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Legal Issues in Medical Practice Management

Presented to:

American College of Osteopathic Internists

By

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Hot Topics in Healthcare

- Accountable Care Organizations
- Independent Practice Associations
- MACRA/MIPS Final Rule

Accountable Care Organizations

ACO's designed to coordinate high quality health care to Medicare patients

ACO participants usually include hospitals, primary care physicians and other health care providers

Commercial ACO's are generally set up by third party payors

Offers potential to share in savings generated by coordination of care

Shared Savings ACO's

Primary care physicians can participate in only one ACO

Specialists can participate in more than one

Referrals of Medicare patients are directed to physicians within the ACO network

ACO must coordinate care across and among PCP, specialists, acute and post-acute providers

ACO must have at least 5,000 Medicare beneficiaries

ACO Risk Models

Tracks during Initial agreement period

- Track 1: ACO participates only in shared saving; OR
- Track 2: ACO participates in savings and losses; OR
- Track 3: ACO participates in both savings and losses but different benchmarks will be applied to determine savings and losses

Track 1 can be selected only for two agreement periods

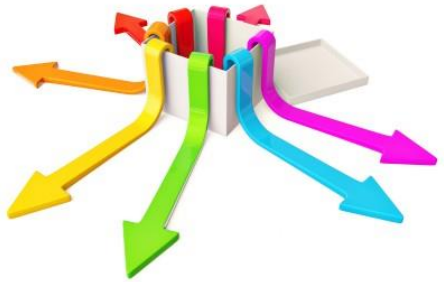
Distributions of Shared Savings

After expenses of ACO are covered, savings are distributed by provider class

Formula not set by statute

Generally, distributed by provider class

- Hospital
- Primary Care Physicians
- Specialists



Largest percentage should go to PCP because of case management oversight and coordination responsibilities

Distribution of Shared Savings (cont.)

All provider classes need to be involved to ensure fairness in distribution

Formula should be simple to understand and based on:

- Citizenship measures (e.g., communication with other providers)
- Individual performance against performance metrics
- Patient outcomes
- Costs measured against targets

Shared Losses

ACO's may incur a loss if the expenditures exceed its benchmark rate by 2%

ACO will be expected to pay the difference between the benchmark and actual expenditures multiplied by its loss rate

Loss rate capped at 5% for 1st year, 7.5% in 2nd year and 10% in 3rd year

ACO's in two-sided model must show ability to pay back losses

Commercial ACO's

Similar in structure to MSSP ACO's

Can create separate quality metrics and benchmarks

Shared savings are usually split among payor and physician practices

Distribution formula is determined by payor in conjunction with providers and hospital system partners

ACO Historical Experience

- Paperwork Intensive
- High overhead expenses
- Distribution formula determines bonuses
- Anecdotal experience: Physicians' bonuses under $50,000 annually

Independent Physician Associations

A business entity owned by independent physician practices

Provides services to member practices with the goal of reducing overhead

Can negotiate on behalf of member practices with third party payors to achieve better reimbursements

Serves as mechanism for physicians to work toward growth and clinical integration

IPA's (cont.)

IPA can participate with ACO and other collaborative ventures with hospital systems

IPA models include:

- Messenger model: the IPA cannot bind the member practices but operates as a conduit between member practices and payors
- Clinically integrated model: integration via EMR to provide quality controls and optimal health outcomes to patients

IPA's (continued)

Achieving Clinical Integration:

Physician alignment is crucial – check the egos at the door!!

- Collaborative and coordinated approach to quality metrics
- Family physicians and internists in IPA can utilize their unique skills and expertise in care management, interface between specialists and hospitals and focus on preventative care
- IPA focus should be on producing quality clinical outcomes in a cost efficient manner
- Centralized contracting

IPA Antitrust Issues

The Federal Trade Commission (FTC) and the Department of Justice (DOJ)regulate anti-competitive activities in the United states.

Physician collective bargaining has been the subject of a number of cases

FTC has promulgated safe harbors and advisory opinions which provide guidance to IPA's and other physician organizations

Antitrust Issues (cont.)

FTC implemented statements on healthcare antitrust safe harbors in 1996 based on the rule of reason:

1. Participants share economic risk
2. Organization functions as an integrated joint venture
3. Non-exclusive network - physician participants can contract with payors independent of IPA
4. Utilization management/quality assurance metrics are created to provide cost efficiencies

Reasons for Alignment

Move from fee for service in billing to value based (MACRA & MIPS)

Increased complexity in regulatory compliance (HIPAA, HITECH and state identity theft laws)

Reductions in reimbursement

Increased practice overhead

Pressure from hospital-based practices

MACRA and MIPS Final Rule

Issued on October 14, 2016

Relates only to Medicare billing

Repeals Sustainable Growth Rule (SGR)

Collects data from Medicare Participating physicians for 2017

Positive payment updates .5% through 2019

Physicians in alternate payment models receive

5% bonus from 2019 to 2024

Glossary:

MACRA – Medicare Access & CHIP Reauthorization Act

MIPS – Merit-Based Incentive Payment System

APMs – Alternative Payment Models

QPP – Quality Payment Program

MACRA MIPS Final Rule (cont.)

- MIPS – will be primary payment model
  - Payments based on:
    - Quality
    - Resource Use
    - Meaningful Use
    - Clinical Practice Improvement Activities

Quality Metrics

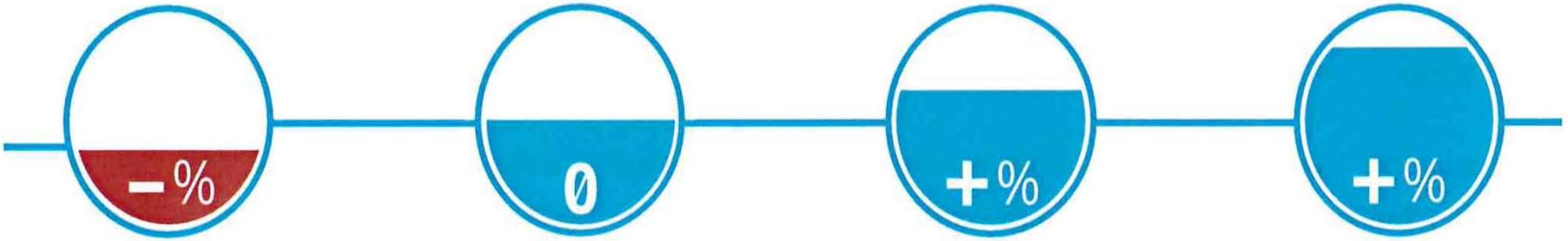
% of Overall MIPS Score

	Proposal	Now
Quality	50%	60%
Advancing Care Information	25%	25%
Clinical Practice Improvement Activities	15%	15%
Resource Use: Cost	10%	----*

*will not be counted until 2018

Quality Payment Program

Pick your pace in MIPS: If you choose the MIPS track of the Quality Payment Program, you have three options.



Not participating in the Quality Payment Program: If you don't send in any 2017 data, then you receive a negative 4% payment adjustment.

Test: If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), you can avoid a downward payment adjustment.

Partial: If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment.

Full: If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment.

No Quality data reported in 2017	→	4% penalty on Medicare receipts in 2019
Some data reported	→	Neutral
90 days of data	→	Estimate 0-2% update
Full year of data	→	Estimate 0-4% update

MACRA Alternate Payment Models

- Payment for High Value Service
- Reimbursements can increase by a maximum of 5%
- Physicians enrolled in APM's are exempt from MIPS

Resources:

CMS Resources:

Quality Payment Program: https://qpp.cms.gov/

Quality Payment Program Education & Tools: https://qpp.cms.gov/education

Executive Summary: https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf

Fact Sheet: https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf

Resources:

AMA Resources:

MACRA Checklist: Steps to Take Now (AMA): www.ama-assn.org/ama/pub/advocacy/topics/medicare-new-payment-systems.page

Prepare for changes happening through the Medicare Access & CHIP Reauthorization Act (MACRA www.ama-assn.org/ama/pub/advocacy/topics/medicare-physician-payment-reform.page

Payment Model Evaluator https://apps.ama-assn.org/pme/#/

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Thank you.

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