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PBN Perspectives

New OIG RFI shows Stark reform push is real — but results may be small

A new request for information (RFI) from the Office of Inspector General (OIG) on Stark law suggest that reform, a longtime topic of discussion among health care analysts, may be coming — but probably at a slower rate of speed than reformists would like.

The new RFI comes on the heels of an RFI on the same subject from CMS, and some encouraging words from HHS officials. For years, CMS and OIG have been reinterpreting and tinkering with regulations pertaining to Stark law, which tightly regulates the conditions under which referrals for designated health services

*(see **PBN perspectives,** p. 4)*

Patient encounters

As advance care planning booms, use 5 tips to expand your offerings

Practices have been part of a boom in advance care planning (ACP) in recent years, but CMS' open-ended rules and the wide eligibility parameters for ACP codes **99497-99498** suggest plenty of room for growth.

That's good news for providers who are ready to engage patients in conversations about their health care decisions as patients age or face serious illnesses. The ACP codes, which debuted in 2016, have been a positive gain for providers, says

*(see **Advance care planning,** p. 7)*

Elevate medical decision-making, boost cash

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room — you are less likely to implicate privacy regulations by contacting the third-parties." He cautions that his are only general statements of legal principle and advises you consult an attorney if you have a particular situation.

Nonetheless, Correll advises precautions: "A provider doesn't want to open itself up to civil liability, such as a defamation suit or poor publicity, in an age where everyone has a cell phone camera." If they feel the need to call the cops, staff should be circumspect: "If you need to summon law enforcement due to in-progress criminal activity, you should consider having police conduct their own investigation and draw their own conclusions rather than to editorialize" — that is, "when communicating to third parties, stick to things readily observed by the employee rather than speculation or guesswork. Speculation, if false, can open tort liability." In other words, report disoriented behavior rather than "this lady is stoned."

If the suspicious party presents a credible threat to the other patients and staff, you certainly have the right to remove them (*PBN 6/13/18*). Practices of a certain size "may want to consider subcontracting security services in an effort to insulate themselves from tort claims," says Correll.

Obviously there were good reasons for the practice people in the cases our questioner mentioned to summon the law. But if the patient-in-waiting provides neither danger nor a disturbance, maybe you needn't do anything. "Criminals need health care services just like anyone else," says Correll. — *Roy Edroso* (*redroso@decisionhealth.com*)

PBN Perspectives

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(DHS) among providers related by family or partnership can be made, and the anti-kickback statute (AKS), which prohibits inducements and rewards for all health services paid by the federal government (*PBN 6/1/04*). Sometimes federal courts have even had to step in to interpret their limits, as when a District Court ruled in 2002 that CMS could not include lithotripsy among its list of DHS (*PBN 10/1/02*).

Further tinkering was necessitated by the emergence of CMS' Shared Savings and other accountable care organization (ACO) programs, which required waivers and safe harbors to prevent constant violation of the rules, as the programs were designed to promote referral of patients and services within networks.

And the reform-minded Trump administration — including HHS Secretary Alex Azar — has expressed an eagerness to make Stark changes, particularly when it comes to ACOs and other quality-based models (*PBN 4/2/18*). In June, CMS released an RFI asking providers to weigh in on the negative impact of the physician self-referral law aspect of Stark on coordinated care arrangements such as bundled payment programs, with an obvious eye toward scaling back the burden (*PBN 7/2/18*).

And on Aug. 27, OIG issued its own Stark- and AKS-related RFI asking, among other things, how "relieving or eliminating beneficiary cost-sharing obligations might improve care delivery, enhance value-based arrangements and promote quality of care." While the CMS RFI has closed to comments, the OIG RFI is open for comments until Oct. 26 (*see resources, below*).

Value-based care needs a break

Kathy H. Butler, officer and attorney in the Health Care Practice Group at Greensfelder, Hemker & Gale, P.C., in St. Louis, sees the RFIs as evidence that HHS "is realizing that regulations are impeding success and willingness to participate [in value-based programs]." Federal penalties can be "draconian," she says, and Stark penalties in particular are "written into the law, so they'll have to create new exceptions" to protect providers.

Also, value-based programs, current and future, present new compliance challenges. For example, "there are CMPs [civil monetary penalties] for reducing services provided to Medicare beneficiaries in a hospital setting," says Butler. "But what does that mean in the context of quality-based payments? Say a patient is being treated as an inpatient for a condition and, according to objective data and best practices, with medically appropriate treatment, unless they're an outlier, they should be out in three days. … If you have a hospital with excessive lengths of stay and enter into a contract that pays a physician or physician group a bonus for bringing that length of stay within the norm, does it violate CMP in that you're incenting reduced services? It could be construed that way. I'm reluctant to advise clients that it's completely safe to enter into such arrangements. The RFIs are looking at these kinds of agreements — whether they can safely relax standards to allow care coordination for more efficient delivery of medical services without creating a perverse incentive that will cost more money or create risk for the patient."

Law change 'not in the cards'

All this activity, coupled with tantalizing statements like CMS Administrator Seema Verma's assertion that

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"we are going to do something on Stark, I'm very certain about that, and we hope to have something out by the end of the year," suggests the administration is preparing to make bigger-than-usual moves on Stark and AKS soon.

But there are impediments to that, says John F. Williams, a former Capitol Hill staffer now with law firm Hall, Render, Killian, Heath & Lyman in Washington, D.C. For one thing, he says, all the changes would be to regulations, not to the law, which would limit the scope of what they could accomplish. "I can tell you for certain that Congress won't be doing anything on Stark this year," he says. "I've spoken to staff on both sides of the aisle and they all agree that moving Stark legislation isn't in the cards. I don't believe they've even come to an agreement on what might go into a Stark bill."

New guidance can help

In addition to whatever regulatory changes HHS can effect, Butler would like to see more advisory opinions to help providers understand the lay of the land. Providers are most familiar with OIG's advisory opinions, but such guidance also appears in other documents — for example, in "preambles and/or commentary from CMS on its interpretation of the Stark law" in the Medicare physician fee schedule and other rules.

"The OIG issues advisory opinions on AKS and CMP issues and, even though they only technically apply to the person requesting the opinion, they are routinely used within the industry to provide support for various arrangements," says Butler. "There's so much that's unclear, so people rely on commentary and sub-regulatory guidance. Advisory opinions at least provide something in writing you could point to and say, 'here, they say you can do this.'"

Near term, just small changes

Michael Abrams, managing partner of the Numerof & Associates consultancy in St. Louis, expects only small-bore changes. "The most likely outcome of this area of activity would be additional carve-outs to liberalize the understanding of what's acceptable and what's not," he says.

Abrams is aware that some industry groups want bigger changes, and soon, but he's not convinced. "It's interesting that organizations like AHA [the American Hospital Association] are trying to make the case that progress toward value-based care is impeded by existing regulations," he says, when "most delivery organizations have only dipped their toe in this pool. From my perspective, they are using this argument as a crowbar to pry open the door to new revenue streams."

Regarding beneficiary inducements, Abrams would prefer to see more "transparency and accountability" in health care spending first.

"In other areas of commerce where a service provider is offering a discount, it's not controversial because consumers probably know enough about what they're offering to evaluate whether the trade-off makes sense," says Abrams. "Maybe this provider isn't platinum quality or maybe is in a less desirable location, and that's why they're offering a discount. None of these things is visible to the patient now, and until it is, we'd be getting ahead of

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ourselves to expand those inducements." — *Roy Edroso* (*redroso@decisionhealth.com*)

Resources:

- Medicare Program; RFI Regarding the Physician Self-Referral Law: *www.federalregister.gov/documents/2018/06/25/2018-13529/medicare-program-request-for-information-regarding-the-physician-self-referral-law*
- Medicare and State Health Care Programs: Fraud and Abuse; RFI Regarding the Anti-Kickback Statute and Beneficiary Inducements CMP: *www.federalregister.gov/documents/2018/08/27/2018-18519/medicare-and-state-health-care-programs-fraud-and-abuse-request-for-information-regarding-the*

Advance care planning

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Ken Kephart, M.D., a geriatrician with Fairview Health Services in Minneapolis.

The codes mark "another progression in Medicare realizing that talking to patients is worth something," says Kephart, who is also medical director of Honoring Choices Minnesota, a non-profit dedicated to promoting advance care planning.

In 2017, providers gained nearly $72 million in payments for the two ACP codes, which marks a 65% increase in revenue compared with the year before. Nearly all, or about $70 million, of the total revenue was tied to base code 99497, which pays $86 per claim and requires 30 minutes of discussion related to a patient's advance directives or other aging-related concerns. Providers billed about 1.2 million claims for 99497 in 2017 (*see benchmark, p. 5*).

Despite the rise in claims and revenue, the latest numbers could reveal that providers are only beginning to scratch the surface on ACP potential. "It's totally low," says M. Jane Markley, health care ethics adviser and president of M. Jane Markley Consulting in Derwood, Md. "There should be much, much more since the subject should be brought up with all patients over the age of 18."

Several factors, including a provider's reluctance to talk about end-of-life care, may be suppressing overall use, Markley says. "Our society is so reluctant to deal with death," she says. "Physicians may not want to bring this up because they don't want to make patients think they're sicker than they are."

While providers can be cautious about these types of conversations, patients often want to talk about their choices, says Karl Steinberg, M.D., a geriatrician and chair of the public policy committee with The Society for

Patient encounters

Easing the conversation: A game to promote advance care planning

Practices that want to introduce a dose of levity into their advance care planning efforts can find an outlet in card games that steer patients through what are sometimes challenging conversations.

One example is *Hello: The Conversation Game For Living and Dying Well,* which describes itself as an "easy, non-threatening way to start a conversation with your family and friends about what matters most to you." Created by Philadelphia-based Common Practice, the game includes multiple booklets, each containing a series of questions about one's wishes about aging and, potentially, dying.

"We're very interested in the conversations that are necessary for advance care planning to happen," says Jeff Cohn, M.D., medical director of Common Practice. The Hello Game seeks to lay the groundwork for people and patients to have serious conversations about illness and aging, but it does so in an engaging way.

"Most people playing the game think, 'This isn't as hard as I thought,'" Cohn says. "It can even be fun."

Cohn says that his company has engaged health care personnel to enhance their own conversation-savvy, but mainly the game is directed at patients as they explore their personal desires on aging needs. For instance, the game asks, "In order to provide you with the best case possible, what three non-medical facts should your doctor or health care team know about you?"

Other products, including the *Go Wish* game, offer similar entry points to card-based advance care planning conversations. If you do use a card game to steer advance care planning conversations, be sure to document the scope of your discussion and the link to advance directives, as the code stipulates. — *Richard Scott* (*rscott@decisionhealth.com*)

Resources:

- *Hello* Game: *https://commonpractice.com/*
- *Go Wish* game: *http://gowish.org/*