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Scripps Health ACO Update

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10 Key Points from the 963 Page Proposed Rule

#1 Tight Timelines

MACRA Law Passed
April 14, 2015

Proposed Rule Published
April 27, 2016

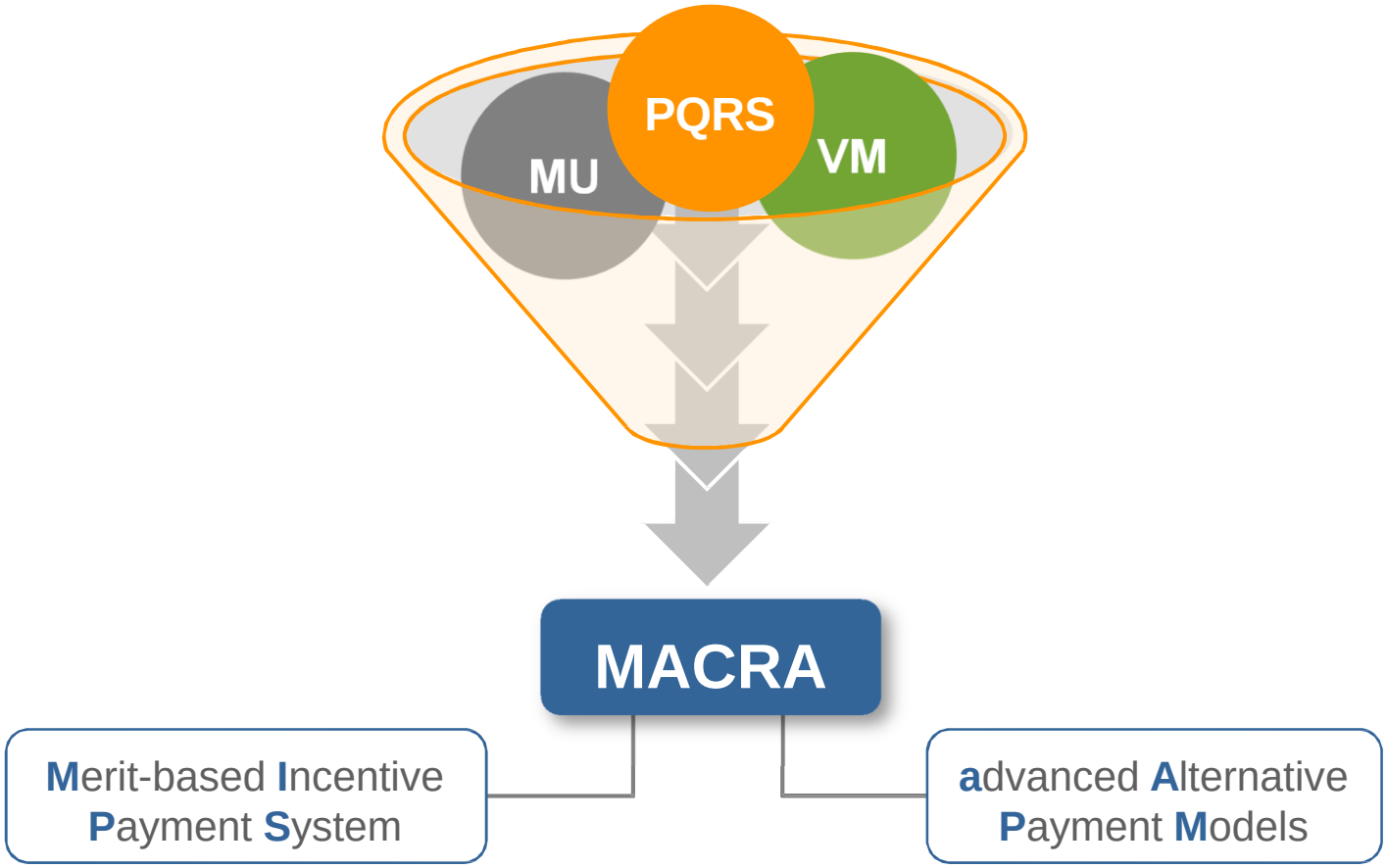
MSSP Application
July 29, 2016

Final Rule Expected
Fall 2016

First Performance Period Starts
Jan 1, 2017

Initial Payment Adjustments Take Effect
Jan 1, 2019

#2 MACRA Restructures Payments Around Clinician Performance

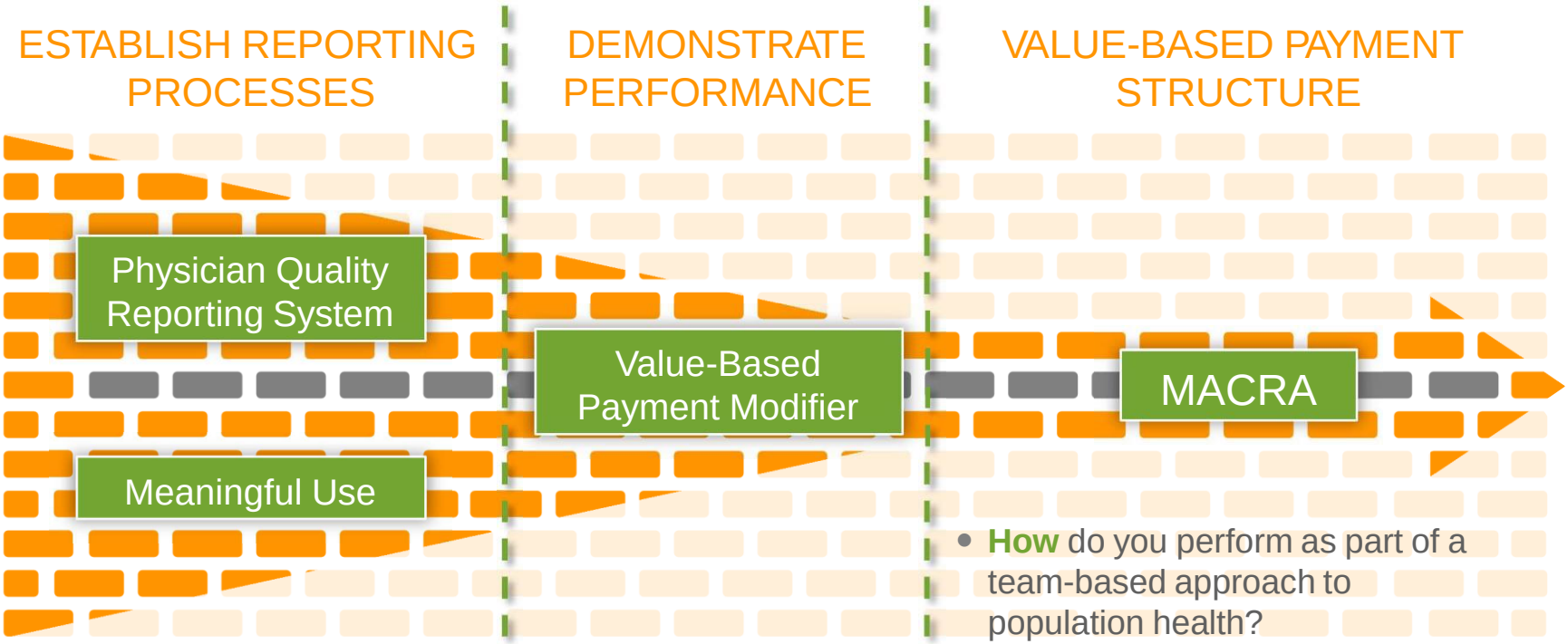


MU = meaningful use; PQRS = Physician Quality Reporting System; VM = Value-based Payment Modifier.
Sources: CMS. Proposed Rule: MIPS and APM Incentive Under the PFS. May 9, 2016; Sg2 Analysis, 2016.

KEY TAKE AWAY

Sg2 health care intelligence

#3 This is an evolution to outcome based payments



- **Can** you effectively report on quality measures?
- **Did** you adopt certified EHR?

- **Does** your practice preform well on cost and quality compared to peers?

- **How** do you perform as part of a team-based approach to population health?
- **How** are you using your EHR to improve patient outcomes?
- **How** are you implementing elements of medical home?

KEY TAKE AWAY

Sources: CMS. Proposed Rule: MIPS and APM Incentive Under the PFS. May 9, 2016; Sg2 Analysis, 2016.

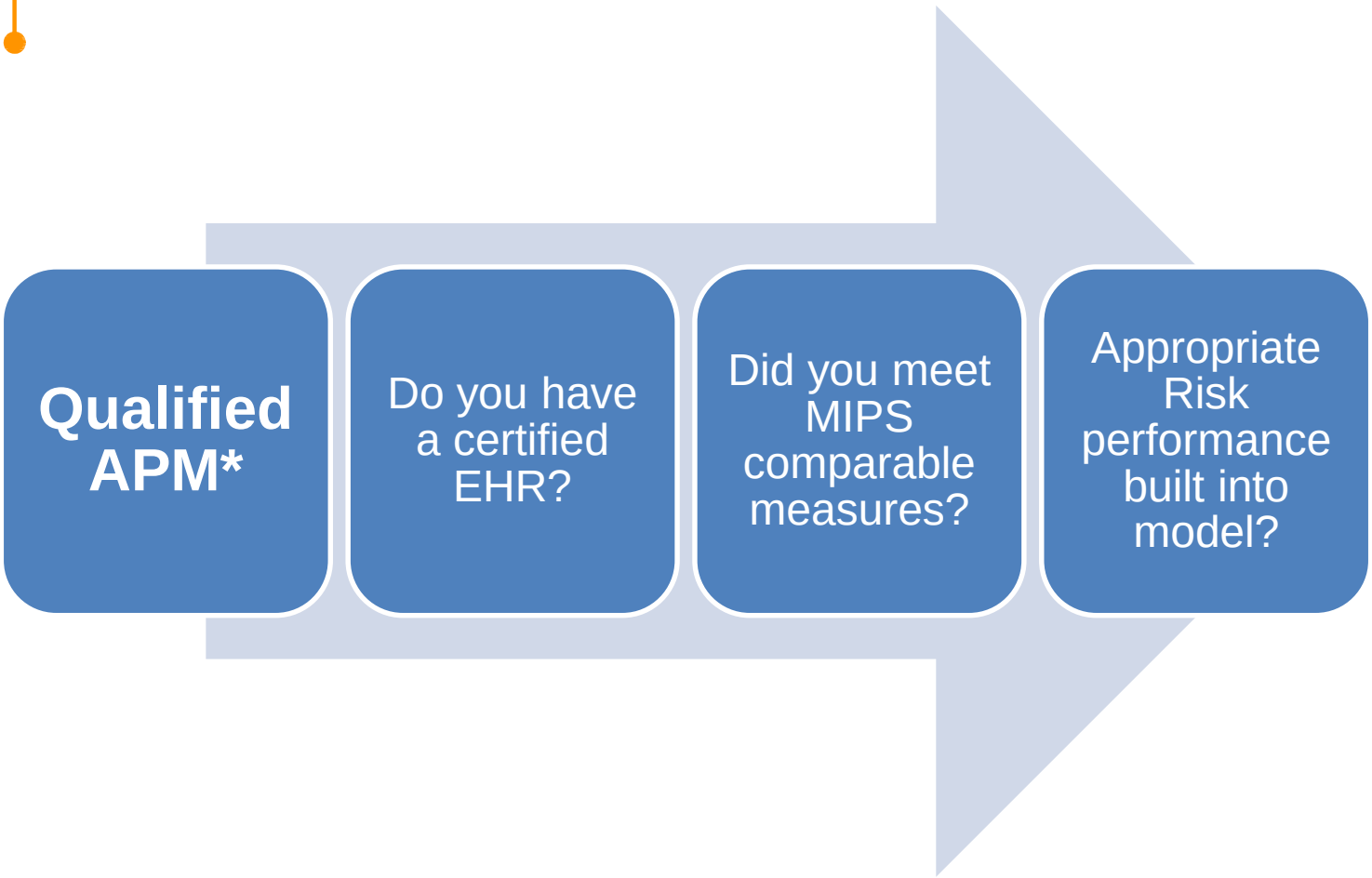
#4 MIPS will be the new normal

MIPS

- Performance will be tracked starting January 1, 2017.
- Most clinicians (~95%) will be under MIPS.
  - MIPS is the “new default” for Part B.
  - Most providers will receive “average” payment (read: little or no adjustments).
- The quality piece appears simplified, but it’s complicated.
  - Number of measures reduced, but some performance thresholds have gone up
  - The large list of quality and utilization metrics provides many reporting options for non-ACO clinicians, which could also be overwhelming.
  - CMS Quality Plan may modify measures annually
- There is an increasing focus on cost.
  - CMS does give clinicians some lead time to adjust to the cost category by gradually shifting the relative weighting of quality and cost categories over 3 years.
- EHR is no longer all-or-nothing meaningful use.
  - Select customizable metrics to report on that reflect technology use in day-to-day practice.

Sources: CMS. Proposed Rule: MIPS and APM Incentive Under the PFS. May 9, 2016; Sg2 Analysis, 2016.

#5 APMs eligibility has requirements



5% lump sum bonus payment 2019 - 2024

KEY TAKE AWAY

*MSSP Track 2 or 3, Oncology Care Model (two sided), CPC+, Comprehensive ESRD, Next Gen ACO

#6 APMs are different

aAPM

- Participation will be unknown during performance years.
  - All providers will report MIPs data until qualified provider status is determined at end of each performance year.
- Not everything counts.
  - MSSP Track 1 and/or participation in BPCI are currently not considered aAPMs.
- Few will qualify.
  - Although CMS projects less than 5% will qualify for aAPM incentives, Sg2 believes that this number will grow over time as the availability of aAPMs increases from both CMS and commercial payers.
- Expanded participation down the road
  - In later years, clinicians may qualify for aAPM incentives through models outside of traditional Medicare fee-for-service revenue (eg, commercial ACOs, Medicaid ACOs, Medicare Advantage)
- Deadlines soon approaching
  - Clinicians interested in qualifying or applying for aAPM incentives must act now.

Sources: CMS. Proposed Rule: MIPS and APM Incentive Under the PFS. May 9, 2016; Sg2 Analysis, 2016.

#7 APMs enrollments is by TIN

Physicians elect to join by Tax ID Number rather than individually

#8 A QRUR reports is a “Crystal Ball”

Practice Size	Eligible Clinicians	% Clinicians Receiving MIPS Penalty	% Clinicians Receiving MIPS Bonus
Solo	102,788	87%	13%
2–9	123,695	70%	30%
10–24	81,207	60%	40%
25–99	147,976	45%	55%
100+	305,676	18%	81%
Overall	**761,342**	**46%**	**54%**

#9 Are we exclusive?

Our practice TIN would like to affiliate with an ACO, however, we don't wish to be exclusive to that ACO. May we affiliate with an ACO as an "other entity" instead of as an ACO participant, even though our practice TIN is Medicare enrolled?

A Medicare-enrolled entity may enter into an agreement with an ACO as an "other entity". The "other entity" providers don't appear on the certified list of ACO participants and they wouldn't be used for program operations such as assignment. Therefore, they aren't required to be exclusive to a single Medicare Shared Savings Program ACO.

"Other entity" providers do not qualify for the 5% APM bonus

#10 Leadership is the key to success

Key point:
Strong ACO board needed to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care

(a) *General rule.* An ACO must maintain an identifiable governing body with authority to execute the functions of an ACO as defined under this part, including but not limited to, the processes defined under §425.112 to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care.

(b) *Responsibilities of the governing body and its members.*

(1) The governing body must have responsibility for oversight and strategic direction of the ACO, holding ACO management accountable for the ACO's activities as described in this part.

(2) The governing body must have a transparent governing process.

(3) The governing body members must have a fiduciary duty to the ACO and must act consistent with that fiduciary duty.

(4) The governing body of the ACO must be separate and unique to the ACO in cases where the ACO comprises multiple, otherwise independent ACO participants.

(5) If the ACO is an existing entity, the ACO governing body may be the same as the governing body of that existing entity, provided it satisfies the other requirements of this section.

So, What Can You Do?

1. Individual physician practices can participate in MIPS on their own, assuming they have, or can put the capability in place for 2019

-or-

2. Physicians can join Qualifying APM Programs (via TIN) like the Scripps ACO. Scripps will

- Create a legal entity and enable a physician governance group to govern the MSSP.
- Submit an MSSP *Track 3* application by July 29, 2016.
- Fund the infrastructure necessary for the MSSP application, data management, and governance for a January 1, 2017 start date.
- Be responsible for the downside risk
- Share the majority of upside savings with physicians, after recovery of administrative costs and losses from prior years of the MSSP.

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So, What Can You Do?

- Decide if you (everyone within your Tax ID Number) plan to participate in MIPS or an APM beginning in 2017.
  - Payment in 2019 is based on 2017 performance. If you wait until 2018 to join an APM, you will not be eligible for the 5% bonus until 2020.
- You will receive participation information and an agreement from the Scripps ACO for Medicare Shared Savings Program, Track 3 in mid June.
- If you wish to participate, you will need to sign and return the participation agreement by mid-July. The term of the agreement is 3 years, in conjunction with the MSSP term. Most physicians can participate in only one APM agreement.
- You can opt out of participation in the MSSP if you change your mind and notify the Scripps ACO prior to the January 1, 2017 start date. There are also other opt out provisions that will be included in the participation agreement.

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