Looking Ahead - MACRA
Picking Your Path

Agenda
1. The Big Picture: Connecting the Dots
2. CMS Quality Initiatives
3. Value Modifier
4. MACRA - MIPS or APM?
5. Summary

The Big Picture: Connecting the Dots

All Payers – Common Themes
- Triple Aim
- High Performing Narrow Networks
- Patient Liability Increasing
- Increasing Transparency & Cost Focus
- Focus on Quality Measures
- Provider Profiling
- Value Based Payment Methodologies Rolling Out

The Tipping Point at Altitude
Risk Capable
Are you ready to assume more risk?

Transparency – Medicare Program

Transitioning
One definition of APM... different than the operational definition under MACRA.
How do we plan far enough in advance to optimize our opportunities?

Provider Payment Framework
Connecting the Dots — Better performance in each program positively impacts initiatives across the continuum of care

Bundled Payments
Value Based BPCI
Medical Home
improved care
improved
patient focus on Value Based Purchasing improved lower effective outcomes attention on ACOs Replacement Savings
MIPS
DEGREE OF INTEGRATION 2 Performance-
Payments
Provides for differential payment to a physician or group of physicians
• What is your opportunity?
$1,000,000
$2,000,000
$(500,000)
+/-4% by 2018). care furnished compared to cost during a performance period (up to
maintain privacy/security of patient health information.
quality, safety, efficiency, patient satisfaction, care coordination and data (individually or as a group) including 9 quality measures across 3 domains.
Meaningful Use (MU)
• Quality initiative rewarding or penalizing medical practices using certified electronic health record (EHR) technology to improve: quality, safety, efficiency, patient satisfaction, care coordination and maintain privacy/security of patient health information.
Value-Based Payment Modifier (VM)
• Provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule based upon the quality of care furnished compared to cost during a performance period (up to +/-4% by 2018).

Value Modifier

CMS Quality Initiatives - Today
Physician Quality Reporting System (PQRS)
• Health care quality improvement program where providers submit data (individually or as a group) including 9 quality measures across 3 domains.
Meaningful Use (MU)
• Quality initiative rewarding or penalizing medical practices using certified electronic health record (EHR) technology to improve:
quality, safety, efficiency, patient satisfaction, care coordination and maintain privacy/security of patient health information.
Value-Based Payment Modifier (VM)
• Provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule based upon the quality of care furnished compared to cost during a performance period (up to +/-4% by 2018).

CMS Quality Initiatives - Tomorrow
Understanding the Financial Implications for Your Practice
Value Modifier

What is your opportunity?
Over the next seven years, the return on highest to lowest reimbursement is estimated to grow at 36% for Medicare patients.

Value Modifier

CMS Quality Initiatives

DHG healthcare

DHG healthcare

DHG healthcare

DHG healthcare

DHG healthcare

DHG healthcare

DHG healthcare
2016 Value Modifier Projected Adjustments

There are 5,418 groups that will receive a -2% penalty in VM (est $74 million) in addition to a -2% PQRS penalty this year for a net impact of -4% to Medicare payments in 2016.

<table>
<thead>
<tr>
<th>Cost Domain</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Per Capita Cost</td>
<td>$37,785,744</td>
<td>$38,106,138</td>
<td>$39,426,532</td>
</tr>
</tbody>
</table>

Average Per Episode Cost and HCC Percentile Ranking by Provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>Average Per Episode Cost</th>
<th>HCC Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. A</td>
<td>$25,000</td>
<td>50%</td>
</tr>
<tr>
<td>Dr. B</td>
<td>$30,000</td>
<td>25%</td>
</tr>
<tr>
<td>Dr. C</td>
<td>$35,000</td>
<td>0%</td>
</tr>
</tbody>
</table>

Your Quality Composite Score Establishes a new framework for rewarding health care providers for giving better care not more just more care (MIPS and APM).

- MACRA:
  - Ended the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers’ services.
  - Establishes a new framework for rewarding health care providers for giving better care not just more care (MIPS and APM).
  - Sunsets existing programs – PQRS, VM, MU
  - Provides consistent physician fee schedule increases (0.5% from 2015 through 2019)
MACRA in Action

Feb 16, 2016: CMS and major commercial health plans, in concert with physician groups and other stakeholders, announce $20 million/year 2016-2020 for technical assistance to

MACRA: MIPS or APM?

- First set of core measures, used as basis for quality-based payments, were developed by new broad collaborative of healthcare system participants
- Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMH), and Primary Care
- Cardiology
- Gastroenterology
- HIV and Hepatitis C
- Medical Oncology
- Obstetrics and Gynecology
- Orthopedics

Clinical Practice Improvement Activities

The Secretary is required to specify clinical practice improvement activities. Categories of activities are also specified in the statute, which are:

- Established Patient Access
- Population Management
- Care Coordination
- Patient Safety & Assessment
- MIPS
- Participation in APM

MIPS

- New 1st each year, CMS to publish measure list for MIPS
- Update list for coming performance period
- MACRA explicitly states – must emphasize outcome measures
- CMS may use:
  - Facility-based measures for MIPS EPs
  - Outpatient hospital measures may be used for emergency physicians, radiologists and anesthesiologists
- Population based measures are allowed for MIPS
- In selecting MIPS measures and applying the MIPS formula, Secretary shall give consideration to “non-patient facing” specialties

APMs

- Can partially qualify with low thresholds but – not all financial upside will apply
- $20 million/year 2016-2020 for technical assistance to small practices to participate in APMs/MIPS
- MACRA authorizes coverage for telehealth services in APMs
- Federal physician advisory panel established to review physician proposals for new APMs
- Secretary of HHS must issue a request for information from stakeholders, proposed rule before establishing criteria for advisory panel recommendations on new APMs

Case Study – MIPS or APM 2019-2026

- Expected financial impact

Case Study – MIPS or APM

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MIPS

- Four Categories which will be harmonized:
  - Quality – PQRS and more measures to come
  - Resource Use – Value Modifier based focus on efficiency
  - Meaningful Use – focus on outcomes, more interoperable
  - Clinical Practice Improvement Activities – CMS evaluating concepts CMS Quality Measure Development Plan currently open for comment

APMs

- Require providers to take on “more than nominal” financial risk for a significant portion of patients.
- Must use certified EHR
- 2019-2020: 25% of Medicare revenue received through APM
- 2021-2022: 50% of Medicare revenue or 50% of all-payer revenue along with 25% of Medicare revenue must be received through APM
- 2023 and beyond: 75% of Medicare revenue or 75% of all-payer revenue along with 25% of Medicare revenue must be received through APM

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Higher Risk = Potential Higher Reward

Estimated Impact 2019 Forward High Performers:
- Better Performers have access to more $$$
  +9%
  -9%
  +18%

APM 5% lump sum, no downside risk

Estimated Cumulative Impact 2019 Forward:
- APM guaranteed $3.2 million – no risk here...
- MIPS $5.4 million - at risk

2026-2030 Fee Schedule Impact
- APM/MIPS: By 2030 there is $300k variance between APM/MIPS

Summary through 2026

<table>
<thead>
<tr>
<th></th>
<th>APM (%)</th>
<th>MIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Score</td>
<td>$0 (no downside)</td>
<td>$5.4M</td>
</tr>
<tr>
<td>Social Performance</td>
<td>$0.5M [lump sum]</td>
<td>$6.0M</td>
</tr>
<tr>
<td>Additional Revenue</td>
<td>$18.5M</td>
<td>Exceptional Performance</td>
</tr>
<tr>
<td>2026-2030 Fee Schedule Increases</td>
<td>I: $100,000</td>
<td>I: $100,000</td>
</tr>
<tr>
<td>MIPS Reporting Requirements</td>
<td>Waived – but still reporting</td>
<td>Mandatory</td>
</tr>
</tbody>
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MACRA: MIPS or APM?

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<tr>
<th></th>
<th>APM (%)</th>
<th>MIPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Downside Risk</td>
<td>Yes Downside or Physician Fee Schedule</td>
<td>Maximum: Risk 8%</td>
</tr>
<tr>
<td>Financial Upside Potential</td>
<td>waiver with APM + 5% Long Term Value-Based Bonus on Medicare Revenue</td>
<td>Maximum: 0% plus 15% of Medicare Revenue for Exceptional Performance</td>
</tr>
<tr>
<td>Reporting Requirements</td>
<td>Waived – but still reporting</td>
<td>Mandatory but being “harmonized”</td>
</tr>
<tr>
<td>Population Health Implications</td>
<td>Mandatory for success</td>
<td>Mandatory for success</td>
</tr>
<tr>
<td>Commercial Contract Implications</td>
<td>Favorable posture for accepting risk contracts</td>
<td>Less favorable posture for assuming risk contracts</td>
</tr>
</tbody>
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