POLSINELLI

in the news

Health Care

June 2016

Understanding the Implications of MACRA, MIPS and APMs

On May 9, 2016, the Centers for Medicare & Medicaid Services (CMS) published a notice of proposed rulemaking to implement the bipartisan *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA).

Although the provisions of MACRA and its proposed rule that are related to the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) involve a dizzying array of acronyms, calculations and other complexities, the underlying policy objectives and future direction are clear – Congress (through a bipartisan piece of legislation) and CMS (through its power to implement MACRA) seeks to both build upon and solidify new payment and delivery models that move from volume to value, combine with and build upon private sector initiatives, and migrate to financial risk.

The law and proposed rule provide a timeline for this migration and provide for clear advantages (and benefits) to "early adopters" of the new APM payment and delivery models. For individual Medicare providers and groups, the ability merely to sit on the sideline and to refrain from participation, while not eliminated, now has a better-defined financial cost.

The proposed rule establishes an architecture that will dramatically change the Medicare payment model for physicians and other health care practitioners. Building on the legislative framework established by MACRA and prior efforts by CMS' Innovation Center, the proposal would implement a payment system in which all eligible clinicians would either receive payment rate increases or cuts based on their ability to meet standards under a new "Merit-Based Incentive Payment System," at their election. The proposed rule would make extra bonuses potentially available for those who participate in certain risk-based models.

In this Issue:

This article provides information about the law and proposed rule. In future articles, we will drill deeper into the implications of the proposed rule for physicians and other providers; hospitals and health systems; and Accountable Care Organizations (ACOs), clinically integrated networks and other organizations.

MACRA Background – Policy Focus and Objectives

In January 2015, the U.S. Department of Health and Human Services (HHS) announced that CMS was setting benchmark goals for value-based payments and alternative payment models in the Medicare program. By the end of 2016, CMS declared, 30 percent of Medicare payments would be tied to quality or value through APMs, with an increase to 50 percent by the end of 2018. In addition, by the end of 2016, 85 percent of Medicare fee-for-service payments would be tied to quality or value, rising to 90 percent by the end of 2018.

This announcement was not without foundation; CMS has invested significant resources and developed extensive programming in its Centers for Medicare & Medicaid Innovation (CMMI) and launched the Medicare Shared Savings Program (MSSP) for ACOs as required by the Affordable Care Act. Nonetheless, the goals seemed aspirational to many stakeholders, particularly those clinicians who were already struggling to meet the growing obligations of other CMS programs related to electronic health records (EHRs), value-based purchasing and quality reporting.

Then, on April 14, 2015, the U.S. Senate passed the most extensive piece of legislation affecting physician reimbursement in decades, and two days later, President Barack Obama signed the bill into law. H.R. 2 or MACRA, repealing the long-criticized sustainable growth rate (SGR) formula for determining Medicare updates to physician and other Medicare provider reimbursement and replacing it with a new system that builds on Medicare fee-for-service (FFS) payments to encourage participation in programs that tie care delivery to quality or value. The MACRA legislation both addressed ongoing frustrations with the old SGR formula for physician and other Medicare provider reimbursement and created a pathway for the agency to reach its goals for care delivery and payment.

The proposed rule would implement the MACRA legislation to establish a new payment program for clinicians or groups that bill under the Medicare Physician Fee Schedule (PFS), including the following:

- The establishment of the new MIPS for eligible clinicians and groups under the PFS that consolidates and streamlines components of three existing CMS programs: the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM) and the Electronic Health Record (EHR) Incentive Program (also called Meaningful Use or MU).
- The establishment of incentives for eligible clinicians and groups to participate in APMs supporting CMS' goal of moving more fee-for-service payments into alternative delivery models and payment systems.
- The establishment of proposed criterion for use by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in further redefining physician payment models across all payers.

Key proposals in each of these areas are summarized below.

Merit-Based Incentive Payment System

Overview and Background. The proposed MIPS begins in 2017 and streamlines and consolidates several pre-existing CMS programs into one program. Prior to MACRA, physician payments were increasingly being tied to various value-based programs, including PQRS, the VBM and the Meaningful Use Program. Each of these programs had divergent timelines for

reporting and inconsistent measures, so many stakeholders advocated that Congress should roll them into one program to simplify reporting and increase the likelihood that physicians and other providers could successfully participate. MACRA did so, and MIPS was born.

MIPS consolidates MU, VBM and PQRS for physicians and other providers and creates four overarching categories for measurement (percentages for Year 1):

- Quality Performance (50 percent, replaces PQRS and some aspects of the VBM)
- Resource Use (10 percent, replaces the cost portion of the VBM)
- Clinical Practice Improvement Activity (15 percent, new category)
- Advancing Care Information (25 percent; formerly MU)

The measures will apply to "MIPS eligible clinicians" — defined to include physicians and other providers that bill under the PFS, but excluding certain categories such as physicians and other providers (e.g., newly Medicare enrolled clinicians, Qualifying APM Participants (QPs), certain Partial Qualifying APM Participants (Partial QPs) and clinicians who fall under the proposed low-volume threshold). MIPS eligible clinicians are identified by the APM participant identifier using the Tax Identification Number (TIN)/ National Provider Identifier (NPI) combination.

Performance Period and Payment Adjustments Under MIPS. MIPS eligible clinicians will be paid a traditional fee-for-service rate for Medicare Part B items/services, adjusted for their historic quality performance score derived from the four domains reported in a designated performance year through a MIPS composite performance score (MIPS Score or CPS).

CMS has proposed that the first performance period for 2019 payment adjustments under MIPS will be the 2017 calendar year (Jan. 1 – Dec. 31, 2017). Advocacy efforts are underway to request that CMS push this back to a later date, given the tight timeline between the expected publication of the MACRA final rule in October 2016 and the beginning of the proposed performance period in 2017.

For the first year (2019 payment adjustments based off of 2017 reporting), CMS has authorized up to a 4 percent negative payment adjustment and up to a 4 percent positive payment adjustment, with the maximum positive adjustment to be scaled up or down as required to achieve budget neutrality. Per the law, both positive and negative adjustments will increase for later performance years to the maximum of 9 percent in 2022 and beyond.

The maximum adjustments are set forth in the chart below.

Year	2019	2020	2021	2022 and after
Maximum Adjustment	± 4%	± 5%	± 7%	± 9%

Additionally, in the first five payment years, CMS may extend up to $500 million in additional performance adjustments to high-performing providers — these payments will not be considered subject to budget neutrality. This exceptional performance adjustment will provide high performers an increased positive adjustment based on their MIPS score, capped at an additional 10 percent.

Measuring and Reporting Performance. Starting in 2017, the first performance period, MIPS eligible clinicians participating in MIPS will have to track and report data annually across the four performance domains. Data reported during the performance period will be measured against standards established by CMS and used to determine

the payment adjustment to be applied to claims that are submitted by the MIPS eligible clinician two years later in 2019. CMS has stated that the exact measures and activities to be reported will vary annually and by performance category. Yet, CMS has established some program parameters that will remain constant from year-to-year in order to enable providers to plan for optimal compliance.

As a general matter, MIPS eligible clinicians may elect to report data for the four performance categories as an individual clinician or as part of a group or an APM group. Whichever reporting method selected must be used uniformly to report data across all four performance measures (i.e., a MIPS eligible clinician cannot report Quality Measures individually but Clinical Practice Improvement Activities as a group). Further, MIPS eligible clinicians may report certain of the required data via third-party data submission entities (i.e., health information technology (IT) vendors, qualified registries, Qualified Clinical Data Registry (QCDR) and CMS approved survey vendors), but all MIPS eligible clinicians in a reporting group must agree to outsource reporting for the same data categories.

CMS is required to establish the scoring methodology and performance thresholds in advance and in a uniform method that applies across all four performance categories, such that MIPS eligible clinicians can decipher what they need to do to perform well under MIPS. CMS intends to establish a MIPS score for each eligible clinician (or group) for each performance year and assess it against a base or threshold score set by CMS to determine the adjustment to a MIPS eligible clinician's reimbursement rate.

The MIPS Score will be calculated by aggregating the MIPS eligible clinician's (or group's) score from the four performance metrics into a single CPS. MIPS eligible clinicians that achieve a CPS exceeding Medicare's previously set performance threshold score will receive a positive payment adjustment by the MIPS adjustment factor. MIPS eligible clinicians falling below the CPS by a pre-defined performance threshold will receive a negative payment adjustment. Those falling at the performance threshold will receive no payment adjustments. The law requires MIPS to be budget neutral; therefore, CMS will annually score all MIPS eligible clinicians' CPS in a manner to ensure that all positive, negative, and neutral adjustments to provider's Medicare Part B payments collectively are budget neutral.

Performance Feedback and Technical Assistance from CMS. Under the MIPS program, CMS proposes to provide performance feedback to MIPS eligible clinicians annually initially, but possibly more frequently in later years. CMS is proposing to allow MIPS eligible clinicians to challenge their performance scores and resulting MIPS adjustments through a targeted review process. A MIPS eligible clinician may request that CMS review the calculation of the CPS and MIPS adjustment factor generally and the factor particular to that MIPS eligible clinician for a performance year.

MACRA requires CMS to provide technical assistance to MIPS eligible clinicians in small practices, rural areas, and practices located in geographic health professional shortage areas. CMS must contract with appropriate entities, such as quality improvement organizations, regional extension centers or regional health collaboratives) to offer guidance and assistance to MIPS eligible clinicians in practices of 15 or fewer MIPS eligible clinicians. Assistance will be prioritized to two categories of MIPS eligible clinicians: (1) those small practices in rural areas (counties designated as Metropolitan or Non-Core Based Statistical Areas using HRSA's 2014-2015 Health Resource File), Health Professional Shortage Areas (HPSAs) and medically underserved areas, and (2) practices with low composite scores. Details of the technical assistance programs will be developed by separate, future rulemaking.

Exemptions for MIPS Eligible Clinicians. In the proposed rule, CMS would establish a series of exemptions and

modifications to the MIPS reporting and/or payment adjustment process for certain MIPS eligible clinicians, as follows.

- Non-patient facing MIPS eligible clinicians are subject to modified reporting criteria and re-weighted performance categories in calculating their CPS. A "Non-Patient Facing eligible clinician" is defined as "an individual MIPS eligible clinician or group that bills 25 or fewer patient-facing encounters during a performance period." Annually, CMS will publish a list of the qualifying patient-facing encounters, which should include codes for general office visits, outpatient visits, surgical procedures and telehealth services. MIPS eligible clinicians in specialties that are typically non-patient facing (such as pathology or radiology) will qualify, as will others who only occasionally provide patient-facing services. Since telehealth services are considered patient-facing, a clinician can be subjected to full MIPS reporting by providing such services if the 25 encounters threshold is exceeded.

- Eligible clinicians who first become enrolled in Medicare during a performance period and have not previously submitted Medicare claims will not be treated as MIPS eligible clinicians for the performance year, thereby exempting them from data reporting and subsequent payment adjustments for that year.

- Eligible clinicians or groups who do not exceed the low-volume threshold — defined as those having Medicare billing charges of $10,000 or less and provide care to 100 or fewer Part B beneficiaries during a performance year — also are not considered MIPS eligible clinicians who are subject to the reporting requirements or MIPS adjustment. This exemption means that reimbursement rates for non-eligible clinicians will remain flat until eligibility is achieved.

- "Qualifying APM Participants" and "Partial APM Participants" (described below) are not required to report MIPS data and will not be subject to MIPS adjustments — although many Partial APM Participants may elect to report under MIPS and be subject to MIPS adjustments.

- MIPS adjustments will not be applied to the Medicare Part B facility component for items/services provided by MIPS-eligible clinicians in Critical Access Hospitals (CAHs) billing under Method 1; however, MIPS adjustments would apply to the professional component of CAH services and all components of Method II CAH payments.

- Under the proposed rule, MIPS adjustments would not be applied to the Medicare Part B facility component for items/services furnished by MIPS eligible clinicians in rural health clinics and federally qualified health centers that bill for such items/services under an all-inclusive payment methodology. However, if the items/services are billed under the PFS, the MIPS adjustment applies to those payments.

Overview of MIPS Performance Categories and Scoring. MIPS creates the following four performance categories:

Performance Category	Former Program	Points Needed to Attain Full Performance Score *(2017 Performance Year; 2019 Payment Adjustments)*	Relative % of MIPS Score *(2017 Performance Year; 2019 Payment Adjustments)*
Quality Measure	PQRS	80 to 90 points *(depending on group size)*	50%
Resource Use (Cost) Measure	VBM	Average score of all resource use measures in which provider qualified for measurement	10%
Clinical Practice Improvement Activities (CPIA) Measure		60 points	15%
Advancing Care Information Measure	MU	100 points	25%

The MIPS rate adjustment to be made based on the CPS is calculated based on performance in the four categories above generally is budget neutral — meaning that the positive adjustments must be consistent with the negative adjustments — although Congress authorized an additional $500 million each year from 2019 to 2024 to be used for those MIPS eligible clinicians who are exceptional performers (called "aggregate incentive payments"), with the increase capped at a total of 10 percent.

The calculation of how a MIPS eligible clinician's CPS is translated into a rate increase under MIPS is complicated. In general, CMS will compute a performance threshold for the applicable payment year and this will be published on the CMS website prior to each performance year. The performance threshold is the level of performance on a composite basis (i.e., CPS level) that is established for a performance period. A CPS above the performance threshold triggers a positive MIPS adjustment factor and a CPS below the performance threshold triggers a negative MIPS adjustment factor. MIPS eligible clinicians with a CPS at the performance threshold receive no adjustment (i.e., the rates remain flat).

By statute, any MIPS eligible clinician who scores between zero and one-fourth of the performance threshold will receive the maximum negative adjustment (i.e., for 2019, -4 percent), and any MIPS eligible clinician who scores 100 percent will receive the maximum positive adjustment (i.e., for 2019, 4 percent but this may be scaled up or down to achieve budget neutrality) plus the aggregate incentive payment.

By statute, the performance threshold for any year must be either the mean or median of the CPS for all MIPS eligible clinicians for a period prior to the performance period. For 2017, CMS proposes to use a composite of various data from 2014 and 2015 to set the performance threshold that all MIPS eligible clinicians will be measured against in 2017 with a stated goal of picking a level where half of all MIPS eligible clinicians would score higher and half would score lower.

Exceptional Performance Scoring. In addition to the performance threshold, CMS also will establish the additional performance threshold for purposes of receiving the additional aggregate incentive adjustment for exceptional performance. CMS proposes that the additional performance threshold will be a CPS score that is either (i) equal to the 25th percentile of the range of *possible* CPS above the performance threshold or (ii) equal to the 25th percentile of the *actual* CPS for MIPS eligible clinicians with CPS above the performance threshold as calculated with respect to the prior period used to determine the performance threshold.

Because no CPS exist for prior periods available for 2017, CMS proposes to use the 25th percentile of possible CPS above the performance threshold. For example, if the performance threshold is 60, then the range of possible positive CPS is 61-100, and the 25th percentile of those possible values is 70. Therefore, in this example, any MIPS eligible clinician who received a score of 70 or above would be eligible to receive the additional aggregate incentive adjustment. The additional performance threshold also will be published by CMS on the CMS website prior to the beginning of a performance period.

The proposed rule gives examples of how CPS scores would be translated into the performance rate adjustment and the additional performance rate adjustment. The calculation is complex as it involves scaling adjustments to achieve budget neutrality. Suffice it to say, the rule should be reviewed to better understand the calculation and how it is applied.

MIPS Performance Categories. In the proposed rule, CMS outlined its proposed requirements in the four performance categories above, including differences from existing programs. A summary of each category is provided below.

1. Quality Measures. The MIPS Quality Performance

measure replaces the PQRS and will account for 50 percent of the MIPS Score in the first performance year. Under the MIPS Quality Performance category and in contrast to PQRS, physicians and other eligible providers are only required to report six measures, instead of nine, and may receive partial credit for measures. Reporting under Quality Performance would also include increased flexibility for physicians, adopting an approach more consistent with the QCDR requirements.

Key aspects of the proposed rule relating to the Quality Performance measure include:

- The Quality Performance measures that MIPS-eligible clinicians must report will be selected annually by CMS through a call for quality measures process. Specifically, by Nov. 1 of the year immediately preceding a performance period, CMS will publish a final list of the Quality Performance measures to be reported during the upcoming performance period. Selected measures are to align with CMS priorities. As a category, the Quality Performance measures reported will account for 50 percent of the MIPS eligible clinician's CPS in the first performance year, 45 percent of the CPS in the second performance year and 30 percent for years thereafter, subject to adjustment by a weighted factor established by CMS for certain populations (i.e., non-patient facing MIPS eligible clinicians).

- The six Quality Performance measures to be reported in a given year must include at least one cross-cutting measure for patient-facing MIPS eligible clinicians and one outcome measure (if available). Alternatively, if outcome measures are not available, the MIPS eligible clinician must report a "high quality" measure. High quality measures are defined as measures related to patient outcomes, appropriate use, patient safety, efficiency, patient experience and care coordination. CMS expects to provide more than 200 high quality measures to pick from, with more than 80 percent of them tailored to a specific specialty.

- MIPS eligible clinicians may select the Quality Performance measures that they will report either ad hoc or from a pre-defined measure set that CMS established for their particular specialty or sub-specialty (respectively, "Specialty Specific Measure Set" or "Sub-Specialty Specific Measure Set"). For example, orthopedic hand surgeons may have a Specialty Specific Measure Set. However, when reporting as a group, the measures selected for reporting must be consistent across the entire group. Anyone who fails to report all of the required measures or activities required for a measure will receive a zero score for the unreported items in that category, drawing down their aggregated CPS. Certain Specialty-Specific Measure Sets have less than six measures. In these instances, patient-facing MIPS eligible clinicians must report on all of the available measures including an outcomes measure (or if one is unavailable, another high priority measure within the set) and a cross-cutting measure, but they will not be penalized for reporting less than six measures.

2. Resource Use / Cost Category Measure. The Resource Use measure replaces the cost measures in the VBM Program and will account for 10 percent of the MIPS Score in the first performance year. CMS will analyze Medicare administrative claims data, rather than require reporting by providers, to determine individual MIPS eligible clinician's performance. The Resource Use measure is intended to reward those clinicians that provide high quality care efficiently for a particular condition (i.e., achieve quality patient care outcomes while attaining the lowest cost of care or most efficient resource use).

- CMS is charged with cooperating with various stakeholders annually to identify cost measures, which are those care episodes and patient condition groups

that, in the aggregate, account for 50 percent of Medicare Part A and B expenditures (with this target ratio increasing over time). CMS will, with physician and community stakeholder input, define and publish the list of cost measures on its website in advance of the performance year. For those MIPS eligible clinicians that treat a sufficient number of patients falling within a particular cost measure (generally, treat 20 patients or more with a particular condition or care episode), CMS will analyze the claims data that particular MIPS eligible clinician submitted for his or her patients falling within the cost measure to determine whether the individual clinician is efficient in resource use in treating such patients, relative to other clinicians.

- CMS proposes to adjust a MIPS eligible clinician's resource use score for geographic payment rate differences and beneficiary risk factors. Likewise, a physician who treats a patient with multiple co-morbidities will not be penalized for the higher cost of care resulting for that patient, relative to patients with only one diagnosis.

- If a MIPS eligible clinician (or group) does not have a sufficient number of patients (20 or more) for CMS to track a cost measure, then the cost score will not be calculated, and CMS will re-weight the remaining categories so that the MIPS CPS Score is not reduced and the individual clinician is not penalized. If the MIPS eligible clinician qualifies for calculation of a few cost measures but not others, the score will be calculated solely based on resource utilization for those cost measures that qualify for measurement; no penalties will be assessed for failing to qualify for other cost measures.

3. Clinical Practice Improvement Activities Measures. The Clinical Practice Improvement Activity (CPIA) category represents an area where many physicians and group practices will look to improve their overall MIPS score. The CPIA measures will account for 15 percent of the MIPS Score in the first performance year. CPIAs are generally activities that relevant MIPS eligible clinician organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines are likely to result in improved care outcomes. These measures are intended to reward providers for engaging in activities that focus on care coordination, beneficiary engagement and patient safety as well as reward providers for participating in APMs and PCMH.

- CMS will define annually the CPIAs that can be reported for any performance year and the criteria for those activities in a CPIA Inventory published annually. CMS is not requiring MIPS eligible clinicians to report a minimum number of CPIAs at this time but rather is encouraging their reporting generally. CMS lists specific programs and activities that will count toward the CPIA score, such as after-hours availability and participation in certain recognized medical home programs. Of interest to those providers offering telehealth services, MACRA specifically included telehealth as a qualifying CPIA activity.

- CMS has outlined some general scoring rules for this category, as follows:

    - MIPS eligible clinicians (or groups) must perform an activity for at least 90 days during the performance period to obtain CPIA credit, and the period may be increased for future performance years. Qualifying activities that are initiated before a performance year or last beyond a performance year's duration may still qualify, provided that the activity was engaged in for 90 days during the performance year.

    - MIPS eligible clinicians (or groups) who are certified as a PCMH or comparable specialty practice in a given performance period must be given the

highest potential score for the CPI performance category for that period (100 percent).

- MIPS eligible clinicians (or groups) who are participating in an APM during the performance year will earn at least 50 percent of the highest potential score for the CPIA performance category.
- MIPS eligible clinicians (or groups) that participate in CMS' study on practice improvement and measurement will receive 100 percent for the CPIA category of MIPS after successfully electing, participating in, and submitting data to CMS for the study.
- To achieve the highest score (100 percent) on the CPIA Performance measure, the MIPS eligible clinician (or group) must earn 60 points, by submitting three high-weighted CPIAs (counting for 20 points each) or six medium-weighted CPIAs (counting for 10 points each) or some combination of the two to earn a total of 60 points. Those MIPS eligible clinicians (or groups) that select less than these CPIAs will receive partial credit based on the weighting of the CPIAs that are selected.
- A 50 percent score on the CPIA measure will be granted to those who report one high-weighted and one medium-weighted CPIA or three medium-weighted CPIAs. Exceptions to these rules are granted for certain eligible clinicians: MIPS small groups (15 or fewer clinicians); MIPS eligible clinicians in rural areas or HPSAs; and non-patient-facing MIPS eligible clinicians who report one CPIA. These excepted categories would achieve a 50 percent score on the CPIA Performance measure, regardless of whether the activity is medium or high. Thus, these MIPS eligible clinicians can achieve a 100 percent score by reporting any two CPIAs. Additionally, non-patient-facing eligible clinicians earn 30 points for any reported CPIA.
- Groups that participate in an PCMH or APM achieve a 100 percent or 50 percent CPIA Score respectively by virtue of participation alone; for APM-participating clinicians, if they report other CPIAs equivalent to 30 points, they can achieve a 100 percent score on the CPIA Performance Measure. Eligible clinicians that report no CPIA will receive a zero score, unless they are a PCMH or a comparable specialty practice.

- For the first performance year, CMS has proposed more than 90 activities that MIPS eligible clinicians may choose to participate in for CPIA credit from the following nine subcategories:
  - Expanded patient access
  - Population management
  - Care coordination
  - Beneficiary engagement
  - Patient safety and practice assessment
  - Promoting health equity and continuity
  - Social and community involvement
  - Achieving health equity
  - Integrated behavioral and mental health
  - Emergency preparedness and response
  - Integration of primary care and behavioral health

4. Advancing Care Information Measures (ACI). The ACI measure will account for 25 percent of the MIPS Score in the first performance year. Key aspects of the proposed rule related to the ACI measure include the following:

- The proposed rule does not have any effect on participation in the Medicaid Electronic Health Record Incentive Program and MIPS eligible clinicians who participate in that program will continue to be eligible for incentive payments through 2021. Additionally, the proposed rule does not replace or affect the application of the MU for hospitals.

- The "MIPS eligible clinician" definition is much broader than the definition of "Eligible Professional" under MU because it includes physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs). Because of the uncertainty whether the measures specified for the ACI performance category will be applicable and available to the non-physician MIPS eligible clinicians, CMS has proposed that a weight of zero will be assigned to the ACI performance category for non-physician MIPS eligible clinicians who do not submit any data for any of the measures and the other APS performance categories would be re-weighted. After the first MIPS performance period, CMS will then evaluate the continued participation of these types of non-physician MIPS eligible clinicians in the ACI performance category.

- CMS recognized that an insufficient number of ACI measures may be applicable to hospital-based MIPS eligible clinicians. Such clinicians also do not have control over the type of Certified Electronic Health Record Technology (CEHRT) that is available to them, and certain types of hospital-based specialists, such as pathologists, do not generally have face-to-face interactions with patients. For these reasons, a weight of zero would be assigned to the ACI performance category for hospital-based MIPS eligible clinicians (i.e., clinicians who furnish 90 percent or more of their covered professional services in an inpatient or emergency room setting as identified by the codes used in submitting claims), and the other MIPS performance category scores would be re-weighted to make up the difference. Similar re-weighting of the ACI performance category would be applied for non-patient-facing MIPS eligible clinicians.

- Twenty-five percent of the MIPS CPS is based on the ACI performance category. The ACI performance category scoring is based on 100 points – 50 points for a base score, a possible 80 points for a performance score, plus 1 possible bonus point (the total score can exceed 100 points. However, once 100 points are reached, no additional points are counted, and the MIPS eligible clinician receives the full 100 points toward the ACI score used in calculating the MIPS score).

- In order to earn points, a MIPS eligible clinician must (i) utilize CEHRT during the performance period, and (ii) report on certain required measures. Under MU, EPs are not only required to report on all measures but also to achieve a certain level of performance on each measure in order to be considered a meaningful user of CEHRT. Consistent with the goal of creating flexibility, the proposed rule changes this "all or nothing" approach, and, although each required measure must be reported by a MIPS eligible clinician to achieve the base score, a MIPS eligible clinician is not required to achieve a certain performance threshold for all of the measures in order to earn points towards the ACI performance category.

- To receive the 50-point base score, a MIPS eligible clinician must do all of the following:

    1. Utilize the required CEHRT during the entire performance period (from Jan. 1 to Dec. 31). CMS declined to apply the 90-day reporting period that is made available under MU to first time attesters, reasoning that, unlike MU, the ACI performance category does not require that a MIPS eligible clinician reach certain performance thresholds

related to the required measures.

2. Report a numerator/denominator or a yes/no statement for all measures required to be reported (with exception for the e-prescribing measure where the MIPS eligible clinician writes fewer than 100 permissible prescriptions in a performance period).

3. Report a "yes" to the Protect Patient Health Information objective.

4. Report a "yes" for the Immunization Registry Reporting measure (with exceptions for providers that do not administer immunizations).

5. Affirmatively attest to a three statement attestation to demonstrate support for information exchange and prevention of health information blocking.

6. Attest affirmatively to demonstrated cooperation with the Office of National Coordinator's (ONC's) authorized surveillance of CEHRT.

- If a MIPS eligible clinician does not earn the ACI base score of 50, then the MIPS eligible clinician will receive an ACI performance category score of zero toward the MIPS CPS. If a MIPS eligible clinician achieves the 50-point base score, the MIPS eligible clinician may then earn an additional performance score of up to 80 points (up to a 100-point maximum). Because the 80 possible performance points, together with the 50-point base score, exceeds 100 points, each MIPS eligible clinician has flexibility in meeting measures that are most relevant to his or her practice.

- The ACI performance score is based on the level of achievement that the clinician shows for each of the following eight measures: patient access; patient-specific education; view, download or transmit; secure messaging; patient-generated health data; patient care record exchange; request/accept patient care record; and clinical information reconciliation. A clinician can earn 10 possible points for each of the eight measures. The numerator and denominator that are reported for each of the measures is converted to a percentage and then the percentage is divided by 10 and converted into points ranging from 0 to 10. For example, if a MIPS eligible clinician has a 75 percent performance rate on a measure, the clinician will receive 7.5 points towards his or her performance score for that measure.

- A MIPS eligible clinician can also earn 1 extra bonus point by reporting a "yes" for any (or all) of the measures under the Public Health and Clinical Data Registry Reporting objective, in addition to the Immunization Registry Reporting measure, which is required for the clinician to achieve the base score.

- The resulting base score plus the performance score and the extra bonus point, if earned, will then be converted to the 25 possible ACI performance category points. For example, if a MIPS eligible clinician's aggregate base, performance and bonus score is 75, then the ACI portion of the MIPS eligible clinician's MIPS APS will be 18.75 (which is 75 percent of 25).

- To achieve the ACI performance category base score in 2017, a MIPS eligible clinician must use either 2014 or 2015 Edition CEHRT during the performance period. Depending on what edition of CEHRT the MIPS eligible clinician utilizes, in 2017 only, the MIPS eligible clinician will have a choice for reporting the objectives and measures related to either Stage 2 or Stage 3 of the MU. Beginning in 2018, MIPS eligible clinicians will be required to use 2015 Edition CEHRT and meet the proposed MIPS objectives and measures that correlate to the Meaningful Use Stage 3 requirements in order to achieve the base score.

- The proposed rule outlines two separate proposals related to the measures that must be reported to achieve the base score:

    1. The primary proposal: Requires that all Stage 3 (or modified Stage 2 in 2017 only) objectives and measures adopted by the Meaningful Use Program be reported, except for those under the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives.

    2. The alternate proposal: Requires that all Stage 3 (or modified Stage 2 in 2017 only) objectives and measures be reported, including CDS and CPOE objectives.

- In addition to automatically re-weighting the ACI performance category to zero for hospital-based and non-patient-facing MIPS-eligible clinicians, CMS also may re-weight the ACI performance category in the following instances, upon the application and demonstrated need for re-weighting by the MIPS-eligible clinician:

    1. Insufficient internet

    2. Extreme and uncontrollable circumstances (e.g., a natural disaster that destroys the EHR)

    3. Lack of control over the availability of EHR technology

- MIPS eligible clinicians may request a re-weighting of the ACI performance category on a rolling basis, but the applications must be submitted no later than the close of the submission period for the relevant performance period (i.e., March 31, 2018 for the 2017 performance period), unless a later date is specified by CMS. Applications need to be resubmitted on an annual basis for re-weighting to occur each year.

- In addition to re-weighting the ACI performance category on an individual MIPS eligible clinician basis, if in any year the Secretary of HHS estimates that the proportion of EPs who are "meaningful EHR users" is 75 percent or greater, the Secretary may reduce the applicable percentage weight of the ACI performance category in the MIPS CPS, but not below 15 percent. If the ACI performance category weight is reduced, then the weights in the other performance categories will be increased in an aggregate amount that is equal to the ACI reduction. The proposed definition of a "meaningful EHR user" for this purpose is a physician MIPS eligible clinician who has earned an ACI performance category score of at least 75% for a performance period. The alternate proposal is to define a "meaningful EHR user" as those physician MIPS eligible clinicians who earn an ACI performance category score of 50 percent for a performance period.

Advanced Payment Models

APM Overview. The proposed rule defines standards applicable to advanced payment model incentive payments authorized under MACRA. The incentive payment would be made to "Qualified APM Participants" (QPs). **Under the proposed rule, beginning in 2019, if an eligible clinician participates in an Advanced APM, the clinician may be classified as a QP, and by doing so, will be excluded from the MIPS and will receive an additional incentive payment equal to 5 percent of the clinician's prior year's Part B professional billings.**

Eligible and "Advanced APMs". Under the MACRA law and proposed rule, APMs are defined as certain payment models under Section 1115A (other than health care innovation awards), the Medicare Shared Savings Program (MSSP), certain demonstrations under Section 1866C, or other demonstrations that are compulsory and required by Federal law. However, simply participating in any APM is

not enough under the proposed rule to qualify for the incentive payments. Only participation in what CMS refers to as an "Advanced APM" will allow a clinician to become a QP with the ability to earn the APM incentive bonus. APMs may be considered Advanced APMs where they:

1. Require participants to use CEHRT (discussed previously in connection with MIPS).

2. Provide for payment for covered professional services based on quality measures comparable — but not necessarily precisely the same in all respects — to those in the MIPS quality performance category (e.g., outcome, patient experience, care coordination and measures of appropriate use of services such as measures of overuse). Quality measures that meet this criteria include any MIPS quality measures, those identified by a consensus-based entity and others, and CMS proposes to specifically grant approval to those measures that are endorsed by the National Quality Forum.

3. Require participating APM Entities to bear "financial risk" for monetary losses of more than a "nominal amount," or involve a medical home model.

Importantly, the proposed rule clarifies that an Advanced APM Entity may qualify as such where it meets the defined criteria; regardless of whether it actually earns shared savings or generates shared losses under the particular APM. Thus, mere participation in a qualifying APM can be sufficient to earn the APM bonus, without regard to whether the entity is successful in achieving the particular APM' s goals.

Financial Risk Standards. **The proposed rule outlines financial risk standards that would need to be met for an APM to qualify as an Advanced APM. That criterion generally requires that:**

- The APM Entity must bear financial risk in its arrangement with CMS

- The amount of risk must be in excess of a "nominal" amount

The overall financial risk standard applies to the financial relationship between CMS and the APM Entity — not necessarily how the AMP Entity translates that risk to its participating eligible clinicians. Put otherwise, the clinicians need not personally bear financial risk so long as the APM Entity bears the necessary financial risk.

Financial Risk Arrangement with CMS. The proposed rule outlines both general and medical home-specific standards. Under the general financial risk standard, CMS would be able to use withholds, repayment obligations or arrangements through which the APM Entity owes payments to CMS and therefore is financially responsible to CMS, where the APM Entity's actual expenditures exceed expected expenditures for an applicable performance period.

The financial risk arrangement between CMS and medical home model APMs may include these same mechanisms plus the additional option that the subject APM Entity may lose the right to all or part of otherwise guaranteed payments. Medical home model APMs would be limited to entities that have 50 or fewer eligible clinicians in the organization through which the APM Entity is owned and operated. Where the APM Entity has more than 50 eligible clinicians, it would be subject to the general standards (not the unique standards for medical homes).

Nominal Amount Requirement. The APM must also bear financial risk that is in excess of a "nominal" amount. Here, too, the proposed rule sets forth both a general standard and a unique standard applicable to entities using a medical home model. The general standard defines risk as a percentage of the APM Entity's assigned financial benchmark, while the risk percentages for medical home

models are based on the medical home models actual Medicare Part A and B revenue. CMS viewed this distinction important given the nature of medical home models (in that medical homes commonly have a relatively small number of providers, more limited revenues and limited, if any, experience with financial risk).

The proposed general standard provides that an APM would meet the in excess of "nominal" risk standard where:

- The marginal risk borne by the APM Entity — defined as the percentage of the amount by which actual expenditures exceed expenditures for which the APM Entity would be liable — is at least 30 percent of the losses
- The minimum loss rate — defined as the percentage by which actual expenditures may exceed expected expenditures without triggering financial risk — must be no greater than 4 percent
- The total potential risk — defined as the maximum potential payment for which an APM Entity could be liable under the APM — is at least 4 percent of expected expenditures

For medical home model APMs to meet the excess of "nominal" risk standard, the total annual amount that the Advanced APM Entity potentially owes CMS or forgoes must be at least 2.5 percent of the APM Entity's total part A and B revenues in 2017. These amounts increase on an annual basis to 5 percent applicable in 2020 and later years. Where a medical home model APM Entity meets the general financial and nominal risk standards applicable to all APMs, then the unique medical home specific standards would not apply.

The proposed rule notes that various entities participating in CMS initiatives would qualify as Advanced APMs based on the proposed financial risk criteria, including Medicare Shared Savings Program ACO (track 2 and 3), NextGen ACO, the recently announced Comprehensive Primary Care Plus program (CPCT+) and certain other programs sponsored by the Center for Medicare & Medicaid Innovation (CMMI).

Entities that are in Track 1 of the MSSP (with upside only) would not qualify as Advanced APM models.

Under the proposal, the APM Entity must have direct financial risk to CMS under the particular AMP model, with that risk able to be satisfied through any number of means such as withholds, direct payments through which the APM owes money to CMS and other means. CMS expressly rejected the notion that APM Entities could have indirect financial risk through the investment in infrastructure and other operating costs that themselves can be significant.

A full capitation arrangement would meet the criteria to qualify as an Advanced APM, although capitated arrangements involving Medicare Advantage organizations would not qualify for such purposes until the Other Payer APMs begin in 2021.

Overall, the risk thresholds were intended by CMS to motivate desired changes in care patterns to reduce costs and improve quality. Thus, the concept of "nominal" is less than what CMS might otherwise consider optimal, but still was considered by CMS to be sufficiently substantial that it can drive performance.

Payment and Patient Count Thresholds. In addition to the requirements outlined above related to eligible APMs, the incentive payment may be earned only if the eligible clinician or group participates in an Advanced APM where certain thresholds are met. These thresholds are based on either patient counts or payment amounts coming through the Advanced APM. In 2019 and 2020, the threshold must be met based on Part B payments or counts of patients under Part B. Beginning in 2021, the All Payer Combination

Option applies, which includes participation in Other Payer Advanced APMs for purposes of meeting the threshold.

The thresholds are determined as of Dec. 31 of the applicable performance period. As of such date, the Advanced APM Entity would need to meet, through the collective evaluation of its aligned eligible clinicians, either a "QP Payment Amount Threshold" or a "QP Patient Count Threshold" in order to qualify as an Advanced APM (and thus allowing the eligible clinicians in the APM to become Qualified APM Participants or QPs and earn the APM incentive bonus). The alternative thresholds would be evaluated at the level of the Advanced APM Entity — meaning that the APM Entity as a whole must meet at least one of the thresholds, which then allows all eligible clinicians who are aligned with that Advanced APM Entity to qualify as QPs for the applicable performance period and receive the incentive bonus.

Consistent with MACRA's policy objective of moving from a volume-based payment system to one linked with value and ultimately, financial risk, the payment and patient-based thresholds increase incrementally over time. Thus, beginning in 2019, in order for an Advanced APM Entity to meet the QP Payment Amount Threshold, 25 percent of the payments made by CMS for Part B covered professional services furnished to the Advanced APM Entity's attributed beneficiaries must be furnished through the Advanced AMP Entity, with this percentage changing over time.

The payment amount threshold would be calculated by CMS by dividing the aggregate payments made for Medicare Part B professional services furnished by the eligible clinicians in the Advanced APM Entity to attributed beneficiaries during the QP Performance period, by the aggregate Medicare Part B professional service payments furnished by those same eligible clinicians to all attribution-eligible beneficiaries during the QP Performance Period. The patient count threshold would be calculated by determining the number of attributed beneficiaries to whom eligible clinicians in the Advanced AMP Entity furnished covered professional services during the performance period, and dividing that number by the number of attribution-eligible beneficiaries to whom eligible clinicians in the Advanced APM Entity furnished any performance services during the same performance period. For 2019, the patient count threshold equals 20 percent.

"Attributed beneficiaries" are beneficiaries who are attributed to the Advanced APM Entity based on the APM's respective attribution rules (e.g., with different rules applied under the MSSP, Next Generation ACO, etc.). "Attribution eligible beneficiaries" are those beneficiaries who meet the attribution criteria (e.g., are not enrolled in Medicare Advantage, do not have Medicare as secondary and others), and have at least one claim for E&M services by an eligible clinician in an APM Entity during the QP Performance Period.

Based on the attribution rules, there can be many more attribution-eligible beneficiaries than attributed beneficiaries as generally only those beneficiaries who receive a plurality of services from the APM Entity may be attributed. For each APM Entity group or eligible clinician, a unique Medicare beneficiary would be counted no more than once in both the numerator and denominator of the calculation, although CMS proposes to count the same beneficiary for multiple Advanced APM Entities. For example, a Medicare beneficiary may be counted for purposes of a MSSP APM Entity and also in connection with an episode of care APM.

Under the proposal, CMS would calculate both the patient count and payment thresholds and use the most beneficial of the two calculations to identify QPs. In essence, the use of this calculation and the resulting percentage would create incentives for the Advanced APM Entity to ensure that more services are furnished to the APM's attribution-eligible beneficiaries by physicians and other providers who

are participating in the APM Entity as consistent with the concept of population health (i.e., a group of clinicians that is responsible and accountable for the total cost and quality of care rendered to a defined population of beneficiaries).

Clinician Alignment with APMs. Under the proposed rule, only eligible clinicians in Advanced APM Entities during a performance period would have the potential to become QPs and qualify for the APM Incentive Payment. Physicians and other eligible clinicians would be identified through a TIN/NPI combination, where that combination is itself linked to a particular APM combination of four unique identifiers and would collectively link individual clinicians to a TIN used for Medicare billing, which would link to an individual APM Entity, and then link to an APM payment relationship with CMS that meets the financial risk and other criteria outlined above.

Where an Advanced APM Entity meets one of the payment amount or patient count thresholds, then all clinicians in the APM, whether individually or through a group, would qualify as QPs, and the QP status (and the incentive bonus) would apply to every TIN to which the clinician has reassigned the right to Medicare payment, not solely the TIN that is participating in the Advanced APM Entity. As with many CMS programs, the eligible clinicians would generally be identified in lists provided to CMS by the APM Entity. Thus, the eligible clinician must be officially identified as such on the APM Entity's participation list submitted to CMS (with certain exceptions when the APM model does not have such a participant list). This means that groups or eligible clinicians who are not identified as participants by an APM Entity may not be able to qualify as its clinicians to receive the bonus.

Importantly, the proposed rule provides for lower "Partial QP Thresholds" where the payment amount and patient count thresholds are not sufficient to qualify participating eligible clinicians as QPs, but which, if met, will make the eligible clinicians "Partial QPs" who can elect to avoid the payment adjustments under MIPS. In essence, CMS is providing "partial credit" to encourage participation in Advanced APM Entities — even if that participation is not sufficient to earn the APM bonus.

Medicare-Only Thresholds. The transitional implementation of the QP and Partial QP thresholds based on the payment amount and patient count thresholds over the first few years are as follows under the proposed rule:

Thresholds	2019 and 2020	2021 and 2022	2023 and Beyond
Medicare Only Option			
QP Payment Amount	25%	50%	75%
Partial QP Payment Amount	20%	40%	50%
QP Patient Count	20%	35%	50%
Partial QP Patient Count	10%	25%	35%

Other Payer Thresholds. Beginning in 2021, in addition to the Medicare option for meeting the payment amount or patient count thresholds, eligible clinicians may become QPs through arrangements with payers other than fee-for-service Medicare. The "Other Payer Combination Option" is designed to permit clinicians with lower levels of participation in Advanced APMs under Medicare to still meet the applicable threshold through similar at-risk arrangements with commercial, Medicare Advantage and other payers.

The Other Payer Advanced APMs would be required to meet the same basic design criteria applicable to Medicare Advanced APMs including use of CEHRT electronic health records, quality measures comparable to the MIPS quality performance category and bear more than nominal financial risk or involve a medical home model. The proposed rule outlines similar criteria for Other Payer medical home models including primary care practices (single or

multispecialty), empanelment of patients to each primary clinician and defined elements such as planned chronic and preventative care, patient access and continuity, risk-stratified care management, shared decision-making and others.

The transitional implementation of the QP and Partial QP thresholds based on the payment amount and patient count thresholds over the first few years for the All-Payer Option are set forth below. The levels in each year represent the minimum amount under All Payers, but in each year, a minimum amount of Medicare patients (evaluated using the Medicare-only option referenced above) would also need to be met.

Thus, in 2021, in addition to requiring 35 percent of the APM's patients from all payers to be attributed to the APM during the applicable performance year (e.g., 2019), under the patient count threshold option at least 20 percent of the APM's Medicare beneficiaries must be attributed to the AMP during that year. This means a "commercial only" entity cannot alone be used to achieve QP status. The thresholds for the All-Payer Combination Option are as follows under the proposed rule:

Thresholds	2021 and 2022	2023 and Beyond	Additional Medicare Option Requirements
All-Payer Combination Option			
QP Payment Amount	50%	75%	Plus 25% payment threshold
Partial QP Payment Amount	40%	50%	Plus 20% payment threshold
QP Patient Count	35%	50%	Plus 20% patient count threshold
Partial QP Patient Count	25%	35%	Plus 10% patient count threshold

Because the Other Payer option would involve payers in addition to Medicare, Advanced APM Entities and/or its eligible clinicians would be required to submit information to CMS including specific payment and patient numbers to permit CMS to calculate the thresholds. CMS will ask each payer to attest to the accuracy of the submitted information. The thresholds would be calculated in a manner similar to those outlined above relative to the Medicare Option, but using data based on the All Payer Combination.

Determining Incentive Payments

Under MACRA and the proposed rule, APM incentive payments would be based on a Base Period defined as the full calendar year prior to the payment year and uses that Base Period to determine the APM Incentive Payment amount that is earned and paid to QPs. For example, CY 2018 will be the Base Period for payment year 2019, CY 2019 will be the Base Period for payment year 2019, CY 2019 will be the Base Period for payment year 2020 and so on. Should an eligible clinician participate in an APM Entity in 2017 (the Performance Period) where that APM Entity meets the payment amount or patient count thresholds as outlined above, then all eligible clinicians in the APM Entity will qualify as QPs and receive an APM Incentive Payment that will be paid during 2019 based on the 2018 Base Period.

In 2019, the incentive amount will equal 5 percent of the APM estimated aggregate payments for covered professional services of the applicable QP (through all TINs in which the QP bills for Medicare professional services) during the preceding calendar year — for example, CY 2018 for payments made in 2019. For the purposes of calculating the estimated aggregate payment, CMS will use a three month claims run-out period ending on March 31 of the payment year (e.g., ending March 31, 2019 using the example above). For such purposes, the proposed rule

defines covered professional services under Medicare Part B, and excludes certain payments from that definition (e.g., certain incentive payments under other programs, financial risk payments such as shared savings payments under the MSSP or net reconciliation payments under other programs etc.).

APM Incentive Payments would be paid to each TIN associated with the QPs participation in the Advanced APM entity that met the QP threshold during the applicable performance period. In the event that, due to passage of time, the QP is no longer affiliated with that TIN, CMS will make the payment to the TIN listed on the clinician's CMS-588 EFT Application. Where a single QP is associated with multiple Advance APMs, CMS will allocate the bonus payment among the TINs in proportion to professional services billed by the clinician through the TINs.

APM Compliance Requirements. The proposed rule sets forth compliance-related requirements that build on those used in multiple CMS payment initiatives such as the MSSP and others. These include:

- Compliance with Medicare conditions of participation requirements
- Maintenance of records under the program (including in connection with the All Payer Combination Option) for at least 10 years
- CMS audit and recoupment rights
- Maintenance of authority by the Office of Inspector General (OIG) to audit, investigate, inspect and evaluate the AMP Entity, eligible clinicians and other individuals and entities performing services related to its APM activities

Physician Focused Payment Models

Overview. The proposed rule also outlines general requirements related to "Physician Focused Payment Models" involving Medicare as a payer, and physician group practices and individual physicians as APM Entities that target the cost and quality of physician services. The proposed rule and associated commentary emphasize that the Physician Focused Payment Models are intended to pay for higher value care, provide for flexibility, improve quality and cost, and use innovative payment methodologies that are designed to meet the program's goals. A Physician Focused Advisory Committee (PTAC) will review, evaluate and approve proposals for Physician Focused Payment Models that meet criteria established by the Secretary.

In essence, the PTAC and the Physician Focused Payment Models are intended to expand the portfolio of available APMs, and to provide an expanded vehicle for APM Entity participation. Under the proposed rule, any such model must be able to be evaluated, provide for care delivery improvements, patient choice and promote patient safety.

Implications and Conclusion

For medical groups — whether physician-owned, hospital or health system affiliated, and/or investor-backed — each group will need to make strategic choices in the near and long term regarding the best means to an end. Although MACRA and the proposed rule clearly support the expanded use of MSSP ACOs as the platform for participation in APMs, the composition of providers within those ACOs is likely to change over time.

Hospitals and health systems will also likely need to re-evaluate their overall strategies related to the delivery and location of clinician and other health care services over the next few years. While fee for service and volume remains king, hospitals and health systems will understandably

furnish ancillary and other services in settings that yield higher reimbursement (i.e., in hospital inpatient or outpatient settings). But as risk becomes more real and significant, expect to see greater emphasis (and internal dialogue and potential strife) on migration of those services to lower cost ambulatory settings and payment structures, coupled with increased emphasis on appropriate usage to promote cost and quality.

Overall, the MACRA legislation and the manner in which the law is implemented by CMS in the future has the potential to constitute the "game changer" that many in the health care delivery system have sought (or perhaps feared). And while the Affordable Care Act or "Obamacare" is commonly criticized by different sectors of the political landscape, the bi-partisan nature of MACRA likely means that a change from volume to value is more likely to become a reality.

For More Information

For questions regarding this information, please contact one of the authors, a member of Polsinelli's Health Care practice, or your Polsinelli attorney.

- Janice A. Anderson | 312.873.3623 | janderson@polsinelli.com
- Bruce A. Johnson | 303.583.8203 | brucejohnson@polsinelli.com
- Laura Little | 404.253.6055 | llittle@polsinelli.com
- Cybil G. Roehrenbeck | 202.777.8931 | croehrenbeck@polsinelli.com
- Rebecca Frigy Romine | 314.889.7013 | rromine@polsinelli.com
- Sidney Welch | 404.253.6047 | swelch@polsinelli.com

To contact a member of our Health Care team, click here or visit our website at www.polsinelli.com > Services > Health Care Services > Related Professionals.

To learn more about our Health Care practice, click here or visit our website at www.polsinelli.com > Services > Health Care Services.

POLSINELLI

real challenges. real answers. SM

About Polsinelli's Health Care Practice

The Polsinelli Health Care practice represents one of the largest concentrations of health care attorneys and professionals in the nation. From the strength of its national platform, the firm advises clients on the full range of hospital-physician lifecycle and business issues confronting health care providers across the United States.

Recognized as a leader in health care law, Polsinelli is ranked as "Law Firm of the Year" in Health Care by *U.S. News & World Report* (November 2014), no. 1 by *Modern Healthcare* (June 2015) and nationally ranked by *Chambers USA* (May 2015). Polsinelli's attorneys work as a fully integrated practice to seamlessly partner with clients on the full gamut of issues. The firm's diverse mix of attorneys enables our team to provide counsel that aligns legal strategies with our clients' unique business objectives.

One of the fastest-growing health care practices in the nation, Polsinelli has established a team that includes former in-house counsel of national health care institutions, the Office of Inspector General (OIG), and former Assistant U.S. Attorneys with direct experience in health care fraud investigations. Our group also includes current and former leaders in organizations such as the American Hospital Association. Our strong Washington, D.C., presence allows us to keep the pulse of health care policy and regulatory matters. The team's vast experience in the business and delivery of health care allows our firm to provide clients a broad spectrum of health care law services.

About Polsinelli

real challenges. real answers.[SM]

Polsinelli is an Am Law 100 firm with more than 800 attorneys in 19 offices, serving corporations, institutions, and entrepreneurs nationally. Ranked in the top five percent of law firms for client service*, the firm has risen more than 50 spots in the past five years in the Am Law 100 annual law firm ranking. Polsinelli attorneys provide practical legal counsel infused with business insight, and focus on health care, financial services, real estate, intellectual property, mid-market corporate, and business litigation. Polsinelli attorneys have depth of experience in 100 service areas and 70 industries. The firm can be found online at www.polsinelli.com. Polsinelli PC. In California, Polsinelli LLP.

** 2016 BTI Client Service A-Team Report*

About this Publication

Polsinelli provides this material for informational purposes only. The material provided herein is general and is not intended to be legal advice. The choice of a lawyer is an important decision and should not be based solely upon advertisements.

Polsinelli PC. In California, Polsinelli LLP.

POLSINELLI

real challenges. real answers. SM