CHCANYS CLINICAL FORUM & STATEWIDE CONFERENCE

Managing Risk in a New Payment World

presented by:

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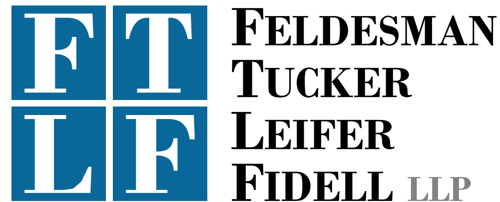
of



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Outline

- Accountable Care Organizations
- Health reform opportunities
- Risk management recommendations

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Delivery System Reform

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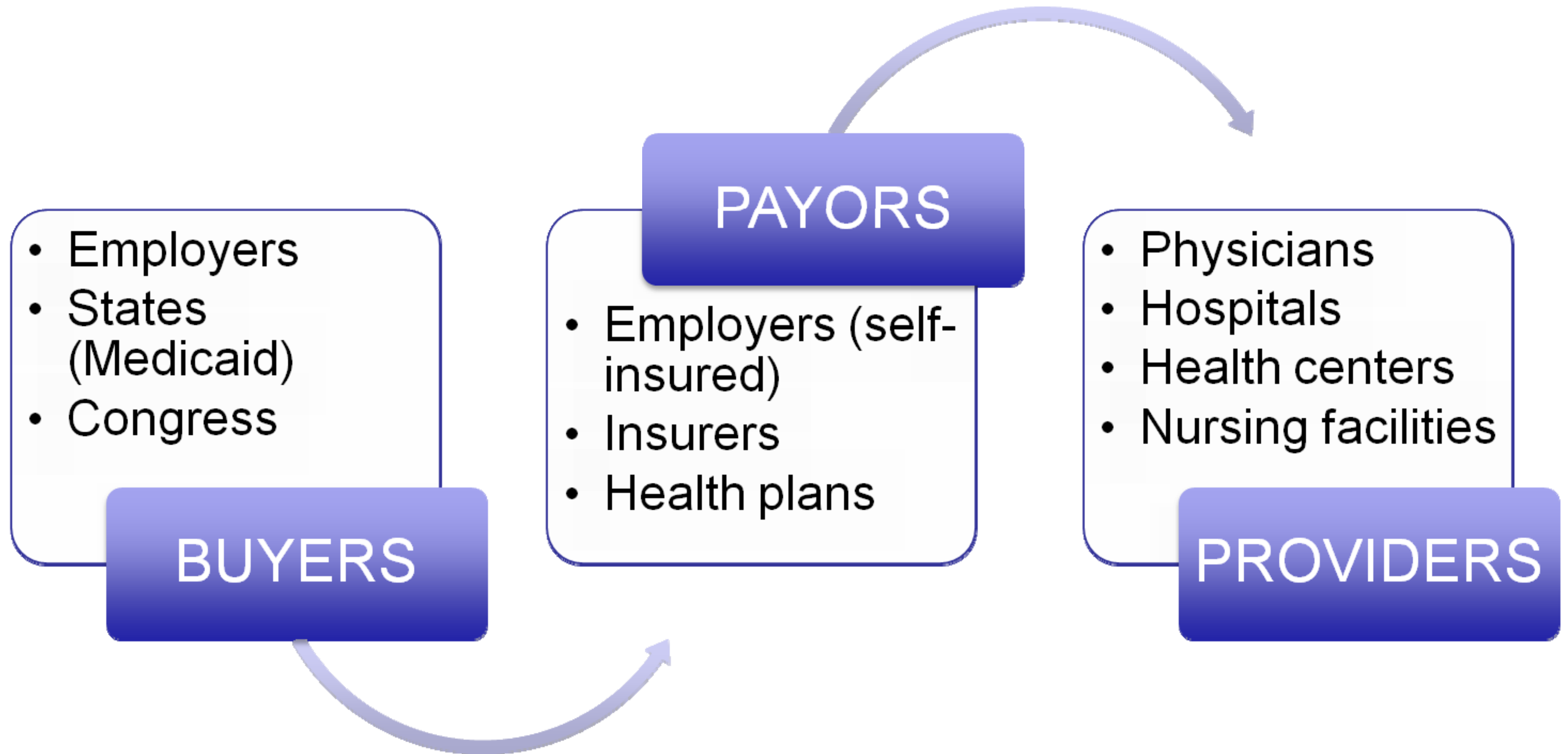
Health Care Markets – Overall



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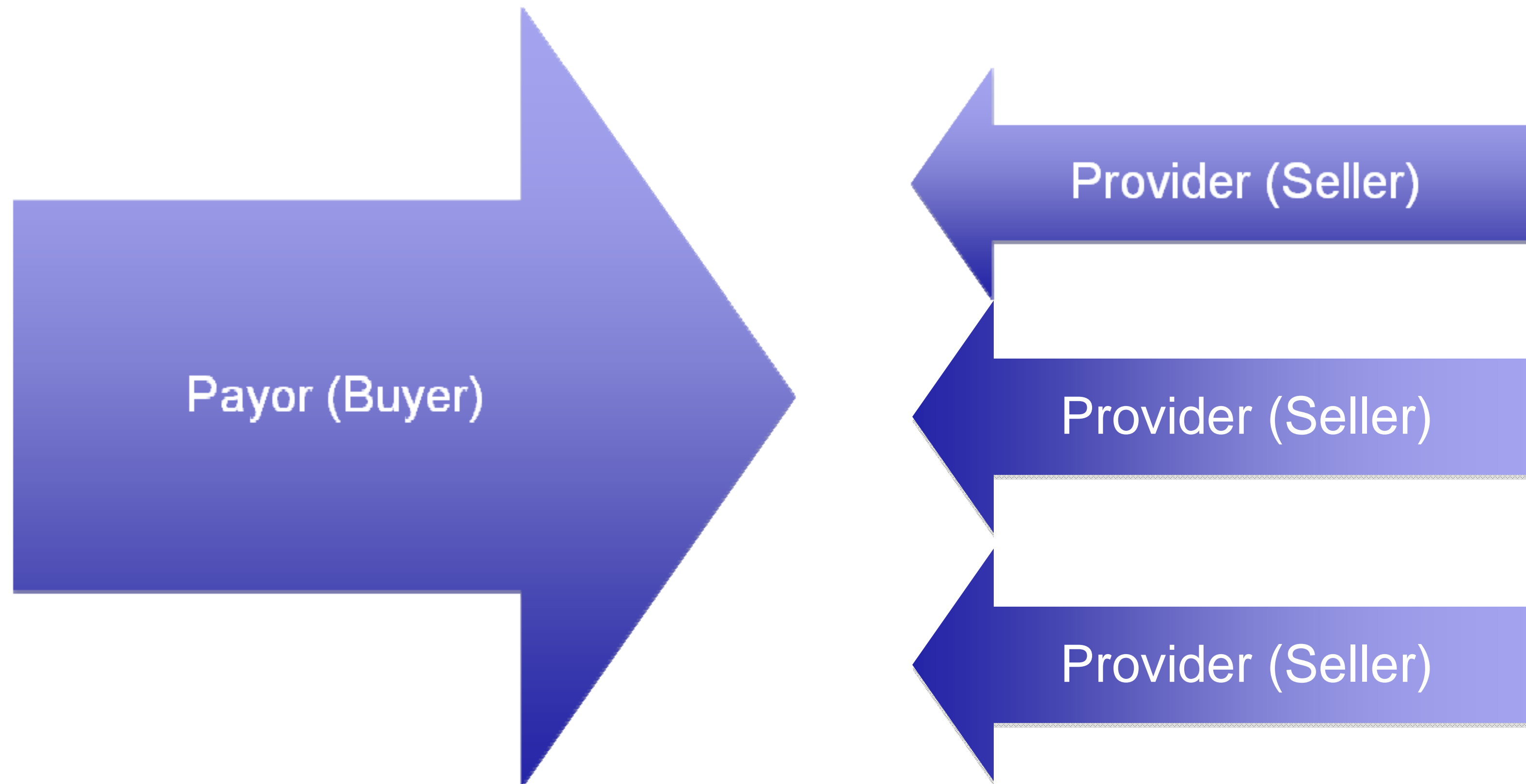
Health Services Market – Current State



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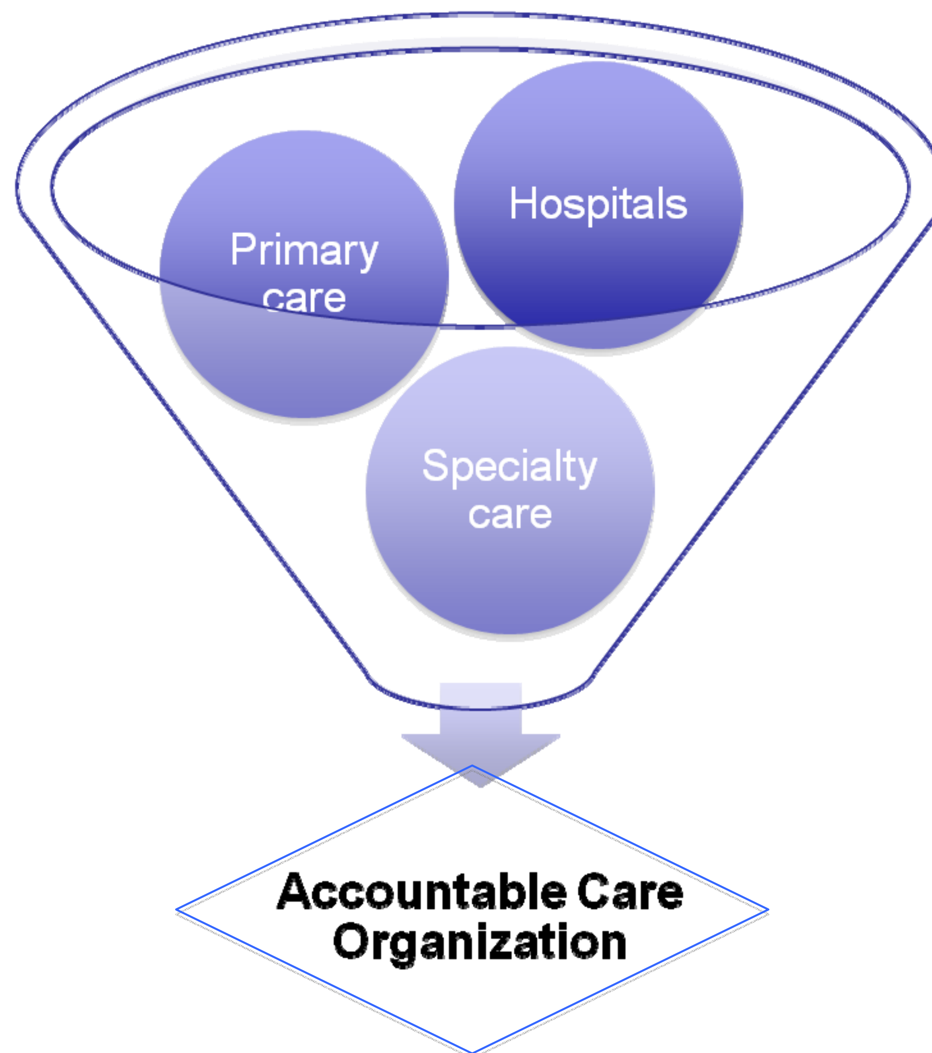
Accountable Care Organization (ACO)



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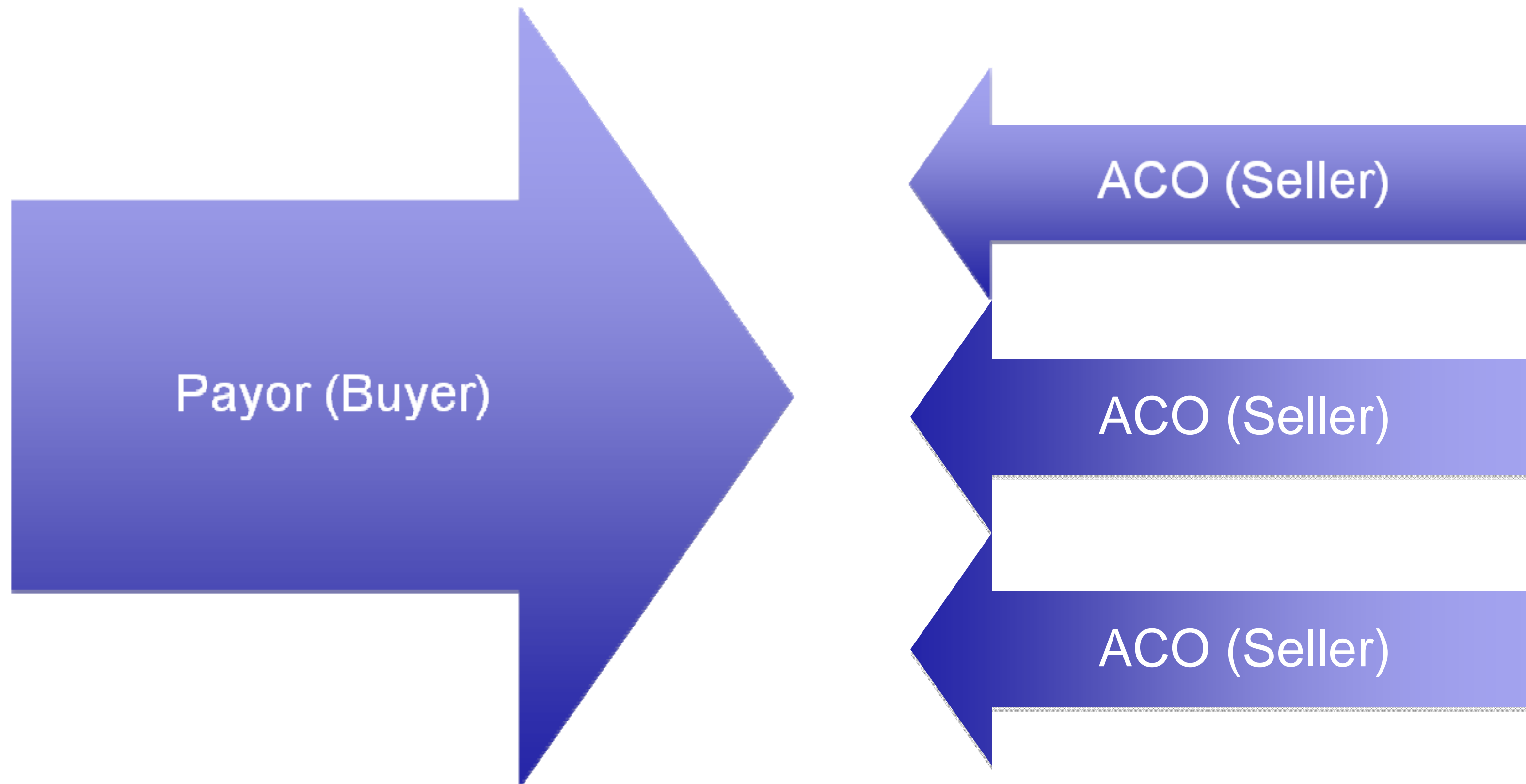
Health Services Market - Reformed



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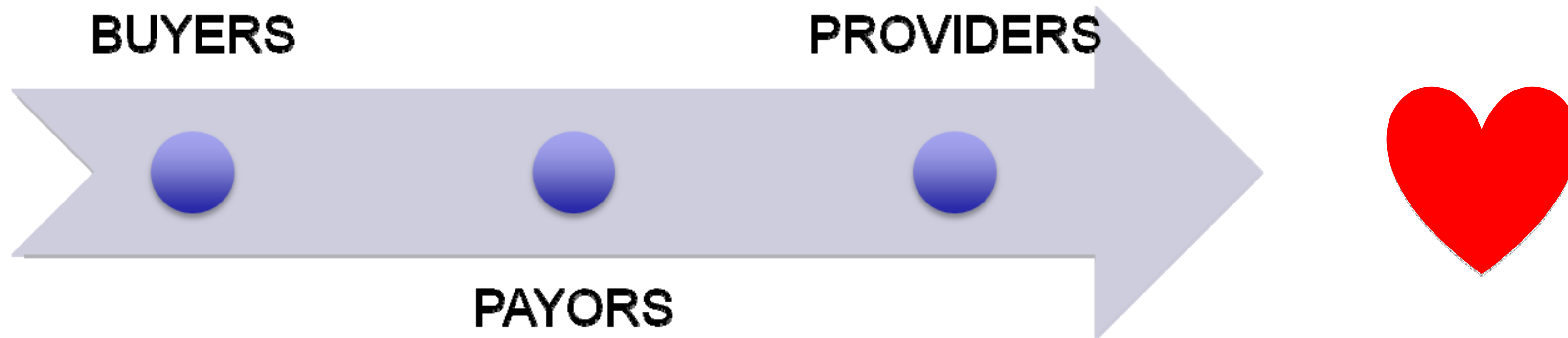
Healthy Markets, Healthy People



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Accountable Care Organizations (ACO)

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Accountable Care Organizations

"*Networks of physicians and other providers that could work together to improve the quality of health care services and reduce costs for a defined patient population*."

- Health Affairs, Robert Wood Johnson Foundation, Health Policy Brief, *Accountable Care Organizations. Under the health reform law, Medicare will be able to contract with these to provide care to enrollees. What are they and how will they work?* (July 27, 2010)

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Basic Features of the ACO

- Combination of one or more hospitals, physician groups (primary care and specialty), and other providers
- Local accountability
- Financial incentives to meet quality benchmarks or cost-savings
- Shared governance structure
- Formal legal structure that allows organization to receive and distribute payments to participating providers
- Leadership and management structure that includes clinical and administrative systems
- Performance measurement

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Key Issues in Forming ACO

- Combination of providers
- Shared governance by providers
- Legal structure
- Financial incentives with payors
- Financial incentives within ACO
- Infrastructure requirements / capitalization

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Combination of Providers

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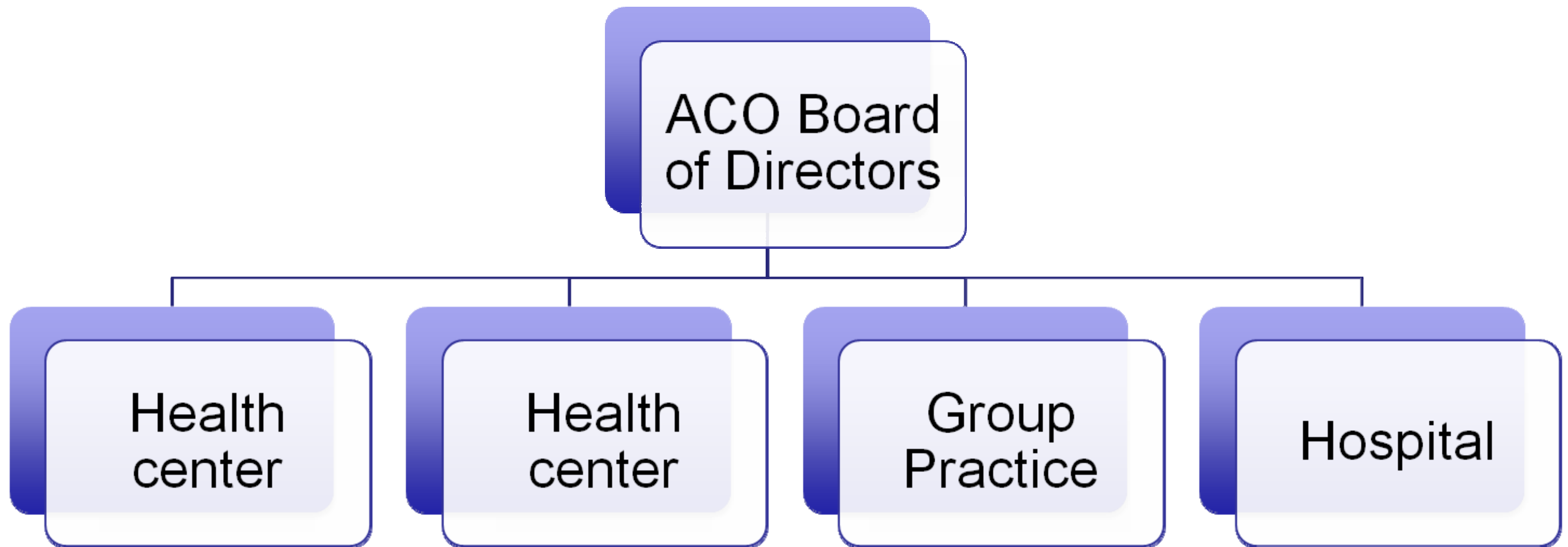
Shared Governance by Providers



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Legal Structure

Full Integration	Partial Integration	Joint Venture
• Kaiser-Permanente • Mayo Clinic • Cleveland Clinic	• Joint ownership or joint control of new legal entity	• Contractual relationships • Joint governance committee

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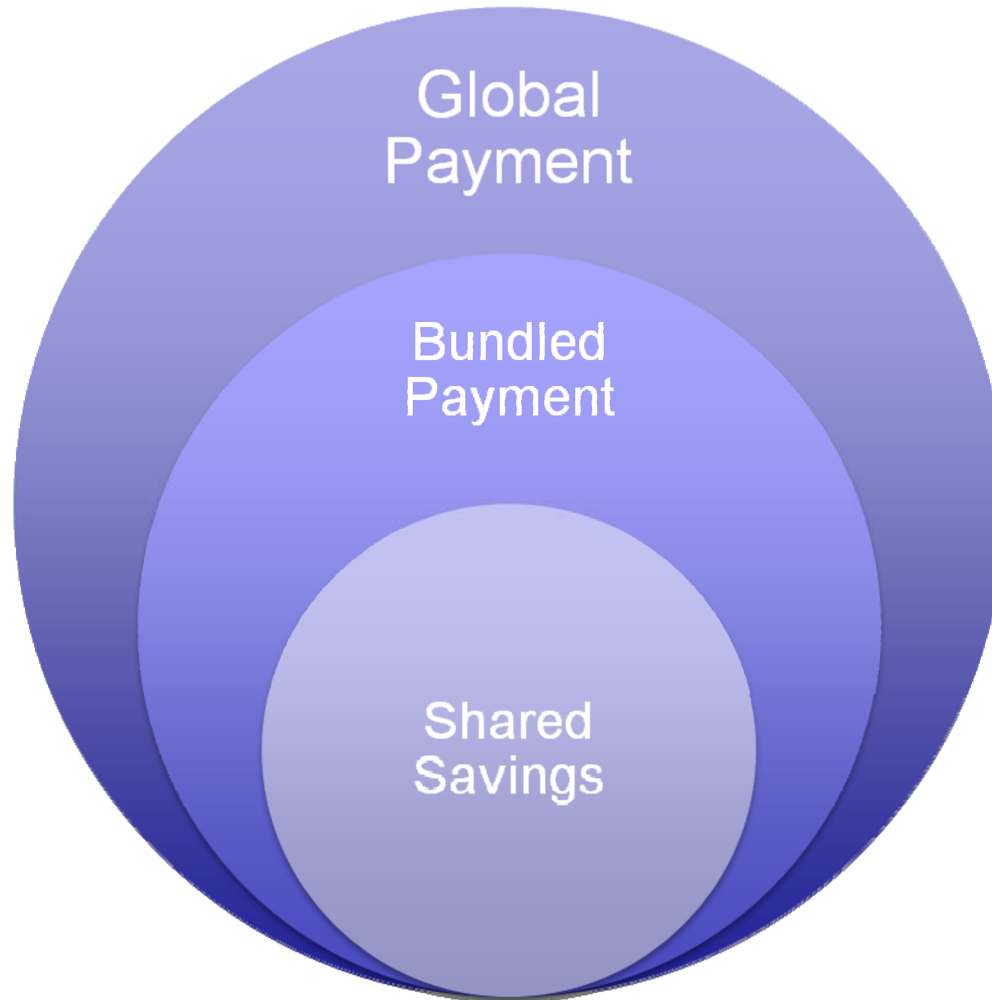
Financial incentives with Payors



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Shared Savings ACO Model

- Providers continue to be paid fee-for-service for services provided to patients.
- Providers eligible for bonus payments if savings are obtained.
  - Expenditure benchmarks based on historic trends, adjusted for patient mix
  - If expenditures are below particular benchmark, then the payor “shares savings” with the ACO.

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Bundled Payments ACO Model

- Bundled payments
  - ACO receives a set amount to cover all of the care associated with an episode of care around a hospitalization.
  - Costs exceeding this budget must be absorbed by the ACO.

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Global Payment ACO Model

- Global payment
  - ACO receives a set payment to furnish all or part of the care for a given population of patients over a defined period of time
  - ACO must be prepared to manage the risk associated with a limited budget for an undefined amount of possible services

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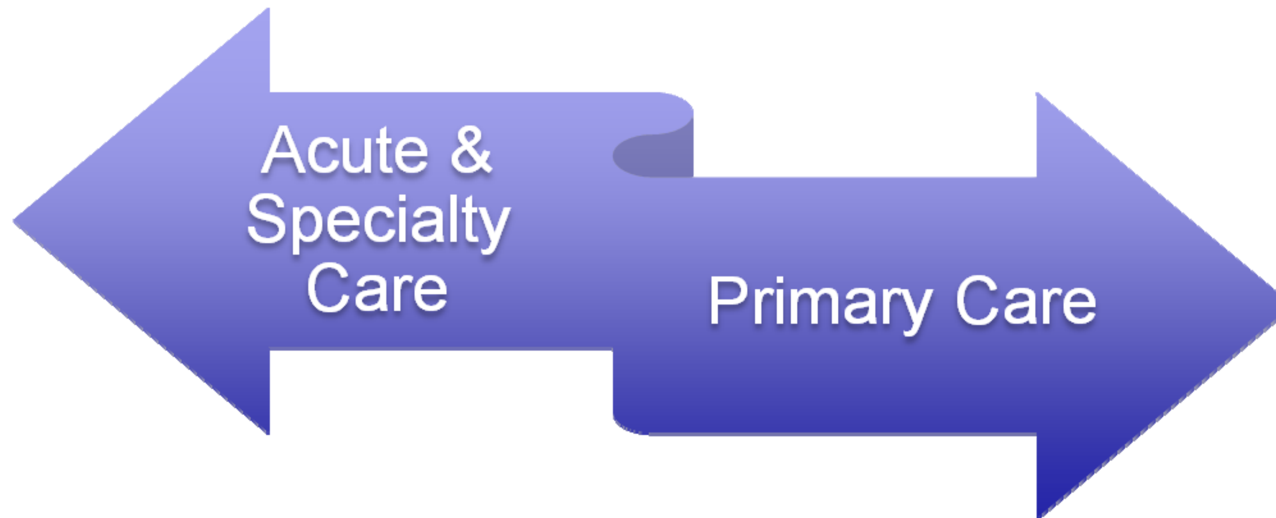
Financial Incentives Within ACO



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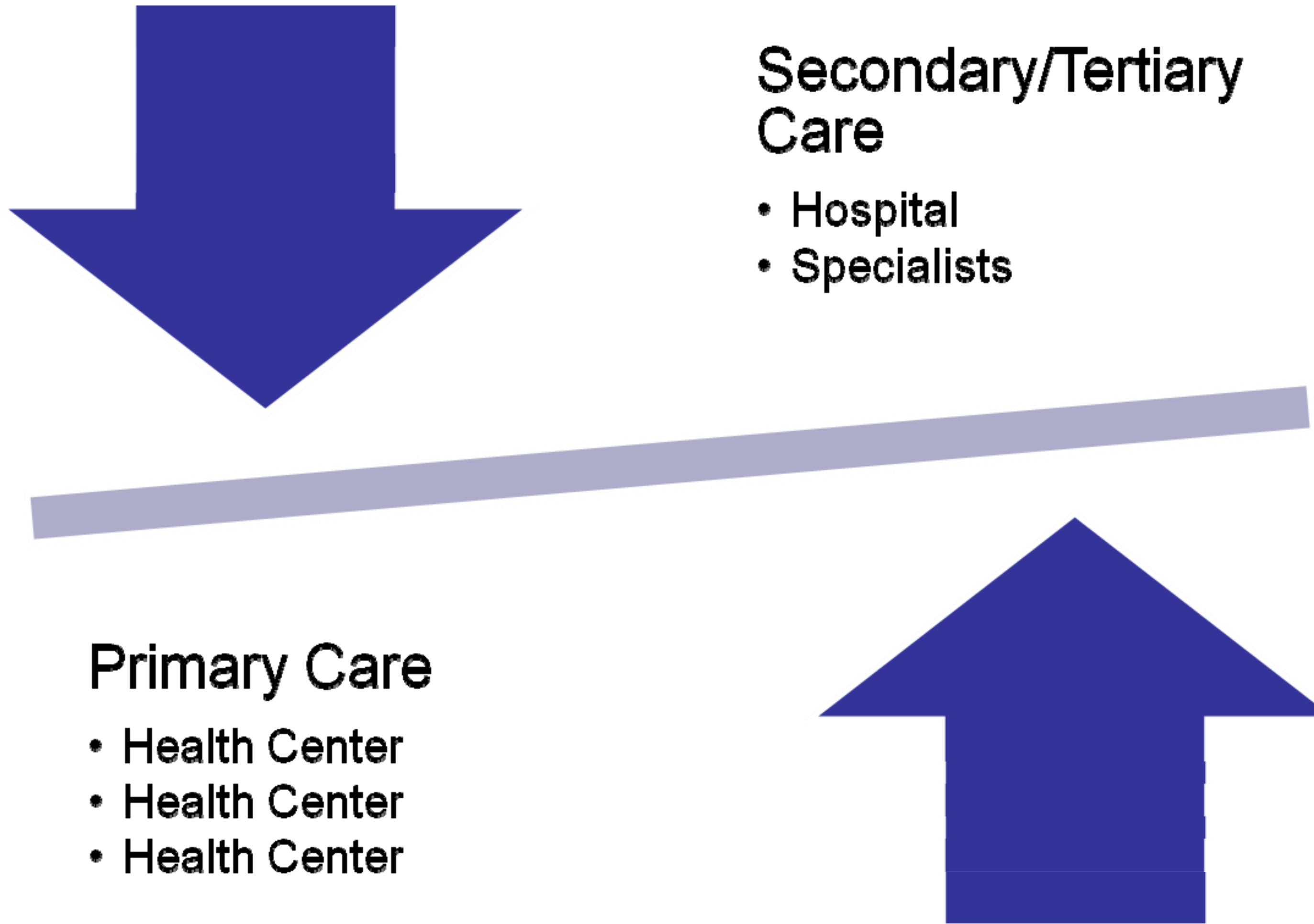
Financial Incentives within ACO



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Opportunities in Health Reform

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Center for Medicare and Medicaid Innovation

- Housed within CMS
- Authority to test proposed methods of coordinated care delivery
- Must be established by January 1, 2011.
- Receives $10 billion over ten years

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Grant Programs

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Community-Based Collaborative Care Networks (PPACA § 10333)

- Beginning FY 2011, five year grant program to support community-based collaborative care networks
- Eligible entities: consortium of health care provider and <u>must</u> include a hospital and all community FQHCs wishing to participate
- Priority given to networks with broadest range of services and providers, and to networks that include a county or municipal health department
  - Must have a joint governance structure
  - Must provide comprehensive coordinated and integrated health care services for low income populations

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Shared Savings

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- Eligible ACOs may be composed of:
  - Physicians and other professionals in group practices
  - Physicians and other professionals in networks of practices
  - Partnerships or joint venture arrangements between hospitals and physicians/professionals
  - Hospitals employing physicians/professionals
  - Other groups of physicians/professionals as determined by the HHS Secretary

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Medicare Shared Saving (ACO) Program (PPACA §§ 3022, 10307)

- Begins no later than January 1, 2012
- Allows qualified groups of providers/suppliers to manage and coordinate care for FFS beneficiaries through an ACO
  - Participating ACOs will be eligible to receive payments for shared savings if the ACO achieves quality and cost containment standards
  - Payments for services will continue to be made to providers under the original Medicare FFS program

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Medicare Shared Saving (ACO) Program (PPACA §§ 3022, 10307)

- ACOs must:
  - Become accountable for the quality, cost, and overall care of the Medicare beneficiaries assigned to it
  - Enter a three-year agreement to participate
  - Have a formal legal structure to receive and distribute shared savings payments
  - Have at least 5,000 assigned beneficiaries
  - Have a sufficient number of necessary ACO professionals
  - Have a leadership and management structure that includes clinical and administrative systems
  - Have defined processes to promote evidence-based medicine and patient engagement, to report on quality and cost measures, and to coordinate care
  - Demonstrate that it meets patient-centeredness criteria

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Medicare Shared Saving (ACO) Program (PPACA §§ 3022, 10307)

- The Secretary may apply sanctions if an ACO takes steps to avoid high-risk patients
- Providers who participate in the ACO program may not receive payments under other Medicare shared savings programs
- HHS Secretary may give preference to ACOs who are participating in similar arrangements with other payers

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Medicaid Pediatric ACO Demonstration Project (PPACA § 2706)

- Qualifying pediatric providers in participating states will be eligible to be recognized as pediatric ACOs
  - Program funded for five years beginning in January 1, 2012
  - Providers wishing to participate must do so for at least 3 years.
- Earn incentive payments based on shared savings
- Each state (with HHS Secretary) will determine quality performance guidelines and a minimal level of savings that must be achieved for a provider to receive the incentives
  - Amount of incentive payment will be equal to a portion of the shared savings, as determined by the HHS Secretary, beyond this minimal level of savings

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Bundled Payments

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Medicare Pilot Testing of Bundled Payments (PPACA §§ 3023, 10308)

- Pilot program encourages hospitals, physician groups, skilled nursing facilities, and home health agencies to improve the coordination, quality, and efficiency of healthcare through bundled payment models
  - Program funded for five years beginning in January 1, 2013
- Bundled payment covers costs of all services furnished to a beneficiary during an "episode of care"
  - "episode of care" - three days prior to hospital admission, hospital stay, and 30 days following discharge
- Program focuses on a maximum of 10 medical or clinical conditions defined by the HHS Secretary, and includes quality measures

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Global Payments

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Medicaid Global Payment System Demonstration (PPACA § 2705)

- States may adjust payments to eligible safety net hospital systems or networks from a FFS structure to a global capitated payment model (*Note: It is unclear whether FQHCs qualify as "eligible safety net hospital systems or networks"*)
  - Limited to five states
  - Program funded in from 2010 to 2012
- Coordinated through CMS Innovation Center

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Risk Management

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Risk Management

- Health centers are exposed to risks on a daily basis.
  - Regulatory compliance
  - Legal liability
  - Medical malpractice
  - Financial risks
  - Property risks

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Risk Management

- FQHCs should “identify, and plan for, potential and actual risks to the FQHC in terms of its facilities, staff, clients, financial, clinical, and organizational well-being.”
- Risk management policies should address quality assurance and improvement, compliance with fire and life-safety codes, regulatory compliance, and liability.

HRSA Policy Information Notice (“PIN”) #98-23, Program Expectations, p. 23.

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Risk Management

- Risk management is defined as "creating and applying a system and procedures designed to reduce liability exposures."
- Liability stems "from a long list of potential risk areas, including medical malpractice, noncompliance with Federal and State statutes and regulations that cover fraud and abuse in billing and payment, safety of clients and employees, employment practices, and procurement of goods and services, to name but a few."
    - National Association of Community Health Centers, "Implementing a Risk Management Program for Your Health Center," *Risk Management Issue Bulletin Series #8*, NACHC (Dec. 2003).

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Managing Legal Risks

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Managing Legal Risks: Antitrust

- *Consider forming a single integrated legal entity to conduct collaborations with other providers.*
- Independent providers that negotiate jointly with payors expose themselves to risks under the Antitrust Laws for price-fixing or market allocation
- <u>Only</u> when providers meet certain legal criteria related to risk sharing or clinical integration, is joint contracting by providers permitted under the antitrust laws

- Continued…

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Managing Legal Risks: Antitrust

- Non-integrated entities (e.g. IPAs, POs, or PHOs) must rely on the so-called "messenger model" to contract with payors
- <u>However,</u> engage in due diligence of provider partners to determine suitability, capability, and potential liabilities

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Managing Legal Risks: Tax Exemption

- *Consider forming a taxable legal entity to conduct collaborations with other providers.*
  - Unlike for-profit entities, tax-exempt entities cannot distribute profits
    - IRC 501(c)(3) prohibits inurement of exempt organization's net earnings to private individuals and requires exempt organization to pursue charitable purposes with only incidental private benefit
  - Distributions of revenue from financial incentives may require formation of taxable legal entity

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Managing Legal Risks: Kickbacks

- *Consult qualified counsel to minimize kickback exposures in collaborations between providers.*
  - Financial arrangements (including capital investments and distributions) between referring providers in an ACO will likely implicate the Federal Anti-Kickback Statute ("AKS"), which:
    - Prohibits willfully offering, paying, soliciting, or receiving remuneration as an inducement for the referral of Medicare or Medicaid business
    - Section 10606 of PPACA transforms AKS violations into a False Claim
    - Under Section 3022 of the PPACA, the HHS Secretary has authority to waive certain provisions under the AKS to carry out certain demonstrations

- Continued…

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Managing Legal Risks: Kickbacks

- Current AKS safe harbors may not protect ACO arrangements, though falling outside of the safe harbor does not necessarily result in a violation
- Series of favorable OIG Advisory Opinions on "gainsharing" in which a hospital rewards physicians for efforts to reduce costs

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Managing Legal Risks: False Claims

Establish compliance oversight mechanisms within legal entity.

- Reporting of data related to performance will influence payments.
- Misrepresentations will have legal consequences under the False Claims Act or Civil Monetary Penalties (CMP) Law
- PPACA expanded False Claims Act and CMP liability
  - Overpayments must be returned within 60days to Medicare and Medicaid
  - Civil Monetary Penalties for a false statement or misrepresentation increases to $50,000 per violation
- A corporate compliance program to prevent misrepresentations and false claims (as well as to repay overpayments within 60 days) will be essential to reduce potential liability

Managing Legal Risks: FTCA

Reassess insurance coverage and ensure sufficient reserves to cover any potential losses

- FTCA does not cover losses from indemnification in which one party agrees by contract to cover the loss or liability of the other
- If the ACO is not assuming risk for the clinical and financial outcomes of its providers, then the individual providers may be incurring the risk themselves, exposing them to significant financial losses
- If the ACO is assuming risk for the clinical and financial outcomes of its providers, then it may need to meet certain state law requirements for risk-bearing entities

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Managing Legal Risks: Stark Law

- Federal physician self-referral law prohibiting physicians who have a financial relationship with an entity from referring to that entity the opportunity to furnish services that may have been paid for by Medicare
  - There is a proposed "Shared Savings Exception"
- Health care provider may not bill Medicare for improperly referred services

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Closing Checklist

- Successful ACOs will have the appropriate:
  - *Combination of providers*
  - *Shared governance by providers*
  - *Legal structure*
  - *Financial incentives with payors*
  - *Financial incentives within ACO*
  - *Infrastructure requirements / capitalization*

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Questions?

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