Illinois Rural Community Care Organization©

Alternative Payment Models: Business and Physician Perspectives

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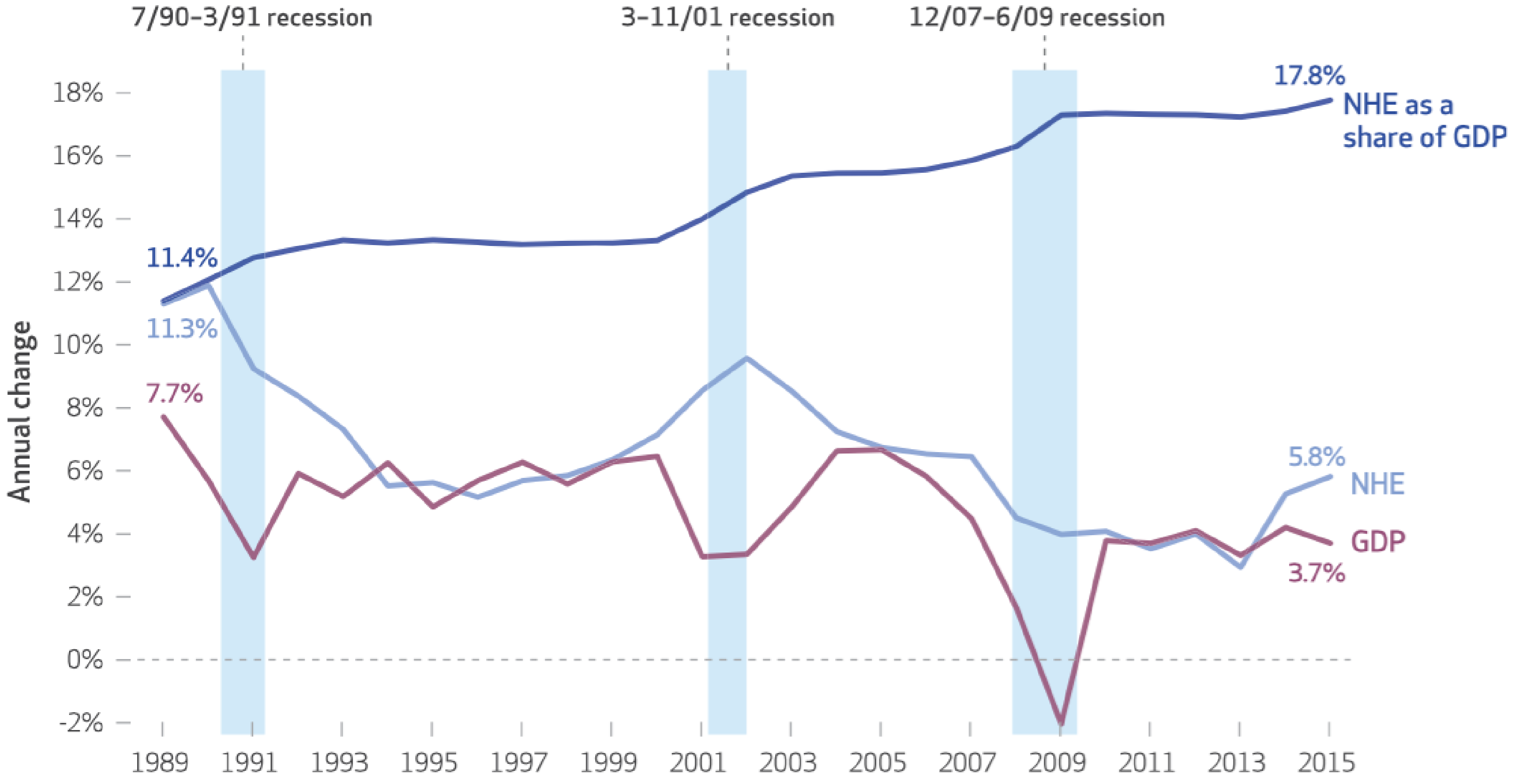
Agenda

- Medical Economics
- Value-Based Payment Framework
- The Rise of ACOs
- MACRA, MIPS, and APMS
- Messages from CMS
- New Revenue Opportunities

Medical Care Expense is 19.9% GDP in 2016

EXHIBIT 2

Growth in national health expenditures (NHE) and gross domestic product (GDP), and NHE as a share of GDP, 1989–2015



SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; US Department of Commerce, Bureau of Economic Analysis; and National Bureau of Economic Research Inc.

Value-Based Payment Framework

Fee for Service

- Traditional FFS
- Infrastructure incentives
- Care Management

Adjusted Fee for Service

- Pay for Reporting
- Pay for Performance
- Pay/Penalty for Performance

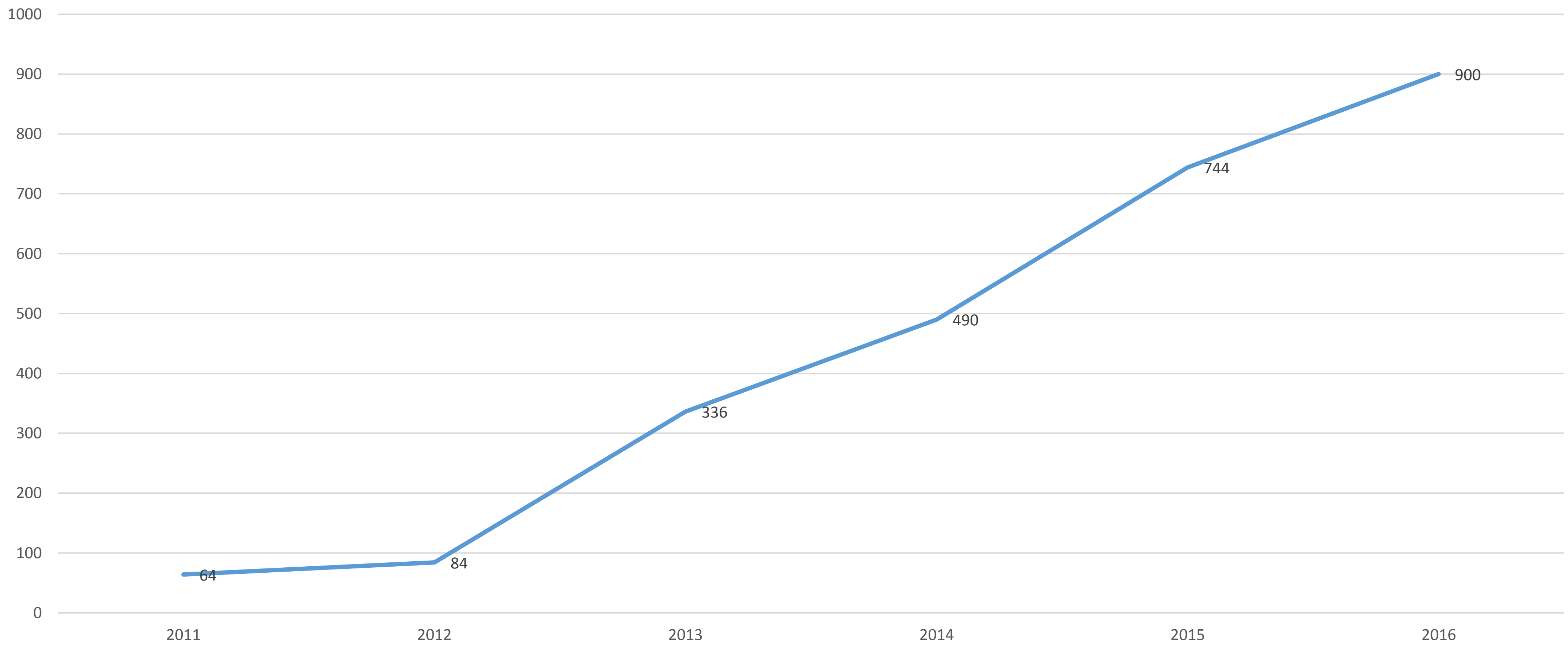
APM with Fee for Service

- Cost of care shared savings
- Cost of care shared risk
- Bundled payments

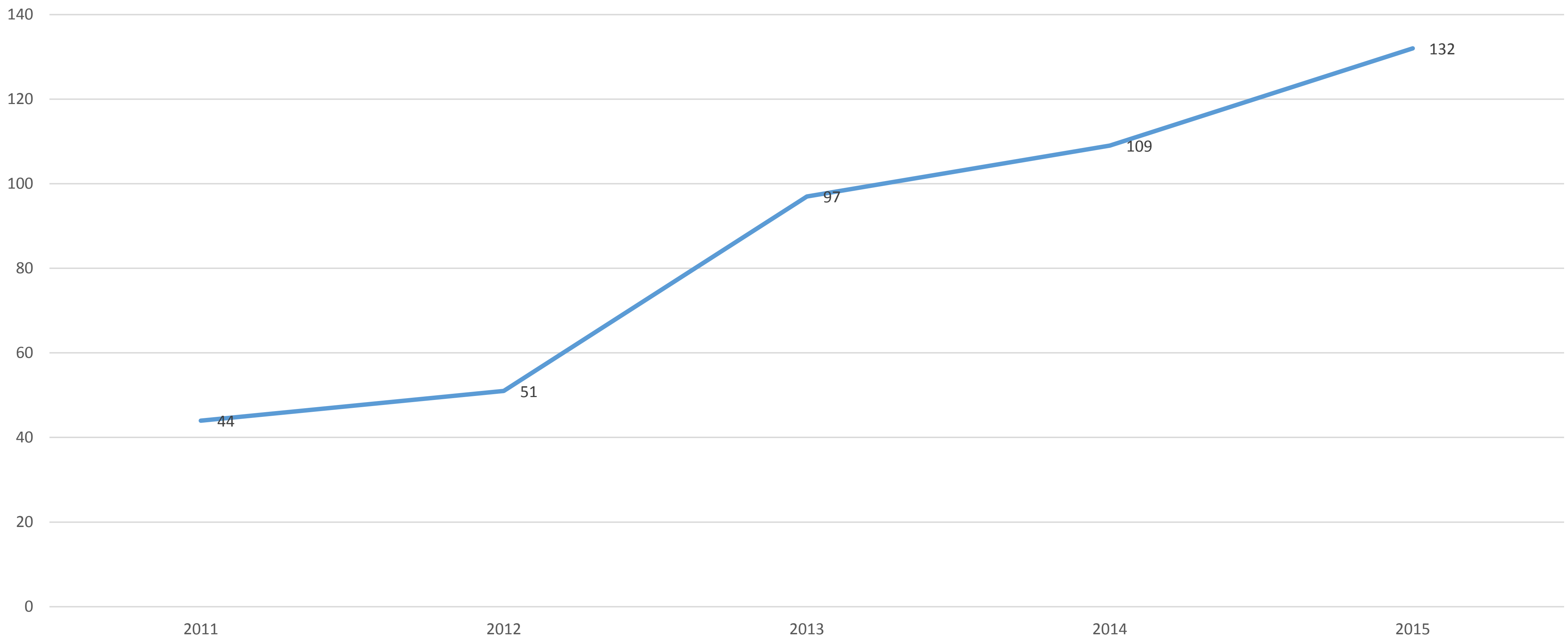
Population based APM

- Condition specific
- Primary Care
- Comprehensive Care

Total Accountable Care Organizations



Payers Participating in Accountable Care



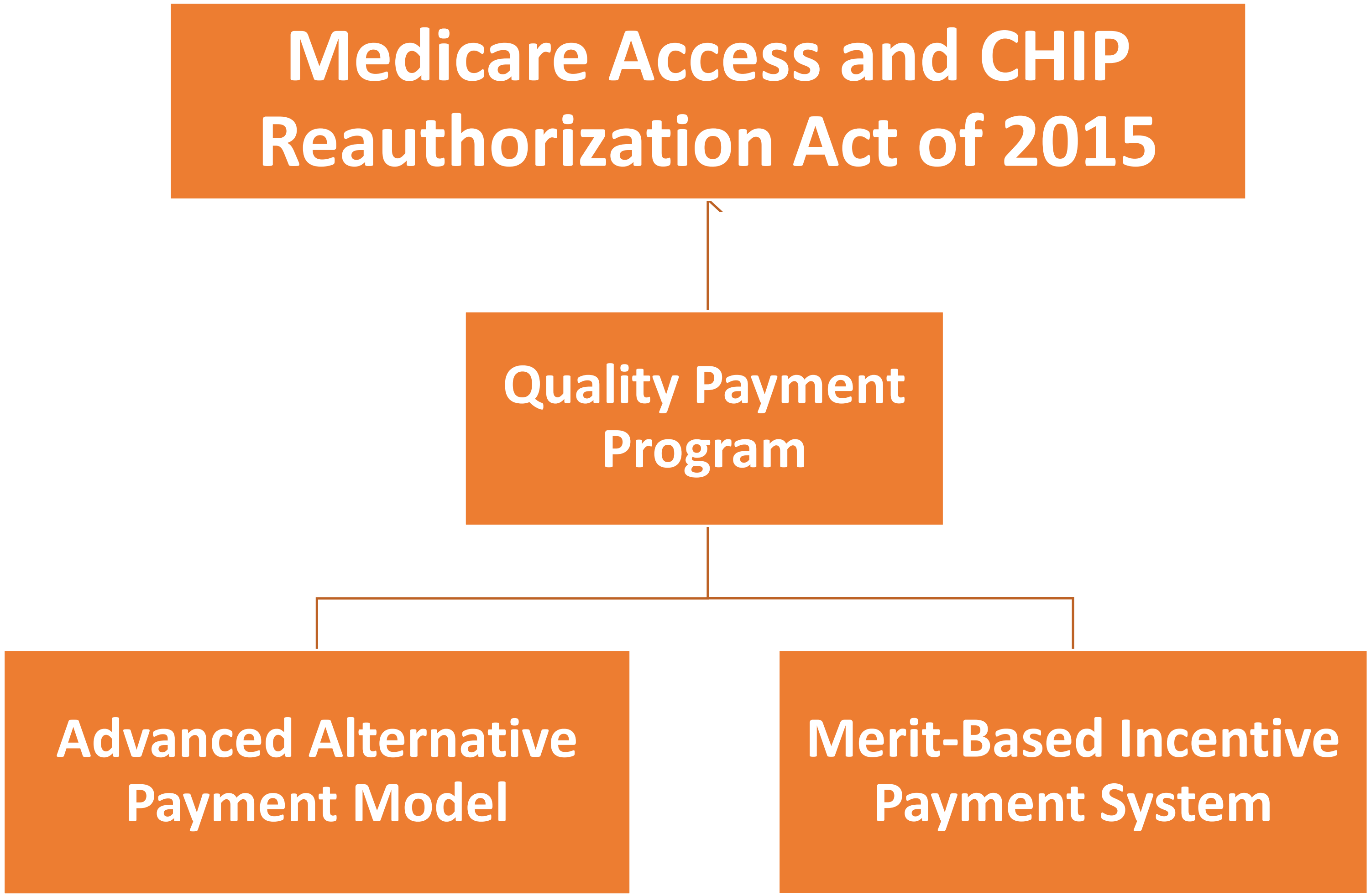
What are the Actions of CMS Telling Us

- Incentivize providers to join large groups
- Bend the cost curve
- Incentivize and measure ‘quality’
- Enhance provider transparency
- Incentivize providers to joint Quality Payment Programs (QPP)
- MACRA will impact all providers

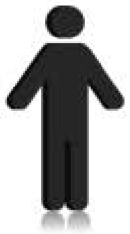
Take Away Ideas

- ACOs are here to stay and are spreading to commercial payers
- Volume to value transition will continue

MACRA


Medicare Access and CHIP Reauthorization Act of 2015
Quality Payment Program
Advanced Alternative Payment Model
Merit-Based Incentive Payment System

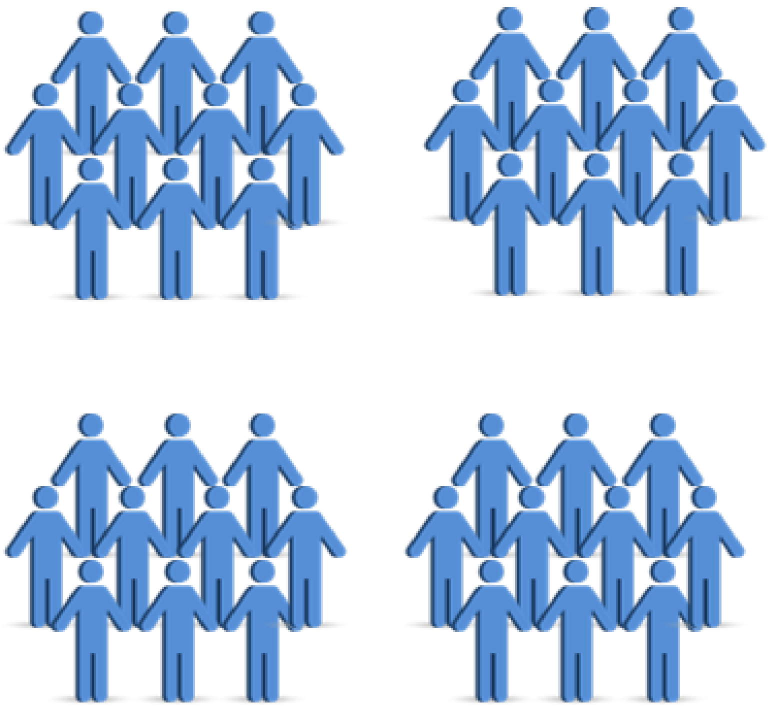
MACRA Eligible Clinicians

Years 1 and 2	Years 3+
	
Physicians, (MD/DO, DPM, OD, DC, DMD/DDS) PA, APRN, CRNA	Physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, dietitians/nutritional professionals

A physician or non-physician practitioner practicing in an RHC or FQHC still is subject to MACRA

Most providers will be subject to MIPS

MIPS



Non-Advanced APM

QP in Advanced APM

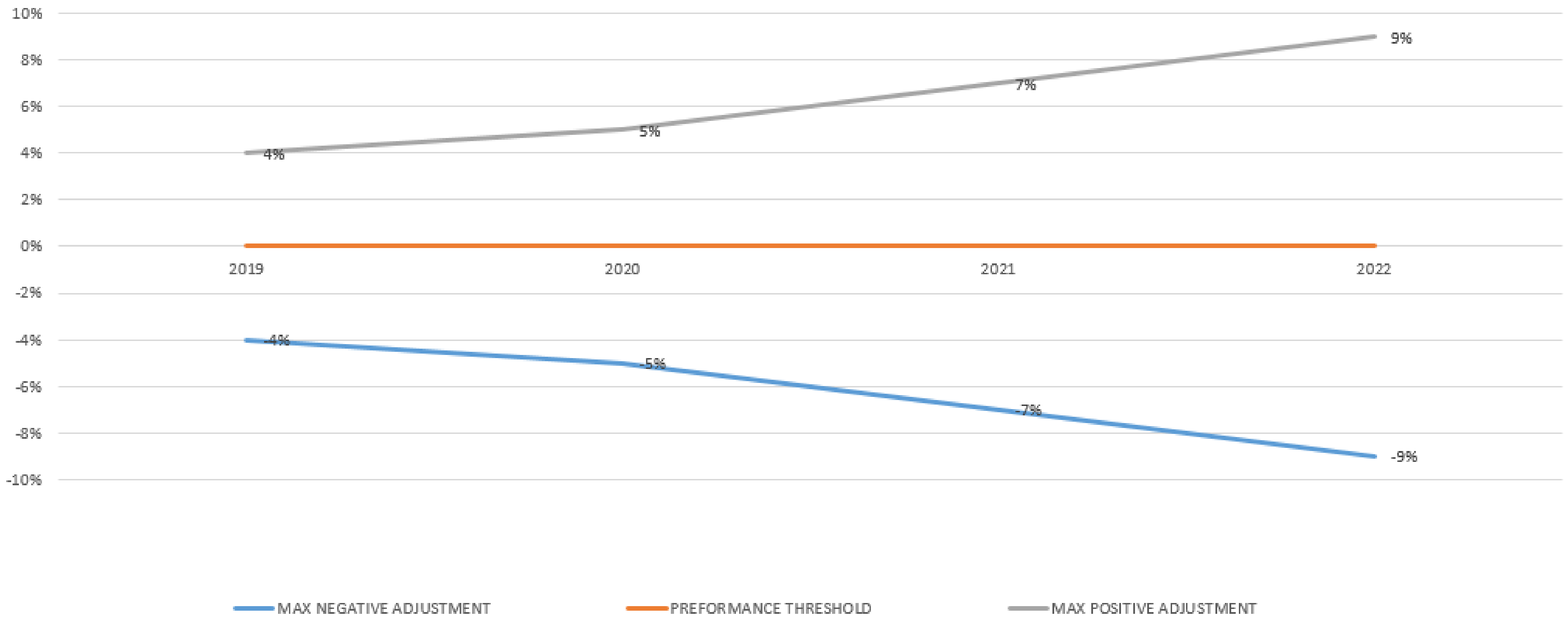
Who is exempt from MIPS?

- **Newly enrolled providers**
- **Low volume provider** (<100 beneficiaries or < $30k)
- **2018 participants in a qualified alternative payment model if they:**

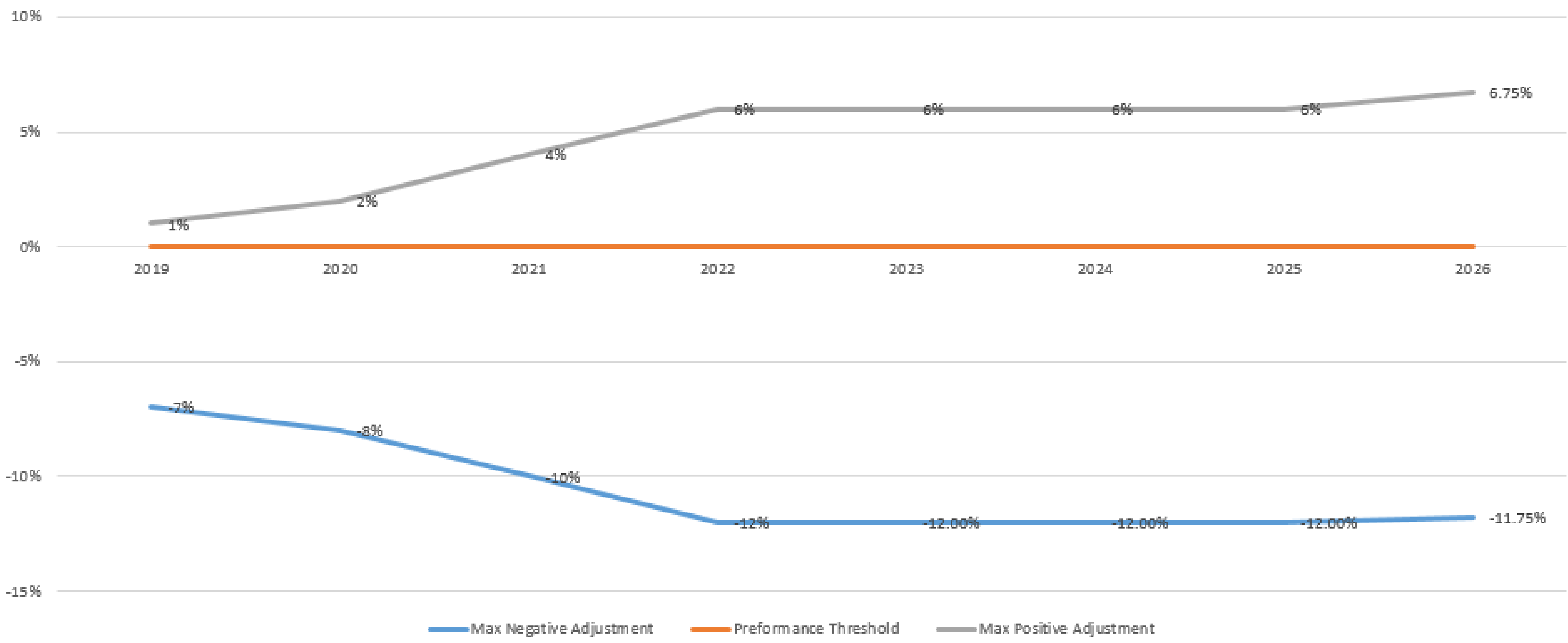
  >25% of MC payments through an AAPM -or-

  >20% of MC patients are attributed to AAPM

MIPS Payment Adjustment



MIPS payment adjustment after inflation and fee schedule adjustments



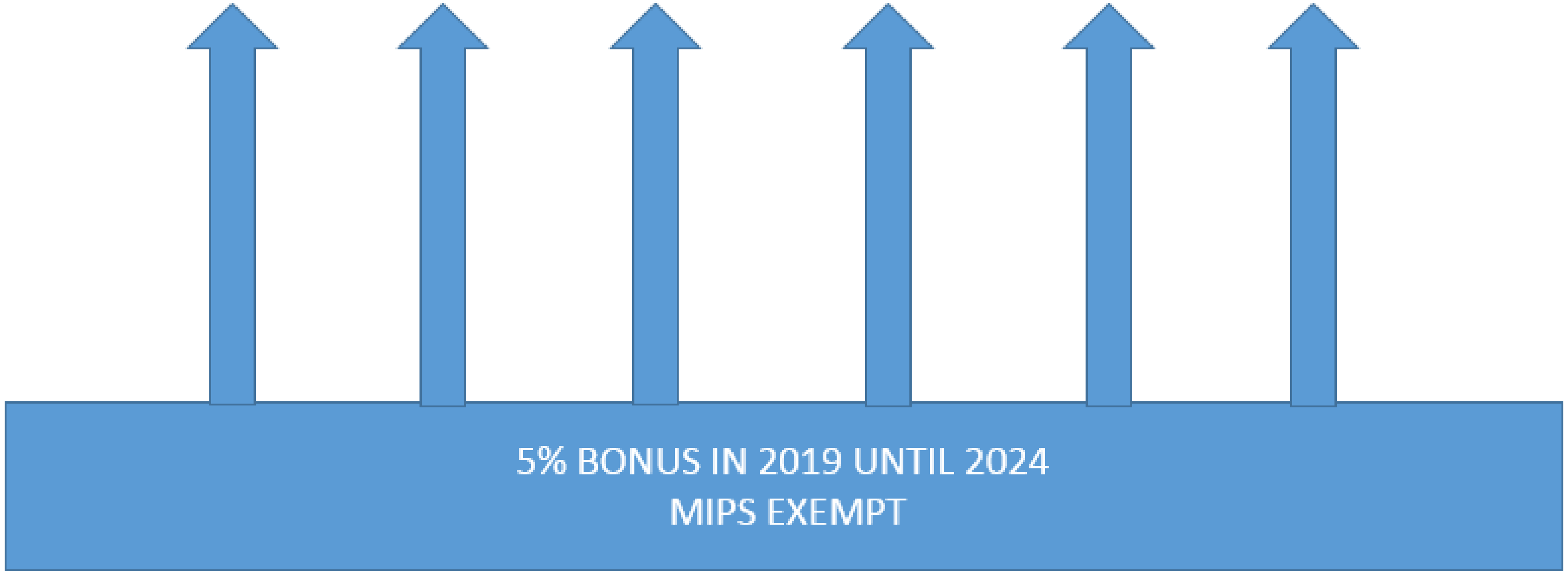
Projected Impact of MIPS by Practice Size

table 64: MIPS Proposed Rule Estimated Impact

Practice Size	Percentage Eligible Clinicians with Negative Adjustment
Solo	87%
2-9	69.9%
10-24	59.4%
25-99	44.9%
100 or more	18.3%
Over all	45.5%

ADVANCED APM

- More than nominal, bi-directional risk
- Quality reporting structure similar to MIPS or medical home model
- Certified EHR
- Provider must be ‘qualified’



APM Categories

- **Pay For Performance:** Fee for Service +/- adjustment based on benchmark variance
  - PQRS
  - Hospital Value-Based Purchasing Program
  - Hospital-Acquired Conduction Reduction Program
- **Shared Saving:** Fee for service plus % of savings
  - MSSP, Next Generation ACO
- **Episodic Payments:**
  - Bundled payments
- **Global Budgets**
  - Comprehensive ESRD, Direct Primary Care

Advanced Alternative Payment Models

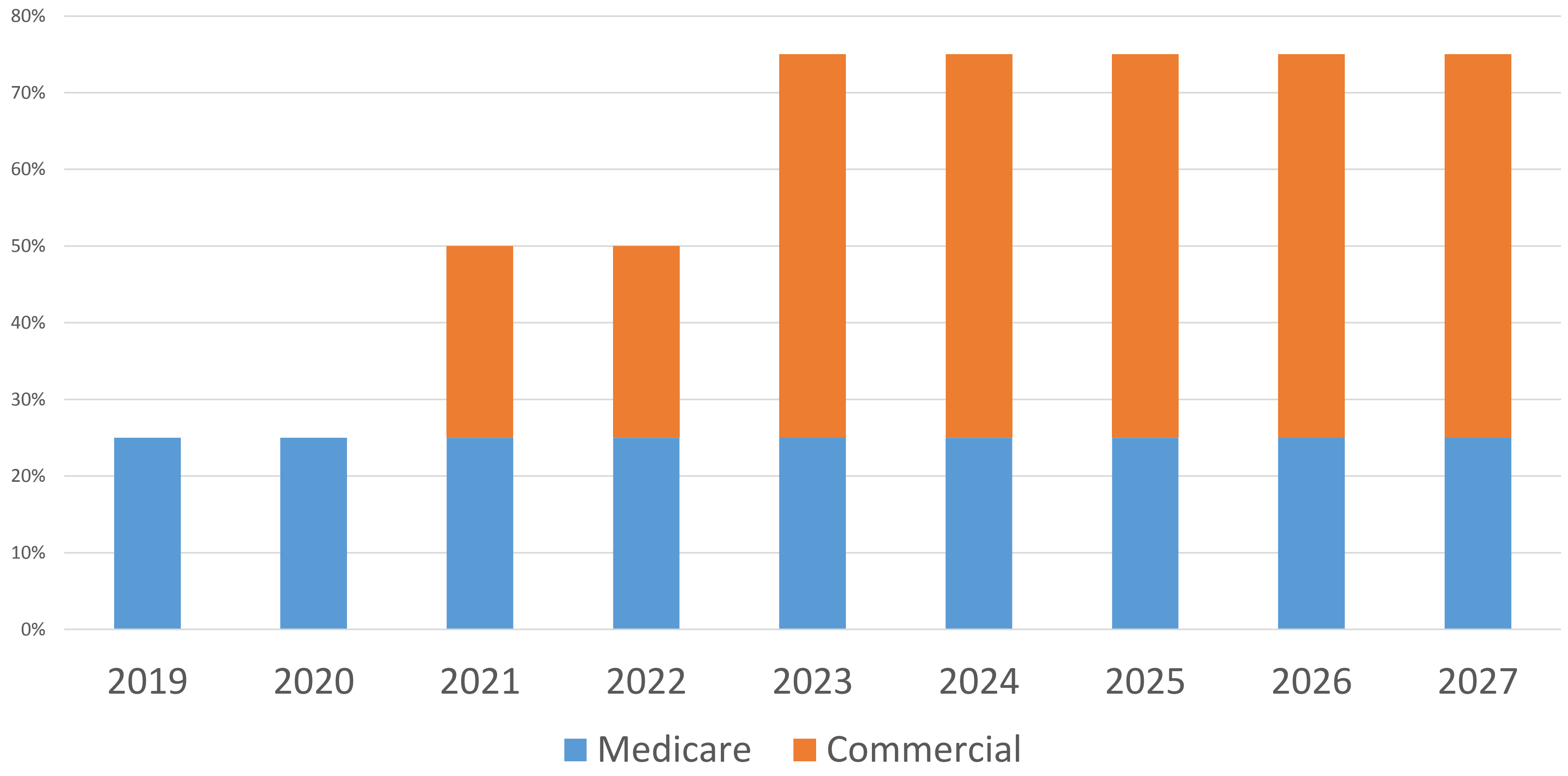
Definite

- Medicare Shared Savings Programs – Tract 1+, 2, and 3
- Next Generation
- Comprehensive ESRD
- Comprehensive Primary Care Plus
- Oncology Care

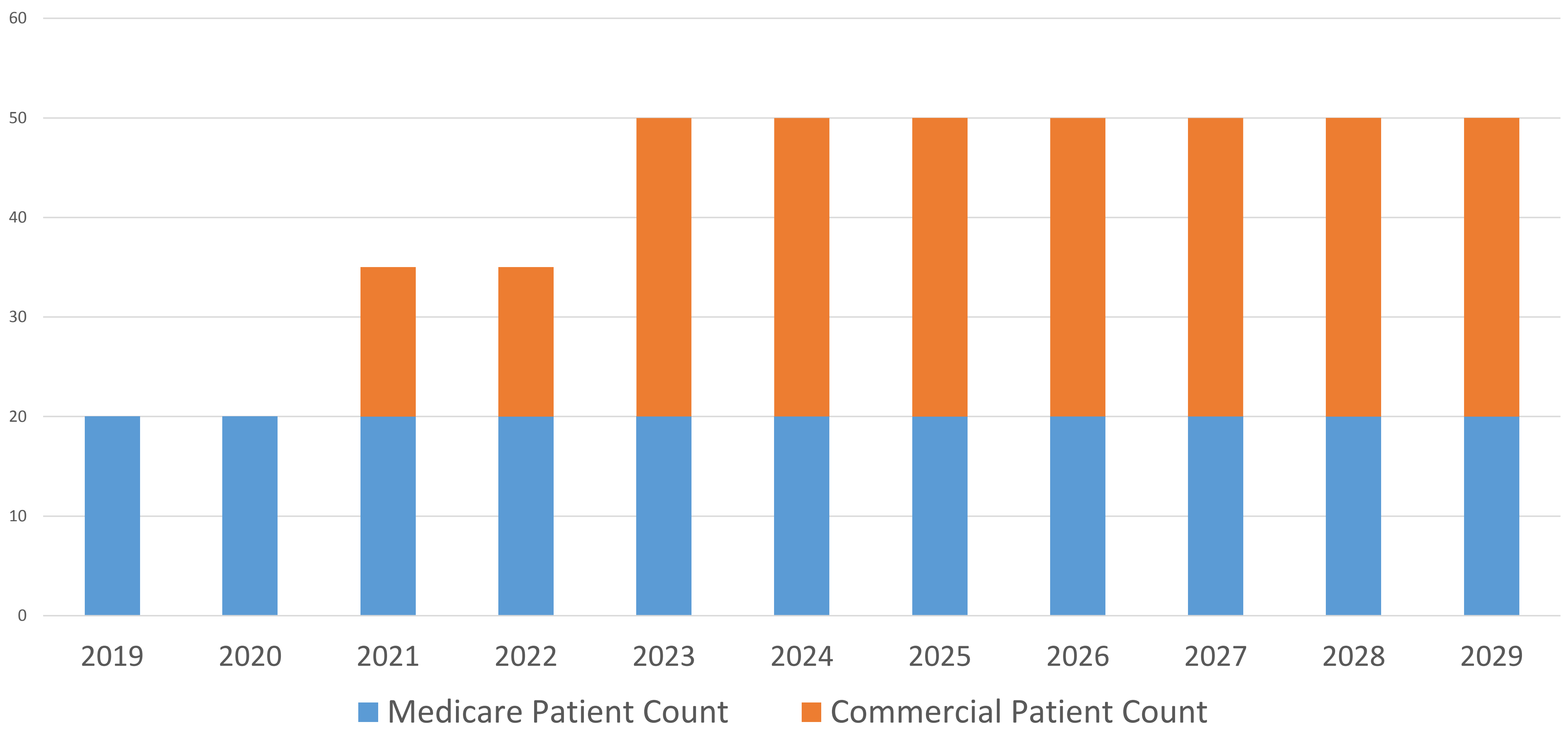
In Development

- Comprehensive Care for Joint Replacement
- Episodic Payment Model
- Cardiac Rehabilitation Incentive Payment Model
- Medicare Diabetes Prevention Program
- Voluntary Bundled Payment Program
- Vermont Medicare ACO Initiative

Qualifying Provider Percentage of Payment Threshold



Qualifying Provider Percentage Patient Count Threshold



Provider Impact

- Choose between strategy to maximize MIPS or join an Advanced APM and be a qualified provider
- Consider:
  - The increasing qualified provider threshold
  - The adoption of value-based payment in the commercial market
  - The cost of Health Information Technology
  - Need for practice redesign
  - Timing the APM: Balance downside risk of Advanced APM against the 5% bonus window

Provider Impact continued

- Focus on coordination among providers
- Technology and process will drive provider consolidation
    - Mergers and large system
    - Virtual groups

Factors to consider when choosing an APM

- Certified EHR
- Necessary partnerships for success
- Organizational structure
- Medicare volume
- Availability
- Prospective vs. retrospective assignment of beneficiaries
- Responsibility for total cost of care vs. specific episodes of care

2017 MIPS ‘Pick Your Pace’

- If clinician reports performance data by end of Q1 2018:

  Neutral or positive adjustment

- If clinician fails to report -4% adjustment

2017 Data Reporting Options

Don’t participate

-4%

Test –
Submit something

0%

Partial Submission

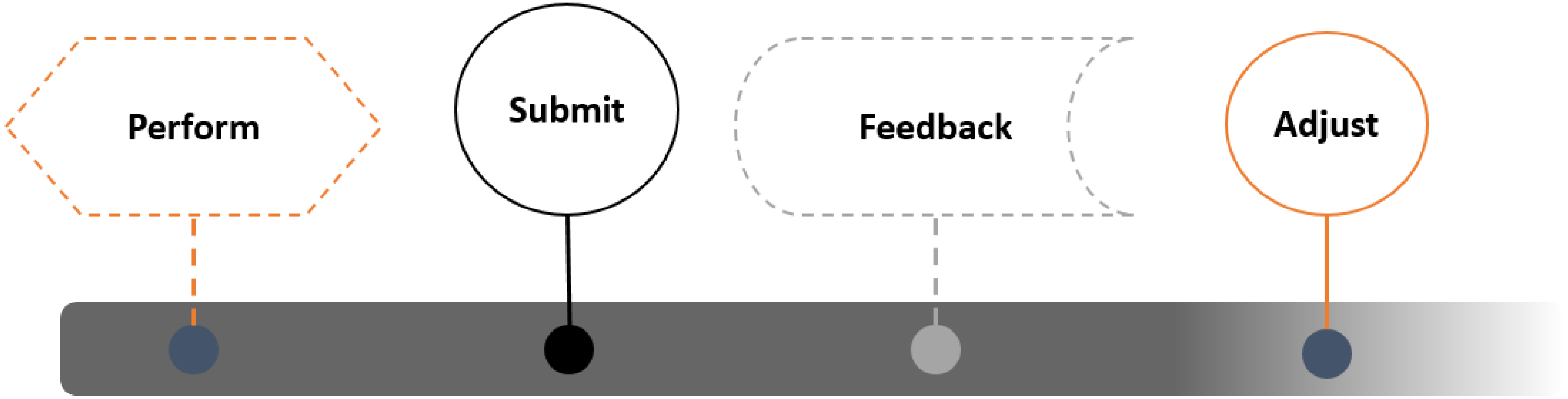
90-day data
submission
of two required
measures

Small ?+%

Full year data
submission
of all required
measures

Possible
moderated +%

Performance-to-Adjustment Cycle



CY 2017	March 31, 2018	Q3 2018	CY 2019
Performance Measurement Period *You may elect 90 or 365 continuous performance period*	Deadline to report on required measures	CMS gives feedback on performance	Positive or negative MPFS payment adjustments based on 2017 Final Score

Take Away Ideas

- CMS is allowing providers to ease into pay for value
- Report something in 2017 – Pick your pace and avoid a 4% reduction
- The Medicare base fee schedule is frozen for several years and will not keep up with historic inflation
- CMS is encouraging the transition to alternative payment models, including commercial payer
- To be successful, providers must transition to risk contracts

Data Options

Quality Measure

Replaces PQRS

Clinical Improvement Activity

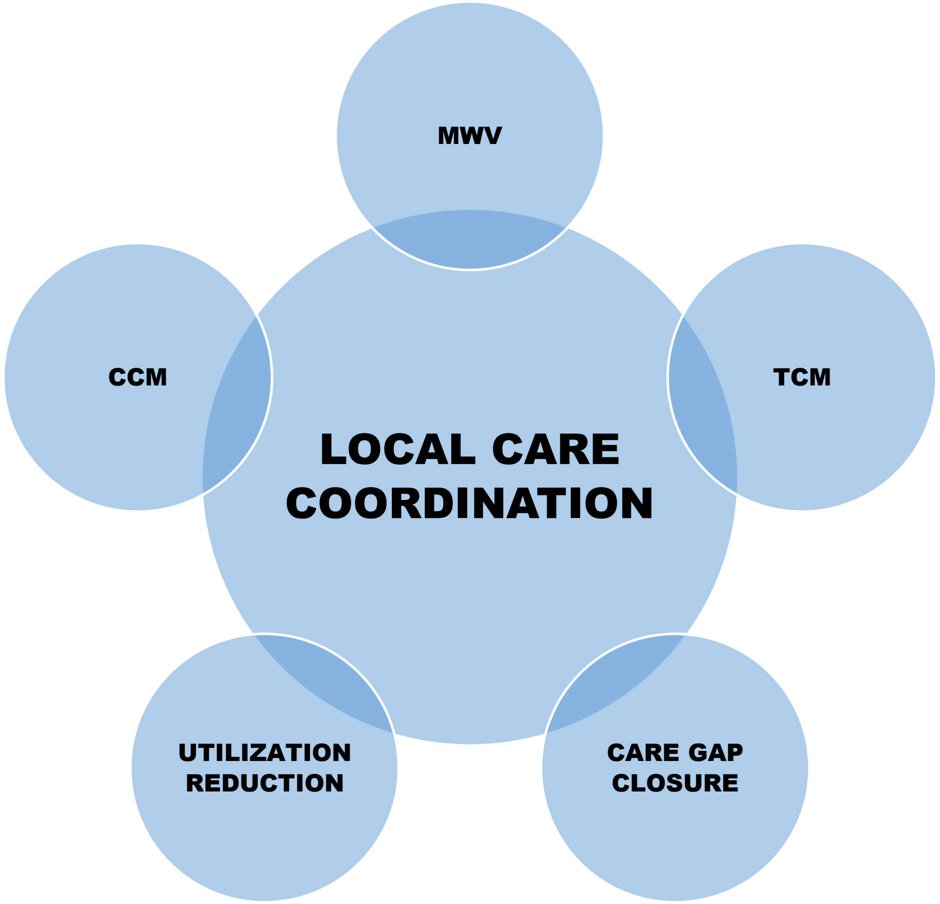
Advancing Care Information

Replaces meaningful use

New Opportunities for Revenue

- MIPS, Alternative Payment Models
- Commercial ACO
- Medicaid ACO
- Medicare Well Visits
- Care Gap Closures
- Transitional Care Management (TCM)
- Chronic Care Management (CCM)
- Better Utilization of Services

Care Coordination Model



Modeling Assumptions

- <u>**MY PRACTICE DATA**</u>

➢An adoption rate of:
Year One - 25%, **Year Two** - 35%, **Year Three** - 50%

➢Roll out # providers/year: **Year 1** - 48: **Year 2** - 100; **Year 3** - 148

➢66% of Medicare patients qualify for chronic care management

➢78 annual admissions, with 66% qualifying for transitional care

➢20% Medicare patients have gap closures at $800/month

Annual Revenue Projections

	YEAR ONE	YEAR TWO	YEAR THREE
MWV	$787,644	$2,297,295	$4,660,227
UTILIZATION REDUCTION DOLLARS	$316,000	$474,000	$790,000
UR = $15.7 REDUCTION ASSUMPTION	2%	3%	5%
CCM	$1,831,358	$5,341,460	$11,445,985
TCM	$680,309	$703,042	$725,776
CARE GAP CLOSURE	$881,280	$2,570,400	$5,214,240
TOTALS	$4,496,491	$11,386,197	$22,836,227

Impact of Volume to Value Transition

REDUCED IN NETWORK ER $ + REDUCED IN NETWORK HOSPITALIZATION$ =$74,790,507 MAX LOST REVENUE FROM 100% VOLUME REDUCTION	YEAR #1 2% REDUCTION IN VOLUME	YEAR #2 3% REDUCTION IN VOLUME	YEAR #3 5% REDUCTION IN VOLUME
REVENUE LOST FROM VOLUME REDUCTION	$1,495,810	$2,243,715	$3,739,525
TOTAL REVENUE GAIN FROM VALUE	$4,496,590	$11,386,197	$22,836,227
TOTAL NET REVENUE GAIN	$3,000,780	$9,142,482	$19,096,702
ROI	3	5	6
MARKET SHARE	GAIN	GAIN	GAIN
QUALITY OF CARE	IMPROVED	IMPROVED	IMPROVED
POSITIONING FOR COMMERCIAL	POSITIVE	POSITIVE	POSITIVE

Take Away Ideas

- **To maintain or grow your revenue, you need to implement every new opportunity**
- **Results of a full care coordination program/ROI**
  - The reduced revenue from lost volume is replaced 6:1 by value-driven revenue at a 5% reduction in volume

Questions