

# Value-Based Health Care? MIPS, CJR and How the Hospital's Dirty Bathroom May Cost Physicians Thousands of Dollars

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# Is This Really The Future?

- FFS has been unpopular for decades.
- Remember the '80s?
- Capitation.
- “Quality” has a better ring to it.
  - Patients who smoke.
  - Is the patient’s blood pressure controlled?
  - Keeping patients safe.

# CMS Goals

- By 2016, 30% of payments tied to quality/value through alternative payment, 85% tied to quality or value.
- By 2018 those rise to 50%/90%.
- MIPS arguably link nearly all Part B physician payments to quality/value.

# Proposed MIPS Rule

- Issued May 9.
- Comment period passed 6/27.
- It's "only" 500 pages.
- <https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf>.

# Replaces Current Quality/Value Programs

- Physician Quality Reporting Program (PQRS).
- Value-Based Payment Modifier (VM)
- Electronic Health Records Incentive Program (EHR).

# Welcome to Acronym, OH

- APM- Alternative Payment Models.
- EP- Eligible Professional.
- FFS - Fee for Service.
- MACRA - Medicare Access and CHIP Reauthorization Act.
- MIPS – Merit-based Incentive Payment System.
- PFPM - Physician Focused Payment Model.
- QCDRs - Qualified Clinical Data Registries.



# APMs

- CMS Innovation Center Model.
- Medicare Shared Savings Program.
- Demonstration under Quality Demonstration Program.
- Demonstration required by federal law.

# APM Benefits

- APM participants get favorable scoring.
- Advanced APM are out of MIPS.
- Qualified APM participants get 5% lump sum bonus.

# Advanced APM

- Requires certified EHR tech.
- Bases payment on quality measures like MIPS.
- Either:
  - Requires more than “nominal” financial risk; or
  - Medical Home under CMMI.
- CJR does not qualify.

# MIPS: Proposed Rule

- Year 1 (data 2017/payment 2019?) MD, DO, DDS, PA, NP, CNS, CRNA.
- Year 3: Add PT, OT, SLP, Aud., Midwife, CSW, psychologist, dietician/nutrition.
- Excluded: First year in Medicare B, fewer than 100 patients and \$10,000, participants in some advanced APM.
- Only applies to professionals, not facilities.

# What's at stake?

- 2019 +/- 4%
- 2020 +/- 5%
- 2021 +/- 7%
- 2022 +/- 9%
- This is misleading: must be budget neutral. Upside may be tripled.

# Participation

- Individually.
- Under group TIN.
- Eventually under a “virtual group?”

# Performance Categories Year 1

- Quality 50%
- Resource Use aka Cost 10%
- Clinical Practice Improvement Activities 15%
- Advancing Care Information 25%

# What Are the Quality Measures?

- List found at 81 FR 28399.
- Choose your 6 measures.
- You report.

MIPS ID Number	NQF/ PQRS	CMS E-Measure ID	National Quality Strategy Domain	Data submission Method	Measure Type	Measure Title and Description <sup>v</sup>	Measure Steward
1	N/A/398	N/A	Effective Clinical Care	Registry	Outcome	<b>Optimal Asthma Control:</b> Patients ages 5-50 (pediatrics ages 5-17) whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools.	Minnesota Community Measurement



# Resource Use

- Calculated from claims.
- Total per costs capita for all attributed beneficiaries and Medicare Spending per Beneficiaries (MSPB) with minor technical adjustments (like Value Based Modifier payment).
- Compared to other care episodes.
- Converted to points.

# Clinical Practice Improvement

- Care coordination, shared decision making, safety checklists, improved access.
- 90 choices.
- Full credit for patient centered medical home.

# Advanced Care Information

- FKA Meaningful Use.
- Weight likely to fall as EHR becomes norm.
- Interesting math:
  - 50 base points, 80 performance points, 1 bonus point “up to a total of 100 points.”

# Composite Performance Score (CPS)

- Each criteria is converted to points.
- Possible adjustments for small or rural practices, non-patient facing practices.
- Still working out the kinks: “‘additional performance threshold’ defined as the 25<sup>th</sup> quartile of possible values above the CPS performance threshold...”



# Network Arrangements; Sources of Legal Concern

## Government Rules:

- MSSP.
- New Models (MIPS).
- Stark.
- Antikickback.
- Antitrust.
- Tax Exemption.
- Insurance Regulation.
- HIPAA.
- PIP Rules.

# Contracts

- Network as Middleman Between Contracting Parties.
  - Payor Contracts.
  - Participant Agreements.
- The biggest source of legal complication for a provider Network is the contracts that it signs with payors.

# Upstream Agreements

- Payor contract may contain a representation that the Network has authority to bind the participants.
- In what situations can participants opt out?
- Does the Network make representations about how the Network will operate or make distributions?



# The “Downstream” Participation Agreement

- Does the downstream participant agree to everything in the upstream contract?
- What about future changes to the arrangement?
- How hard or easy is it for a participant to get out of the arrangement? And what impact does departure have on the financial terms?
- Does the downstream participant see the upstream agreement?

# Sequencing

- If Network starts with a weak, vanilla model participant agreement, it will likely not synch up with the requirements of payor contracts.
- If Network goes first to the payors, it will not have a contracted group to offer.
- If Network develops a very strong agreement, it may have difficulty recruiting participants.

# Term and Termination of Network Agreement

Problems with payor contracts.

- Discretionary distributions rather than defined distributions; lack of transparency.
- Overlapping attribution or uncertainty as to whether a patient belongs to your Network or another Network.
- Network requirement to get authorizations and consents to provide information
- Audit obligations.

# Financial Structures

- A. Shared Savings– Bonus only (upside).
- B. Shared Savings/Shared Losses.
  - What are the savings opportunities?
  - What is the loss exposure?
- C. Full risk/capitation arrangements.
  - Global/TCC.
  - Bundled (episodes of care) payments.

# Financial Structures

- In many total cost of care arrangements participating members will have their own underlying agreements with payers that create the fee-for-service payments.
- In Capitated or Bundled arrangements, all of the payments are typically structured through the Network.

# Participant Buy-in

- Most providers will sign a non-exclusive upside only deal.
- Track record or demonstrable opportunity important for exclusive deals that feature greater risk.

# Must All Members Take the Same Downside Risk?

- No. But some will argue about this.
- For Medicare and Medicaid populations: If arrangement places more than 25% of a physician's potential payments at risk, there must be reinsurance at prescribed attachment points, surveys, reporting.
- Also need to consider State PIP requirements.

# How Are Network Earnings Distributed?

- Downside Risk and Withholds may support idea of clinical or financial integration.
- Distributions in Proportion to Payments.
- Stark and Antikickback Issues.



# Exclusivity in Network Arrangements

- A. Providers in MSSP that perform services upon which CMS bases patient attribution are required to be exclusive to one Medicare ACO.
- B. Some states may restrict exclusive arrangements.
- C. Participants in a Network of providers may view exclusivity as benefitting one member more than another.

# Care Management

What can we do to encourage members to seek care from the lower cost providers in our Network?

- For government patients, the civil monetary penalty rules are important.
  - Subject to limited exceptions, a person cannot offer or provide a financial inducement to encourage someone to select a particular provider/supplier of Medicaid or Medicare payable items or services; “knows or should know” standard.
    - OIG permits “inexpensive gifts” of less than \$10 retail value (and no more than \$50 in the aggregate per patient year) or if the incentive falls within one of five statutory exceptions.
    - An exception for non-cash incentives to promote the delivery of certain preventive care services, if not disproportionate to the value of the preventive care provided.
  - OIG Special Advisory Bulletin on Offering Gifts and Other Inducements to Beneficiaries (Aug 2002).
- Anti-kickback statute is also relevant to this.

# State Regulation of Insurance

- Does the arrangement constitute the business of insurance?
- Is the Network entity directly regulated?
  - PPO and IPA regulation.
  - Some states exercise significant oversight.
  - Is it a utilization review organization?
  - A TPA?

# Clinical Integration

- Do the activities of the network indicate a need to be clinically and/or financially integrated?
- Avoids a *per se* violation of price fixing, market allocation or agreement not to compete.
  - antitrust test becomes, instead, the “rule of reason” test: balancing the pro-competitive benefits versus the anticompetitive effects of the collaboration.
    - Are anti-competitive activities “ancillary to” and “reasonably necessary” to further the legitimate purpose of the network (e.g., achieving cost efficiencies and increased quality of care that benefit patients and payers)?
    - Will the network have market power?

# Clinical Integration

- Clinical Integration:
  - the network effects a high degree of provider interdependence and cooperation to control health care costs and ensure quality health care through the clinically integrated network (CIN).
- Are you prepared to engage in activities that will result in clinical integration?
- Does the contract or other information from the network give you an understanding of what will be required and what the cost may be to your organization?

# Data Sharing

- Purpose:
- Restrictions:
  - HIPAA.
  - State privacy laws.
  - Specific types of records.
  - Patients limiting sharing.

# Data Sharing

- HIPAA: Definition of “health care operations” includes conducting quality assessment and improvement activities; certain patient safety activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment.

# Data Sharing

## HIPAA limits sharing among CEs for the receiving entity's own health care operations:

With a few exceptions, a “covered entity may disclose protected health information [without a patient’s authorization] to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship, and the disclosure is:

- (i) For a purpose listed in paragraph (1) or (2) of the definition of health care operations; or
- (ii) For the purpose of health care fraud and abuse detection or compliance.”



# Data Sharing

HIPAA permits members in an “organized health care arrangement” (an OHCA) to share PHI for healthcare operations, treatment or payment purposes of the OHCA.

“A covered entity that participates in an organized health care arrangement may disclose protected health information about an individual to other participants in the organized health care arrangement for any health care operations activities of the organized health care arrangement.”

# Organized Health Care Arrangement

*Organized health care arrangement* includes (among other things):

- (1) A clinically integrated care setting in which individuals typically receive health care from more than one health care provider.
- (2) An organized system of health care in which more than one covered entity participates and in which the participating covered entities:
  - (i) Hold themselves out to the public as participating in a joint arrangement; and
  - (ii) Participate in joint activities that include at least one of the following:
    - (A) Utilization review, in which health care decisions by participating covered entities are reviewed by other participating covered entities or by a third party on their behalf;
    - (B) Quality assessment and improvement activities, in which treatment provided by participating covered entities is assessed by other participating covered entities or by a third party on their behalf; or
    - (C) Payment activities, if the financial risk for delivering health care is shared, in part or in whole, by participating covered entities through the joint arrangement and if protected health information created or received by a covered entity is reviewed by other participating covered entities or by a third party on their behalf for the purpose of administering the sharing of financial risk.

# Organized Healthcare Arrangements

- Hold themselves out to the public as participating in a joint arrangement.
- Include at least one of the following participating certain joint activities:
  - Utilization review.
  - QA and QI.
  - Payment activities with financial risk.

# Strategy

- Start small, with an idea you can sell to participants. It should be non-exclusive.
- Create incentives to reduce cost that are vetted with compliance experts.
- Develop meaningful integration. Financial integration is easier to show than clinical integration. Cover risks through withholds and reinsurance.

# Continued

- Make the arrangement public.
- Police consent/authorization issue.
- Negotiate contracts that work together but permit modification over time.
- Make the arrangement public.

# Comprehensive Care for Joint Replacement (CJR)

- Makes hospital responsible for cost of a bundle from admission to 90 days post discharge for nearly all Part A/B payments for Total Hip/Knee replacements (DRGs 469/470).
- Hospital will get bonus/penalty based on meeting a target price, patient satisfaction and outcomes measures.
- Applies in 67 MSAs unless hospital is episode initiator in Model 2 or 4 of BCPI, or in Model 1.

# MSAs Included in the CJR Model

10740	Albuquerque, NM	26300	Hot Springs, AR	36740	Orlando-Kissimmee-Sanford, FL
11700	Asheville, NC	26900	Indianapolis-Carmel-Anderson, IN	37860	Pensacola-Ferry Pass-Brent, FL
12020	Athens-Clarke County, GA	28140	Kansas City, MO-KS	38300	Pittsburgh, PA
12420	Austin-Round Rock, TX	28660	Killeen-Temple, TX	38940	Port St. Lucie, FL
13140	Beaumont-Port Arthur, TX	30700	Lincoln, NE	38900	Portland-Vancouver-Hillsboro, OR-WA
13900	Bismarck, ND	31080	Los Angeles-Long Beach-Anaheim, CA	39340	Provo-Orem, UT
14500	Boulder, CO	31180	Lubbock, TX	39740	Reading, PA
15380	Buffalo-Cheektowaga-Niagara Falls, NY	31540	Madison, WI	40980	Saginaw, MI
16020	Cape Girardeau, MO-IL	32820	Memphis, TN-MS-AR	41860	San Francisco-Oakland-Hayward, CA
16180	Carson City, NV	33100	Miami-Fort Lauderdale-West Palm Beach, FL	42660	Seattle-Tacoma-Bellevue, WA
16740	Charlotte-Concord-Gastonia, NC-SC	33340	Milwaukee-Waukesha-West Allis, WI	42680	Sebastian-Vero Beach, FL
17140	Cincinnati, OH-KY-IN	33700	Modesto, CA	43780	South Bend-Mishawaka, IN-MI
17860	Columbia, MO	33740	Monroe, LA	41180	St. Louis, MO-IL
18580	Corpus Christi, TX	33860	Montgomery, AL	44420	Staunton-Waynesboro, VA
19500	Decatur, IL	34940	Naples-Immokalee-Marco Island, FL	45300	Tampa-St. Petersburg-Clearwater, FL
19740	Denver-Aurora-Lakewood, CO	34980	Nashville-Davidson—Murfreesboro-Franklin, TN	45780	Toledo, OH
20020	Dothan, AL	35300	New Haven-Milford, CT	45820	Topeka, KS
20500	Durham-Chapel Hill, NC	35380	New Orleans-Metairie, LA	46220	Tuscaloosa, AL
22420	Flint, MI	35620	New York-Newark-Jersey City, NY-NJ-PA	46340	Tyler, TX
22500	Florence, SC	35980	Norwich-New London, CT	48620	Wichita, KS
23540	Gainesville, FL	36260	Ogden-Clearfield, UT		
23580	Gainesville, GA	36420	Oklahoma City, OK		
24780	Greenville, NC				
25420	Harrisburg-Carlisle, PA				

# Target Price

- Blend of hospital specific and regional expenditures.
- Uses moving 3 years of data.
- Begins 2/3 hospital, 1/3 regional years 1-2, then flips year 3, regional only thereafter.
- Some quirks for low volume, merged split hospitals.



# Caps

- Some caps on repayment.
  - 0 year one.
  - 5% year 2.
  - 10% year 3.
  - 20% year 4-5.
- Same caps on bonus but can be 5% in year one.

# CCJR Details

- Hospitals may, but are not required to incent other care providers/suppliers (“collaborators”).
- Other care providers are not at direct risk, so the hospital will feel real pressure.
- Participation Agreements (similar to gainsharing) are a legitimate alignment tool for hospitals and surgeons.
- The legal impact is small. The practical impact is likely huge.

# “Episode of Care”

- Hospital is responsible for all costs in the episode.
- Costs that may seem unrelated to joint replacement are included (MH/CD, hospice).
- Target prices are based on historical data.
- Is this really rationing?? What are other explanations?

# “Episode of Care”

- 1) Physicians’ services.
- 2) Inpatient hospital services (including hospital readmissions).
- 3) Inpatient psychiatric Facility services.
- 4) Long Term Care Hospital services.
- 5) Inpatient Rehabilitation Facility services.
- 6) SNF services.
- 7) Home Health Agency services.
- 8) Hospital outpatient services.
- 9) Outpatient therapy services.
- 10) Clinical laboratory services.
- 11) DME.
- 12) Part B drugs and biologicals.
- 13) Hospice services.
- 14) Per Beneficiary Per Month payments under models tested under section 1115A of the Act.

# FAQ

- Can hospitals require patients to use certain physicians therapists or SNFs?
- Can you fire patients using expensive vendors? Can you fire non-compliant patients?
- Can the hospital require collaborators to agree to a contract?
- Can collaborators share gain without sharing downside risk?

# Limits on Risksharing

- Must set terms before care is furnished to any patients.
- Must agree upon quality criteria that the collaborator must satisfy in order to receive the payment.
- The total distribution payments paid to a physician practice in a year may not exceed 50% of the total Medicare physician fee schedule payments for services to CJR beneficiaries.
- Only physicians who actually perform services to CJR beneficiaries during at least one episode of care may receive any portion of the gainsharing payment.
- Must use EFT.

# Limits on Risksharing

- Hospital may not recoup money from a collaborator unless the hospital owes CMS.
- Hospital may not recoup from collaborators more than 50% of what it owes CMS.
- Hospital may not collect more than 25% of what it owes CMS from any single collaborator.
- No payment if collaborator “subject to any action for noncompliance with this part or fraud and abuse laws.”

# Can You Have Long Term Payments?

- Yes!
- The conventional wisdom limits gainsharing payments to one year. It's wrong.
- See Advisory Opinion 12-22. "The management agreement is written with a three-year term, and thus is limited in duration."
- Some people claim it only addresses co-management. They're wrong.
- The payment must be reasonable.



# What are the quality metrics?

- THA/TKA Complication measure:
  - acute myocardial infarction;
  - pneumonia, or sepsis/septicemia within 7 days of admission;
  - surgical site bleeding, pulmonary embolism or death within 30 days of admission; or
  - mechanical complications, periprosthetic joint infection, or wound infection within 90 days of admission. (50%)
- Hospital Consumer Assessment of Health Providers and Systems Survey Measure (HCAHPS) survey. (Patient satisfaction tool covering bathrooms cleanliness to pain management. (40%))
- Voluntary submission of outcomes & risk variable data. (10%)

# Quality Metrics Notes

- Collaborators have limited impact on many measures.
- Metrics are converted to points.
- Generally speaking, must avoid being in the bottom 30% of either measure to receive any reconciliation payment.
- Quality Improvement Points awarded for a 3 decile improvement.

# CCJR as a Tipping Point: Practical Impacts

- Hospitals have responsibility/control over total joint episodes. (They are the general contractor, but the sub can do an end run!)
- Hospitals will need to drive cost reductions in episode of care.
- Most key costs are outside of the hospital's direct control. Implants are a notable exception. ("We have the best price.")
- Hospitals outside of 67 MSAs will be watching.
- Other service lines?



# QUESTIONS?

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