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MACRA AND VBP

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MACRA BASICS

An Evolution in Medicare Payment Incentives

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What is MACRA?

Medicare and CHIP Reauthorization Act of 2015

Replaces SGR* for updating Medicare physician rates	New bi-partisan policy direction for physician payment

• Paid fee-for- service
• Physicians faced annual 20%+ reductions in payment, leading Congress to intervene
	• Payments based on quality and value
	  • Builds on current Medicare physician quality programs
	  • Advances Federal value-based payment (VBP) goals

*SGR = Sustainable Growth Rate.

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4 Advances Federal Value-Based Payment (VBP) Goals, Focus on Value over Volume

VBP Arrangements

Quality incentives
- Pay-for-performance

Alternative payment models
- Shared savings (“ACO”)
- Capitation

2018 Goals

All Payments

VBP Arrangements 90%

Alternative Payment Models 50%

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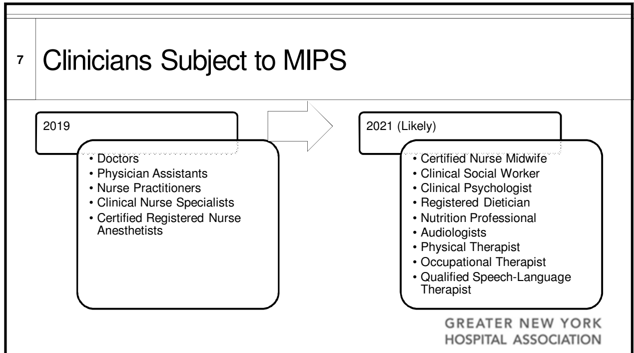
5 MACRA Provides Options for Physicians

Physicians choose one of two tracks :

Merit-based Incentive Payment System (MIPS)	Alternative Payment Model (APM)
• Quality track	• Shared risk/capitation track • Advanced VBP models

6 Physician Updates Under MACRA

	2017	2018	2019	2020	2021	2022-2024	2025	2026+
Fee Schedule Updates	0.5%	0.5%	0.5%	0%	0%	0%	0%	**0.25%*** / **0.75%****
Physician Quality Reporting System (PQRS)	-2%	-2%	**Merit-based Incentive Payment System (MIPS)***					
Meaningful Use (MU) Penalty	-3%	-3%	±4%	±5%	±7%	±9%	±9%	±9%
Value Modifier	±2% / ±4%	±2% / ±4%						
Qualifying APM Participants**			5%	5%	5%	5%	0%	0%
			Excluded from MIPS					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Clinicians Subject to MIPS
2019
• Doctors
• Physician Assistants
• Nurse Practitioners
• Clinical Nurse Specialists
• Certified Registered Nurse Anesthetists
2021 (Likely)
• Certified Nurse Midwife
• Clinical Social Worker
• Clinical Psychologist
• Registered Dietician
• Nutrition Professional
• Audiologists
• Physical Therapist
• Occupational Therapist
• Qualified Speech-Language Therapist
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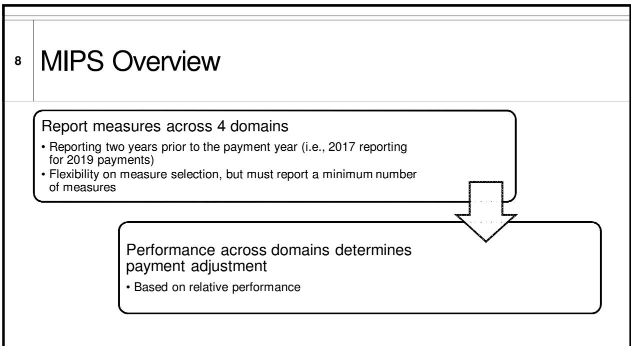
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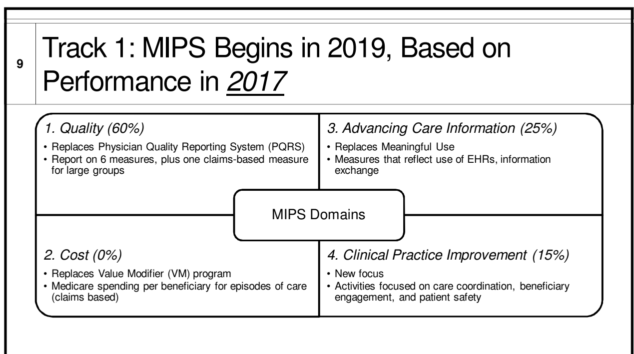
MIPS Overview
Report measures across 4 domains
• Reporting two years prior to the payment year (i.e., 2017 reporting for 2019 payments)
• Flexibility on measure selection, but must report a minimum number of measures
Performance across domains determines payment adjustment
• Based on relative performance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Track 1: MIPS Begins in 2019, Based on Performance in 2017
1. Quality (60%)
• Replaces Physician Quality Reporting System (PQRS)
• Report on 6 measures, plus one claims-based measure for large groups
3. Advancing Care Information (25%)
• Replaces Meaningful Use
• Measures that reflect use of EHRs, information exchange
MIPS Domains
2. Cost (0%)
• Replaces Value Modifier (VM) program
• Medicare spending per beneficiary for episodes of care (claims based)
4. Clinical Practice Improvement (15%)
• New focus
• Activities focused on care coordination, beneficiary engagement, and patient safety

10 Sample Measures by Performance Category

MIPS Domain	Sample Measures
Quality	**Diabetes:** Hemoglobin A1c (HbA1c) Poor Control (>9%) -- Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.
	Heart Failure (HF): ACE Inhibitor or ARB Therapy for LVSD -- Percentage of patients with a diagnosis of HF with a current or prior left for ventricular ejection fraction < 40% who were prescribed ACE inhibitor or ARB therapy
	Care Plan: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record
Advancing Care Information	**Exchange Information with Other Physicians or Clinicians**
	Exchange Information with Patients
	Clinical Information Reconciliation
Cost	**Total Medicare cost (payment) per capita** **Total Medicare cost (payment) by episode (e.g., breast cancer, cataract procedures)**
Clinical Practice Improvement	**Patient-Centered Medical Home (PCMH) Certification**
	Population Management: Participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, patient self-management program) for 60 percent of practice patients in year 1 and 75 percent of practice patients in year 2
	Expanded Practice Access: As a result of Quality Innovation Network-Quality Improvement Organization technical assistance, performance of additional activities that improve access to services (e.g., investment of on-site diabetes educator)

11 2017 Transition Period: "Pick Your Pace"

Fail to report	*Submit something*	*Submit partial data*	*Submit full data*
-4% penalty	0% adjustment	+0-4% adjustment	+0.5-10% adjustment

12 Track 2: Advanced APMs Overview

- Incentives to participate in Advanced APM Track
  - Exempt from MIPS!
  - Receive 5% bonus payment (Medicare Part B revenue)
  - Opportunity to receive bonus payments from APM arrangement
- Minimum payment and/or patient thresholds:

Payment Year	2019	2020	2021*	2022*	2023*	2024+*
% of payments	25%	25%	50%	50%	75%	75%
% of patients	20%	20%	35%	35%	50%	50%

- Eligibility criteria
  - Financial risk, quality measures comparable to MIPS, and use certified EHRs

13 Qualifying Medicare APM Models

2017

- Comprehensive ESRD Care Model
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program (MSSP) Tracks 2 & 3
- Next Generation ACO Model (Next Gen)
- Oncology Care Model (OCM) two-sided model

2018

- Comprehensive Care for Joint Replacement (CJR) Track 1
- Episode-Based Payment Models Track 1
- MSSP Track 1+
- Other?

14 Transition Policy Should Mitigate Financial Impact on Small Practices in 2019 ($ in Millions)

Practice Size	Eligible Clinicians	Aggregate Impact (Negative)	Aggregate Impact (Positive)	Net Impact
1-9	147,739	-$99	$244	$145
10-24	63,829	-$37	$80	$42
25-99	132,406	-$47	$101	$54
100+	332,748	-$16	$274	$258
Total	676,722	-$199	$699	$500

15 Challenges for Physicians to be Successful: Significant Infrastructure Required

- Successfully report
  - Analyze performance
- Connect with other providers in the community
  - Episode spending measures
- Have an electronic health record
- Invest in clinical practice improvement activities

Options:

1. Dropout of the Medicare program
2. Don't actively participate, take payment penalty
3. Partner with other small practices to work with a vendor
4. Build reporting infrastructure internally
5. Affiliate with a hospital or large practice (quality or APM track)
6. Hospital employment

16

VBP BASICS

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Goal of VBP: Coordinate Care Across Silos, Reduce Fragmentation and Cost

Payer
Integrated Delivery System
Hospital
Clinic/Physician
Nursing Home
Home Health
Other
VBP
Quality-Based Payment Programs
Bundled Payments
Accountable Care Organizations (ACOs)
Pay-for-performance
Shared Savings
Shared Risk
Capitation

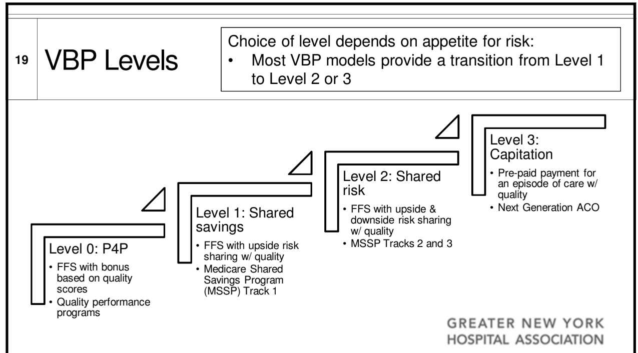
18

Basic VBP Arrangements

Bundled payments

- Procedure (e.g. hip/knee replacement)
- Chronic condition (e.g., diabetes)

Accountable Care Organization



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LEGAL AND COMPLIANCE CONSIDERATIONS

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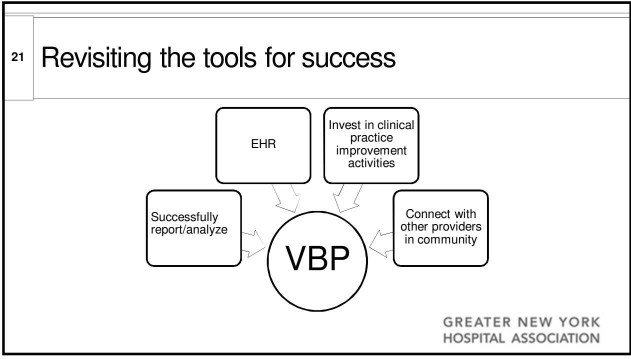

22

Hospital-physician alignment

Physician options in response to MACRA/VBP

- Drop out of the Medicare program
- Don't actively participate, take payment penalty under MACRA
- Partner with other small practices to work with a vendor
- Build reporting infrastructure internally
- **Affiliate with a hospital or large practice**
- **Hospital employment**

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Goals of hospital-physician alignment

Hospitals	Physicians
More control over costs and expenses	Accessing infrastructure, especially IT/analytics
Quality assurance	Compliance sophistication
Patient engagement	Assumption/spread of risk

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VBP risks

- False reports or certifications, e.g., quality, compliance and data certifications
- Violation of model-specific requirements
- Sixty-day overpayment rule
- "Worthless services"
- Funds flow
- Data use agreements and privacy
- Antitrust
- Tax exempt issues
- Fee splitting/corporate practice of medicine
- Under-utilization and risk avoidance
- Avoidance of high-cost patients

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25 Fraud and abuse laws made for a FFS world

- Anti-Kickback Statute
- Stark
- Civil Monetary Penalties
  - Gainsharing law
  - Beneficiary inducement

26 Fraud and abuse refresher

Stark
- Prohibits a physician from making referrals for certain designated health services to an entity with which he or she (or a family member) has a financial relationship
- **Strict liability**, no intent required
- Must fit into **exception**

AKS
- Provides criminal penalties for individuals or entities that **knowingly and willfully** offer, pay, solicit, or receive **remuneration** to induce or reward the referral of business reimbursable under Federal health care programs
- Must fit into **safe harbor**

Beneficiary Inducement Law
- Prohibits the provision of certain items or services ("**remuneration**") to Medicare or Medicaid beneficiaries that are likely to influence the beneficiary to receive a reimbursable service from a particular provider
- Items and services of "**nominal value**" not considered remuneration. Nominal value updated to $15 individually and $75 aggregate annually

Gainsharing Law
- Prohibits hospitals from knowingly making a payment to induce physician to limit **medically necessary** services

FCA
- Establishes liability for any person who knowingly presents to the government a false or fraudulent claim or record for payment or makes a false record or statement to conceal, avoid, or decrease an obligation to pay
- Civil penalty plus treble damages
- Enforcement tool for Stark and AKS

State Laws

27 MACRA: key legal and compliance considerations

Activity	Applicable fraud and abuse laws
Physician alignment; provider integration	Stark, AKS
Data accuracy and documentation	FCA
Under-utilization, risk avoidance	Gainsharing law
Beneficiary incentives/engagement	Beneficiary inducement law

28

Stark law issue-spotting gets harder

- Commercial Reasonableness, FMV, Volume or Value standards must be adapted for VBP
- Can hospitals provide infrastructure, start-up costs to bring non-employed physicians into alignment?
- Can hospitals pay for care management, quality performance/improvement?
- Can hospitals accept a “losing” arrangement?

29

CMS/OIG fraud and abuse waivers

Authority given by Sec. 1115(d)(1) of Social Security Act to HHS Secretary to waive certain fraud and abuse laws for purpose of carrying out testing by CMMI of certain payment and delivery service models (APMs)

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Qualifying Medicare APM models and waivers

2017	2018
☐ Comprehensive ESRD Care Model	☐ Comprehensive Care for Joint Replacement (CJR) Track 1
☐ Comprehensive Primary Care Plus (CPC+)	☐ Episode-Based Payment Models Track 1
☐ Medicare Shared Savings Program (MSSP) Tracks 2 & 3	☐ MSSP Track 1+
☐ Next Generation ACO Model (Next Gen)	☐ Other?
☐ Oncology Care Model (OCM) two-sided model	

No specific waivers for MACRA/MIPS

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How fraud and abuse waivers work

- NOT a get-out-of-jail-free card
- Must be eligible and meet conditions
- Must comply with underlying program requirements
  - Some of which incorporate concepts from the waived laws
- Won't know if you can't use them until too late

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CJR: waiver example

Payment Waiver
- Stark and AKS
- Gainsharing and alignment payments

Patient Engagement Incentives
- Beneficiary inducement provisions of CMP
- Items or services to beneficiaries

Physician Group Practice (PGP)
- Stark and AKS
- Distribution of gainsharing payments from a PGP to physician and non-physician practitioners

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Buttressing waivers

Key existing safe harbors and exceptions
- Employment (Stark and AKS)
- Personal services (Stark and AKS)
- FMV (Stark)
- EHR (Stark and AKS)
- Risk sharing (Stark)
- Managed care (AKS)

New safe harbors and exceptions as of January 2017
- AKS Safe Harbor for Free and Discounted Local Transportation
- Exception to Beneficiary Inducement CMP for Remuneration Promoting Access to Care with Low Risk of Harm
- Exception to Beneficiary Inducement CMP for Remuneration Addressing Financial Need

34

New AKS Safe Harbor for Free and Discounted Local Transportation Services

Applies to programs in which **Eligible Entities** provide free or discounted **Local Transportation** to **Established Patients** for the purpose of obtaining **Medically Necessary Items or Services**

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AKS Safe Harbor for Free and Discounted Local Transportation Services: Key Terms

Eligible Entities

- Hospitals
- Clinically integrated networks
- ACOs

Free or Discounted Local Transportation

- No more than 25 miles for urban, 50 miles for rural
- "As the crow flies"

Established Patients

- Includes those who have scheduled, but not yet attended, an appointment with the provider
- But can't be a "recruiting tool"

Medically Necessary Items or Services

- Non-health related services not included
- OIG ongoing consideration

36

New Exception for Remuneration Promoting Access to Care with Low Risk of Harm

Protects non-cash or cash equivalent remuneration intended to **Promote Access to Care** while having a **Low Risk of Harm** to government health care programs or beneficiaries.

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Exception for Remuneration Promoting Access to Care with Low Risk of Harm: Key Terms

Care
- Defined as access to items and services payable by Medicare/caid
- No requirement for medical necessity

Promote Access to Care
- Not intended to protect arrangements that "merely reward" beneficiaries for accessing care
- Must be designed to improve beneficiaries' ability to access care, not access to "healthy living"

Low Risk of Harm
- Unlikely to interfere with clinical decision making
- Unlikely to increase costs through over- or inappropriate utilization
- Not associated with patient safety or quality of care concerns
- No monetary limit specified by OIG

38

New Exception to Beneficiary Inducement CMP for Remuneration to Address Financial Need

Free or discounted items or services that are not advertised or **tied to the provision of other reimbursable items or services**, where there is a **reasonable connection between the items or services and the medical care** of the individual, and the recipient has been determined to be in **financial need**.

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Exception to Beneficiary Inducement CMP for Remuneration to Address Financial Need: Key Terms

Not Tied to Provision of Other Items or Services
- Can be "connected to" other a reimbursable service, but not "conditioned on"
- No monetary limit specified by OIG for the remuneration

Reasonable Connection to Care
- Generally as determined by a medical professional
- Must be both financially and medically reasonable
- Cost must be proportional to the possible harm being prevented

Financial Need
- Set policy, uniformly applied
- No specific form of documentation dictated by OIG
- No specific methodology dictated

40

Practical considerations for adapting your compliance program to new APMs/VBP

- Educating governing body to ensure proper oversight
- Tracking multiple programmatic and documentation requirements
- Quality/compliance connection
- Engaging consultants to rethink FMV analysis for VBP
- Contract compliance
- Leveraging internal and external resources, including partners' compliance function

REDUCE, REUSE, RECYCLE

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Questions

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