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The Path to Successful Utilization of Alternative Payment Models

By Todd Zigrang, MBA, MHA, FACHE, CVA, ASA and Jessica Bailey-Wheaton, Esq., Health Capital Consultants, St. Louis, MO, and Khaled Klele, Esq., Riker Danzing Scherer Hyland & Perretti LLP, Morristown, NJ

I. Introduction

The U.S. healthcare system is in the process of shifting from traditional fee-for-service (FFS) payment to value-based alternative payment models (APMs).[1] The number of APMs were significantly accelerated by the Patient Protection and Affordable Care Act (PPACA), which established the Medicare Shared Savings Program (MSSP) for accountable care organizations (ACOs).[2] Ten years after the passage of PPACA, and five years after the passage of the Medicare Access and CHIP Reauthorization Act (MACRA),[3] the evolution of these value-based reimbursement (VBR) models may provide some insight as to the future success of these arrangements. Toward that end, this article reviews recent trends and changes to federal, quasi-federal, and private APMs, and discusses the indications that may be drawn from these developments.

II. Federal APMs

The changes to the MSSP in the December 2018 Final Rule (December Final Rule) were significant.[4] The reasons for the changes, as expressed by the Centers for Medicare & Medicaid Services (CMS), are also important because they are an indication of future changes and trends in the MSSP. This section will discuss the background of the MSSP, the relevant data, reasons for and themes behind the changes, the addition of new definitions, a description of the major changes, and whether the new data will lead to further changes.

A. Background of the MSSP

The MSSP was established by CMS to achieve savings in how providers delivered healthcare services while maintaining the quality of those services. Providers could share in those savings by particpating in the MSSP through an ACO. CMS established the MSSP in 2012 with just two tracks.[5] Track 1 was an upside-only track, meaning the provider could receive compensation for achieving shared savings, but the provider had no downside risk so it would not have to pay CMS for failing to achieve savings. Track 2 was a two-sided model, meaning it had an upside benefit and a downside risk. In 2016, CMS added Track 3, a two-sided model where the benefits and risks were greater than Track 2.[6] Started January 1, 2018, based on the experience with Tracks 1, 2, and 3, CMS created a Track 1+, which was based on the upside benefits of Track 1, but included limited downside risk that was less than Track 2.[7]

B. The Relevant Data

As of the 2019 Performance Year, there were 518 ACOs in the MSSP.[8] ACOs are the provider entities that execute agreements with CMS to participate in the MSSP.[9] A single physician, therefore, cannot participate in the MSSP unless that physician joins or forms an ACO that meets the requirements, such as having responsibility for at least 5,000 Medicare beneficiaries per year.[10]

Prior to the 2018 MSSP changes, CMS reported that an overwhelming majority of the 561 ACOs in the MSSP, 460, were in Track 1. Only eight ACOs were in Track 2 and 38 were in Track 3.[11] Even though it was only in effect for approximately one year, 55 ACOs were in Track 1+.[12]

Despite a vast majority of ACOs avoiding tracks with downside risk, the data showed that ACOs in tracks with downside risk performed better than those ACOs in tracks with upside-only risk. Over the 2016- to 2018-timeframe, the data showed that two-sided models performed better than one-sided models in achieving savings:[13]

(1) 2016: 68 percent of ACOs (15 of 22 ACOs) in two-sided models had shared savings compared to 29 percent in upside-only models;

(2) 2017: 51 percent of ACOs (20 of 39 ACOs) in two-sided models had shared savings compared to 33 percent in upside-only models; and

(3) 2018: ACOs in two-sided models reduced spending by $96 per beneficiary, compared to $68 in upside-only models.

The data was even more stark when comparing low revenue ACOs (which typically includes physician-led ACOs) to high revenue ACOs (which typically includes hospital systems), showing that low revenue ACOs outperformed high revenue ACOs:[14]

(1) 2016: 41 percent of low revenue ACOs achieved shared savings compared to 23 percent of high revenue ACOs;

(2) 2017: 44 percent of low revenue ACOs achieved shared savings compared to 28 percent of high revenue ACOs; and

(3) 2018: Low revenue ACOs reduced spending by $180 per beneficiary compared to $27 for high revenue ACOs.

CMS also found that the longer an ACO is in the program, the better the ACO performs, primarily because ACOs gain experience and their benchmarks become more predictable.[15]

C. Reasons for Changes

CMS's goal is to achieve increased savings while maintaining quality care. Since a majority of ACOs were in upside-only tracks, it was clear to CMS that an overwhelming majority of ACOs had a limited appetite for entering a two-sided model with the types of risk available under Tracks 2 and 3. At the same time, CMS recognized that ACOs were willing to take on some risk that was below the risk in Track 2, considering that many ACOs transitioned to Track 1+.[16] By moving more ACOs to tracks with some downside risk, CMS would achieve more savings because, as explained above by the data, ACOs in tracks with downside risk achieve more savings.[17]

D. Themes for CMS Changes to the MSSP

There are several themes that CMS used to make and implement changes to the MSSP. First, CMS limited the timeframe for upside-only models, and provided incentives to move ACOs to two-sided models.[18] Second, CMS eliminated the ability for ACOs to game the system through churning, by addressing how and when an ACO that leaves the MSSP could rejoin.[19]

Third, and probably the most significant theme, is that CMS used ACOs' ability to control the total Medicare Parts A and B FFS expenditures for their assigned beneficiaries to develop changes.[20] Whether an ACO achieves savings depends in large part on the total expenditures of the ACO's assigned Medicare beneficiaries. Those expenditures include Medicare dollars that beneficiaries spend by going to any provider, regardless of whether or not that provider participates in the ACO. Low revenue ACOs cannot easily control expenditures. This is contrary to high revenue ACOs, which typically include hospital systems, because they can control the continuum of care of their Medicare beneficiaries from inpatient care, to outpatient care, to home care, since hospital systems tend to provide the full range of services.[21]

E. New Definitions That Set Up The MSSP Changes

CMS created many new definitions to set up the changes to the MSSP, including the definitions for High Revenue ACO and Low Revenue ACO:[22]

(1) Low Revenue ACO: Total Medicare Parts A and B FFS revenue of its ACO participants (i.e., providers) is less than 35 percent of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries.

(2) High Revenue ACO: Total Medicare Parts A and B FFS revenue of its ACO participants is at least 35 percent of the total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries.

When calculating the revenue and expenditures, CMS looks at total revenue and expenditures of Medicare Parts A and B FFS from the ACO's assigned beneficiaries and non-assigned beneficiaries. In other words, if an ACO participant sees a beneficiary that is not assigned to his or her ACO, or that beneficiary goes to a non-ACO participant provider, those revenues/costs are still factored in the calculation, which is consistent with how CMS calculates an ACO's benchmark.[23]

CMS also created definitions for Experienced ACO and Inexperienced ACO:[24]

(1) Experienced ACO: (1) The ACO is the same legal entity as a current or previous ACO that is participating in, or has participated in, a performance-based risk Medicare ACO, or that deferred its entry into a second MSSP agreement period under Track 2 or Track 3 or (2) 40 percent or more of the ACO's participants participated in a performance-based risk Medicare ACO initiative, or in an ACO that deferred its entry into a second

MSSP agreement period under Track 2 or Track 3, in any of the five most recent performance years prior to the agreement start date.

(2) Inexperienced ACO: (1) The ACO is a legal entity that has not participated in any performance-based risk Medicare ACO initiative, and has not deferred its entry into a second MSSP agreement period under Track 2 or Track 3; and (2) Less than 40 percent of the ACO's participants participated in a performance-based risk Medicare ACO initiative, or in an ACO that deferred its entry into a second MSSP agreement period under Track 2 or Track 3, in each of the five most recent performance years prior to the agreement start date.

In other words, if an ACO is a new legal entity, but over 40 percent of the ACO's providers participated in an ACO, then the ACO is considered experienced.[25] In addition, the phrase "Medicare ACO initiative" is not limited to the MSSP and includes other Medicare ACO initiatives, such as the Pioneer ACO Model and Next Generation ACO Model.[26] CMS included these definitions to prevent ACOs from gaming the system by attempting to exit the MSSP to avoid a potentially poor year, but then re-form as a new entity for purposes of re-entering the MSSP.[27]

For the same reasons, CMS created definitions for Renewing ACO and Re-entering ACO:[28]

(1) Renewing ACO: An ACO that continues its participation in the MSSP for a consecutive agreement period, without a break in participation.

(2) Re-entering ACO: An ACO that is the same legal entity as an ACO that previously participated in the MSSP and is applying to participate in the MSSP after a break in

participation, because its agreement expired or terminated. It also includes a new legal entity where more than 50 percent of its participants were included on the ACO participant list in any of the five most recent years.

F. Summary of Major Changes

The December Final Rule made several significant changes, effective July 1, 2019, including changes to the tracks, extending the agreement term, revising the beneficiary assignment methodology, increasing incentives to encourage ACOs moving to two-sided tracks, and revising the benchmarking.

1. Changes to the Tracks

CMS eliminated the previous tracks and created a Basic Track and an Enhanced Track.[29] The Basic Track consists of five levels, Level A to Level E. Level E is similar to the eliminated Track 1+:[30]

Level A	Upside only. Up to 40% of savings with a cap of 10% of benchmark.
Level B	Upside only. Up to 40% of savings with a cap of 10% of benchmark.
Level C	Two-sided model. Up to 50% of savings with a cap of 10% of benchmark. Pay up to 30% of losses with a cap of 2% of Medicare FFS revenue of ACO participants, but not more than 1% of the benchmark.

Level D	Two-sided model. Up to 50% of savings with a cap of 10% of benchmark. Pay up to 30% of losses with a cap of 4% of Medicare FFS revenue of ACO participants, but not more than 2% of the benchmark.
Level E	Two-sided model. Up to 50% of savings with a cap of 10% of benchmark. Pay up to 30% of losses but not to exceed the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program, capped at the amount that is one percentage point higher than the percentage of the updated benchmark specified in the expenditure-based nominal amount standard under the Quality Payment Program.

The Enhanced Track is a two-sided model with up to 75 percent of shared savings, but not to exceed 20 percent of the benchmark.[31] The loss sharing rate is determined based on the inverse of the final sharing rate, but not less than 40 percent (i.e., between 40-75 percent), not to exceed 15 percent of benchmark.[32]

An ACO's ability to enter the Basic Track or Enhanced Track, or any particular Level in the Basic Track, depends on whether the ACO is Low Revenue or High Revenue, as follows:[33]

Low Revenue ACOs

New Inexperienced ACO may enter at any Basic Level

New Experienced ACO cannot enter Levels A to D
Re-entering Inexperienced ACOs cannot enter Level A
Re-entering Experienced ACO cannot enter Levels A to D
Renewing Inexperienced ACO cannot enter Level A
Renewing Experienced ACO cannot enter Levels A to D

High Revenue ACOs

New Inexperienced ACO may enter at any Basic Level
New Experienced ACO cannot enter the Basic Track
Re-entering Inexperienced ACO cannot enter Level A
Re-entering Experienced ACO cannot enter Basic Track
Renewing Inexperienced ACO cannot enter Level A
Renewing Experienced ACO cannot enter Basic Track except for ACOs with a first or second agreement period beginning in 2016 or 2017 in the Track 1+ Model can enter Level E

The Basic Track is a glide path, wherein an ACO is automatically advanced to the next level of the Basic Track at the start of each subsequent performance year.[34] So an ACO that starts at Level A during the First Performance Year will advance to Level B at the start of the Second Performance Year.[35] An ACO may elect to advance more quickly by skipping levels, but an ACO cannot go backwards.[36] A Low

Revenue ACO that is inexperienced, however, may elect to remain in Level B during the Third Performance Year, but it must then move to Level E at the start of its Fourth Performance Year.[37]

2. Change in Length of Agreement

CMS changed the agreement length from three to five years. Importantly, however, low revenue ACOs can stay in the Basic Track for two agreement periods (for a total of 10 years) and those periods do not have to be not sequential, so if a low revenue ACO transitions to the Enhanced Track after a single agreement period (i.e., five years), the ACO can return back to Basic Track, but under Level E.[38]

3. Changes to the MSR/MLR Selection

The minimum savings rate/minimum loss rate (MSR/MLR) percentage identifies the level of risk the ACO is willing to take. For example, the higher the MLR, the higher the threshold an ACO has to meet before paying losses. However, the flip side is true – an ACO has to reach a higher threshold before sharing in savings.[39]

The MSR/MLR selection is based on whether the ACO is an upside-only model or a two-sided model. The MSR/MLR selection for an ACO in an upside-only model is based on the number of beneficiaries assigned to the ACO.[40] Thus, the ratio can range from a high of 3.9 percent for ACOs with at least 5,000 assigned beneficiaries to a low of 2.0 percent for ACOs with 60,000 or more assigned beneficiaries.[41]

ACOs in two-sided models can have a (1) fixed MSR/MLR from 0 percent to 2 percent in .5 percent increments or (2) variable MSR/MLR based on the number of beneficiaries assigned to the ACO. [42] The

fixed MSR/MLR is more popular.[43] Among the 101 ACOs participating in two-sided models in the 2018 performance year, 80 were subject to one of the fixed options.[44]

4. Beneficiary Assignment

There are two types of Medicare beneficiary assignments: (1) preliminary prospective assignment with retrospective reconciliation or (2) prospective assignment.[45]

In a preliminary prospective assignment with retrospective reconciliation, beneficiaries are preliminarily assigned to an ACO, based on a two-step assignment methodology, at the beginning of a performance year and quarterly thereafter during the performance year.[46] However, the final beneficiary assignment is determined after the performance year based on where beneficiaries chose to receive the plurality of their primary care services during the performance year.[47]

In a prospective assignment, beneficiaries are prospectively assigned to an ACO at the beginning of the performance year using the same two-step methodology as noted above, based on where the beneficiaries chose to receive the plurality of their primary care services.[48] The ACO is held accountable for beneficiaries who are prospectively assigned to it for the performance year.[49]

The old Tracks 1 and 2 had the preliminary prospective assignment with retrospective reconciliation, with Track 1+ and Track 3 having a prospective assignment methodology.[50]

ACOs now have the opportunity to annually elect their choice of beneficiary assignment methodology during each performance year.[51] However, if an ACO changes its beneficiary assignment methodology, then that will change the ACO's historical benchmark calculation, as discussed below.[52]

Once an ACO chooses its beneficiary assignment, CMS calculates the total amount the beneficiaries spent during the last three years.[53] With some caps and other adjustments, that number becomes the ACO's benchmark.[54] The benchmark is important because, generally speaking, if the ACO's expenditures are below the benchmark, the ACO saved money.[55] If the ACO's expenditures are above the benchmark, then the ACO lost money.[56]

5. Benchmarking Changes

CMS made several changes to the benchmarking calculation such as, among other things, focusing on regional (in contrast to national) FFS expenditures, establishing the benchmark based on three-year historical Medicare Parts A and B expenditures, annual updates to the benchmark based on blended national and regional growth rates with caps on regional factors, and rebasing before every subsequent agreement period.[57] Many of these changes apply complicated formulas, but these changes appear to reflect CMS's intention to make an ACO's goals achievable under the MSSP.

6. Added Incentives

CMS added numerous incentives to the MSSP to encourage ACOs to take on downside risk, including the following applicable to ACOs in two-sided models:

(1) APMs: ACOs are eligible to receive APM incentive payments in the corresponding payment year between 2019 through 2024, and then higher fee schedule updates starting in 2026.[58]

(2) Skilled Nursing Facility (SNF) 3-Day Rule Waiver: The waiver was previously limited to Track 3 and selecting the prospective assignment methodology, but the December Final Rule expands the waiver to any two-sided model and any beneficiary assignment methodology. CMS also expanded the 3-Day Rule Waiver so that critical access hospitals and other rural hospitals furnishing SNF services under swing bed agreements are included in the SNF 3-Day Rule Waiver.[59]

(3) Telehealth Services: Telehealth services can be billed by ACOs in a two-sided model as long as the ACO elects the prospective assignment methodology. In addition, the beneficiary's home can be the "originating site" in certain circumstances, but no facility fee may be charged.[60] The originating site is where the patient is located.

(4) Cash Payments to Beneficiaries: ACOs can expand their beneficiary incentive program to include monetary incentives of up to $20 per qualifying service as long as the program is approved by CMS.[61]

G. What's Next?

In 2017, CMS realized gross savings of $1.1 billion, and CMS netted $314 million in savings after paying out shared savings payments.[62] In 2018, CMS netted $739.4 million in savings (i.e., $73 per beneficiary) after paying out shared savings payments based on a total of $1.7 billion in gross savings.[63] The intention behind the December Final Rule changes was to further refine the MSSP based on data for purposes of achieving more savings. The industry should expect CMS to make additional changes based on data trends.

For example, the Department of Health and Human Services' Office of Inspector General (OIG) studied 20 high performing ACOs to determine what those ACOs were doing to reduce spending, which it noted may offer "earning opportunities to other ACOs, including Medicaid and commercial ACOs as well as to participants in other [APMs]."[64] The OIG considered an ACO to be high performing if it had both a reduction in spending relative to its benchmark and an overall quality score of 90 or above during its second, third, or fourth performance year as an ACO.[65] The study found that these ACOs implemented strategies that fall into seven categories:

(1) Working with physicians: These ACOs hire physicians who are committed to reducing costs, and almost all of the ACOs provide their physicians with data on tests or how much a specialist costs. In addition, some of these ACOs created lists of preferred specialists committed to reducing costs.[66]

(2) Engaging beneficiaries: These ACOs ensure that patients complete their annual wellness visits and found that when patients completed these visits, they saw their physicians more often throughout the year to manage their condition as opposed to going to more costly emergency rooms.[67]

(3) Managing beneficiaries with costly or complex needs: These patients account for a disproportionate amount of healthcare spending. Almost all of these ACOs used care coordinators to manage the care for these patients. One ACO reported a 43 percent reduction in emergency room visits and a 47 percent reduction in hospital readmissions by the second year of its program. In addition, over half of the ACOs provided services at home.[68]

(4) Managing hospitalizations: Inpatient care accounts for the largest amount of spending under the Medicare system. These ACOs have taken numerous steps including, among other things,

broadening services to primary care physicians to avoid hospitalizations by extending hours or including hours on evenings and weekends. Many of these ACOs use data to identify and then focus on patients who frequent emergency rooms, and some have care coordinators to manage patients admitted into a hospital to make sure they receive the proper care and do not overstay. In addition, to prevent recidivism, many ACOs will have a care coordinator manage the patient's care post-discharge, such as managing follow up visits with the patient's primary care physician.[69]

(5) Managing skilled nursing and home healthcare: SNF costs comprised 13 percent of Medicare spending. Many of these ACOs have a list of preferred SNFs or home health agencies that share the same philosophy on shared savings and must meet certain requirements to get on the preferred list. Some of these ACOs also embed staff within the SNF to manage the patient's care.[70]

(6) Addressing behavioral health needs and social determinants of health: CMS research has found a strong association between behavioral health conditions and a high utilization of healthcare services. Several of the ACOs have noted that when left untreated, behavioral health conditions often result in more emergency room visits and longer hospital stays. As a result, many of these ACOs recruit behavioral health providers and integrate behavioral healthcare services into their primary care setting.[71]

(7) Using technology for information sharing: Sharing medical information between ACO participants can be challenging, especially if providers are using different systems. Many ACOs are moving toward interoperability by requiring all of their providers to use one type of system, and almost half of the ACOs receive information from providers not in their ACO through the use of state or regional health information exchanges.[72] Health information

exchanges allow healthcare professionals and patients to access and share, in a secure manner, a patient's medical information electronically.

III. Private Side APMs

Just as trends among federal APMs, notably MSSP ACOs, may provide indications as to the future of government-run value-based arrangements, so too can APM arrangements among private actors signal the next iteration of value-based payment models.

A. Quasi-Private APMs

Private APMs have also grown in number and popularity, in part because of CMS's embracement of this option. Prior to the 2015 passage of MACRA, CMS principally utilized APMs such as the MSSP as a means to reimburse those who provided care to Medicare beneficiaries, and incentivize them to provide that care efficiently. After the passage of MACRA, which created the APM and MIPS tracks, CMS incrementally broadened the types of payment arrangements (not just between CMS and physicians, but between any payor and physicians) utilized in determining whether physicians were eligible to receive a positive payment adjustment to their reimbursement based on their participation. In 2019, CMS began offering the Other-Payer Advanced APM (AAPM) Option,[73] wherein eligible clinicians[74] may engage in non-Medicare FFS payment arrangements with any payor other than traditional Medicare so long as certain criteria are met.[75] Prior to this option, eligible clinicians could not have APMs with private payors and meet QPP requirements, meaning that eligible clinicians had to also participate in MIPS in order to be eligible for a positive payment adjustment.[76]

In order to be eligible for the five percent incentive payment by virtue of participating in the AAPM Option, the Other-Payer AAPM payment arrangement must fit into one of the below categories:

(1) Medicaid;[77]

(2) Medicare Health Plans (including Medicare Advantage, Medicare-Medicaid, 1876 Cost Plans, PACE Plans);[78]

(3) CMS Multi-Payor Models;[79] or

(4) Commercial/Private Payor Arrangements.[80]

Additionally, the arrangement must "meet the Other-Payer [AAPM] criteria."[81] First, at least 75 percent of eligible clinicians in each participating APM Entity group (or hospital)[82] must use certified electronic health record technology (CEHRT).[83] Second, the arrangement must base payments for covered professional services on quality measures comparable to the Quality performance category in MIPS.[84] These quality measures must be: "[f]inalized on the MIPS final list of measures…"; "[e]ndorsed by a consensus-based entity"; or, "[d]etermined by CMS to be evidenced-based, reliable, and valid."[85] Additionally, the arrangement must also include at least one outcome measure, which measure must meet the same criteria as the quality measures "if there is such an applicable outcome measure on the MIPS quality measure list."[86] Third, participants must bear a certain amount of financial risk. A payment arrangement meets the financial risk if:

(1) The arrangement meets (a) the financial risk standard and (b) the nominal amount standard; or,

(2) The arrangement is a Medicaid Medical Home Model that meets criteria comparable to Medical Home Models.[87]

A payment arrangement meets the financial risk standard if the APM Entity does one or more of the following:

(1) "Withhold[s] payment for services to the APM Entity or the APM Entity's eligible clinicians;

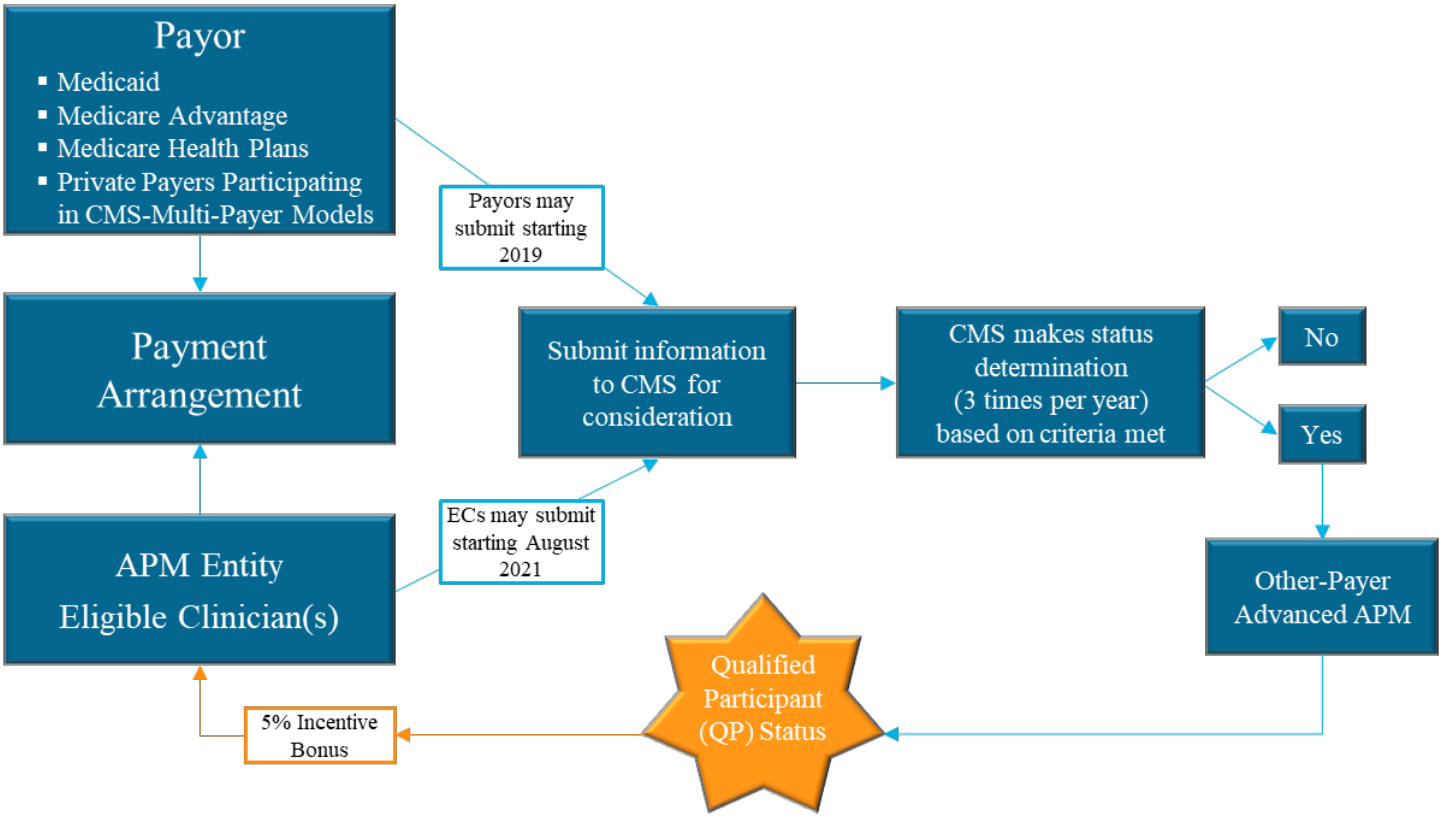
(2) Reduce[s] payment rates to the APM Entity or the APM Entity's eligible clinicians; or

(3) Require[s] direct payment by the APM Entity to the payor."[88]

A payment arrangement meets the nominal amount standard if the criteria set forth below are met:[89]

Expenditure Based Nominal Amount Standard	**Revenue Based Nominal Amount Standard[90]**
Nominal amount of risk must be: • Marginal risk[91] of at least 30%; • Minimum loss rate of no more than 4%; and • Total risk of at least 3% of the expected expenditures the APM Entity is responsible for under the APM.	Nominal amount of risk must be: • Marginal risk of at least 30%; • Minimum loss rate of no more than 4%; and • Total risk of at least 8% of combined revenues from the payor to providers and other entities under the payment arrangement.

Currently, only payors may apply to be an Other-Payer AAPM – beginning August 2021, an eligible clinician (EC) (including a physician practice) may initiate the process of achieving Other-Payer AAPM status for commercial and private payor arrangements,[92] which process is summarized below:[93]



The ultimate goal for providers is to become a Qualifying Alternative Payment Model Participant (QP), i.e., an EC who has met the Other-Payer AAPM criteria listed above, which renders the EC able to receive the five percent APM incentive payment and absolves the EC from MIPS reporting requirements.[94]

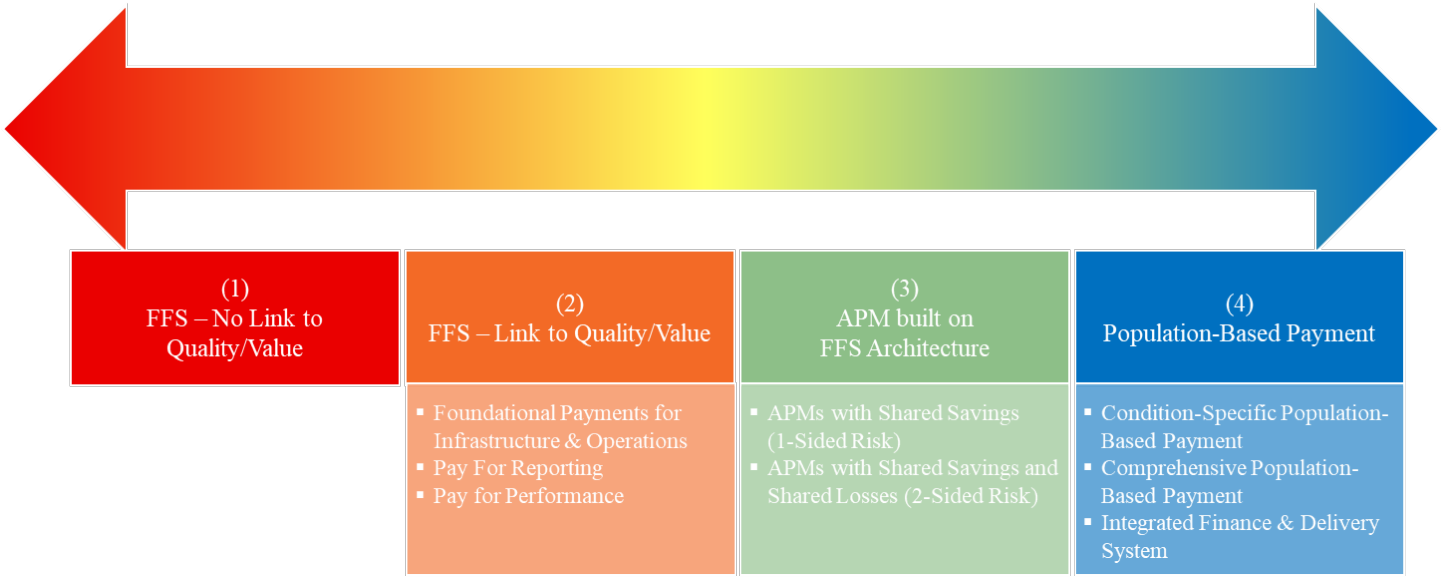
For Performance Year (PY) 2019, there were no Other-Payer AAPM participants, but there are five confirmed participants for PY 2020, as set forth below:[95]

Entity Name	Payment Arrangement Name	Multiyear Determination	Location
Aetna	Accountable Care Organization Attribution Model	Through 2024	Nationwide
Anthem	Anthem, Inc., Cooperative Care (CC) Contract	Through 2025	CA, CO, CT, GA, IN, KY, MA, ME, MO, NH, NY, OH, VI, WI
Blue Cross and Blue Shield of Illinois (BCBSIL), a division of Health Care Service Corporation, a Mutual Legal Reserve Company	Commercial HMOs of BCBSIL	Through 2020	Illinois
Blue Care Network of Michigan / Blue Cross Blue Shield of Michigan	Advanced Risk Arrangement for Commercial HMO	Through 2025	Michigan
Health 2 Business, Inc.	Direct Corporate Health Partnership Other Payer AAPM	Through 2025	Nationwide

B. Private APM Payment Arrangements

In addition to private APMs that may fulfill the requirements set forth by CMS under the QPP, private payors have also contracted with providers for private APM arrangements – which are often more profitable for the providers than participating in government-run models. As illustrated below, typical

private APM models fall along a spectrum ranging from FFS to population-based (i.e., capitated) payment:[96]



These various categories, defined below, were devised by the Health Care Payment Learning & Action Network (HCP LAN), which "was created to drive alignment in payment approaches across the public and private sectors of the U.S. healthcare system."[97] A "collaborative network of public and private stakeholders," HCP LAN established the APM Framework and Progress Tracking Work Group, which created this APM framework and classification system as a way to monitor the shift to VBR.[98]

Under FFS Models with No Link to Quality and Value (Category 1), providers are reimbursed on a per unit of service (i.e., productivity) basis, and those payments are not linked to quality or value.[99] FFS Models Linked to Quality and Value (Category 2) are a variation on FFS models, wherein productivity-based reimbursement is linked to the quality and/or value of care provided, and may include some reporting requirements.[100] Some of these enhanced FFS models may also incentivize infrastructure

investments,[101] in order to eventually allow the model to assume more risk. Such models may operate by supplementing FFS payments with bonuses/penalties based on achievement of specified measures.

Under APMs Built on FFS Architecture (Category 3), providers and payors take on shared savings and (possibly) shared losses.[102] Providers are still reimbursed at FFS rates, but a percentage of those reimbursements are typically withheld by the payor; at the entity's year-end reconciliation (during which the payor may adjust the budget target for severity of illnesses or other types of outliers), total FFS expenditures of all members are compared against the provider network's budget target.[103] If expenses fall under that target, providers may receive a portion of shared savings, provided they met certain quality metrics. However, if expenses exceed the target budget, providers may be required to reimburse for some portion of those losses (if the arrangement is a two-sided risk model).[104] One way in which this arrangement may manifest is through episode-based payments, wherein the payor establishes a fixed price for all services across an episode of care (e.g., knee replacement surgery).[105]

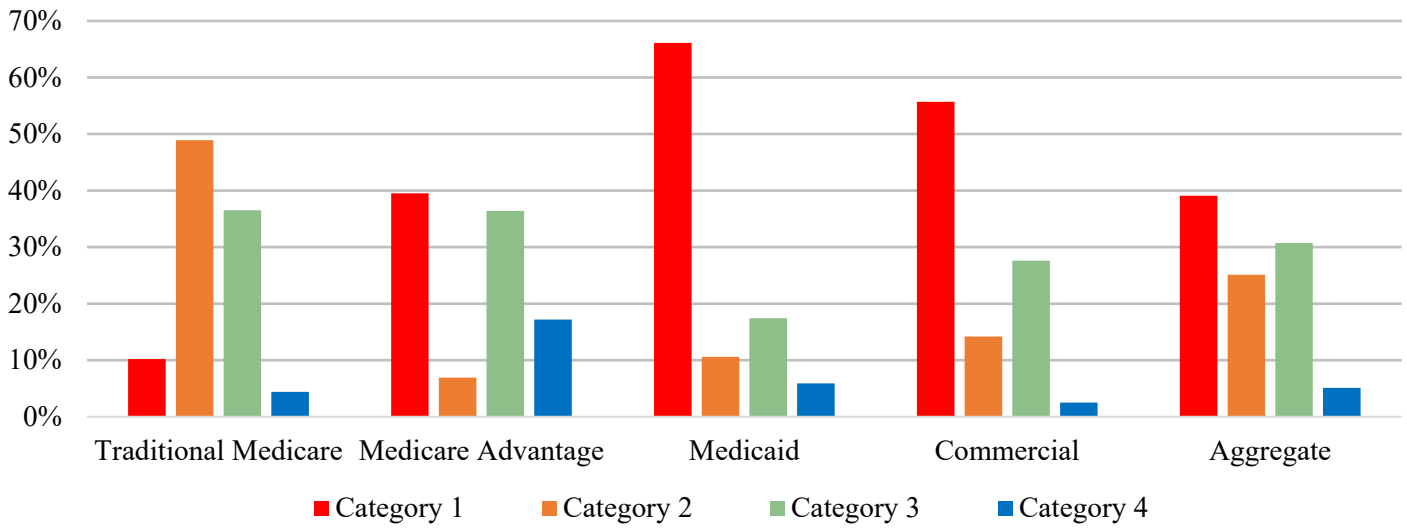
Lastly, under Population Based Payment arrangements, also known as bundled payments or capitation, the payor makes one comprehensive, prospective payment per person per specified time period, e.g., per member per month (PMPM).[106] It is the providers' goal (and responsibility) to ensure that the total amount of PMPM reimbursements is greater than the providers' costs.[107]

IV. Navigating the Path Forward

The path forward for both public and private APMs is anticipated to be – similar to its path to date – a windy one, with more directional changes, but fewer potholes. The healthcare industry should expect CMS to make further MSSP changes to incorporate some of the suggestions from the OIG Report and to

take further action on consolidation. For example, the report found that ACOs with strong care coordination polices and robust primary care programs are more successful at reducing costs and maintaining/improving quality.[108] It is possible that CMS may make these a requirement for all ACOs in future rule changes.

In its *2019 Methodology and Results Report*, HCP-LAN reported on the payments made by payors in 2018 to providers in the following payor types: Traditional Medicare, Medicare Advantage, Medicaid, and Commercial:[109]



As illustrated above, approximately 36 percent of the aggregated payments in 2018, across all payors, were made via an APM built on FFS Architecture (Category 3) or Population-Based Payment (Category 4).[110] Medicare Advantage appears to be ahead of other payor programs in the shift to VBR, with over 53 percent of its payments falling under Category 3 or Category 4.[111] These figures are similar to 2017 numbers, with modest shifts, across all payors, along the continuum.[112] However, the 2018 payment arrangements are significantly advanced compared to 2015 (when HCP-LAN began tracking such data).

In 2015, approximately 62 percent of all payment arrangements were Category 1, and only 23 percent of payments fell under Category 3 or Category 4.[113] These numbers indicate that the shift to VBR is occurring, but dispels any notion that private payment arrangements are ahead of the curve compared to Medicare (both traditional and Medicare Advantage).[114] This data may also indicate that private APMs take their cues from CMS, waiting to see what initiatives and requirements are set forth before promulgating their own. This means that future changes to public APMs (such as those prophesied above) may also filter down to, and affect, private APMs.

In HCP-LAN's accompanying survey of payors, respondents generally agreed that the payment arrangements will largely shift to Category 3-type arrangements going forward.[115] Additionally, respondents identified the biggest barriers to adoption of APMs to be:

(1) "Provider willingness to take on financial risk;"
(2) "Provider ability to operationalize [i.e., put into operation programs established by the payor such as care coordination, population health management, etc.];" and,
(3) "Provider interest/readiness."[116]

The ability to overcome these listed roadblocks may be the key to the future success of APMs, particularly as they move away from upside-only risk. While there is no one singular path to effective two-sided risk, the most significant barriers to moving to APMs with downside risk appear to be providers; thus, any tools that may align provider and payor interests may result in the clearest route forward.

Regarding provider willingness to take on financial risk, hospitals and health systems have a demonstrated appetite to accept financial risk;[117] however, physicians (which comprised 20 percent of national healthcare spending in 2018,[118] and are often the entry point into an episode of care) have been historically less likely to accept financial risk[119] for a number of reasons: less access to capital, nonexistent margins to withstand downside payments, and lack of appropriate data and care coordination resources to effectively manage their patient population. In fact, the number of ACO contracts (principally with smaller ACOs) decreased subsequent to the December Final Rule, which may have been due to provider unwillingness to move to downside risk.[120] One way in which to ameliorate this concern may be through the engagement of a risk partner. For example, ACO consultants (also known as ACO enablers) remove the fear of incurring losses by partnering with the ACO to assume any losses incurred by the ACO.[121] Having this safety net may encourage providers to take the next step to downside risk without fear of going bankrupt.[122]

The inability of providers to operationalize may be due to the absence of a clear roadmap to success that providers can follow (as there are a wide range of APMs that have mixed, or indeterminate, results) and thus revert back to FFS models.[123] Further, providers may be frustrated by the relatively lengthy timeframe to achievement of savings; the focus on improving the health of the provider's patient population may not result in immediate cost reductions (and may actually increase costs initially due to the building of appropriate infrastructure), but will likely result in cost savings in the long term. Focusing on cost savings in the short term, without committing resources to the development of appropriate infrastructure, is not sustainable. In order to alleviate the risk inherent in shifting to a model with uncertain results and convince providers to take the long view, further research on the relative success of various payment models, and which actions (both short-term and long-term) providers should

take to ensure that success, would reduce provider uncertainty and potentially accelerate APM development.[124]

Providers (principally physicians) may not be interested in or ready for APMs for a number of reasons. They may already feel stretched thin, or even burned out; they may not fully trust the payors who are attempting to move them to such a model; they may not believe that they are required to participate; or they may not think that they have the resources to effectively participate. Combatting physician disinterest and unpreparedness must begin with the education of physicians through professional societies and payors. Eliminating perceived roadblocks to APM adoption and informing physicians of the potential upside(s) of entering into such a payment model may go a long way.

Yet another barrier may have been revealed by the recent COVID-19 pandemic. This stress test on U.S. healthcare delivery has exposed critical weaknesses in the preparedness of the nation's healthcare system. While most ACOs are very concerned about the effects of COVID-19 on their ACO,[125] the ultimate impact of the pandemic on these providers is too early to tell. On April 6, 2020, CMS released interim guidance changing the MSSP's Extreme and Uncontrollable Circumstances Policy, which seeks to alleviate losses by changing the reporting timeframe under which providers will receive payment adjustments.[126] However, further regulatory action is likely imminent in order to stave off a mass exodus of ACOs from the MSSP.[127]

V. Conclusion

The shift to VBR has caused the advent, and subsequent modifications, of myriad arrangements that seek to achieve the elusive "Triple Aim": "improving the individual experience of care; improving the

health of populations; and reducing the per capita costs of care for populations."[128] Across all APMs, whether with federal or private payors (or a combination thereof), and despite the payment and risk methodology used, the next steps in this latest iteration appear to be shifting providers to downside risk models, which will necessitate the alignment of provider and payor interests. While there are a variety of means to this end, no "silver bullet" has yet been devised to ensure the ultimate success of such a shift.

1 Colla, C.H., *Moving Forward with Accountable Care Organizations: Some Answers, More Questions*, 177 JAMA INTERNAL MEDICINE 527 (2017), p. 527.
2 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3022, 124 Stat. 395 (2010).
3 MACRA established the Quality Payment Program (QPP), in which eligible clinicians (ECs), as defined in n. 74, *infra*, may achieve positive payment adjustments based upon the achievement of various quality and performance measures by way of participation in either: (1) the Merit-based Incentive Payment System (MIPS); or (2) APMs.
4 Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success and Extreme and Uncontrollable Circumstances Policies for Performance Year 2017, 84 Fed. Reg. 67816 (Dec. 31, 2018) (to be codified at 42 C.F.R. pt. 425).
5 *Id*. at 67819-20.
6 *Id*.
7 *Id*. at 67820.
8 *Performance Year 2019 Medicare Shared Savings Program Accountable Care Organizations* (As of July 1, 2019), DATA.CMS.GOV, https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/Performance-Year-2019-Medicare-Shared-Savings-Prog/seu9-q8uk/data.
9 42 C.F.R. § 425.20 (2018).
10 42 C.F.R. § 425.110 (2018).
11 84 Fed. Reg. at 67830.
12 *Id*.
13 *Id*. at 67820, 27-28; Commins, J., *Medicare Shared Savings ACOs Generated $1.7B in Savings in 2018*, MODERN HEALTHCARE (Oct. 1, 2019), https://www.healthleadersmedia.com/finance/medicare-shared-savings-acos-generated-17b-savings-2018.
14 *Id*.
15 84 Fed. Reg. at 67820.
16 *Id*. at 67830-31.
17 *Id*. at 67820.
18 *Id*. at 67821.
19 *Id*.
20 *Id*. at 67831-32. Medicare Part A covers Medicare inpatient care, including, for example, care received while in a hospital or a skilled nursing facility. Medicare Part B covers Medicare outpatient care including, for example, office visits and durable medical equipment.
21 Although High Revenue ACOs can more easily control expenses, they do not perform as well as Low Revenue ACOs, principally because High Revenue ACOs typically include hospitals, which have higher facility fees, and thus, less savings. 84 Fed. Reg. at 67831-32.
22 42 C.F.R. § 425.20.
23 84 Fed. Reg. at 67864-67, 78.
24 42 C.F.R. § 425.20.
25 84 Fed. Reg. at 67894-97, 67904-05.
26 *Id*. at 67895; 42 C.F.R. § 425.20. The Pioneer ACO Model and Next Generation ACO Model are models that CMS created outside of the MSSP. For more information about these other models, *see* https://innovation.cms.gov/innovation-models/aco.
27 84 Fed. Reg. at 67893, 96.
28 *Id*. at 67885-87, 90; 42 C.F.R. § 425.20.
29 84 Fed. Reg. at 67831-35, 41, 44-46, 50-53.
30 42 C.F.R. § 425.600 (2018); 42 C.F.R. § 425.605 (2018).
31 42 C.F.R. § 425.600; 42 C.F.R. § 425.610.
32 *Id*.
33 84 Fed. Reg. at 67910-13; 42 C.F.R. § 425.600.
34 *Id*. at 67844.
35 *Id*.
36 *Id*.
37 *Id*. at 67905.
38 *Id*. at 67879.
39 *Id*. at 67923.
40 *Id*. at 67923-25.
41 42 C.F.R. § 425.605(b).
42 *Id*; 84 Fed. Reg. at 67923-25.
43 84 Fed. Reg. at 67926.
44 *Id*.

45 *Id*. at 67959.
46 *Id*.
47 *Id*.
48 *Id*.
49 *Id*.
50 *Id*. at 67859-60.
51 *Id*. at 67860; 42 C.F.R. § 425.226 (2018).
52 84 Fed. Reg. at 67861.
53 *Id*. at 68005.
54 *Id*.
55 *Id*. at 68005-30.
56 *Id*; 42 C.F.R. § 425.604-605 (2018); 42 C.F.R. § 425.610.
57 84 Fed. Reg. at 68005-30; 42 C.F.R. § 425.601-603 (2018).
58 84 Fed. Reg. at 67834.
59 *Id*. at 67968-71, 73; 42 C.F.R. § 425.612 (2019).
60 84 Fed. Reg. at 67973-78; 42 C.F.R. § 425.613 (2018).
61 84 Fed. Reg. at 67981-85, 90-91. ACO beneficiary incentive programs (BIPs) may "provide monetary incentive payments to Medicare [FFS] beneficiaries who receive a qualifying [primary care] service," such as vouchers for wellness programs, meal programs, and over-the-counter medications. 42 C.F.R. § 425.304 (2018); Bazell, C. & Philip, S., "*Pathways to Success" MSSP proposed rule: Beneficiary incentive program*, MILLIMAN (Sept. 26, 2018), https://www.milliman.com/en/insight/pathways-to-success-mssp-proposed-rule-beneficiary-incentive-program
62 Sweeney, E., *CMS Data Shows ACOs Saved Medicare $314M in 2017*, FIERCEHEALTHCARE (Aug. 31, 2018), https://www.fiercehealthcare.com/payer/cms-data-shows-acos-saved-medicare-314m-2017.
63 Commins, J., *Medicare Shared Savings ACOs Generated $1.7B in Savings in 2018*, MODERN HEALTHCARE (Oct. 1, 2019), https://www.healthleadersmedia.com/finance/medicare-shared-savings-acos-generated-17b-savings-2018.
64 Chiedi, J.M., *ACOs' Strategies for Transitioning to Value-Based Care: Lessons From the Medicare Shared Savings Program*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL 2 (July 2019), https://oig.hhs.gov/oei/reports/oei-02-15-00451.pdf.
65 *Id*. at 5.
66 *Id*. at 6-10.
67 *Id*. at 11-12.
68 *Id*. at 13-14.
69 *Id*. at 15-17.
70 *Id*. at 18-21.
71 *Id*. at 22-24.
72 *Id*. at 25-27.
73 Submissions began in January 2019 for payors, but clinicians will not be able to apply on their own initiative, without a payor, until September 2020. *All-Payer Advanced Alternative Payment Models (APMs) Option*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://qpp.cms.gov/apms/all-payer-advanced-apms (last visited Apr. 29, 2020).
74 For both MIPS and APMs, eligible clinicians include the following healthcare professionals: physicians (including doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry); osteopathic practitioners; chiropractors; physician assistants; nurse practitioners; clinical nurse specialists; certified registered nurse anesthetists; physical therapists; occupational therapists; clinical psychologists; qualified speech-language pathologists; and qualified audiologists, registered dietitians or nutrition professionals. *How MIPS Eligibility is Determined*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://qpp.cms.gov/mips/how-eligibility-is-determined?py=2020#cliniciansInAdvancedApms-2020 (last visited Apr. 29, 2020).
75 *All-Payer Advanced Alternative Payment Models (APMs) Option*, *supra* n. 73.
76 *Id*.
77 Under this arrangement, state Medicaid agencies "may submit information to CMS about their payment arrangements with eligible clinicians" which CMS will use to determine whether the payment arrangement qualifies as an Other-Payer AAPM. *Medicaid Other Payer Advanced APMs in the Quality Payment Program for Performance Year 2019*, CENTERS FOR MEDICARE & MEDICAID SERVICES 1, *available at* https://qpp-cm-prod-content.s3.amazonaws.com/uploads/170/Medicaid%20Other%20Payer%20APM%20Determination%20List%202018%2008%2030.pdf (last visited Apr. 29, 2020).
78 *Id*. Under these arrangements, Medicare health plans other than traditional fee-for-service Medicare, such as Medicare Advantage plans, Medicare-Medicaid plans, 1876 Cost Plans, and Programs of All-Inclusive Care for the Elderly (PACE) Plans, "may submit information to CMS about their payment arrangements with eligible clinicians" which CMS will use to determine whether the payment arrangement qualifies as an Other-Payer AAPM.
79 An Advanced APM "in which CMS partners with other payers (such as Medicaid, Medicare Health Plans, and commercial payers) to create aligned incentives for health care providers across both Medicare and other payer populations. Examples of CMS Multi-Payer Models include the Comprehensive Primary Care Plus Model, the Oncology Care Model (2-sided risk arrangement), and the Vermont All-Payer ACO Model." *Quality Payment Program All-Payer Combination Option & Other Payer Advanced Alternative Payment Models Frequently Asked Questions*, CENTERS FOR MEDICARE & MEDICAID SERVICES 5, *available at* https://qpp-cm-prod-content.s3.amazonaws.com/uploads/133/QPP%20All-Payer%20External%20FAQ_Remediated_2018%2004%2020.pdf (last visited Apr. 29, 2020).
80 42 C.F.R. § 414.1420; *All-Payer Advanced Alternative Payment Models (APMs) Option*, *supra* n. 73.
81 *Id*; *CMS Multi-Payer Other Payer Advanced APMs in the Quality Payment Program for Performance Year 2019*, CENTERS FOR MEDICARE & MEDICAID SERVICES 1-2, https://qpp-cm-prod-content.s3.amazonaws.com/uploads/181/2019%20CMS%20Multi-Payer%20Other%20Payer%20APM%20Determination%20List.FINAL.pdf (last visited Apr. 29, 2020).
82 An APM Entity group is defined as "the group of eligible clinicians participating in an APM Entity." An APM Entity is defined as "an entity that participates in an APM or other payer arrangement…." 42 C.F.R. § 414.1305 (2019).
83 CMS increased this percentage from 50% as of January 1, 2020. 42 C.F.R. § 414.1420(a)-(b).
84 42 C.F.R. § 414.1420(c)(1).
85 42 C.F.R. § 414.1420(c)(2)(ii).
86 42 C.F.R. § 414.1420(c)(3)(ii).

87 42 C.F.R. § 414.1420(d).
88 *Id*. How many of these criteria a payment arrangement needs to meet is "based on whether an APM Entity's actual expenditures for which the APM Entity is responsible under the payment arrangement exceed expected expenditures during a specified period of performance."
89 *Quality Payment Program All-Payer Combination Option & Other Payer Advanced Alternative Payment Models Frequently Asked Questions*, *supra* n. 79, at 6.
90 CMS notes that "total combined revenues from a payer include any financial risk payments or supplemental service payments including but not limited to payments comparable to care management fee payments, shared savings payments, or other types of performance-based incentive payments typically used in APMs and Advanced APMs with Medicare." *Id*; 42 C.F.R. § 414.1420(d)(3).
91 The "marginal risk rate" is defined as "the percentage of actual expenditures that exceed expected expenditures for which an APM Entity is responsible." 42 C.F.R. § 414.1420(d).
92 *All-Payer Advanced Alternative Payment Models (APMs) Option*, *supra* n. 73.
93 *Quality Payment Program All-Payer Combination Option & Other Payer Advanced Alternative Payment Models Frequently Asked Questions*, *supra* n. 79, at 7-9.
94 *All-Payer Advanced Alternative Payment Models (APMs) Option*, *supra* n. 73.
95 *Alternative Payment Models in the Quality Payment Program as of December 2019*, CENTERS FOR MEDICARE & MEDICAID SERVICES 22, https://qpp-cm-prod-content.s3.amazonaws.com/uploads/810/2020%20and%202019%20Comprehensive%20List%20of%20APMs.pdf (last visited Mar. 19, 2020).
96 *Alternative Payment Model: APM Framework: Refreshed for 2017*, HEALTH CARE PAYMENT LEARNING & ACTION NETWORK 3, 2017, https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf (last visited Mar. 19, 2020).
97 *Id*. at 1.
98 *Id*.
99 *Id*. at 24.
100 *Id*.
101 *Id*.
102 *Id*. at 25-27.
103 *Id*.
104 *Id*.
105 *Id*.
106 *Id*. at 27-28.
107 *Id*.
108 *See* Chiedi, *supra* n. 64.
109 *See 2019 Methodology and Results Report*, HEALTH CARE PAYMENT LEARNING & ACTION NETWORK 17-20, http://hcp-lan.org/workproducts/apm-methodology-2019.pdf (last visited Apr. 29, 2020).
110 *Id*. at 15.
111 *Id*. at 17-20.
112 *2018 Methodology and Results Report*, HEALTH CARE PAYMENT LEARNING & ACTION NETWORK 14-19, http://hcp-lan.org/workproducts/apm-methodology-2018.pdf (last visited Apr. 29, 2020).
113 *Measuring Progress: Adoption of Alternative Payment Models in Commercial, Medicare Advantage, and State Medicaid Programs*, HEALTH CARE PAYMENT LEARNING & ACTION NETWORK 14, 2016, https://hcp-lan.org/workproducts/apm-measurement-final.pdf (last visited Apr. 29, 2020). Note that both the measurements surveyed and the number of respondents across all payors are not the same between 2017 and 2015, which limits the comparability of these figures.
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115 *Id*. at 16.
116 *Id*.
117 *Providers Prepared to Increase Risk Model Participation: Navigant/HFMA Survey*, GUIDEHOUSE (Jun. 19, 2019), https://guidehouse.com/insights/healthcare/2019/risk-readiness.
118 *National Health Expenditures 2018 Highlights*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/files/document/highlights.pdf.
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125 *Survey Shows ACOs' Concerns About the Effect of COVID-19*. NATIONAL ASSOCIATION OF ACOS, https://www.naacos.com/assets/docs/pdf/2020/SurveyReportACO-EffectsCOVID19-04132020.pdf (last visited Apr. 14, 2020).
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Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, is the President of Health Capital Consultants, where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. He has over 25 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives, and other professionals. He may be reached at tzigrang@healthcapital.com.

Jessica L. Bailey-Wheaton, Esq. serves as Vice President and General Counsel of Health Capital Consultants, where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare transactions. Additionally, she provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. Ms. Bailey-Wheaton also serves as Chair of the ABA YLD Health Law Committee, and as YLD Liaison to the Health Law Section's Membership Committee. She may be reached at jbailey@healthcapital.com.

Khaled John Klele is a partner at Riker Danzig Scherer Hyland & Perretti LLP, where his practice focuses on healthcare regulatory, transactional and litigation work. He provides counsel to a variety of providers including, among others, ambulatory surgery centers, laboratories, hospitals, imaging centers, addiction centers, skilled nursing facilities, urgent care centers and pharmacies. He regularly assists his clients in a variety of areas including state and federal regulatory compliance issues, medical billing audits and litigation, negotiating provider agreements, Medicare and/or Medicaid audits, healthcare reimbursement issues and litigation, medical board investigations and fair hearings, fraud and abuse issues, insurance fraud litigation, pharmacy audits and coupon/copayment assistance programs. He may be reached at kklele@riker.com.

