Healthcare Reform:

Compliance Implications of New Reimbursement and Integration Models

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Agenda

- Discussion of new payment initiatives under healthcare reform
- Compliance landmines associated with these initiatives
- Auditing and monitoring tools / ideas
New Initiatives

- ACOs / Shared Savings Programs
- Medical Homes
- Global Payments / Bundled Payments
- Quality Measures
- Value Based Purchasing
What do these mean?
Accountable Care Organizations / Shared Savings Programs

- Facilitate coordination and cooperation among providers to improve the quality of care and reduce unnecessary cost

- Designed to improve beneficiary outcomes and increase value by:
  - Promoting accountability for the care
  - Requiring coordinated care for all services
  - Encouraging investment in infrastructure and redesigned care processes
Medical Homes

- An approach to providing comprehensive primary care that facilitates partnerships between individual patients, and their personal providers, and when appropriate the patients family

- Purpose is to provide better access to care and increase satisfaction with care and improve health
Global / Bundled Payments

- Process of one payment for a service or combination of services, provided by a group of health care providers
Quality Initiatives / Measures

- Measures of health care quality that make use of readily available hospital inpatient administrative data.

- Includes:
  - Prevention Quality Indicators
  - Inpatient Quality Indicators
  - Patient Safety Indicators
  - Pediatric Quality Indicators
Value Based Purchasing

- Improve clinical quality, make appropriate use of services, focus on patient-centered care, decrease adverse events, improve patient safety, avoid unnecessary costs, and make performance results transparent and usable by consumer.

- Focus on value, outcomes and innovations instead of basing payment on merely volume.
Drivers of New Initiatives

- Threat of payer program insolvency
- Contain or reduce costs
- Improve quality of care
- Coordinate care among providers
- Promote healthier population
- Gain a competitive edge in the market
  - Physicians are combining to form super groups
  - Commercial plans (United) are getting into the game
Will New Initiatives Work?
ACO Challenges

- Industry reaction to the proposed regulations is lukewarm at best
  - Few healthcare organizations are pioneers - they tend to adopt what works for others

- CMS does not expect widespread participation
  - **75-150**: CMS estimate of the number of Medicare ACOs formed to participate in the Shared Savings Program during first 3 years
  - **$1.75 Million**: CMS estimate of the start-up and first year operating expenditures for each ACO

- Many organizations are not prepared to be a Medicare ACO
  - Not enough integration between providers (financial/clinical/trust)
  - Don’t have data to accurately measure quality or costs
  - Don’t have mechanism to share risk
Demonstration Projects

- Legal Implications – Waivers don’t represent real world after demonstration project is over

- Financial Implications – Challenges on splitting reimbursements and covering costs. Must make hard decisions. Rationing???

- “Pioneering” Program – many organizations opting out of initial programs; adopting a “wait and see” attitude.
Compliance Landmines

- ACOs / Shared Savings Programs
  - Antitrust
  - Stark / Kickback
  - Quality and Clinical Issues

- Medicare Requirements
  - CMS will grant Stark, Anti-Kickback and Civil Monetary Penalty Waivers to ACOs participating in the Shared Savings Program.
  - Waivers are narrow and apply only to:
    - Shared savings distributions to or among ACO participants; and
    - Activities necessary for and directly related to participation in the Shared Savings Program.
  - Waivers from the Anti-Kickback and Civil Monetary Penalty Statute will be granted for other financial relationships only if the other relationship fits within a Stark exception.
  - Accordingly, ACO relationships (such as ACO/Physician relationships and capitalization of the ACO) will have to be carefully structured to comply with Stark.
Compliance Landmines

- Medical Homes
  - Stark / Kickback Issues – who pays costs?
  - Relationships among providers

- Global Payments / Bundled Payments
  - Structure / Payment Issues (Contractual; PHO; Other)
  - Gainsharing
  - Licensing / Insurance
  - Financial Risk – who takes the risk?
Compliance Landmines

- Quality Measures
  - Reverse kickback
  - LOS payments
  - Inducements to reduce care
  - False claims for poor care

- Value Based Purchasing
  - Current financial incentives with providers does not mirror goals of VBP
  - Data reporting – credibility of information
  - Financial – Medicare = 2% reduced payment by FFY 2017
  - Staffing / Monitoring of quality indicators
  - IT infrastructure
Auditing Issues - General

1. Does current compliance plan cover new initiatives?
   - Separate compliance plan and policies may be needed or required

2. Does current compliance training program address new initiatives?

3. Do existing contracts need to be modified?

4. Do new provider relationships need to be documented? If so, how?

5. Are quality measures being audited and monitored?

6. Are new financial arrangements supported as FMV?

7. If part of a government sponsored program (Medicare ACO or demonstration project), is the organization “following the rules”?
Auditing Issues – VBP / Quality

1. Validation reviews for VBP data submissions
   - Quality data submitted – Has it been reviewed by hospital and documentation maintained?
   - What procedures are being performed to internally test?
   - Can the quality measure data elements be recreated under audit?
   - Must meet a correlation of at least 75% for data to be considered reliable.
   - Risk – Loss of 2% add on payment
   - Can hospital afford not to comply with new requirements?

2. Who is responsible for maintaining clinical measures?

3. What department or area within the hospital will measurement and maintenance of data fall under?

4. How will this information be communicated to the compliance officer and committee?
Auditing Issues - ACOs

1. Was the ACO set up correctly?
2. Are the participants of the Governing Board in compliance with the requirements of the structure?
3. How is the organization monitoring its process compared to the application submitted to organize the ACO?
4. Is the ACO following the structure outlined in the ACO application?
5. Have state licensure issues been evaluated, checked, and monitored?
6. How will the organization monitor validation of Quality Assessment and Performance Improvement (QAPI), including performance standards?
7. What practices are in place to monitor patient centered care?
8. What procedures and documentation are in place to monitor the treatment of at risk beneficiaries?
Auditing Issues - ACOs

9. Did the ACO get its marketing materials approved by CMS? Documentation maintained? Where? By whom?

10. How do the participants in the ACO publicize their participation? Are signs posted in noticeable places in the organization?

11. Has the ACO communicated to CMS changes in legal structure, sanctions or investigations by regulatory agencies?

12. Contracts with others – Do all contracts include a requirement to adhere to the terms of the ACO with CMS?

13. Have the antitrust issues been analyzed? Complied with?
Auditing Issues – Medical Home

1. How are patients’ physical and mental health care needs met?
2. What is the structure of the medical home? Suite of providers affiliated with one another? Suite of providers operating in a virtual team of care providers?
3. What is the relationship between the acute care provider and the medical home?
4. Who pays for the infrastructure of the medical home? Are there any issues with the payment for infrastructure? Inducement? Referrals?
5. Is the payment for coordinating patient care in line with the services provided?
6. Are there any unwritten agreements with providers of services?
7. Are the payments in line with the patients best interest and at fair market value related to other payments of this nature?
8. Have contracts with payers who are sponsoring the Medical Homes been reviewed? Has the review been documented?