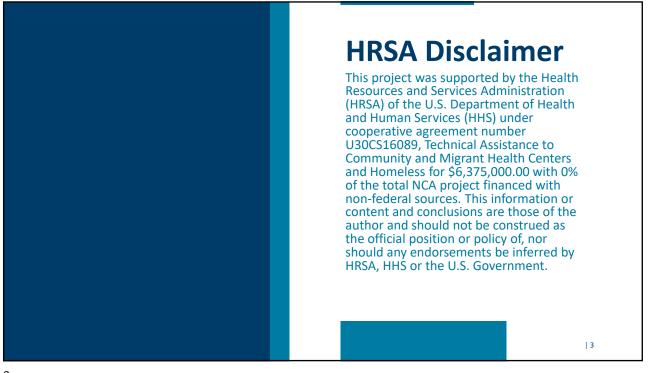
# Accountable Care Academy 2020

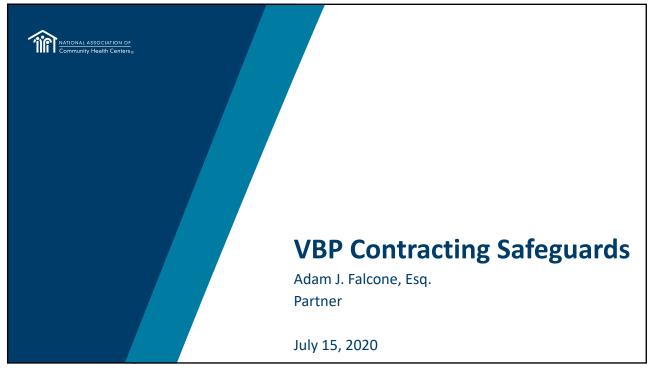
As health centers continue to transition to value-based care and population health, more and more payer contracts include some form of risk (or financial burden for the services provided versus the amount of reimbursement expected in return). NACHC's Accountable Care Academy is a 4 part webinar series focused on the fundamental considerations for risk-based contracts and how to prepare health centers for participation in arrangements with risk. Each session will be led by Adam Falcone, Esq., of Feldesman, Tucker, Leifer, Fidell. Tools will accompany the webinars, including a glossary, checklists, and links to supplementary relevant resources, to reinforce key concepts.

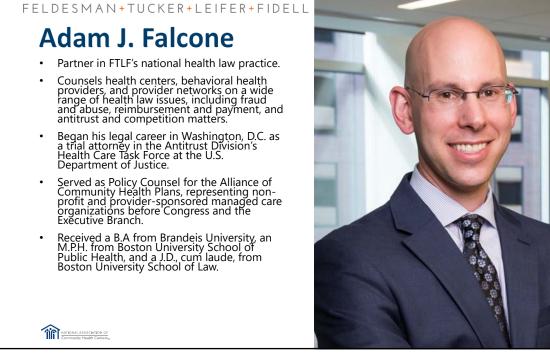
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## AGENDA

### **Value-Based Contracting Safeguards**

Care Management Programs

Pay-For-Performance Programs

Minimizing Down-side Risk Exposures

Attribution Methodologies

Benchmark Calculation for Shared Savings/Shared Risk

Capitation Methodologies

•Term and Termination Rights

•Amendment and Amendment Rights

HIPAA / Part 2 Confidentiality Considerations

Community Health Centers,

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# CARE MANAGEMENT PROGRAMS

### "Primary care medical home" (PCMH) model:

•Each patient has a relationship with a PCP who serves as patient's first contact

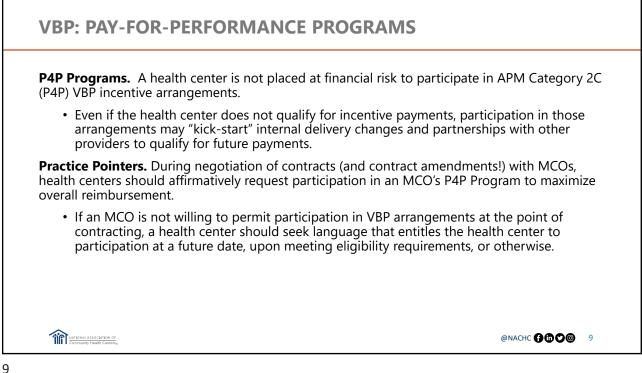
•PCMH programs encourage PCPs to provide care management and other enabling services

•Recent years have also seen rise in "disease management" programs in which PCP is required to implement plan of care addressing chronic condition

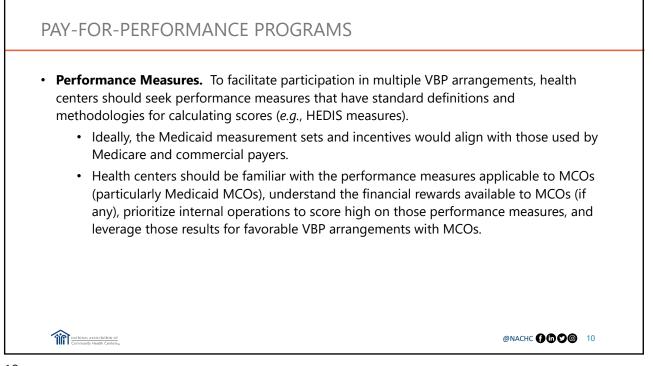
•Some payors will offer a modest per-member-per-month fee for care management services when the health center is otherwise paid on fee-for-service basis

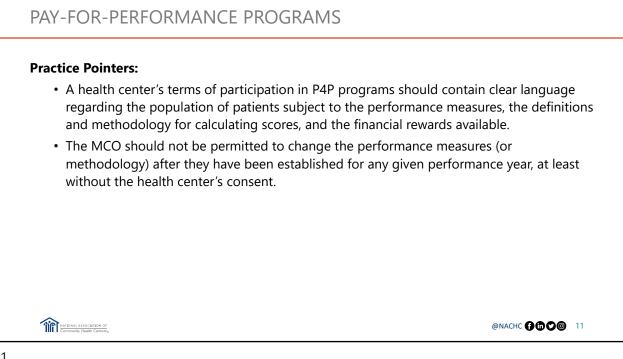
•Payors will usually define the activities that the health center is expected to do as care management in earning the fees.

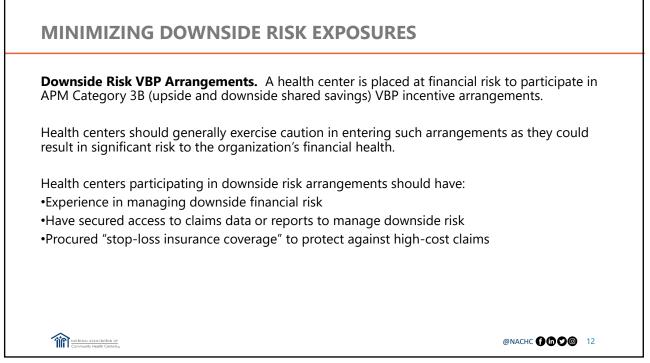
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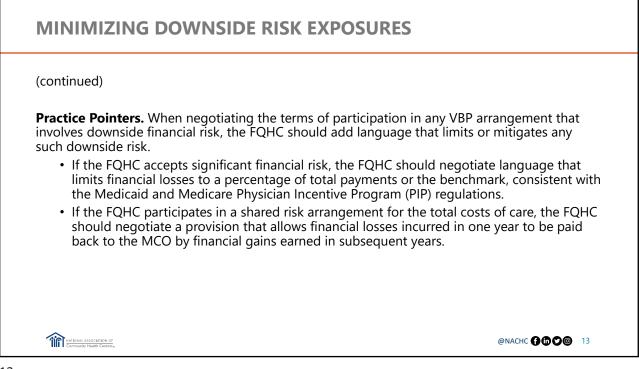


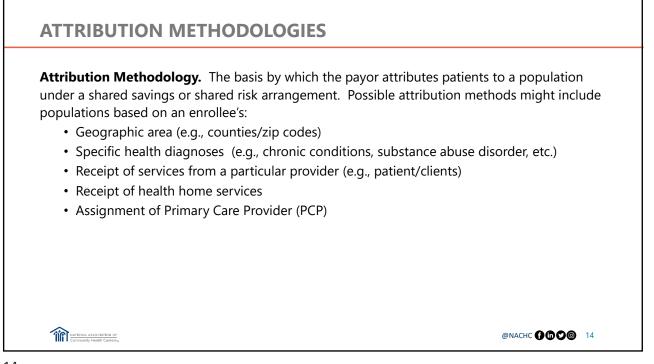


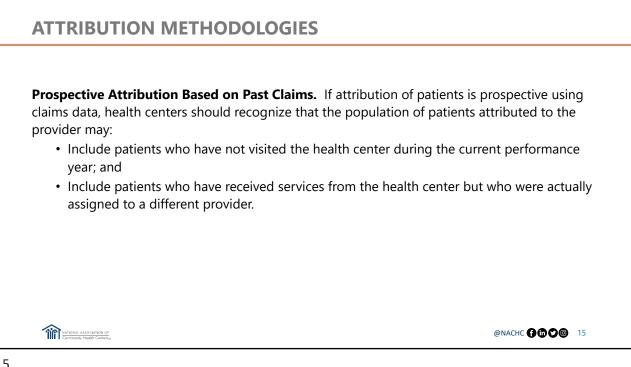












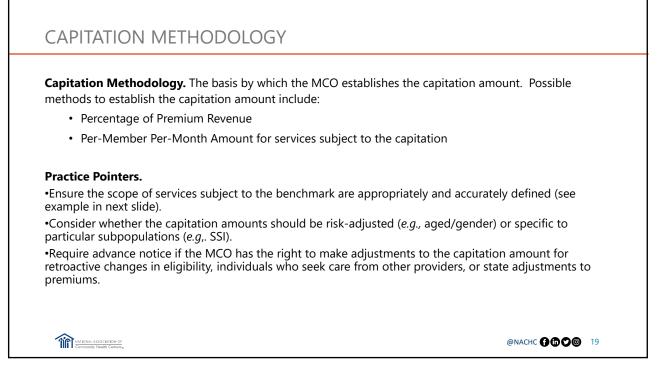
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ATTRIBUTION METHODOLOGIES	
(continued)	
•	attributed patient population, a health center should: patients based on prior year's data so that the health d have been attributed to the health center under a
•Negotiate a provision that requires the MCO to pro- 90 days prior to the start of the performance period •Negotiate a provision that requires the MCO to pro-	vide monthly or quarterly patient rosters of attributed
patients for the current performance year as well as the health center against the health center's own rec	the right to confirm or reject individuals attributed to
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arrang	mark Methodology. The basis by which the payor establishes the benchmark under a VBP ement. Possible methods to establish the benchmark include:
-	Percentage of Premium Revenue
•	Medical Loss Ratio (MLR)
•	Per-Member Per-Month Claims Experience (projected forward)
Practio	e Pointers:
saving	stand how the benchmark is set. If the benchmark is set too low, it will be impossible to generate s under a shared savings arrangement (or you will more quickly incur downside losses under shared angement). <u>Generally, you'll want the benchmark set as high as possible!</u>
•Review which MCO expenditures count (such as incurred claims) against the benchmark. <u>Generally, you'll</u> want the "allowed spend" to be as low as possible to qualify for savings and avoid downside losses!	

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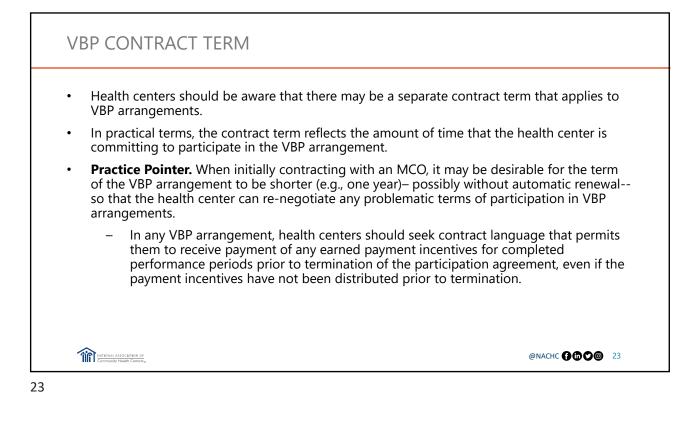
BENCHMARK METHODOLOGIES	
(Continued)	
<ul> <li>Practice Pointers. To appropriately establish the benchmark, a health center should:</li> <li>Request that the MCO apply the methodology to attributed patients based on prior data so that the health center understands how claims experience compares against the proposed benchmark.</li> <li>Negotiate a provision that requires the MCO to provide monthly or quarterly report the performance year on how expenditures for the attributed population compares ag benchmark.</li> </ul>	ne ts during
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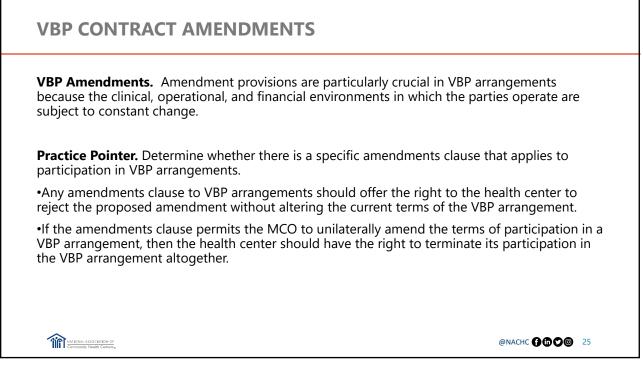
e contract define the scope	of services? A recent contract defined primary care services to include the follo DESCRIPTION	OWING: CPT CODE	
Office visits	New and established patients	99201-99205; 99211-99215	
Hospital Inpatient	Observation, initial hospital care, subsequent hospital care/discharge	99217-99220; 99221-99223; 99231-99233;	
Consultation	Outpatient and inpatient	99241-99245; 99251-99255; 99261-99263;	
Emergency Department	Between hours of 5pm and 8am	99281-99285	
Critical Care / Neonatal Intensive Care		99291-99292; 99295-99297	
Intermediate Care Facility / Skilled Nursing Facility		99321-99333; 99341-99350	
Preventive Medical Services	New Patients - Initial history and examination; Established Patients - Interval History and Examination	99391-99397	
Newborn Care		99431-99440	
Administrative Services	Arterial Puncture, withdrawal of blood; initial (new patient) visit for surgical procedure; services after office hours; services between 10pm and Barr, Hem – Phiebotomy; Therapeutic; prolonger services; case management services; case plan oversight services	36600; 99025; 99050; 99052; 99195-99199; 99354- 99359; 99361-99373; 99374-99380	
Injections	IV Fluids; Allergy	90780; 95115-95170;	
Special Services	Burn treatment, anoscopy, catheterization, urethra; inrigation, endocenvical polyp removal; removal of foreign body (eye); EKG and interpretation; pulmonary function; urinalysis; pregnancy test; occult blood; hematocrit; hemoglobin; strep screen; cocci skin test; TB skin test	16000; 46600; 53670-53675; 57150; 57500; 65205; 93000-93014; 93040-93042; 94010-94060; 94640; 94760-94762; 81000-81002; 81025; 82270; 82947- 82448; 83002; 85013-85014, 85018; 85651-85652; 86403; 86490; 86580-86585;	
Miscellaneous	Treadmill; Holter monitoring; ambulatory BP monitoring (including interpretation)	93015-93018; 93224-93237; 93784	
Minor surgical and other miscellaneous procedures	Surgical procedures; debridement; biopsy; excision; evacuation; repair; cryotherapy; arthrocentesis; minor casting; sigmoidoscopy; circumcision; vasectomy; proctosigmoidoscopy; IUD removal	Various	
Auditory System	Removal of foreign body; removal of cerumen impaction	69200-69210; 92551; 92552; 92567	
Radiology		70010-79999	
Immunizations			

ACCESS TO DATA AND REPORTS
<ul> <li>Health centers need timely, accurate and usable data to be successful in VBP arrangements.</li> <li>Timely receipt of patient health information related to emergency room visits, hospitalizations, and physical health care is essential for performing well on P4P incentives and managing the total costs of care of the attributed population.</li> </ul>
<ul> <li>Practice Pointers. A health center's terms of participation in VBP arrangements should contain language that requires the MCO to furnish to the health center the necessary claims information related to a patient's use of services (or provide access to integrated databases), patient risk scores, and prior authorization requests on a real-time basis.</li> <li>Ideally, the contract would specify the type of data that the health center is entitled to receive and the frequency in which the MCO must provide the data to the health center.</li> </ul>
<ul> <li>If the MCO fails to meet its data sharing obligations, the health center should be held harmless from any loss of revenue arising from unearned payment withholds or downside financial risk.</li> </ul>

<b>EXAMPLE: SAMPLE REPORTS</b>			
REPORT NAME	DATA	FREQUENCY	
Attribution	Attributed Medicaid Members with demographic and contact Information	Monthly	
Emergency Department Utilization Overview	Overview of emergent and non-emergent utilization that will include a Summary Report and Member Level Detail Report for members with 3+ non-emergent ED visits.	Monthly	
Inpatient Utilization Overview	Overview of inpatient utilization that will include a Summary Report and Member Detail Report for members with the greatest number of inpatient admissions, and a Readmission Report.	Monthly	
Quality Threshold Targets	A report that tracks the quality threshold targets.	Monthly	
Performance Measures	A report that tracks performance measures; includes current rate (numerator and denominator) as compared to benchmark and previous time period.	Quarterly	
Budget Tracking Report (Financial Reporting)	Shows at service category level, budget, actual performance and variance to the budget.	Quarterly - by the 15th of the second month following the end of the quarter	
Claims Data	Member-level claims data	Monthly	
IBNR	IBNR for Attributed Members	Monthly	
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to	ermination Rights. If participation in a VBP arrangement involves financial risk, the health center may wish include contract language that permits the health center to terminate its participation in the VBP rangement if the health center is incurring (or is likely to incur) financial penalties under the arrangement.
C	ontracts can typically be terminated "for cause" or "without cause".
	• For cause. The situations that constitute cause will be listed in the contract, e.g., breaches of material terms of the contract.
	<ul> <li>Practice Pointer: The health center may want to add other circumstances that would permit participation in the VBP arrangement to be terminated for cause, e.g., the MCO modifies the performance measures or methodologies or does not provide agreed upon data or reports.</li> </ul>
	• Without cause. In some contracts, a party may also terminate without cause after providing written notice to the other party.
	<ul> <li>Practice Pointer: Contracts that contain termination without cause provisions mean that, from a practical perspective, the term of the contract is the notice period. This may be a desirable mechanism to exit the VBP arrangement if necessary.</li> </ul>



<ul> <li>A Covered Entity may disclose protected I health care provider (including providers)</li> </ul>	nealth information ("PHI") for the treatment activities of any not covered by the Privacy Rule).
<ul> <li>Covered Entities include health care p as well as health plans (e.g., health ins</li> </ul>	roviders who transmit health information in an electronic form urers, state Medicaid programs)
services among health care providers	ision, coordination, or management of health care and related or by a health care provider with a third party, consultation ing a patient, or the referral of a patient from one health care
<ul> <li><u>Note</u>: Disclosures for treatment purport Standard" and can result in disclosure</li> </ul>	ses do not need to abide by the "Minimum Necessary s of all the patient's PHI.
	e and use of substance use disorder records which are nance of a federally-assisted Part 2 program.
• Unlike HIPAA, patient consent is requi	red even for disclosures for the purposes of treatment.

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