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HEALTH CARE LAWYERS

HIPAA and Payment Reform ACOs, Medical Home & Bundled Payments

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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
 - ❖ “Next Generation Model” LOIs due May 1, 2015
- Patient-Centered Medical Home
 - Provides comprehensive care management and coordination
 - 3-year ACA-funded pilot covering 434 FQHCs concluded 2014
 - First evaluation report issued March, 2015
- Bundled Payments
 - Links payments for multiple services during an episode of care
 - Medicare Bundled Payment Improvement Initiative began April, 2013
 - First evaluation report issued February, 2015

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 provides a platform for clinical integration

Medicare ACOs

- An ACO is a separate legal entity, consisting of:
 - Primary care physicians
 - Other professional and institutional health care providers
- Governing body:
 - At least 75% controlled by ACO participants
 - Separate from governing bodies of its members (unless the ACO has only one participant)

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
 - Under the Next Generation model, beneficiaries can self-assign
 - ❖ Beneficiaries retain freedom of choice of providers
- Medicare continues to pay providers in the normal way
 - ❖ Next Generation model allows direct capitation payment to ACO
- 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

Medicare ACOs

- Performance Standards

- To qualify for full shared savings, ACO must report and meet quality standards
- 33 quality measures in four domains--
 - ❖ Patient/caregiver experiences
 - ❑ E.g., patient's rating of doctor
 - ❖ Care coordination/patient safety
 - ❑ E.g., screening for fall risk
 - ❖ Preventive health
 - ❑ E.g., blood pressure screening
 - ❖ At risk population
 - ❑ E.g., diabetes management

Medicare ACOs

- ACO Participants provide treatment
- The ACO—
 - Coordinates care
 - Provides clinical management and oversight
 - Monitors and reports compliance with quality criteria
 - Receives and distributes shared savings
- These are functions of--
 - Payment
 - Health care operations

Medicare ACOs

- CMS provides data on assigned beneficiaries under the HIPAA rule allowing disclosure of PHI to a CE (the provider) or its BA (the ACO) for operations where the CE relates to a common relationship with the individual
- Health care operations include—
 - Care coordination
 - Quality assessment and improvement
 - Population health management
- Limited by HIPAA 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
 - ❖ The rule has a non-exclusive list of data elements
 - Limit use to developing processes and improving quality and efficiency
 - Not use the data to reduce or limit care to specific beneficiaries

Medicare ACOs

- To get the CMS data, the ACO must--
 - Certify 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.
 - Sign a data use agreement (DUA)

Medicare ACOs

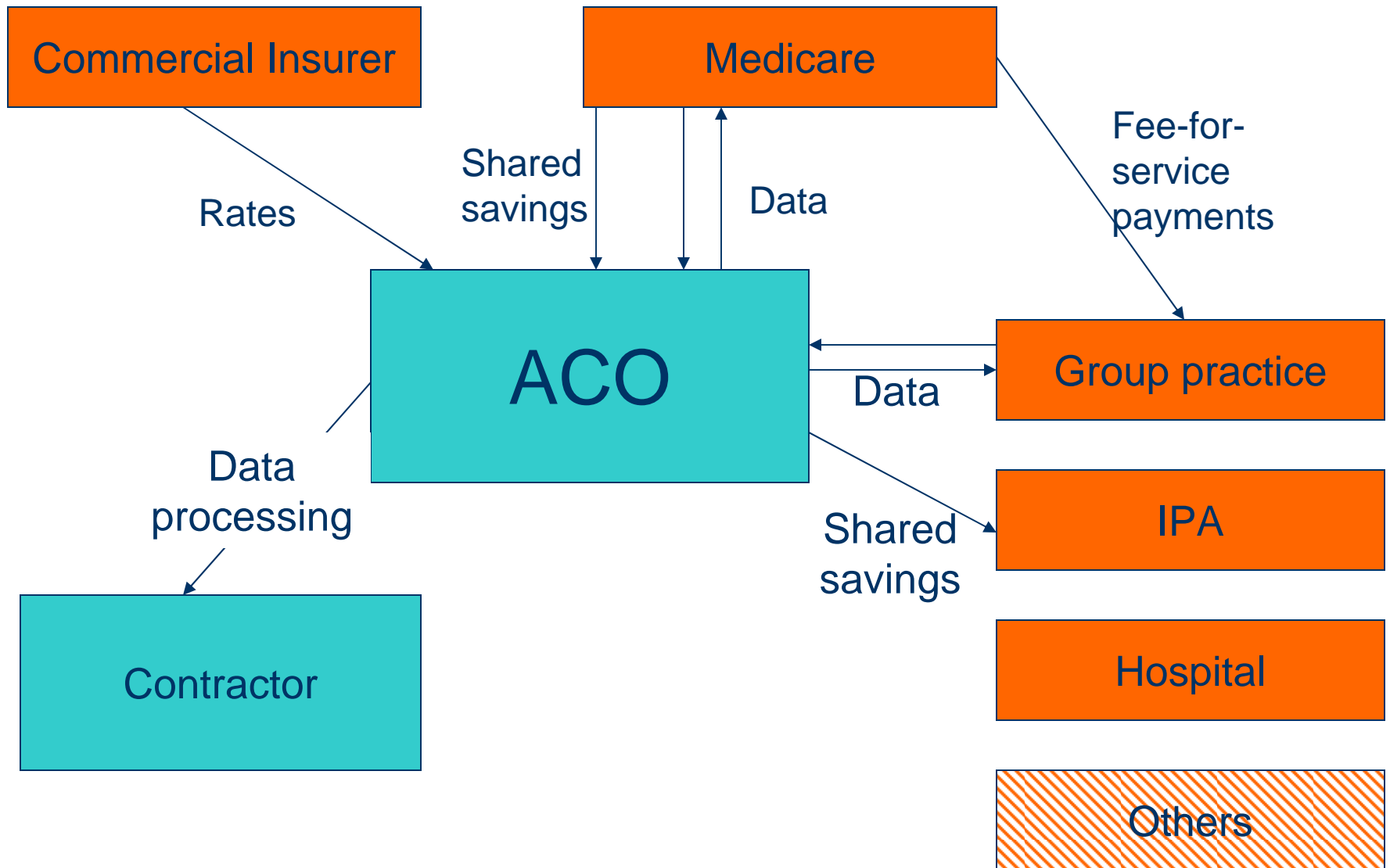
Data Use Agreement

- The DUA is the standard CMS DUA with a supplement for ACOs.
 - (It's not a HIPAA limited data set DUA)
- Allows linking to other patient information and use within the ACO for treatment, care management and coordination, quality improvement and provider incentives
- Prohibits disclosure outside ACO participants and providers/suppliers
- Prohibits uses not permitted under HIPAA
- Requires reasonable efforts to limit use to minimum necessary
- Requires reporting of breaches within one hour by email or telephone

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

Medicare ACOs



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 CEs in the OHCA for health care operations of the OHCA (and they can also share PHI for treatment)

Medicare ACOs

In an ACO OHCA--

- Participating CEs do not require BAAs with one another in order to engage in OHCA-related functions
- If the ACO entity is not a CE, participating CEs will need a BAA with it
- Uses and disclosures within the OHCA for purposes other than treatment are limited to the minimum necessary

Medicare ACOs

Practical challenges--

- Participants have differing technologies
 - ACO needs to communicate with them to
 - ❖ Provide assignment data
 - ❖ Collect quality data
 - ❖ Report on participant's quality and care management
 - ❖ Report on shared savings
 - Population health management systems and IT support may not be eligible for Stark EHR donation or community-wide health information system exceptions

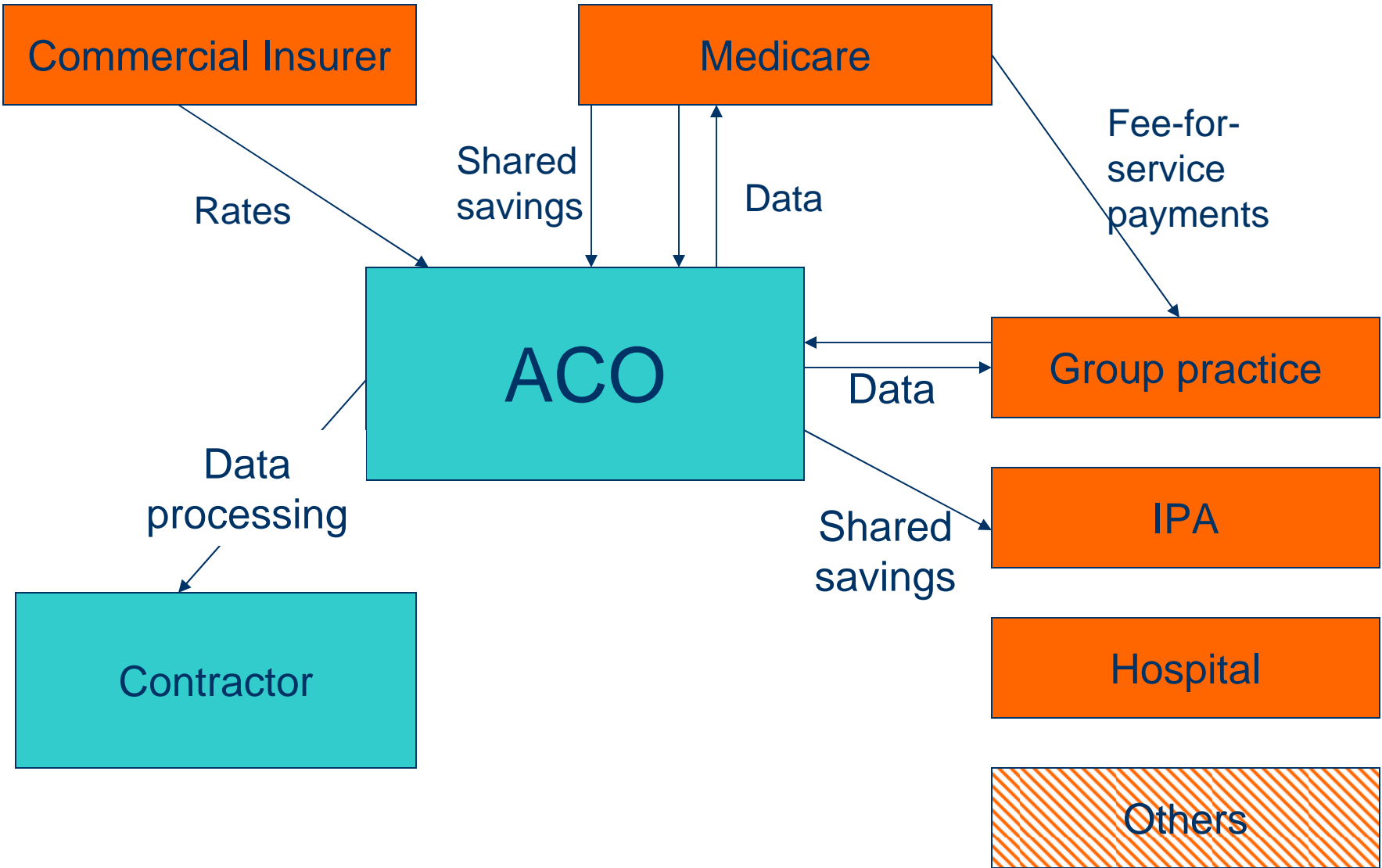
Medicare ACOs

- Participants have differing privacy and security practices
 - The HIPAA BA structure doesn't work well
 - ACO needs uniform privacy and security policies and procedures
 - ❖ Permitted uses and disclosures of ACO data
 - What is the minimum necessary?
 - ❖ Patient opt-out
 - ❖ Sensitive data
 - ❖ Derivative data

Medicare ACOs

- Proliferation of business associates
 - Data services providers and their contractors
- Data breach reporting
 - Heightened risk of breaches
 - Handling incidents
 - ❖ Determining whether a breach is reportable
 - ❖ Reporting timelines
 - ❖ Notification within the ACO network
 - ❖ Liability for costs of notification and mitigation
 - ❖ Insurance and indemnification
 - Encryption
- Privacy and security training

Medicare ACOs



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
- Structure not well defined

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 providers to share PHI with one another for payment
- 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:
 - Hospital alone or hospital and physicians
 - Inpatient and post-acute care for up to 90 days
- Requires providers to share information concerning services and fees
- May be an OHCA
 - HIPAA permits sharing of PHI for health care operations of the OHCA
- Even if it's not, HIPAA permits sharing of PHI for treatment and payment, and for health care operations where the shared data relates to a common relationship