

FALL 2016/WINTER 2017 EDITION

Medicare

Inside this Issue:

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CMS has Issued Final Rule on MACRA; Resources are Available to Help with Implementation

On Oct. 14, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to implement the Medicare Access and CHIP Reauthorization Act (MACRA). To learn more about MACRA, visit the CMS webpage dedicated to it by clicking [here](#).

An initial review by the American Medical Association (AMA) found that CMS responded to many of the concerns expressed by physicians about the proposed rule issued last spring.

Examples include:

- Details are provided about the 2017 transition period announced in September. The only physicians who will experience payment penalties in 2019 are those who choose to report no performance data next year, and those who report for at least 90-days will be eligible for positive payment adjustments.
- The low-volume threshold that exempts physicians from all performance reporting has been increased from \$10,000 in annual Medicare revenue and less than 100 Medicare patients to \$30,000 in revenue or 100 patients. CMS estimates that this change will exempt 32.5% of physicians and other clinicians from the program.
- Performance reporting requirements have been further reduced, and the resource use component of the Merit-based Incentive Payment System (MIPS) has been reweighted to zero for 2017.

CMS has created a resource library, [available here](#), that contains links to official information to help physicians prepare for success in the Quality Payment Program.

You can also [click here](#) to access the AMCNO webpage dedicated to MACRA for more information.

Physicians Need to Consider Immediate Action to Comply with Section 1557 - New ACA Anti-discrimination and Effective Patient Communication Posting Requirements

Earlier this year, the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (HHS) adopted final Federal regulations concerning the anti-discrimination mandate of Section 1557 of the Affordable Care Act. Section 1557 will require many medical practices that receive federal funding to post an anti-discrimination notice and provide information for effective communications as of October 16, 2016.

Under Section 1557, individuals are protected from discrimination in health care on the basis of race, color, national origin, age, disability, and sex, including discrimination based on pregnancy, gender identity, and sex stereotyping.

The Final Rule applies to those who provide or administer health-related services or insurance coverage and receive "federal financial assistance," which includes Medicare, Medicaid, meaningful use payments, Centers for Medicare and Medicaid Services gain-sharing demonstration projects, and other federal funds. Every healthcare provider must determine whether this rule applies to its operations.

Among the mandate, affected medical practices must conspicuously post notices containing the following information:

- The medical practice does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- The availability of auxiliary aids and interpreter services to people with disabilities or limited English proficiency for purposes of effective communications.
- The procedure for reporting a complaint.
- Where to file a discrimination claim with the OCR.
- Medical practices with 15 or more employees need to provide contact information for the employee responsible for coordinating Section 1557 compliance investigations within the medical group.

Additionally, medical practices must post "taglines," which are short statements indicating the availability of language-assistant services free of charge. Notices and taglines must also be posted on the medical practice's website.

Affected medical practices, regardless of the number of employees, must **develop a written plan outlining the procedure** that will ensure the adequate and timely provision of language-assistant services. In addition, medical practices with 15 or more employees need to designate a coordinator to handle Section 1557 complaints. Private medical practices, ambulatory surgery centers, and other providers that receive any federal funds should assess whether they need to become compliant with the October 16 deadline notice requirements. Failure to act could expose health care providers to considerable penalties or legal sanctions. Complaints to OCR can result in investigations by HHS and the Department of Justice.

To assist with implementation, OCR has translated into 64 languages a [sample notice and taglines](#) for use by covered entities. In addition, OCR has published a [summary of the rule](#), [factsheets on key provisions](#) and a list of [frequently asked questions](#).

Transitioning from PQRS and MU to MIPS

The Patient Protection and Affordable Care Act (ACA) of 2010 was landmark legislation that created the National Quality Strategy (NQS) and included the redesign of Medicare's fee-for-service (FFS) payment structure. Medicare adapted the NQS with the express purpose of becoming an active purchaser of quality healthcare instead of a passive payer for medical services. As the Medicare Quality Innovation Network-

Quality Improvement Organization (QIN-QIO) for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands, Health Services Advisory Group (HSAG) provides technical assistance to healthcare providers to help in making this transition to payment for quality clear and seamless.

HSAG's current work supports physician incentive programs including the Physician Quality Reporting System (PQRS) and Meaningful Use (MU). PQRS serves as the foundation for assessing the quality of care individual or group practices provide through electronic health record (EHR) submission of evidence-based quality measures. However, 2016 is the last year that quality measures and EHR MU attestation are required for providers who bill Medicare FFS. As set out in the new Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation signed into law in April 2015, providers will now submit quality measures through the Merit-based Incentive Program System (MIPS). MACRA replaces the Medicare Sustainable Growth Rate (SGR) and puts into place two types of quality payment programs: Alternative Payment Models (APMs) and MIPS.

MACRA streamlines PQRS, MU, and the value-based modifier into one quality program, MIPS. Its requirements mirror the PQRS quality measures and MU requirements (with only six instead of nine quality measures reported), with additional requisites for health information exchange, patient care coordination, and interoperability. Data submission methods remain the same: EHR, qualified registry, web interface, clinical data registry, and claims.

Regardless of which data submission method the provider chooses, HSAG is here to provide technical assistance to make the transition to MACRA logical and efficient. For more information, contact Howard Pitluk, MD, MPH, FACS, HSAG, Vice President for Medical Affairs & Chief Medical Officer, at hpitluk@hsag.com.

This material was created by Health Services Advisory Group, the Quality Improvement Organization for Arizona, California, Ohio, Florida, and the U.S. Virgin Islands, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

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CMS Changes MACRA Regulations Based on Physicians' Concerns

Last April, the Centers for Medicare & Medicaid Services (CMS) issued a draft regulation proposing a requirement for physicians to begin reporting under the Merit-based Incentive Payment System (MIPS) or through the advanced alternative payment model (APM) option on Jan. 1, 2017, under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), even though the final regulations for the payment system changes wouldn't be issued until this fall.

Following news of the draft proposal, physician organizations had voiced their concerns about the proposed start date. In a recent [blog posting](#), Andrew Slavitt, Acting Administrator for CMS, acknowledged the physicians' concerns and stated that based on the feedback they received, CMS has decided that the final MACRA regulation will exempt physicians from any risk of penalties if they choose one of three distinct MIPS reporting options in 2017, along with the option of participating in an advanced APM:

- Full-year reporting that begins on January 1;
- Partial year reporting for a reduced number of days; and
- A "test" option under which physicians can report minimal amounts of data.

Among the physicians who report in 2017, and depending on which option they choose, they may be eligible for bonus payments in 2019. Those who opt for full-year reporting will be eligible to receive a modest positive payment adjustment, and those who choose partial year reporting will be eligible for a small positive payment

adjustment, according to CMS. Physicians who choose the “test” option will not be subject to any payment adjustments. Qualified participants in advanced APMs will be eligible for 5% incentive payments in 2019.

The American Medical Association (AMA) praised Slavitt and Department of Health & Human Services Secretary Sylvia Burwell for listening to physicians and providing the necessary flexibility to launch a successful payment system under MACRA. Visit the AMA’s webpage dedicated to MACRA by [clicking here](#).

PQRS and QRUR Reports are Now Available

On Sept. 26, the Centers for Medicare & Medicaid Services (CMS) released the 2015 Physician Quality Reporting System (PQRS) Feedback Reports and the 2015 Annual Quality and Resource Use Reports (QRURs).

The PQRS reports show a physician’s program year 2015 PQRS reporting results, including payment adjustment assessment for calendar year 2017. The QRUR reports show how physician groups and physician solo practitioners performed in 2015 on the quality and cost measures used to calculate the 2017 Value Modifier as well as their 2017 Value Modifier payment adjustment. These reports also contain information about care delivered to Medicare beneficiaries that can be used to better understand and improve quality and cost performance under the Value Modifier, including information about hospitalizations and other providers that can be used to improve quality and better coordinate care, according to CMS.

You must access the reports through an Enterprise Identity Management (EIDM) account with the appropriate role. If you already have an account, follow the instructions [provided here](#) to sign up for the appropriate role in EIDM. To sign up for an EIDM account, visit the [CMS Enterprise Portal](#) and click “New User Registration” under “Login to CMS Secure Portal.” The instructions for signing up for EIDM account are [provided here](#).

To learn more about PQRS reports, [click here](#). To learn more about how to obtain a QRUR, [click here](#).

The CGS Administrators Newsletter is Available on the AMCNO Website

The summer 2016 edition of the CGS Administrators J15 newsletter has been posted on the AMCNO website for review. This newsletter is provided to the AMCNO by CGS on a regular basis. The newsletter contains a wealth of information from CGS for providers and their staff. To view the newsletter, [click here](#).



Medicaid

CMS Denies Healthy Ohio Program Waiver

Previously, we informed you of the 1115 Demonstration Waiver request the Ohio Department of Medicaid (ODM) submitted to the Centers for Medicare & Medicaid Services (CMS) to implement the Healthy Ohio program, as required in law by the FY16/17 Operating Budget (review the article [here](#)). Now, CMS has announced that they have denied the waiver for several reasons, which you can read in the [letter](#) they sent to Medicaid Director John McCarthy.

In 2015, Gov. John Kasich proposed Medicaid enrollees who are not disabled and have income above 100% of poverty pay a portion of their insurance premiums, which is the norm for private health insurance. The final

version of the budget replaced the Administration's premium program with a legislative requirement to enroll most Medicaid recipients into health savings accounts regardless of income. The Kasich Administration has stated that they will restart talks with the General Assembly about other options to ensure greater personal responsibility as they had outlined in their request.

For more information about the Healthy Ohio program, [click here](#).

Ohio Department of Medicaid Releases 2016 Managed Care Plans Report Card

In a continuation of the state's efforts to inform consumers and provide incentive for health plans to improve their services, the Ohio Department of Medicaid (ODM) has released its second annual report card for Ohio Medicaid managed care plans.

To compile the report, ODM used data provided by the plans and patient surveys to evaluate each plan on the following five categories: access to care, doctors' communication and service, keeping kids healthy, managing illness, and women's health.

CareSource had the highest rankings, scoring above average in three categories (keeping kids healthy, managing illness, and women's health), and scoring average in the other two categories.

Molina Healthcare scored above average in two categories (managing illness and women's health), and improved this year to average in access to care.

UnitedHealthcare Community Plan scored above average in two categories (access to care and doctors' communication and service), but scored below average in two categories (managing illness and women's health).

Buckeye Health Plan scored above average in women's health and average in doctors' communication, but was ranked below average in the remaining three categories.

Paramount Advantage received average scores in all five categories.

To view the complete report card, [click here](#).

Anthem

To access the Anthem October Network Update, [click here](#).

UnitedHealthcare

To access the October UnitedHealthcare Network Bulletin, [click here](#).

To access the November UnitedHealthcare Network Bulletin, [click here](#).

Medical Mutual

To view recent Medical Mutual provider updates, [click here](#).

AMCNO Attends Ohio BWC Fall Stakeholder Meeting

The Ohio Bureau of Workers' Compensation (BWC) held its fall Medical Provider Stakeholder Meeting recently, and AMCNO staff attended the event via video conference.

Tammie Mihaly, Manager of Provider Relations, gave an overview of the agenda, which included the following topics: Medical Services Administration Update, BWC Innovations in Spine Care, Enhanced Care Program Update, and ICD-10 Transition Refinement, among several others.

Of particular note, **Mary Charney**, Nursing Director, discussed the 2017 Medical & Health Symposium. It will be held March 9-10, 2017, in Columbus and will feature 250 continuing education sessions from national and state-level speakers. Registration is free for the event. The full agenda will be coming out soon and will be available on the [BWC website](#).

Also, **John Hanna**, Director of the Pharmacy Department, talked about the BWC's stance on opioids, formulary revisions, changes to the Prior Authorization process, and medical marijuana. In addition, Tammie Mihaly updated attendees on the BWC system transition, which the AMCNO reported on in [this article](#).

The next meeting is scheduled for May 2017.

BWC Issues Opioid Rule for Prescribers

On Oct. 1, 2016, the BWC implemented their new opioid prescribing rule that applies to all BWC-certified prescribing physicians. The rule will help prevent opioid dependence for Ohio's injured workers through its three primary goals that:

- Encourage prescribers to incorporate best clinical practices when prescribing opioids for treating Ohio's injured workers;
- Establish provisions and criteria for treating opioid dependence that arises secondary to treatment with opioid medications covered by BWC;
- Provide and strengthen BWC's peer review processes for opioid prescribing that addresses serious noncompliance with best practices.

BWC is also working on educational materials that prescribers can share with injured workers.

Prescribers are asked to pay attention to the duration of time an injured worker may be on opiates. BWC also has established prescriber duration dose checkpoints to review pain treatment plans; they are as follows:

- 50 mg MED/Day for more than six weeks after injury or during the subacute injury phase;
- 80 mg MED/Day or for more than 42 to 84 days;
- 80 to 120 mg MED/Day or for more than 12 weeks for the chronic pain phase.

The BWC has also made sure the new rule includes policies for supporting an injured worker and his or her physician if the injured worker receiving opioids covered by BWC wants to stop using them. BWC will reimburse for opioid treatment programs that include medication-assisted treatment, behavioral and psychological counseling and inpatient detoxification. If necessary, BWC will reimburse for up to 18 months as long as the injured worker follows the plan developed collaboratively with his or her physician. For added safeguards, this rule also allows the injured worker to relapse twice during the 18-month period. The injured worker may complete these programs without adding drug dependency as an allowed claim condition as long as the injured worker has a treatment plan. For more information visit the BWC website at www.bwc.ohio.gov.

CDC's Clinician Outreach and Communication Activity Resource Provides Zika Update

Recently, the Clinician Outreach and Communication Activity—a resource provided by the Centers for Disease Control and Prevention—released an update concerning the Zika virus. During a free CME session, representatives reviewed the new guidelines, which focus on clinical laboratory testing and the care of infants with congenital Zika virus infection.

It's estimated that more than 1,000 pregnant women in the United States and its territories show laboratory evidence of possible Zika virus. Challenges with diagnosing the infection exist, however, and the new guidelines help address these issues.

To learn more about what was discussed and to review slides from the presentation, [click here](#).

You can also view the AMCNO webpage dedicated to Zika to learn more about the virus by [clicking here](#).

SMBO Clarifies Letters Sent to Prescribers Concerning OARRS Violations; Sends New Letters from September Data

Ohio law requires all prescribers of opioids or benzodiazepines to register for and consistently use Ohio's Automated Rx Reporting System (OARRS). And, Guidelines for the Management of Acute Pain Outside of Emergency Departments were established in January. Now that the law and guidance are in place, the State Medical Board of Ohio (SMBO) has begun to use OARRS data to identify and contact prescribers who have failed to register for OARRS or who demonstrate a pattern of failure to check patients in OARRS.

In October, the SMBO contacted approximately 12,000 physicians who appeared in a report from the Ohio State Board of Pharmacy that they may be in violation of the OARRS law. The SMBO has since clarified that the vast majority of those 12,000 physicians have non-egregious issues and minimal non-compliance matters that need to be addressed. In fact, they stated that the median number of non-checks for each prescriber was in the single digits.

The SMBO added that the intent of the letter was to encourage physicians to check their individual OARRS report, identify if/how a check was missed, and make any necessary adjustments to office procedures to prevent missed checks in the future. Often a quick review of OARRS practices can correct most issues, they said. Resources are available [here](#).

In fewer than 1% of all instances, licensees had prescribed opioids or benzodiazepines without checking OARRS at rates that warrant additional, personalized discussion.

Medical organizations across the state, including the AMCNO, were concerned about the tone and content of the original letter and shared our concerns with the SMBO, which subsequently led to the clarified letter.

In the meantime, the SMBO received and processed September data from the Board of Pharmacy concerning OARRS data, and the SMBO has started contacting the specific prescribers who have been identified as potentially not having checked OARRS for at least one prescription of opioids or benzodiazepines during the month of September.

The SMBO letters provide a communication based on the range of reported unchecked OARRS records: less than 20, 21-50, and more than 50.

In addition, a news release issued by Governor John Kasich's office indicates that since contacting 12,000 prescribers in late September who were found to have some type of violation of the OARRS law, more than 1,800 new accounts have been created in OARRS, and daily use of the system has increased from 83,544 requests to more than 96,300 per workday. The AMCNO will continue to monitor this issue.

For more information, you can also visit the SMBO website: www.med.ohio.gov.

State Medical Board of Ohio Reports Recent Activities

The State Medical Board of Ohio (SMBO) released its annual report on August 1; the AMCNO article about the report is available by [clicking here](#). The SMBO has also reported additional activities in their latest newsletter, including a new lead testing video and changes to wallet cards.

To help reduce pediatric exposure to lead, the SMBO and Ohio Department of Health collaborated on a new video that outlines blood lead testing guidelines for children. Under Ohio law, primary healthcare providers are required to administer blood lead tests to at-risk children. This training video contains information on risk factors, screening and medical management of lead poisoning. Although the module isn't mandatory, its review is strongly encouraged. The video is available [here](#).

The SMBO is no longer automatically printing wallet cards for each license that is issued or renewed, but providers can print a copy of their credentials for proof of licensure from the SMBO website: www.med.ohio.gov. Starting in the spring of 2017, applicants will have the option to print a wallet card from the online eLicense system.

Additional updates found in the SMBO's newsletter can be viewed [here](#).

Ohio State Board of Pharmacy Amends Draft Compounding Rules Again

In response to concerns brought forward by the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and other local and national physician associations, the Ohio State Board of Pharmacy (OSBOP) has amended the draft compounding rules again.

The AMCNO, Ohio State Medical Association (OSMA), and other physician associations have been communicating with the pharmacy board to express their concerns on a regular basis since the rules were released in May 2016. ([Click here](#) to review one of our joint letters to the BOP.) In response to these concerns the pharmacy board delayed the implementation of the rules that governed the practice of compounding dangerous drugs in physician offices.

Initially, the board created a new set of draft rules adding the "immediate use" rule that exempts physicians from having to invest in costly environmental control equipment, as long as compounded drugs are used within a 6-hour time period. While this amendment was appreciated by the physician community, there were still sections of the compounding rules that would restrict physicians from compounding in the manner that is consistent with the current standard of care.

The following additional changes were made to the draft rules.

Reconstitution will NOT be considered compounding.

- The reconstitution or dilution of a conventionally manufactured nonsterile dangerous drug product with no intervening steps in accordance with the manufacturer’s labeling for administration and beyond use dating. Any other reconstitution or dilution of a conventionally manufactured nonsterile product is considered compounding and shall be performed in accordance with United States Pharmacopeia Chapter <795>, USP 39-NF 34, or any official supplement thereto (6/30/2016).
- The reconstitution or dilution of a conventionally manufactured sterile dangerous drug product with no intervening steps in accordance with the manufacturer’s labeling for administration and beyond use dating. These drug products shall be prepared using aseptic technique and procedures shall be in place to minimize the potential for contact with nonsterile surfaces and introduction of particulate matter or biological fluids. Any other reconstitution or dilution of a conventionally manufactured sterile product is considered compounding and shall be performed in accordance with this rule.

Preparation of Cosmetic Fillers will not be considered Compounding

- The Board exempted the reconstitution or preparation of a drug device from its definition of compounding. The FDA classifies fillers as drug devices.

Closed System Transfer Devices will not be required when compounding

- The Board removed this requirement from the rules.

The rule drafting process is not yet complete and many still have concerns about the most current draft of the compounding rules. The rules have entered the formal review process and will undergo more regulatory scrutiny and possible additional changes before being made final.

The AMCNO will continue to keep our members informed about this important issue.

Reduce Your Workers’ Compensation Premiums through the AMCNO Group Rating Program

Join other AMCNO members already seeing their annual workers’ compensation premium reduced by participating in group rating, group retrospective rating or other alternative discount programs available in Ohio.

Through our workers’ compensation third party administrator, **CompManagement, Inc.**, your organization can see how participation in a program will impact your costs as well as how these programs can be stacked together to achieve the **maximum savings** available for your organization.

Don’t miss your opportunity to be evaluated for participation in an incentive/premium discount program. Discounts vary by program but are as high as 53%, the maximum discount allowed by BWC.

Simply [click here](#) to complete the Temporary Authorization to Review Information (AC-3) form or contact CompManagement at (800) 825-6755, select option 3, and speak to a customer support representative.

Let CompManagement, our Workers’ Compensation third party administrator, work harder for you for your best cost savings solutions.

What Should I Know about MACRA Alternative Payment Models?

*By LaDonna Kessler, CMUP, and Tamiya Williams, CMPE
Senior Managers at Medic Management Group, LLC*

The implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislative proposal includes significant changes to the way providers will attest to quality improvements and technology

use, but also includes a heavy emphasis on value-based reimbursements, alternative frameworks for payments, and patient-centered care.

What's the difference between MIPS and APMs?

There are two paths for participation in the quality improvement programs included in the MACRA legislation for Eligible Clinicians (EC): the Merit-Based Incentive Payment System (MIPS) and the Alternative Payment Models (APMs).

Clinicians will need to begin attestation under one of these two models in 2017 and will receive their first payments under the new framework in 2019. Both MIPS and APMs are value-based payment models that incentivize providers on quality, outcomes and cost containment.

MIPS is a program that streamlines parts of the Physician Quality Reporting System, the Value-based Payment Modifier and the Medicare Electronic Health Record (EHR) Incentive Program into one single program called the Quality Payment Program. Under MIPS, ECs will be measured on quality, cost, clinical practice improvement and use of certified EHR technology.

Under MACRA, 50% of the MIPS score would be based on quality, 25% of the score would be based on care information. The cost category would make up 10% of the score. This category would involve Medicare claims and would use 40 episode-specific measures to account for differences among specialties. Clinical Practice Improvement category makes up the remaining 15%.

Clinicians who are in their first year of Medicare participation and those who successfully participate in the APM track are exempt from attesting to the MIPS program—if they qualify for bonus payments.

The APM program, on the other hand, includes the Medicare Shared Savings Program (MSSP) ACOs, all CMS Innovation Center initiatives except Health Care Innovation awards, and certain demonstration programs. Only certain APMs will be categorized as an “eligible APM” under the MACRA proposal.

MACRA requires that payments under an APM be based on quality measures that are comparable to those used in the MIPS program. To qualify for payments, the APMs must also use certified EHR technology, report on certain quality measures, and bear more than nominal financial risk. Overall, APMs offer greater potential financial risks and rewards than MIPS.

It is important to note that not all providers who participate in an APM will qualify for an exemption to MIPS attestation, though they will receive favorable scoring under MIPS for undertaking an APM agreement. Only those providers participating in Advanced APM structures will have the potential to escape MIPS attestation.

What are Advanced APMs?

Advanced APMs are very similar to APMs. They just have a few additional requirements. According to MACRA, there are actually two types of advanced APMs: Advanced APMs and Other Payer Advanced APMs.

Advanced APMs must:

- Require participants to use Certified EHR Technology
- Provide payments based on quality measures comparable to those used in MIPS
- Require participants to adopt a Medical Home Model or accept more than a nominal amount of financial risk

To qualify as an Other Payer Advanced APM, a commercial or Medicaid APM must:

- Require participants to use Certified EHR Technology

- Provide payments based on quality measures comparable to those used in MIPS
- Require participants to adopt a *Medicaid* Medical Home Model or bear financial risk for more than a nominal amount

The Medical Home Model requirement is what sets the Advanced APM apart from regular APMs. Success under the Advanced APM umbrella may allow participants to become qualifying APM participants (QPs), which can produce additional financial incentives.

What are the financial implications of MIPS, APMs and Advanced APMs?

Under MIPS, providers' base rate of Medicare Part B payment would be adjusted based on a composite performance score. Providers would receive positive, negative, or neutral adjustments. In 2019, the maximum negative payment adjustment is -4%, but a positive payment adjustment could be as much as +12% when the bonus potential is accounted for. The baseline then incrementally increases to +/-9% in 2022 and onward.

Each of the four MIPS performance categories are weighted to help determine performance. For 2019 to 2024, CMS will give an additional payment adjustment to the highest MIPS performers for exceptional performance.

QPs in one or more eligible APMs will be exempt from MIPS, receive a 5% bonus on Medicare Part B services, and receive higher annual increases in their payments.

According to the Healthcare Financial Management Association, MACRA identified specific eligible APMs that will qualify for bonus payments and exemption from MIPS reporting. These include:

- Next Generation ACO
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program (MSSP) Tracks 2 and 3
- Oncology Care Model with two-sided risk
- Comprehensive ESRD Care (for large dialysis organizations)
- An additional proposed ruling has been submitted to qualify Bundled Payment Models as an Advanced Payment Model

However, 95% of MSSP ACOs are participating in Track 1 of the program, which would not qualify them for an exemption from MIPS. These providers, who do not currently accept downside risk from Medicare, would have to attest to the MIPS program instead.

Additionally, under MACRA, a bonus payment would be made to providers who operate under the most advanced APMs. Advanced APMs would still be able to get APM specific rewards. However, clinicians would also be subject to a quality performance score that could lead to reductions or increases in their Medicare reimbursement.

Who can receive financial incentives under the eligible APM framework?

An Advanced APM that expands the Medical Home Model or requires participants to accept a significant amount of downside financial risk is considered to be an "eligible APM," according to MACRA law. Eligible APMs are able to gain even more financial benefits compared to MIPS and regular APMs. Eligible APM participants can get specific rewards as well as a 5% lump sum bonus.

How do ECs become a Qualifying APM Participant (QP)?

Clinicians that participate in the most advanced APMs may be able to become qualifying QPs. QPs are exempt from MIPS. They will receive 5% lump sum bonus payments for years 2019-2024. They will also receive a higher level of reimbursement during fee schedule updates for 2026 and going forward.

QPs are providers who receive 25% of their payments through an eligible APM. Starting in 2021, this threshold percent may be reached through a combination of Medicare and other non-Medicare payer arrangements, such as Medicaid and private payers.

Websites referenced for this article: MGMA.com, RevCycleIntelligence.com, and CMS.gov.

Ohio Medical Marijuana Law to Take Effect in September

By Cassandra Manna, JD, Roetzel and Andress, LPA

Ohio's new medical marijuana bill (HB 523) becomes effective on September 6, 2016. Passed by the Ohio General Assembly at the end of May and signed by Governor Kasich on June 6, the law makes Ohio the 25th state to pass a medical marijuana bill. The new law will have far-reaching effects on the business community but it is silent on many issues that concern employers.

Below is a summary of the law. We have listed facts for ease of reference; issues not fully addressed by the law are also noted.

Who can legally use medical marijuana?

1. Only people with the following medical conditions can legally use medical marijuana:
2. HIV/AIDS
3. ALS – Amyotrophic Lateral Sclerosis
4. Alzheimer's Disease
5. Cancer
6. CTE – Chronic Traumatic Encephalopathy
7. Crohn's Disease
8. Epilepsy or other seizure disorders
9. Fibromyalgia
10. Glaucoma
11. Hepatitis C
12. Inflammatory Bowel Disease
13. Multiple Sclerosis
14. Pain – chronic, and severe or intractable
15. Parkinson's Disease
16. PTSD – Post-Traumatic Stress Disorder
17. Sickle Cell Anemia
18. Spinal Cord Disease or injury
19. Tourette's Syndrome
20. Traumatic Brain Injury
21. Ulcerative Colitis

How and where do patients get medical marijuana?

Patients will need a recommendation from a doctor to receive a medical marijuana prescription. They must have an ongoing relationship with the doctor. The bill does not say where patients will get medical marijuana.

Patients will have to receive the marijuana from states with legal dispensaries or will have to obtain it in other manners.

What are the rules and regulations for medical marijuana?

The bill is silent on direct rules and regulations. The bill calls for the formation of a bipartisan Medical Marijuana Advisory Committee within the Board of Pharmacy. The Committee must include two pharmacists, two physicians, a nurse, a researcher, and a member from each of a listed interest group. The committee will issue recommendation related to the Medical Marijuana Control Program.

Additionally, the Department of Commerce, Ohio State Pharmacy Board, and Ohio State Medical Board will need to determine how many licenses to issue and the guidelines for writing a marijuana prescription and filling that prescription.

What are the rules for and the steps to receiving a license?

No rules for or steps to receive a license have been established at this time. The rules, standards, and regulations will be established by the Medical Marijuana Control Program (the Program). The Program will be housed within the department of commerce and the board of pharmacy. The Program will issue four different licenses. First, a party can obtain a cultivator license for growing medical marijuana. Second, a party can obtain a processor license for processing the marijuana plant into a legal consumable form. Third, a party can obtain a laboratory license for testing and research purposes. Finally, a party can obtain a retail dispensary license for distributing the medical marijuana to registered patients and caregivers. The department of commerce will adopt the rules establishing standards and procedures for the Program for cultivators, processors, and laboratories. The board of pharmacy will adopt rules establishing standards and procedures for the retail dispensaries.

The department of commerce must establish the following standards and procedures for the Program's processor and laboratory licenses by September 6, 2017, and for cultivator licenses by May 4, 2017:

1. Application procedures and fees for licenses and registration
2. All of the following:
 - a. Conditions for eligibility for a license
 - b. Criminal offenses that disqualify a party from obtaining a license
 - c. Criminal offenses that do not disqualify a party from obtaining a license if the offense is more than five years old
3. Number of cultivator licenses allowed at any time
4. Establish license renewal schedule, procedures, and fees
5. Specify reasons license suspended, revoked, or renewal withheld
6. Standards to lift license or registration suspension
7. Determine whether a cultivator or processor that existed at a location before a school, church, public library, public playground, or public park became established within 500 feet of the cultivator or processor may remain in operation, shall relocate, or have license revoked
8. All of the following:
 - a. Criminal offenses that disqualify a person from employment with a license holder
 - b. Criminal offenses that do not disqualify a person from employment with a license holder if the offense is more than five years old
9. Standards and procedures for testing medical marijuana by a licensed laboratory

The board of pharmacy must establish the following standards and procedures for the Program's retail dispensary licenses by September 6, 2017:

1. Application procedures and fees for licenses and registration
2. All of the following:
 - a. Conditions for eligibility for a license
 - b. Criminal offenses that disqualify a party from obtaining a license
 - c. Criminal offenses that do not disqualify a party from obtaining a license if the offense is more than five years old
3. Number of retail dispensary licenses allowed at any time
4. Establish license renewal schedule, procedures, and fees
5. Specify reasons license suspended, revoked, or renewal withheld
6. Standards to lift license or registration suspension
7. Procedures and requirements for registration of patients and caregivers
8. Training requirements of employees of retail dispensaries
9. Determine whether a retail dispensary that existed at a location before a school, church, public library, public playground, or public park became established within 500 feet of the cultivator or processor may remain in operation, shall relocate, or have license revoked
10. Specify by form and tetrahydrocannabinol content the 90-day supply allowed for possession by a patient
11. Paraphernalia and accessories allowed to administer weed to registered patient
12. Procedures for issuance of patient and caregiver identification cards
13. Forms and methods of medical marijuana use attractive to minor patients
14. All of the following:
 - a. Criminal offenses that disqualify a person from employment with a license holder
 - b. Criminal offenses that do not disqualify a person from employment with a license holder if the offense is more than five years old
15. Establish a program to assist veterans and indigent patients in obtaining medical marijuana

In addition, the law states that no less than 15% of all licenses available must go to Ohio residents who are also a member of one of the following economically disadvantaged group: Blacks/African Americans, American Indians, Hispanics/Latinos, and Asians.

Again, the rules, standards, and procedures for the Program have not been established. This is an overview and list of the rules, standards, and procedures the Program must develop once it is established and functioning; until then, no licenses are available. Roetzel will continue to provide updates as more information is released but do not hesitate to contact the firm with further questions or concerns.

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SMBO Medical Marijuana Update

What is required of a physician to recommend medical marijuana now that House Bill 523 is effective?

A physician is not permitted to issue a state of Ohio approved written recommendation to use medical marijuana until the physician has obtained a certificate to recommend from the State Medical Board of Ohio. Per House Bill 523, the rules outlining the standards and process needed to obtain such a certificate to recommend will be developed no later than September 8, 2017.

As a way to protect patients and parents or guardians of minor patients who seek to use marijuana prior to the creation and implementation of all the administrative rules necessary to run the Ohio Medical Marijuana Control Program, HB 523 created an affirmative defense for certain marijuana-related crimes. According to the law, a patient, parent, or guardian can only raise an affirmative defense if they have, among other requirements, received a written recommendation from his or her doctor that certifies a certain number of criteria are met. The Board recommends that physicians consult with their private legal counsel and/or employer for interpretation of the legislation.

Read more at medicalmarijuana.ohio.gov.

Save the Date: March 24-25, 2017, AMCNO/CMBA Medical Legal Summit

The 2017 Medical Legal Summit will be held March 24-25 at the Cleveland Metropolitan Bar Association (CMBA) Conference Center. This annual event is co-sponsored by the AMCNO, CMBA, and the Academy of Medicine Education Foundation.

Gail Wilensky, PhD, will be this year's keynote speaker. She is an economist and senior fellow at Project HOPE, an international health foundation. Dr. Wilensky directed the Medicare and Medicaid programs from 1990-1992 and served in the White House as a senior health and welfare advisor to President George H.W. Bush. From 1997-2001, she chaired the Medicare Payment Advisory Commission, which advises Congress on payment and other issues relation to Medicare and previously chaired one of its predecessor commissions, the Physician Payment Review Commission.

During the event, three plenary sessions and a breakout session will be held. The topics for the plenary sessions will be: MACRA, Addressing the Opioid Crisis in Northeast Ohio, and Lawsuits: How to Survive, How to Avoid them (a Medical Legal Perspective). And, the breakout session with feature Medical Marijuana and Legal Issues in the Care of the "Vulnerable" Patient.

This summit is intended to bring together physicians, attorneys, healthcare professionals and others who work in allied professions for education, lively discussion and opportunities to socialize. To learn more, [click here](#).

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)

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