The Latest on Alternative Payment Models

By Neil Issar | April 27, 2017

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The Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") provided, among other things, an opportunity for eligible providers to earn incentives for providing high-quality, efficient, and coordinated care, including a five percent annual payment for participating in advanced alternative payment models ("APMs").

The Centers for Medicare & Medicaid Services ("CMS") currently has several ongoing initiatives in promoting and building APMs and new payment processes. For example, CMS recently introduced three new care coordination models: two cardiac care episode payment models ("EPMs") for items and services furnished to patients receiving treatment for heart attacks and bypass surgery, and one EPM applicable to items and services furnished to patients who receive surgery after a hip fracture, other than hip replacement.[1] CMS also created a new incentive payment system to encourage use of cardiac rehabilitation following a heart attack or heart surgery, and added an Accountable Care Organization ("ACO") Track 1+ model under the Medicare Shared Savings Program ("MSSP") that involves lower downside risk than the current APM-qualifying MSSP ACO models. The new track is intended to encourage more provider practices, particularly small rural practices, to participate in APMs with performance-based risk.[2]

Additionally, CMS recently solicited new payer participation in its Comprehensive Primary Care Plus (CPC+) program—a national advanced primary care medical home delivery model,[3] and the agency received several comments on pediatric APM and collaboration concepts, including:

- Opportunities and impediments to extending and enhancing integrated service model concepts like ACOs to the pediatric population
- Flexibilities and support states and providers may need in order to offer such models of care to a state's pediatric population; and
- Approaches for states and providers to coordinate Children's Health Insurance Program ("CHIP") benefits and waivers with other health-related social services for children and youth.[4]

CMS is also accepting letters of intent to apply for 2018 Next-Generation ACO Models until May 4, 2017.[5] The Next-Generation ACO Model is an initiative for ACOs that are experienced in coordinating care for populations of patients. It allows such organizations to assume higher levels of financial risk and reward than are available under the MSSP. For example, Next-Generation ACOs enjoy certain "benefit enhancements," including:

- A waiver of the rule requiring a three-day inpatient stay prior to admission to a Skilled Nursing Facility;
- Waivers of certain telehealth requirements to allow for telehealth services to be furnished to beneficiaries in their residences as well as in originating sites in non-rural areas; and
- A waiver allowing post-discharge home visit services to be furnished under general supervision instead of direct supervision. In other words, physicians can bill for services

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provided in patients' homes by contracting with other licensed clinicians to provide the services rather than being required to be present themselves.[6]

New HHS Secretary Tom Price has supported MACRA and innovative payment models. But Price has criticized mandatory bundled payment programs for "experimenting with Americans' health" because they "overhaul major payment systems, commandeer clinical decision-making, and dramatically alter the delivery of care." There is evidence, however, that properly implemented bundled payment models are associated with greater collaboration between providers, substantial hospital savings, and reduced Medicare payments.[7]

The latest Affordable Care Act ("ACA") replacement bill—the American Health Care Act ("AHCA")—did not address MACRA, APMs, or EPMs, and it was recently withdrawn from a House floor vote. So, for the time being, it appears CMS will continue updating the growing list of care models that qualify for APM incentive payments. But the failure to repeal the ACA likely means Republicans will increasingly use their regulatory authority to water down certain aspects of existing or pending health care laws and regulations. For example, CMS's new EPMs were initially set to become effective on February 18, 2017, but a White House memorandum postponed all regulations that were published but not yet in effect for 60 days, and an interim rule further postponed the effective date for these specific EPMs. So, the effective date has been pushed forward to May 20, 2017.[8]

CMS justified the delays as necessary to allow time for additional review and to ensure that:

- The agency has adequate time to undertake notice and comment rulemaking to modify the policy if modifications are warranted; and
- Participants have a clear understanding of the governing rules and are not required to take needless compliance steps if the rule is only in effect for a short duration before any potential modifications are effectuated.[9]

But unless the ACA is repealed, industry experts expect the transition toward value-based purchasing and more efficient care, including the rollout of new APMs, to continue despite the delays. Consequently, providers should continue to keep abreast of the latest legislative and policy changes involving APMs.

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[1] *See* 82 Fed. Reg. 180 (Jan. 3, 2017).

[2] *CMS Finalizes Testing of New Episode Payment Models and MSSP Track 1+ ACO*, ROPES & GRAY (Jan. 13, 2017). *See also* Maggie Van Dyke, *Rural Docs Move Into Value-based Payment*, H&HN (Jan. 17, 2017).

[3] Ctrs. for Medicare & Medicaid Servs., *Comprehensive Primary Care Plus*, CMS (last updated Mar. 23, 2017).

[4] Ctrs. for Medicare & Medicaid Servs., *Pediatric Alternative Payment Model Opportunities: General Information*, CMS (last updated Mar. 28, 2017).

[5] Ctrs. for Medicare & Medicaid Servs., *Next Generation ACO Model*, CMS (last updated Apr. 25, 2017).

[6] Ctrs. for Medicare & Medicaid Servs., *Open Door Forum: Next Generation ACO Model – Benefit Enhancements Overview*, CMS (last updated Apr. 25, 2017).

[7] *See, e.g.*, Amol S. Navathe et al., *Cost of Joint Replacement Using Bundled Payment Models*, 177 JAMA INTERN. MED. 214 (2017).

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[8] *See* 82 Fed. Reg. 10,961 (Feb. 17, 2017); 82 Fed. Reg. 14,464 (Mar. 21, 2017).
[9] 82 Fed. Reg. at 14,466.

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