Collaborator Agreements, Gainsharing and Program Waiver

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Collaborator Agreements

- Hospitals may enter into certain financial arrangements with collaborating providers and suppliers who are engaged in care redesign with the hospital and who furnish services to the beneficiary during an episode.

- Under these arrangements, a participant hospital may share with CJR Collaborators: (1) payments received from Medicare as a result of reduced episode spending; and (2) hospital internal cost savings.

- Participant hospitals may also share financial accountability for increased episode spending (i.e., downside risk).

Collaborator Agreements (continued)

- Selecting collaborators:
  - Based on quality
  - Not based on volume/value of referrals
  - Must be voluntary

- Hospitals cannot coerce, require or penalize non-collaborators.

- Selection criteria must be identified in agreement.

- Hospital is responsible for compliance.

- “Gainsharing” Payments & “Alignment” Payments.
Collaborator Agreements (continued)

- Only care provided after agreement is entered into counts for payment under agreement (but, you can enter into an agreement at any time!)
- CJR collaborators must provide care to CJR beneficiaries
- CJR collaborator must engage in “care redesign”
- Gainsharing/Alignment payments cannot directly account for volume/value of referrals or business generated between the parties or affiliates
- Gainsharing payments at least in part based on quality

Collaborator Agreements (continued)

- Gainsharing:
  -- Capped for physicians at 50% of their Medicare collections for CJR services at hospital
  -- Paid by electronic funds transfer, annually
  -- Actually and proportionally related to CJR services
- Cannot induce any party to reduce or limit “medically necessary” services to beneficiaries
- Cannot restrict CJR collaborator’s ability to make decisions in patient’s best interest
- Internal cost savings:
  -- Transparent, measurable, verifiable
  -- Calculated in accord with GAAP
  -- Result from care redesign
Collaborator Agreements (continued)

- Alignment payments may be made at any interval agreed to by the parties
- Aggregate alignment payments cannot exceed 50% of the repayment amount owed by hospital to CMS
- No single Collaborator may be asked to pay more than 25% of the total amount owed by the hospital
- Alignment payments must:
  -- Not be issued, distributed or paid prior to CMS determining a repayment amount as reflected in a reconciliation report
  -- Not be a loan, advance payment or payment for referral

Collaborator Agreements (continued)

- Many specific requirements regarding what must be included: quality criteria, selection criteria, hospital’s right to recoupment, financial terms and calculations, care redesign, safeguards, compliance with certain regulatory requirements
- Practical tips:
  -- Consider including beneficiary notice templates
  -- Consider including as much detail as possible
  -- Consider change in law/jeopardy provision
  -- Consider cross-referencing policies, regulations
  -- Consider attaching a form of “Distribution Agreement” to any CJR Collaborator Agreement with a medical group
Joint Replacement Program: Fraud & Abuse Waivers

- The Fraud & Abuse Waivers cover (1) beneficiary incentives, (2) gainsharing or alignment payments made by hospital to CJR Collaborators, and (3) distribution payments from medical group to its members.

- Waiver applies to the Anti-Kickback Law, the Stark Law, and the Civil Monetary Penalty (CMP) Law.

- Collaborator agreements permit gainsharing payments and alignment payments from/to hospitals and their “CJR collaborator,” e.g., (1) SNF, (2) HHA, (3) LTCH, (4) IRF, (5) Physician, (6) Non-physician Practitioner, (7) Outpatient Therapy Provider, or (8) Physician Group Practice.

- The hospital’s governing body and compliance department document must oversee the policies and agreements and compliance with CJR requirements.

Joint Replacement Program: Fraud & Abuse Waivers (continued)

- Hospitals must maintain a list of their CJR collaborators and post it on their website.

- Hospitals must document their policies, criteria, agreements, payments, calculations, internal cost savings tracking system, etc.

- Medical groups may distribute gainsharing payments received from hospitals only in accordance with specific requirements, e.g., using written agreements (“Distribution Agreements”) between the group and each participating physician; payments cannot be based on referrals; payment can be made only to physicians providing services to beneficiaries receiving care covered by joint replacement program, etc.
Joint Replacement Program: Fraud & Abuse Waivers (continued)

- The waivers apply to the Stark Law and Anti-Kickback Statute, for both gainsharing payments and alignment payments, if:
  - All the requirements of the joint replacement program are met
  - The hospital does not add conditions, limits or restrictions beyond what the regulation permits
  - The CJR collaborator is selected in part based on quality of care, and the CJR collaborator meets these quality criteria as established by the hospital
  - The method for paying gainsharing must include quality
  - All payments must be by electronic funds transfer

- The waivers apply only as to the joint replacement program and not beyond it – BEWARE OF INCLUDING NON-CJR ACTIVITIES!

- There is a corresponding waiver for payments from a group to its physicians
- There is a waiver for in-kind items or services provided to beneficiaries
Patient Engagement Waiver

- Patient engagement waiver permits certain beneficiary incentives
- Waives certain fraud and abuse laws, and protects certain activities from the Anti-Kickback Statute and the Anti-Beneficiary Inducements Law (CMP Law)
- Requirements related to:
  -- Provider of the incentive (hospital or its agent);
  -- Nature of the incentive (for preventive care or to incentivize adherence to treatment plan, reductions in readmission and management of chronic conditions, i.e., reasonably connected to care provided);
  -- Value of incentive ($1,000 limit on technology; in-kind, not cash; technology worth over $100 must be returned);
  -- Documentation of incentive; and
  -- Timing of incentive (only during the 90 days of the CJR episode).

Program Waivers: SNF

- CJR model waives the SNF three-day rule for coverage of a SNF stay following hospitalization, effective on January 1, 2017
- Beneficiaries discharged pursuant to the waiver must be transferred to SNFs rated three-stars or better (at least seven of the previous 12 months)
- Beneficiaries must NOT be discharged prematurely to SNFs, and must retain freedom of choice without patient steering
**Program Waivers: Home Visits**

- For CJR post-discharge home visits, CMS waives the “incident to” direct supervision rule for physician services
- Allows clinical staff of a physician or non-physician practitioner to furnish a visit, in the beneficiary’s home, under physician’s general supervision
- Permitted only for beneficiaries who do not qualify for home health agency services
- Waiver allows a maximum of nine visits during the episode, billed under the Physician Fee Schedule using a HCPCS code created for the model

**Program Waivers: Telehealth**

- CJR model waives the geographic site requirement for any service on the Medicare-approved telehealth list and the originating site requirement only to permit telehealth visits to originate in the beneficiary’s home or place of residence
- Telehealth visits under the waiver cannot be a substitute for in-person home health agency services
- Requires all telehealth services to be furnished in accordance with all other Medicare coverage and payment criteria except that payment for the special home health visits under the model will be paid at a special rate
- The facility fee paid by Medicare to an originating site for a telehealth service is waived if the service was originated in the beneficiary’s home
Implementation Examples: Beneficiary Engagement

- Pre-surgery “Boot Camps” and Booklets
  -- Create expectations that patient will go home
  -- Insist on live-alone patients enlisting caregiver
- Software programs that track information and automatically send patients queries/reminders, text physicians, nurse, etc. on a daily basis post-discharge
- Many/most use a care coordinator (nurse or even unlicensed individual) to monitor patient post discharge
- High-tech gizmos? (fitbits, in-home camera to measure body movement, etc.)

Implementation Examples: Physician Engagement

- Most are doing Gainsharing (some moving to add alignment payments later)
- How gainsharing payments are being made:
  -- Pay based on physician’s Medicare collections for CJR patients at the hospital, subject to quality
  -- Some pay for all CJR services, subject to quality
  -- Some net those CJR beneficiary cases that lose money against those that generate savings, subject to quality
  -- Some pay only on CJR beneficiaries that generated savings, subject to quality
- Care redesign is leading to higher engagement/involvement
Implementation Examples: Physician Engagement (continued)

- Internal cost savings can be a key:
  - Implants
  - Standardizing surgery packs
- Make sure to keep careful track of physicians coming and going, of data, of documentation
- Is hospital able to access and use necessary data to calculate payments to physicians?

Implementation Examples: PAC Engagement

- Issuing RFP for PACs seeking preferred status; site visits
- Monthly meetings of SNFs to review data
- Which physicians are following patients at SNFs?
- What percentage of discharges go to SNFs?
- What if your hospital has a TCU/SNF?
- Bed reservation agreement?
**Do’s:**

- **Do** engage in robust care redesign
- **Do** enter into CJR Collaborator Agreements
- **Do** allow physicians gainsharing opportunities, including both CMS savings achieved and internal cost savings
- **Do** use the CMS quality metrics when measuring quality

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**Do’s:**

(continued)

- **Do** be careful and thorough in policies, documentation, data measurement, etc.
- **Do** look for ways to engage with patients
- **Do** develop a PAC strategy
- **Do** pay attention to developments in strategy, tactics, technology and clinical care
**Don’ts:**

- Don’t enter into alignment payment arrangements without careful consideration
- Don’t establish a gainsharing allocation method unless your data allows it to be calculated
- Don’t be sloppy with documentation, policies, calculations, data, etc.
- Don’t overlook collaborative opportunities with CJR collaborators beyond CJR

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**Don’ts:**

(continued)

- Don’t tie or condition CJR collaboration to non-CJR activities or patients
- Don’t forget, there are more bundled payment initiatives coming!!!
Questions?

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