manatt

NEW YORK
ALLIANCE FOR
INCLUSION & INNOVATION
Strength Together

Managed Care Community of Practice

An Introduction to IPAs

December 18, 2018

204 777 448

Agenda

- **Transition timeline**
- **Introduction to IPAs**
- **Limitations of IPAs**
  – Limited functions
  – Corporate governance issues
  – Anti-trust concerns

Specialized I/DD Plans – Provider Led (SIP-PL) Transition

Projected Timeline for Managed Care Transition

Key Events	Anticipated Date
Release of Final OPWDD Managed Care Requirements and Standards and Application	December 2018
Deadline for Plan Submission of Applications to New York State	February 2019
State announces approved SIPs-PL	June 2019
SIPs-PL begin to enroll individuals with I/DD downstate voluntarily	August 2019
SIPs-PL begin to enroll individuals with I/DD in the rest of State voluntarily	2020
Expansion to Mandatory enrollment begins for individuals with I/DD beginning Downstate and moving to rest of State	2021-2022

SIP-PLs

SIP-PLs will provide comprehensive coverage of all Medicaid covered benefits.

Medical services and supports

Long term services and supports

Behavioral health and substance abuse services

Care management services

OPWDD services

Introduction to IPAs

Understanding IPAs

IPA stands for Independent Practice Association

- The purpose of an IPA is to:
  - Assemble a network of separate providers who are independent of each other
  - Act as a group, enter into a master contract with a health plan on behalf of the entire group
  - Collectively negotiate with the health plan regarding key terms and aspects of ongoing operations to serve the health plan's covered members
- IPAs are entities which are sometimes utilized in value-based payment contracts

Understanding IPAs

IPAs are entirely optional.

– Providers do not have to create an IPA in order to contract with a health plan

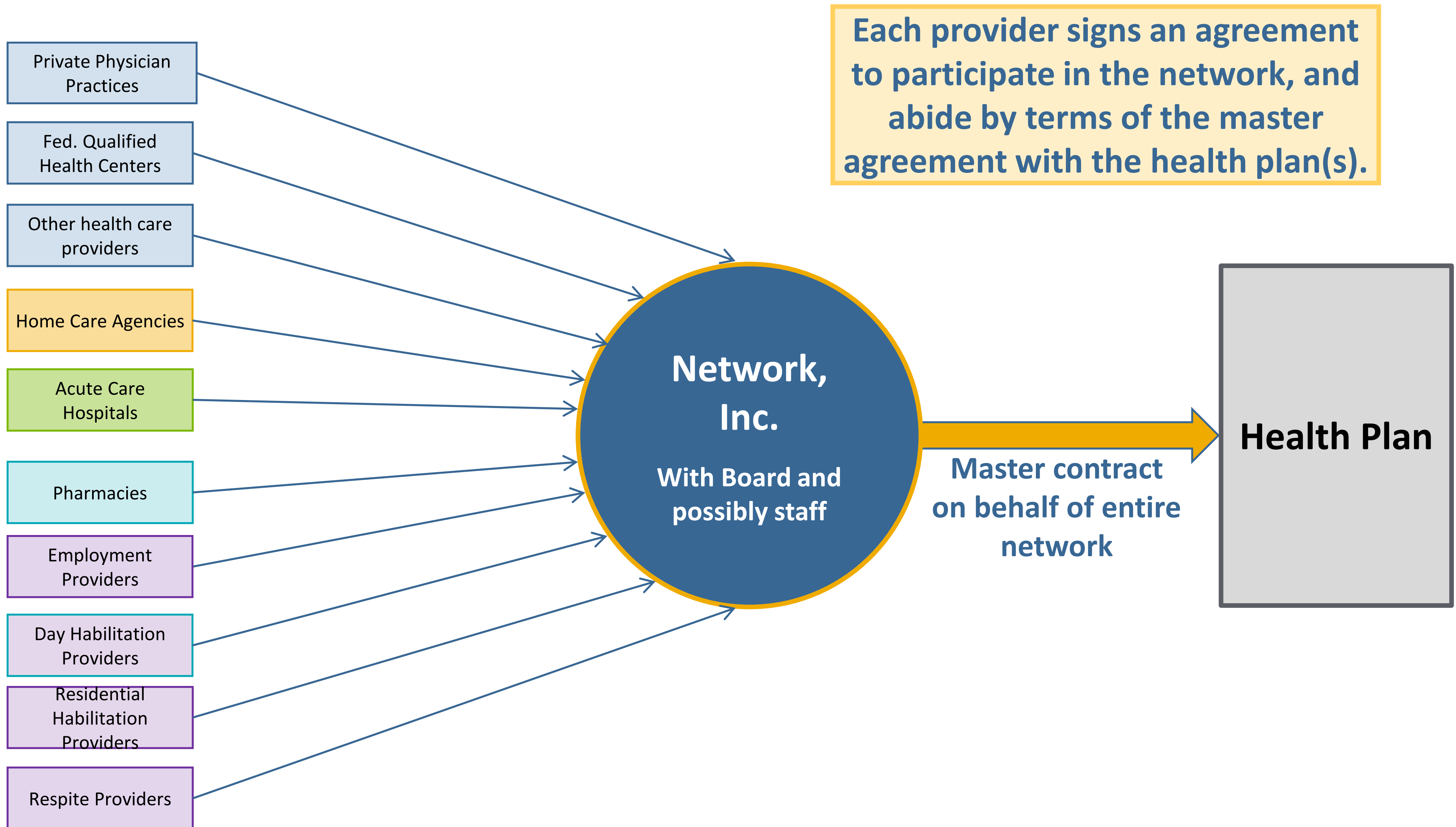
– Health plans do not have to contract with IPAs

IPAs are extensively regulated.

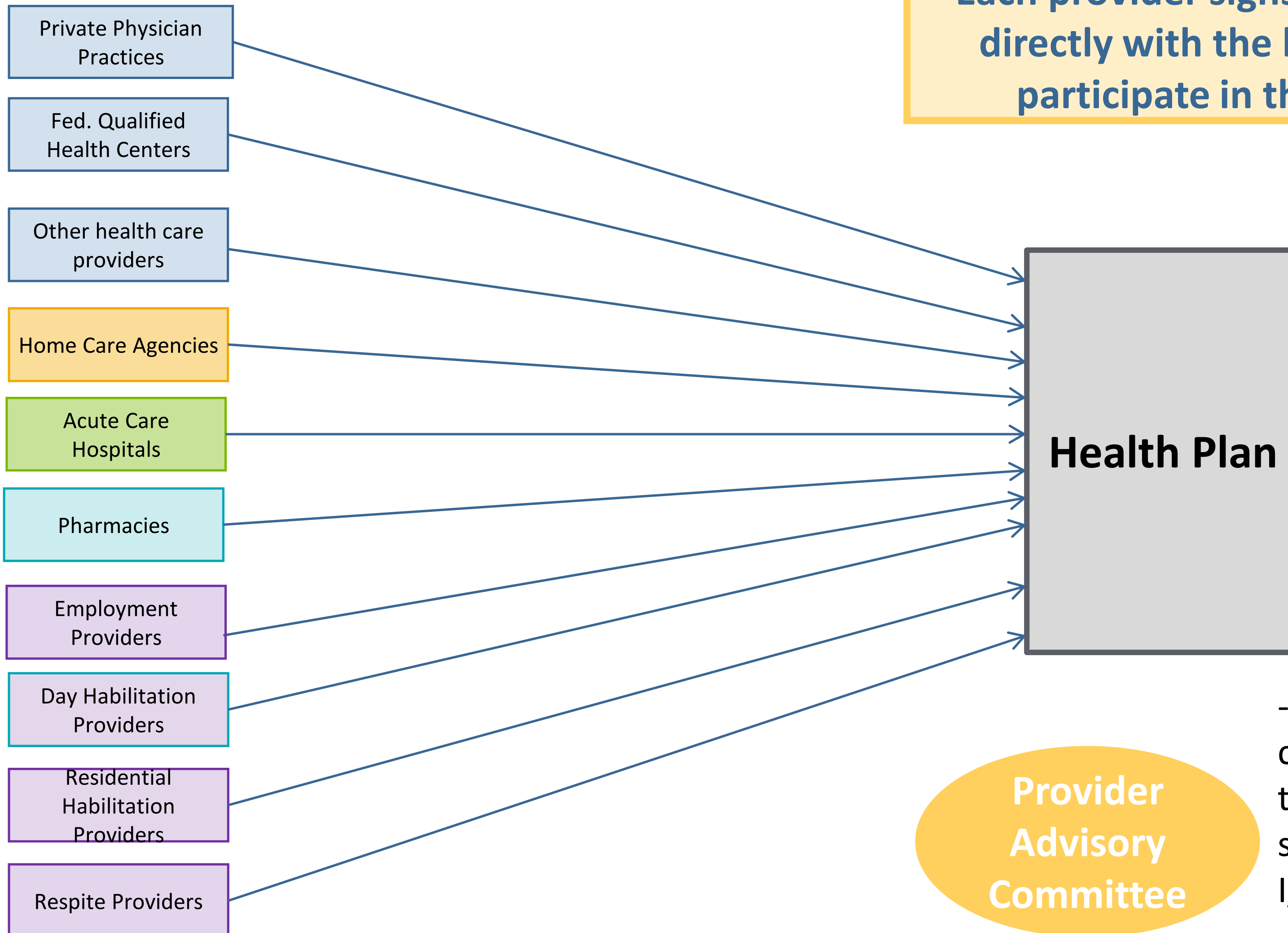
– NYSDOH regulations prescribe the role and formation process for IPAs

– IPAs must carefully navigate antitrust rules

IPA- Concept of an Intermediary Contracting Entity



"Direct" Participation Contracts Are The Alternative



Each provider signs an agreement directly with the health plan to participate in the network.

Provider Advisory Committee

-SIP-PLs will be required to create an Advisory Committee that includes providers of I/DD services and individuals with I/DD.

-Agenda may include same issues an IPA would address

Two Options in NYS for Network Intermediaries

IPAs

- Is limited to contracting with Art. 44 health plans, such as Medicaid Managed Care plans, Medicare Advantage plans, and some employer coverage which is issued by Art. 44 health plans
- IPA can not contract with other health plans, such as Art. 42 or Art. 43 insurers
- IPA is frequently used and well recognized
- Can encompass a wide range of activities-from rudimentary to sophisticated

ACOs

- Can contract with all health plans
- Has more oversight from NYSDOH
- Requires more sophistication on day one

Understanding VBP

VBP stands for Value-Based Payment

- A new concept: a set of contracting terms which move away from typical fee-for-service claims payments
- Usually includes 3 key features:
    - Better coordination of care
    - Quality metrics to measure quality, and where quality scores affect payment levels
    - Fundamentally changed financial incentives, such as shared savings, shared losses, or eventually capitation/population-based payments, etc.
- NYSDOH calls it "paying for value instead of paying for volume"
- Under DSRIP, CMS is paying NYSDOH $8 billion over 5 years to fund this transition
- DOH has produced a guidance document called "the Roadmap" which highlights key steps in this fundamental transition

VBP Example

- A group of providers commits in a contract to undertake improved coordination of care for a defined set of patients, including smoother hand-offs between providers and/or elimination of provider silos
- Quality of care data will be collected. Target quality scores will be established.
- Spending targets will be set, such as $100 per member per year.
  - Claims will continue to be paid on a fee for service basis at the standard fee schedule.
  - At year end a tabulation occurs.
  - If actual aggregate claims costs are (for example) $96 pmpy, there is a savings of $4 pmpy.
  - Under a 50/50 split, the health plan pays a lump sum of $2 pmpy to the providers at year end. Under shared losses, aggregate costs of $104 pmpy would require the providers to pay $2 pmpm to the health plan at year end.
  - High quality scores might increase that year-end shared savings payment to $3 pmpm.
  - Low quality scores might decrease that year end shared savings payment to $1 pmpm.
- One purpose of VBP is to blunt financial incentives thought to encourage providers to simply bill more claim forms for more visits

Limitations of IPAs

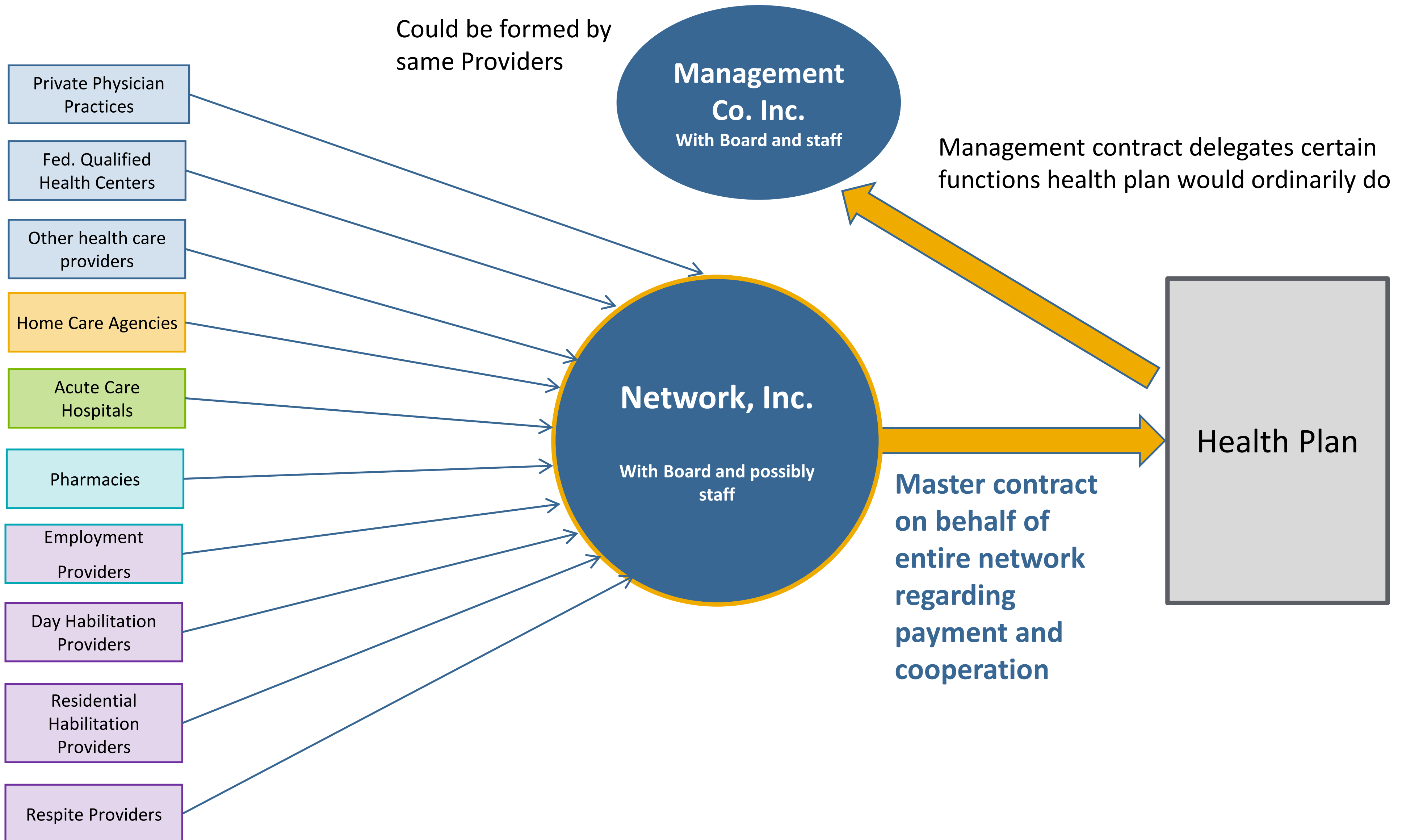
Limited roles

NYSDOH rules restrict the functions performed by an IPA

- **IPAs can *only* do the following**
  - Assemble and contract with the network of providers, care coordination
  - And assistance to the health plan on other issues such as utilization and quality improvement, although health plan has final authority
- **Traditionally, DOH has restricted IPAs from performing management services.**
  - Managed care plans are permitted to contract with management services companies and delegate the following "plan functions:"
    - Claims payment, quality assurance and improvement (includes credentialing), utilization review, fraud detection, and adoption of final policies regarding delivery of services
  - Management contractor can not do both utilization review and quality assurance

- **Providers which seek to perform some or all of the above would form two separate entities**
  - An IPA which has a network contract with the health plan
  - And a management company which has a management contract with the health plan

IPA + Management Company



manatt

IPA Corporate Issues

- **IPA can be a not-for-profit corporation, business corporation , or LLC.**
  - One advantage of a not-for-profit is it may better deflect potential criticisms from advocates or others who allege "…that IPA is a just a for-profit tool to send profits to IPA owners that should be devoted to patient care…"
  - Advantage of business corporation may that solicitation and distribution of capital contributions is simpler
- **Even not-for-profit IPA corporations pay income taxes. Are not tax exempt.**
  - However, there are often few "profits" for the IPA to pay taxes on
  - Any excess of IPA revenue over IPA expenses can usually be distributed to participating providers as year-end bonus under value-based payment (VBP), so IPA can have $0 in annual income
- **Must create IPA by-laws and an IPA Board governance structure.**
  - Often requires balancing the interests (and contributions) of large volume providers with small volume providers

Formation process requires submission to NYSDOH for review of corporate purposes and character and competence-type review of IPA owners.

Antitrust Rules

The primary antitrust concern when creating network intermediaries are agreements to restrain trade

- These concerns primarily focus on providers who compete with each other.
- If two or more providers compete with each other, their participation in the same network may be viewed as agreements to restrain trade.
- That "agreement" is embodied in the network participation agreements each provider has signed with the IPA.
- Significant problem: Under antitrust law these violations are considered "per se" violations of law.
  - Thus network entity does not have much opportunity to justify the conduct or prove that it had little or no impact on health care or other (residential) costs to the State

Even if two providers are friendly with each other, they are "competitors" if a consumer could choose to obtain comparable services from one or the other.

Two steps to evaluate:

1. Compare the services offered for sale (example: primary care physicians do not compete with transplant surgeons)
2. Compare the geographic markets where those services are offered for sale (example: primary care physicians in one region do not compete with primary care physicians 150 miles away)

Antitrust Rules

It is generally a prohibited restraint of trade when competitors:

1. Join together to collectively negotiate fee schedules, or other compensation from payors.
2. Join together to collectively negotiate medical necessity and other clauses in a payor contract that significantly impact compensation from payors.
3. Join together to collectively negotiate provisions regarding quality of care and availability of care.

However, it is a permitted "joint venture" of sorts when competing providers cooperate to a significant extent when delivering services to patients

1. Exception because providers are considered to have a sufficiently united interest in, and process for, delivering clinical services in an improved and/or consistent fashion
2. Therefore, is treated as a procompetitive, permitted "joint venture among partners," rather than treated as a "prohibited collusion among competitors"
3. Must be structured to achieve efficiencies via a high degree of interdependence and cooperation among participating providers

Solutions To The Antitrust Problem

Exception 1: Financial Integration

- Requires an active and ongoing program to evaluate and modify practice patterns by the network's partners to create a high degree of interdependence and cooperation among the providers to control costs and ensure quality. For example-as ACOs do.

Exception 2: Clinical Integration

- Distinction is that the network providers must share substantial financial risk in delivering services that are jointly priced through thru network
  - The financial risk sharing is not a desired end in itself; rather the financial risk sharing is considered a clear and reliable indicator that the provider network probably involves sufficient (unstated, but presumably clinical type) integration by its participating providers to achieve significant efficiencies
  - When structured to achieve efficiencies via a high degree of interdependence and cooperation among participating providers
  - Examples: Health plan pays capitation ($100 pmpm) to IPA; IPA then pays fee for service claims to par providers. Or Health plan pays fee for service claims to providers, with year end opportunity for bonus (or loss) if aggregate claims costs are less than (or more than) spending targets

Antitrust: Issues To Be Discussed

- **If OPWDD and DOH payment and other key processes will not require (or permit) the IPA to negotiate key terms (such as fee schedules) with the health plan, there may be no antitrust concern at all**
  - Although that concern may arise down the road when OPWDD no longer mandates that health plans pay the State mandated payment rates
- **On the other hand, if there will be no significant negotiations with the health plan, why bother having an IPA?**
  - Would an IPA for each region be a convenient method to create regional focus groups to discuss issues and provide advice to a health plan serving a large geographic region?
  - Does the use of an IPA entity create a greater sense of assured input to the health plan, more-so than the use of a health plan advisory committee when there is no IPA?
- **An IPA entity can be cumbersome and expensive to create and maintain.**
  - The direct contracting model (with or without an Advisory Committee) does not create the same antitrust concerns an IPA does.
  - If input to the health plan will be sufficient via the direct contracting model, an IPA may not be worth the trouble

Questions

Questions For IPA Discussion

- Is ownership and management of the SIP-PL relatively knowledgeable about I/DD and accommodating to the unique issues of I/DD?
  - At least initially, all plans must be controlled by one or more not-for-profit organizations with a history of providing or coordinating health and long-term care services to individuals with I/DD
  - So is there reason to bother with an IPA structure?
  - Would the Advisory Committee to the SIP-PL be sufficient?
- Are payment fee schedules and other key financial issues on the table for negotiation?
  - Not for the first two years
  - So is there reason to bother with an IPA structure?
- What are the costs and processes to establish an IPA entity and operate it over time?
  - Since the SIP-PL will have an Advisory Committee, is it worth the marginal improvement in leverage and input that an IPA (arguably) provides more than an Advisory Committee?

Questions

Manatt Health Strategies

James Lytle
Partner

518.431.6704

jlytle@manatt.com

David Oakley
Counsel

518.431.6705

doakley@manatt.com

Megan Sherman
Associate

518.431.6707

msherman@manatt.com

About Manatt Health

Manatt Health integrates legal and consulting expertise to better serve the complex needs of clients across the healthcare system.

Combining legal excellence, first-hand experience in shaping public policy, sophisticated strategy insight, and deep analytic capabilities, we provide uniquely valuable professional services to the full range of health industry players.

Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions, and lead healthcare into the future.

For more information, visit https://www.manatt.com/Health.