THE HEALTHCARE QUALITY COALITION

Current Medicare Fee-for-Service Pay-for-Performance Initiatives for Hospital and Physician Services

July 13, 2015

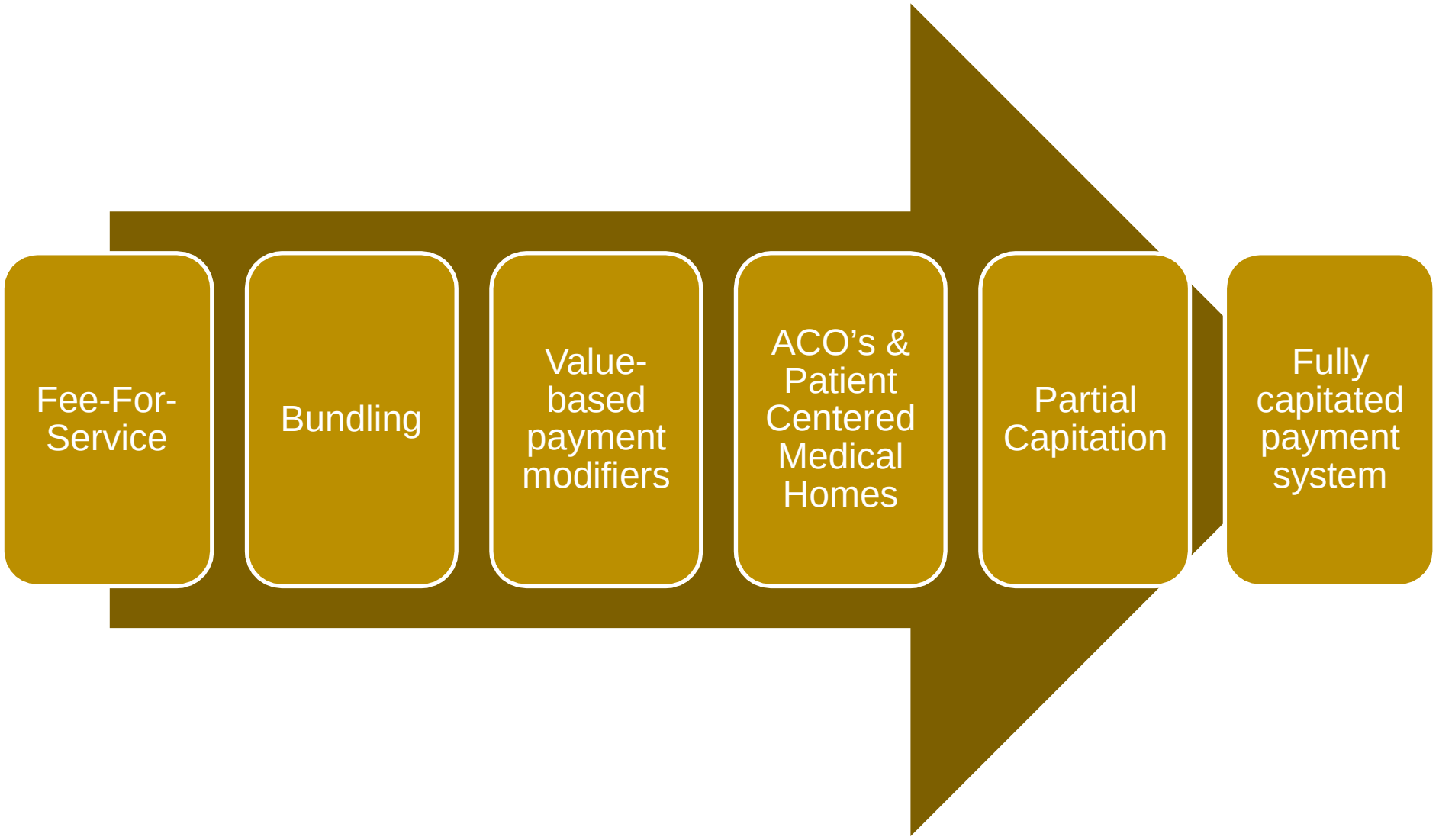
Agenda

- Broad Overview of Payment Policy Direction
  - Current State
  - Future State
- Current mandatory Medicare Pay-for-Performance Programs
  - Hospital/Inpatient
  - Physician/Clinical
- Future state: Recently enacted Medicare Access and CHIP Reauthorization Act (MACRA)

Where we are at…the current state

- Fee-for-Service still dominates public programs
- Various Initiatives aim to reduce cost; incentivize quality and efficiency
  - Pay for quality reporting
  - Patient-Centered Medical Homes
  - Bundled/Global Payments (surgical packages, etc.)
  - Value-based modifiers
  - Accountable Care Organizations
  - Advanced Primary Care Demonstration
  - Payer-specific and managed care contracts
  - Penalties: Readmissions and Healthcare Acquired illness/injuries
- Providers/Hospitals may feel stuck between two different “worlds” of payment: Fee-for-service & global payment

Basic spectrum of service payment



The Future State

- January 2015 – Secretary Burwell issues announcement of goals to tie Medicare fee-for-service payment to value
- Alternative Payment Models – ACO's, bundled payments
  - 30% by the end of 2016
  - 50% by the end of 2018.
- Fee-for-Service pay for performance programs, such as Value-based purchasing and readmissions reduction
  - 85% by 2016
  - 90 % by 2018

Medicare Hospital Performance Initiatives

Value-Based Purchasing Program,
Readmissions Reduction, and Healthcare Acquired Conditions

The Healthcare Quality Coalition

Medicare Hospital Quality Reporting Infrastructure

- Pay-for-Performance programs generally follow an existing reporting infrastructure
- Measures are reported or abstracted, then assessed per program scoring methodology
  - **CMS Hospital Inpatient Quality Reporting Program Measures**
  - **CMS Hospital Outpatient Quality Reporting Measures**
  - **Inpatient Psychiatric Facility Quality Reporting Program Measures**
- At this point, none of the Medicare hospital-based quality programs include specific measures related to diabetes and/or depression (yet)

Hospital Readmissions Reduction (HRR) and Hospital-Acquired Conditions (HAC) Programs

Hospital Readmissions Reduction (HRR) Program Background

Section 3025 of the Affordable Care Act

- Penalty Program Only- no reward for strong performance
- Payment reduction based on "higher than expected" readmissions
- Commenced on October 1, 2012
- Currently in third year of implementation

2,610	• Total hospitals penalized FY 2015 (78%); 433 more than FY 2014
39	• Hospitals nationally penalized the maximum 3%
496	
-0.63%	• Average penalty assessed

HRR – Basics

Conditions used in HRR
Heart Failure (HF)
Acute Myocardial Infarction (AMI) (heart attack)
Pneumonia (PN)
COPD – Chronic obstructive pulmonary disease
THA/TKA - elective hip and knee replacements
CABG - Coronary Artery Bypass Graft surgery (for FY 2017)

FY Year	Maximum Payment Penalty
2013	**1%**
2014	**2%**
2015 and beyond	**3%**

Hospital-Acquired Conditions (HAC) Program Background

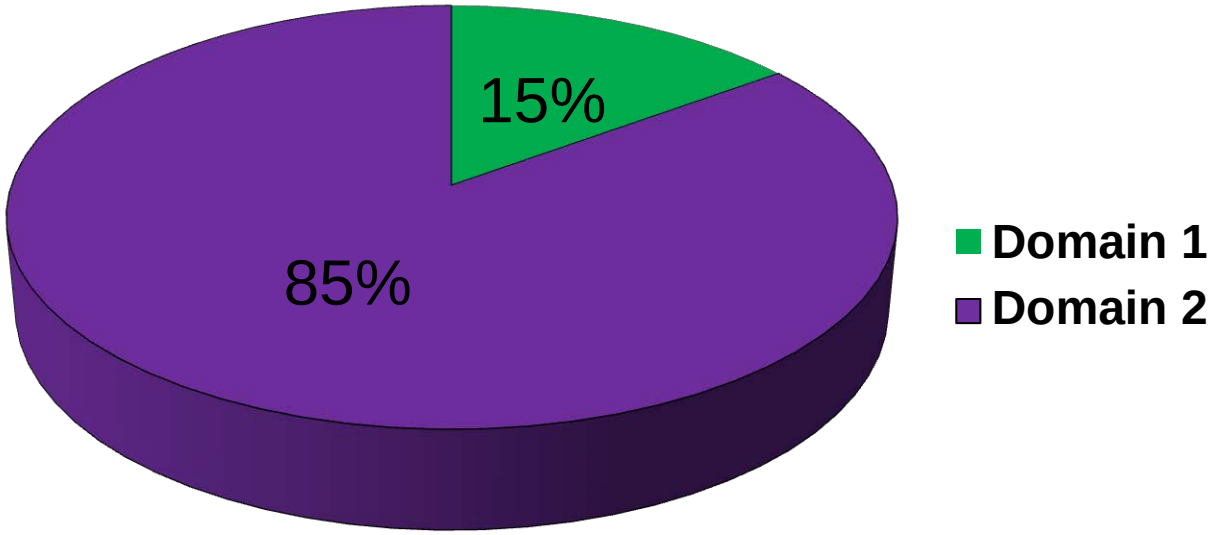
Since 2008	• Medicare has not typically reimbursed for avoidable complications not present on admission (POA)
Section 3008	• Affordable Care Act authorized the HAC reduction program • Penalty only – no reward for strong performance • Top quartile always penalized, regardless of distributive performance
Exemptions	• Critical Access Hospitals (CAH) and specialty hospitals (Cancer centers, long-term, etc.)
Penalties	• FY 2015 (first year), 721 hospitals penalized for a total $373 million • 1% statutory cap on penalties
Rulemaking Update	• Details on FY 2016 IPPS Proposed Rule Implementation starts on page 24509

Future state – FY 2017 HAC Program

Domain 1 PSI-90 AHRQ Pt Safety Composite
PSI-3: pressure Ulcer
PSI-6: Iatrogenic pneumonthorax
PSI-7: central venous catheter-related blood stream infection rate
PSI08: hip fracture
PSI-12: perioperative PE/DVT rate
PSI-13: sepsis rate
PSI-14: wound dehiscence rate
PSI-15: accidental puncture

Domain 2 CDC Measures – chart abstracted
CLABSI: Central Line Bloodstream infections
CAUTI's: Catheter Urinary Tract Infections
SSI: Colon & Abdominal Hysterectomy
NEW!: MRSA- Methicillin-Resistant Staphylococcus aureus
NEW!: C Diff – Clostridium difficile

FY 2017 HAC Domain Weights



Implementation Trends

- CMS authority to expand list of "applicable conditions" in Readmissions program and HAC
  - FY 2015 added 2 new conditions - chronic obstructive pulmonary disorder and total hip and knee replacement
  - FY 2017 CMS finalized adding coronary artery bypass graft
  - FY 2017, proposes to expand measure cohort for 30-Day Pneumonia Readmission Measure
- More hospitals are being penalized by readmissions (78% in FY 2015), but average penalties remain below 1%
- Results publicly posted on Hospital Compare – we're seeing more and more Medicare data being publicly posted

Hospital Value-Based Purchasing Program

Hospital VBP Program - Basic Framework

- Existing value-based initiative for hospitals
- One of several “value” programs created by the Affordable Care Act
  - Goal to pay for better value of care
  - Builds on existing Hospital Inpatient Quality Reporting (IQR) infrastructure
  - Applies to payments for hospital discharges occurring on or after Oct. 1, 2012
- Budget-neutral incentive payments
  - Amounts withheld redistributed to hospitals by performance rates
  - Statutory ceiling on payment withheld at 2% by FY 2017
- Hospitals are scored by either their achievement or improvement
  - Achievement – Performance compared to all other hospitals in baseline period
  - Improvement – Current performance compared to own baseline period performance

Upcoming FY 2016 & FY 2017 Hospital VBP Program Highlights

FY 2016 (Oct. 2015)

- DRG withhold 1.75%
- >$1.5 billion available for redistribution
- Efficiency increases to 25% weighting
- Removes 5 process measures; adds outcomes

FY 2017 (Oct. 2016)

- DRG withhold reaches 2% statutory ceiling
- Performance measure domains modified
- Increased emphasis on quality outcomes
- Removes 6 more process measures

FY 2016 Measures & Domain Weights

Clinical Process of Care

AMI 7a Fibrinolytic agent received w/in 30' of hospital arrival
PN 6 Initial antibiotic selection for CAP immunocompetent pt
SCIP 2 Received prophylactic Abx consistent with recommendations
SCIP 3 Prophylactic Abx discontinued w/in 24 hrs of surgery end time or 48 hrs for cardiac surgery
SCIP 9 Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2
SCIP-Card 2 Pre-admission beta-blocker and perioperative period beta blocker
SCIP VTE2 Received VTE prophylaxis within 24 hrs prior to or after surgery
New! IMM-2 Influenza Immunization
Removed! AMI 8a PCI received w/in 90' of hospital arrival
Removed! HF 1 Discharge instructions was removed from FY2016 measures
Removed! PN 3b Blood culture before 1st antibiotic received in hospital
Removed! SCIP 1 Abx w/in 1 hr before incision or w/in2 hrs if Vancomycin/Quinolone is used
Removed! SCIP 4 Controlled 6 AM postoperative serum glucose – cardiac surgery

Patient Experience

Communication with nurses
Communication with doctors
Responsiveness of hospital staff
Pain management
Communication about medications
Cleanliness and quietness
Discharge information
Overall rating of hospital

1.75% DRG withhold

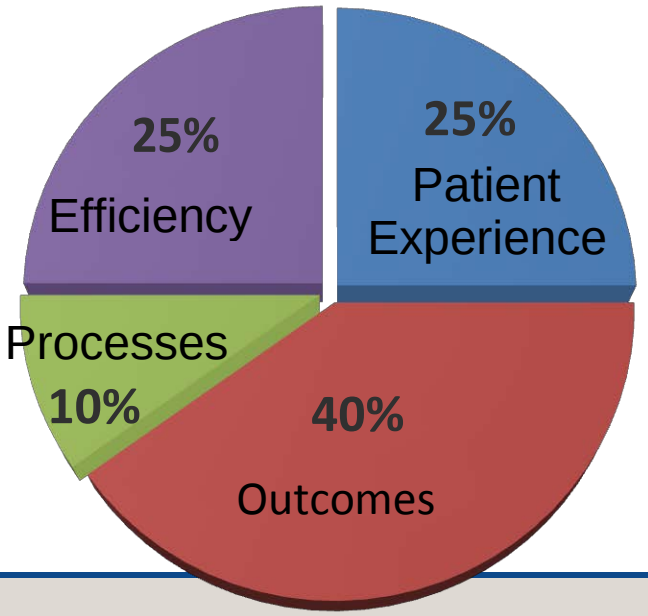
FY 2016 performance scores expected this summer

Outcomes

AHRQ PSI composite
CLABSI
New! CAUTI
New! SSI Colon‡
SSI Abdominal Hysterectomy‡
30-day mortality, AMI
30-day mortality, heart failure
30-day mortality, pneumonia

Efficiency

MSPB-1 Medicare spending per beneficiary



Hospital VBP Implementation Trends

- Budget neutral, re-distribution program by withholding hospital payments; capped at 2% withhold in FY 2017 and beyond
- Incentives -- payment linked to the better of total performance score
  - Achievement (national benchmark)
  - Improvement (self benchmark)
- Implementation Points of Emphasis
  - Utilizes Hospital IQR program as foundation, measures are usually reported first before inclusion in VBP
  - FY 2017 additional movement away from process-based measures towards outcomes; eliminates 6 process measures.
  - FY 2018 follows suit, proposing to eliminate process domain completely and seeking input on measures of efficiency for the FY 2018 IQR program
  - No direct measures specific to depression or diabetes yet (but may be relevant/related to other diagnoses).

Pay for Performance in Clinical Services

Medicare Physician Value-Based Payment Modifier & the Merit-Incentive Payment System

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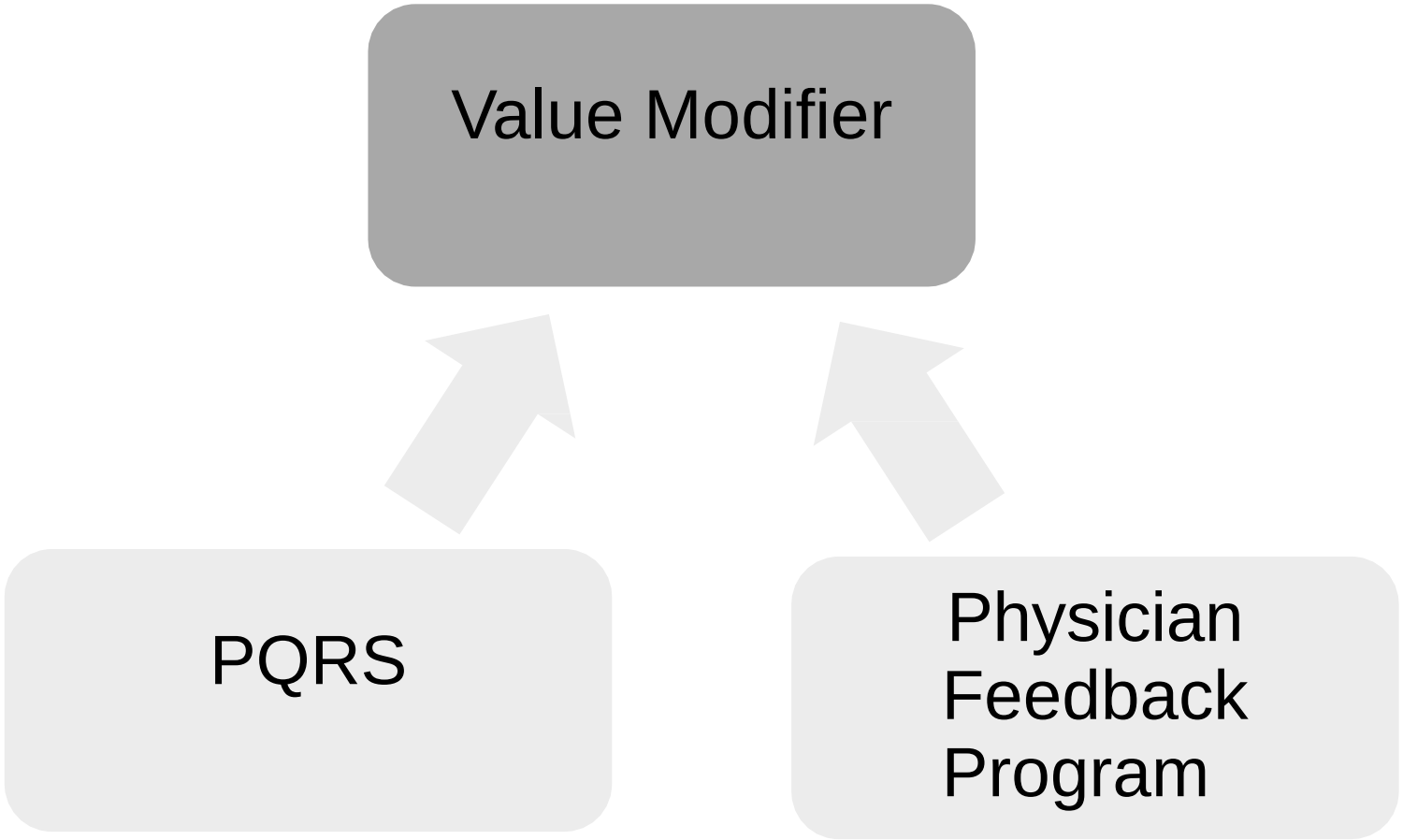
What is the Medicare Physician VBPM?

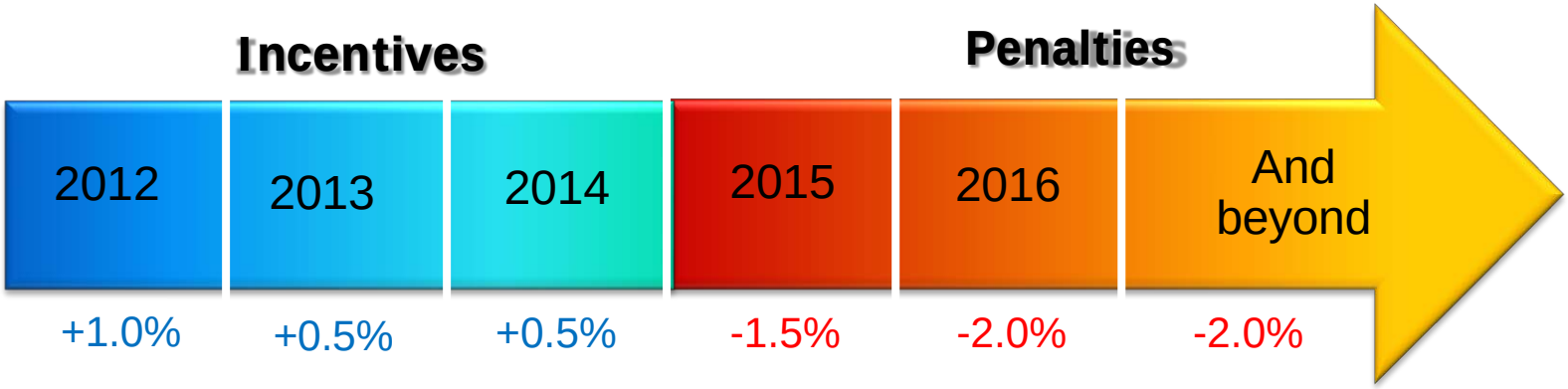
- Section 3007 of the Affordable Care Act (ACA)
- Based on existing physician fee schedule, payment adjustments based on the quality and cost of care
- Considered a payment "at-risk" program; differs from the hospital value-based purchasing program as an up-front withholding and redistribution
- Like the hospital VBP, the physician value modifier is budget neutral – **some physicians and groups are paid more, some will be paid less, but total program spending remains the same**
- Performance is categorized based on standard deviation(s)
- Gradual implementation, but by **2017 ALL** Medicare providers will be subject to the value modifier in some way

PQRS and Physician Feedback Program form the Foundation of the Value Modifier



What is PQRS?

- Commenced as voluntary quality reporting program for physicians since 2007
- Provides incentives and imposes penalties based on satisfactory quality reporting
- Failure to satisfactorily report under PQRS will result in maximum penalty under VBPM, which will be applied on top of the separate PQRS penalty



Cost and Quality Measures

COST/Efficiency

- Total per capita costs measure (annual payment standardized and risk-adjusted Part A and Part B costs)
- Total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, Coronary Artery Disease, Diabetes
- Medicare Spending Per Beneficiary measure (added CY 2016)

Quality

(150+ to choose from)

- All Cause Readmission
- Composite of Acute Prevention Quality Indicators: (bacterial pneumonia, urinary tract infection, dehydration)
- Composite of Chronic Prevention Quality Indicators: (chronic obstructive pulmonary disease, heart failure, diabetes)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Diabetes & Depression Measures

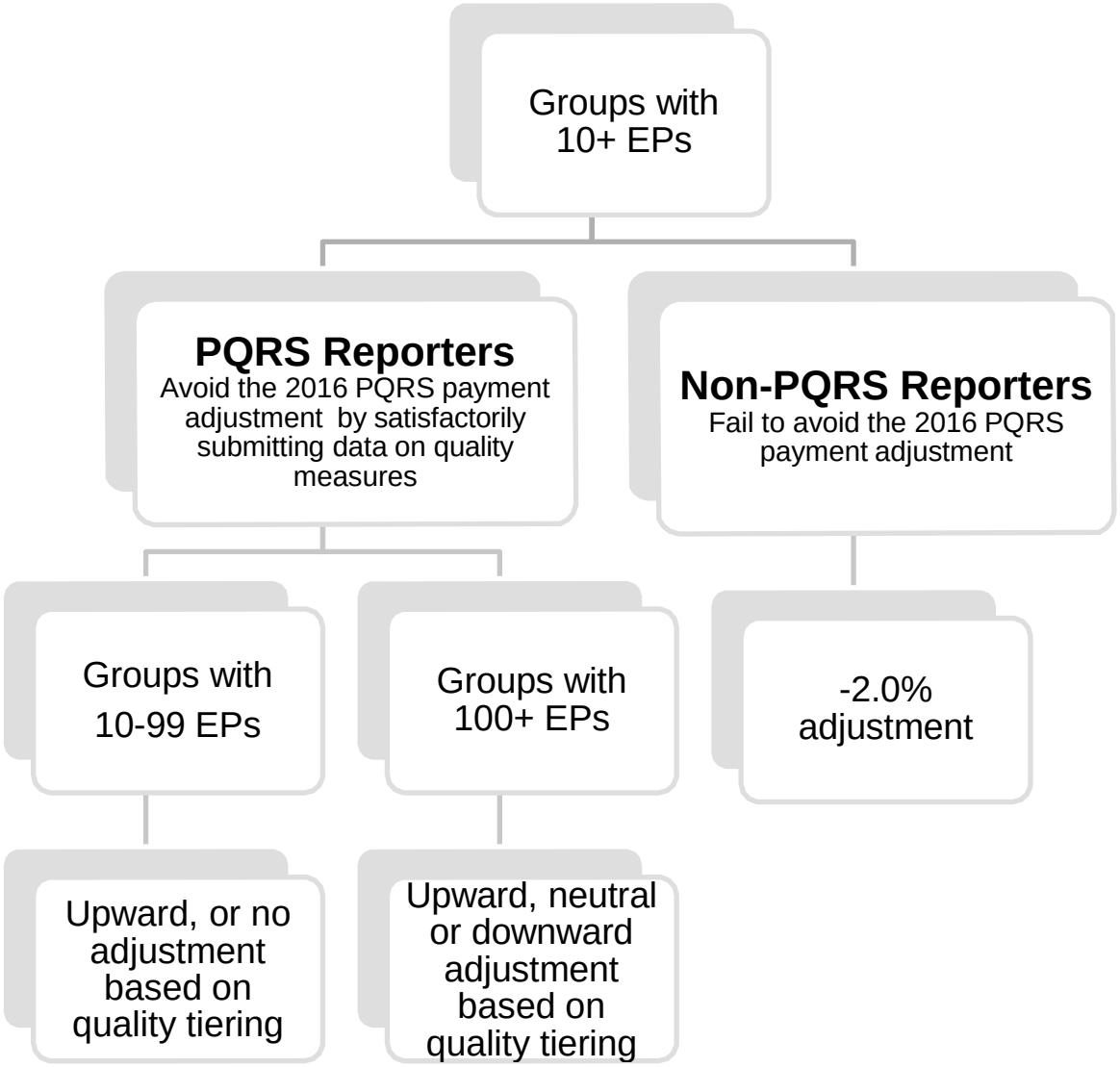
Overview	Diabetes Measures Group
1	Diabetes: Hemoglobin A1c Poor Control
110	Preventive Care and Screening: Influenza Immunization
117	Diabetes: Eye Exam
119	Diabetes: Medical Attention for Nephropathy
163	Diabetes: Foot Exam
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Overview	Preventive Care Measures Group
134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

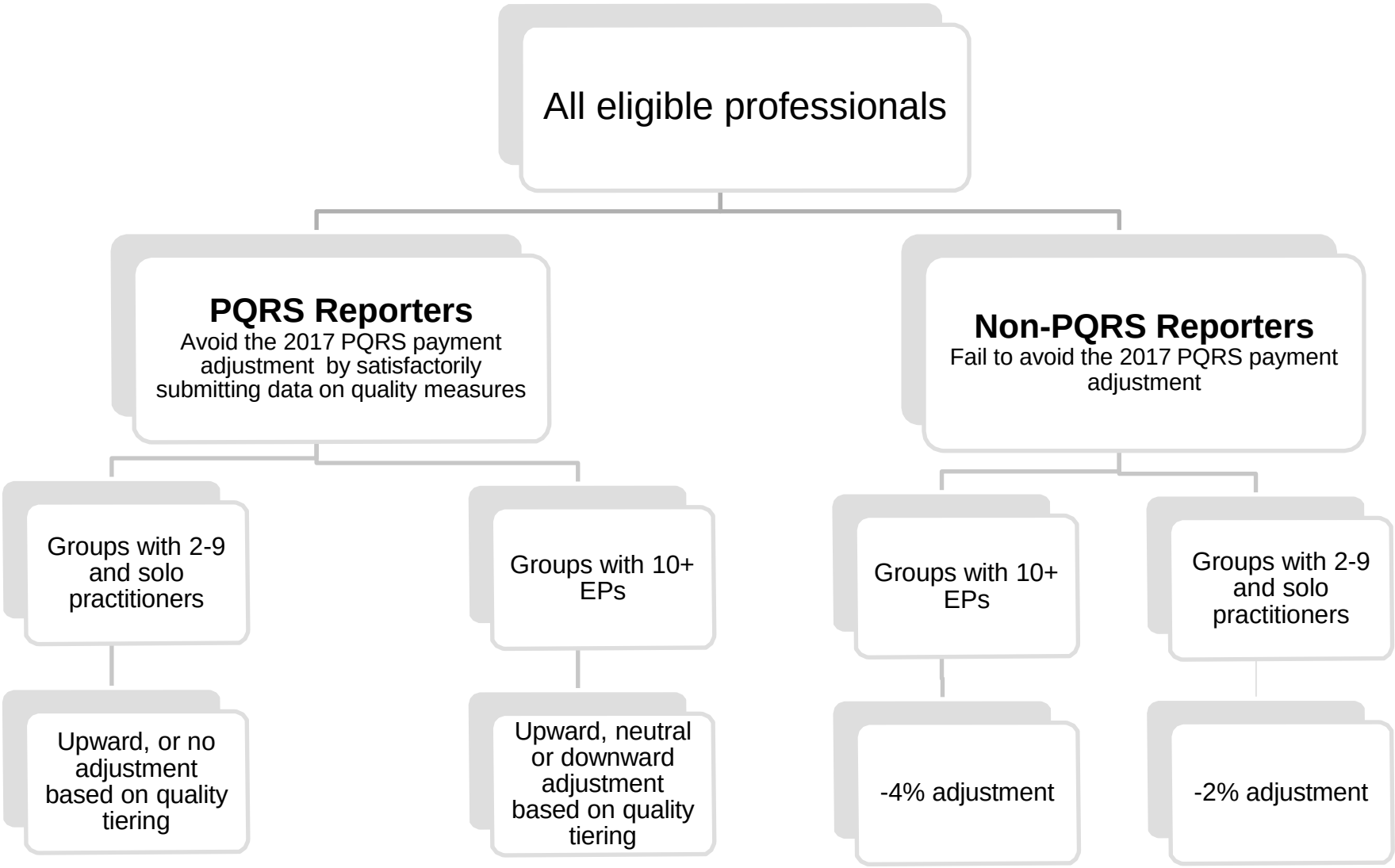
Overview	Dementia Measures Group
285	Dementia: Screening for Depressive Symptoms

Measure specifics can be found using the 2015 PQRS Measures Groups Specifications Manual and more info on PQRS here.

2016 Value-Based Payment Modifier



2017 Value-Based Payment Modifier: Mandatory Quality Tiering



Quality Tiering- Performance is categorized

2016

Quality/Cost	Low cost	Average Cost	High Cost
High Quality	+2.0x*	+1.0x*	+0.0%
Average Quality	+1.0x*	+0.0%	-1.0%
Low Quality	+0.0%	-1.0%	-2.0%

2017

Quality/Cost	Low cost	Average Cost	High Cost
High Quality	+4.0x*	+2.0x*	+0.0%
Average Quality	+2.0x*	0.0%	-2.0%
Low Quality	+0.0%	-2.0%	-4.0%

x* represents an undefined bonus factor

Future State

Overview of Payment System Reforms in the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2)

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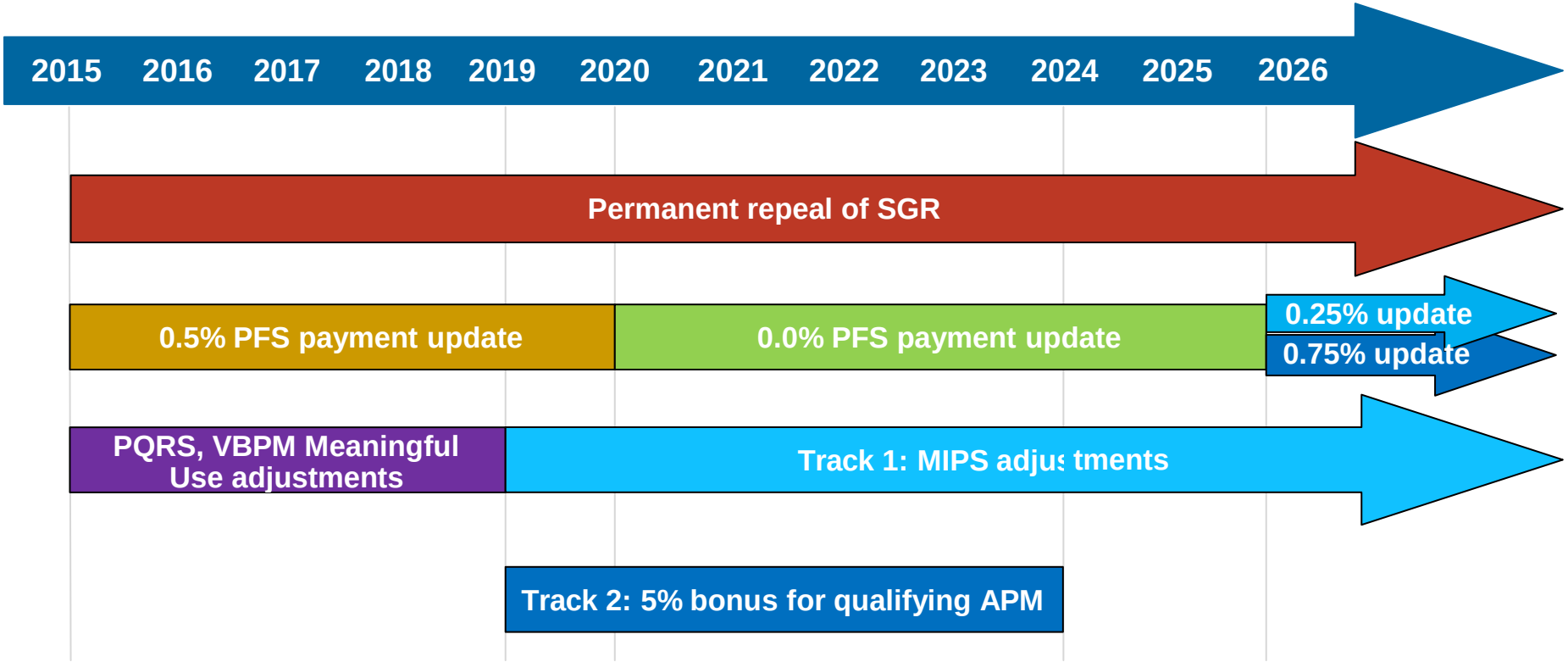
Timeline of Medicare physician payment reforms



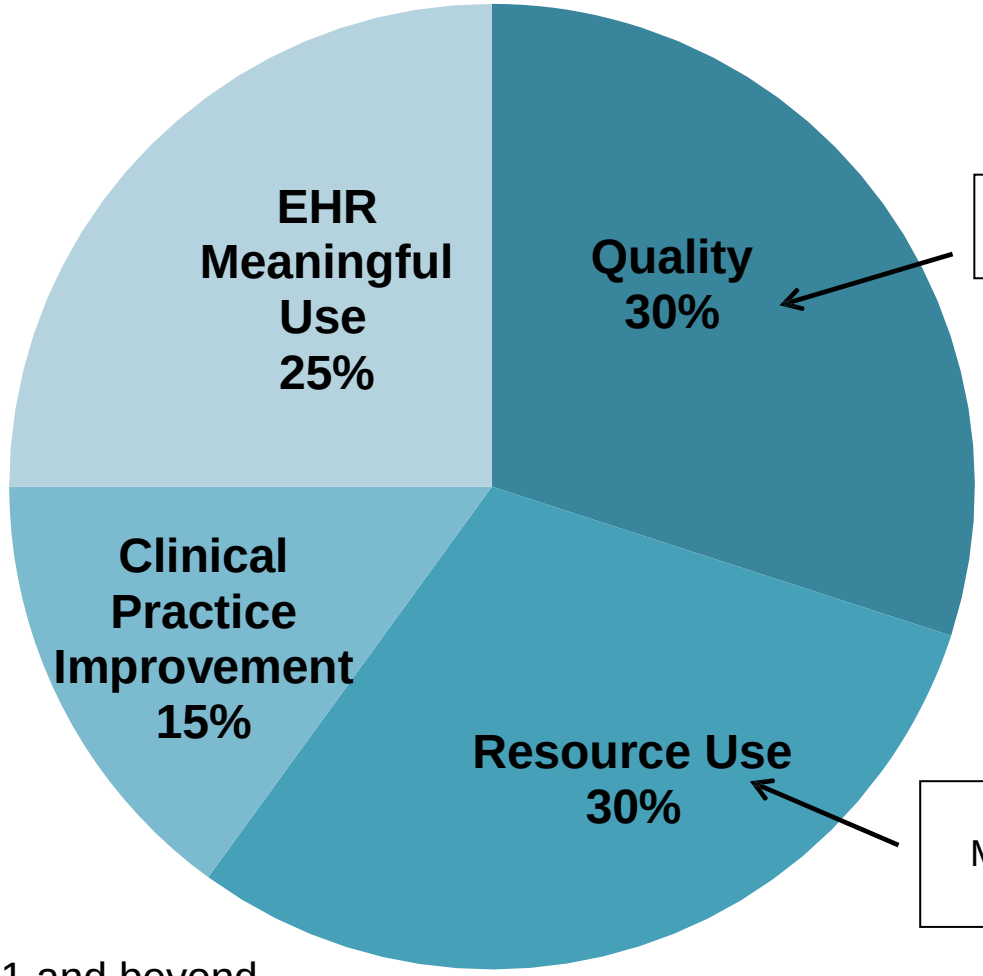
TRACK 1

MIPS: *COMING IN 2019*

PAYING FOR "VALUE" IN FFS

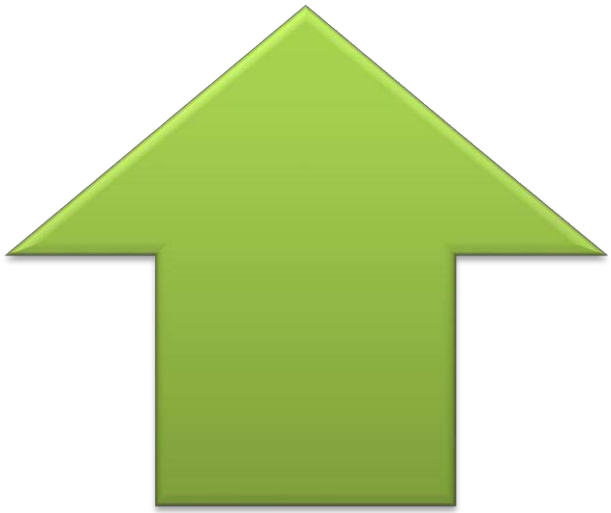
Track 1: MIPS Structure

Eligible professionals will be measured in 4 performance categories, and receive a composite score ranging from 0-100



*Weightings for 2021 and beyond

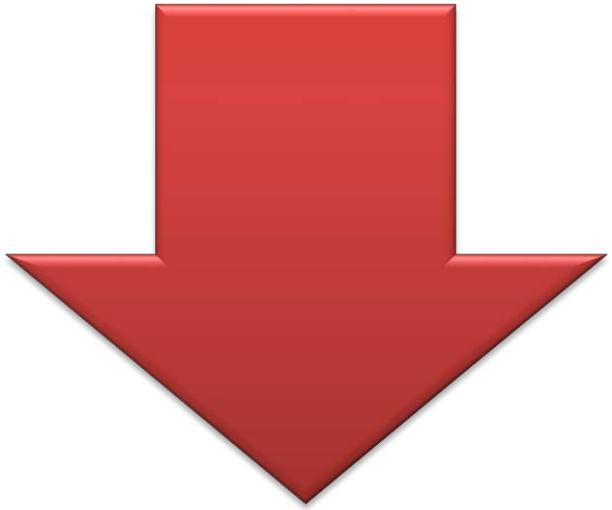
Performance against a threshold will dictate payment adjustment, which will phase in over time



Positive adjustments applied on a linear sliding scale, capped* at:

- 4% for 2019
- 5% for 2020
- 7% for 2021
- 9% for 2022 and beyond

Performance threshold *(mean or median of scores)*



Negative adjustments applied on a linear sliding scale, capped at:

- -4% for 2019
- -5% for 2020
- -7% for 2021
- -9% for 2022 and beyond

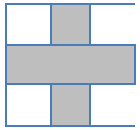
**Highest performers get extra adjustment of up to additional 10% through 2024*

TRACK 2

INCENTIVIZING ALTERNATIVE PAYMENT MODELS (APM)

1. Participation in an "eligible alternative payment entity"

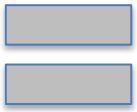
- **CMMI Model**
- **MSSP ACO**
- **Health Care Quality Demo under 1866C**
- **Demo required by federal law**



Requires use of certified EHR

And

Payment based on quality measures



Eligible Alternative Payment Entity

And

Bears financial risk for losses

OR

Medical home expanded under CMMI

2. Earning a significant share of revenue through the eligible alternative payment entity

- To qualify, a minimum percentage of payments must be attributable to Part B services furnished through the eligible alternative payment entity
- As an alternative, Secretary is granted authority to use patient counts in lieu of payments, subject to same thresholds

Thresholds			
2019-2020	**2021-2022**		
25% Medicare Part B payments	**Option 1:** **Medicare threshold** 50% Medicare Part B payments **Option 2:** **All-Payer threshold** 50% all-payer, including 25% Medicare Part B payments		**Mec** 75% pay **All-** 75% 25% pay

CONCLUSION

Key Take-Aways & Trends

- Medicare will continue trend of tying payment to value,
  - focus still remains on adjustments to fee-for-service chassis
- Separation remains on hospital and physician/clinical mandatory performance programs
- Some consistency across programs exists
  - Mixture of pay for reporting, penalty and performance programs in current state
  - Statutory caps on payment risk for all initiatives
  - Several programs use measure composites classified into “domains”, weighted, and then scored
- What’s next
  - Over the next 2-3 years, providers and systems will need to decide on whether to focus on MIPS or develop a Track 2 APM as result of new law

Contact Info

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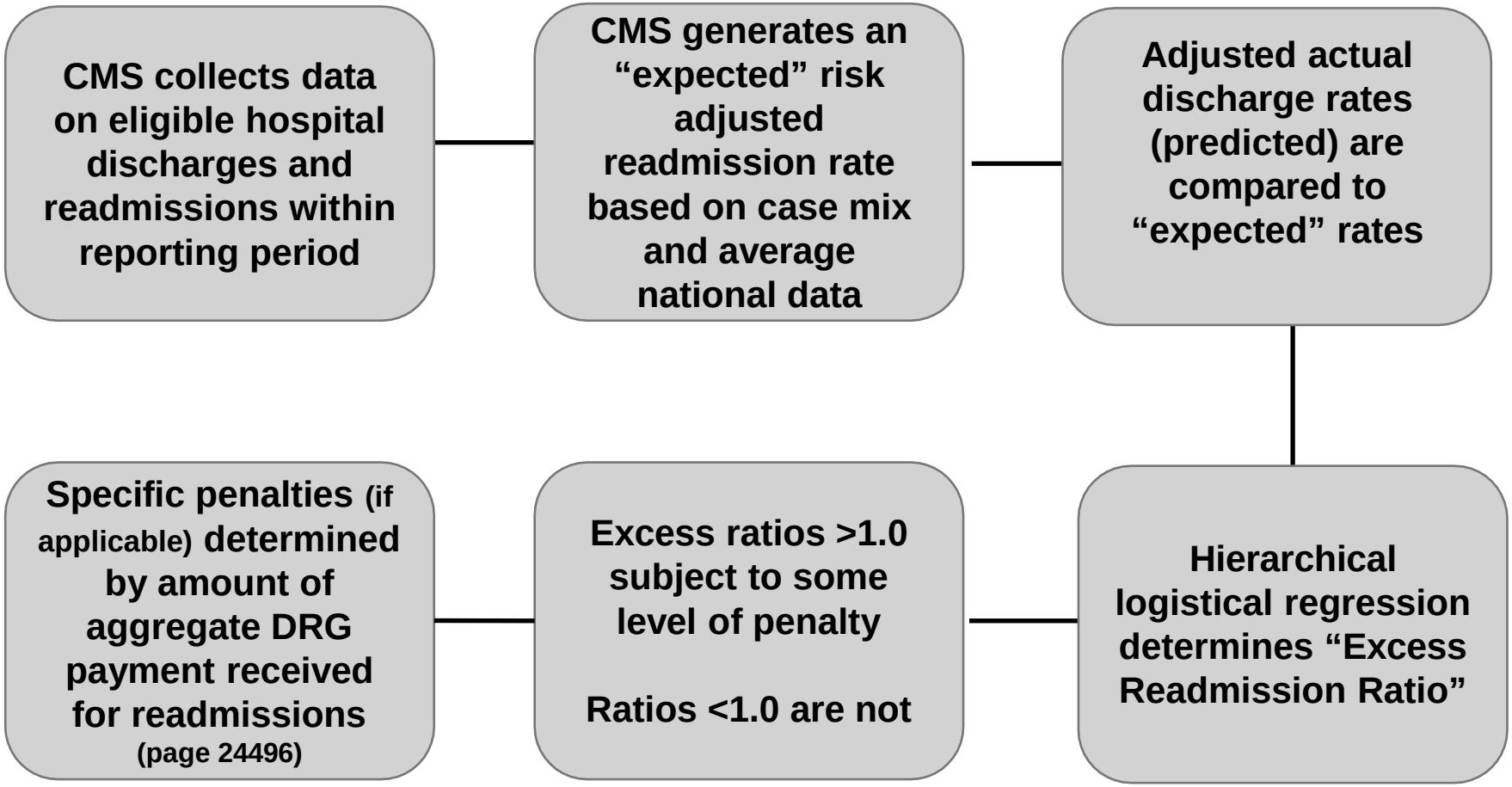
Appendix

Hospital Readmissions Reduction Program – How the program works

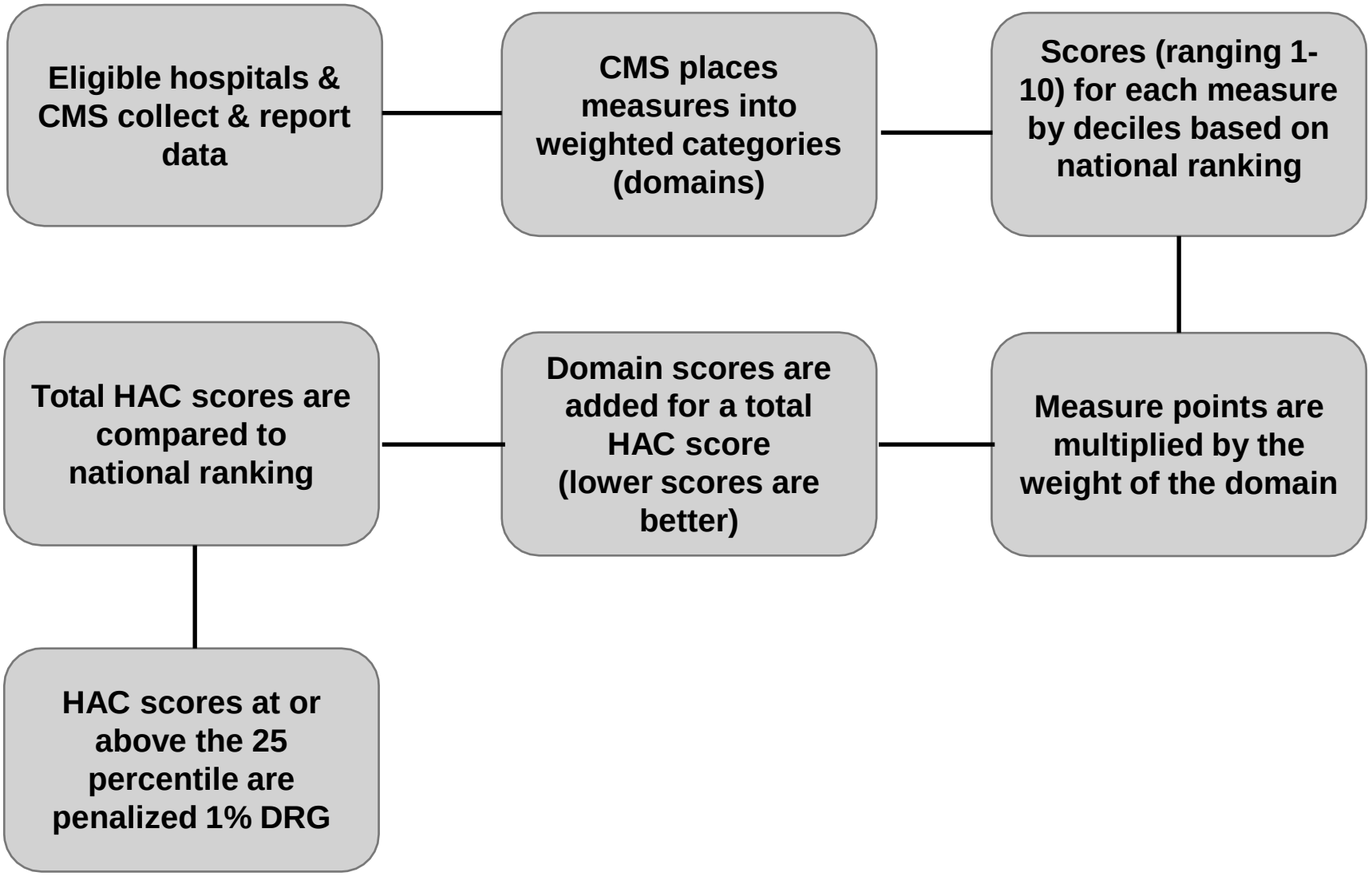


HRR Basic Scoring Example

Measures	Number eligible discharges	Number of Readmissions	Predicted (actual) Readmission Rate	Expected Readmission Rate	Excess Readmission Rate
AMI – Heart Attack	325	71	22.3%	19%	1.17
COPD – Lung Disease	185	24	13.1%	15%	0.87
HF – Heart Failure	341	94	27.5%	24.3%	1.13
PN - Pneumonia	195	21	11%	17%	0.65
THA/TKA – Hip/Knee	564	17	3.2%	5.1%	0.62

This hospital would receive some level of penalty across all inpatient discharges, but not greater than 3%

HAC Program – How the program works

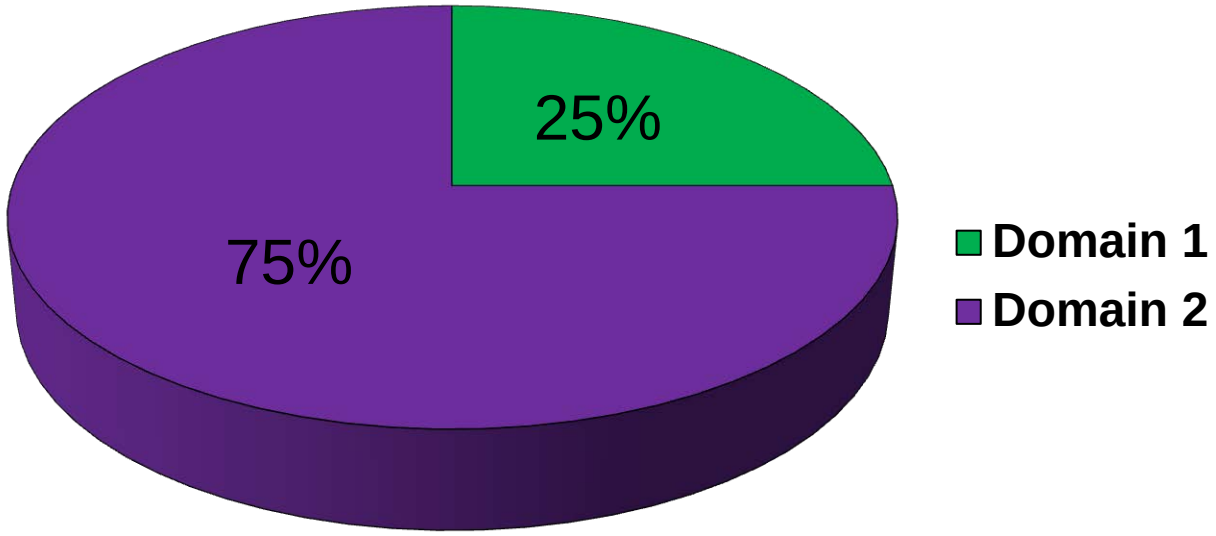


FY 2016 HAC Program (finalized)

Domain 1 PSI-90 AHRQ Pt Safety Composite *Performance period: July 1, 2012—June 30, 2014*
PSI-3: pressure Ulcer
PSI-6: Iatrogenic pneumonthorax
PSI-7: central venous catheter-related blood stream infection rate
PSI08: hip fracture
PSI-12: perioperative PE/DVT rate
PSI-13: sepsis rate
PSI-14: wound dehiscence rate
PSI-15: accidental puncture

Domain 2 CDC Measures *Performance period: January 1, 2013—Dec. 31, 2014*
CLABSI: Central Line Bloodstream infections (expanded from ICU's only to all hospital units)
CAUTI's: Catheter Urinary Tract Infections (expanded from ICU's only to all hospital units)
NEW!: SSI: Colon & Abdominal Hysterectomy

FY 2016 HAC Domain Weight



HAC Scoring Sample

Domain	Measure Result	Performance Decile	Points based on decile	Domain Score
Domain 1 Score	0.8732	6th	6	6
Domain 2 Score				5
CLABSI	0.535	4th	4	
CAUTI	1.20	6th	6	

Domain 1 Score	Weight of Domain 1	Domain 1 weighted score	Domain 2 Score	Weight of Domain 2	Domain 2 weighted score
6.0	**0.35**	**2.1**	**5.0**	**0.65**	**3.25**

Your hospital's total HAC Score (2.1+3.25)	FY 2015 payment reduction threshold (75th percentile)	Subject to payment reduction?
5.35	**7.0**	**No**

Summary of HAC and MRR

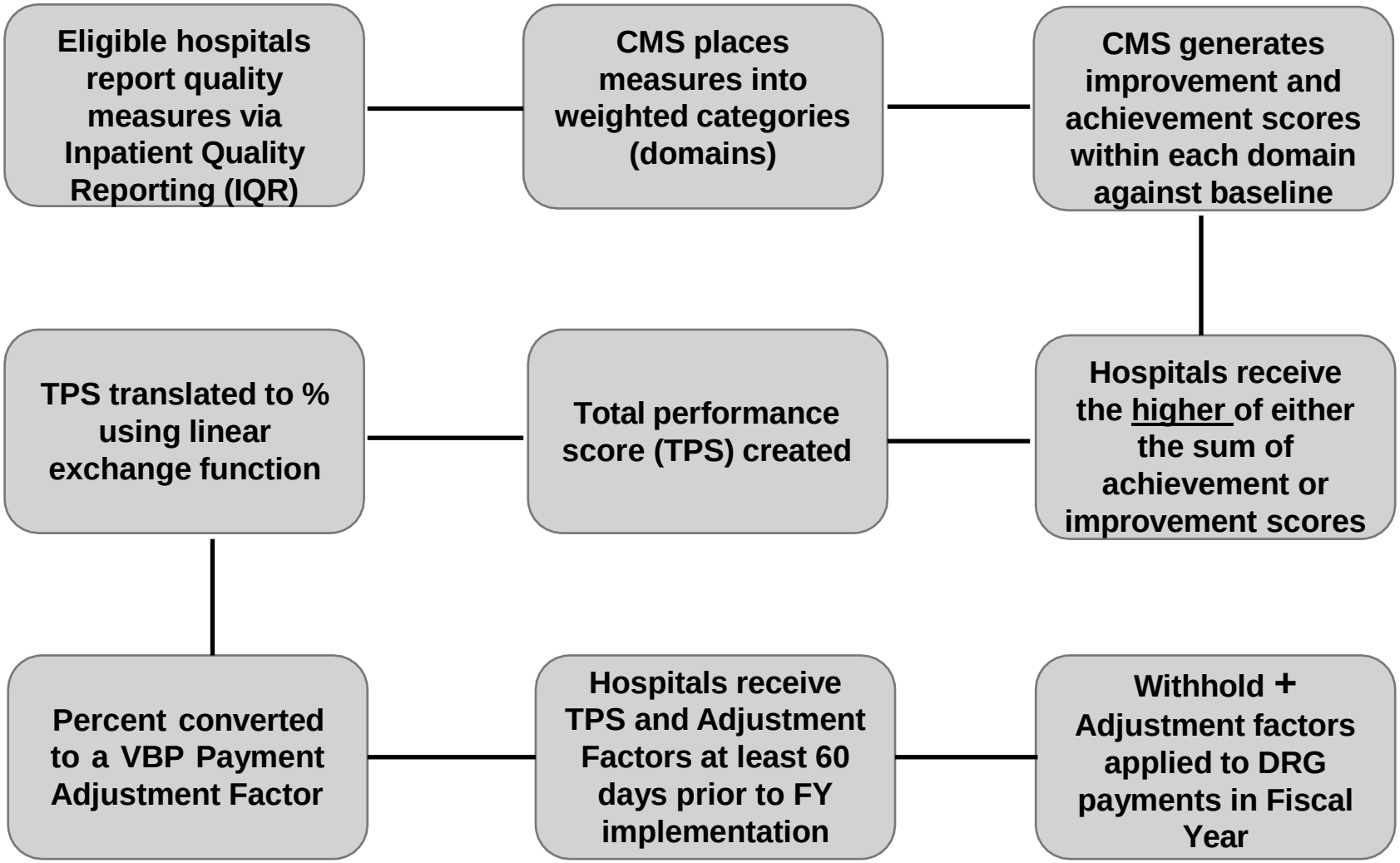
- Both are penalty programs only
- HAC program
  - Risk-adjusted and assessed against a national benchmark- SIRs (standardized infection rates)
  - Points are scored based on decile categories (30%=3 points)
  - Lower scores are better
  - Will always have a 1% penalty assessed to lowest performing quartile (aka highest quartile in points scored)
- MRR program
  - Assessed against the average rate of hospitals with similar case mixes (similar to HAC)
  - Risk-adjusted
  - Lower scores are better
  - Penalty for excessive readmissions varies from minimal to up to 3%

Hospital VBP Financing

Year	Hospital DRG Withhold Amount Subject to re-distribution
FY 2013	1.00%
FY 2014	1.25%
FY 2015	1.50%
FY 2016	1.75%
FY 2017	2.00%
FY 2018 and beyond	2.00%

- Budget Neutral (Per Statute)
- DRG withholds simultaneously align with VBP Adjustment Factors (each Fiscal Year)
- $1.4 billion set aside for re-distribution in FY 2015

Hospital VBP- How the program works



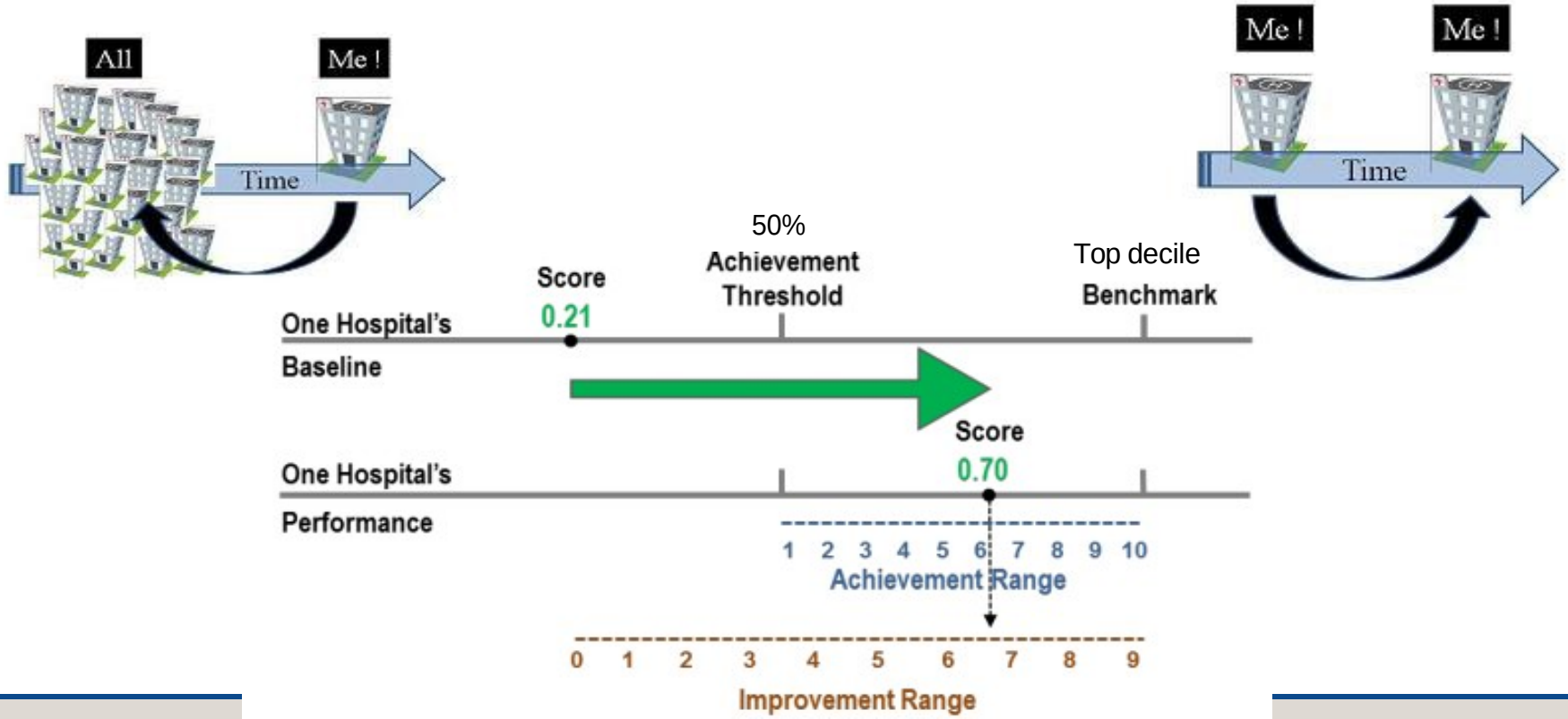
Achievement vs. Improvement
What's the difference?

Achievement Points

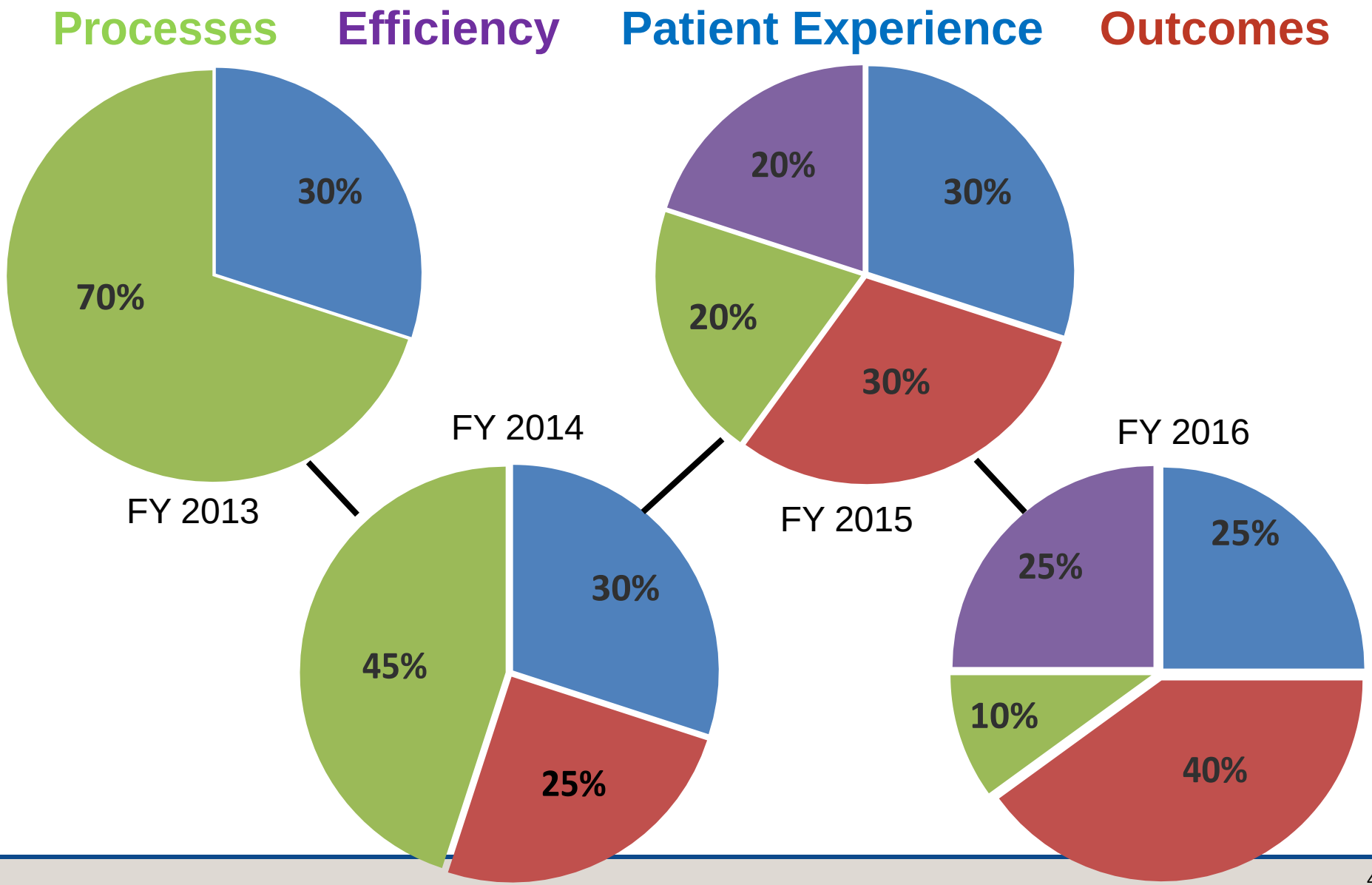
- At or above benchmark=10 points
- Between threshold and benchmark= 1-9
- Below threshold= 0

Improvement Points

- At or above benchmark=9
- Rate less than or equal to baseline=0
- Between baseline and benchmark=0-9



Weighting of Hospital VBP Measure Domains continues as a Key Policy Direction



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FY 2017 Measures & Domain Weights

Currently in performance periods for all measures.
Payment adjustment effective for discharges from October 1, 2016 to September 30, 2017
Baseline periods generally 1-3 years prior

Clinical Process of Care
AMI 7a Fibrinolytic agent received w/in 30' of hospital arrival
IMM-2 Influenza immunization
NEW! PC-01 Early elective delivery prior to 39 weeks
REMOVED! PN 6 Initial antibiotic selection for CAP immunocompetent pt
REMOVED! SCIP 2 Received prophylactic Abx consistent with recommendations
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REMOVED! SCIP-Card 2 Pre-admission beta blocker and perioperative period beta blocker
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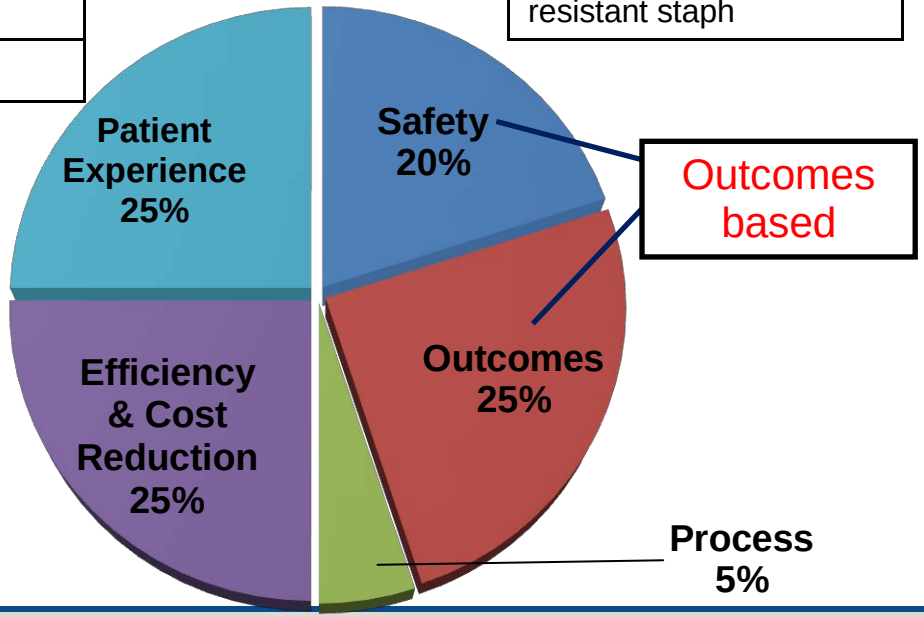
Patient Experience & Care Coordination
Communication with nurses
Communication w/ physicians
Responsiveness of staff
Pain management
Communication about medications
Cleanliness and quietness
Discharge information
Overall rating

Clinical Outcomes
AMI 30-Day mortality rate
HF 30-day mortality rate
PN 30-day mortality rate

Efficiency & Cost Reduction
MSPB – Medicare spending per beneficiary

Safety **NEW!**
Catheter-associated urinary tract infection
PSI-90 AHRQ Pt Safety Composite
CLABSI – blood infection
Surg. Site infection
NEW! C.diff clostridium difficile infection
NEW! MRSA methicillin-resistant staph

2.0% DRG withhold



Example FY 2015 performance score calculation breakdown

	Unweighted Improvement Score	Unweighted Achievement Score	Unweighted Score	Weighting	Weighted Domain Score
Clinical Process of Care	68.3	62.1	68.3	20%	13.66
Patient Experience of Care	52.7	39.2	52.7	30%	15.81
Outcome Domain	61.0	63.5	63.5	30%	19.05
Efficiency	21.2	34.5	34.5	20%	6.9
				Total Performance Score (TPS)	**55.4**
				National TPS	**41.7**

Base Operating DRG Percent Payment Amount Reduction	1.5%
Net Change in Base Operating DRG Payment Amount (Linear Exchange)	+0.574%
Value-Based Incentive Payment Adjustment Factor	1.00574

1.00 is the “break even” point of the withhold

Upcoming FY payments for DRG's would increase by over ½ of 1%

Example: $10,000 surgery would be reimbursed $10,057 for the fiscal year

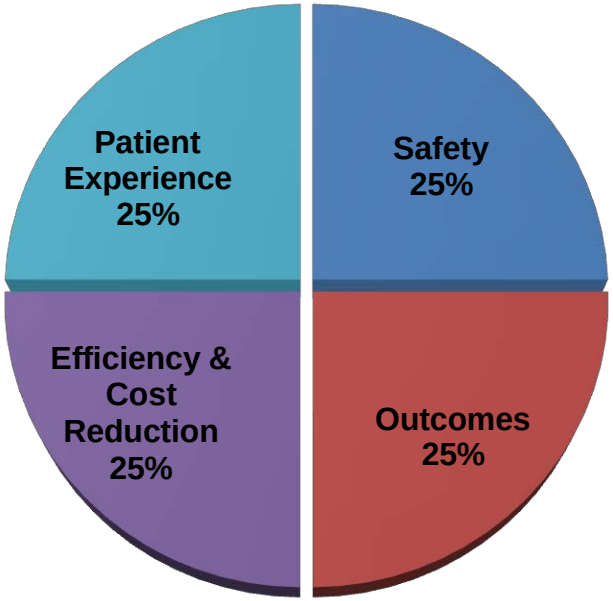
FY 2018 Performance Measures and Domain Weights (Proposed)

Clinical Processes of Care
~~AMI 30-Day mortality rate~~ **REMOVED!** AMI-8a Fibrinolytic agent received w/in 30' of hospital arrival
~~HF 30-day mortality rate~~
~~PN 30-day mortality rate~~ **REMOVED!** IMM-2 Influenza immunization
~~COPD 30-day mortality~~ **(FY 2021 proposed)**
PC-01 Early elective delivery prior to 39 weeks

Safety
CAUTI – urinary catheter infect.
PSI-90 AHRQ Pt Safety Composite
CLABSI – blood infection
Surg. Site infection
C.diff - Clostridium difficile infection
MRSA Methicillin-Resistant staph
PC-01 elective delivery prior to 39 weeks

Patient Experience & Care Coordination
Communication with nurses
Communication w/ physicians
Responsiveness of staff
Pain management
Communication about medications
Cleanliness and quietness
Discharge information
Overall rating
NEW! 3-Item Care Transition Measure (CTM–3)
▪ Patient and Family preferences in care received
▪ Clear understanding of patient responsibility for managing health post-discharge
▪ Understand purpose of medications

Efficiency & Cost Reduction
MSPB – Medicare spending per beneficiary



Refer to the FY 2016 Proposed Rule, pages 24506 – 24507 for performance thresholds and benchmarks for all measures

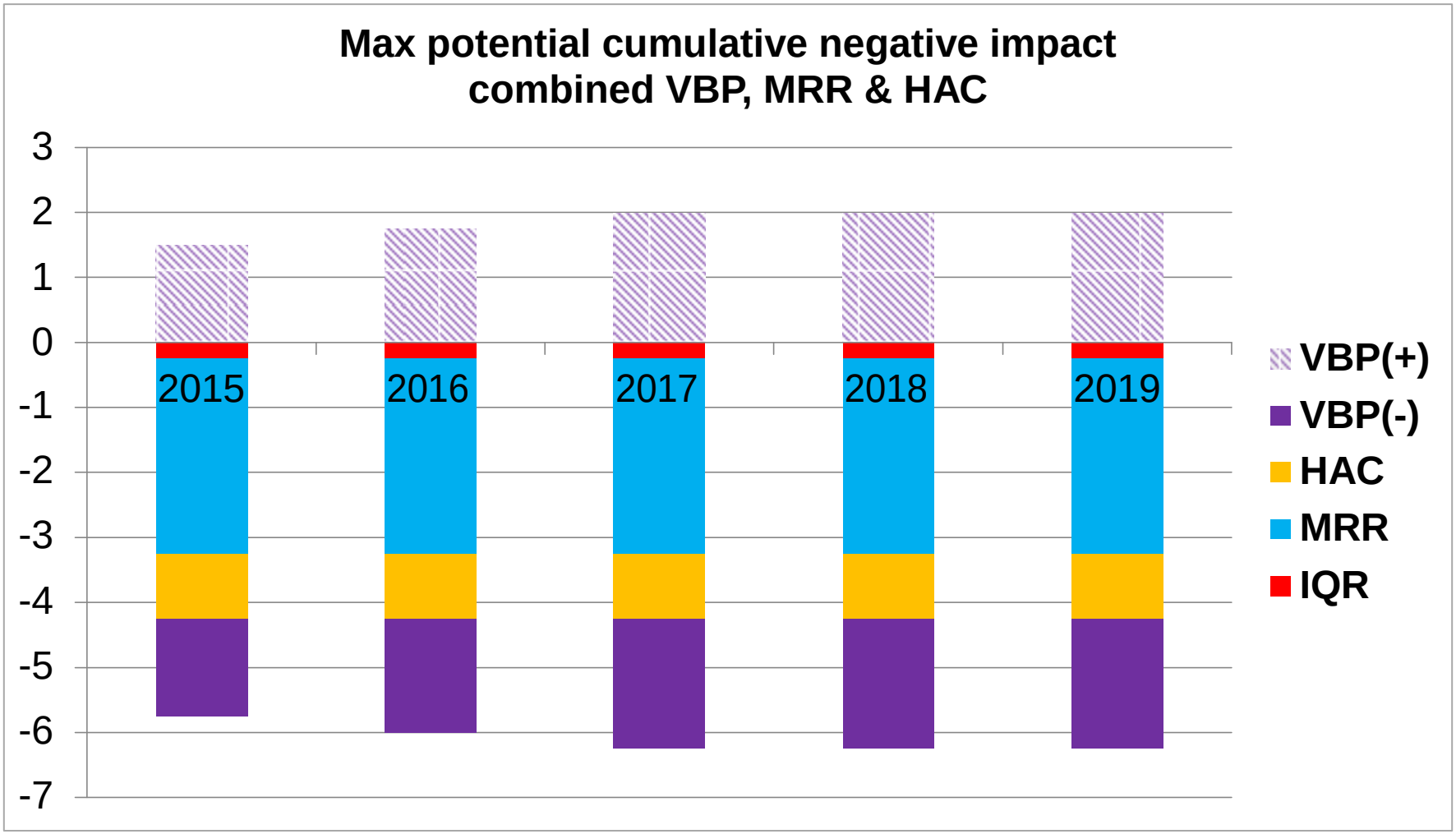
FY 2018 IQR Proposed Cost Measures

- Although a first step, CMS seems to be setting direction with additional efficiency measures
  - Conditional approval by Measure Application Partnership (MAP) but not yet NQF endorsed (measures submitted)
  - Linked to hospital services and high variation
  - Numerous references to the general approach and alignment with the MSPB measure
  - First finalized in the Hospital Inpatient Quality Reporting (IQR) program

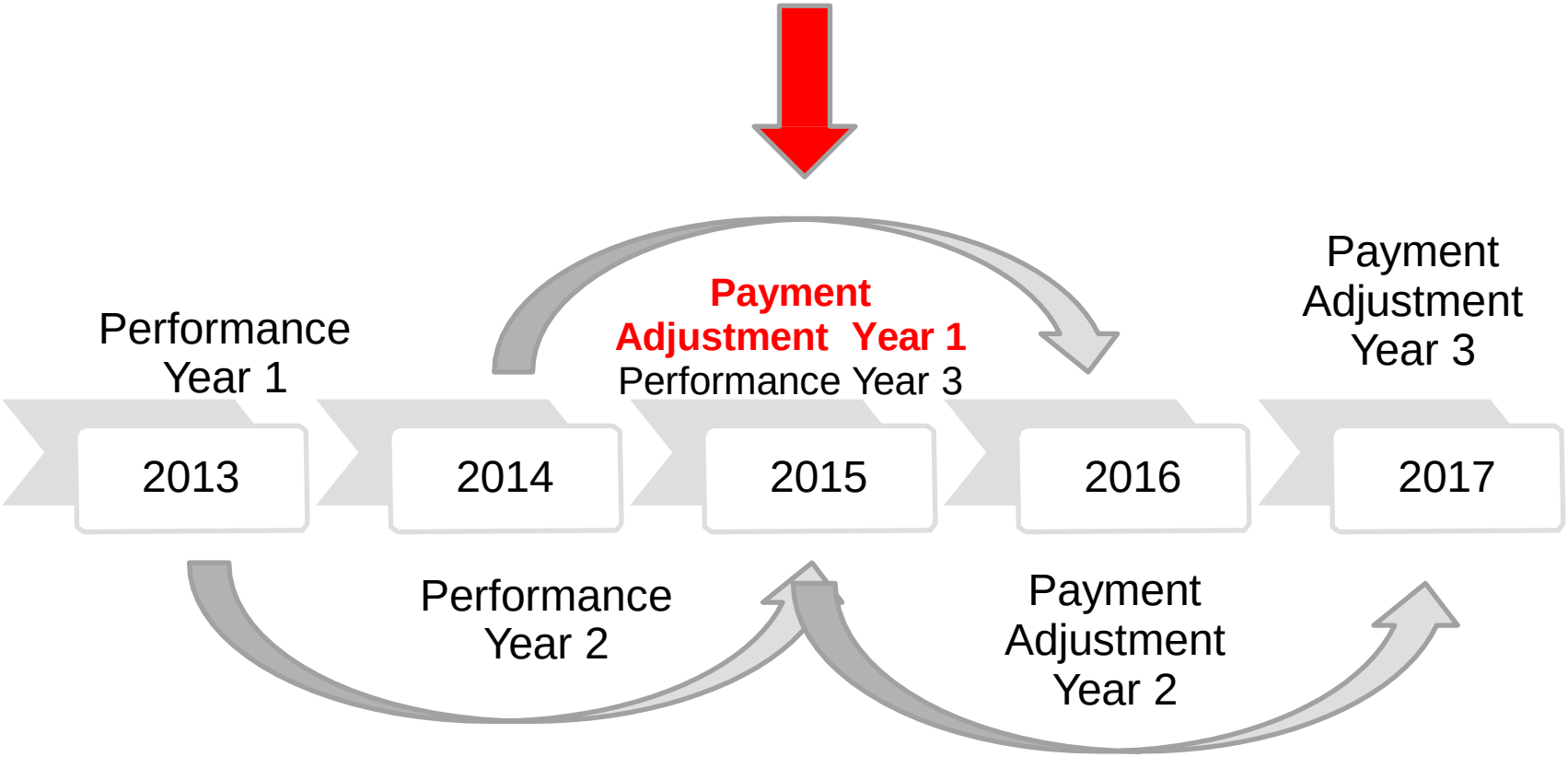
Medical	Surgical
Kidney/Urinary Tract Infection	**Hip replacement/revision**
Cellulitis	**Knee replacement/revision**
Gastrointestinal hemorrhage	**Lumbar spine fusion/refusion**

- Additional details on proposed efficiency/payment measures are on pages 24568 through 24574 of the proposed rule

MRR, HAC, and VBP in context



Physician Value-Based Payment Modifier Implementation Timeline



Basic Overview of VBPM Scoring Methodology

Step 1: CMS will calculate a standardized score for each cost and quality measure

→

Step 2: Standardized score is classified into a domain

→

Step 3: Domain scores are equally weighted and developed into quality or cost composites

↓

Step 4: Quality and cost composites are classified into low, median or high tiers compared to mean composite

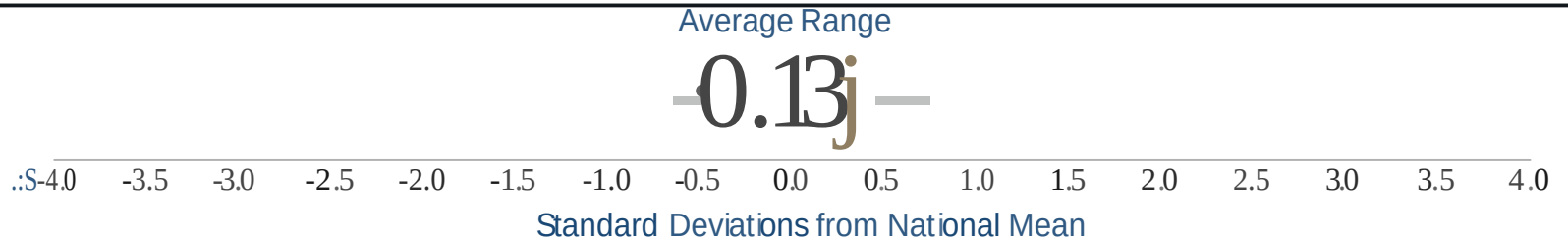
→

Step 5: Modifier is calculated based on tier placement

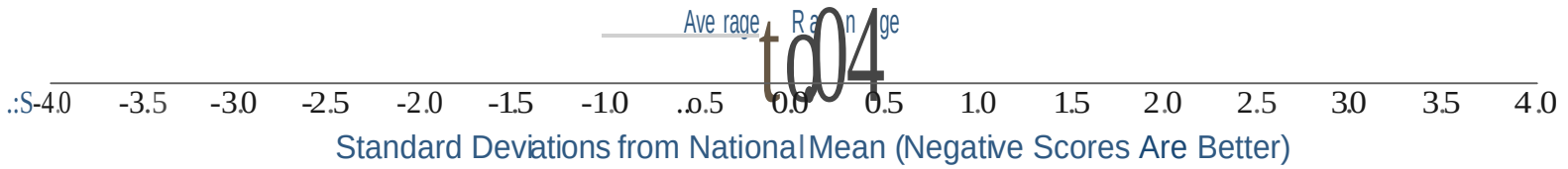
Physician Value Modifier Example Score

PERFORMANCE HIGHLIGHTS

YOUR QUALITY COMPOSITE SCORE: AVERAGE



YOUR COST COMPOSITE SCORE: AVERAGE



Quality Tiering Sample

Best performers

Lowest performers

Adjustment as Illustrated on Sample QRUR

YOUR VALUE-BASED PAYMENT ADJUSTMENT BASED ON QUALITY TIERING

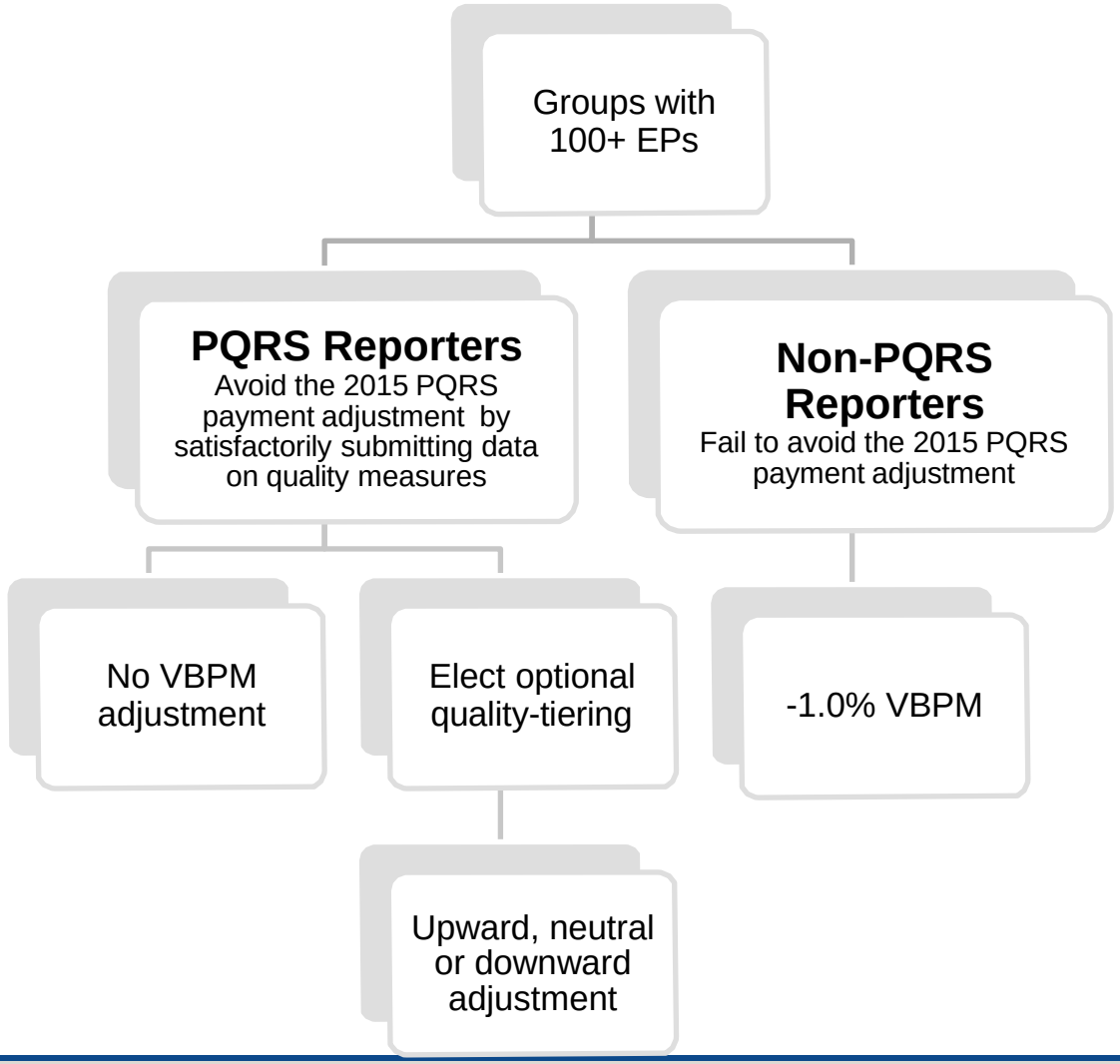
- Based on 2012 performance, electing the quality tiering approach would result in a payment adjustment of +0.0%.

Payment adjustments for each level of performance are shown below:

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0x%	+3.0x%
Average Cost	-0.5%	+0.0%	+2.0x%
High Cost	-1.0%	-0.5%	+0.0%

Note: x refers to a payment adjustment factor yet to be determined due to budget neutrality requirements.

Application of 2015 Value-Based Payment Modifier: Optional Quality Tiering



Groups that elect quality tiering will be eligible for an upward, neutral or downward adjustment in 2015

Quality/Cost	Low cost	Average Cost	High Cost
High Quality	+2.0x*	+1.0x*	+0.0%
Average Quality	+1.0x*	+0.0%	-0.5%
Low Quality	+0.0%	-0.5%	-1.0%

* Additional +1.0x for groups that care for high-risk patients (top 25%)

Applying Value Modifier to MSSP Accountable Care Organizations

Quality/Cost	Low cost	Average Cost	High Cost
High Quality	+4.0x*	+2.0x	+0.0%
Average Quality	+2.0x*	0.0%	-2.0%
Low Quality	+0.0%	-2.0%	-4.0%

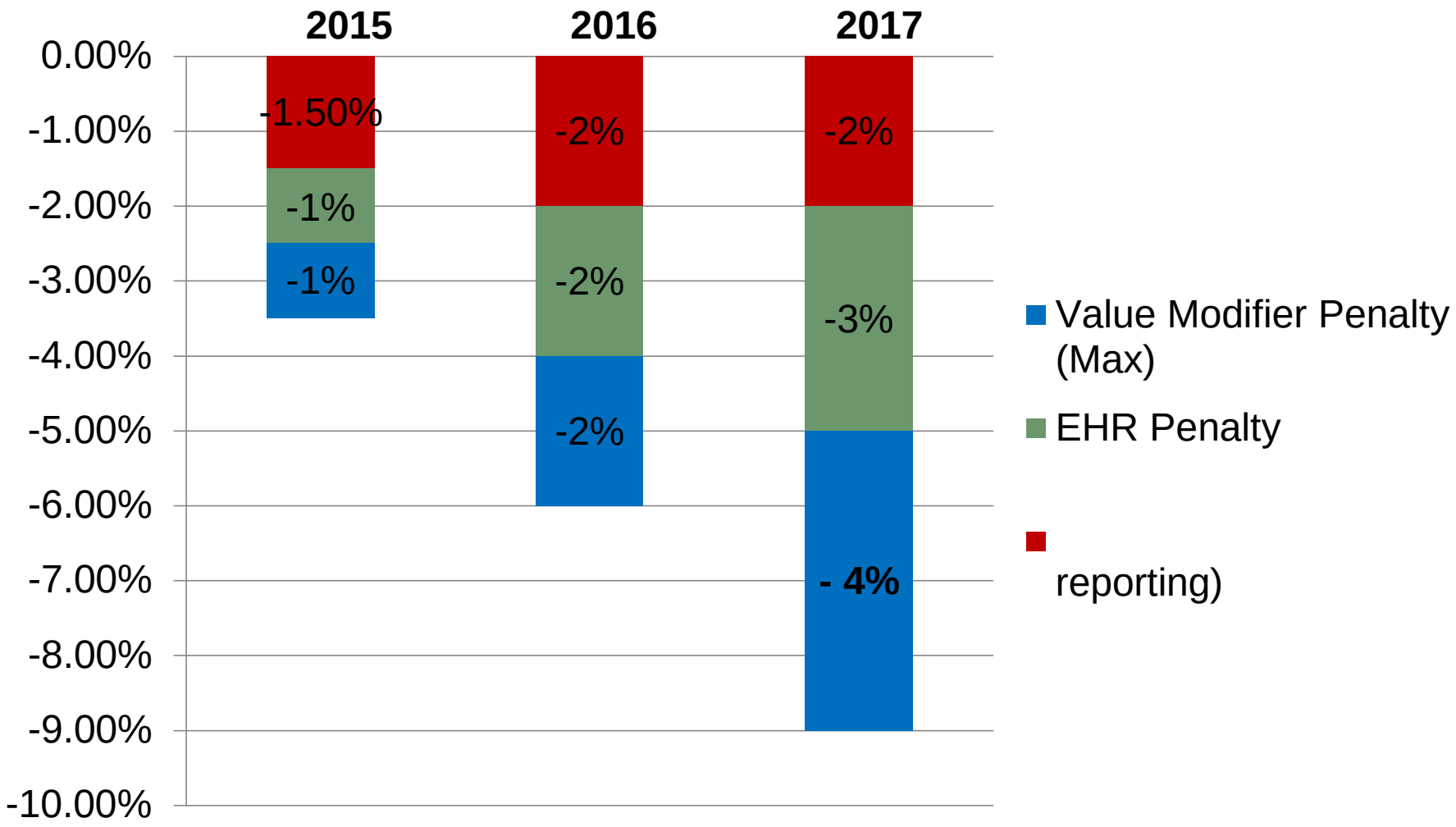
- Quality composite score based on quality data submitted by ACO during performance period and applied to all TINs participating in ACO
- Cost composite score will not be calculated and all TINs participating in ACO will be considered “average cost”
- Additional +1.0x for groups that care for high-risk patients
- TINs with 2-9 EPs and solo practitioners held harmless for negative adjustments in 2017

Applying Value Modifier to Participants in Pioneer ACOs, the Comprehensive Primary Care Initiative, and "Other Similar Innovation Center Models or CMS Initiatives"

Quality/Cost	Low cost	Average Cost	High Cost
High Quality	+4.0x*	+2.0x	+0.0%
Average Quality	+2.0x*	0.0%	-2.0%
Low Quality	+0.0%	-2.0%	-4.0%

- Groups and solo practitioners in these models will be classified as "average cost" and "average quality"
- Modifier will apply to all physicians billing under a group's TIN

The Physician Value Modifier in Context



Overview of H.R. 2 (Public Law 114-10)

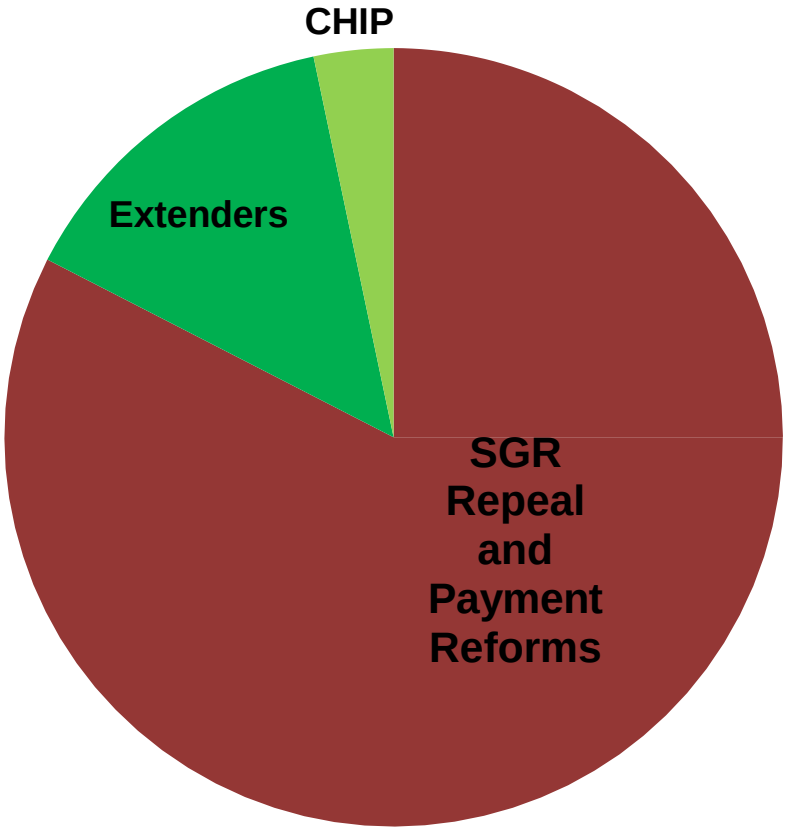
- Permanently repeals SGR and provides schedule of fixed payment updates
- Creates new Merit-Based Incentive Payment System (MIPS)
- Incentivizes movement to alternative payment models

H.R. 2 marks the end of an era

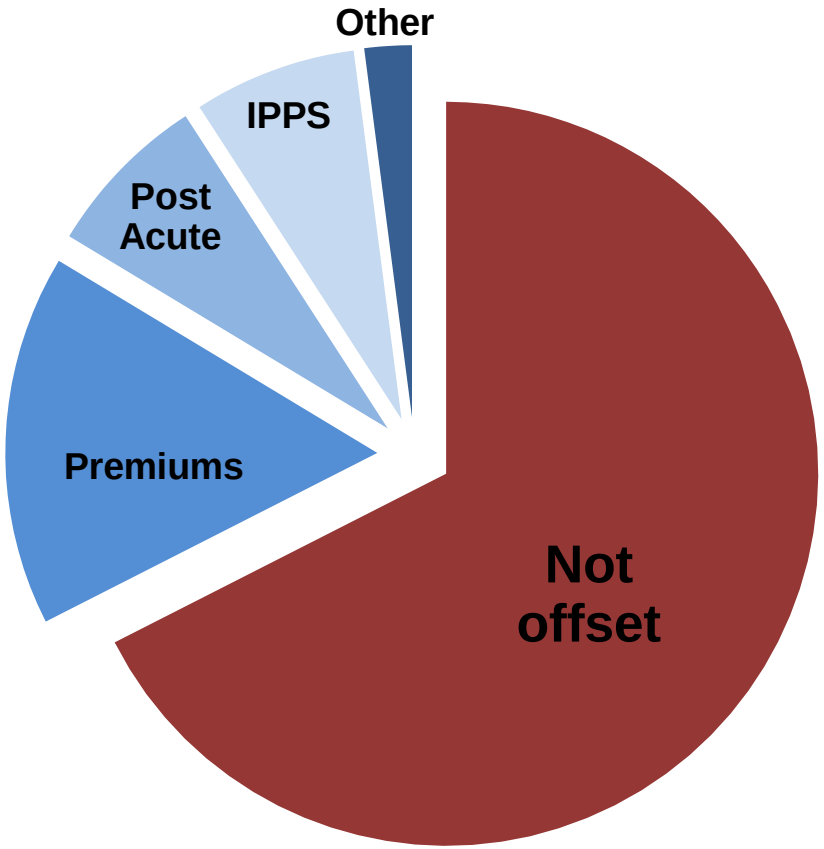
12	Years that the SGR formula has threatened substantial cuts to physician pay
17	Short-term legislative “doc fixes”
$150 billion	Amount spent on short-term fixes

Debate over "pay-fors" ended with agreement to *partially* offset new spending

$214 billion in new spending



$70 billion in offsets



2019 - two new payment systems emerge

Track 1: FFS and Merit-Based Incentive Program	Track 2: Participation in Qualifying Alternative Payment Models
• Assessment on measures of quality, resource use, clinical practice improvement, and EHR meaningful use • Payment adjustment increases over time: ✓ 2019= +/-4% ✓ 2020= +/-5% ✓ 2021= +/-7% ✓ 2022 and beyond = +/-9% • Excludes “partial” qualifying APMs and low-volume practices • 0.25% update 2026 and beyond	• 5% bonus between 2019-2024 • For professionals who receive a “significant share” of payments through an alternative payment entity that is risk-bearing or is a Medicare–recognized medical home • Must have quality component and use EHR • “Significant share” determined by % of revenue in APMs • Excluded from MIPS • 0.75% update 2026 and beyond

MIPS Performance Measures

Measures largely based on existing programs, but opportunities exist for stakeholder engagement and program formalization

Quality	Process for stakeholder input on operational plan for quality measure development
Resource Use	Process for stakeholder input on development of episode and patient condition groups, attribution methodology, and measures

"Clinical Practice Improvement Activities" introduced as new performance category

- Statute specifies performance subcategories, but measures undefined in the new law:
  - Expanded practice access
  - Population management
  - Care coordination
  - Beneficiary engagement
  - Patient safety and practice assessment
  - Participation in an alternative payment model
- Statute directs CMS to seek stakeholder input in defining activities and criteria for assessing performance (request for information and rulemaking)

Qualifying APM participants will receive 5% bonus from 2019-2024

- To qualify, an eligible professional must do 2 things:

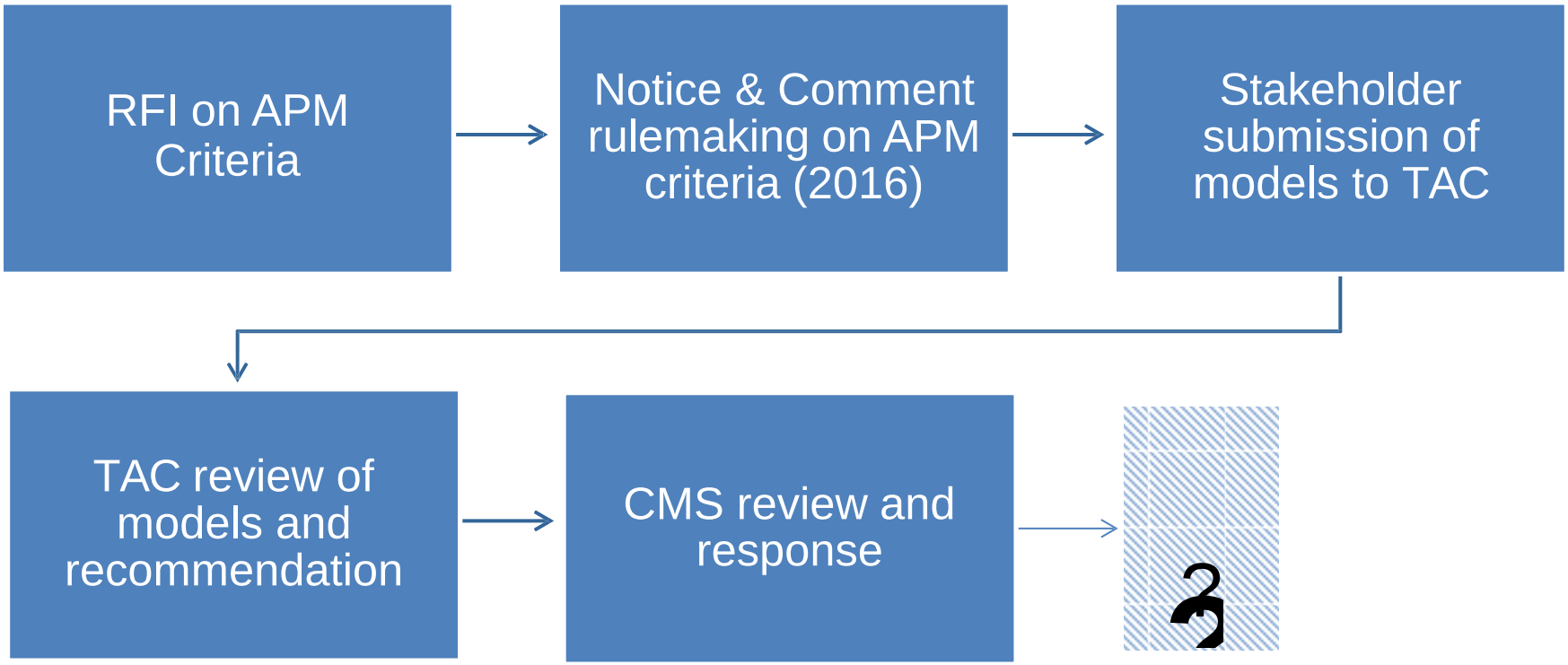
1

- Participate in an “eligible alternative payment entity”

2

- Earn a significant share of Part B revenue through that entity

New Technical Advisory Committee (TAC) will recommend new "Physician-focused" APMs



Pulling it all together: Performance-based payment under old and new regimes