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PERMITTED FINANCIAL ARRANGEMENTS BETWEEN PARTICIPANT HOSPITALS AND PHYSICIAN GROUP PRACTICES UNDER THE NEW CARDIAC-RELATED EPISODE PAYMENT MODELS

Pursuant to its recently issued final rule ("Rule"), CMS is implementing two cardiac-related episode payment models ("EPMs"). One of the EPMs pertains to episodes of care surrounding an acute myocardial infarction ("AMI EPM"); the other EPM pertains to episodes of care surrounding a coronary artery bypass graft ("CABG EPM"). Generally, participation in the AMI and CABG EPMs is mandatory for all IPPS hospitals located in one of the 98 MSAs designated by CMS. A list of the names and locations of the participant hospitals can be found here.

Participant hospitals may share their financial gains under the EPMs (and, if agreed to, their financial losses) with physician group practices ("PGPs") and other health care professionals and entities that have worked to redesign care processes or otherwise provided care to the hospitals' EPM beneficiaries. This article provides an overview of these permitted financial arrangements.

BACKGROUND: "RECONCILIATION PAYMENTS" AND "REPAYMENTS"

The AMI and CABG EPMs will be in effect for 5 performance years. Performance year 1 is the period from July 1, 2017 through December 31, 2017, and performance years 2 through 5 are calendar years (2018, 2019, 2020 and 2021, respectively).

During each of the 5 performance years, CMS will continue paying hospitals and other providers and suppliers according to regular FFS payment rates for services and items provided to EPM beneficiaries during AMI and CABG episodes of care. However, after the completion of a performance year, for each participant hospital, CMS will undertake a cost reconciliation process under the AMI EPM and, separately, under the CABG EPM. The process is the same for both EPMs. Basically, if the total amount of claims payments for the performance year (for AMI episodes of care and, separately, for CABG episodes of care) is less than the amount that Medicare would have been paid based on a quality-adjusted target price calculated for the participant hospital, Medicare will pay the participant hospital a sum equal to the difference between the two amounts (subject to certain stop-gain limits and other factors and provided that the hospital had achieved a quality category of "acceptable" or higher). This Medicare payment to a participant hospital is referred to as a "reconciliation payment." Separate reconciliation payments will be paid under the AMI EPM and the CABG EPM.

Beginning with EPM episodes of care ending in performance year 3 (or with episodes of care ending in performance year 2 for participant hospitals that elect to assume downside risk earlier[1]), if the amount of total payments for a performance year (for AMI episodes of care and, separately, for CABG episodes of care) is greater than the amount that would have been paid for the year based on the quality-adjusted target price, the participant hospital will be required to pay to Medicare a sum equal to the difference between the two amounts (subject to certain stop-loss limits and other factors). This payment from a participant hospital to Medicare is called a "repayment." Separate repayment obligations will be owed under the AMI EPM and the CABG EPM.

"SHARING ARRANGEMENTS" AND THE THREE PERMITTED FINANCIAL ARRANGEMENTS UNDER THE AMI AND CABG EPMS

In effect, the EPMs render a participant hospital financially responsible for the cost of AMI and CABG episodes of care that initiate at the hospital. However, CMS acknowledges that improving the quality and cost of the care provided to EPM beneficiaries, including the implementation of effective care redesign initiatives, requires meaningful collaboration among hospitals, physicians, post-acute care providers and other health care professionals and entities. Reflecting CMS's belief that it may be "essential for key providers to be aligned and engaged, financially and otherwise,"[2] the Rule authorizes participant hospitals to enter into certain financial arrangements, which CMS dubs "sharing arrangements," for purposes of incentivizing collaboration between participant hospitals and other health care providers that render care to the hospitals' EPM beneficiaries or otherwise engage in "EPM activities" (described below). These financial arrangements are outlined below.

- **The Three Permitted Financial Arrangements Under a Sharing Arrangement**

  A "sharing arrangement" is a direct financial arrangement between a participant hospital and an "EPM collaborator." Only certain

health care professionals and entities may serve as an EPM collaborator, including PGPs, Medicare Shared Savings Program ACOs (those not in Track 3), comprehensive outpatient rehabilitation facilities, inpatient rehabilitation facilities, home health agencies, skilled nursing facilities, PPS hospitals and critical access hospitals, certain therapy groups, individual physicians and certain individual non-physician practitioners.

Through a sharing arrangement, an EPM collaborator (including a PGP) may share in a participant hospital's financial gains and losses for a performance year under the AMI EPM and/or the CABG EPM. A participant hospital is not required to enter into a sharing arrangement, but if it elects to do so, it must include at least one of the following three financial arrangements.

1. *Sharing a Reconciliation Payment with an EPM Collaborator.* As noted earlier in this article, under the AMI EPM, and separately under the CABG EPM, Medicare will pay a "reconciliation payment" to a participant hospital in the event the total amount of Medicare payments for the hospital's episodes of care for a performance year is less than the amount that would have been paid based on CMS's quality-adjusted target price. A participant hospital may agree to pay all or a portion of its reconciliation payment for a performance year to one or more EPM collaborators (including a PGP). A participant hospital's payment of all or a part of its reconciliation payment to an EPM collaborator is termed a "gainsharing payment." See *Additional Information Regarding Gainsharing Payments and Alignment Payments* below for additional details regarding gainsharing payments.

2. *Sharing Internal Cost Savings with an EPM Collaborator.* "Internal cost savings" are the measurable and actual cost savings, verifiable in accordance with GAAP and government "Yellow Book" accounting principles, realized by a participant hospital during a performance year resulting from redesigned care processes undertaken by the hospital (alone or in conjunction with one or more EPM collaborators) in connection with providing items and services to EPM beneficiaries within EPM episodes of care. Per the Rule, internal cost savings "do not include 'paper' savings from accounting conventions or past investment in fixed costs." Nor do internal cost savings include any savings realized by any individual or entity other than the participant hospital. A participant hospital may agree to pay all or a portion of its internal cost savings for a performance year to one or more EPM collaborators (including a PGP). This payment from a participant hospital to an EPM collaborator is also considered a "gainsharing payment." See *Additional Information Regarding Gainsharing Payments and Alignment Payments* below for additional details regarding gainsharing payments.

3. *Sharing a Repayment Obligation with an EPM Collaborator.* As explained earlier in this article, beginning with AMI and CABG episodes of care ending in performance year 3 (or episodes of care ending in performance year 2, for participant hospitals electing to assume downside risk earlier[3]), a participant hospital, under the AMI EPM and separately under the CABG EPM, will pay a "repayment" to Medicare if the total amount of Medicare payments for the hospital's episodes of care for a performance year is greater than the amount that would have been paid based on CMS's quality-adjusted target price. One or more of a participant hospital's EPM collaborators (including a PGP) may agree to pay an amount to the participant hospital so as to share in the hospital's repayment obligation. This payment from an EPM collaborator to a participant hospital is called an "alignment payment." See *Additional Information Regarding Gainsharing Payments and Alignment Payments* below for additional information regarding alignment payments.

- **Currently, No Waiver of Fraud and Abuse Laws**

  The Rule implementing the AMI and CABG EPMs did not include a waiver of any fraud and abuse laws. Consequently, although the Rule establishes the parameters of permitted financial arrangements between participant hospitals and EPM collaborators (and the parameters of permitted financial arrangements between PGPs and PGP members, as discussed later in this article), all parties must nevertheless be careful to structure their financial arrangements so as to comply with applicable Stark and anti-kickback requirements. CMS advises that HHS is considering fraud and abuse waivers for the EPMs, but it gave no assurance that such waivers will, in fact, be issued.

- **Hospital Obligations When Selecting EPM Collaborators and Requirements for Sharing Arrangements**

  Before entering into a sharing arrangement, participant hospitals must develop and use a set of written policies for selecting individuals and entities to serve as EPM collaborators. The selection criteria must include a consideration of the quality of care furnished by potential EPM collaborators, and hospitals are allowed to consider whether a potential EPM collaborator has performed a reasonable minimum number of services that would qualify as "EPM activities." Pursuant to the Rule, "EPM activities" include managing and coordinating care, care process redesign, investment in infrastructure and enabling technologies, the provision of care to EPM

beneficiaries in a manner that reduces costs and improves quality and carrying out any other obligation under the EPM.

A sharing arrangement must not induce the participant hospital or EPM collaborator to reduce or limit medically necessary services to any Medicare beneficiary. Moreover, a sharing arrangement must not restrict the ability of the EPM collaborator to make decisions in the best interests of its patients. However, so long as the interests of patients are not compromised, participant hospitals and EPM collaborators are free to agree on matters such as the use of standardized devices, supplies and treatments.

A sharing arrangement must be in writing, signed by the parties and entered into before care is furnished to EPM beneficiaries under the sharing arrangement. The written agreement must address a number of topics, including the methodology and accounting formula for determining the amount of a gainsharing payment (which must be "substantially" based on quality of care and the provision of EPM activities) and the amount of an alignment payment.

- **Additional Information Regarding Gainsharing Payments and Alignment Payments**

1. *Gainsharing Payments.* As described above, a "gainsharing payment" is a payment from a participant hospital to an EPM collaborator, under a sharing arrangement. A gainsharing payment may only be composed of a participant hospital's reconciliation payment for a performance year, its internal costs savings for a performance year or both. To be eligible to receive a gainsharing payment, an EPM collaborator (including a PGP) must meet the quality of care criteria established for the EPM collaborator by the participant hospital. In addition, specifically with regard to a PGP's eligibility for a gainsharing payment, a PGP must have billed for an item or service that was provided by at least one of the PGP's members[4] to an EPM beneficiary during an EPM episode of care that occurred during the same performance year for which the participant hospital accrued the internal cost savings, and/or earned the reconciliation payment, that comprise the gainsharing payment. Furthermore, for these same episodes of care, the PGP must have contributed to EPM activities and been "clinically involved" in the care of EPM beneficiaries.

   The amount of a gainsharing payment to an EPM collaborator (including a PGP) must be determined in accordance with a methodology established by the participant hospital that is "substantially" based on: (i) quality of care; and (ii) the provision of EPM activities. With regard to PGPs specifically, the amount of a PGP's gainsharing payment may not exceed 50 percent of the Medicare approved amounts under the PFS for items and services billed by the PGP and furnished by the PGP's members to the hospital's EPM beneficiaries during EPM episodes of care that occurred during the same performance year for which the hospital accrued the internal cost savings, and/or earned the reconciliation payment, that comprise the gainsharing payment.

2. *Alignment Payments.* As noted previously in this article, an "alignment payment" is a payment from an EPM collaborator (including a PGP) to a participant hospital. An EPM collaborator may only make an alignment payment pursuant to a sharing arrangement, which the EPM collaborator must have voluntarily entered into. An EPM collaborator may not make an alignment payment for any purpose other than to share in a participant hospital's repayment obligation. Alignment payments may be paid at any interval agreed to by an EPM collaborator and a participant hospital, but no alignment payment for a performance year may be paid prior to CMS's calculation of the repayment amount owed by the participant hospital (as reflected in a reconciliation report issued by CMS for the performance year). An EPM collaborator may not loan or advance an alignment payment to a participant hospital.

   For a performance year, the aggregate amount of all alignment payments received by a participant hospital from all of its EPM collaborators may not exceed 50 percent of the participant hospital's repayment amount. The aggregate amount of alignment payments paid by a single EPM collaborator (including a PGP) to a participant hospital for a performance year may not exceed 25 percent of the hospital's repayment amount (except that the aggregate amount of alignment payments paid by an ACO to a participant hospital for a performance year may not exceed 50 percent of the hospital's repayment amount).

DISTRIBUTING A GAINSHARING PAYMENT WITHIN A PGP

A "distribution arrangement" is a voluntary financial arrangement entered into between an EPM collaborator (including a PGP) and a "collaboration agent" for the sole purpose of distributing to the collaboration agent some or all of a gainsharing payment received by the EPM collaborator. This distribution of a gainsharing payment by an EPM collaborator to a collaboration agent, under a distribution arrangement, is called a "distribution payment."

When a PGP, as an EPM collaborator, receives a gainsharing payment from a participant hospital, the PGP may make a distribution payment to one or more of its members by entering into distribution arrangements with those members. In turn, when a PGP member enters into a

distribution arrangement with the PGP, the member becomes the PGP's collaboration agent.

The amount of a PGP member's distribution payment may be calculated using one of two methodologies. Under the first option, a PGP may calculate the amount of a PGP member's distribution payment (provided the member is a collaboration agent) using a methodology that is "substantially" based on quality of care and the provision of EPM activities. Under this methodology, a PGP member is eligible to receive a distribution payment only if he/she furnished an item or service rendered to the participant hospital's EPM beneficiary during an EPM episode of care that occurred during the same performance year for which the participant hospital accrued the internal cost savings, and/or earned the reconciliation payment, that comprise the gainsharing payment being distributed by the PGP. In addition, the amount of a distribution payment to a PGP member may not exceed 50 percent of the total Medicare approved amounts under the PFS for items and services furnished by the member to the participant hospital's EPM beneficiaries during EPM episodes that occurred during the same performance year for which the participant hospital accrued the internal cost savings, and/or earned the reconciliation payment, that comprise the gainsharing payment being distributed.

Under the second option, a PGP may determine the amount of a PGP member's distribution payment in a manner that complies with the Stark Law regulation that governs the distribution of profits and the payment of performance bonuses by PGPs. According to CMS, this approach would allow physician members of a PGP who are not collaboration agents, even those who did not furnish items or services to EPM beneficiaries, to receive a share of the PGP's profits derived from the monies comprising a gainsharing payment received by the PGP.

PGPS SERVING AS ACO PARTICIPANTS IN MSSP ACOS

- **Distribution Payments from ACOs to PGPs**

  A participant hospital may enter into a sharing arrangement with a Medicare Shared Savings Program ("MSSP") ACO, if the ACO is not in Track 3. Upon entering into a sharing arrangement with such an ACO, the ACO becomes an EPM collaborator - eligible to receive gainsharing payments from its participant hospital and eligible to make distribution payments to its collaboration agents.

  Pursuant to the MSSP regulations, a PGP may serve as an "ACO participant" in a MSSP ACO. Under the Rule, when a PGP serves as an ACO Participant in a MSSP ACO that is an EPM collaborator, the ACO and the PGP may enter into a distribution arrangement and, upon doing so, the PGP becomes the ACO's collaboration agent. As an ACO's collaboration agent, the PGP may receive a distribution payment from the ACO. The requirements surrounding a PGP's receipt of a distribution payment from an ACO are almost identical to the requirements, described in *Distributing a Gainsharing Payment Within a PGP* above, surrounding a PGP's provision of distribution payments to its members. The most significant difference concerns the methodology used in determining the amount of a PGP's distribution payment. The option of calculating a PGP's distribution payment using a methodology that complies with the above-referenced Stark Law regulation is not available to an ACO. Instead, an ACO must determine the amount of a PGP's distribution payment using a methodology that is "substantially" based on quality of care and the provision of EPM activities.

  A PGP is only eligible to receive a distribution payment from an ACO if the PGP billed for an item or service rendered to an EPM beneficiary during an EPM episode that occurred during the same performance year for which the participant hospital accrued the internal cost savings, and/or earned the reconciliation payment, that comprise the gainsharing payment being distributed by the ACO. In this regard, the total amount of distribution payments for a performance year paid by an ACO to a PGP may not exceed 50 percent of the total Medicare-approved amounts under the PFS for items and services billed by the PGP for items and services furnished by PGP members to the participant hospital's EPM beneficiaries during EPM episodes that occurred during the same performance year for which the participant hospital accrued the internal cost savings, and/or earned the reconciliation payment, that comprise the gainsharing payment being distributed.

- **"Downstream" Distribution Payments from PGPs to PGP Members**

  A PGP that has entered into a distribution arrangement with an ACO (as described above) may pay all or a portion of any distribution payment it receives from the ACO to the one or more members of the PGP. This payment from a PGP to a PGP member is termed a "downstream distribution payment," and such a payment may only be made in accordance with a "downstream distribution arrangement" entered into between the PGP and a PGP member. When a PGP member enters into a "downstream distribution arrangement" with its PGP, the member becomes the PGP's "downstream collaboration agent."

  The requirements governing a PGP's provision of *downstream* distribution payments to its members are virtually identical to the

requirements, described in *Distributing a Gainsharing Payment Within a PGP* above, governing a PGP's provision of *distribution* payments to its members. For purposes of calculating the amount of a downstream distribution payment, a PGP may elect to calculate the amount in a manner that complies with the aforementioned Stark Law regulation or pursuant to the aforementioned methodology that is "substantially" based on quality of care and the provision EPM activities (including the methodology's eligibility requirements for receiving a distribution payment and the cap on the amount of a PGP member's distribution payment).

If you have any questions, or would like additional information about this topic, please contact Tim Kennedy at (317) 977-1436 or tkennedy@hallrender.com or your regular Hall Render attorney.

[1] Basically, a participant hospital's assumption of downside risk under the AMI EPM or the CABG EPM will cause the EPM, with regard to the hospital, to become an Advanced APM under MACRA (if the hospital also satisfies the applicable CEHRT requirements). When an EPM becomes an Advanced APM, suffice it to say that, with respect to a PGP that has entered into a "sharing arrangement" with the hospital (sharing arrangements are described later in this article), the members of the PGP will have an opportunity to satisfy the requirements to become Qualifying APM Participants ("QPs"). For calendar years 2019 through 2024, a QP will receive an "APM Incentive Payment" equal to five percent of the QP's aggregate FFS payments for professional services for the prior year (and, beginning in 2025, QPs will receive a more favorable PFS payment update). For these reasons, a participant hospital may wish to begin assuming risk under an EPM as early as performance year 2 (i.e., 2018).

[2] 82 Fed. Reg. 180, 223 (January 3, 2017)

[3] See footnote number 1.

[4] As defined in the Rule, a "member" of a PGP is a physician, nonphysician practitioner or therapist, who is an owner or employee of the PGP and who has reassigned to the PGP his/her right to receive Medicare payment.

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