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HEALTH CARE LAWYERS

HIPAA and Payment Reform ACOs, Medical Home, Bundled Payments and Exchanges

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22nd National HIPAA Summit

Washington, D.C.
February 6, 2014

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
- Bundled Payments
    - Links payments for multiple services during an episode of care
    - Medicare Bundled Payment for Care Improvement initiative began April, 2013

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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
  - ACO model does not require financial integration, but provides a model for clinical integration

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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

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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 in the normal way
- Shared savings are paid to the ACO 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

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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

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Medicare ACOs

- An ACO must be able to–
  - Coordinate care
  - Provide clinical management and oversight
  - Monitor and report compliance with health care quality criteria
  - Receive and distribute shared savings
- These are functions of payment and health care operations

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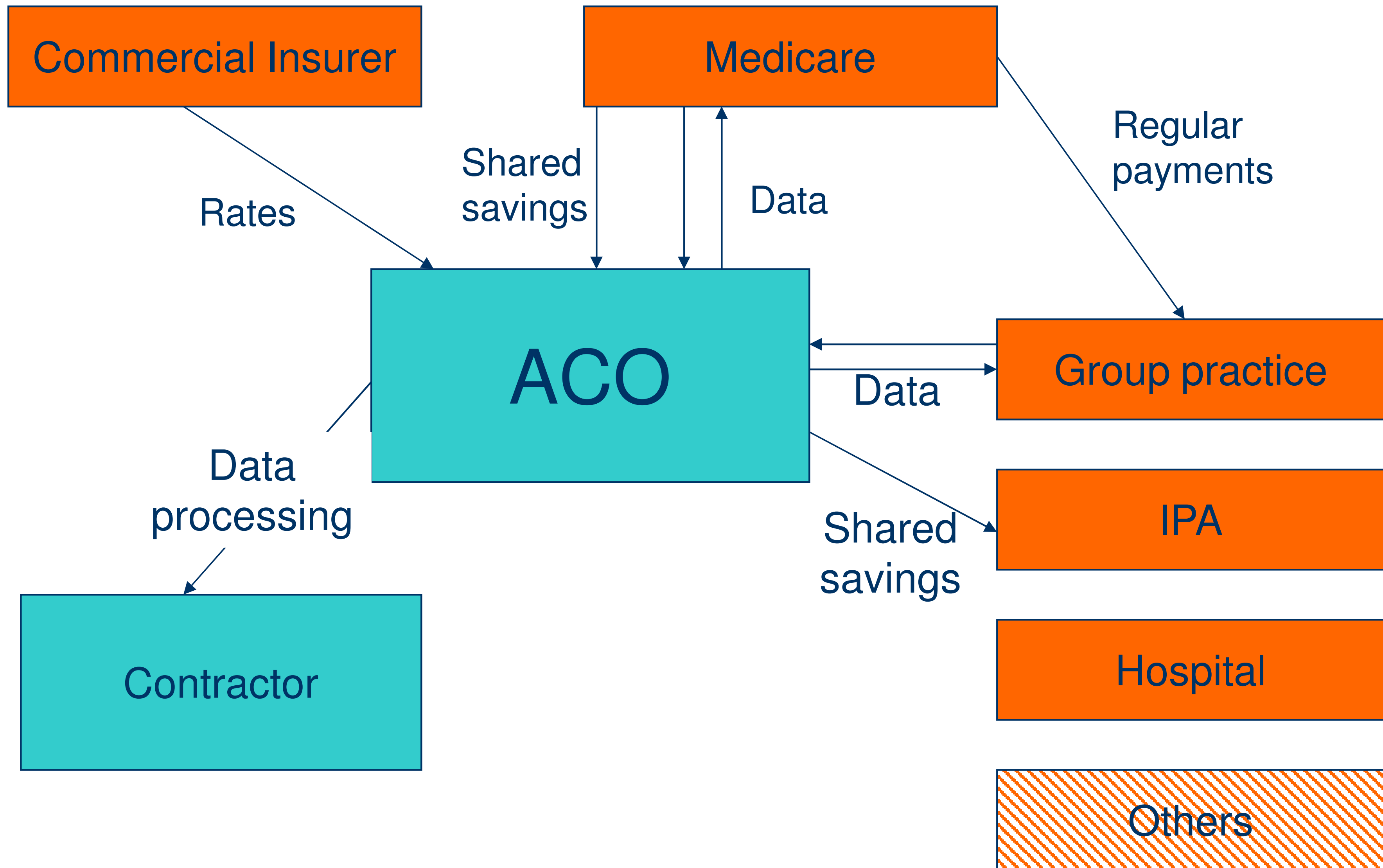
Medicare ACOs



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Medicare ACOs

- CMS provides data on assigned beneficiaries under the 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

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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

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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, quality improvement and provider incentives
- Prohibits disclosure outside ACO participants and providers
- Prohibits uses not permitted under HIPAA
- Requires reasonable efforts to limit use to minimum necessary
- Requires reporting of breaches within one hour by telephone or email

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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

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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

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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 does not 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

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Medicare ACOs

Sharing of PHI within the ACO

- Not affected by ACO rule – HIPAA governs
- ACO needs data for
  - Health care operations
  - Payment
- 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

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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 in the OHCA may disclose PHI to other CEs in the OHCA for health care operations of the OHCA

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Medicare ACOs

In an ACO OHCA

- Participating CEs do not require reciprocal BAAs in order to engage in OCA-related functions
- If the ACO entity is not a CE, participating CEs will need BAAs with it
- Uses and disclosures within the ACO will be limited by the minimum necessary rule

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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

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Medical Home

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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

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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

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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
- Outside an OHCA HIPAA permits sharing of PHI for treatment and payment, and for health care operations where the shared data relates to a common relationship

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Health Care Exchanges

- Providers want to use health information to assist patients in enrolling in exchanges.
- OCR says that using PHI to encourage patients to enroll in Medicare and Medicaid is not marketing, because it has no remunerative value.

http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/marketingrefillreminder.html

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Health Care Exchanges

- In federally-facilitated exchanges (FFEs), HHS contracts with Certified Application Counselor Designated Organizations (CDOs) to facilitate enrollment in the exchange.
- CDOs certify their employees as Certified Application Counselors (CACs)

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Health Care Exchanges

- CDOs collect personally identifiable information (PII) from prospective applicants to facilitate enrollment
  - PII is demographic information, and tobacco use history
- Would be PHI if the CDO is a CE
  - PHI includes demographic information
  - CDO might want a hybrid entity designation under HIPAA

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Health Care Exchanges

- PII may be used only for "Authorized Functions":
  - Providing information on plan options
  - Assisting with applications and facilitating enrollment in insurance plans and premium subsidy programs
- Initial authorization is required for use for Authorized Functions, and any other use requires further "informed consent"
  - CMS provides a model form for the initial authorization

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Health Care Exchanges

- CDO agreement has a 10-page set of Privacy and Security Standards and Implementation Specifications, covering—
  - Individual access to PII
  - Openness and transparency (privacy notice)
  - Individual choice (authorization and informed consent)
  - Restrictions on use and disclosure
  - Authorized Functions (enrollment assistance)
  - Exchange operations
  - Non discrimination

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Health Care Exchanges

- Data quality and integrity
- Verification of identity of persons requesting access or amendment
- Accounting for disclosures
  - Except those necessary for carrying out required functions
  - Maintained for 10 years
  - Made available to consumer on request

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Health Care Exchanges

- Breach incident reporting to CMS
- Standard operating procedures (policies and procedures0
- Training and awareness
- Security controls

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