MACRA

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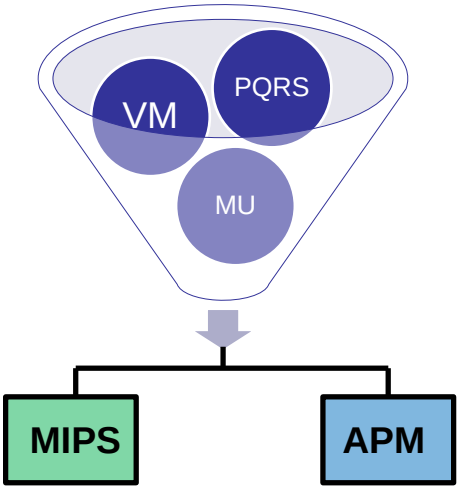
Physician Quality Payment Program

Starting in 2019….



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Why MACRA Matters

- **Physicians:** Impact on payment, performance measurement requirements
- **Hospitals:** May defray cost of implementation and compliance by employed/affiliated physicians
- Continued shift in **hospital-physician relationships**
- Incentives to participate in **alternative payment arrangements** increasing interest in risk-bearing arrangements

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MACRA Final Rule: Key Takeaways

- Starts Jan. 1, 2017, but clinicians can "pick their pace"
- Few advanced APMs qualify for incentives in the 2017 (but more may be coming)

- More data reported in 2017 means better chance of payment increase
- Fewer clinicians than expected subject to MIPS in the first year
- Expectations will ramp up over time

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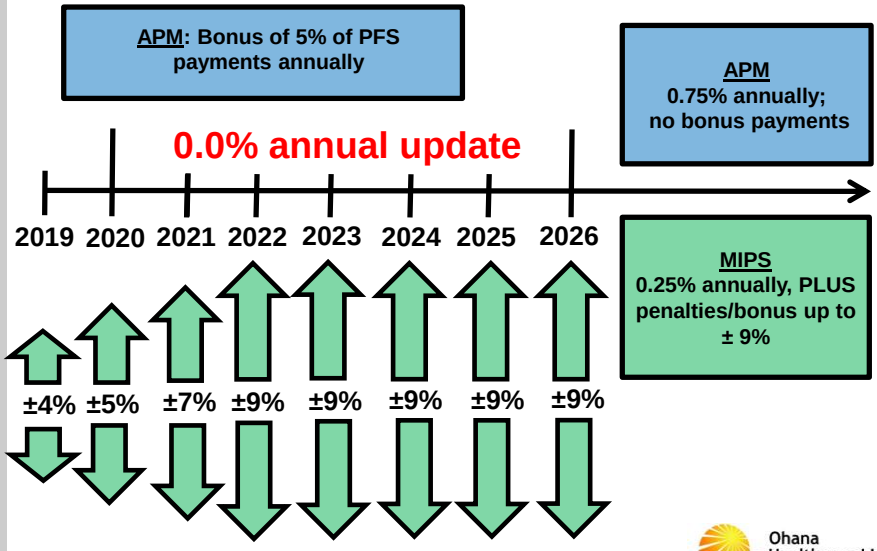
Payment Under MACRA

MIPS OR APM



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Merit-based Incentive Payment System

- MIPS is default payment system
- Applicable to physicians, PAs, NPs, CNSs and CRNAs beginning in 2019
  - Others can be added in 2021
- Participate as individual or group practice
- Exemptions for:
  - Certain participants in alternative payment models
  - Clinicians in first year of Medicare
  - **Low-volume threshold**

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MIPS: Performance Categories

Category	CY 2019	CY 2020	CY 2021 and beyond
Quality	**60%**	**50%**	30%
Resource use (Cost)	**NA**	**10%**	30%
Clinical practice improvement activities	**15%**	**15%**	15%
Advancing Care Information (i.e., Meaningful Use)	**25%**	**25%**	25%

CMS invoking statutory flexibility to not score cost category in first year

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MIPS Flexibility for Year 1

- Shortened reporting period for CY 2017
  - Continuous 90-day period across all MIPS categories

- "Pick your pace" options that help clinicians avoid penalties
- Increased low-volume threshold
  - Clinicians excluded from MIPS if they bill **$30,000 or less of Medicare charges, OR see fewer than 100 patients**
  - Threshold may change in future years

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MIPS Flexibility for Year 1

"Pick Your Pace"

Three options for 2017 MIPS participation:

- Report **"some" data** to avoid penalty (but receive no incentive)
  - One measure, one improvement activity or meet base ACI requirements
- Report **more than minimum data for 90 days** to avoid penalty and potentially receive small incentive
  - More than one measure, more than one improvement activity or meet more than base ACI requirements
- Report **all required data across all categories for at least 90 days** to maximize opportunity for incentive

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MIPS: Applicability to Rural Providers

- **CAHs:** MIPS **<u>will apply</u>** to CAHs billing under Method II whose clinicians have reassigned their billing rights to the CAH
- **FQHCs/RHCs:**
  - MIPS **<u>does not apply</u>** to clinicians billing under the payment systems for FQHCs/RHCs
  - However, MIPS **<u>may apply</u>** if FQHC/RHC clinicians bill services under the PFS (such as in moonlighting arrangements)

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MIPS: Data Reporting Mechanisms

MIPS Category	Individual Data Reporting Options	Group Data Reporting Options
Quality	- Part B claims-based reporting - Qualified Clinical Data Registry (QCDR) - Qualified Registry - EHR	- Qualified Clinical Data Registry (QCDR) - Qualified Registry - EHR - CAHPS Survey Vendor (for groups of 25+ only) - CMS Web interface (for groups of 25+ only)
Resource Use (Cost)	- Part B claims-based reporting (no submission required)	- Part B claims-based reporting (no submission required)
Clinical Practice Improvement Activities	- Attestation - QCDR - Qualified Registry - EHR	- Attestation - QCDR - Qualified Registry - EHR - CMS Web Interface (for groups of 25+ only)
Advancing Care Information (ACI)	- Attestation - EHR - QCDR - Qualified Registry	- Attestation - EHR - QCDR - Qualified Registry - CMS Web Interface (for groups of 25+ only)

- Must select one mechanism per category
- Data requiring submission due to CMS by Mar. 31, 2018
- Data completeness thresholds apply

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MIPS: Quality Measure Requirements

- For most reporting mechanisms, clinicians and groups would report at least 6 measures. Of the 6:
  - **Report at least 1 outcome measure**
- Can choose any measure from list of available measures
  - Specialty measure sets also available
- For groups of 16 or more clinicians, CMS also will calculate a claims-based hospital readmission measure

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MIPS – Cost Category

- **Category not counted towards MIPS score for CY 2019 (but will for CY 2020)**
- CMS will use:
  - Total costs per capita
  - Medicare spending per beneficiary for physicians
  - Clinical condition and procedure episode cost measures from a list of 10 measures
- Cost score = average score of all the measures that can be attributed to clinician / group
  - Various attribution methodologies

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MIPS – Improvement Activities

- List of 93 activities from which clinicians can choose
- Each activity assigned a weight of "medium" or "high" towards score
  - Participate in up to 4 activities for full credit
- Participation in certified PCMH automatically receives highest score
- Participation in MIPS APM automatically receives at least half the highest score
  - CMS assesses APM requirements against improvement activities list
  - MSSP Track 1 and Next Generation ACO would receive full credit

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Advancing Care Information

- Continuous 90-day reporting period for 2017 and 2018 for the ACI category
- Finalizes a Base Score, Performance Score and Bonus Point structure
- Offers the 2017 ACI Transition objectives and measures with fewer reporting requirements
- Modifies some measures in the ACI objectives available in 2017 and required in 2018
  - Reduction in the measure threshold for patient electronic access
- Reporting public health and clinical data registry reporting measures available for Bonus Points

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MIPS Alternative Payment Models

- CMS will use alternative scoring approach for participants in “MIPS APMs”

- Defined as APM with:
  - Participation agreement with CMS
  - One or more MIPS-eligible clinicians
  - Payment incentives based on quality and cost

MIPS Category	Weight for MSSP and Next Gen ACO	Weight for other MIPS APMs
Quality	50%	0%
Resource Use	0%	0%
CPIA	20%	25%
ACI	30%	75%

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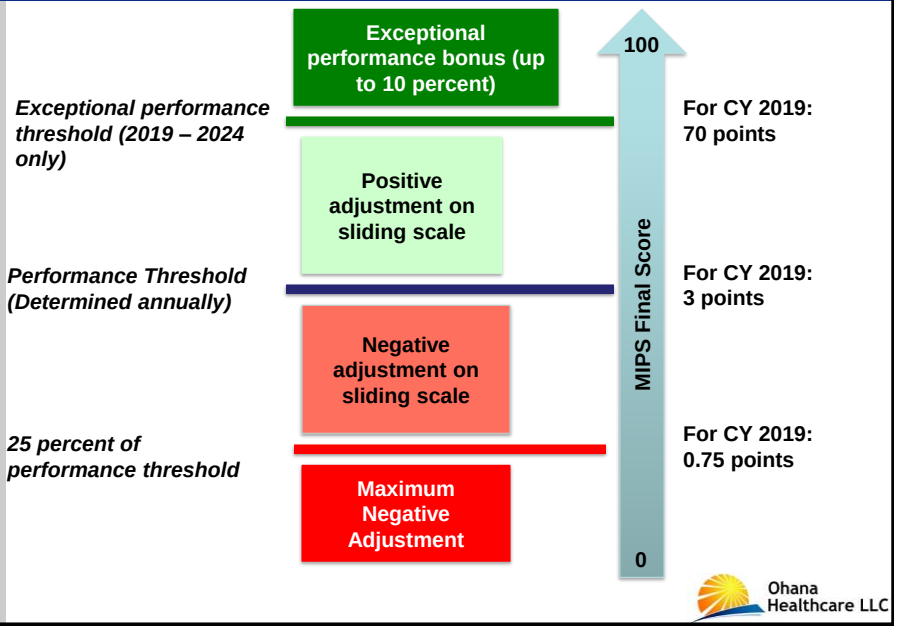
MIPS: Incentives and Penalties



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MIPS: Getting Started…

- Determine whether to participate as individuals or group practice
- Identify applicable quality measures and improvement activities
- Determine a reporting mechanism (e.g., registry, EHRs)
- Examine readiness of EHR systems

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Advanced APMs: Incentives

- **MACRA provides incentives for qualifying professionals (QPs)**
  - Lump-sum bonus payment of 5% of Part B payments for professional services
  - Exemption from MIPS reporting requirements and payment adjustments
  - Higher base rates beginning in 2026
- **Incentives in 2019 based on 2017 APM participation**

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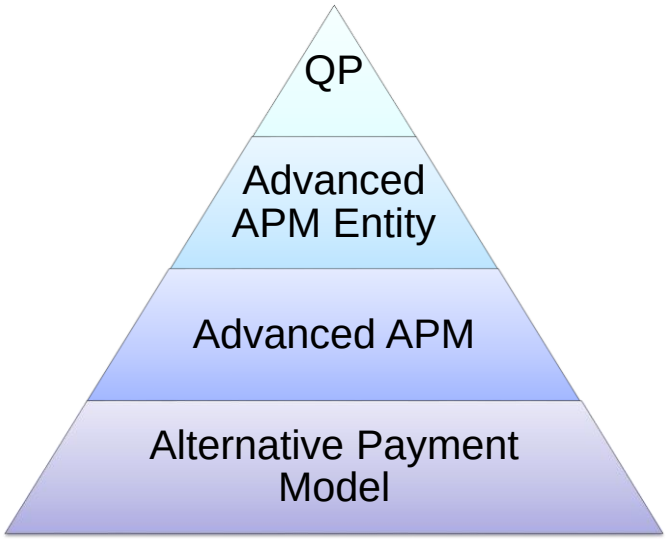
Determining QP Status



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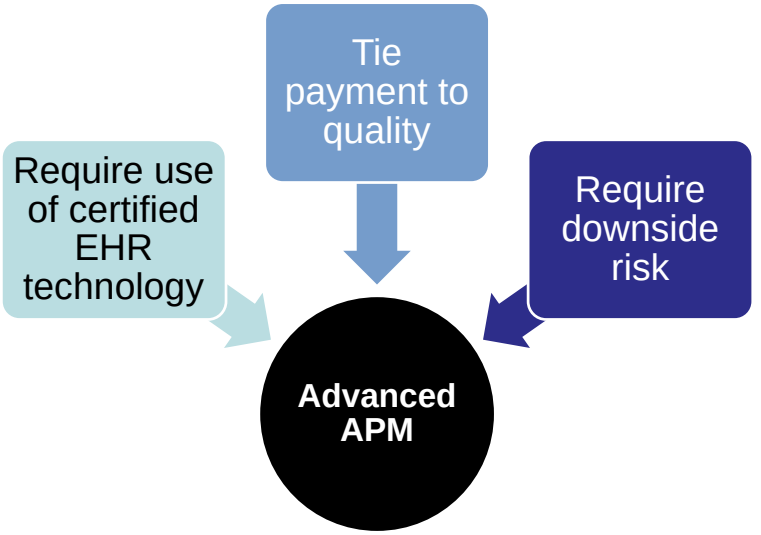
Advanced APM Criteria



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Advanced APM Criteria

Certified Use of EHR Technology	Quality Measurement
• Require 50 percent of clinicians to use certified EHR technology • Or, hospital if APM entity	• Base payment on at least one evidence-based, reliable and valid measure • At least one outcome measure

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Advanced APM Criteria

Financial Risk

General Standard

- Require repayment if actual spending exceeds expected
- Required potential risk:
  - 3% of APM entity's expected spending, or
  - 8% of total Parts A & B revenues of APM entity (2017-2018)

Medical Home Standard

- Require repayment based on spending ***or*** performance
- Currently only applies to CPC+ model
- Limited applicability after 2017 (organizations with <50 clinicians)

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Limited Medicare Models Available

Models that qualify in 2017:

- **MSSP Track 2**
- **MSSP Track 3**
- **Next Generation ACO**
- **Comprehensive ESRD Care**
- **Oncology Care Model (two-sided track)**
- **Comprehensive Primary Care Plus (as medical home)**

Models that do not qualify in 2017:

- **MSSP Track 1**
- **Bundled Payments for Care Initiative**
- **Comprehensive Care for Joint Replacement**

Other Payer Option

- **Other payer APMs** = Medicare Advantage, Medicaid, private payer arrangements
- Applicable to performance year 2019
- Advanced APM criteria parallel to those for Medicare advanced APMs
- CMS would require clinicians to submit information to verify eligibility of arrangements

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APM Entity Determinations

- **APMs with Participation List = group assessment**
- **APMs with Affiliated Practitioner List = individual assessment**

- **Clinicians in more than one APM but no one APM entity qualifies = individual assessment**

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APM Participation Thresholds

QP Payment Amount Thresholds

		2019-2020	2021-2022		2023 and beyond	
Medicare Option	QP	25%	50%		75%	
	Partial QP	20%	40%		50%	
All-payer Option	QP	N/A	25%	50%	25%	75%
	Partial QP	N/A	20%	40%	20%	50%
			Medicare	Total	Medicare	Total

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APM Participation Thresholds

QP Patient Count Thresholds

		2019-2020	2021-2022		2023 and beyond	
Medicare Option	QP	20%	35%		50%	
	Partial QP	10%	25%		35%	
All-payer Option	QP	N/A	20%	35%	20%	50%
	Partial QP	N/A	10%	25%	10%	35%
			Medicare	Total	Medicare	Total

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QP Determinations: Timing

- CMS will evaluate advanced APM participation based on “snapshots” of participation lists
  - March 31
  - June 30
  - August 31

- Once clinician is included in an APM entity, will be included in later snapshots even if no longer on participation list
- Subsequent snapshots allow APM entities to capture added clinicians

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Advanced APMs: Key Considerations

Participating in Advanced APM:

- Keep participation lists updated throughout year
- Estimate whether APM volume will meet thresholds; if not, evaluate voluntary MIPS participation

Not Participating in Advanced APM:

- For 2017, focus on MIPS reporting
- Consider Medicare APM options for 2018, all-payer arrangements for 2019

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Questions?

Marc Aguilar

CPC, CPMA, CPB, CDEO

COO

marc@ohanahc.com

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