Consolidation and Provider Network Management

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To swim with the fishes, that is the question . . .
Physician Practice Consolidation

• Commonly cited reasons for consolidating medical practices include:
  – To leverage value in the marketplace.
  – Improve quality of care (through peer review and other methods of knowledge sharing)
  – Be able to more easily (both legally and financially) engage in the provision of ancillary care, resulting in better quality and new revenues.
  – Be better able to afford:
    • More sophisticated practice management; and
    • More effective marketing
Consolidation Drivers

• Market reform will outpace legislative reform
• Reimbursement will be increasingly tied to quality and outcomes
• Cost reduction pressures will increase
• Shift from inpatient to outpatient
• Restrictions on physician self-referral will continue
• Data will be king
• Reductions in Medicare/Medicaid reimbursement to hospitals and physicians
• Shortage of physicians as boomers age
• Hospitals will still need doctors and doctors will still need hospitals
Legal Barriers to Consolidation

• Laws aimed at preventing collaboration:
  – Anti-Kickback Statute
  – Stark Law
  – Civil Monetary Penalties
  – Antitrust Law
  – Tax Exempt Status
Applicable Fraud and Abuse Laws

• **The Stark Law**
  – Prohibits providers from referring Medicare patients for DHS to an entity with which the physician has a financial relationship, unless an exception applies

• **The Anti-Kickback Statute**
  – Providers may not knowingly receive remuneration to induce or influence the furnishing of services for which payment is made under a federal health care program

• **Gainsharing CMP**
  – A hospital may not knowingly make a payment to a physician as an inducement to limit services provider to a Medicare beneficiary

• **Beneficiary Inducement CMP**
  – Remuneration may not be provided to a Medicare beneficiary where the remuneration is likely to influence the beneficiary re a particular provider
Antitrust Law

• Federal and State antitrust laws preclude consolidation of competitors for the purpose of gaining “leverage,” or power, over payers. In order to enjoy many of these benefits, federal and state antitrust laws will require sufficient “integration” of the entire group to cause the new practice to be considered a single business entity.

• So long as no monopoly power arises, competitors may consolidate operations with a view to improve quality, create better systems, or even make more money by economies of scale.
  
  – *Per Se* Violation vs. “Rule of Reason.”
  
  – Do the procompetitive effects of the consolidation outweigh anticompetitive effects → Balancing Act.
Continuum of Structural Integration Forms

Clinically Integrated Network:
The parties create a clinically integrated network (potentially also with some level of financial integration).

Joint Operating Company:
The parties retain ownership of their hospitals and other facilities but create a joint operating company to manage them.

Whole Hospital or System Joint Venture:
The parties contribute the assets of one or more of their hospitals into a joint venture.

Antitrust Single-Entity:

Management Agreement:
The parties enter into a contractual relationship for one to manage the other’s services.

Service Line Joint Ventures/Mergers:
The parties contribute the assets of discrete service lines into a joint venture.

Merge or Consolidation:
A full merger of the assets and liabilities of the two systems into a single entity.
Consolidation Models and Trends

- Consolidation of medical practices / IPOs
- Clinically integrated networks
- Physician Practice Acquisitions
- AMCs and Clinical Integration
- Virtual Mergers and the JOA Model
- Hospital - Physician co-management
- Hospital - Physician joint ventures
- Recovery care
- Integrating behavioral health & primary care
Please visit the Hall Render Blog at http://blogs.hallrender.com for more information on topics related to health care law.

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Clinical Integration:
MIPS, ACOs and Population Health
Sue Deitz, MPH
About Caravan Health

Helping Providers Navigate the Challenges of Value-Based Payments

- Founded in 2013
- 40 Accountable Care Organizations
- >14,000 Providers
- >1,000,000 Patient Lives
- 2015 Results (cms.data.gov)
  - 97% Quality Scores
  - 257% National Average of Shared Savings
Physician Fee Schedule Increases Will Not Keep Pace With Inflation

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<td>Schedul e Updates</td>
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<td>0.25 N-QAPMCF*</td>
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**Estimated 10 Year Inflation Adjusted Payments Per $100,000 Part B**

Source: CMS
ACOs Enable and Fully Qualify Clinically Integrated Networks

- Physician Leadership
- Performance Improvement
- Information Technology
- Payor Contracting
- Legal Entity and Waivers
- Flow of Funds
- Participation Criteria

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MIPS places the final score of each clinician on a curve, and adjusts Part B payments based on their precise location as compared to others.

- Dollars shift from the bottom 50% to the top 50%
- The top performers get another $500 million for five years
- In 2018, 30%- 40% of QPP participants will be in Track 1 ACOs who earn higher MIPS scores due to special scoring
MIPS Scoring

MIPS Payment Adjustment
- 2019 +/- 4%
- 2020 +/- 5%
- 2021 +/- 7%
- 2022 +/- 9%

Advancing Care Information (Replaces Meaningful Use)

Quality (Replaces PQRS)

Improvement Activities (New)

Cost (Replaces Value Modifier in 2018)
MIPS-APM Participants Score Higher

MIPS
- MACRA LAW: Cost must be 30% of MIPS score by 2019 – average cost will mean maximum score is 85 points

MIPS-APM
One MIPS score for all providers
- Exempt from Cost
- Automatic 100% for CPIA
- Weighted Average ACI score – Stage 2 MU > 85 points
- ACO Quality Scores Average 91%
ACO Participation Improves MIPS Score

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<thead>
<tr>
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<th>Practice Score – No ACO</th>
<th>2019 MIPS Weight</th>
<th>2019 MIPS Score</th>
<th>Same Practice but in ACO</th>
<th>2019 MIPS–APM Weight</th>
<th>2019 MIPS–APM Score</th>
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<tbody>
<tr>
<td>Quality</td>
<td>85%</td>
<td>30%</td>
<td>25.5</td>
<td>91%</td>
<td>50%</td>
<td>45.5</td>
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<tr>
<td>Improvement Activities</td>
<td>100%</td>
<td>15%</td>
<td>15</td>
<td>100%</td>
<td>20%</td>
<td>20</td>
</tr>
<tr>
<td>COST</td>
<td>50%</td>
<td>30%</td>
<td>15</td>
<td>50%</td>
<td>0%</td>
<td>0</td>
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<tr>
<td>Advancing Care Info.</td>
<td>90%</td>
<td>25%</td>
<td>22.5</td>
<td>90%</td>
<td>30%</td>
<td>30</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
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<td><strong>78</strong></td>
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<td><strong>95.5</strong></td>
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The very best, top-performing practices will get average MIPS scores and little or no upward adjustment if they are not in an ACO.

- ACO quality scores are better due to having claims data to find missing results, six weeks to polish data and only reporting on a sample of attributed patients. National average ACO quality score is 91% vs National average PQRS is 85%.
- In 2019, cost will weigh 30%. ACO participants have an average 15 point advantage.
- On Physician Compare (yelp, Angie’s List) the ACO is the difference between an “A” and a “C”.
Benefits of Track 1 MIPS-APM

**Clinical and Community**

- Provide coordinated, proactive care for our community
- Engage patients with important wellness visits and preventative care services like mammograms and colonoscopies
- Receive claims data from CMS and use it to predict and prevent disease progression
- Strengthen local providers’ reputation and income
- Sustain a strong local health care system, preventing out-migration

**Financial Performance**

- Sustain existing fee-for-service reimbursement and avoid unnecessary downside risk
- Grow wellness revenues by $500 to $1,000 annually per Medicare patient
- Maximize MACRA bonuses and quality scores with the least amount of effort
- Protect our employed and community physicians from MACRA penalties
- Earn additional financial incentives for improving quality and lowering costs
- Receive infrastructure and support to succeed under value-based reimbursement models
Increased net revenue between $1.5M and up to $29M per hospital.

Within one year of ACO participation, hospitals increased their overall quality score by 15%.

Top 20% of all providers in the country under MIPS and are expected to get an upward adjustment of Part B payments in 2019.

Earned 2.57x Shared Savings above national average.
In Summary

**Value-based Payment is Here to Stay**
In 2018, more than half of all providers will participate in these programs.

**Now is the Time to Take Action**
Today, providers can earn value-based incentives while receiving fee-for-service payment without downside risk. Resources and support are available to lessen your upfront and ongoing costs.

**Avoid Penalties**
Hospital-based physicians are not excluded from MACRA and most are expected to penalized if not part of either a large organization or an ACO.

**Strengthen Provider Reputation**
Quality data will be displayed on Physician Compare in 2018.

**Maximize Value-based Reimbursement**
Get >10% upward adjustment of Part B payments. As a Track 1 ACO, earn Exceptional Performance bonuses through MIPS-APM special scoring that boosts score by at least 15 points.
Value Based Collaboration

“Making healthcare work better”
Our goal: develop and implement value based agreements that improve the customer experience, focus on clinical outcomes, and reduce total cost of care. With the ultimate objective of rolling out a market-wide and scalable contracting approach that foster collaboration, coordination, and communication with essential stakeholders.
Premera Blue Cross

- Mountlake Terrace and Spokane, Washington
- 2.1 million members in Washington and Alaska
  - Fully Insured
  - Self Funded
  - Medicare Advantage
- Value Based Agreements that align interests of customers, providers, & payer
- Common thread in all agreements
  - Supporting delivery system transformation
  - Controlling the total cost of care
  - Reimbursing for quality care and managing health
  - Using data and analytics transparently and collaboratively
Transformation from volume to value is underway

- 60% claims in 2Q17 run through value-based contracts, to be 90% by 1Q21
- 77 value-based contracts executed
- 1,300+ providers contracted and engaged
- 600K+ customers impacted
  - Hospital quality program – 24 facilities putting a portion of fees at risk
  - Global Outcomes Contracts – 20+ groups touching 300K+ lives
  - ACO (“PersonalCare Plans”) – 6 partner organizations with 14,000 lives
  - Specialty care – immediate focus on oncology, knee/hip, cardiology & maternity
  - PCP – proof of concept pilot expanding
  - Urgent Care Centers – 33 sites with bundled case rates
“Don’t out think the drill.”
Our objectives are their objectives

Addressing the customer problems with solutions

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
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<tbody>
<tr>
<td>I don’t get what I need</td>
<td>• Incorporate quality metrics and targets</td>
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<tr>
<td></td>
<td>• Preventative screening</td>
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<td></td>
<td>• Monitoring of disease to optimize function</td>
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<tr>
<td></td>
<td>• Focus on behavioral health integration</td>
</tr>
<tr>
<td>I get what I don’t need</td>
<td>• Payment models incorporate and reward efficiency and efficacy</td>
</tr>
<tr>
<td></td>
<td>• Integrate shared decision making tools</td>
</tr>
<tr>
<td>I don’t have the experience I deserve</td>
<td>• Guarantee of a good member and family experience</td>
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</tbody>
</table>
“The old saying, ‘It’s not personal; it’s only business’ is nonsense. Good business IS personal.”

- Family member of a cancer patient
10 Lessons Learned

- We know a lot but we don’t know it all
- Find common objectives
- Drop your positions
- Collaborate – Coordinate - Communicate - Continuum of Care
- It’s not a patient medical home; it’s a village
- Care coordination
- It’s about information and transparency and trust
- Zig and Zag
- Take the long view and invest
- Be nice
- It’s about the patient