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The RAP Sheet

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Table of Contents

CMS Creates New Episode Payment Models

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On January 3, 2017, the Centers for Medicare & Medicaid Services (CMS) published a final rule implementing new episode payment models (EPMs) covering acute myocardial infarction (AMI), coronary artery bypass graft (CABG), and surgical hip/femur fractures (SHFFT) (the Final Rule).[1] The Final Rule represents CMS' further exercise of its authority under the Affordable Care Act (ACA) to develop new payment and service delivery models and demonstration projects. The models will be mandatory for acute care hospitals in certain designated Metropolitan Statistical Areas (MSAs). CMS will perform retrospective reconciliations comparing total Medicare Part A and Part B reimbursement to quality-adjusted targets for defined episodes of care. Acute care hospitals will bear both upside risk and downside risk for a portion of the amounts determined pursuant to the reconciliation process.

The models permit acute care hospitals to collaborate with other Medicare providers and suppliers participating in the care of covered beneficiaries to develop and implement strategies for care redesign. To help align financial incentives, the models also permit acute care hospitals to enter into agreements with certain Medicare providers and suppliers to share upside and downside financial risk associated with CMS' retrospective reconciliation, and to share internal cost savings achieved by the acute care hospitals as a result of care redesign activities.

Since publication of the Final Rule, CMS delayed the applicability of the regulations governing the new EPMs twice.[2] Most recently, in a Final Rule published May 20, 2017, CMS established the effective date of the Final Rule as May 20, 2017, and delayed the applicability of the regulations governing the new EPMs until January 1, 2018.[3]

As with other payment models implemented by CMS' Innovation Center, the future of the EPMs implemented by the Final Rule may well depend upon legislative efforts to repeal the ACA and the Trump Administration's executive action related to the ACA.

AMI, CABG, and SHFFT EPMs/Participating Hospitals

The new EPMs are retrospective reconciliation models that apply to Medicare Severity Diagnosis Related Groups (MS-DRGs) associated with AMI, CABG, and SHFFT episodes.[4] When one of these MS-DRGs is assigned to an inpatient admission at an acute care hospital covered by the EPMs, the applicable EPM governs the beneficiary's episode of care unless the beneficiary is excluded. The Final Rule excludes beneficiaries covered by the CMS Innovation Center's Bundled Payments for Care Improvement (BPCI) program, Medicare managed care, and certain CMS shared savings and other programs.[5]

Unlike the voluntary BPCI initiative, the EPMs are mandatory for acute care hospitals located in MSAs identified in the Final Rule.[6] CMS will implement the AMI and CABG Models in 98 MSAs and the SHFFT Model in the 67 MSAs in which the Comprehensive Care for Joint Replacement Model currently operates.[7] CMS anticipates that approximately 1,120 hospitals will participate in the AMI and CABG Models and 860 hospitals in the SHFFT Model.[8]

Financial Considerations

The new EPMs will be effective for five performance years. Under the EPM Models, providers and suppliers will receive normal Medicare Part A and Part B reimbursement for services provided to AMI, CABG, or SHFFT beneficiaries during an episode of care.[9] An episode of care begins with an inpatient admission, extends for 90 days after a patient's hospital discharge, and includes the entire inpatient stay and all related care, including hospital, post-acute, and physician services.[10] Each performance year will include episodes of care concluding during such performance year.[11]

As a result of the reconciliation process, the acute care hospital to which an EPM beneficiary is admitted to begin an episode of care will be financially responsible for *all* Medicare reimbursement, not only for the inpatient hospitalization, but also for all related care provided by any Medicare provider or supplier during the period ending 90 days after hospital discharge. Beginning not later than the third performance year, if actual Medicare spending exceeds quality-adjusted targets, the participant hospital must pay CMS the difference, subject to stop-loss limits.[12] If actual Medicare spending is less than quality-adjusted targets, the participant hospital receives an additional payment from CMS equal to the difference, subject to stop-gain limits.[13]

Prior to the commencement of each performance year, CMS will determine a hospital-specific quality-adjusted target price for each covered MS-DRG.[14] The quality-adjusted target prices are determined by MS-DRGs and include all services provided under the episode of care. The target price determination begins with a benchmark amount reflecting historic reimbursement for each model using a blend of

hospital-specific and regional reimbursement data.[15] The benchmark amount is then adjusted by a required discount factor of up to 3%.[16] A participant hospital's actual discount is determined based upon its performance on quality metrics set forth in the Final Rule, with higher quality resulting in a lower discount.[17] CMS will communicate the target prices to EPM participants prior to the performance year to which such prices will apply.[18]

CMS will perform annual reconciliations of actual reimbursement to quality-adjusted target prices. Commencing two months following the conclusion of each performance year, CMS will determine the total reimbursement for all covered services for non-cancelled episodes of care[19] in the just-concluded performance year.[20] CMS will then determine the total of the quality-adjusted target prices by multiplying the quality-adjusted target price for each MS-DRG by the number of episodes for such MS-DRG and adding the results.[21] The sum of the quality-adjusted target prices is then subtracted from the actual aggregate reimbursement for covered episodes to determine the Net Payment Reconciliation Amount (NPRA) for the performance year.[22]

For performance years after the first performance year, CMS will actually perform two reconciliations—one for the performance year just ended and a "subsequent reconciliation" for the performance year prior to the performance year just ended.[23] The subsequent reconciliation accounts for changes since the initial calculation of NPRA, generally based upon receipt of additional claims or cancellation of episodes.[24] The result of the subsequent reconciliation calculation is combined with the NPRA amount for the performance year just ended to determine the amount of the reconciliation payment due from CMS to the participant hospital or the repayment amount due from the participant hospital to CMS, in either case subject to stop-loss and stop-gain limits.[25]

Stop-loss and stop-gain limits differ by the performance year to which they apply. In performance year one, participant hospitals will have no downside risk. In performance year two, participant hospitals will not have downside risk unless they elect to do so, in which case the stop-loss amount is 5%.[26] In performance years three, four, and five, the stop-loss limits are 5%, 10%, and 20%, respectively. The stop-gain limits are 5% for performance years one, two, and three; 10% for performance year four; and 20% for performance year five.[27]

To protect beneficiaries from stinting of care and discourage "gaming" of the models, as a part of the reconciliation process, CMS will monitor for systematic under delivery of care and efforts to shift care to periods following the conclusion of the episode. Participant hospitals found to be engaged in systematic under delivery of care will be ineligible to receive reconciliation payments.[28] As a part of the subsequent reconciliation process, if average post-episode spending for a participant hospital's EPM beneficiaries is greater than three standard deviations above the regional average post-episode spending, the difference will be included in the determination of the reconciliation or repayment amount for the participant hospital.[29]

EPM Collaborators

CMS acknowledged in the Final Rule that improving the care provided to EPM beneficiaries will require meaningful collaboration by and among EPM participant hospitals and other providers and suppliers following an EPM beneficiary's inpatient discharge.[30] In recognition of the fact that participant hospitals are financially responsible for the costs of EPM episodes that include care provided by otherwise unaffiliated providers and suppliers, the Final Rule permits hospitals to enter into certain "sharing arrangements" with these providers and suppliers, referred to as "EPM collaborators," which the Final Rule provides may include physician groups, home health agencies, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, inpatient rehabilitation facilities, PPS hospitals and critical access hospitals, certain therapy groups, individual physicians, certain individual non-physician practitioners, and Medicare Shared Savings Program accountable care organizations (ACOs) (other than those participating in Track 3).[31] Sharing arrangements allow EPM participant hospitals to allocate financial risk and/or reward between themselves and EPM collaborators.

EPM participant hospitals are not required to enter into sharing arrangements with EPM collaborators but may do so to (1) share in reconciliation payments;[32] (2) share in internal cost savings;[33] and (3) share responsibility for a repayment obligation.[34] Payments from EPM participant hospitals to EPM collaborators of reconciliation payments and internal cost savings are referred to as "gainsharing payments," and payments from EPM collaborators to EPM participant hospitals of a portion of the amount owed by EPM participant hospitals to CMS are referred to as "alignment payments." As with the reconciliation process for EPM participants, gainsharing and alignment payments are subject to caps.[35]

EPM collaborators other than physicians, non-physician practitioners, and physician group practices are eligible to receive the full amount of an EPM participant hospital's internal cost savings and reconciliation payments under a sharing arrangement.[36] Conversely, the Final Rule caps gainsharing payments to physicians, non-physician practitioners, and physician group practices at 50% of the physician fee schedule amount for items and services furnished by these providers to EPM beneficiaries, which CMS indicated was meant to reduce the risk that these providers will limit or deny medically necessary care to EPM beneficiaries.[37]

Unlike gainsharing payment caps, alignment payment caps apply to all EPM collaborators.[38] The Final Rule provides that alignment payments from an individual EPM collaborator other than an ACO may not exceed 25% of the EPM participant's total repayment obligation.[39] In addition to individual caps, the aggregate amount of alignment payments from all EPM collaborators to an EPM participant may not exceed

50% of the EPM participant's Medicare repayment amount for the applicable performance year.[40] In imposing the caps, CMS reasoned that, because EPM participants must develop and implement care coordination and redesign strategies for EPM episodes of care, EPM participants should remain largely responsible for any EPM repayment obligations.[41]

In addition to permitting EPM collaborators to participate in the financial rewards of the EPMs, CMS added another incentive for physicians to participate as EPM collaborators by providing that certain EPMs meet the participation criteria for Advanced Alternative Payment Models (APMs) of CMS' new Quality Payment Program (QPP). Physicians who meet the participation criteria for the Advanced APMs are eligible to receive the QPP's 5% incentive payment and are also exempt from the otherwise mandatory participation in the Merit-Based Incentive Payment System (MIPS) program.

In addition to controls on the allocation of financial risk, the Final Rule imposes several obligations on EPM participant hospitals when selecting and engaging EPM collaborators. First, prior to engaging any EPM collaborators, EPM participants are required to develop a written set of selection criteria that must include the quality of the proposed EPM collaborators' services. The selection criteria may not relate, directly or indirectly, to the volume or value of referrals generated by a party to the sharing arrangement, a party's affiliate, or any collaboration agent or downstream collaboration agent.[42] An EPM participant may, however, include as a selection criterion a requirement that a potential EPM collaborator has performed a reasonable minimum number of services that would qualify as "EPM activities" in order to ensure the quality of care furnished to EPM beneficiaries.[43] For purposes of financial arrangements under the EPMs, the Final Rule defines "EPM activities" to include activities related to (1) promoting accountability for the cost, quality, and overall care for EPM beneficiaries, including coordinating and managing care; (2) encouraging investment in infrastructure, technology, and redesigned care processes for high-quality, efficient service delivery; (3) the provision of items and services in a manner that reduces costs and improves quality; and (4) carrying out any other obligation under the EPM.[44]

Second, a sharing arrangement must not induce the EPM participant hospital, EPM collaborator, or any of their respective employees or contractors to reduce or limit medically necessary services to any Medicare beneficiary or restrict the ability of an EPM collaborator to make decisions it believes are in the best interests of its patients, including the selection of supplies, devices, and treatments.[45] Finally, the sharing arrangement must be in writing, signed by the EPM participant and EPM collaborator, and in place before care is provided to EPM beneficiaries under the agreement.[46] The board or other governing body of the EPM participant must maintain responsibility for overseeing the EPM participant's participation in the EPM, its arrangements with

EPM collaborators, its payment of gainsharing payments, its receipt of alignment payments, and its use of beneficiary incentives in the EPM.[47]

While the Final Rule provides for the allocation of shared savings through gainsharing payments and losses through alignment payments, CMS did not include in the Final Rule any waiver of the fraud and abuse laws potentially implicated by sharing arrangements. CMS advised in the Final Rule that it is considering promulgating fraud and abuse waivers[48] but has chosen not to do so to date; therefore, EPM participants must be careful to comply with existing fraud and abuse guidance in structuring sharing arrangements with EPM collaborators.

Approved Waivers

Although the Final Rule does not include fraud and abuse waivers addressing sharing arrangements, CMS does provide for waivers of certain Medicare program requirements, including the waiver of the skilled nursing facility (SNF) three-day rule and certain telehealth requirements.[49]

The Final Rule waives Medicare's SNF three-day rule with respect to the AMI Model.[50] The SNF three-day rule requires Medicare beneficiaries to have an inpatient hospital stay of at least three consecutive days prior to a beneficiary's receipt of inpatient SNF care in order for Medicare to cover the SNF care.[51] With the waiver, however, an EPM participant may discharge an EPM beneficiary in an AMI episode of care absent a qualifying three-day stay as long as the discharge occurs on or after October 4, 2018, and the SNF to which the EPM beneficiary is discharged holds at least a three-star rating, based on the Five-Star Quality Rating System used to rate SNFs on the Nursing Home Compare website, for a minimum of seven of the previous 12 months.[52]

In addition to the SNF waiver, the Final Rule provides flexibility for EPM participants to use telehealth services to control costs. Under the waiver, except with respect to face-to-face meeting requirements for home health certification, EPM participants may furnish EPM telehealth services, as long as those telehealth services may otherwise be provided under all applicable requirements, without meeting the geographic site and originating site requirements.[53] This waiver, designed to promote cost-effective communication, allows EPM participants to offer telehealth services to eligible EPM beneficiaries at a beneficiary's place of residence and without regard to the EPM beneficiary's geographic location.[54]

Takeaways

The Final Rule implementing the new EPMs continues CMS' efforts to shift away from fee-for-service payments and toward improved quality and lower costs. It does so by placing acute care hospitals financially at risk for total Medicare Part A and Part B reimbursement for episodes of care beginning with a hospital admission and ending 90 days post-discharge. Because hospitals' own reimbursement largely

will be fixed, the real opportunity for managing financial risk associated with CMS repayment obligations will depend upon the hospitals' ability to engage other providers and suppliers to collaborate to increase quality and reduce cost.

While other providers and suppliers are not required to participate as collaborators, the Final Rule provides a number of incentives to do so. Because hospitals will be at risk financially for care provided following discharge, hospitals have an incentive to strengthen and expand preferred provider relationships with providers and suppliers who are committed to providing high-quality, low-cost services, even in the absence of any sharing of financial risk. In addition, the Final Rule's financial risk sharing provisions provide flexibility in how risk is shared—hospitals can engage collaborators by sharing upside risk only, upside risk and internal cost savings, or upside risk, downside risk, and internal cost savings. While some providers and suppliers may be hesitant to voluntarily assume downside risk, others may do so to demonstrate commitment to the acute care hospitals. Finally, suppliers may find the benefits of participating in an Advanced APM increasingly attractive as they focus on the ramifications of QPP and MIPS on reimbursement.

CMS' decision to delay implementation of the EPM Models may reflect uncertainty associated with efforts to repeal the ACA and an administration that may be hostile to such programs. On the other hand, commercial payers and plans share CMS' desire to move to episode-based reimbursement models and alternative delivery systems. The EPM Models offer opportunities for hospitals and other providers and suppliers to collaborate in ways that could benefit not only Medicare, but also equip them to respond better to commercial market pressures. Even absent the EPMs, those commercial market pressures will remain, and health care providers must find ways to engage one another in collaborative efforts to increase quality and reduce cost.

1 Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR), 82 Fed. Reg. 180 (Jan. 3, 2017). The Final Rule also implemented an incentive payment program for certain cardiac rehabilitation services and modified the existing Comprehensive Care for Joint Replacement Model to make it more consistent with the EPMs implemented by the Final Rule. Details of those aspects of the Final Rule are beyond the scope of this article.

2 In an Interim Final Rule, CMS delayed the effective date of the Final Rule from March 21, 2017, until May 20, 2017, and delayed the applicability of the regulations governing the new EPMs from July 1, 2017, until October 1, 2017. See Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model; Delay of Effective Date, 82 Fed. Reg. 14464 (Mar. 21, 2017).

3 Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR); Delay of Effective Date, 82 Fed. Reg. 22895 (May 19, 2017).

4 82 Fed. Reg. at 184, 191. The covered MS-DRGs for AMI are 280-282 and 246-251 (for AMI admissions treated by percutaneous coronary intervention); for CABG are 231-236; and for SHFFT are 480-482.

5 *Id.* at 191, 225-26; *see* 42 C.F.R. § 512.230(h). Excluded beneficiaries include those covered by Medicare by virtue of ESRD, beneficiaries covered by a Medicare managed care plan, beneficiaries prospectively assigned to certain ACOs, beneficiaries for whom the attending or operating physician is a member of a group practice participating in BPCI, or beneficiaries otherwise covered by BPCI.

6 82 Fed. Reg. at 185.

7 *Id.* at 236, 596.

8 CMS Fact Sheet, "Advancing Care Coordination through Episode Payment Models (Cardiac and Orthopedic Bundled Payment Models) Final Rule (CMS-5519-F) and Medicare ACO Track 1+ Model" (Dec. 20, 2016).

9 42 C.F.R. § 512.305(a).

10 82 Fed. Reg. at 191.

11 As a result of the Final Rule published on May 19, 2017, the first performance year will begin January 1, 2018, and end December 31, 2018 with subsequent performance years running with the calendar years. 82 Fed. Reg. at 22898.

12 42 C.F.R. § 512.305(d)(3).

13 *Id.* at § 512.305(d)(2).

14 42 C.F.R. § 512.300(c)(9).

15 *Id.* at § 512.300(b). The blend of hospital-specific and regional data depends upon the performance year, with performance years one and two weighing hospital-specific data two-thirds and regional data one-third, year three weighing hospital-specific data one-third and regional data two-thirds, and years four and five using only regional data.

16 *Id.* at § 512.300(d).

17 *Id.*; 42 C.F.R. § 512.315.

18 42 C.F.R. § 512.300(c)(9).

19 The grounds for cancellation of an EPM episode are set forth in 42 C.F.R. § 512.240, and generally include the beneficiary's death, transfer during the initial hospitalization, or becoming covered by a program that would cause the episode to be excluded from the EPM.

20 42 C.F.R. § 512.305; 82 Fed. Reg. at 191-92.

21 42 C.F.R. § 512.305(c)(2)(ii).

22 *Id.*

23 42 C.F.R. § 512.307(a)(2). For example, the reconciliation conducted following performance year two will include a reconciliation for performance year two and a subsequent reconciliation for performance year one.

24 *Id.* at § 512.307(a)(1).

25 *Id.* at § 512.307(a)(2)(ii).

26 A participant might voluntarily accept downside risk in performance year two because doing so would enable the participant to meet the Advance Alternative Payment Model criteria under the Medicare Quality Payment Program.

27 42 C.F.R. 512.305(c)(iii)(A) and (B). The Final Rule includes additional stop-loss limits for Sole Community Hospitals, Medicare-Dependent Hospitals, and Rural Referral Centers. 42 C.F.R. § 512.305(c)(iii)(C).

28 42 C.F.R. at § 512.305(e).

29 42 C.F.R. at § 512.307(c).

30 *See* 82 Fed. Reg. at 441.

31 42 C.F.R. § 512.230(f)(3).

32 42 C.F.R. § 512.500(a)(1), (c)(1).

33 CMS has imposed certain requirements on the calculation of internal cost savings as an internal safeguard because they may be shared with EPM collaborators. First, an EPM participant's methodology for accruing, calculating, and verifying internal cost savings must be transparent, measurable, and verifiable in accordance with generally accepted accounting principles and Government Auditing Standards (The Yellow Book). 82 Fed. Reg. at 454. Second, the Final Rule requires that the methodology used to calculate internal cost savings must reflect the actual, internal cost savings achieved by the EPM participant through the documented implementation of EPM activities

identified by the EPM participant and must exclude (i) any savings realized by any individual or entity that is not the EPM participant and (ii) "paper" savings, which CMS deems to include savings from accounting conventions or past investment in fixed costs. 42 C.F.R. at § 512.500(c)(3).

34 42 C.F.R. § 512.500(a)(1), (c)(10).

35 *Id.* at § 512.500(c)(4), (6), (12), (13).

36 *See id.* at § 512.500(c)(4).

37 *Id.*; 82 Fed. Reg. at 459.

38 42 C.F.R. § 512.500(c)(12), (13).

39 *Id.* at § 512.500(c)(13)(i). Alignment payments for EPM collaborators that are ACOs may be up to 50% of the EPM participant's total repayment obligation. *Id.* at § 512.500(c)(13)(ii).

40 *Id.* at § 512.500(c)(12).

41 82 Fed. Reg. at 461.

42 42 C.F.R. § 512.500(a)(3).

43 82 Fed. Reg. at 442–443.

44 *Id.* at 450.

45 *Id.* at 441. Both EPM participant hospitals and EPM collaborators are also required to provide beneficiaries with notice of their participation in the EPMs and with certain information regarding the program. *See* 42 C.F.R. § 512.450(b)-(c). The EPM participant hospital is responsible for ensuring each of its EPM collaborators provides the requisite beneficiary notices, and the EPM collaborators must be able to generate a list of all beneficiaries who have received the notices, including the date on which the notice was provided, upon CMS' request. *Id.* at § 512.450(b).

46 82 Fed. Reg. at 452-453.

47 *Id.* at 452.

48 *Id.* at 434–435.

49 82 Fed. Reg. at 484.

50 42 C.F.R. § 512.610(a).

51 42 U.S.C. 1395x(i); *see* 82 Fed. Reg. at 499.

52 42 C.F.R. § 512.610(b). CMS will post a list of qualifying SNFs to its website prior to the quarter in which the list will apply.

53 42 C.F.R. § 512.605(a), (b).

54 In circumstances in which an EPM beneficiary receives telehealth services from the beneficiary's place of residence, Medicare will not pay the EPM participant the facility fee that is otherwise payable to an originating site. *Id.* at § 512.605(c).

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New Systems = New Risks – Navigating Challenges Associated With Electronic Enrollment Systems

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Today providers and suppliers (collectively, for purposes of this article, "providers") are able to submit provider enrollment applications to Medicare, and in many instances Medicaid, electronically. The Centers for Medicare & Medicaid Services (CMS) uses the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). Some Medicaid agencies are able to access some of its information for verification purposes and many have adopted their own electronic enrollment systems. Typically in the case of PECOS, application processing is faster, more efficient, and eliminates the need to rely upon the Medicare Administrative Contractor (MAC) to correctly key in the data entered on paper forms and so is presumably more accurate. These systems, particularly PECOS, can be great tools when used regularly and properly. However, they create new and unique compliance risks due to (1) technical limitations of the systems themselves and (2) providers' potentially improper use (sometimes due to technical limitations). This article will address several of these issues and offer advice on mitigating relevant risks.

Background on Electronic Enrollment Systems

PECOS Overview

Providers are now able to access, review and edit their current enrollment records via PECOS. Once obtaining access to these systems, authorized personnel can typically view existing enrollment records for each entity to which they have access. This makes it easy on provider personnel to update records in compliance with timely reporting requirements for Medicare.

Chair's Column: Souvenirs from MMI

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This year marked my ninth time attending AHLA's Institute on Medicare and Medicaid Payment Issues ("MMI," fondly pronounced "Mimmie," at least by me). After so many years in attendance, I've concluded that Andy Williams was wrong when he sang about Christmas as "The Most Wonderful Time of the Year." As my fellow reimbursement geeks can attest, the most wonderful time of the year is MMI! While all AHLA in-person programs are high-caliber, my personal favorite is MMI, not only because of the depth of substantive knowledge (it's always in Baltimore, which is right in CMS' backyard), but also because of the personal connections I've made there with fellow Regulation, Accreditation, and Payment Practice Group (RAP PG) and AHLA members.

So please forgive my sentimentality, but listed below, in no particular order, are my favorite souvenirs and recollections of MMI over the years:

- *The Familiarity of the Baltimore Marriott Waterfront Hotel.* Like Anne Tyler's protagonist in the "The Accidental Tourist," who always looked for a McDonald's no matter where he landed on the globe, I find it extremely comforting that the Waterfront Marriott is always the site of MMI and is always the same (in a good way). I have memorized the locations of all of the Harborside and Grand Ballrooms. I've snapped cool pictures of Baltimore Inner Harbor as I ride the escalator down between ballroom levels, and I've waved to old friends as I ride the escalator up. I know that my room will always have the framed photograph of the thick dock rope around the nautical piling. I love the bartenders at the on-premises receptions (they know how to give a lady a big pour of sauvignon blanc!).
- *Roving HHS'ers:* I've always appreciated the visibility of the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) and Centers for Medicare & Medicaid Services (CMS) folks at MMI. They not only speak at their own presentations, but they're also enthusiastic and interactive audience members for others' presentations, as well as friendly hallway minglers. Vicki Robinson (Chief, Industry Guidance Branch, OIG), Julie Burns (Office of General Counsel, HHS, CMS Division), Janet Nolan (Deputy Associate General Counsel for Program Integrity, Office of General Counsel, HHS), and Lisa Ohrin Wilson (Senior Technical Advisor, CMS) are regulars. In addition, for several years in a row at MMI, I've had the pleasure of co-presenting with Jan Lundelius (Chief Counsel, Office of General Counsel, HHS, Philadelphia, PA) on Changes of Ownership (CHOWs). An extra treat at our CHOW presentation both this year and last year was to have David Eddinger (Technical Director, Hospital Survey & Certification,

Effective use of PECOS can substantially assist compliance/credentialing personnel in effectively complying with reporting requirements imposed by Medicare. For many providers, Medicare requires reporting of changes within 30-90 days. For example, if a board member of an enrolled entity is replaced, the provider must report this change to Medicare within 90 days.1 Prior to the time when a provider could actually review its current Medicare approved enrollment record online, if a provider needed to report this change, it would also need to know if the board member had been previously reported to CMS for that enrollment record. In many instances, the person who originally submitted an 855 enrollment form would no longer be associated with the reporting organization or the organization may not have retained copies of prior submissions.

Once obtaining access to PECOS, providers can essentially view their existing enrollment record(s), which includes much of the same information that a MAC or CMS can review.

Provider staff can make modifications against the *current* approved Medicare enrollment record. The information in the record is what the MAC and CMS have on file.[2] This also allows the provider to audit information entered by MAC personnel from paper applications. I have personally seen on several occasions incorrect enrollment records resulting from data entry errors caused by the MAC. While these issues do not appear to be a systemic problem, having access to electronic systems can help reduce the human errors of a paper world. It does, however, create new areas of error based on misuse by providers and technical deficiencies seen in the system.

Medicaid Systems Overview

Most state Medicaid authorities are also implementing separate and distinct electronic provider enrollment databases. Some of these systems rely upon the same technology infrastructure and, thus, can be less difficult to navigate for those who regularly assist providers with Medicaid enrollment issues in multiple states. This article addresses some of the challenges previously encountered with these systems below.

CMS) in the audience. David was kind enough this year to address the audience from his seat in order to help me out with a difficult hypothetical that I had inserted into the slides, in the hopes that he would be there!

- *The RAP Year in Review:* Though there wasn't an official "RAP" Year in Review at the 2017 MMI, some of my fondest memories are of the RAP Years in Review of the past. The humor of Ken Marcus and the "Jeopardy"® game show format are a proud legacy of RAP. I can remember years when we rehearsed this "spontaneous" game show well into the evening over dinner at Apropoe's Restaurant (in the lobby of the Marriott Waterfront). And Judy Waltz made her own place in the spotlight by bringing the best props, toys, and bling for the RAP Year in Review (I still have my sparkly, whirly-twirly outer space gun!).
- *Dinner at Amicci's:* Amicci's is an unpretentious, fun, and "good eats" Italian restaurant in (where else?) Baltimore's Little Italy. For several years, the RAP PG leaders have been meeting there, usually on the Thursday night of the conference, as a way to wind down and relax after another year of hard work. Actually, it's not hard work; my co-leaders make my job fun and easy. Cheers and a raised glass of chianti to Judy Waltz, Emily Cook, Jeanne Vance, Jeff Moore, Ross Sallade, Ross Burris, and Dan Hettich (cheers to Dan despite the fact that he has missed dinner the past couple of years, on the weak excuse that he has firm business, and so is in danger of having to pick up the whole tab in a future year!). Cheers as well as to our RAP PG Leadership Development Program participants who came to dinner, including Matt Horton, Blake Adams, and Hope Levy-Biehl.
- *The RAP Night Cap:* A recently added (and instantly successful) feature of MMI is the RAP "Night Cap," held on either Wednesday or Thursday night of the conference. It usually takes place around 9:00 pm, after the on-site receptions and after dinner. We've gotten a good crowd both years. If you come, you might even get to appear in a photo on the RAP PG Twitter feed!
- *AHLA Staff:* And last, but never least, are the unfailingly helpful and cheerful AHLA staffers who are always there at MMI to help out in a pinch. Extra kudos this year to Valerie Eshleman, who dropped what she was doing (figuratively) to help me load a last-minute version of a PowerPoint presentation on a conference room laptop. And, of course, all-year-round thanks to our wonderful staff liaisons, Trinita Robinson and Magda Wencel.

And that's a wrap (or "RAP"), folks! Here's hoping that you can join in the fun at all future MMIs. Maybe some year the AHLA Programs Committee will even schedule MMI in April to coincide with an Orioles' game (hint, hint)!

Sincerely,
Claire

In our experience, there are approximately three different types of Medicaid systems in which providers can access the online enrollment database: (1) PECOS-similar systems; (2) unique access for each provider-number; and (3) hybrid systems.

PECOS-Similar: Several enrollment systems exhibit characteristics similar to PECOS where an Authorized or Delegated Official can obtain access and distribute such access to other authorized users. This type of system poses very similar issues as PECOS with respect to initially obtaining access and signatures to applications.

Unique Access for each Provider Number: This type requires users to share a single user name/password for each provider number. In some instances the user can type a name for the specific signatory, but access to the system is inherently linked to the provider number. This type of system is challenging because users must share user names or passwords in order for multiple individuals to access/review an application, which makes it difficult to identify who made specific changes to an application. Also, without specific guidance from the Medicaid authorities regarding sharing such user names and passwords, providers potentially face regulatory scrutiny for such a practice.

Hybrid Systems: This type may generate unique user names/passwords for a particular application, but once an enrollment record is generated, the provider's Authorized Officials can issue access to multiple users in a manner similar to PECOS. This system presents the same challenges as PECOS after an application is approved and as systems require unique access for each provider numbers.

Issues Associated with Use of Electronic Enrollment Systems

Technical Limitations of Enrollment Systems

Gaining access to electronic enrollment systems is almost always challenging. Once users can gain access to these systems, each can present additional practical difficulties, including: (1) updating pending applications; (2) documenting previous applications submitted; and (3) reporting ownership percentages (and other information). Each of these can adversely impact providers without the use of thoughtful protocols.

Recalling Applications

Risk: For many electronic application systems, including PECOS, after an application is filed/signed, there is no mechanism to recall an application to report newly-changed information without requesting that the MAC return the application. This can present problems when information on a pending application changes during review.

For example, assume a provider submitted its revalidation application approximately 120 days prior to relocating to a new address and the revalidation is not approved prior

to the relocation. If the provider is unable to modify the application to update its address, the site visit contractor will likely visit the vacant/old location and determine that the provider "was not operational," resulting in a revocation under 42 C.F.R. § 424.535(a)(5).

This scenario is outlined in a revocation appeal before the Departmental Appeals Board.[3] In this case, a durable medical equipment supplier was initially unable to update its revalidation application to disclose its new location while the application was pending. When personnel of the provider spoke with the National Supplier Clearinghouse (NSC) about the issue, the NSC employee indicated that the change could not be completed while a revalidation enrollment application was pending. Although the revocation in this case was not directly related to technical deficiencies of PECOS, it indicates the potential for information to become stale while an application is pending and, as a result, adversely affect the provider.

Risk Mitigation: In order to avoid having to update an enrollment record while an application is pending, carefully consider all updates included and whether additional updates may be necessary in the future. Many items included on an application have effective dates, so providers can sometimes add information in advance by using a future effective date.[4] In addition, while the limitations of PECOS will not allow the filing of a subsequent electronic application until the one being processed has been completed, the provider may file new changes using paper applications, while allowing the provider to comply with legal reporting deadlines.

Documenting Previous Applications

Risk: Although PECOS and other electronic systems enable providers to verify information on file, it does not fully eliminate user error by MAC analysts reviewing applications or allow providers to monitor updates made by MACs behind the scenes. Our providers have seen MAC analysts not include all information on an application either on the approval letter or even in the approved record. As a result, we verify all enrollment records following approval to confirm essential items are included.

For example, assume a home health agency provider submitted an application to update its ownership structure. The MAC approves the application, but certain of the updated owners are not listed among the approved changes. The provider submits a revalidation and appropriately lists its owners, including those which were previously disclosed to the MAC but not included among approved changes. If the MAC determines the provider did not timely report its new owners in connection with its Medicare enrollment, it could move to revoke the provider for non-compliance.[5] Unless the provider maintained stellar records of submitted and approved applications, the provider would have no mechanism to rebut a determination that it did not provide timely notice to the MAC.

There are also several cases involving disputes as to when or whether an application was filed in PECOS.[6] Providers in several of these cases claimed that they submitted an application on an earlier date and should be granted the requested effective date, but the providers were unable to document these submissions and ultimately lost their appeals.

There are several other instances where providers could face compliance risk by not having sufficient documentation of changes submitted electronically. Without the ability to substantiate the submission of accurate information, providers face potential revocation of Medicare billing privileges. This could result in repayment obligations for services furnished after the revocation effective date,[7] reciprocal revocation of Medicaid billing privileges (as required under CMS regulations)[8] and loss of billing privileges for other provider numbers held by the entity suffering a revocation.[9]

Risk Mitigation: Providers should save every application submitted[10] as well as each approved enrollment record immediately following the approval. This requires the submitter to save an application immediately upon submission and also to save the enrollment record as well as any other documentation of the approval. We recommend establishing a comprehensive system to better manage the various components of enrollment applications as well as monitor ongoing reporting requirements. This should include protocols governing where items are saved, who can access such items and naming conventions. In order to avoid loss of data following turnover of staff, these item should be saved on a system accessible by other personnel.

Navigating Medicaid Systems

Risk: Many online Medicaid enrollment systems have technical deficiencies that do not permit users to accurately report certain information to submit an application.[11] For example, these systems only allow enrollees to report ownership of up to 100%. This does not accurately take into account indirect ownership percentages that will collectively exceed 100%. For example, assume a limited liability company enrollee is 100% directly owned by another entity, which is owned by two individuals with 50% each. The enrollee should report the direct owner with 100% direct ownership and two indirect owners with 50% each. These systems only allow reporting of collectively 100% interest, so users are required to modify the ownership percentages reported. There are several ways failure to report this information can result in legal risk to a provider: (1) CMS may revoke the provider's privileges for non-compliance; (2) to the extent any owners or other individuals with control have suffered any final adverse action (i.e., exclusion, conviction, etc.), CMS could revoke for those bases; (3) CMS could claim that the provider reported false information; and (4) CMS could demand repayment for services furnished after the dates of non-compliance for physician and non-physician practitioners.[12]

Risk Mitigation: First, try to contact the Medicaid authority to obtain guidance on how to complete the application. Then, try to attach an organizational chart and statement to demonstrate accurate ownership information. In any event, submit something in writing to the Medicaid authority fully disclosing the accurate information, even if the communication is not authorized by the Medicaid authority.

Provider Use of Enrollment Systems

Risk: Provider practices in authenticating electronic enrollment applications by electronic signature present additional compliance concerns. Electronic systems, particularly PECOS, make it relatively easy for users to sign applications electronically. While there is certainly some difficulty in initially gaining access to PECOS, signing applications is fairly seamless for those who have secured this access or can, at a minimum, complete electronic signature prompts if they do not have access. Nevertheless, we believe in many instances providers may be asking provider staff to electronically sign enrollment applications on behalf of Medicare "Authorized or Delegated Officials." Authorized Officials are individuals appointed by providers to act on behalf of organizations on enrollment applications (e.g., chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner).[13] Delegated officials are individuals delegated by the Authorized Official to report changes and updates to the enrollment record.[14] These individuals tend to be very senior within an organization and may be difficult to track down. It is distinctly possible that CMS or state Medicaid agencies would oppose such delegation for enrollment purposes, depending on the circumstances.

For example, when Authorized Officials obtain access to PECOS for an organization, they must sign-in and attest that they are the Authorized Official for the organization and that their "signature legally and financially binds this employer to the laws, regulations, and program instructions as established by [CMS]."[15]

CMS would certainly view an Authorized Official asking another individual to sign a paper CMS-855 application (or other filing) on the official's behalf as a significant issue or even a false/fraudulent certification. CMS' clear position is that stamped signatures on paper applications are not acceptable, presumably because of the ease with which individuals could use that stamp to sign someone's name.[16] CMS would not likely accept a PECOS-submitted form where an Authorized Official gave his/her user name and password to another individual and allowed them to electronically sign applications on their behalf. Although it's possible CMS may not view simply obtaining access to the PECOS the same as delegating the actual signature on an enrollment application, without additional guidance from CMS, it creates risk for the provider organization.

If CMS were to view the delegation of signing authority of an electronic enrollment application to a person that is not the provider's Authorized or Delegated Official as problematic, the submission of the application could potentially result in revocation of a provider's billing privileges under 42 C.F.R. § 424.535(a)(1) (noncompliance with enrollment requirements) or 42 C.F.R. § 424.535(a)(4) (submitting false or misleading information on the enrollment application to be enrolled or maintain enrollment in the Medicare program). This is particularly true for Medicare providers because CMS utilizes several provider-friendly concepts in PECOS which enable Authorized Officials to formally delegate tasks to "end-users" for the completion of applications and Delegated Officials to actually sign applications. This formal delegation enables each individual to use their own account when completing applications and PECOS to identify each individual submitting or signing applications. The convenience associated with these capabilities of allowing staff to complete enrollment tasks by either using the Authorized Official's user name/password or even creating the user name/password surely does not outweigh the downside risks of revocation, suspension, etc.[17]

Electronic Medicaid systems create similar issues with respect to gaining access, but they also present unique challenges when actually signing an application. Unlike PECOS, where personnel who are given access to the system by an Authorized Official can prepare and submit an application for signature, most electronic Medicaid systems simply ask for the signer to type his or her name to certify the accuracy of an application. This is particularly true because most Medicaid authorities do not utilize a Delegated Official concept where the Authorized Official can formally delegate signature authority to another individual in accordance with established rules. So, every time an application needs to be signed, the Authorized Official needs to be directly involved or the provider is forced to rely upon informal procedures—which are not expressly permitted—to obtain approval. While this seems like a particularly tedious task, if Medicaid authorities do not offer guidance on how to make these processes more provider-friendly, providers are forced to weigh inconvenience with potentially significant risk.

This ultimately could result in revocation or overpayments from the date an application was submitted or inappropriately signed, as the Medicaid authority could assert the application was never appropriately submitted, which could carry with it substantial repayment obligations. Although this may be unlikely to happen, we recommend implementation of protocols to reduce this risk.

Risk Mitigation: The first step in reducing risk that improper enrollment procedures result in adverse actions to a provider is to review current practices and implement a plan/policy on proper procedures personnel should follow. The plan should address which department(s) should be responsible for completion of enrollment/credentialing applications. This responsibility may ultimately be split by provider type and/or payor type (i.e., governmental/non-governmental). Next, providers should evaluate which individuals should have signature authority for enrollment applications and confirm

these individuals satisfy CMS requirements. It may even be prudent to craft board resolutions or other documents certifying this authority. Providers should also take the time to review which individuals have access to PECOS and other systems, then delegate access to appropriate individuals to limit the burden on Authorized Officials.[18]

Providers should also review their Medicaid authority's electronic system to identify access and signature authority considerations/issues. Different systems/protocols may ultimately present unique challenges, many of which the Medicaid authority likely has not considered. Providers should not avoid consulting with Medicaid officials to obtain feedback on these challenges, as it may result in helpful guidance.

Conclusion

In sum, electronic enrollment systems are a great resource for providers to promote compliance, but they can also lead to a host of legal issues if provider personnel do not carefully follow established protocols to ensure applications are being accurately certified and carefully documented to defend against CMS allegations. If providers are proactive and thoughtful, they can position themselves for success in being compliant and, as a side-benefit, by having access to electronic systems that help monitor reporting deadlines and information requests. By using these electronic provider enrollment systems, providers can avoid the payment disruption that comes from untimely submissions of applications, including revalidation applications.

1 42 C.F.R. § 424.516 (2017).
2 Note that in our experience there are certain exceptions to this rule. Bank account information is regularly missing from an enrollment record in PECOS, but we know this information is ultimately on file because the provider receives payments in this account.
3 *Foot Specialists of Northridge v. CMS,* Docket No. C-15-3864 (Feb. 9, 2016).
4 It is also very possible PECOS may add a recall feature. CMS recently added a feature allowing a user to recall unsigned applications.
5 42 C.F.R. § 424.535(a)(1) (2017).
6 *Ashleigh Byrne, M.D. v. CMS,* Docket No. C-14-69 (Jan. 30, 2014); *Abundant Health Family Medicine, LLC v. CMS,* Docket No. C-14-465 (Apr. 15, 2014).
7 42 C.F.R. § 424.535(b); 42 C.F.R. § 424.555.
8 42 C.F.R. § 455.416(c).
9 *See, e.g.,* 42 C.F.R. § 424.535(a)(1); 42 C.F.R. § 424.535(a)(9).
10 We recommend saving the application submitted/pending signatures and fully-signed application to demonstrate a signed version was submitted.
11 On an ad hoc basis as of the date of this article, we know Arkansas, Colorado, Ohio, and Washington Medicaid systems have these constraints.
12 42 C.F.R. § 424.565 (2017).
13 42 C.F.R. § 424.502.
14 42 C.F.R. § 424.502. Please note these individuals must be an individual with ownership/control interest in or be a W-2 employee of the provider.
15 Ctrs. For Medicare & Medicaid Servs., Identify & Access Mgmt. System, https://nppes.cms.hhs.gov/IAWeb/profile/display.do (last visited Jan. 26, 2017).
16 Ctrs. for Medicare & Medicaid Servs., Medicare Program Integrity Man., Ch. 15, 15.5.15.2 (2017); Ctrs. for Medicare & Medicaid Servs., Medicare Program Integrity Man., Ch. 3, § 3.3.2.4 ("stamped signatures are not acceptable") (2017).
17 Additional risks under federal law may also exist. For example, in July 2016, the Ninth Circuit ruled in *United States v. Nosal* that the Computer Fraud and Abuse Act applied to a former employee whose access to a company computer program with proprietary information had been revoked but gained access to the computer program through a current employee's voluntary sharing of her log-in information. *United States v. Nosal,* Nos. 14-10037 and 14019275, 2016 WL 7190670, at *1 (9th Cir.). It seems unlikely that this would apply to an employee intentionally sharing his or her password with another employee, but it nevertheless presents an additional consideration for providers.
18 Providers should also review to remove individuals who are no longer with the organization.

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MACRA and the New Model of Provider Reimbursement

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On April 16, 2015, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law.[1] This article provides an overview of the history leading up to the groundbreaking law, a summary of its recent implementation, and an overview of how MACRA may transform in the future.

MACRA was passed to change the way Medicare reimburses physicians, shifting from a volume-based fee for service model to a value-based care model. It delivers Medicare payment reform through the Quality Payment Program (QPP), which replaces the Sustainable Growth Rate (SGR) formula and focuses on three goals to transform the health care system: (1) incentives to physicians, (2) care delivery, and (3) information sharing. The QPP has two tracks:

- Advanced Alternative Payment Models (Advanced APMs); and
- The Merit-based Incentive Payment System (MIPS).[2]

Although the final rule's effective date was January 1, 2017,[3] some in the health care community have anticipated a delay in MACRA's implementation because of the new administration. Nevertheless, the Centers for Medicare & Medicaid Services (CMS), for the most part, has moved full steam ahead.

Still, a recent survey suggests that a majority of physicians are unprepared to implement MACRA and need help, especially with the information technology (IT) component of the program.[4] With the transition year in full swing, it remains to be seen if the program's goals will come to fruition or if physicians become frustrated with the process, unmotivated by the incentives, and choose not to participate altogether.

Before MACRA

In 1997, Congress passed the Balanced Budget Act of 1997, which included the Medicare SGR.[5] The SGR's purpose was to control Medicare and Medicaid expenditures for physician services by establishing a fee-for-service (FFS) system. To maintain control, if expenditures did not exceed the annual target, payments to providers were adjusted upward for the following year.[6] If expenditures exceeded the annual target, however, payments were adjusted downward for the following year.[7]

Over time, the SGR became unsustainable. In 2002, payments were set to be adjusted downward by 4.8%. Instead, Congress stepped in and temporarily adjusted the rate from a 4.8% decrease to a 1.6% increase in what would become known as one of many "doc fixes."[8] After nine "doc fixes" over 16 years, Congress faced yet another dilemma on April 1, 2015, when Medicare payments to providers were reduced by 21%.[9] Barring congressional action, it was feared that physicians would exit Medicare and Medicaid programs en masse. Congress responded by passing bipartisan legislation in the form of MACRA with the goals of controlling the annual rise in rates and moving away from FFS to a pay-for-performance model.

MACRA

MACRA, through the QPP, provides a set of unified policies to promote quality measures while incentivizing physicians. This coordinated framework for health care is divided into two parts: Advanced APMs and MIPS.

Advanced Alternative Payment Models

Advanced APMs provide an opportunity for eligible clinicians to earn incentives for providing high-quality, efficient, and coordinated care. They provide more revenue variability than MIPS because Advanced APMs offer both greater potential financial risk and greater potential financial reward.[10] To become an Advanced APM, an APM[11] must (1) use certified electronic health record technology (CEHRT); (2) include quality measure results as a factor when determining payment to participants under the terms of the APM; and (3) either meet the financial risk and nominal amount standards under the regulations or be an expanded Medical Home Model.[12] To participate in an Advanced APM, the clinician must be designated as a qualified APM participant (QP). A QP must have met or exceeded the relative QP payment amount or QP patient count threshold for a year based on participation in an Advanced APM Entity to be an eligible clinician under CMS' criteria.[13]

Which Advanced Alternative Payment Models Qualify?

Currently, seven models have been designated as Advanced APMs for 2017.[14] This article discusses each below. Medicare Shared Savings Program Tracks 2 and 3 are combined.

1. Comprehensive End Stage Renal Disease Care Model—Two-Sided Risk

Comprehensive End Stage Renal Disease (ESRD) Care Models provide improved care for Medicare beneficiaries suffering from ESRD. These models bring together nephrologists, dialysis clinics, and other providers to deliver seamless, coordinated care to improve financial outcomes, measured by Medicare Part A and Part B spending, and clinical quality outcomes.[15]

CMS offers two tracks for participating in the Advanced APMs: (1) the Comprehensive ESRD Care (CEC) Model Large Dialysis Organization (LDO) payment track and (2) the Non-large dialysis organization (Non-LDO) two-sided payment track.[16] Chains with 200 or more dialysis facilities are considered LDOs, while Non-LDOs consist of 200 or fewer facilities.[17] While higher risks may result in shared losses, these organizations are incentivized with shared savings payments from CMS by "provid[ing] patient-centered care that will address beneficiaries' health needs, both in and outside of the dialysis clinic."[18]

2. Comprehensive Primary Care Plus

As of 2017, more than 13,000 clinicians in 2,891 primary care practices are participants in the Comprehensive Primary Care Plus (CPC+) model.[19] CPC+ constitutes an innovative payment structure that seeks to support the delivery of comprehensive primary care and offers two tracks that include three payment elements: (1) Care Management Fee; (2) performance-based incentive payment; and (3) payment under the Medicare Physician Fee Schedule.[20]

By providing additional financial resources to support staff and training improvements, thus strengthening infrastructure to deliver better care, CMS aims to reduce unnecessary treatments resulting in healthier Medicare patient populations.[21] To further expand the program's goals, CMS announced a second round, CPC+ Round 2, beginning in 2018 and based on payer interest, that is accepting applications in four new regions from May 18 through July 13, 2017.[22]

3. Medicare Shared Savings Program (Tracks 2 and 3)

The Medicare Shared Savings Program rewards accountable care organizations (ACOs) that meet certain quality performance standards for patient care and lower the growth of their health care costs.

An ACO may participate in the Shared Savings Program by meeting several requirements.[23] Tracks 2 and 3 of the Shared Savings Program qualify as Advanced APMs because the ACOs share in both Medicare savings and losses.[24] CMS currently is considering the development of a Medicare ACO Track 1+ Model in 2018 for ACOs new to the Shared Savings Program and ACOs already participating in Track 1.[25] This payment model would allow for less downside risk than currently is present in Tracks 2 and 3 but sufficient financial risk to be an Advanced APM.[26]

4. Next Generation ACO Model

Next Generation ACO Models constitute higher risk for experienced ACOs, but also offer higher rewards compared to the Shared Savings Program.[27] ACOs have the option of two risk arrangements that determine the portion of savings or losses.[28] Currently, only 44 ACOs participate in this model.[29] Arrangement A consists of 80% shared savings/losses while arrangement B consists of 100% shared savings/losses.[30] Both arrangements limit savings and losses to a 15% cap.[31]

To determine savings and losses, Next Generation ACO Models calculate the difference between actual expenditures and a prospectively set benchmark, a core feature of the model.[32] The Performance Year Benchmark is "set initially by using the expenditure, risk score, and quality data available" for the performance year baseline.[33]

The model also provides the following four payment mechanism options to test the effectiveness of alternative payment mechanisms in facilitating investments in infrastructure and care coordination to improve health outcomes: (1) nominal FFS payment; (2) nominal FFS payment + monthly infrastructure payment; (3) population-based payments; and (4) all-inclusive population-based payments.[34] Recently, CMS accepted a new round of applications for the 2018 Next Generation ACO Model.[35]

5. Oncology Care Model (OCM)—Two-Sided Risk

OCM is an episode-based payment model (EPM) that incentivizes clinicians to improve care and coordinate costs for beneficiaries undergoing chemotherapy.[36] There is a two-part payment system for practices participating in OCM: (1) a per-beneficiary Monthly Enhanced Oncology Services (MEOS) payment for the duration of the episode and (2) the potential for a performance-based payment for episodes of chemotherapy care.[37]

6. Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1—CEHRT)

CJR bundles payments and quality measurements for an episode of care for knee and hip replacements (the most common inpatient surgeries for Medicare beneficiaries).[38] CJR incentivizes increased coordination of care and holds participant hospitals financially accountable for quality and cost of an episode of care. Participant hospitals receive separate target prices based on the type of discharge classification. At the end of the year, spending for the episode is compared to the Medicare target episode price. Based on quality and episode spending performance, a participant will receive either additional payments from Medicare or be required to pay Medicare back for a portion of the episode spending.[39] To qualify as an Advanced APM, Track 1 CJR participants must maintain documentation of attestation to CEHRT use

and submit clinician financial arrangements lists to CMS.[40]

In addition to the seven Advanced APMs currently available, CMS finalized EPMs for cardiac care and surgical hip and fracture treatment.[41] However, the start date for the incentive payment models has been delayed from July 1, 2017 to January 1, 2018.[42]

Providers and the Merit-Based Incentive Payment System

MIPS consolidates three existing programs: (1) the Physician Quality Reporting System (PQRS), (2) the Physician Value-Based Modifier (VM), and (3) the Medicare Electronic Health Record (EHR) Incentive Program for eligible professionals (EPs).[43] MIPS eligible clinicians[44] are evaluated across four categories and provided with a single score.[45] Based on that score, CMS will determine if the clinicians receive a fee increase, a fee reduction, or no change at all to their Medicare payment. Clinicians can choose to report as either an individual or a group. MIPS does not apply to: physicians and practitioners who are below the low-volume threshold, in their first year of Medicare participation, or are participants in eligible APMs who qualify for a bonus payment; and hospitals or facilities.[46]

CMS will evaluate MIPS eligible clinicians according to the following performance categories:

Quality (Replaces PQRS)	Improvement Activities	Advancing Care Information (Replaces Medicare EHR Incentive Program)	Cost (Replaces Value-Based Modifier)
Comprises 60% of a MIPS eligible clinician's final score for MIPS payment year 2019.[47]	Comprises 15% of a MIPS eligible clinician's final score for MIPS payment year 2019 and for each MIPS payment year thereafter.[48]	Comprises 25% of a MIPS eligible clinician's final score for MIPS payment year 2019 and each MIPS payment year thereafter.[49]	Comprises 0% of MIPS eligible clinician's final score for payment year 2019.[50]
Participants can report up to six measures, including one outcome measure.[51]	Depending on the type of participation, most participants will earn credit by completing four improvement activities for at least 90 days.[52]	Participants have two options of reporting measures based on the electronic health record edition.[53]	CMS will calculate performance on certain cost measures and give this information in performance feedback to clinicians although not included in 2019 final score.[54]

Submitting MIPS Data

Medicare payment adjustments will be made in 2019 for the performance period of January 1, 2017 to December 31, 2017.[55] Reports can be submitted anytime throughout the performance period, but to earn a neutral or positive payment and become eligible for the maximum payment, clinicians must submit data for at least 90 days.[56] MIPS eligible clinicians must report all performance data by March 31, 2018 to receive a payment adjustment. Clinicians who do not participate will receive a negative payment adjustment of 4%, while clinicians who submit a full year, will receive a positive adjustment rate of up to 4% and an additional payment for exceptional performance.[57] Rates will gradually increase to 9% by year 2022.[58]

Physician-Focused Payment Model Technical Advisory Committee

MACRA also established an 11-member independent federal advisory committee, the Physician-Focused Payment Model Technical Advisory Committee (PTAC), whose role is to "make comments and recommendations to the Secretary [of Health and Human Services] on physician-focused payment models (PFPMs)."[59] The Secretary then reviews PTAC's comments and recommendations and posts a detailed response on the CMS website. CMS, in its role in approving PFPMs, will post its determinations on an ad hoc basis, but not less than once a year.

The goal of PTAC is to usher in innovative payment models in a more efficient manner. For a proposal to make it out of PTAC, the PFPM must meet ten criteria specified by the Secretary under 42 C.F.R. § 414.1465.[60] The scope of the proposed PFPM, quality and cost, and payment methodology are among the highest priorities. PTAC is an important link between CMS and providers because it offers an opportunity for those charged with implementing APMs that affect their specific practice to play a major role in design and development.

Indeed, many providers are developing and proposing APMs with the hopes that CMS will approve them. As of April 2017, PTAC has received 16 letters of intent and six full proposals for PFPMs from various groups.[61] PTAC deliberated and voted on the first four PFPM proposals April 10-11, 2017.[62]

While the results of the vote have not been officially made public, none of the PFPM proposals received a preliminary recommendation to be reviewed by the Secretary.[63] This suggests a high bar for additional PFPM proposals.

Current Implementation

In a survey of 19,200 physicians, 43% indicated that they will participate in MACRA, but over 35% are unsure of how they will approach the new rule.[64] The specialties with the highest planned participation are (1) ophthalmology, (2) nephrology, (3) urology, (4) dermatology, and (5) cardiology, while psychiatry, plastic surgery, and pediatrics were least likely to report expected participation in MACRA.[65] As 2017 is a transition year, it is too early to determine the impact MACRA will have on providers.

Nevertheless, once providers have determined that they will participate in MIPS or an Advanced APM, it is vital to evaluate their "health information technology (HIT) capabilities and practice redesign needs."[66] Although many providers have some type of electronic health record system in place, HIT may take the longest to implement as a more robust system is needed. Infrastructure should be interoperable with both internal and external systems, have the ability to report on required model measures, and execute actionable population management analyses.[67] Providers also should create operational improvement plans and address changes in processes, patient flow, and practice focus. Additionally, Advanced APM providers may need to identify external partners to coordinate efforts and establish legal and payment structures.[68]

Future of MACRA

Although MACRA is in its early stages, recent studies suggest several areas to watch in terms of MACRA budgetary impacts.[69] First, some predict that providers will receive lower Medicare payments under MACRA because "of both low rates of annual increases in physician payment rates under MACRA—payments per unit of service will not keep pace with practice cost inflation—and changes that physicians are expected to make in the provision of care under APMs."[70] Payments are estimated to fall below pre-MACRA levels by year 2025 "as a result of 0% payment rate updates between

2019–2024 and the expiration of the 5% APM bonus in 2025."[71] This result may set the stage for a political showdown similar to that with the SGR. Further, as providers implement cost-saving measures and aim to reduce admissions and readmissions, hospitals may be negatively affected by MACRA and could lose up to $250 billion by 2030.[72] Medicare also is considering new hospital payment models, which could reduce hospital revenue even more.[73]

Conclusion

MACRA is in early stages of implementation and it remains to be seen if the SGR replacement can live up to expectations to control Medicare and Medicaid costs, provide some degree of certainty about payment rates, and usher in a new era of coordinated care focused on quality, advancing care through electronic health records, and improving outcomes. Furthermore, the extent to which providers are able to understand and incorporate MIPS or Advanced APMs into their practices will play a large role in whether MACRA is sustainable in the long term.

1 Pub. L. No. 114-10, 129 Stat. 87 (2015).
2 *See* Ctrs. for Medicare & Medicaid Servs. (CMS), *MACRA: Delivery System Reform, Medicare Payment Reform*, *available at* https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/macra-mips-and-apms/macra-mips-and-apms.html (last visited May 1, 2017).
3 MIPS and APM Final Rule, 81 Fed. Reg. 77008 (Nov. 4, 2016) (to be codified at 42 C.F.R. pts. 414 and 495).
4 *See* Stoltenberg Consulting, Inc., *5th Annual Health IT Industry Outlook Survey* (2017), *available at* http://www.stoltenberg.com/documents/surveys/2017HITOutlookSurvey.pdf.
5 Pub. L. No. 105-33, 111 Stat. 251, 433-34 (1997).
6 *See* Cong. Budget Office, *The Sustainable Growth Rate Formula for Setting Medicare's Physician Payment Rates 2* (2006), *available at* https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/75xx/doc7542/09-07-sgr-brief.pdf.
7 *Id.*
8 *See* Nathan Brown, *From MSGR to MACRA: The Long & Wild Ride of Medicare Compensation*, Nextech Blog (Apr. 16, 2015), *available at* http://www.nextech.com/blog/from-msgr-to-macra-the-long-wild-ride-of-medicare-compensation.
9 *See* Robert Lowes, *Congress Repeals Medicare SGR Formula* (Apr. 14, 2015), *available at* http://www.medscape.com/viewarticle/843078 (visited May 1, 2017).
10 *See* CMS, *How Do I Participate in Alternative Payment Models?* Quality Payment Program (2017), *available at* https://qpp.cms.gov/learn/apms (last visited May 1, 2017).
11 Alternative Payment Model (APM) means any of the following: (1) a model under Section 1115A of the Social Security Act (other than a health care innovation award); (2) the shared savings program under Section 1899 of the Act; (3) a demonstration under Section 1866C of the Act; or (4) a demonstration required by federal law. 42 C.F.R. § 414.1305.
12 42 C.F.R. § 414.1415.
13 Furthermore, QPs are not subject to MIPS and receive a higher fee schedule update for 2026 and onward. Beginning in 2021, QPs may reach their threshold percentage through a combination of Medicare and non-Medicare payer arrangements. 42 C.F.R. § 414.1305.
14 *See How Do I Participate in Alternative Payment Models?* Quality Payment Program (2017), *available at* https://qpp.cms.gov/learn/apms (last visited May 1, 2017).
15 CMS, *Comprehensive ESRD Care Model*, *available at* https://innovation.cms.gov/initiatives/comprehensive-esrd-care/ (last visited Apr. 18, 2017).
16 *Id.*
17 *Id.*
18 *Id.*
19 CMS, *Comprehensive Primary Care Plus*, *available at* https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus (last visited May 22, 2017).
20 *Id.*
21 *Id.*
22 CMS, *Comprehensive Primary Care Plus (CPC+) Round 2 Region Announcement*, *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-05-17.html (last visited May 22, 2017).
23 First, the ACO must have at least 5,000 assigned Medicare Fee-For-Service beneficiaries. Second, the ACO must establish a governing body that represents ACO participants and Medicare beneficiaries. Third, ACOs must engage in routine self-evaluation to ensure they continuously improve the care delivered to Medicare patients.
24 MIPS and APM Final Rule, 81 Fed. Reg. 77008, 77421 (Nov. 4, 2016) (to be codified at 42 C.F.R. pts. 414 and 495).
25 *Id.*
26 *Id.*
27 CMS, *Next Generation ACO Model*, *available at* https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/ (last visited May 1, 2017).
28 CMS, *Next General ACO Model Benchmarking Methods* (Dec. 15, 2015), *available at* https://innovation.cms.gov/Files/x/nextgenacomethodology.pdf.
29 *See supra* note 27.
30 *See supra* note 28, at 23.
31 *Id.*
32 *See supra* note 28.
33 *Id.*
34 *Id.*
35 *See supra* note 27.
36 *See* CMS, *Oncology Care Model*, *available at* https://innovation.cms.gov/initiatives/oncology-care/ (last visited May 1, 2017).
37 *Id.*
38 *See* CMS, *Comprehensive Care for Joint Replacement Model*, *available at* https://innovation.cms.gov/initiatives/cjr (last visited May 1, 2017).
39 *Id.*
40 Advancing Care Coordination through EPMs Final Rule, 82 Fed. Reg. 180, 215 (Jan. 3, 2017) (to be codified at 42 C.F.R. pts. 510 and 512).
41 *Id.*
42 Advancing Care Coordination through EPMs Final Rule, 82 Fed. Reg. 22815 (May 19, 2017) (to be codified at 42 C.F.R. pts. 510 and 512).
43 MIPS and APM Final Rule, 81 Fed. Reg. 77008 (Nov. 4, 2016) (to be codified at 42 C.F.R. pts. 414 and 495).
44 To take part in MIPS and receive payments, a physician must be deemed MIPS eligible. Eligibility is defined as those clinicians who are identified by a unique billing TIN and NPI combination used to assess performance. Eligible clinicians are (1) physicians; (2) physician assistants; (3) nurse practitioners; (4) clinical nurse specialists; and (5) certified registered nurse anesthetists. 42 C.F.R. § 414.1305.
45 Currently, physicians are only evaluated by three performance categories; quality, improvement activities, and advancing care information. Cost, the fourth factor, will be calculated in 2017 but will not be used to determine payment adjustments until 2018. *See* CMS, *How Do I Participate in Alternative Payment Models?* Quality Payment Program (2017), *available at* https://qpp.cms.gov/learn/qpp.
46 CMS, *The Merit-Based Incentive Payment System (MIPS)*, *available at* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MIPS-NPRM-Slides.pdf (last visited May 1, 2017).
47 42 C.F.R. § 414.1330(a)(1).

48 42 C.F.R. § 414.1355(b)(1).
49 42 C.F.R. § 414.1375(a).
50 42 C.F.R. § 414.1350(b)(1).
51 *See* CMS, *How Do I Participate in Alternative Payment Models?* Quality Payment Program (2017), *available at* https://qpp.cms.gov/measures/quality (last visited May 1, 2017).
52 CMS, *Improvement Activities*, Quality Payment Program (2017), *available at* https://qpp.cms.gov/measures/ia (last visited May, 1, 2017).
53 *See Advancing Care Information*, Quality Payment Program (2017), *available at* https://qpp.cms.gov/measures/aci (last visited May 1, 2017).
54 *Quality Payment Program: Executive Summary* (Oct. 14, 2016), *available at* https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf.
55 *See* CMS, *Quality Payment Program*, *available at* https://qpp.cms.gov/ (last visited May 1, 2017).
56 *Id.*
57 42 C.F.R. § 414.1405.
58 *Id.*
59 MIPS and APM Final Rule, 81 Fed. Reg. 77008, 77009 (Nov. 4, 2016) (to be codified at 42 C.F.R. pts. 414 and 495).
60 The ten criteria are (1) scope of proposed PFPM; (2) quality and cost; (3) payment methodology; (4) value over volume; (5) flexibility; (6) ability to be evaluated; (7) integration and care coordination; (8) patient choice; (9) patient safety; and (10) health information technology. 42 C.F.R. § 414.1465.
61 *See* Office of the Assistant Secretary for Planning and Evaluation, *Proposal Submissions: Physician-Focused Payment Model Technical Advisory Committee*, *available at* https://aspe.hhs.gov/proposal-submissions-physician-focused-payment-model-technical-advisory-committee (last visited May 1, 2017).
62 *Id.*
63 *Id.*
64 *See* Sarah Grisham, *Medscape Physician Compensation Report 2017*, (Apr. 5, 2017), *available at* http://www.medscape.com/slideshow/compensation-2017-overview-6008547#23; *see also* Emily Rappleye, *Which specialties plan to participate in MACRA in 2017?*, Becker Hosp. Rev. (Apr. 6, 2017), *available at* http://www.beckershospitalreview.com/hospital-physician-relationships/which-specialties-plan-to-participate-in-macra-in-2017.html.
65 *See* Emily Rappleye, *Which specialties plan to participate in MACRA in 2017?*, Becker Hosp. Rev. (Apr. 6, 2017), *available at* http://www.beckershospitalreview.com/hospital-physician-relationships/which-specialties-plan-to-participate-in-macra-in-2017.html.
66 Kathryn Toone, Natalie Burton, and David Muhlestein, Leavitt Partners, *MACRA in 2017: Overview, Impact & Strategic Considerations of the Quality Payment Program*, 9 (Mar. 2017), *available at* https://leavittpartners.com/wp-content/uploads/2017/03/MACRA2-2017-Final-3.30.2017.pdf.
67 *Id.*
68 *Id.*
69 Peter S. Hussey, Jodi L. Liu, and Chapin White, *The Medicare Access And CHIP Reauthorization Act: Effects On Medicare Payment Policy And Spending*, Health Affairs 697, 703 (Apr. 2017).
70 *Id.* at 704.
71 *Id.* at 701.
72 *Id.* at 703.
73 *Id.*

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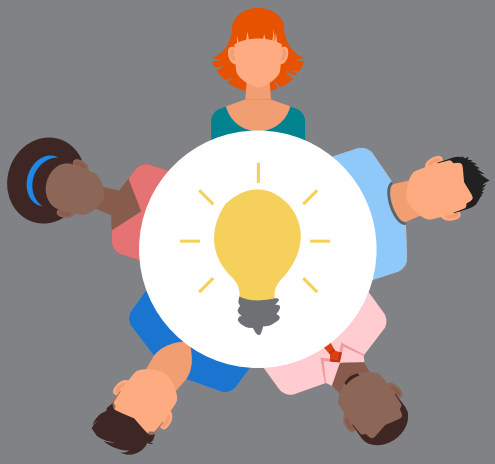

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