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LEGISLATIVE NEWS

Trump breaks expectations, pushes for 'simultaneous' ACA repeal and replace

President-elect Donald J. Trump has called for a quick repeal of the Affordable Care Act (ACA) without the two or three-year implementation delay that has consistently featured in the repeal strategy of Republican legislators, undermining, if not defeating, careful maneuvers by Republican lawmakers to make good on their political promises without disrupting patient coverage and insurance markets.

Now, the repeal and replacement of the ACA will be "essentially simultaneous," Trump said at a wide-ranging Jan. 11 press conference in New York, his first such event in nearly six months. "We're going to be submitting, as soon as our secretary's approved, almost simultaneously, shortly thereafter, a plan. It'll be repeal and replace."

Trump's pick for HHS secretary – Rep. Tom Price, a former orthopaedic surgeon from Georgia (see story, pg. 4) – began his confirmation hearings with a session before the Senate Health Committee on Jan. 18. His hearings resume with an appearance before the Senate Finance Committee on Jan. 24. Price has led efforts in the House of Representatives to repeal Obamacare, including crafting a 242-page proposal, the Empowering Patients First Act of 2015 (H.R. 2300), that would satisfy Trump's demand for a simultaneous repeal-and-replace bill.

Previous Republican bills to replace the ACA, or Obamacare, featured a delayed implementation date so that patients, providers, and insurers could prepare for yet another major shift in healthcare policy. "Anytime you have a new law that's going to affect millions of people, you need a plan to transition," says Bradley Coffey, government affairs manager for the AAOE in Indianapolis. "Having the insurance companies hanging there in purgatory, not knowing whether and when to pull their plans off the market or what new plans to create, is not going to be good for patients or providers."

The stakes are high: An estimated 20 million Americans now have insurance coverage under Obamacare, according to a recent report by HHS.

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Major Congressional battle looms

Republicans began the repeal process by passing a budget measure in the early morning hours of Jan. 12 that will protect the eventual repeal bill from a Democratic filibuster. The measure passed on a virtually party-line, 51-48 vote and sets up the repeal bill to pass under the budget reconciliation process, which allows passage under a simple majority vote rather than a two-thirds majority.

The problem is that, while repeal provisions that defund key elements of Obamacare could pass under the reconciliation process, a replacement program is likely to contain provisions that affect more than just federal spending and taxation. The reconciliation process can only be used to pass legislation relating to spending and taxation; thus elements of Obamacare such as the requirement that insurers cover patients with preexisting conditions could not be repealed via reconciliation.

Further complicating the process for Republicans are Trump's past statements that he would want to keep popular Obamacare provisions, such as the preexisting conditions requirement. Under Senate rules, there is virtually no way Republicans could pass a true Obamacare replacement without some measure of Democratic support, Coffey says.

Republicans aren't fully united in how to handle the repeal-and-replace process; House GOP members including Majority Leader Paul Ryan (R-Wis.) have included language in the repeal bill that will defund the non-profit Planned Parenthood organization. This makes the legislation tougher for moderate Republicans, including two female Senators, Susan Collins of Maine and Lisa Murkowski of Alaska, to support.

What ACA's successor may look like

It's important to note that there is no Republican consensus behind any single piece of legislation to replace Obamacare, but Trump has stated that the repeal-and-replace will occur only after his HHS secretary, Rep. Price, is confirmed.

If Trump is suggesting that Price will play a key role in the repeal-and-replace process, it's reasonable to look at the Empowering Patients First Act of 2015, the replacement bill that Price introduced in the House of Representatives.

Broadly speaking, this bill would roll back Obamacare's Medicaid expansion without replacing it, leaving poorer Americans with far less help in securing coverage. They would get some help, along with everyone else, from the bill's provision offering age-adjusted tax credits to help with premiums. Young adults (ages 18-35) would get $1,200 in credits and older adults (ages 51 and up) would get the highest amount, $3,000 in credits.

The bill also eliminates Obamacare's definition of an essential benefits package, which would mean insurers could sell plans that offer far less coverage and are thus cheaper – ideal for younger, healthier Americans.

Expect Price's plan to get a much closer look by legislators in both parties over the coming weeks.

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HUMAN RESOURCES

GOP's 'midnight' bill could kill overtime rule before it takes effect

The U.S. Department of Labor's overtime rule has been frozen since November by way of a last-minute court injunction, but now there's a chance that it will never go into effect thanks to legislative action.

Republicans in the House of Representatives passed the Midnight Rule Relief Act on Jan. 4, a bill that would allow Congress to repeal any rule finalized in the last 60 legislative days of the Obama administration with a single vote. A large number of Obama-signed laws could thus be reversed in one stroke, assuming the "midnight" bill passes the Senate and is signed by President-elect Donald J. Trump. The bill also gives Congress an easier way to strike down specific rules that have already been signed into law. There is an existing route, known as the Congressional Review Act, that could be used to reverse recently passed laws such as the overtime rule, but it has only been exercised successfully once, in 2001.

Remember: The overtime rule more than doubles the salary threshold above which employees would be exempt from getting overtime pay. For medical practices, positions such as front office managers, medical assistants, and other non-clinical staff would be the likeliest to be affected. The rule also

has a built-in clause that would automatically increase the threshold every three years, prompting some industries to argue that the Department of Labor had overstepped its authority.

The previous House also passed the midnight bill in November, but with Trump headed for the White House, GOP lawmakers can count on executive support rather than a guaranteed veto from President Obama.

Republicans also argued that the bill has only become more important since President Obama issued a volley of rules aimed at protecting various elements of the Democratic agenda. During the past month, Obama created a permanent ban on offshore oil and gas drilling across wide swaths of the Arctic and the Atlantic seaboard, invoking a little-known provision of a 1953 law to do so. Obama also ordered a partial and dormant registry of male immigrants from Muslim countries to be deleted, and issued a record number of presidential pardons.

For cardiologists, orthopaedists, and other physician specialties involved in cardiac and orthopaedic surgery, another relevant target could be the CMS Episode Payment Model (EPM) rule, which was finalized on Dec. 20 and thus falls within striking distance of the midnight bill. The EPM rule takes effect on July 1, 2017 and will bundle surgical hip and femur treatments into a single 90-day episode of care to reduce costs and improve outcomes.

Overall, for medical practices and other businesses, the overtime rule remains the most consequential target and Republican hostility to the rule all but ensures its inclusion in the list of Obama actions to be scrapped via the "midnight" bill's powers.

Obama fast-tracks appeal of injunction

Despite the increasingly bleak outlook for the overtime rule, the Obama administration is going down swinging, citing the limbo that businesses have been placed in due to the rule's uncertain status.

Just weeks after the injunction prevented the overtime rule from taking effect on the planned implementation date of Dec. 1, attorneys from the U.S. Department of Justice filed an appeal on behalf of the Department of Labor. The U.S. Court of Appeals for the Fifth Circuit then agreed to expedite its review of the appeal, but even with this move, the process is expected to last through the Jan. 20 inauguration of President-elect Trump. His pick for labor secretary, Andy Puzder, would be sure to support dropping the appeal. Mr. Puzder, who is currently CEO of CKE Restaurants (the parent company of Hardee's and Carl's Jr. fast food chains), is a well-known critic of labor laws pushed by the Obama administration, including both a higher minimum wage and the overtime rule.

The current threshold is $23,660, which means anyone making more than that amount annually does not have to be paid for overtime (hours in excess of 40 per week). The final overtime rule sets the threshold to $47,476. Most practices have decided to keep raises given as a result of the rule, or to withhold raises if the employees had not been notified by the time the injunction was announced.

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PROFILES

REP. TOM PRICE (R-GA., PHOTO FROM CONGRESS.GOV)

Tom Price, former orthopaedic surgeon, tapped to head HHS

Rep. Tom Price, a former orthopaedic surgeon, has gotten the nod from President-elect Donald J. Trump to be the next HHS secretary, a position that has not been held by a physician in more than two decades.

The nomination of Price, a staunch conservative who retired from active practice in 2005 when he became the representative for Georgia's 6th congressional district in the House of Representatives, has split physicians nationwide. The AMA was quick to offer its endorsement, calling him "a leader in the development of health policies to advance patient choice and market-based solutions as well as reduce excessive regulatory burdens that diminish time devoted to patient care and increase costs."

But some physicians took pains to express their opposition to Price. A petition against his nomination entitled "The AMA Does Not Speak for Us" garnered more than 6,400 physician signatures as this issue of *The Business of Medicine* goes to press. Though their reasons for opposing Price were mixed, most expressed concerns that his record as a legislator – which showed a hostility to the cost-saving initiatives from the CMS Innovation Center and a preference for privatizing Medicare

and effectively converting Medicaid into a series of block grants for states.

If confirmed, Price would wield considerable power over federal regulations, with the ability to exercise his interpretation of federal statutes wherever the phrase "The HHS Secretary shall" appears. The last physician to serve as secretary was Louis Wade Sullivan, MD, an internist chosen by President George H.W. Bush in 1989.

A consistent conservative advocate for physicians

Those who have known Price longest believe his nomination will benefit both providers and patients, and describe the 62-year-old as a straight shooter and physician advocate who is not fundamentally opposed to modern trends such as the shift away from fee-for-service towards pay-for-performance.

"He has been a physician his whole life and he has championed independent physician practices, free markets, and reduced regulations," says Kay Kirkpatrick, MD, an orthopaedic surgeon who specializes in hand surgery at Resurgens Orthopaedics in Atlanta.

Dr. Kirkpatrick has known Price since 1986, when they both worked as independently practicing surgeons. They later merged their practices into what is now Resurgens, which has grown into a large multispecialty orthopaedic group with more than 95 physicians spread across 21 office locations.

"He is a big supporter of independent practices being able to survive, and all the regulations foisted on us over the last 10 years have made it very difficult for small practices to stay independent," Kirkpatrick says.

At the same time, Kirkpatrick describes Price as a firm believer in the free market who would be supportive of alternative payment models and cost-saving measures such as grouping episodes of care – so long as practices are given time to prepare and implement successfully, she says.

"I think everybody feels there's a lot of waste in the system that needs to be eliminated by doing things like grouping episodes of care," she says. "A lot of us think the market has already started down this path, and that's going to continue regardless of what happens with [Obamacare]. When it comes to the idea of paying for value instead of fee-for-service forever, that train has already left the station."

Thus Price would be unlikely to oppose the Merit-based Incentive Payment System (MIPS), or the law that birthed it, the Medicare Access and CHIP Reauthorization Act (MACRA). "MACRA and MIPS have a bipartisan effort behind it and people at CMS have been reaching out to physicians with regards to implementing it, so I think everyone feels this is about as good as it gets from a regulatory standpoint," Kirkpatrick says.

Mixing medicine and politics

Price earned his MD from the University of Michigan Health System and completed his residency at Emory University in Atlanta. His ambition for political office surfaced early in his career, Kirkpatrick says. "Every Thursday he'd go to the Rotary

Club meeting," she recollects. "I never saw another physician go the Rotary Club every single week."

Price practiced as a general orthopaedist for nearly 20 years before taking a position at Emory as assistant professor of orthopaedic surgery. He ran for the George state senate in 1996, serving four terms before running for the U.S. House of Representatives in late 2004. "He is probably the most qualified person that could ever have been selected for the position," Kirkpatrick believes. "You may not agree with everything he says, but you'll know where he stands because he means everything he says," Kirkpatrick says. "He is not wishy-washy as a politician or a physician, he is very honest and straightforward."

Kirkpatrick stresses that though she spoke to Price within the last several weeks, the Congressman has kept a low profile while preparing for his nomination hearings. His first hearings with the Senate Health Committee began Jan. 18, and he faces the Senate Finance Committee for more hearings beginning Jan. 24.

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COMPLIANCE

4 MIPS tips for 2017, the first performance year

While the election of Donald J. Trump means that the days of the Affordable Care Act (ACA) are numbered, Medicare's Merit-based Incentive Payment System (MIPS) is expected to live a long and healthy life. MIPS is the key cog of the Medicare Access and CHIP Reauthorization Act (MACRA), the bipartisan law that eliminated a longstanding rule requiring CMS to cut Part B payments each year.

As such, Republicans are not expected to do much to MACRA or MIPS, other than tweak it, which CMS has already committed to doing, based on the changes made to MIPS between its proposed rule and final rule.

All this means that you and your practice are stuck with MIPS, and the first performance-measuring year is 2017 – it's already started. But there are few crucial tips for MIPS you should know:

1. 2017 is a performance-measuring year, not a payment year. The first payment year is 2019. On Jan. 1, 2019, your providers' Medicare payments will go up or down (or stay flat) based on their performance this year, 2017. The possible range of adjustments is anywhere from -4% to +4% in 2019, and goes up each year thereafter.

2. You don't have to start MIPS reporting on Jan. 1, 2017. Thanks to various concessions made by CMS in the MIPS final rule, you have multiple reporting options, including ones to observe a 90-day performance period instead of a year-round period.

3. You can guarantee a neutral 2019 update easily. In the final rule, CMS offered providers three options to satisfy 2017 reporting requirements. Each option has a different level of difficulty and a different chance for rewards, but choosing the easiest option still ensures at worst a flat 2019 payment adjustment. This option means you need to accomplish one of the following: one quality measure (derived from the Physician Quality Reporting System or PQRS) or one activity in the clinical improvement activities performance category (specific activities that qualify are here). This option doesn't require even a 90-day reporting period.

4. Your payment adjustment depends on how much everyone else does. CMS will establish a baseline payment adjustment that takes into account all MIPS reporting, including those providers who do not participate whatsoever (those individuals will be guaranteed a negative update).

Are you MIPS exempt?

The vast majority of providers are subject to MIPS, dubbed "MIPS-eligible clinicians" by CMS. However, there are some providers who will be exempt from MIPS in 2017 (and who won't have their payments adjusted by MIPS in 2019). First, a provider who is enrolling in Medicare for the first time and has not previously submitted claims to Medicare, is exempt for 2017. Second, providers who are under a special "low-volume" threshold are exempt from MIPS for each year in which they meet the threshold. CMS determines this threshold automatically based on claims review, but in a nutshell a provider must bill Part B for fewer than $30,000 over a 12-month period or care for fewer than 100 Part B patients.

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EDITORIAL

Is our industry still the 'Wild West'?

In recent years, prominent voices in the healthcare industry have described federal fraud and abuse efforts in unflattering terms. The entities that have drawn the most ire are those private corporations who have federal contracts to conduct data mining and perform coding and documentation audits based on that data. These terms included calling them "contracted bounty hunters" who have enabled payers to go on "a rampage" against providers.

In this article, we argue that these terms, minus the more sensational adjectives, do apply to the work being done by the various federal contractors. Making things worse for providers is the fact that we are currently in the midst of a 10-year backlog of provider appeal cases waiting to be heard at the Medicare Administrative Law Judge (ALJ) level.

The purpose of this article is to shed light on some of the behaviors and tactics deployed at payers and their contractors and what medical practices should be aware of. We have no intention of demonizing payers or their employees, but at a time when "fraud, waste, and abuse" in the healthcare system is an easy, bipartisan target, practices must understand the stakes and the environment they face. They shouldn't lapse into complacency because Republicans are now in control of all three branches of the federal government. Incoming President Donald J. Trump, an avowed opponent of excessive regulation, has stated that there is "tremendous" fraud and waste in the healthcare sector, and pledged to eliminate it.

Do the words fit?

First, when contractors are hired to perform audits of provider documentation and they are paid a contingency fee (i.e. payment based on recoveries), they are clearly incentivized to identify as many potential errors as possible and question the medical necessity of everything billed by a medical practice. Dictionary.com defines a "bounty hunter" as "a person who seeks a reward for recovering valuable property." Based on their payment structure, it seems fair to depict contractors like

New DoctorsManagement clients	
Client	**Services provided**
Plastic surgery practice, TX	Accounting and tax services
Hospital, GA	Compliance audit
Surgery center, TN	Practice valuation
Alzheimer center, VT	Practice start-up due diligence
Urology/gynecology practice, FL	Practice start-up
Hearing aid centers	Enrollment and contracting services
AIDS resource center	Enrollment and contracting services
Physician group, TX	Enrollment and contracting services
Medical group, MD	Enrollment and contracting services
Dermatology practice, MN	Enrollment and contracting services
Pediatric clinic	Enrollment and contracting services
Solo practitioner	Enrollment and contracting services
Women's health center, NC	Employee handbooks
Primary care group	Employee handbooks
Urgent care group, TN	CLIA start-up
Dental practice, TX	Onsite OSHA/HIPAA training
18 new NAMAS memberships, 33 membership renewals	

Medicare's Recovery Audit Contractors (RACs) as entities who are seeking rewards for recovering another's valuables.

As far as RACs and similar companies being on a rampage, Dictionary.com defines a "rampage" as "violent or excited behavior that is reckless, uncontrolled, or destructive." While we can't call payer audits violent in a dictionary sense, their behavior has been characterized to fit every other aspect of that definition. The OIG itself said in a 2015 report that "the significant lack of oversight of ZPIC contractors, who were awarded contracts averaging $81.9 million, is evidenced by the extreme and ill-founded actions taken by some ZPICs in unwarranted efforts to show CMS a return on investment. Contractors often employed significant, aggressive, and over-zealous audits, claims reviews and investigations against legitimate, not fraudulent, providers of healthcare services."

This has resulted in a massive backlog at the Office of Medicare Hearing and Appeals (OMHA). The number of requests for an ALJ hearing or review increased 1,222% from 2009 to 2014; as of last April, OMHA had over 750,000 pending appeals. Weigh this against the 2014 productivity of ALJs under OMHA: each ALJ issued on average 1,048 decisions and 456 dismissals. The expected processing time for an ALJ case has gone for 94.9 days in 2009 to 547 days in 2014, and this is some of the latest available data from HHS.

Payer auditors lack training, experience

The reasons for the backlog are twofold: First, the incentive for entities like RACs to see and hear evil at every turn is obvious and mercenary. Second, the auditors they employ often lack training and experience, despite efforts by CMS and HHS to tighten standards.

Even so, there is an ongoing lack of training on how to conduct a fraud investigation and many auditors at these contractors have never had formal training on what constitutes fraud. Egged on by cash incentives they often find errors in documentation and often turn those into accusations of fraud.

We've represented providers who were accused by payers whose auditors were clearly unfamiliar with their organizations' provider manuals, Local Coverage Determinations (LCDs), or other rules and processes that relate to appeals. One of the biggest issues we face as an industry is the lack of standardization when it comes to audits. Healthcare providers and their employees are held to a very high standard in terms of compliance and accuracy, but payer employees are often not held to the same standard.

Here are two examples to illustrate this point. First, I was recently asked to join a call between a provider group and the special investigative unit for a prominent payer. The group I was representing was a sub-specialty group focused on a very specific ailment of pediatric and adolescents. At DoctorsManagement, we always begin such conversations by asking each person from the payer to state their name and credentials, including any professional licensure they have attained. What I heard was disturbing: the physician representing the payer had never treated a patient with the type of disorder in the cases we were examining, and was not trained in its diagnosis or treatment. The auditor who performed the review had never audited this specialty before. As we went through each of the claims, the auditor was unable to defend their position on why they downcoded the services and on more than one occasion the payer physician said, "I don't see anything wrong with this claim … it should not have been downcoded." At the end of the call the auditor for the payer had an 80% error rate but payer officials persisted in demanding a refund from the practice.

In the second example, I was again on a call with a practice and one of its payers. The question was why a large number of level 3 evaluation and management (E/M) codes were downcoded to level 2 codes. The payer physicians on the call stated that level 3 E/M codes require a *moderate* complexity of medical decision making (MDM). I sent the payer physicians and auditors a copy of the CMS E/M guidelines which obviously show that a *low* complexity of MDM is required to support a level 2 E/M service.

One payer physician asked, "When did the guidelines change?" It was difficult to suppress my shock when I responded "in 1995." This audit is pending dismissal as this issue of *The Business of Medicine* went to press.

Politics matter more than they should

It's a sad fact of life that when it comes to the regulations governing the healthcare industry, payers and providers do not enjoy equal representation and advocacy on Capitol Hill. Payers have one of the strongest lobbying arms of any industry stakeholder group in the country, while physician advocates are smaller and more divided. Even the American Medical Association (AMA), which most laymen believe wields tremendous political power, counts only 25% of all licensed physicians as members, a figure that has dropped since the

1950s as various medical specialty societies and state-specific groups have begun doing more to represent physicians.

Payers tend to have more unifying goals, such as increasing profits while reducing costs (e.g. coverage and payments). Physician groups often compete with one another in lobbying for more of the same federal reimbursement pie. This dynamic is one reason the nation is faced with a physician shortage even as more and more Americans require consistent primary care, to say nothing of those needing more specialized, complicated, interdisciplinary care.

We at DoctorsManagement pride ourselves on being physician advocates first and foremost, even as we acknowledge the ongoing difficulties outlined in this article. While we aren't lobbyists, we do have longstanding relationships with payers and federal officials in addition to our reservoir of expertise and experience on all aspects of medical practice compliance and management. Even as a new President takes office, promising less regulations, we believe practices should continue to be on guard for aggressive targeting of fraud, waste, and abuse, and prepare to defend themselves if necessary against a new sheriff.

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