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HEALTH CARE LAWYERS

# *HIPAA and Payment Reform*
# *ACOs, Medical Home & Bundled Payments*

By: Paul T. Smith, Shareholder
Hooper, Lundy & Bookman, P.C.
psmith@health-law.com

21st National HIPAA Summit

Washington, D.C.
February 20, 2013

# Payment Delivery Reform

- Accountable Care Organizations
  - Allows providers to participate in cost savings for traditional Medicare fee-for-service
  - Final regulations issued November, 2011
  - Started April 2012
- Patient-Centered Medical Home
  - Provides comprehensive care management and coordination
  - ACA included funding for demonstration projects
  - Pilot projects under way
- Bundled Payments
  - Links payments for multiple services during an episode of care
  - Medicare Bundled Payment for Care Improvement initiative beginning April, 2013

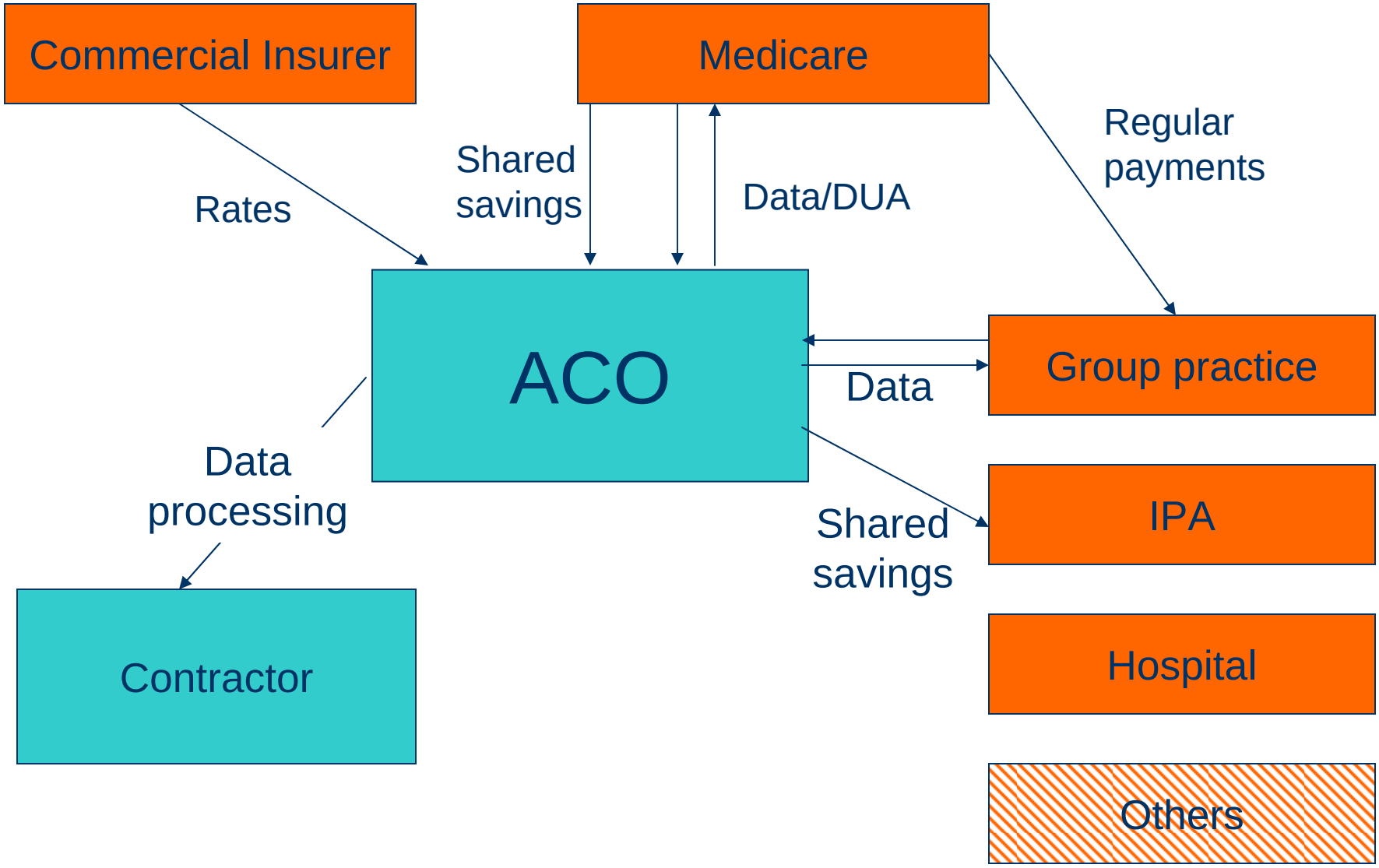
# Medicare ACOs

- An ACO is a group of providers that:
  - Coordinate care for at least 5,000 Medicare fee-for-service beneficiaries
  - Agree to be accountable for quality and cost
  - Share in savings (and potentially losses)
  - Contract with CMS for the shared savings program (SSP)
- May also provide services to beneficiaries of private insurers
  - Clinical integration

# Medicare ACOs

- An ACO is a separate legal entity, consisting of:
  - Group practices
  - Networks of professionals
  - Joint ventures of hospitals and professionals
  - Hospitals employing professionals
  - Others
- Governing body:
  - At least 75% controlled by ACO participants
  - Separate from governing bodies of its members (unless ACO has only one participant)

# Medicare ACOs



# Medicare ACOs

- Beneficiary Assignment
  - Medicare fee-for-service beneficiaries are assigned to the ACO based on whether a plurality of their primary care physician services were obtained from ACO participants
  - Beneficiaries retain freedom of choice of providers
- Medicare continues to pay providers and suppliers for items and services furnished to beneficiaries as it currently does
- Shared savings are paid if—
  - Actual Medicare expenditures are less than budget (based on historic costs of beneficiaries who "would have" been assigned to ACO in prior three years)
  - The ACO meets quality performance standards

# Medicare ACOs

- Performance Standards
  - To qualify for full shared savings, ACO must meet and report quality standards
  - 33 quality measures in four domains--
    - Patient/caregiver experiences
    - Care coordination/patient safety
    - Preventive health
    - At risk population

# Medicare ACOs

- An ACO must be able to—
  - Coordinate care
  - Establish, monitor and report compliance with health care quality criteria
  - Provide clinical management and oversight
  - Receive and distribute shared savings

# Medicare ACOs

In an ACO--

- Participants provide treatment
- ACO performs—
  - Health care operations
    - Care coordination
    - Quality assessment and improvement
    - Population health
  - Payment-related functions

# Medicare ACOs

- CMS provides PHI on condition that the ACO
  - Certifies that—
    - it is a HIPAA covered entity or the BA of ACO participants that are CEs
    - the data is the minimum necessary for the ACO to conduct population-based activities relating to improving health or reducing growth in health care costs, process development, case management, care coordination and provider evaluation.
  - Signs a data use agreement

# Medicare ACOs

- Data sharing based on HIPAA rule allowing disclosure of PHI to a CE or its BA for operational purposes where the PHI relates to a common relationship with the individual
- Health care operations include:
  - Care coordination
  - Quality assessment and improvement
  - Population health
- Limited by HIPAA to minimum necessary

# Medicare ACOs

## Data Use Agreement

- Standard CMS DUA with a supplement for ACOs.
  - Not a HIPAA DUA
- Allows linking to other patient information and use within the ACO for—
  - treatment
  - care management and coordination
  - quality improvement
  - provider incentives

# Medicare ACOs

## Data Use Agreement

- Prohibits disclosure outside ACO participants and providers/suppliers
- Prohibits uses not permitted under HIPAA
- Requires reasonable efforts to limit use to minimum necessary

# Medicare ACOs

- Initially shared data consists of—
  - Data of beneficiaries prospectively assigned to the ACO, provided at the outset and quarterly thereafter--
    - Name
    - Date of birth
    - Sex
    - Health Insurance Claim Number
  - Purpose--
    - Identify assigned beneficiaries
    - Review health records
    - Identify care processes in need of change
    - Contact beneficiaries to describe available benefits and services

# Medicare ACOs

- Additional claims data monthly for individuals who had a visit with an ACO PCP during the performance year
- The ACO must—
  - Make a formal request for the data
  - Certify that the requested data is the minimum necessary for its operational purposes
    - There is a non-exclusive list of data elements in the final rule
  - Limit use to developing processes and improving quality and efficiency
  - Not use the data to reduce or limit care to specific beneficiaries

# Medicare ACOs

- The beneficiary must be given the opportunity in writing to opt out of data sharing
  - Opt-out notice may be given by mail prior to initial ACO visit, and the additional data may be requested if the beneficiary doesn't opt out in 30 days
  - Beneficiaries must be given an opt-out form on first primary care ACO visit
  - Must include an explanation of how the ACO intends to use the data to improve quality of care and coordinate care
  - Opt-out does not affect
    - beneficiary participation
    - data sharing within the ACO

# Medicare ACOs

Sharing of PHI within the ACO

- Not affected by ACO rule – HIPAA governs
- ACO needs data for
  - Payment
  - Health care operations
- ACO is an organized health care arrangement (OHCA)
  - An organized system of health care in which more than one covered entity participates, and in which the participating covered entities:
  - Hold themselves out as a joint arrangement; and
  - Participate in joint activities including
    - Utilization review
    - Quality assessment
    - Payment activities

# Medicare ACOs

In an OHCA--

- Participating CEs can have a common notice of privacy practices
- A CE that participates in an OHCA and engages in BA activities for the OHCA is not necessarily the BA of the other CEs in the OHCA
- CEs participating the OHCA may disclose PHI to other CE in the OHCA for health care operations of the OHCA

# Medical Home

- Model of patient-centered organized care encompassing—
  - Comprehensive physical and mental health care
  - Patient-centered, relationship-based care
  - Coordination of care across the health care system
  - Accessible services
  - Quality and safety
- Payment typically a monthly care management fee

# Medical Home

# Medical Home

- HIPAA allows disclosure of PHI to health care providers for treatment
  - *Treatment* means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.
- HIPAA also permits sharing of health information among providers for payment (subject to minimum necessary)
- Sharing with non-providers (such as social service agencies) would require patient authorization

# Bundled Payment

# Bundled Payments

- Single or linked payments to multiple providers for a single episode of care
- Medicare program has four models
  - Acute hospital stay – hospital services only
  - Acute hospital stay – hospital and physician services
  - Acute hospital stay plus post-acute care for 30-90 days
  - Post-acute care

# Bundled Payments

- Requires providers to share information concerning services and fees
- May be an organized health care arrangement
  - HIPAA permits sharing of PHI for health care operations of the OHCA
- HIPAA permits sharing of PHI for treatment and payment, and for health care operations where the shared data relates to a common relationship