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CMS PROPOSES ADDITIONAL HARDSHIP EXEMPTIONS FOR eRx INCENTIVE PROGRAM

The Centers for Medicare & Medicaid Services (CMS) recently released a proposed rule creating hardship exemptions for physicians not meeting the requirements of the Electronic Prescribing Incentive Program (eRx Program) in the first half of 2011 (Proposed Rule). The eRx Program is intended to encourage eligible professionals to use electronic prescribing by providing such professionals with financial incentives for successful use of an electronic prescribing system or reducing their payments for the unsuccessful use of an electronic prescribing system. Professionals who are eligible to participate in the eRx Program include physicians, practitioners, and certain therapists that are Medicare-participating providers (Eligible Professionals). Under current rules, Eligible Professionals must complete at least 10 paperless drug orders using an electronic prescribing system to be considered a successful electronic prescriber and to receive incentive payments. Eligible Professionals who fall short of this benchmark are considered unsuccessful electronic prescribers and are subject to payment reductions beginning in 2012. Payment reductions will be equal to a 1 percent Medicare pay cut in 2012, escalating to 1.5 percent in 2013 and 2 percent in 2014. CMS currently offers exemptions to the eRx payment reductions for Eligible Professionals (or group practices) who are unsuccessful electronic prescribers in rural areas with limited high-speed Internet access or have limited available pharmacies for electronic prescribing.

CMS has proposed the following additional exemptions from eRx payment adjustments, which will be determined on a case-by-case basis:

- Eligible Professionals participating in the Medicare or Medicaid Electronic Health Record (EHR) Incentive Programs, who may have delayed adopting eRx technology to comply with the EHR meaningful use requirements
- Eligible Professionals who are limited in their ability to electronically prescribe by local,

state, or federal regulations (for example, physicians in states prohibiting or limiting transmissions through third-party networks such as Surescripts or physicians prescribing a large volume of narcotics)
- Eligible Professionals with limited prescribing activity during the six-month timeframe from January 1, 2011 to June 30, 2011
- Eligible Professionals who have sufficient visits with qualifying billing codes, as determined by CMS, but do not normally write prescriptions associated with these visits (for example, surgeons)

To request a hardship exemption under any of the proposed new categories, an Eligible Professional must provide the following information:

- Identifying information (Tax Identification Number, National Provider Identifier, name, address, and e-mail address)
- The applicable exemption category
- A justification statement explaining how compliance with eRx requirements would result in significant hardship
- An attestation of the accuracy of the information provided

CMS has proposed creating a website where Eligible Professionals could submit the necessary information to request one of the new hardship exemptions; however, if the website is not available before publication of the final rule, requests must be sent to CMS via mail.

To ease the burden on eRx participants requesting hardship exemptions, CMS has delayed the deadline for submission of requests and supporting information from June 30, 2011 to October 1, 2011.

CMS is soliciting comments on the Proposed Rule. Such comments must be received by CMS by July 25, 2011. A final rule is anticipated before October 1, 2011.

CMS PROPOSES NEW ACO INITIATIVES

The Center for Medicare and Medicaid Innovation (Innovation Center) recently proposed three new initiatives to provide health care providers and entities with options and incentives to create and participate in Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program (Shared Savings Program). The Innovation Center is a new entity within the Centers for Medicare & Medicaid Services (CMS) authorized to test new payment and service delivery models to reduce Medicare expenditures while maintaining or improving the quality of care provided to Medicare beneficiaries.

Advanced Payment ACO Initiative

Under the Shared Savings Program, certain medical providers and suppliers that meet eligibility criteria established by the Secretary of the Department of Health and Human Services (HHS) may establish an ACO. If the ACO holds costs below certain benchmarks and satisfies the quality standards established by HHS, it will receive a shared savings payment, in addition to the fee for service payments the ACO participants and providers and suppliers receive under Medicare Parts A and B for medical services rendered. Read more about the

proposed requirements for ACO participation in the Shared Savings Program here. Health care organizations and groups of providers have expressed concerns about the costs associated with forming and operating an ACO under the Shared Savings Program, particularly regarding the necessary capital to build the infrastructure required to coordinate care and adequately report quality measures to CMS. In what appears to be a response to these concerns, the Innovation Center announced that it is considering an Advance Payment ACO Initiative, which will test prepaying a portion of future shared savings to ACOs entering into the Shared Savings Program. Prepayment will be in the form of a monthly payment for each Medicare beneficiary aligned with the ACO. Receipt of these funds will allow ACOs to build care coordination capabilities and meet other organizational criteria for participation in the Shared Savings Program. An ACO will be required to repay CMS for the advanced payments through the shared savings that it receives under the Shared Savings Program.

The Pioneer ACO Model

The second new initiative has been designed as an alternative to the Shared Savings Program for organizations that have experience with clinical integration and outcome-based payments (Pioneer ACO Model). The Innovation Center is seeking applicants that either already have, or are willing to implement, payment arrangements that include financial accountability and performance incentives. The Pioneer ACO Model has several components that differ from the Shared Savings Program proposed rule. These differences include the following:

- **Beneficiary Alignment** — ACOs participating in the Pioneer ACO Model (Pioneer ACO) must have at least 15,000 Medicare beneficiaries, compared to the 5,000 beneficiary minimum under the Shared Savings Program. Beneficiaries may be aligned with a Pioneer ACO either prospectively or retrospectively. Generally, beneficiary alignment with a Pioneer ACO is based upon the group of primary care providers who billed for the plurality of primary care services such beneficiary received during the prior three-year period. For purposes of the Pioneer ACO Model, primary care providers include primary care physicians, nurse practitioners, and physician assistants. However, a Medicare beneficiary may be aligned to a Pioneer ACO based upon a group of eligible specialty physicians if 10 percent or less of that beneficiary's allowed Medicare charges were billed by primary care providers. Eligible specialty areas include, but are not limited to, oncology, neurology, and cardiology. Like the Shared Savings Program, a beneficiary's alignment with a certain Pioneer ACO does not limit that beneficiary's choice of provider.
- **Term of Agreement with the Innovation Center** — A Pioneer ACO must enter into an agreement with CMS to participate in the Pioneer ACO Model for approximately three years (Agreement). CMS may extend the Agreement by two 12-month performance periods, for a total of approximately five years of participation, depending upon the Pioneer ACO's success.
- **Payment Arrangements** — Like the Shared Savings Program, Pioneer ACOs will be rewarded for higher quality performance, receive a percentage of shared savings generated, and share in any losses. However, Pioneer ACOs will be able to elect one of two payment arrangements: the Core Payment Arrangement or the Alternative Payment Arrangement.

  The Core Payment Arrangement is similar to the two-sided model of the Shared Savings Program. Under the two-sided model, an ACO will receive a portion of shared savings but is also responsible for repaying CMS for any losses if its expenses are above certain benchmarks. The Core Payment Arrangement offers participants higher levels of risks and rewards than the two-sided model. Additionally, a Pioneer ACO that

initially selects the Core Payment Arrangement can elect to participate in the Core Payment Arrangement as proposed, or it can choose to participate in one of two options, Option A or Option B. These options are distinguished by the Pioneer ACO's share of savings or losses, with participants of Option B bearing a greater share of the losses (and receiving a greater portion of the savings) than Pioneer ACOs participating in the Core Payment Arrangement or in Option A. A central feature of each option is escalating levels of financial accountability. For example, in year one of the Core Payment Arrangement, a Pioneer ACO will receive up to 60 percent of shared savings and losses while in year two it will receive up to 70 percent of shared savings and shared losses.

Pioneer ACOs meeting minimum savings benchmarks during their first two years of participation will be transitioned to a population-based payment model for year three. Under the population-based payment model, a Pioneer ACO will receive (1) fee-for-service payments at 50 percent of the payment rates for services rendered to aligned beneficiaries and (2) a monthly payment for each aligned beneficiary that will equal the remainder of the Pioneer ACO's projected fee-for-service revenue. CMS anticipates that Pioneer ACOs will receive additional funds under population-based payment, which will allow a Pioneer ACO to invest in its infrastructure and further support care coordination for Medicare beneficiaries. The level of financial risk assumed under population-based payment will be the same as that in the Pioneer ACO's second year of participation under the traditional fee-for-service reimbursement. A Pioneer ACO that does not generate the minimum average amount of savings in years one and two will not transition to the population-based payment in year three.

The Alternative Payment Arrangement has not yet been released. The Innovation Center will develop this arrangement based upon payment arrangements proposed by applicants for participation as a Pioneer ACO.

- **Participation of Other Payors** — Pioneer ACOs must commit to entering into outcome-based contracts with payors other than Medicare, such as private health plans, state Medicaid agencies, and/or self-insured employers. The Innovation Center defines outcome-based contracts as those that include financial accountability, evaluate patient experiences of care, and include substantial quality performance incentives.

The Innovation Center expects to partner with 30 organizations for participation in the Pioneer ACO Model. Priority will be given to applicants that collaborate with federally qualified health centers and/or other entities that serve disadvantaged populations. The Innovation Center is also seeking to partner with organizations that serve Medicare/Medicaid dual-eligible beneficiaries.

Organizations interested in applying for participation in the Pioneer ACO Model must submit a nonbinding letter of intent to the Innovation Center by Tuesday, June 30, 2011. Completed applications must be postmarked by Friday, August 19, 2011.

Accelerated Development Sessions for Accountable Care Organizations

The Innovation Center's third new initiative is the implementation of four separate accelerated development learning sessions (Sessions) designed to encourage executives from new or newly emerging ACOs to participate in the Shared Savings Program. The Sessions will include

hands-on individual and group activities to provide executives with the opportunity to learn about core functions of an ACO and ways to build their ACO's capacity in order to succeed in the Shared Savings Program. Session faculty will include executives from organizations that have already developed many of the characteristics required for participation in the Shared Savings Program and other experts in ACO core competencies. The Innovation Center intends to test whether the Sessions expand and improve the capabilities of an ACO to coordinate the care of its Medicare beneficiary population.

Each Session will be held for three days. ACOs wishing to participate should send a team of two to four senior-level leaders, including executives with financial/management and clinical responsibilities. The Innovation Center anticipates offering Sessions in September, October, and November. Interested teams should monitor the Innovation Center website, www.innovations.cms.gov, for more details.

CMS RELEASES FINAL RULE ON CREDENTIALING AND PRIVILEGING OF TELEMEDICINE PRACTITIONERS

The Centers for Medicare & Medicaid Services (CMS) recently revised the Conditions of Participation (CoPs) governing hospital credentialing and privileging of telemedicine health practitioners. Current CoPs require hospitals to credential and privilege telemedicine providers in the same manner as they credential on-site practitioners. CMS intends for the revised CoPs to (1) reduce duplication in the credentialing and privileging process by permitting a hospital to rely on a distant site's credentialing and privileging process, (2) increase the access of small and rural hospitals to telemedicine providers, and (3) encourage innovation in the timely delivery of patient care. The revised CoPs, which take effect on July 5, 2011, permit hospitals to rely on the privileging and credentialing process of the hospital or other telemedicine entity at which a telemedicine provider is physically located (distant site) as the basis for a credentialing and privileging decision if certain conditions are satisfied.

If the hospital is seeking telemedicine services from a distant site that is a hospital (DSH), the hospital must enter into a written agreement with the DSH specifying that it is the responsibility of the DSH's governing body to follow CMS' existing requirements for credentialing and privileging. In addition, the hospital's governing body must ensure, and document in the written agreement, that:

- The DSH participates in Medicare
- The telemedicine practitioner is privileged at the DSH (the DSH must provide the hospital with a list of the practitioner's privileges at the DSH)
- The telemedicine practitioner's license is issued or recognized by the state in which the hospital seeking telemedicine services is located

Once the telemedicine practitioner has been granted privileges at the hospital, the hospital should submit all evidence of any internal review of the practitioner's performance to the DSH for use in its periodic appraisal of the practitioner. At a minimum, the hospital must send the DSH all adverse events resulting from the practitioner's provision of telemedicine services and any complaints received by the hospital about such practitioner.

If the distant site is a nonhospital entity (DSE), the hospital seeking to obtain telemedicine services must enter into a written agreement with the DSE. The written agreement must

specify that:

- The DSE is a contractor of the hospital
- The DSE will comply with the hospital CoPs for contracted services
- The DSE will comply with hospital credentialing requirements, even though such credentialing requirements do not otherwise apply to nonhospital entities
- The DSE periodically conducts appraisals of its medical staff
- The telemedicine practitioner is privileged at the DSE and the DSE will provide the hospital with a list of the practitioner's privileges at the DSE
- The telemedicine practitioner's license is issued or recognized by the state in which the hospital seeking telemedicine services is located
- Once the telemedicine practitioner has privileges at the hospital, the hospital will send the DSE evidence of an internal performance review of the practitioner for use in a periodic appraisal
- The hospital seeking telemedicine services must, at a minimum, send the DSE all adverse events resulting from the practitioner's provision of telemedicine services to the hospital and any complaints received by the hospital about such practitioner

The telemedicine procedures contained in the revised CoPs are optional, and hospitals are permitted to continue to independently credential and privilege telemedicine providers.

If you have questions about any of these topics, contact a member of our Health Law Group.

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