How to Navigate MACRA, MIPS and Other Alternative Payment Models

A Guide for Independent Practices

There will be an interactive portion of the presentation. Text matkendall292 to 22333 (You will get a response when you joined the meeting)

Standard text messaging rates apply ;)
What Does Aledade Mean?
Adopting Accountable Care
An Implementation Guide for Physician Practices

November 2014

Editors
Mark McClellan and Farzad Mostashari

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PCPs...

• Patient’s Guide to the System
• Influence 85% of spend
• Account for 4% of cost
• 50% in small practices with low capital reserves
Your poll will show here

1. Install the app from pollev.com/app
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Still not working? Get help at pollev.com/app/help or Open poll in your web browser
MACRA is a complex piece of legislation. This slide deck is designed to help you find your path. It will help you answer:

- What is MACRA and what is MIPS?
- How does MACRA/MIPS change your payments and reporting requirements?
- What does MACRA/MIPS mean for your practice?
- How can your practice take full advantage of new payment systems?
Agenda

Introduction – Evaluating a Shifting Landscape

- Medicare Access and CHIP Reauthorization Act (MACRA) 101
- Merit- Based Incentive Programs (MIPS) 101
- Benefits of Participating in the Medicare Shared Savings (MSSP)
- Conclusion – How Independent Providers Can Prepare for What’s Ahead
There is massive waste in the U.S. healthcare system

The Problem

$3 Trillion
in national healthcare spending

$1 Trillion
in estimated waste (33%)*

Market Reaction

Shift to value-based healthcare

50% Outcome-Based Medicare payments by 2018

The U.S. health care market is enormous, yet fragmented and locally-driven

- 306 hospital referral regions (HRRs)
- 125+ health plans
- 5K hospitals
- 908K physicians / 306K PCPs*
- 319M patients

$3 Trillion in healthcare spend breaks down into…

- 306 hospital referral regions (HRRs)
- 125+ health plans
- 5K hospitals
- 908K physicians / 306K PCPs*
- 319M patients

The 10 largest HRRs have >$30B in total healthcare spend each*

*Estimated based on 2014 National Health Expenditure and apportionment of Medicare dollars by hospital referral region (HRR)
* PCPs includes only Internal medicine and family medicine and excludes Pediatrics, OB/GYN, and Geriatrics
Health Care Spending in Fee-for-Service System

Long-Term Federal Spending Projections, 1974-2039

Source: Congressional Budget Office, 2014 Long-Term Budget Outlook.
The Shift to Value-Based Care Isn’t Just Here to Stay; It’s Accelerating

The Current Landscape

Medicare Payment Reform: Aligning Incentives for Better Care

Modern Healthcare
Where healthcare is now on march to value-based pay

The Wall Street Journal
Hospitals Give Health Law Real-World Test
Accountable-Care Organizations Are Among the Health Act’s Main Cost-Cutting Efforts

Vox
This small, wonky Obamacare program saved $384 million over 2 years

The New York Times
Gov’t to Overhaul Medicare Payments to Doctors, Hospitals
The Result: Providers Are Overwhelmed with Details
The Value-Based Sky Can Look Unconnected…
...But Constellations Are There...
...And the Stars Can Be Aligned…

FFS Enhancements

Transitions of Care

Value Based Modifier

Chronic Care Management

New Payment Models

MACRA

MIPs

MSSP

Future Payment Structures

State Innovation Models

Bundled Payments

Patient-Centered Medical Homes

Comprehensive Primary Care Plus
Your poll will show here

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or
Open poll in your web browser
We’re losing money on every vaccine but we’re making it up on volume.
<table>
<thead>
<tr>
<th>TRANSITIONS OF CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROBLEM</strong></td>
</tr>
</tbody>
</table>
| **OPPORTUNITY**     | • Patient Contact within 48 hours reduces readmission.  
                      | • $250 for post-discharge patient follow-up. |
| **IMPACT**          | • Fewer hospital days.  
                      | • Reduce chances of hospital-acquired infections. |
| **REVENUE POTENTIAL** | $15,075 |
Things Practices Can **Do Now To Prepare for the Future: Chronic Care Management (CCM)**

<table>
<thead>
<tr>
<th>CHRONIC CARE MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROBLEM</strong></td>
</tr>
<tr>
<td>Patients with chronic conditions have costs 2x higher than average.</td>
</tr>
<tr>
<td><strong>OPPORTUNITY</strong></td>
</tr>
<tr>
<td>Monthly $40 payment to provide care management to patients with 2+ chronic conditions.</td>
</tr>
<tr>
<td><strong>IMPACT</strong></td>
</tr>
<tr>
<td>• Support for patients and families</td>
</tr>
<tr>
<td>• Reduced duplicative testing</td>
</tr>
<tr>
<td>• Greater medication adherence</td>
</tr>
<tr>
<td>• Improved quality scores</td>
</tr>
<tr>
<td><strong>REVENUE POTENTIAL</strong></td>
</tr>
<tr>
<td>$52,800</td>
</tr>
</tbody>
</table>
Introduction – Evaluating a Shifting Landscape

Medicare Access and CHIP Reauthorization Act (MACRA) 101

Merit-based Incentive Programs (MIPS) 101

Benefits of Participating in the Medicare Shared Savings (MSSP)

Conclusion – How Independent Providers Can Prepare for What’s Ahead
Definition:
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a law that reforms the Medicare payment system for physicians. MACRA shifts Medicare to a value based system, tying your Medicare payments to cost and quality performance.

MACRA changes Medicare payments in 4 ways:

- Repeals the current, flawed sustainable growth rate (SGR) methodology or “the doc fix”
- Sets extremely modest baseline increases to your Medicare payments over 10+ years
- Consolidates current fee-for-service programs (Meaningful Use, Physician Quality Reporting System, and Value-Based Payment Modifier) into a single, fee-for-service based value program (MIPS)
- Creates a new, completely separate alternative payment track for physicians participating in Advanced Alternative Payment Models (APMs)
### Medicare Before and After MACRA

MACRA repeals SGR, ends current fee-for-service programs, and introduces a **2-track payment system**

<table>
<thead>
<tr>
<th>Before MACRA</th>
<th>After MACRA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre – 2019</strong></td>
<td><strong>2019 &amp; Beyond</strong></td>
</tr>
<tr>
<td><strong>Core Payment Methodology</strong></td>
<td><strong>Core Payment Methodology</strong></td>
</tr>
<tr>
<td>• Physician Fee Schedule (PFS)</td>
<td>• Modest increases to PFS, starting in 2016</td>
</tr>
<tr>
<td>• Sustainable Growth Rate (SGR)</td>
<td>• Repeal of SGR</td>
</tr>
<tr>
<td><strong>Reporting &amp; Incentive Programs</strong></td>
<td><strong>Reporting &amp; Incentive Programs</strong></td>
</tr>
</tbody>
</table>
| • Meaningful Use (MU) | • Replacement of current fee-for-service programs (MU, PQRS, VM) with a **2-track payment system**:
| • Physician Quality Reporting System (PQRS) | 1. Merit-Based Incentive Payment System (MIPS)
| • Value Based Payment Modifier (VM) | 2. Advanced Alternative Payment Models (APMs) |
| **Requirements for Practices** | **Requirements for Practices** |
| • Attest to Meaningful Use | • Report practice metrics for MIPS (if applicable)* |
| • Report practice metrics for PQRS | • Report practice metrics for APMs (if applicable)* |

*Reporting requirements are subject to change in final CMS rule*
Track 1
Merit-Based Incentive System (MIPS)

95% of physicians*

Track 2
Advanced Alternative Payment Models (APMs)

5% of physicians*

*Percentage of physicians in each payment track estimated by CMS
Medicare’s Proposed 2-Track Payment System

Nearly all physicians with Medicare patients will be paid through one of these tracks:

**Likely Payment Track for Your Practice**

**Track 1: Merit-Based Incentive Payment System (MIPS)**
- Medicare’s default payment track, starting in 2019 (performance period begins 2017)
- Practices are scored across quality, cost, EHR, and practice improvement measures
- A composite performance score (CPS) sets annual incentives / penalties*
- Exceptional performers can receive up to 10% in bonus payments from 2019 to 2024*

**Track 2: Advanced Alternative Payment Models (APMs)**
- Practices in an Advanced APM are exempt from MIPS incentives / penalties
- These practices are also exempt from MIPS reporting requirements
- Practices receive a 5% annual payment bonus from 2019 to 2024

*Details of composite performance score and bonus amount for exceptional performers are subject to change in final CMS rule
## Timeline of Medicare Changes

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee Schedule Increases</th>
<th>Current Programs</th>
<th>Track 1: MIPS</th>
<th>Track 2: APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>100% of eligible physicians*</td>
<td>100% of eligible physicians*</td>
<td>95% of eligible physicians*</td>
<td>5% of eligible physicians*</td>
</tr>
<tr>
<td>2017</td>
<td>+ 0.5% per year</td>
<td>Report Meaningful Use</td>
<td>MIPS Incentives/ Penalties begin in 2019</td>
<td>Exempt from MIPS (no payment adjustment, no reporting after Year 1)</td>
</tr>
<tr>
<td>2018</td>
<td></td>
<td>Report PQRS</td>
<td></td>
<td>+ 5% of total Medicare payments</td>
</tr>
<tr>
<td>2019</td>
<td></td>
<td>Report VM</td>
<td>MIPS Incentives/ Penalties begin in 2019</td>
<td>+ 10% exceptional performance bonus</td>
</tr>
<tr>
<td>2020</td>
<td></td>
<td></td>
<td>MIPS Incentives/ Penalties begin in 2019</td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td></td>
<td></td>
<td>MIPS Incentives/ Penalties begin in 2019</td>
<td></td>
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<tr>
<td>2022</td>
<td></td>
<td></td>
<td>MIPS Incentives/ Penalties begin in 2019</td>
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<tr>
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<tr>
<td>2024</td>
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<td></td>
<td>MIPS Incentives/ Penalties begin in 2019</td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td></td>
<td></td>
<td>MIPS Incentives/ Penalties begin in 2019</td>
<td></td>
</tr>
<tr>
<td>2026 &amp; Beyond</td>
<td>+0.75% per year (AAPM**)</td>
<td>+0.25% per year (NQAPM*)</td>
<td>+ 5% of total Medicare payments</td>
<td></td>
</tr>
</tbody>
</table>

*Fee schedule and current programs apply to physicians participating in Medicare; MIPS and Advanced APMs apply to eligible physicians with sufficient Medicare volume.

**Physicians in Qualifying APMs (i.e., AAPM) receive a fee schedule increase of 0.75% per year, starting in 2026.

Physicians not in Qualifying APMs (NQAPM) receive a fee schedule increase of 0.25% per year, starting in 2026.
Implications for Your Practice

Medicare Payments at Risk
Most small practices will likely be penalized by CMS in 2019*:

Due to the burden of new reporting requirements, most small practices are expected to be penalized by CMS in 2019*:
- 87% of solo practices
- 70% of practices with 2 - 9 physicians

In contrast, the majority of large practices (25+ physicians) are expected to receive incentives

*Estimates based on assessment from the CMS Office of the Actuary, posted in Table 64 of the MIPS proposed rule
Introduction – Evaluating a Shifting Landscape

Medicare Access and CHIP Reauthorization Act (MACRA) 101

Merit-Based Incentive Programs (MIPS) 101

Benefits of Participating in the Medicare Shared Savings (MSSP)

Conclusion – How Independent Providers Can Prepare for What’s Ahead
With the passage of MACRA, MIPS is Medicare’s default payment track for physicians:

**Focus of this Document**

**Track 1: Merit-Based Incentive Payment System (MIPS)**
- Medicare’s default payment track, starting in 2019 (performance period begins 2017)
- Practices are scored across quality, cost, EHR, and practice improvement metrics
- A composite performance score (CPS) sets annual incentives / penalties*
- Exceptional performers can receive up to 10% in bonus payments from 2019 to 2024*

**Track 2: Advanced Alternative Payment Models (APMs)**
- Practices in an Advanced APM are exempt from MIPS incentives / penalties
- These practices are also exempt from MIPS reporting requirements
- Practices receive a 5% annual payment bonus from 2019 to 2024

*Details of composite performance score and bonus amount for exceptional performers are subject to change in final CMS rule
MIPS will replace 3 current Medicare reporting and incentive programs:

1. Meaningful Use (MU)
2. Physician Quality Reporting System (PQRS)
3. Value Based Payment Modifier (VM)
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
</table>
| MU      | Meaningful Use               | Part of the EHR Incentives & Certification program, Meaningful Use defines the ways in which healthcare providers are required to use certified electronic health records to improve quality/safety/efficiency, engage patients and family, improve care coordination and population health, and maintain privacy and security of patient health information. Meaningful Use guidelines are staggered into 3 stages, with requirements gradually expanding from 2011 to 2016. Failure to attest to Meaningful Use results in annual penalties of up to 3% of Medicare payments by 2017.  

*Note: Penalties and incentives levered under Meaningful Use will expire in 2018*

For more information, see guidelines published by the Office of the National Coordinator. |
| PQRS    | Physician Quality Reporting System | The Physician Quality Reporting System is a program overseen by CMS that requires physicians and group practices to report specified quality metrics. Failure to report the specified quality data face penalties of 2% of Medicare payments by 2017.  

*Note: Penalties and incentives levered under PQRS will expire in 2018*

For more information, see the guidelines published on the CMS website. |
# Medicare Programs Being Replaced By MIPS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
</table>
| VM      | Value Based Payment Modifier         | The Value-Based Payment Modifier (VM) is a physician payment program designed to incentivize or penalize physicians according to their performance along several quality and cost metrics. The VM program was the precursor to MIPS, with physician practices facing gradual introduction of penalties and incentives up to +/-2% of Medicare payments from 2016 to 2018.  
  
  **Note:** All eligible professionals (i.e., all currently practicing physicians) in the U.S. face penalties and incentives determined by the VM program through 2018.  
  
  For more information, see the [guidelines](#) published on the CMS website. |
Your practice is subject to MIPS unless you fall into one of 3 exemption categories:

**Physician Exemptions from MIPS**

1. **New Medicare Physicians:** this is your first year receiving payments from Medicare.

2. **Low Volume Medicare Physicians:** you have Medicare billing charges of <$10,000 per year and you provide care for 100 or fewer Medicare patients per year.

3. **Qualified Participants in Advanced APMs:** you participate in an Advanced Alternative Payment Model, such as:
   - Medicare Shared Savings Program – two-sided risk
   - Comprehensive Primary Care Plus
   - Next Generation ACO Model
Under MIPS, your practice faces 3 changes to Medicare payments:

1. **Fee Schedule Increases**
   - Baseline increases of 0.5% per year to your Medicare payments from 2016 to 2019
   - Baseline increases of 0.25% per year to your Medicare payments, starting in 2026*

2. **MIPS Incentives / Penalties**
   - Annual positive/negative adjustments to your Medicare payments, based on your MIPS composite performance score (new scoring index, starting in 2017)
   - Scheduled increases in incentives / penalties over time:
     - 2019: +/- 4% of Medicare payments
     - 2020: +/- 5% of Medicare payments
     - 2021: +/- 7% of Medicare payments
     - 2022: +/- 9% of Medicare payments
   - Applies if your practice scores above the “exceptional performance” threshold on the MIPS scoring index (threshold to be determined)

3. **MIPS Exceptional Performance Bonus**
   - Potential bonus of 10% of Medicare payments per year from 2019-2024*

*Assumes no participation in an Advanced Alternative Payment Model (APM)
*Amount for exceptional performance bonus subject to change in final CMS rule
These changes will create wide variation in revenue for the same set of Medicare services:

**Example: Projected Medicare Payments on $100K Business Today**

- **1.** with FFS schedule increases
- **2.** with maximum MIPS incentives
- **3.** with Exceptional Performance Bonus
- **3.** with maximum MIPS penalties
New Proposed Reporting Requirements

Your practice’s penalties / incentives will be based on a new composite performance score:

<table>
<thead>
<tr>
<th>MIPS Composite Performance Score (CPS) Category</th>
<th>Score Weighting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017*</td>
</tr>
<tr>
<td>Quality (PQRS Style Measures)</td>
<td>50%</td>
</tr>
<tr>
<td>Clinical Practice Improvement Activities</td>
<td>15%</td>
</tr>
<tr>
<td>(Practice Processes)</td>
<td></td>
</tr>
<tr>
<td>Advancing Care Information</td>
<td>25%</td>
</tr>
<tr>
<td>(Rebranded Meaningful Use)</td>
<td></td>
</tr>
<tr>
<td>Resource Use (Total Patient Costs)</td>
<td>10%</td>
</tr>
</tbody>
</table>

- First year of MIPS scoring emphasizes quality metrics*
- Practices in non-Advanced APMs (e.g., Medicare Shared Savings – Track 1) are not scored on costs
- Performance period begins in 2017 and sets your incentives/ penalties for 2019**
- Failure to report = maximum penalties

*Weighting will shift over time, with Quality and Resource Use both weighted at 30% by 2019
+Participants in the Medicare Shared Savings Program – Track 1 are exempt from cost scoring in the proposed rule
++Start date of performance period and weighting of MSSP are subject to change in final CMS rule

Confidential & Proprietary
Starting next year, your practice must submit detailed reporting measures for this score:

<table>
<thead>
<tr>
<th>CPS Category</th>
<th>Reporting Requirements for Practices*</th>
<th>Submission Method*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td>• Pick 6 out of 100 measures to report (PQRS/MU eQuality)</td>
<td>• Claims</td>
</tr>
<tr>
<td></td>
<td>• Must report 1+ outcome measure (e.g., HbA1c poor control)</td>
<td>• GPRO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Registries (Bonus Points)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• EHR Submission (Bonus Points)</td>
</tr>
<tr>
<td><strong>Clinical Practice Improvement Activities</strong></td>
<td>• Pick from menu of 90+ activities with different weights</td>
<td>• Attestation</td>
</tr>
<tr>
<td></td>
<td>• All activities weighted 10 points or 20 points</td>
<td>• Exploring EHR and Registry Submission</td>
</tr>
<tr>
<td></td>
<td>• Need 60 points for full credit</td>
<td>• Can be reported at group level</td>
</tr>
<tr>
<td><strong>Advancing Care Information</strong></td>
<td>12 Total Measures in 3 Categories (11 Required)</td>
<td>• Same as Clinical Practice Improvement Activities</td>
</tr>
<tr>
<td></td>
<td>• Need 100 out of 131 possible points</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 50 points for reporting all 11 measures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 80 possible points for performance on 8 measures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 1 bonus point for reporting the 12th measure</td>
<td></td>
</tr>
<tr>
<td><strong>Resource Use</strong></td>
<td>• No practice reporting required (calculated from claims)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Details subject to change in final CMS rule (published Nov 2016)
MIPS Quality Measures

PROPOSED RULE

MIPS: Quality Performance Category

Summary:

✓ Selection of 6 measures
✓ 1 cross-cutting measure and 1 outcome measure, or another high priority measure if outcome is unavailable
✓ Select from individual measures or a specialty measure set
✓ Population measures automatically calculated
✓ Key Changes from Current Program (PQRS):
  • Reduced from 9 measures to 6 measures with no domain requirement
  • Emphasis on outcome measurement
  • Year 1 Weight: 50%
Clinical Practice Improvement Activities

Subcategories of Clinical Practice Improvement Activities

- Expanded Practice Access
- Beneficiary Engagement
- Achieving Health Equity
- Population Management
- Patient Safety and Practice Assessment
- Emergency Preparedness and Response
- Care Coordination
- Participation in an APM, including a medical home model
- Integrated Behavioral and Mental Health

Six subcategories are specified in MACRA
Three additional subcategories are proposed in the NPRM

PROPOSED RULE
MIPS: Advancing Care Information Performance Category

CMS proposes six objectives and their measures that would require reporting for the base score:

- Protect Patient Health Information (yes required)
- Electronic Prescribing (numerator/denominator)
- Patient Electronic Access (numerator/denominator)
- Coordination of Care Through Patient Engagement (numerator/denominator)
- Health Information Exchange (numerator/denominator)
- Public Health and Clinical Data Registry Reporting (yes required)
## Timeline of Changes

### Fee Schedule Increases

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Increase</td>
<td>+ 0.5% per year</td>
<td>+ 0.75% per year (QAPM*)</td>
<td>+0.75% per year (QAPM*)</td>
<td>+0.25% per year (NQAPM*)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

*Physicians in Qualifying APMs (QAPM) receive a fee schedule increase of 0.75% per year, starting in 2026

*Physicians not in Qualifying APMs (NQAPM) receive a fee schedule increase of 0.25% per year, starting in 2026

**Timing of reporting requirements subject to change in final CMS rule

### Current Programs

- MIPS Incentives/Penalties begin in 2019
- Exceptional Performance Bonus

<table>
<thead>
<tr>
<th>Year</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
<th>2025</th>
<th>2026 &amp; Beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentives/Penalties</td>
<td>+/- 4%</td>
<td>+/- 5%</td>
<td>+/- 7%</td>
<td>+/- 9% of total Medicare payments, based on composite performance score (CPS)</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Meaningful Use
- Report for 2019
- Report for 2020

PQRS
- Report for 2021

VM

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*continued reporting CPS practice metrics for MIPS on 2 year cycle. Failure to report will result in maximum penalty.*

**Confidential & Proprietary**
MIPS impacts your practice in several ways:

| Medicare Payments at Risk | • A growing share of your Medicare payments are at risk  
| | • Your cost and quality performance will lead to penalties or incentives  
| New Reporting Requirements | • Under MIPS, your practice must report quality, EHR use, and practice improvement information  
| | • Failing to report leads to maximum penalties  
| | • Joining an APM can help relieve the reporting burden and improve performance  
| Key Decision on Joining APMs | • MACRA encourages practices to join Alternative Payment Models (APMs)  
| | • You should decide whether APMs offer a better future for your practice  
| | • There are risks in APMs that need to be assessed  
| Preparing for Value Based Care | • Your practice will be penalized / rewarded based on cost and quality performance  
| | • To survive, you need strategic, technological, and operational capabilities to successfully deliver value based care  

Find out more on how to prepare by visiting the <Aledade Value Based Care Resource Center> [www.aledade.com](http://www.aledade.com)
Agenda

Introduction – Evaluating a Shifting Landscape

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Benefits of Participating in the Medicare Shared Savings (MSSP)

Conclusion – How Independent Providers Can Prepare for What’s Ahead
The Rise of The Accountable Care Organization

Source: Leavitt Partners
MSSP Benefits:

Participating in an Independent PCP Led MSSP, provide a practice with several advantages including:

1. Special MIPS Reporting Requirements

2. Experience with quality measure reporting which translate into higher quality scores and higher MIPS payments

3. Enhanced Revenue From Shared Savings

Allow Practices to take advantage of future value based payment systems
If you participate in an ACO (e.g., MSSP – Track 1*), your practice has several advantages:

<table>
<thead>
<tr>
<th>CPS Category</th>
<th>Advantages for Practices in MSSP - Track 1*</th>
</tr>
</thead>
</table>
| **Quality**                       | • No reporting required from practices (ACO submits on behalf of practices through GPRO)  
• ACO’s quality measures replace MIPS measures |
| **Clinical Practice Improvement Activities** | • Same overall requirements (60 points = full credit)  
• Practice gets 30 points automatically for being in MSSP |
| **Advancing Care Information**    | • None (same requirements and submission method) |
| **Resource Use**                  | • Shared savings from MSSP replaces this category  
• Practices not assessed on cost performance for MIPS |

*Medicare Shared Savings Program (MSSP) – Track 1 is an accountable care organization model, but does not qualify as an Advanced Alternative Payment Model (APM)
Independent Provider ACOs Already Do Well on Quality Measures

Quality Scores

Aledade Primary Care ACO
Commonwealth ACO
Aledade Delaware ACO
Family Health ACO
ACOs have achieved tremendous improvement in care quality and utilization (1/2)

Emergency Department (ED) Visits Rate*

Performance Highlights:

- Our 2015 ACOs decreased ED visit rates by ~6-7% in their first year*
- ED visit rates for Aledade ACOs are 15-18% lower than Medicare FFS

*Data shown are for Aledade’s two ACOs that were live in 2015: Delaware and Primary Care (AR, MD, NY)

Source: quarterly performance data reported to Aledade by CMS
ACOs have achieved tremendous improvement in care quality and utilization (2/2)

Performance Highlights:

- Our 2015 ACOs decreased readmissions rates by ~7-11% in their first year*

- Readmission rates for Aledade ACOs are 19-21% lower than Medicare FFS

---

*Data shown are for Aledade’s two ACOs that were live in 2015: Delaware and Primary Care (AR, MD, NY)

*Increase in readmissions from 2014 Q4 to 2015 Q1 are partially due to changed definition to include 30-day death rate in readmissions

Source: quarterly performance data reported to Aledade by CMS

Independent PCPS are the best positioned to coordinate care and drive savings

Medicare Savings Performance by ACO Subgroup (2012 - 2013)

ACOs led by independent PCPs are the only subgroup statistically proven to lower healthcare costs


*5% savings calculated off mean spending of $9,942 per beneficiary in the Chernew study
**Medicare Shared Savings Plan – Track 1 Potential Revenue to a Practice**

<table>
<thead>
<tr>
<th>MSSP TRACK 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROBLEM</strong></td>
<td>Providers are not rewarded for lowering costs while improving quality</td>
</tr>
</tbody>
</table>
| **OPPORTUNITY** | • Decrease unnecessary ED visits  
• Ensure patients get preventative care  
• Manage TOCs  
• Ensure appropriate use of procedures & tests |
| **IMPACT** | • 121 hours of saved ED time  
• $6,000 in savings to patients |
| **REVENUE POTENTIAL** | $159,234.60 |
| **Benchmark (Per Patient):** | $9,700 |
| **Total cost:** | $5,820,000 |
| **Total savings** | $318,469.20 |
| **Savings %** | 5.47% |
| **Medicare share in Track 1** | 50% |
| **Savings to ACO** | $159,234.60 |
Introduction – Evaluating a Shifting Landscape

Medicare Access and Reauthorization Act (MACRA) 101

Merit-based Incentive Programs (MIPS) 101

Benefits of Participating in the Medicare Shared Savings (MSSP)

Conclusion – How Independent Providers Can Prepare for What’s Ahead
Be Prepared:

Things you can do now to prepare for the future:

1. Advocate for policy changes that benefit providers in MSSP programs

2. Understand how CMS views your practices quality costs measures

3. Align MSSP and MIPs Quality Improvement Efforts

Start now to position your practice for the future
Aledade is a new model of primary care that empowers independent physicians and enables them to successfully manage population health.
Federal Rules/Regulations are Complicated

Aledade Advocates for Provider Led ACOs

Find out more on how to prepare by visiting the Aledade Value Based Care Resource Center at www.aledade.com
Analyze your QRUR…CMS Quality/Cost Report Card for Your Practice

PERFORMANCE HIGHLIGHTS

Your Quality Composite Score: Average

Your Cost Composite Score: Average

Your Performance: Average Quality, Average Cost
Leveraging the QRUR/Value Report to Identify Opportunities

- Areas of opportunity identified in Value Report/QRUR data
  - Spend by Service Category
    - Chronic Conditions
    - Acute care utilization
    - Referral Network/Specialist care
    - Post-acute care
  - Project good FFS revenue opportunities
  - Explore impact of ER visits and hospitalizations

### Tabular Data

#### #1: Retain your patients, build loyalty

**Detail on page 2**

| Total new revenue | $92,702 |

#### #2: Reduce preventable ER visits

**Detail on page 3**

| Total savings recouped | $11,219 |

#### #3: Prevent Hospital Readmissions

**Detail on page 4**

| Total savings recouped | $9,908 |

#### #4: Manage your referral networks

**Detail on page 5-6**

| Total savings recouped | $100,921 |

#### Total savings recouped

| $122,049 * |

* Recouped savings figures are practice savings after Medicare and ACO allocations. See appendix for details.

#### #5: Quality programs and penalty avoidance

**Detail on page 8**

| Total penalties avoided | $32,595 |

### Totals

- **Total new revenue**: $92,702
- **Total savings recouped**: $122,049
- **Annual member fee**: $9,528
- **Net cash flow**: $205,223
- **Total penalties avoided**: $32,595
## Prioritizing Savings Opportunities in 2017

### Where to Play

<table>
<thead>
<tr>
<th>Priority for Savings</th>
<th>% of primary care provided outside</th>
<th>Long Term, Post Care</th>
<th>Emergency Dept</th>
<th>Inpatient Hospital</th>
<th>Specialist</th>
<th>Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>42.93%</td>
<td>$7,806,501</td>
<td>$226,365</td>
<td>$9,522,496</td>
<td>$306,419</td>
<td>$133,354</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
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<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
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</tr>
</tbody>
</table>

### Total Opportunity For Savings in Each Service Line

#### Where to Play

<table>
<thead>
<tr>
<th>% of primary care provided outside</th>
<th>Long Term, Post Care</th>
<th>Emergency Dept</th>
<th>Inpatient Hospital</th>
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<td>$133,354</td>
</tr>
</tbody>
</table>

### Total Opportunity For Savings in Chronic Disease Management

<table>
<thead>
<tr>
<th>Chronic Disease Management</th>
<th>Heart Failure (HF)</th>
<th>Coronary Artery (CAD)</th>
<th>Chronic Obstructive Pulmonary Disease (COPD)</th>
<th>Diabetes Mellitus (DM)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$8,329,041</td>
<td>$10,802,215</td>
<td>$4,590,339</td>
<td>$7,295,634</td>
</tr>
</tbody>
</table>
## Medicare Shared-Savings Plan – Two Sided Risk (Track 2, 3 and NextGen)

<table>
<thead>
<tr>
<th><strong>MEDICARE SHARED-SAVINGS TWO SIDED RISK</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROBLEM</strong></td>
</tr>
<tr>
<td><strong>OPPORTUNITY</strong></td>
</tr>
<tr>
<td>Practices with get 5% APM payment for being in two-sided risk program</td>
</tr>
<tr>
<td><strong>IMPACT</strong></td>
</tr>
<tr>
<td><strong>REVENUE POTENTIAL</strong></td>
</tr>
</tbody>
</table>

Increasing Flexibility and Support for Modifications in Clinical Practice

1. **Track 1** - One-Sided Risk
2. **Track 2** - Two-Sided Risk
3. **Track 3** - Increased Two-Sided Risk
4. **Next Gen** - Two-Sided Risk
Contemplating Moving to a NextGen ACO: The Aledade Perspective

Through the Eyes of One ACO: Deciding on Next Generation ACO

Travis Broome

Travis Broome leads rapid and detailed analysis of new regulations pertaining to Medicare and affecting Aledade ACOs. Before joining Aledade, Travis most recently served as a Regional Manager at CMS. In this role he oversaw Medicare Parts A and B, EHR, and ACO operations across 5 states. Prior to this, he was team lead for the group responsible for policy and oversight in the Health IT Group at CMS. Travis received his MPH and MBA in Health Care Organization and Policy from the University of Alabama at Birmingham.

Evaluate, Create, Implement.
VIEW THE CASE STUDY ▶

As the most advanced accountable care organization (ACO) model, Next Generation ACO has its appeal. However, it is the riskiest model, and one ACO explains why it decided to stay with the Medicare Shared Savings Program.

This post was co-written by Bob Kocher, MD (headshot), partner at Venrock; senior fellow at the Schaeffer Center for Healthcare Policy and Economics at the University of Southern California; and consulting professor at the Stanford University School of Medicine.

Deciding to take on accountability for the total quality and cost for patients is a huge commitment. When physicians form an accountable care organization (ACO) they are not saying “I will do my part,” rather they are saying “I will lead.” All 8 of Aledade’s current ACOs and the physicians at the heart of them are committed to leading the shift from volume to value in healthcare.

ACOs confront physicians with an array of options on how to be compensated for value. The Learning and Action Network created an 18-page white paper just to lay out a framework for categorizing the various options for getting paid. The Medicare Access and CHIP Reauthorization Act (MACRA) includes just a few models as advanced alternatives to payment.

• Pro:
  • Ability to use the fee-for-service system to drive improvement and negotiate partnerships to reward value
  • Large potential revenue if achieve savings

• Con:
  • Benchmark set on a single year
  • Not regional benchmark adjustment
  • Potential to have to pay CMS for not achieving significant savings

• Thoughts:
  • CMS wants to make this work
  • Downside risk needs to be adjusted for independent PCP ACO (Aledade isn’t doing this year)

See more at: http://www.ajmc.com/contributor/travis-broome/2016/05/through-the-eyes-of-one-aco-deciding-on-next-generation-aco#sthash.JTnrD4v9.dpuf
Your poll will show here

1. Install the app from pollev.com/app
2. Make sure you are in Slide Show mode

Still not working? Get help at pollev.com/app/help
or
Open poll in your web browser
What Commonwealth is doing to help practices prepare for MIPS:

1. How to Access Practice QR/URs
2. GPRO Reporting
3. Practices receive points for participating in care coordination in the CPIA domain
4. Providing support to succeed in volume to value transition
5. Provide an opportunity to earn more than a 5% lump sum bonus payment
Questions?

Mat Kendall
Executive Vice President for Provider Networks | Co-Founder

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