue to receive fee-for-service (FFS) payments for services furnished to Medicare beneficiaries. Such ACOs are eligible for additional payments if the ACO achieves certain quality and cost savings benchmarks and, in some ACO models, provides also are responsible for some portion of the budget overruns. ACA also created the Center for Medicare and Medicaid Innovation to experiment with other ACO models and alternative payment models as well as patient-centered medical homes.

ACA also changed the way private Medicare Advantage coordinated care plans (MA plans) are paid. MA plans are subject to a 5-star rating program which yields a *quality* rating (based on criteria determined by CMS) that is available for public assessment. The star rating also determines if the MA plan is eligible for additional payment amounts from CMS to administer health benefits for plan enrollees.

ACA's MLR requirements for commercial payors and MA plans are intended, from a policy perspective, to ensure that consumers are receiving *value* for the health benefits which they purchase by requiring that such health plans spend a minimum of 85% or 80% (depending on the health benefit plan product) of their premium dollars on some combination of health care costs and *quality improvement* activities.

In addition to the various VBP and quality initiatives and mandates included in ACA, in 2016, MACRA[9] passed Congress in bi-partisan fashion. MACRA repealed the Sustainable Growth Rate formula, changes the way that Medicare will reward providers for value over volume, streamlines multiple Medicare quality programs under the new Merit-Based Incentive Payments System (MIPS), and provides 5% annual payments for participation in eligible alternative payment models (or, APMs). MACRA is specifically intended to drive increased participation in risk-bearing coordinated care models across all payors (i.e., Medicare Advantage, Medicaid and commercial payers, not just traditional Medicare).

Although some of ACA's VBP programs have had mixed results and acceptance by providers, since the enactment of ACA, private payors and providers have continued to develop and experiment with VBP arrangements and pursue various alignment strategies.We also have seen increasing payor and provider integration strategies whereby providers, in some cases, have increased their tolerance for taking on risk or developing or acquiring affiliated payors. Likewise, payors have increased their tolerance for acquiring, developing or affiliating with provider delivery systems. The next section of this paper will examine some of the collaborative models which payors and providers have been pursuing in the private sector — both before and following ACA. Even with uncertainty around the future of ACA, private sector collaboration appears to continue.

IV. Private Sector Payor VBP Models and Provider Alignment Strategies

Despite the hits and misses of the 1980's, 1990's and early 2000's, payors seem to be embracing VBP and continue to develop VBP payment models and provider alignment strategies that mesh with their own strategic goals which are as diverse as the dynamics in each geographic market in which payors offer their health plan products. Payors do understand that cost controls, alone, are insufficient to curb healthcare spending, and that subpar and fragmented medical care proves to be more expensive than optimal care provided in a coordinated fashion.

A. First Line VBP – Capitation and Risk Sharing Payment Models

The most common alignment strategies involve some sort of risk contracting between a payor and its physicians to which a population of the payor's enrollees are assigned. Such arrangements may involve a combination of capitation payable to the physician group and risk-sharing or other population-based payments made to the physician group, with built-in rewards and, possibly, risks. In certain alignment strategies, a payor will capitate both the physician group and a hospital with which the payor and physician group also are "aligned," both geographically and in the efforts to control cost and quality for a specific population of patients/members. From the hospital capitation, the payor would carve out a portion of its capitation payment to fund an incentive bonus pool which could be earned by physicians as a reward for controlling hospitalization in a manner that does not jeopardize quality. In recent years, these incentives are tied not only to utilization goals, but also to physicians meeting certain quality benchmarks.

An alternative model could involve the payor capitating the physician group for physician services but paying the "aligned" hospital on a fee-for-service basis. In the event that the physicians assist the payor in realizing savings in hospital costs below a pre-determined benchmark, the payor would share those savings with the physicians. In some states, these capitation models may only be used with HMOs because only HMOs are permitted to pay providers on a capitated basis. That is, other states may expressly prohibit or indirectly prohibit PPO products underwritten by indemnity health insurers to pay capitation.[10]

In addition to these basic capitation-based models, payors and providers continue to develop variations that may involve one or more of the following general constructs (subject to permissibility under applicable state HMO/insurance laws):

- Providers earn a bonus for meeting certain quality and/or efficiency metrics. Failure to do so risks loss of the bonus only.
- Payors implement a pay-for-performance incentive system that uses information on adherence to treatment guidelines and practice efficiency to distribute savings to providers that are achieved through better patient care management.

- Providers share in savings realized from managing patient care below baseline costs, provided that quality metrics also are met. Providers have some downside risk in future years if quality and financial goals are not met.
- Providers are at partial risk or full risk (through capitation and/or use of stop loss) for designated sets of services or procedures for the specified patient population. For instance, a Medicaid payor might develop a pre-determined amount for all services relating to pre-natal care and births — i.e., services upon which the physicians and an "aligned" hospital could collaborate.
- Payors could simply develop bundled payments for particular episodes of care or procedures — e.g., paying the physicians and the"aligned" hospital a fixed amount for certain surgeries or for just deliveries.

B. Chronic Care Management and Population Health

In more recent years, VBP payment models have become more focused around areas of greatest healthcare spending. It now has been well documented by healthcare industry studies that approximately 5% of the population in the United States account for nearly 50% of our total spending on healthcare, while 20% of our population account for 80% of total spending. These individuals usually have complex medical problems which can become even more costly for payors if not treated on a regular basis by a coordinated care team of physicians and non-physicians. Therefore, payors are not only seeking out provider groups to coordinate care for their enrollees with complex medical conditions, but intermediaries are emerging to work with payors on a VBP basis in managing the cost and care for these populations. One such intermediary is Landmark Health which helps qualifying members enrolled in payors' health benefit plans better manage their chronic or complex medical conditions by, among other things, making available in-home medical care 24 hours a day, 365 days a year.[11] Landmark contracts with payors on a risk or incentive basis and coordinates with the payors' network providers.

In other collaborative efforts, payors or their affiliated services organizations may offer HIT and health care analytic tools and related resources to providers that are willing to work with them in VBP arrangements. Often, these providers do not have the immediate resources to invest in these robust tools and systems themselves. Yet, once their practices or facilities acquire such tools and resources, they are better equipped to manage care for their patients with chronic or acute conditions and, thus, better able to assume some level of risk (or reward) in VBP arrangements with payors. In 2015, Humana announced that it had embarked on similar initiatives with its Transcend population health subsidiary.[12]

C. Aligning VBP Arrangements and Payor-Provider Integration

VBP payment models of some type are typically incorporated into payors' strategies to better align or more seamlessly integrate with provider "partners." For example, UnitedHealth Group's affiliate, Optum, has been acquiring physician practices and other resources for a number of years, now.[13] In 2014, Independence Blue Cross joined with DaVita Healthcare Partners to create a new care delivery/care coordination organization known as Tandigm to work with the local physician groups.[14] In addition to its other alliances, Aetna has been collaborating with hospital systems to form new jointly-owned HMOs in certain markets[15] and, in other markets, Aetna is partnering with hospitals in other ways to improve care and lower costs.[16] Also, in 2014, competing hospitals in California joined with Anthem Blue Cross to form a new HMO operating as Vivity.[17] Just last August (i.e., in 2016), Geisinger Health System announced a new collaboration with St. Luke's University Health Network in Pennsylvania to offer new insurance products.[18] Additionally, a variety of payors continue to explore the development of co-branded or "community" health plans that utilize the narrow networks of provider systems whose names may carry more cache than that of the payor in the communities in which the providers are located.

The Aetna-type joint ventures mentioned above, among some others, create an interesting opportunity for a provider to have in equal say in the governance of a newly-created health plan entity, and to share equally in the new entity's profits and losses through a captive reinsurer owned by the provider. The provider is a true partner with the payor in the newly created joint venture and, thus, gains the potential for a new revenue stream (i.e., the joint venture's profits payor) to offset the operating revenue lost from the deeply discounted rates the provider offers its jointly-owned health plan. The Tandigm joint venture reflects another type of joint venture where the provider and payor establish a jointly-owned intermediary which, though not licensed as a HMO or health insurer, is authorized under state insurance laws to assume insurance risk from a Pennsylvania managed care entity. In the Commonwealth of Pennsylvania and some other states, this joint venture intermediary may accept a global capitation payment for a population of a payor's enrollees for services furnished and arranged through professionals employed or contracted with the intermediary, including hospital and ancillary health care services that physicians engaged by the intermediary are not licensed to provide. However, as long as the intermediary is contracted with a licensed managed care plan, the intermediary need not to be licensed as an HMO, insurer or other risk bearing entity and would not have the full regulatory burden of a licensed risk-bearing entity. Thus, in applicable jurisdictions, a provider and payor could establish a jointly owned and governed intermediary from which profits and losses could be shared. Some of these intermediaries also may navigate around certain corporate practice of medicine restrictions through statutory authorization to employ or contract with physicians.

V. VBP Models Create Legal Traps for the Unwary

The complexity and variety of VBP arrangements involve conduct and activity that raise a host of legal and regulatory issues to be considered by payors and provider "partners." Some of the regulatory and compliance considerations raised by the collaborative models discussed in this paper and existing in the market today are summarized below. The applicability of these laws to any particular VBP arrangement may determine whether and to what extent:

- HMO and Insurance Laws – Providers are permitted to assume downside financial risk from payors, or payors are permitted to develop certain incentive-based reimbursement models with providers;[19] and whether and to what extent, HMO and insurance laws and, sometimes, course of dealing determine what types of organizations may pay capitation[20] and what types of organizations may accept a capitation payment;
- Scope of Practice / Licensure – Mid-level medical professionals engaged in providing care coordination or extending primary care to other settings (e.g., home) are appropriately licensed and supervised in the applicable state to furnish the intended services to a payor's enrollees;
- Home Health – Care furnished by provider representatives in home settings implicate regulations governing home health agencies;
- Telemedicine and Telehealth – Telephonic, Skype or similar interactions between medical professionals and patients/enrollees satisfy laws in all applicable states (i.e., where the professional is located and where the patient is located) or require additional licensure or oversight in certain jurisdictions;
- Medicare Advantage Benefit Rules – A collaborative program between an MA plan and specific provider(s) constitutes a Medicare Advantage "benefit" which is required to be offered by the MA plan to be offered to all of its enrollees (i.e., not just as part of a VBP arrangement with certain providers);
- Medicare Advantage Marketing Rules – The manner in which a co-branded MA plan-provider relationship may be marketed to prospective or actual MA plan enrollees.
- CPOM – Payor's ownership, management, support or control of provider partners violate the applicable state's prohibitions on the corporate practice of medicine;
- Fraud and Abuse – Resources or incentive payments made available to providers by payors implicate state mini antikickback laws or, when applicable, the Federal Antikickback Statute or the Federal False Claims Act (e.g., an MA plan's inappropriate payments to providers who increase the severity of their Medicare patients' diagnostic codes or refer or "convert" their Medicare patients to their payor "partner's" MA plan);
- HIPAA and State Privacy Laws – Patient information may be shared among competing providers that are part of a payor's regional collaborative, but which maintain no doctor-patient relationship with the individual; and/or
- Antitrust Laws – Competitors may collaborate and share information.

VI. The Future of VBP Models?

Practically, private payors are focused on the transition from FFS to VBP because their customers – be they employer groups or individual consumers – are better informed and demanding lower premiums, more transparency and better health outcomes – i.e., "value." This means that payors have to continue to improve their efficiency and financial performance, "partner" with providers with a common strategic and care delivery vision and be able to deliver more quality and value to consumers as the health financing model continues to transition from a business-to-business model to a business-to-consumer, i.e., retail, model.

Still, despite the public and private sector innovation we have seen in VBP arrangements, we may not know if all or any of the VBP models are yielding the intended results on a sustainable basis for another couple of years when we see if the financial results from the VBP arrangements match or exceed the financial modeling. And, it may take even longer and be more difficult to assess whether these VBP arrangements are improving the health outcomes of specific patients and improving the overall health of populations.

In addition to uncertainty as to whether existing and new VBP models are having the desired results, there still remain obstacles and challenges to wider adoption of VBP arrangements.

- It's Still a FFS World – Despite the incentives and nudges from new laws and government-sponsored VBP models, the healthcare system largely remains entrenched in a FFS world.
- Investments Can be Expensive and Impractical – Not just providers, but many payors still have to adapt their business operations and invest in HIT and comprehensive data analytics to make a meaningful transition from FFS reimbursement and mindsets to that of VBP. Investments in HIT and other technology infrastructure and revamping internal processes are expensive and, perhaps, impractical for private payors that lack sufficient membership to spread those costs against.
- No Common Path Forward – The transition from FFS to VBP will entail a different path forward for different payors and, of course, for different providers as well. The journey and how fast and far each payor progresses will be dependent on a variety of factors that range from local markets, regional biases, state laws, internal corporate cultures and the size, market presence, capabilities, financial stability and willingness of provider "partners."[21]
- Do we Trust Yet? – Even with capable provider allies with which to collaborate, providers must trust that payors will deal with them fairly and are not intending to saddle providers with unlimited risk which the providers did not intend to assume and are not financially capable of handling. Interestingly, in a 2016 survey conducted by Deloitte, approximately half of all health plan executives believe that MACRA would have a positive impact on their total profit margins.[22] In contrast, 72% of health system executives expected that MACRA would drive down their margins.[23] This gap in expectations may reflect a general sense that providers are not yet convinced that VBP has economic value to them while payors view VBP as a mechanism to improve their

financial performance. Until the expectations of payors and providers are more closely aligned, VBP in governmental and private payor settings may stagnate.

- Clear and Concise Contracting – Another challenge to the sustainability of effective VBP arrangements is the development of clear and concise contracting between payors and providers. There is no clear consensus on common sense quality measures among the government, private payors and providers, so providers and payors do not always agree on what evidence reflects "quality" health care or improvement. Also, the concept of "risk" varies broadly among healthcare industry participants – meaning anything from the potential to forfeit an upside bonus to the assumption of "global risk" which may impose financial responsibility on providers for a specified set of healthcare services, including those which the at-risk provider does not furnish or arrange. Furthermore, even when the parties do enter into contracts, the compensation formulae may be too general to enforce or too complex to administer. Imprecise contract drafting raised by such challenges creates higher potential for small and large disputes and, thus, strained or even failed payor-provider collaborations. In the long term, failed payor-provider collaborations increase the potential for re-igniting backlash by disgruntled providers and quelling the progress needed for the systemic transition from FFS to VBP.

This author's hope is that VBP arrangements not only survive into the future, but are more widely adopted notwithstanding the challenges identified above and the looming uncertainty of ACA's future and MACRA's implementation under the Trump Administration. However, the key to that survival may be "trust" and commitment to "true partnership" by both payors and providers. No matter how a VBP arrangement is structured, its ultimate success or failure may depend upon whether the provider and payor participants can develop models in which they are treated as equal partners.

Endnotes

1 *In this paper, we will continue to refer to "payors" and, in so doing, mean and include health insurers, health maintenance organizations and other managed care plans which are licensed or otherwise authorized under state law to bear insurance risk for health benefit plans offered to individuals or groups.*

2 *In this paper, we will continue to refer to "providers" and, in so doing, mean and include physicians, physician groups, however organized, other clinicians and providers of healthcare or medical treatments, hospitals, hospital systems and other healthcare facilities which are licensed or otherwise authorized to provide medical treatment to patients.*

3 *Christine Tobin, What is Managed Healthcare?, AADE News (Jan. 1997), https://nfb.org/images/nfb/publications/vodold/mngdcare.htm.*

4 *Institute of Medicine, "Measuring the Quality of Care" (Feb. 1, 1998).*

5 *Id.*

6 *Id.*

7 *Id.*

8 *See, for example, the Integrated Healthcare established an early non-governmental, voluntary program in California. This program began as a pay-for-performance program for physicians and, post-ACA transitioned to a value-based purchasing program. Issue Brief, Value Based Pay for Performance in California, Integrated Healthcare Association (No. 8, Sept. 2013), http://www.iha.org/sites/default/files/resources/issue-brief-value-based-p4p-2013.pdf; and Fact Sheet, Value Based Pay for Performance in California, Integrated Healthcare Association (Sept. 2016), http://www.iha.org/sites/default/files/resources/vbp4p-fact-sheet-final-2016.pdf.*

9 *Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. No. 114-10, 129 Stat. 87) (2015).*

10 *For instance, in California, indemnity insurers may offer a preferred provider organization (PPO) product and pay providers alternative rates of payment, but placing providers at-risk using capitation or other means is not authorized. See, Cal. Ins. Code § 10133.*

11 *See, https://www.landmarkhealth.org/#home and http://www.prnewswire.com/news-releases/landmark-health-announces-the-enrollment-of-its-5000th-patient-300245552.html*

12 *See, Press Release, Humana Takes a Bold Step Forward in Population Health with the Formation of Transcend and Transcend Insights (Mar. 24, 2015), http://press.humana.com/press-release/current-releases/humana-takes-bold-step-forward-population-health-formation-transcend-; and see, Humana's Transcend Insights Launches Suite of Digital Population Health Management Tools, Mobile Health News (Feb. 24, 2016), http://www.mobihealthnews.com/content/humanas-transcend-insights-launches-suite-digital-population-health-management-tools.*

13 *See, Christopher Weaver, UnitedHealth Buys Another Calif. Doctor Group, NPR (Sep. 1, 2011), http://www.npr.org/sections/health-shots/2011/09/01/140110107/unitedhealth-buys-another-calif-doctor-group.*

14 *See, Dan Mangan, Tandigm Health: An insurer's bet on primary care to trim health costs, CNBC (Apr. 9, 2014), http://www.cnbc. com/2014/04/09/blue-cross-davita venture-signals-shift-in-trimming-health-costs.html.*

15 *See, Press Release, Aetna, Aetna and Inova Health System Establish New Health Plan Partnership in Northern Virginia (June 22, 2012), https://news.aetna.com/news-releases/aetna-and-inova-health-system-establish-new-health-plan-partnership-in-northern-virginia/; and see Press Release, Aetna and Texas Health Resources Establish New Partnership in North Texas (May 26, 1961), https://news.aetna.com/news-releases/aetna-and-texas-health-resources-establish-new-partnership-in-north-texas/.*

16 *See, Press Release, Aetna and Banner Health form partnership to improve care, reduce costs (Oct. 31, 2016), https://news.aetna.com/2016/10/aetna-and-banner-health-form-partnership-to-improve-care-reduce-costs/.*

17 *See, Brett Brune, How Anthem's Vivity venture is faring in Southern Calif. showdown with Kaiser, Modern Healthcare (Oct. 23, 2015), http://www.modernhealthcare.com/article/20151023/NEWS/151029953.*

18 *See, Sam Kennedy, Geisinger and St. Luke's Partner on Insurance, Morning Call (Aug. 31, 2016), http://www.mcall.com/news/local/mc-st-lukes-geisinger-20160831-story.html*

19 *See, for instance:*

a. *Certain insurance laws may only permit an HMO to pay a provider capitation in exchange for health care services furnished by the provider's participating practitioners, and not for any referral services. Slightly less restrictive insurance laws may permit HMOs to pay capitation to providers to cover services that the provider is licensed to provide in that state plus ancillary services -- though ancillary services are not defined. See, e.g., Tex. Ins. Code s. 843.318(b).*

b. *Insurance laws also may authorize certain qualifying organizations, but which are not licensed as HMOs or insurers, to accept global capitation payments or full or substantial downside financial risk for a specified set of health care services covered by a payor's health plan. Such intermediaries are authorized (subject to state specific restrictions and compliance obligations) in Arizona (i.e., a Third Party Intermediary, see, ARS, 20-120), New Jersey (i.e., an Organized Delivery System, see, N.J.S.A. 17:48H-1 et seq.) and Pennsylvania." (i.e., an Integrated Delivery System, see, 28 Pa Code §9.602), among certain other states, to accept full downside financial risk from an economic perspective.*

c. Insurance laws also may authorize provider organizations or groups of providers that satisfy certain qualifications to assume greater financial risk as: Delegated Entities or Delegated Networks in Texas (see, Tex. Ins. s. 1272.001 and Tex. Ins. s. 1272.003, respectively); Delivery System Intermediaries in Nevada (see, NAC695C.025); or Risk-bearing Provider Organizations in Massachusetts (see, Mass. Gen. Laws Chapter 176T).

20 *For instance, under the Texas Health Maintenance Organization Act, "capitation" is defined as "a method of compensating a physician or provider for arranging for or providing a defined set of covered health care services to certain enrollees for a specified period that is based on a predetermined payment per enrollee for the specified period, without regard to the quantity of services actually provided." Tex. Ins. s 843.002. And, only Texas HMOs are specifically authorized to make capitation payments. Likewise, in California, indemnity insurers, even those offering PPO products, are not permitted to pay capitation payments to providers. See, Cal. Ins. Code § 10133.*

21 *See Optum, Navigating the journey from providing care to managing health (White Paper, 2015), https://optum.uberflip.com/i/589935-navigat¬ing-the-journey-from-providing-care-to-managing-health.*

22 *Deloitte 2016 Survey of US Health Care Executives, https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-taking-a-pulse-on-MACRA.pdf.*

23 *Id.*

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