

VBP CONTRACTING WEBINAR SERIES

Webinar 5 Forming Strong Community Partnerships for VBP Arrangements Part 2

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National Council for Behavioral Health
Montefiore Medical Center
Northwell Health
New York State Office of Mental Health
Netsmart Technologies



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- Partner in FTLF's national health law practice.
- Counsels health centers, behavioral health providers, and hospitals on a wide range of health law issues, including transactional matters.
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- This session is provided for general informational and educational purposes only and does not constitute the rendering of legal advice or opinions.
- The information is not intended to create, and the receipt does not constitute, an attorney-client relationship between presenter and participant.
- For legal advice, you should consult a qualified attorney.

Agenda

- Forming Community Partnerships to Participate in VBP Arrangements
 - Referral Agreements
 - Co-Location Agreements
 - Purchase of Services (Lease of Capacity)
 - Mergers and Acquisitions

- Your Questions and Comments!

Affiliation Agreements: Anti-Kickback Statute (AKS)

- Prohibits persons and entities from knowingly or willingly
 - Soliciting or receiving remuneration directly or indirectly, in cash or in kind
 - To induce patient referrals or the purchase or lease of equipment, goods or services
 - Payable in whole or in part by a Federal health care program
- Health Reform Law eliminates specific intent requirement
 - “With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.”

Affiliation Agreements: Anti-Kickback Statute

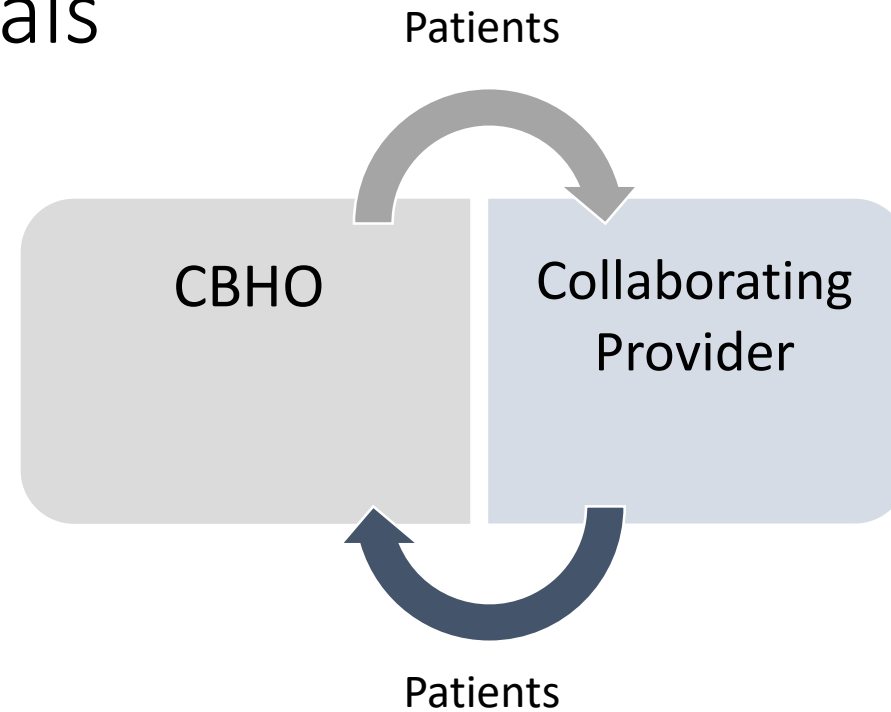
Violations of the statute can result in:

- Criminal liability
 - Felony conviction - \$25K fine, imprisonment up to 5 years, or both
- Civil penalties
 - Up to \$50K fine and damages of 3x amount of remuneration
- False Claims Act (FCA) liability
 - Health Reform Law amended AKS to codify FCA liability for claims resulting from violations of AKS
- Administrative proceedings
 - Suspension or exclusion from participating in federal health care programs
- Criminal liability
 - Felony conviction - \$25K fine, imprisonment up to 5 years, or both
- Civil penalties
 - Up to \$50K fine and damages of 3x amount of remuneration



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Formal Written Referrals



Collaborating provider agrees to furnish services to patients referred by the CBHO (and possibly vice versa), regardless of ability to pay, with no payment between the parties

Referral Agreements

- Each provider is financially, clinically and legally responsible and is solely liable for claims related to services it directly provides
 - Patients are patients of the provider directly providing services
 - Each provider's policies, procedures, standards govern its provision of services
 - Each provider bills and collects payment from patients/payors for the services it directly renders

Referral Agreements

Sample Agreement Terms: Establishing Autonomy

- *To the extent that referred CBHO patients receive primary care services from Primary Care Provider, such individuals are considered patients of Primary Care Provider. Accordingly, Primary Care Provider agrees to be solely responsible for billing and collecting all payments from appropriate third party payors, funding sources, and, as applicable, patients, for such services, observing Primary Care Provider's customary billing, collection, and free care policies .*
- *Primary Care Provider understands and agrees that, as the provider of record of the primary care services to the referred CBHO patients, Primary Care Provider is solely liable for all services furnished by Primary Care Provider, and that CBHO will not be liable, whether by way of contribution or otherwise, for any damages incurred by referred CBHO patients or arising from any acts or omissions in connection with the provision of such primary care services.*



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Referral Agreements

Sample Agreement Terms: Non-Inducement

- *Nothing in the Referral Agreement requires, is intended to require, or provides payment or benefit of any kind (directly or indirectly), for the referral of individuals or business to either party by the other party. Neither provider shall:*
 - (i) *require or encourage their professionals to refer patients to one another (or to any other entity or person); or*
 - (ii) *track such referrals for purposes relating to setting the compensation of their professionals.*

Co-Location Agreements

What are the key considerations if the CBHO and primary care provider seek to co-locate services to promote integration and increase access?

- ✓ Patient must be able to distinguish between the CBHO and the other provider (*i.e.*, separate signage, entrances, etc.)
- ✓ Check New York law (see next slide)
- ✓ May include lease of space/equipment (consider Anti-Kickback Statute and fair market value requirement)

Co-Location Agreements

- Co-location is a permissible option consisting of two or more entities that are located at the same address but each has its own distinct physical space. It is permissible provided the following (NOTE: this list is not exhaustive of all applicable requirements!):
 - Unless otherwise prohibited, when providers are co-located, public space within the building may be accessible to patients of all providers (*e.g.*, a building may have shared entrances and exits, atria, elevators and staircases). Corridors or hallways that lead to separate providers may be available to all co-located providers as long as an individual does not need to travel through the clinical space of one provider to get to another provider.
 - For federally designated providers, waiting rooms may not be shared. CMS has indicated that common waiting rooms with separate intake desks may be approved on a case-by-case basis.
 - Providers that are New York licensed or certified and are not federally designated may share waiting rooms provided patient privacy is protected, there is clear signage and patient awareness of who is providing their care, and the providers are in compliance with any other federal or state requirements. These providers may share some resources, such as telephone and receptionist services, but must maintain accurate records to ensure clarity for any costs claimed and duplicate reimbursement does not occur.
 - No commingling or sharing of clinical staff is permitted.



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Co-Location Agreements

Q. If an MHL Article 31 clinic is planning on co-locating a site in an FQHC, is that considered "shared space" and is it allowed?

- **A.** Two or more entities that are located at the same address, but each with its own distinct physical space, can be considered co-location. An example of this would be an office building with a common atrium and elevator bank that houses multiple providers, each in their own suites. **Co-located providers may only share common areas (i.e., public spaces such as lobbies that are not areas where patients are waiting for care, non-patient restrooms, and public paths of travel such as elevators and corridors through non-clinical areas) and do not share any staff or other space.** The Department hopes to release guidance on shared space in the near future. However, there are numerous options providers already have for integrating care: the existing 2008 Licensure Threshold, DSRIP Project 3.a.i Licensure Threshold, IOS, Multiple Licenses/Certification and, as always, providers may contract for services.



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Lease of Capacity Agreements

- Example: CBHO leases the services of a psychiatrist from a private practice to provide services, on the CBHO's behalf
- Consider differences from Referral Agreements
 - ✓ CBHO is responsible for billing and collecting from third parties / patients and retains all revenue secured for services provided by contracted practitioners
 - ✓ Contracted practitioners provide services in accordance with the CBHO's applicable health care and personnel policies, procedures and standards (e.g., clinical guidelines, productivity and QA standards, standards of conduct, record-keeping), and its grant requirements (if applicable)

Lease of Capacity Agreements

- **Qualifications and Oversight:**

- > Consider selection process
- > Contracted practitioners must meet CBHO's professional standards and qualifications (*e.g.*, maintains necessary and appropriate licensure)
- > Contracted practitioner shall not be excluded from participating in federal health care programs (Note: check the exclusion lists!)
- > CBHO retains the right to terminate the contract or to request / require removal, suspension and/or replacement of any contracted practitioner who lacks qualifications, is non-compliant with policies and procedures, provides sub-standard care or otherwise performs unsatisfactorily
- > Consider additional expectations you may wish to include (*e.g.*, productivity, training, participation in QI activities)



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Lease of Capacity Agreements

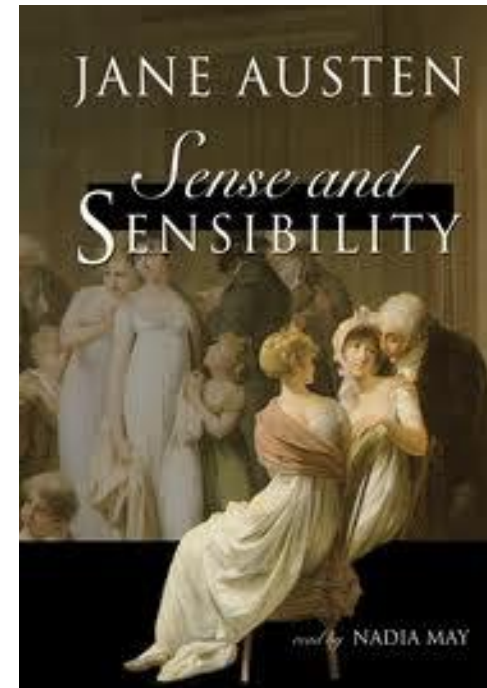
- **Anti-Kickback Statute Safe Harbor: Personal Services and Management Contracts**
 - Written agreement signed by parties
 - Term of at least one year
 - Agreement must specify aggregate payment and such payment must be set in *advance*
 - Compensation must be *reasonable, fair market value* and determined through *arm's length negotiations*
 - Must set exact services required to be performed
 - Compensation must not be determined in manner that takes into account volume or value of referrals

Lease of Capacity Agreements

- CBHO pays a set fee (assessed at fair market value) to the “vendor” for leased services
- Sample Agreement Term:
 - *Nothing in the Lease of Capacity Agreement requires, is intended to require, or provides payment or benefit of any kind (directly or indirectly), for the referral of individuals or business to either party by the other party. Neither provider shall (i) require or encourage their professionals to refer patients to one another (or to any other entity or person); or (ii) track such referrals for purposes relating to setting the compensation of their professionals.*

Mergers and Acquisitions

- **Finding Your Match:**
 - Values/Mission
 - Financial stability
 - Risk
 - Benefits



Mergers

- One entity becomes part of the other entity (the “surviving entity”) and legally dissolves
- Surviving entity takes title to all of the assets and assumes all of the liabilities of the non-surviving entity
- Process for Implementation:
 - Follow procedures mandated under the New York nonprofit corporation law and procedures in organizational documents
 - Consider modifications to Articles of Incorporation and Bylaws for the surviving corporation

Mergers

- Leave time for due diligence! Evaluate assets and liabilities.
- Negotiate terms and conditions of merger which would define, among other things:
 - ✓ Assurances that certain services would be continued post-merger
 - ✓ The extent to which the non-surviving entity's workforce would be transferred to the surviving corporation, either as employees or as independent contractors
 - ✓ Governance strategies (*i.e.*, granting the current non-surviving entity's board limited representation on the surviving entity's board , such as advisory membership or membership on certain committees)

Acquisition

- Entity acquires another entity's operations, purchasing assets, based on fair market value
 - Buyer can avoid assuming most, if not all, of the seller's liabilities
- Continued operations of the seller
 - May use the money generated from the sale of assets to cover certain outstanding liabilities and then could either (1) dissolve or (2) continue to operate as a separate corporation.
- Similar considerations as merger
 - Due diligence for asset purchase (*e.g.*, identify if there is a federal interest in the assets)
 - Consider impact on grant funding

Acquisition

- **Negotiate terms and conditions of acquisition which would define, among other things:**
 - ✓ Define assets being purchased (and the assets excluded from the purchase)
 - ✓ Asset purchase price, based on fair market value
 - ✓ Extent to which the purchaser will assume liabilities related to the assets purchased, if at all
 - ✓ Extent to which the seller's workforce would be transferred to the purchaser either as employees or as independent contractors
 - ✓ Governance strategies (*i.e.*, granting the current non-surviving entity's board limited representation on the surviving entity's board , such as advisory membership or membership on certain committees)

Mergers & Acquisition: Evaluation Steps

- Establish a core group of representatives to coordinate the evaluation and implementation process
- Ask the hard questions early and consider control issues
 - ✓ Will staff transfer to the surviving corporation? Consider compensation and benefits disparities.
 - ✓ How will the integration impact management positions?
 - ✓ How will the integration impact board composition and authorities?
- Jointly develop a timeline (leave time for due diligence!)
 - ✓ Create shared vision
 - ✓ Review bylaws and Articles of Incorporation
 - ✓ Review State law
 - ✓ Develop a communications plan

Questions and Comments

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Additional Webinars in this Series

All Webinars Scheduled for 1:00-2:00pm ET

Webinar 6: [Data Sharing and Confidentiality Part 1](#); Wednesday, August 1

Webinar 7: [Data Sharing and Confidentiality Part 2](#); Wednesday, August 15

Webinar 8: [Employment & Professional Services Agreements](#); Wednesday, August 29

Webinar 9: [Forming Provider Networks to Participate in VBP Arrangements](#); Wednesday, September 12

Webinar 10: [Contracting for EHR Systems](#); Wednesday, September 26

To register for additional webinars, please use the links above or visit the Care Transitions Network website below for more information.

<https://www.thenationalcouncil.org/care-transitions-network-people-serious-mental-illness/technical-assistance/webinars/>



Thank you!

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