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Payment Considerations of Payor-Provider Convergence

Best practices in negotiating convergence arrangements

By John Barnes

Health care reimbursement is going through a metamorphosis. Payors are entering into arrangements where they look more like providers. Likewise, providers are entering into arrangements where they look more like payors. Consequently, the long-established line between payors and providers is blurring.

Payor-provider convergence takes many forms. Payors are acquiring provider systems and operating them as unitary enterprises. The Highmark acquisition of West Penn Allegheny Health System in Pennsylvania is a recent example of a payor getting into the business of providing health care.

Other payors are purchasing practice management companies or forming narrow or tiered networks with providers and steering a significant portion of business to the preferred providers. Alternatively, providers are becoming more experienced in population health management and are taking on more of the financial risk for patient care.

These arrangements take on many forms, including capitation and shared risk arrangements, as well as more direct assumptions of risk, such as purchasing or sponsoring health plans. Sutter Health's sponsorship of a licensed California health maintenance organization—Sutter Health Plus—is a recent example of a provider getting into the payor business.

There are multiple causes for the convergence of payors and providers. The overarching cause is the industrywide recognition that the provision of health care in the United States is inordinately expensive in relation to its clinical outcomes, and that costs must be reduced significantly to keep the system sustainable. At a more granular level, factors driving convergence include:

- Industry acceptance that the fee-for-service model is a major contributor to ballooning health care costs;
- Massive influx of patients into the managed care environment caused by the implementation of the Patient Protection and Affordable Care Act and the expansion of Medicaid;

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- Medicare's endorsement of integrated payors and providers through the accountable care organization (ACO) and Medicare Shared Savings Program (MSSP) regulations;

- Pressure on payors and providers from large purchasers of health care to slow the growth of health care spending;

- Pressure on providers to reduce costs from patients with consumer-driven, high-deductible health plans; and

- Implementation of penalties for hospital readmissions and hospital-acquired conditions.

While the drive toward convergence is inevitable, the road is littered with failed attempts to integrate payors and providers. Capitation models have a checkered past and only recently have reemerged as providers and payors seek to partner to reduce costs.

Many providers resist being included in tiered provider networks unless they are included in the tier with the highest patient benefit. From the provider's perspective, the narrow network only works if the provider is included in the network, but getting into the network may require sacrifices in reimbursement levels that don't make financial sense even if the steerage to the provider is increased.

Most recently, the Pioneer ACO was intended to be a model of payor-provider convergence. Despite early enthusiasm for the program, only 19 of the original 32 Pioneer ACOs were still operating in late 2014, demonstrating the challenges that accompany rapid innovation. [*See Modern Healthcare*, Sept. 25, 2014, *http://www.modernhealthcare.com/article/20140925/NEWS/309259938.*]

Compared with the traditional fee-for-service model that remains dominant in the health care industry, payor-provider convergence still is in its infancy, and, as a result, there is no such thing as a "template" agreement for such arrangements. At a minimum, the agreement must be specifically tailored to the business needs of the parties and the particular needs of the patient population. That said, there are certain best practices that can be employed to give payors and providers a better chance at a successful transition from the fee-for-service model. This article addresses some of the payment, legal and other practical considerations involved with the convergence of commercial payors and providers.

Background

The traditional fee-for-service model is a binary system. Providers submit claims to payors, and the payors adjudicate and pay the claims according to the parties' agreement. For certain services, primarily inpatient admissions, the payor performs utilization management on a concurrent or retrospective basis, in which the patient's medical condition is evaluated and denials are issued when the plan believes that inpatient services were unnecessary.

Largely absent from the fee-for-service model are any incentives to manage population health. Payors seldom coordinate patient care with providers, and providers do not take on financial risk for any services received by patients (other than the risk that the payor may deny payment for services). Financial incentives are driven by the volume of services, not their quality.

The convergence of payors and providers breaks down the traditional fee-for-service system by requiring providers and payors to share roles that formerly were reserved for one party or the other. Under these arrangements, providers can be the payors for services, payors can be responsible for measuring and tracking population health, and both parties share responsibilities to manage patient care. Three such convergence arrangements include capitation, shared savings and clinically integrated networks.

The Capitation Arrangement

The most common convergence is the capitation arrangement. Under the capitation arrangement, the provider accepts a fixed per member, per month amount in exchange for agreeing to be at financial risk for a specified basket of services. Members select a primary care provider that is responsible for coordinating the patients' care. That provider is responsible to either provide the patients' services or arrange and pay for other providers to provide such services. Payors delegate to the provider the obligation to pay claims for referred services and also typically delegate the care management and credentialing

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Affiliation Agreements: Perks and Pitfalls

Resident count cap-sharing considerations

By Elizabeth N. Swayne

A variety of rules restricts how teaching hospitals may train residents and still receive payment from the Medicare program.

One way Congress and the Centers for Medicare & Medicaid Services (CMS) limit payments is based on a historic resident count cap, above which CMS will not compensate the hospital no matter how large a program grows in resident count or cost for a given year. A seemingly rigid limitation, CMS permits a margin of flexibility through the use of affiliation agreements, permitting teaching hospitals to band together to cross-train residents and pool and redistribute unused cap space to other hospitals if certain requirements are met.

This article discusses the basic requirements of hospital affiliation agreements and the special circumstances that participating hospitals may want to keep in mind if they embark on such an agreement.

GME Background

Medicare reimburses teaching hospitals for the costs of training residents in approved medical residency training programs. Approved programs must either be accredited or count toward certification in a specialty for the resident. [*See* 42 C.F.R. §§ 413.75(b), 412.105(f)(1)(i).]

Payment for graduate medical education (GME) has two components: (1) direct graduate medical education (DGME), which is intended to compensate hospitals for the direct costs of

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graduate medical training, such as, resident stipends and benefits, teaching physician salaries, administrative costs and allocated overhead; and (2) indirect medical education (IME), which is intended to compensate hospitals for indirect costs of graduate medical education, such as, higher patient care costs due to more complex patient population and increased costs of specialized services (such as trauma centers and burn units). [*See generally* 42 U.S.C. § 1395ww(h) and 42 C.F.R. § 413.75 *et. seq.* (DGME); 42 U.S.C § 1395ww(d)(5)(B) and 42 C.F.R. § 412.105 (IME).]

As paid under the inpatient prospective payment system, a hospital's DGME payments depend on the hospital's number of full-time equivalent (FTE) residents, multiplied by the hospital-specific per resident amount (PRA), which is the average per resident costs that were incurred by the hospital during the first year in which the hospital participated in any residency training program, otherwise known as the base year. [42 U.S.C. § 1395ww(h); 42 C.F.R. § 413.76.]

A resident who trains full time for an entire academic year may be counted for up to 1.0 FTE. [*See* 42 C.F.R. § 413.78(b).] By contrast, IME payments are percentage add-ons to a hospital's diagnosis-related group (DRG) payments, varied based on the level of teaching intensity at the hospital, as measured by the hospital's resident-to-bed ratio. [42 C.F.R. § 412.105(e).]

Under the Balanced Budget Act of 1997, with limited exception, the number of medical residents for which a teaching hospital may claim reimbursement is capped at the number of FTE allopathic and osteopathic residents from the hospital's most recent cost reporting period ending on or before Dec. 31, 1996. [Pub. L. No. 105-33, 111 Stat 251 (1997), 42 U.S.C. § 1395ww(h)(4)(F); *see also* 42 C.F.R. § 413.79(c)(2).] Separate FTE caps may exist at a given hospital for DGME and IME purposes because, during the 1996 base period, residents training at nonhospital sites were counted for DGME but not IME. Dental and podiatric residents are not capped.

Hospitals that did not train residents in 1996 can establish a cap by meeting the requirements of new medical residency training programs. [42 C.F.R. § 413.79(e).] If a hospital has not established a cap, or has a cap of zero, then it cannot be reimbursed for training medical residents.

The cap was implemented by Congress in an effort to curb the rising costs of GME programs and can significantly limit both DGME and IME payments. Hospitals may expand their medical residency programs but will not receive payment above the cap, regardless of cost.

In addition to the FTE cap limitation, FTE counts for a given year also are based on the average of the count in the current year and prior two years. [*See* 42 U.S.C. § 1395ww(d)(5)(B).] For the purposes of computing the three-year rolling average, a hospital is limited to its FTE cap for a given year, if its actual FTE count is higher.

Affiliation Agreement Basics

Affiliation agreements, also known as cap-sharing agreements, are contractual ways in which a hospital can train and be paid for residents in excess of its cap. Essentially, affiliation agreements allow two or more hospitals that are part of an affiliated group to cross-train residents, share a total combined FTE cap and contractually reapportion the cap slots among themselves. [*See* 42 C.F.R. § 413.79(f) ("[a] hospital may receive a temporary adjustment to its FTE cap... to reflect residents added or subtracted because the hospital is participating in a Medicare GME affiliated group."); 42 C.F.R. § 412.105(f)(1)(vi).] The aggregate FTE cap does not change; one hospital donates a portion of its FTE cap to the other hospital, whose cap increases for the year(s) in which the affiliation agreement is in effect.

Although affiliation agreements allow hospitals to exchange cap space, they also affect (both positively and negatively) the three-year rolling averages for each participating hospital. That is, even if an affiliation agreement allows for a large swing in cap space, the actual payments will be reined in based on prior year FTE counts. To account for this, participating group members may consider negotiating compensation from the transferring hospital for the additional training costs, at least in the initial years of an affiliation agreement.

To form an affiliated group, the hospitals must be:

1. Located in the same geographic area;

2. Jointly listed as the sponsor, primary clinical site or major participating institution for one or more programs; or

3. Under common ownership. [42 C.F.R. § 413.75(b).]

Each hospital in the affiliated group must maintain a "shared rotational arrangement" with at least one other hospital in the group. [*Id.*; 42 C.F.R. § 413.79(f)(2).] Affiliated groups may be made up of more than two hospitals, in which case a shared rotational arrangement requires that each hospital in the group rotates residents to at least one other hospital within the group and that each group member is connected by a series of such connections. [42 C.F.R. § 413.79(f).]

A single resident rotating to a particular hospital can satisfy the shared rotational arrangement. [*See* 42 C.F.R. § 413.75(b) (requiring that affiliation agreements specify the adjustments to hospitals' FTE counts "resulting from the resident's (or residents') participation in a shared rotational arrangement").] Although there is no minimum number of residents that must participate in an affiliated program, each hospital may only claim the proportionate time spent by the shared resident at its location, and no resident may be counted in the aggregate as more than one FTE. [*Id.*] That is, if a resident spends half of the year at Hospital A and the other half of the year at Hospital B, both hospitals would claim only 0.5 FTEs.

The rules related to the contents of affiliation agreements are strict. Affiliation agreements are contractual documents; they must be written, signed and dated, with a term of at least one year, beginning Jul. 1 (the typical starting date of a residency program). [42 C.F.R. § 413.75(b).]

CMS has stated that "there is nothing to prohibit affiliation agreements from being automatically renewable each year or from being for terms greater than one year in length." [67 *Fed. Reg.* 49982, 50071 (Aug. 1, 2002).] However, if hospitals intend but fail to extend the term beyond one year, each hospital will revert to the pre-affiliation cap, which may be zero. [*See* 42 C.F.R. § 413.79(f).]

The agreement must identify participating hospitals by name and provider number. [*Id.*] The agreement must specify each participating hospital's pre- and post-affiliation DGME and IME FTE caps, as well as each participating hospital's adjusted FTE count resulting from the cross-training. [*Id.*] The agreement must be submitted to CMS and the hospitals' respective Medicare administrative contractors (MACs) no later than Jul. 1 of the start of the training period. [42 C.F.R. § 413.79(f).] If a hospital is involved in multiple affiliation agreements, it should submit copies of its other agreements as well so that CMS and the MAC can ensure that the providers do not exceed the aggregate FTE cap. [63 *Fed. Reg.* 26318, 26340 (May 12, 1992).]

CMS allows hospitals to update an affiliation agreement during the year to redistribute FTE cap slots to reflect actual FTE counts, if different from that projected in the original agreement. [67 *Fed. Reg.* at 50071 ("[W]e expect that the modifications to the affiliation agreements, which should be signed by all participating hospitals and submitted to the fiscal intermediary, will reflect the realities of what actually occurred as far as the number of residents that rotated in and out of each hospital during the program year").] However, failing to meet any of the other above requirements (even if something as simple as failing to date the agreement or attempting to backdate the contract to Jul. 1) may mean that CMS finds the affiliation agreement void and thus reapplies the rigid, original FTE caps.

Rotation Timing Issues

In many instances, a hospital's cost reporting period may not match the academic year required by affiliation agreements (Jul. 1 to Jun. 30). There may, therefore, be questions about when a resident can (or must) rotate to the other hospital, how the exchanged FTEs may be claimed and how the caps are properly distributed.

To illustrate, take the hypothetical example of Hospitals A and B, both with approved teaching programs. For ease of example, the hospitals will have the same cap for GME and IME purposes, although, in reality, that may not always be the case, and the affiliation agreement must specify the cap exchange for both.

In the example, the affiliation agreement requires that 10 Hospital B residents will rotate to Hospital A for some portion of the 2017 academic year, and, in exchange, Hospital A will increase and Hospital B will decrease their

respective FTE caps by five FTEs. (*See* Exhibit 1.) Prior to the agreement, Hospital A had room to spare under its cap (that is, it could train more residents and be compensated accordingly), but Hospital B was training in excess of its cap. The affiliation agreement allows Hospital A to train more residents (while still staying under its cap) and Hospital B to avoid extra training costs in excess of its cap by reducing its FTE county. Notably, the total FTE cap (105 FTEs) does not change under the affiliation agreement.

If both Hospital A and Hospital B have fiscal year ends (FYEs) of Sept. 30, 2016, and are in the first year of the affiliation agreement, there may be concern over whether the agreed-to residents must have rotated during the first three months of the affiliation agreement (*i.e.*, from Jul. 1 to Sept. 30, or the "stub period") in order for the hospitals to claim the benefit of the cap transfers on the FYE Sept. 30, 2016, cost report.

CMS has not directly answered this question, but there is a significant amount of guidance indicating that actual rotation during the stub period is not required as long as some rotation occurs during the period covered by the affiliation agreement (*i.e.*, as long as the residents rotate during the 2017 academic year). The regulations at 42 C.F.R. § 413.79(f)(2) simply require that "each hospital in the Medicare GME affiliated group must have a shared rotational arrangement…with at least one other hospital within the Medicare GME affiliated group."

In preamble language, CMS further defines affiliation agreements and suggests that the rotation does not have to match the cost reporting period, but rather that the rotation match the term of the affiliation agreement. For example, CMS stated that "[t]here must be a rotation of a resident(s) among the hospitals participating in the affiliated group *during the term of the affiliation agreement*, such that more than one of the hospitals counts the proportionate amount of time spent by the resident(s) in their FTE resident counts… This requirement is intended to ensure that the participating hospitals maintain a 'cross-training' relationship during the term of the affiliation agreement." [67 *Fed. Reg.* at 50069 (emphasis added).] More directly, CMS stated that "[i]f residents rotate from one hospital to another *at some point* during the period of years required to complete training in a particular program, those hospitals have a 'shared rotational arrangement.'" [67 *Fed. Reg.* at 50073 (emphasis added).]

Although under 42 C.F.R. § 413.75(b) an affiliation agreement must be at minimum one year, it may be longer. Therefore, in the context of a three-year family practice training program, CMS stated that a shared rotational arrangement might mean that residents:

> spend 3 months in [Program Year 1 (PGY1)] at Hospital A and 9 months at Hospital B, or, the residents may spend their entire PY1 training at Hospital A, and spend their entire PGY2 and PGY3 training at Hospital B. In either case, Hospital A and Hospital B have a shared rotational arrangement because they rotate residents over the course of a common training program. However, if Hospitals A and B train residents at their respective hospitals but do not rotate residents between the 2 hospitals, they do not meet the cross-training requirement. [67 *Fed. Reg.* at 50073.]

Again, this indicates that hospitals have flexibility on when a resident actually rotates. If Hospital B successfully rotates the 10 residents to Hospital A at some point during the 2017 academic year beyond the FYE Sept. 30, 2016, the question then turns to what FTEs the hospitals may claim during the stub period (Jul. 1 to Sept. 30) on their Sept. 30, 2016, cost reports.

Hospital A cannot claim the 10 residents who did not yet rotate. However, the hospitals would get the benefit of the affiliation agreement cap-sharing, to a point. That is, "[i]f a hospital cost

Exhibit 1

	Pre-affiliation FTE Cap	Post-affiliation FTE Cap	Pre-affiliation FTE Count	Post-affiliation FTE Count
Hospital A	80	85	75	85
Hospital B	25	20	40	30

report does not correspond with a Jul. 1 to Jun. 30 residency training year, [CMS] will prorate the changes specified in the [affiliation] agreement to each hospital's FTE cap on the basis of a cost reporting period." [63 *Fed. Reg.* at 26339.]

In the example, because the affiliation agreement was only in effect for three months of the hospitals' FYE Sept. 30, 2016, cost reporting periods (*i.e.*, three of 12 months), the prorated cap sharing would allow for one-fourth of the amount that would be allowed under a 12-month period. Because Hospital B agreed to give Hospital A five FTEs of its cap, Hospital B would reduce its FTE cap for Sept. 30, 2016, by 1.25 FTEs (5 multiplied by 0.25), and Hospital A would increase its FTE cap for Sept. 30, 2016, by 1.25.

If the affiliation agreement lasted for only one year, Hospitals A and B would increase and decrease (respectively) their FTE caps for Sept. 30, 2017, by 3.75 FTEs (5 multiplied by 0.75). If the affiliation agreement extended beyond one year (or if the hospitals agreed to another contractual term), then each would get the benefit of the full five FTE cap swing in future years.

Allocating Training Costs

Carrying forward the example, providers also may question whether Hospital A, which is training 10 Hospital B residents (or their FTE equivalent), must incur any of the direct costs (*e.g.*, resident salaries) in order to claim Hospital B's residents on its cost report. The short answer is no, Hospital A need not incur the costs of training Hospital B's 10 residents, although CMS has not directly resolved this question.

After a hospital's PRA is initially set, a hospital generally is reimbursed for DGME based on its PRA, without respect to any increase (or decrease) in its costs. [*See* 42 C.F.R. §§ 413.76(a) and 413.77.] Regulations are stringent for how resident time is counted for GME purposes, but not necessarily resident cost. [*See, i.e.,* 42 C.F.R. § 413.78(b) ("A hospital cannot claim the time spent by residents training at another hospital.").]

However, the regulation does not say that the hospital must incur the costs of the resident while at the hospital, nor does it say that another hospital cannot incur the costs. Because CMS does discuss cost in other circumstances (*i.e.*, that for a hospital to count resident training at a nonhospital site (freestanding clinic, nursing home or physicians' office), the hospital must pay, for example, salaries and fringe benefits of the resident while training at the site, 42 C.F.R. § 413.78(g)), but does not in the context of affiliation agreements between two hospitals with approved teaching programs, a reasonable conclusion is that costs are inapplicable.

Providers also may be wary of the "community support principle," which requires that "[a] hospital must continuously incur costs of [DGME] of residents training in a particular program at a training site since the date the residents first began training in that program in order for the hospital to count the FTE residents" for GME reimbursement. [42 C.F.R. § 413.81(b).] Community support is defined to mean "funding that is provided by the community and generally includes all non-Medicare sources of funding." [42 C.F.R. § 413.75 (b).]

Furthermore, "[i]f the community has undertaken to bear the costs of medical education through community support, the costs are not considered GME costs to the hospital for purposes of Medicare payment." [42 C.F.R. § 413.81 (a) (1).] In other words, the Medicare program will not reimburse residency programs for which the community has assumed financial responsibility. Thus, to avoid application of the community support principle, a provider must continuously incur some (but not necessarily all) direct costs of the training program, even though hospitals are reimbursed based on the PRA statutory formula.

Although most typically affecting the nonprovider site setting, CMS has stated that the community support principle nonetheless applies to hospitals, although, in rare circumstances: "[W]e believe a redistribution of all of the direct GME costs for training that occurs in a hospital setting would be rare. All of the direct costs of the program—resident salaries, teaching physician salaries, overhead expenses, etc., would need to be redistributed to an outside entity in order for there to be a disallowance of direct GME FTE residents for training inside the hospital due to redistribution of costs or community support." [68 *Fed. Reg.* 45346, 45445 (Aug. 1, 2003).]

Nonetheless, CMS states that "there would be no redistribution of costs or community support if a hospital counts a resident when another hospital incurs the resident's salary, as long as the first hospital still incurs other direct GME costs associated with the training of that resident. In any case... the principles of redistribution of costs and community support are not applicable to costs shifted between the hospitals, only costs shifted between a hospital and other education institutions or other organizations that are not Medicare providers." [*Id.*]

Ultimately, the community support doctrine is unlikely to apply to the example Hospitals A and B, as CMS indicates that it does not consider this to be a situation where the community support principle would prohibit reimbursement for the resident's training because those costs are being incurred by another provider, not the community. Furthermore, even if Hospital A does not pay salary or fringe benefits, it is nonetheless likely incurring other direct costs associated with training the resident (*i.e.*, even just overhead expenses). Thus, Hospitals A and B would be free to negotiate amongst themselves how the rotation of residents would be arranged and paid for.

Conclusion

Affiliation agreements are a great way for hospitals to cross-train by filling unused cap slots and reducing unreimbursed FTEs in a given year. However, providers should proceed with caution to before submitting their contracts to CMS and their MACs.

Although CMS has stated that "affiliation agreements need not be lengthy documents" and that it has received contracts ranging from two to 30 pages [67 *Fed. Reg.* at 50071], providers should ensure that all required elements are met. Should an error occur, a hospital risks reversion to its rigid FTE cap, which could have major financial implications for its program. ■

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functions that would otherwise have been performed by the payor.

Capitation arrangements are a critical demonstration of payor–provider convergence because they inherently involve the provider accepting financial risk for services and agreeing to adjudicate and pay claims for services, both of which traditionally are performed by the payor.

Shared Savings

Shared-savings arrangements are a form of convergence because they involve payors and providers agreeing to partner to coordinate patient care and share in the savings derived from that coordination. Shared-savings arrangements take many forms, but the common thread is a predetermined "target" that forms the basis for determining whether the provider will receive additional payment or, in some arrangements, a reduction in payment. The target can be a fixed monetary amount or the costs associated with a control group.

In an "upside-only" shared-savings arrangement, the provider receives a portion of the difference between the target and the actual health care spends when the spend is less than the target but incurs no reduction in payment, when the spend exceeds the target. In an "upside–downside" shared-savings arrangement, the provider has the potential to both increase revenue as well as reduce revenue in the event that the health care spend exceeds the target. Usually, the upside potential for an upside–downside arrangement is higher than an upside-only arrangement, reflecting the provider's acceptance of a higher level of risk.

While primarily used in a fee-for-service environment, shared-savings arrangements can be adjuncts to a capitation arrangement. Providers and payors will agree that certain services as designated are not solely the provider's or the payor's financial risk but instead are "shared risk." As in the fee-for-service environment, the capitated provider can have upside-only risk or agree to have upside–downside risk.

Shared-savings arrangements have appeal to providers because they are a step back from the fully capitated environment and its inherent risks, while providing some measure of incentive to the provider to be more efficient in the provision of care. Because the payor and provider share in any savings, these arrangements usually include programs under which the payor and provider cooperate to coordinate patient care.

Clinically Integrated Networks

Clinically integrated networks (CINs) are combinations of providers that share information and coordinate patient care along the continuum of services—from hospitals and professional providers to skilled nursing facilities and home health agencies. While corporate practice of medicine restrictions can be a hurdle to payor participation in such arrangements in some states, it is becoming more common for payors to sponsor and/or participate in the operation of CINs.

A CIN arrangement with active payor participation is particularly attractive to providers that have limited experience with care management and want to leverage the payor's experience with these activities. CINs may have capitation arrangements, shared-savings arrangements or some combination of both.

Best Practices in Negotiating Convergence Arrangements

Best practices in negotiating convergence arrangements incorporate multiple factors. Those factors include the issues of provider solvency, claims appeal management and quality metrics, among others, as outlined below.

Provider Solvency

Entities accepting financial risk must be sufficiently capitalized to accept such risk both at the time of initial contracting and throughout the contract period. A major component of any capitation or other risk arrangement is the acceptance by the provider of the financial risk of not only their own services but also the services that the at-risk provider arranges for other providers to provide.

This brings with it the risk that the provider will become financially insolvent and either unable to pay other providers or slow in paying other providers due to cash flow issues. This causes major disruption in patient care because other providers may refuse to accept referrals of patients.

Depending on applicable law, it also may leave the rendering provider without recourse for payment and the payor potentially liable for "negligent delegation" of the obligation to pay for claims to a financially unsound at-risk provider. [But *See, e.g., Desert Healthcare Dist. v. PacifiCare FHP, Inc.* 94 Cal.App.4th 781 (2001) (unpaid physicians unable to seek payment from payor that delegated duty to pay for services to capitated IPA).]

Some states have enacted solvency standards that are used by state insurance commissioners and other enforcement agencies to measure the solvency of capitated providers. [*See, e.g.*, 42 C.F.R. § 422.359 (governing solvency of provider-sponsored Medicare Advantage organizations); 28 Cal.Code of Regs. § 1300.75.1 (California); Texas Insurance Code § 1272.152 (Texas); Florida Ins. Statutes § 641.2261 (Florida).] These standards have a variety of metrics that permit the regulator to assess the current financial condition of the capitated provider and to assess whether the capitated provider is at risk of failure.

Financial solvency regulations typically require quarterly reporting, but some states require less frequent reporting. In some states, the enforcement mechanism of solvency standards empower the insurance commissioner to demand that the capitated provider deposit a surety amount with the regulating agency or, in more serious situations, unwind the risk arrangement. [*See, e.g.*, 28 Cal.Code of Regs. § 1300.75.4.5(a)(7).]

Regardless of whether an arrangement between payors and providers is in a state that imposes financial standards on entities that accept financial risk, it is critical that payors and providers agree to contractual provisions that give one or both parties "early warning" of impending insolvency. State regulations provide a good starting point for the information that the parties should exchange on a routine basis. The information can include:

- Cash on hand;
- Ratio of cash to claims;

- Net equity;
- Incurred but not reported claims; and
- Percentage of claims paid/not paid within regulatory time frames.

Keeping tabs on the at-risk provider's financial solvency is critical in capitated arrangements but also can be valuable in a non-capitated shared-savings arrangement in which the provider accepts downside risk. While a shared-risk arrangement does not carry the risk of dissatisfied downstream providers that is inherent to capitated arrangements (unless the shared-risk provider sub-capitates for referred services), there still are risks associated with the at-risk provider being insufficiently capitalized, such as, the provider withholding medically necessary care or the failure of a key network provider. Some payors seek to receive high-level information about providers in downside shared-savings arrangements in order to ensure that shared-risk providers remain able to provide services to members.

Claims Appeal Management

Another best practice is to establish an appeals management process. When a provider or other entity that is not the payor is responsible for processing and paying claims, it is inevitable that the provider will deny claims and that the patient or provider of the claims will appeal the denial.

The prevailing standard is that the entity that issued the denial will process the first-level appeal. If that entity upholds the denial after the first-level appeal, the agreement should specify which entity is to process the second-level appeal. In some instances, payors want to retain the right to adjudicate all second-level appeals.

Some payors want to retain the ultimate right to approve the provision of patient care or see the second-level appeal as the last opportunity to avoid regulatory scrutiny and/or bad publicity. The second-level appeal also is the payor's last opportunity to manage utilization and control costs, particularly when the service in question is a service for which the payor is at financial risk.

Of course, providers may not want to cede to the payor the ability to overturn denials. This particularly is the case when the service in question is a service for which the provider is financially responsible. To avoid future disputes over who is entitled to process second-level appeals, the parties' arrangement should include a matrix such as that shown in Exhibit 1 that specifies the parties' respective rights with respect to appeals.

Exhibit 1

	Responsible Entity	
Activity	**Provider**	**Payor**
Claim authorization	X	
First-level appeal (provider risk services)	X	
First-level appeal (plan risk services)	X	
Second-level appeal (provider risk services)	X	
Second-level appeal (plan risk services)		X

Downstream Risk Agreements

Providers in all types of convergence arrangements may wish to enter into additional risk arrangements with "downstream" providers, which are typically referred to as "subcapitation" arrangements. These arrangements carry with them many of the same risks that are inherent to the first-level capitation arrangement. But subcapitation arrangements also have the added danger that if the subcapitation arrangement falls apart or the subcapitated entity becomes insolvent, the first-level capitated entity may need to refer patients to out-of-network or other non-contracted providers to fulfill patient care needs. Medical costs to the primary at-risk provider under these circumstances will be substantially greater than under contracted arrangements, and the first-level capitated provider may very quickly find itself in dire financial straits.

To avoid such problems, the arrangement between the payor and first-level capitated provider should specify whether that provider is permitted to enter into risk arrangements with other downstream providers. The parties should consider whether it is in the parties' best interest to limit subcapitation arrangements or, at a minimum, impose some level of financial reporting requirements on the downstream provider.

Provider Departures from Networks

As noted, the departure of providers from a risk arrangement has the potential to disrupt the ability of the at-risk entity to arrange for patient care. While any departure can be disruptive, the loss of certain services, such as imaging or laboratory providers, carries with it the potential for a significant breakdown in the ability of the payor or provider to arrange for necessary patient care and control costs.

Parties can mitigate the damage caused by departures by imposing requirements on the providers to notify the participants whenever a physician or ancillary provider leaves the arrangement or gives notice of the intention to do so. These notice provisions, in turn, can be tied to the material breach provisions of the agreement, giving the parties the ability to declare the arrangement over if the departure of a provider will materially affect the provision of care.

Carve-outs for High-cost Outliers and Other Contingencies

While many markets now have combinations of providers and provider groups that are well-capitalized, on balance, the payor likely is always going to be better capitalized than the provider and better able to predict and shoulder the insurance risk associated with high-cost cases.

Consequently, some arrangements place limits on the downside risk that providers can accept. This can take the form of a dollar threshold limitation or a loss percentage limitation (*i.e.*, losses limited to 50 percent of health care costs in excess of threshold). Stop-loss protection also can protect providers for unexpected, outlier cases, but costs for such protection can be steep.

Another strategy is to carve out high-dollar cases from the calculation of losses so that, high-cost cases do not affect the calculation of the potential savings. Providers, however, should be careful to only carve out high-cost claims from the calculation of the shared savings amount—and not from the calculation of the provider's downside risk—otherwise, the provider may not be able to benefit from the protections of any contractual limitations on the provider's downside risk.

In addition to high-cost cases, there are certain services that providers may want to decline to accept financial risk for altogether when entering into a risk arrangement. For example, it is difficult to predict a population's utilization of certain elective services, such as bariatric or infertility services. Many providers will decline to enter into risk arrangements in which they are financially responsible for such services. Services that are carved out of capitation are the financial responsibility of the payor, and providers rendering such services typically are paid on a fee-for-service basis for those carve-outs.

The Role of Quality Metrics

Most shared-savings arrangements use quality metrics as a "gate" to the provider receiving shared savings. If the provider meets the quality standards established by the contract, the provider will be entitled to a portion of the shared savings.

The purpose of this gatekeeping function is to create strong incentives for the provider to focus on quality. Some shared-savings arrangements also use quality metrics as a "ladder," in which the degree to which the provider performs relative to certain quality measurements determines the amount of shared savings received by the provider. Contracts may have both gates and ladders or one but not the other.

The major challenge in negotiating gate and ladder provisions is agreeing on the metrics that will be used to measure quality. One option is to adopt the quality metrics used by the MSSP. The final rule for the MSSP adopted 33 quality measurements in four domains: (1) patient-caregiver experience; (2) care coordination and safety; (3) preventive health; and (4) at-risk populations.

Using these measurements as gates and ladders in a commercial contract makes sense for some parties because many of the measurements already are in use in other Centers for Medicare & Medicaid Services programs, so providers likely will have systems in place to track their performance against the measurements.

There are, however, no requirements that commercial ACOs or other shared-savings arrangements use any particular quality measurements, so the market has responded with a wide range of quality measurements for non-Medicare businesses. Some parties have decided that the 33 MSSP-measured data points are too unwieldy in

the commercial environment and have adopted different measurements that are simpler, less numerous or more closely aligned with the patient population in question. Others have ignored the MSSP measurements entirely and have adopted their own quality measurements.

The focus on quality has placed an enormous premium on providers establishing and maintaining an information infrastructure that is robust, geared towards measuring quality, and secure. Because the quality metrics likely will be different depending on the payor, it also forces providers to develop information systems that are nimble and can track different quality metrics depending on the patient population being measured.

Providers must be mindful that agreeing to meet certain quality metrics and actually tracking performance towards meeting those goals are two entirely different things, and significant ramp-up time will be needed for a provider to establish an information infrastructure that can effectively track performance. To address this reality, some plans and providers agree to track a smaller subset of quality metrics during the first year of a shared-savings agreement and fold in additional metrics in subsequent contract years.

Data Reconciliation

Whatever carve-outs or quality metrics providers and payors agree to include, the parties need processes to reconcile claims and payment information to ensure adherence to the terms of the arrangement. Claims adjudication and payment systems tend to pace behind the innovation curve, leaving providers in a precarious financial state when problems develop in the revenue cycle. This is particularly problematic during the transition from more traditional payment models to capitation or shared-savings arrangements.

The time to negotiate any back-end process for reconciling such data is not after a dispute has arisen. Instead, parties should attempt to agree in advance on a process for reconciling claims data. The reconciliation process should include the following aspects:

- A date certain for the provider or payor to submit a list of claims that are underpaid or overpaid to the other party;
- Agreed-on data elements for the submission and a process for the parties to confer about additional needed data elements;
- An agreed-on time frame for the receiving party to respond to the submission; and
- A process for resolving disputes.

In Conclusion

Payor-provider convergence arrangements are here to stay, and best practices are just now starting to emerge. To avoid past failures, payors and provider must carefully apportion risk and create mechanisms for early warning that the arrangement might fail. Time will tell whether this emerging paradigm yields the cost savings that are so necessary for the system to survive. ■

About the Author

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