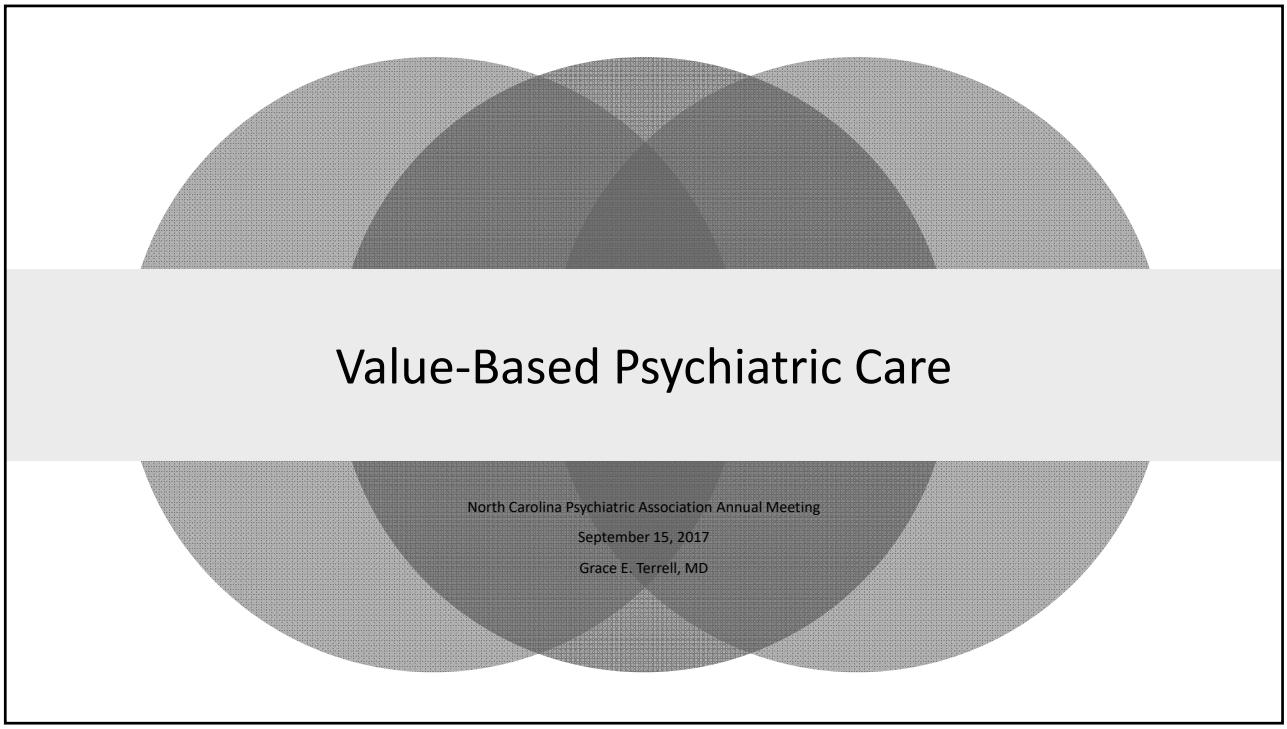


CORNERSTONE™
HEALTH CARE

Mission:

To be your medical home

Vision:

To be the model for physician-led health care in America

Values:

As a physician owned and directed company, we are committed to ensuring that patient care is efficient, effective, equitable, patient centered, safe, and timely

CHESS

MISSION	***To empower providers to make the transition to value-based medicine***
VISION	***To be the force that builds healthy communities through coordinated and sustainable care***
VALUES	***Collaboration, Innovation, Expertise, Integrity***

CHESS is a health care services company that empowers physicians and health systems to make the transition to value-based medicine, a model where they are financially rewarded for improving the quality of care and reducing the cost of care they deliver to patients.

envision genomics

Enabling Superior Healthcare through the Power of Precision Genomic Medicine

Statement of Conflict of Interest

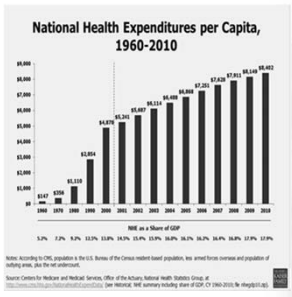
Dr. Grace E. Terrell is a practicing physician at Cornerstone Health Care, a medical group part of the Wake Forest Health System; founder and board member of CHESS, a population health management company; and Chief Executive Officer of Envision Genomics, a company empowering clinical transformation through precision genomic medicine. She serves as a commissioner of the Physician-focused Payment Technical Advisory Committee. All opinions expressed today are her own.

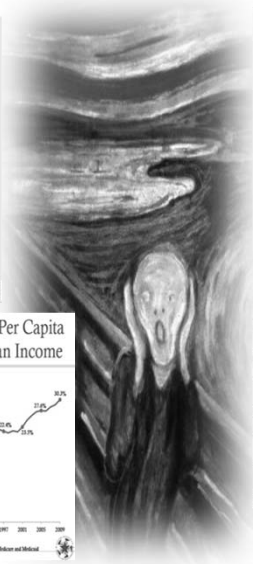
Learning Objectives:

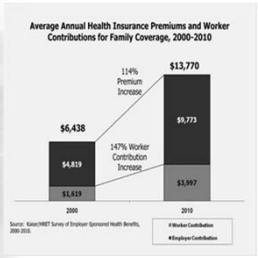
1. Participants will understand the evolution of payment reform in the US healthcare system and how this reform is likely to affect psychiatric practices.
2. Participants will gain the skills necessary to evaluate alternative payment model contracts.
3. Participants will understand the ways they need to transform their practices to prepare for the move to value-based contracting.
4. Participants will explore ways psychiatrists can bring value to primary care.

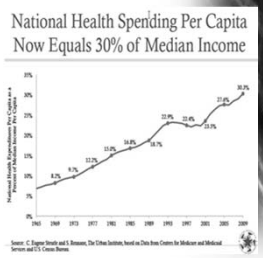
All health care talks seem to present the same three concepts:

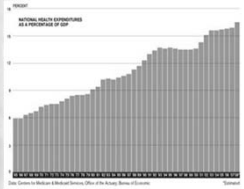
First, the health care system is doomed!



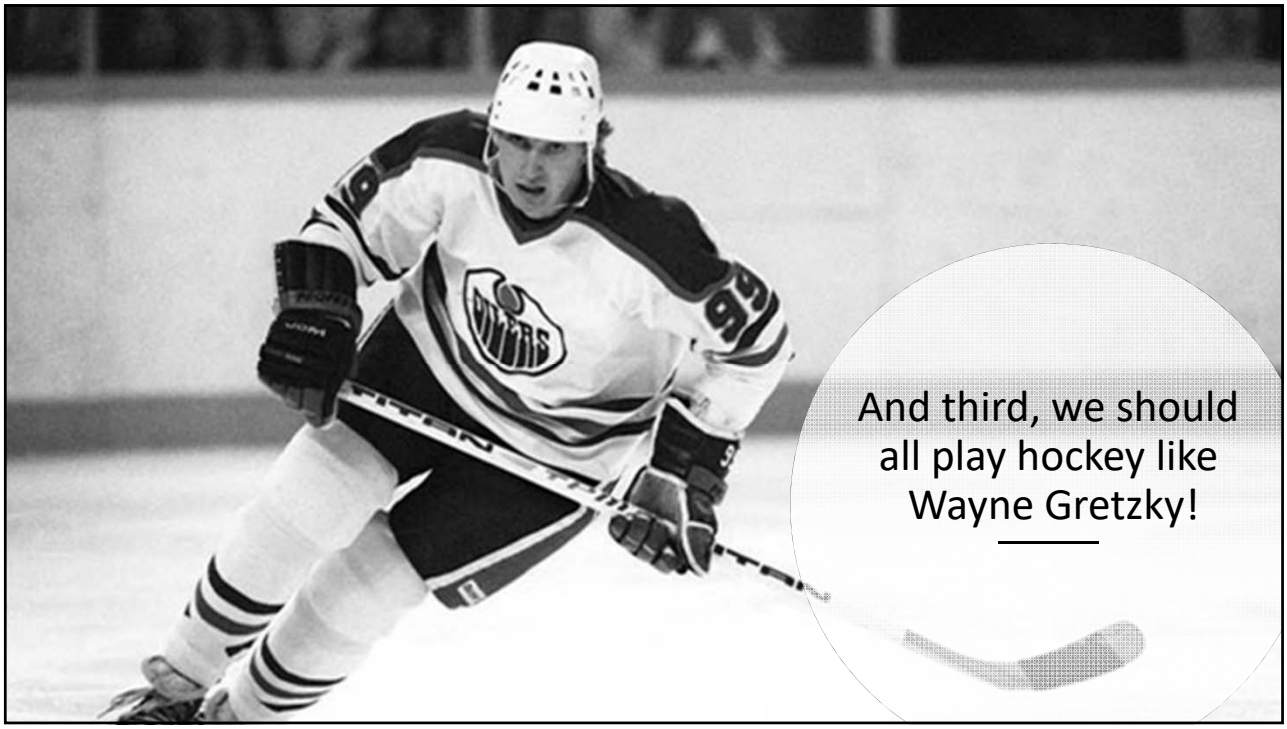









Second, doctors are cats!

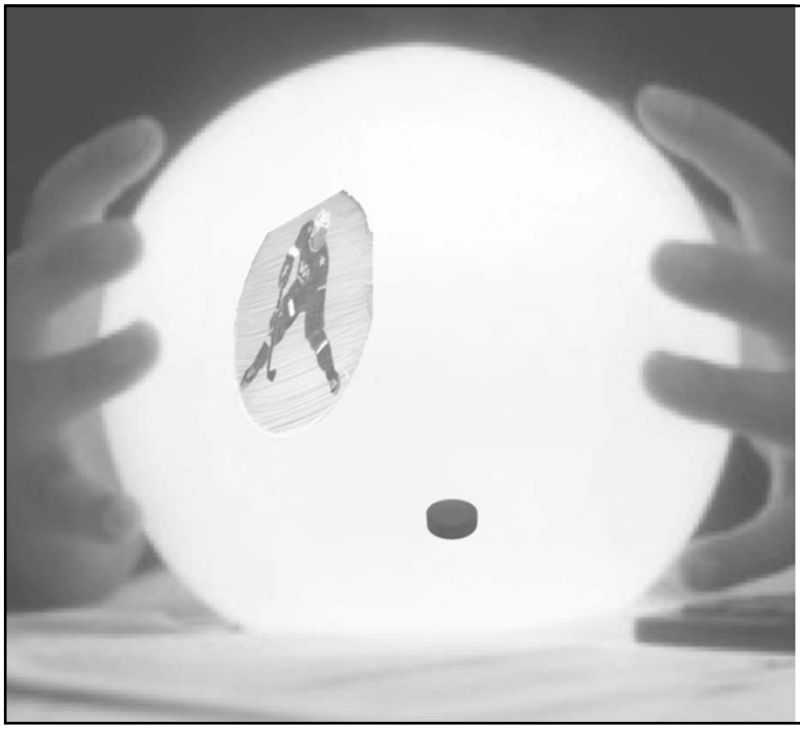

And third, we should all play hockey like Wayne Gretzky!

But I don't believe any of that…

The health care delivery system is going to get much better over the next ten years.

Doctors and other health care providers are going to help lead the transformation of health care.

As far as Gretzky goes… there are a lot of people playing hockey and trying to figure out where to skate…



That's OK, but I'm not the least interested in where the puck is going to be…

Because we're playing an entirely different game now.

The U.S. health care system is too expensive, wildly variable, with lower-than-desired quality and outcomes.

The unsustainability of the US health care system naturally leads to policy changes because it represents one sixth of the entire US economy.

As a result, a miracle occurred in Washington in 2015…

January 26, 2015:

HHS Secretary Sylvia Burwell announced goal of tying 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018.

April 16, 2015:

Obama signed SGR repeal with OVERWHELMING BIPARTISAN SUPPORT that accelerated payment reform.

But health care reform has been going on a long time….

1954:Tax deductibility of health insurance

1974: Medicare HMOs and ERISA

1985: COBRA

1990s: Rise of managed care

2003:Medicare Prescription Drug, Improvement, and Modernization Act

2010: **Patient** Protection and Affordable Care **Act**

1965: Great Society Medicare and Medicaid

1983: Prospective Payment System

1989: OBRA Stark Anti-Kickback Statute

1997: Balanced Budget Act Sustainable Growth Rate

2009: HITECH

2015: MACRA

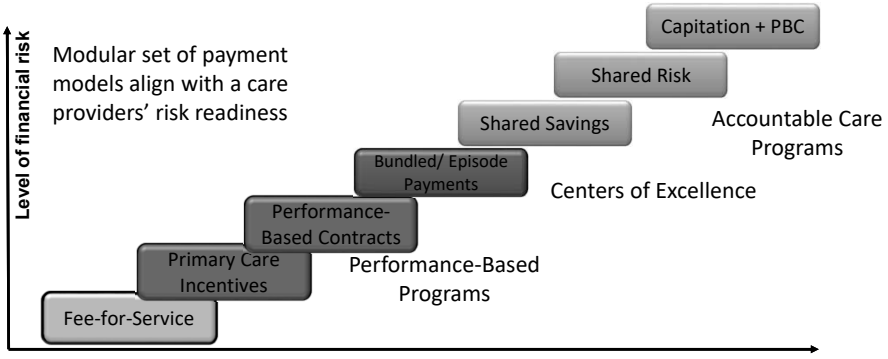
MACRA

Medicare Access and CHIP Reauthorization Act

MACRA will ultimately have a larger impact on how providers deliver care than the Affordable Care Act

- Ended the Sustainable Growth Rate formula and implemented a pay-for-performance system called the Quality Payment Program (QPP)
- Eliminated and consolidated previous quality initiatives such as PQRS, the Value-Based Modifier, and Medicare EHR incentive program known as Meaningful Use.
- Encourages the transition of the payment system from standard fee-for-services to payment for high value care through financial incentives and penalties.
- Establishes two separate tracks for participation: MIPS and APMs.
- Establishes the Physician-Focused Payment Model Technical Advisory Committee (PTAC)

Merit-based incentive payment system will impact physicians who do not participate in Alternative Payment Models.



Over time Medicare payments will be at increasing risk.

2015		2016	2017	2018	2019	2020	2021		2022	2023	2024	2025	2026
Permanent SGR Repeal: Predictable Annual Baseline Updates													
Jan-Jun 0%, Jul-Dec 0.5%	0.50%	0.50%	0.50%	0.50%	0%	0%	0%	0%	0%	0%	0%	0.25%, annually for MIPS →	
												0.75%, annually for APMs →	
Separate Incentive/Penalty Programs Sunset 2018 - Incorporated Into MIPS													
Physician Quality Reporting System (up to %)													
-1.50%	-2.00%	-2.00%	-2.00%										
EHR Meaningful Use (up to %)													
-1.00%	-2.00%	-3.00%	-4.0%?										
Value-Based Payment Modifier (up to %)													
-1.00%	-2.00%	-4.00%	???%										
Post-SGR Payment System													
Option 1: MIPS				**Merit-Based Incentive Payment System (MIPS) Adjustments (up to %)** – Pos. adjustments can be up to 3x amount of neg adjustments, but MIPS bonuses and penalties must balance each other out.									
				-4% to ≈+12%	-5% to ≈+15%	-7% to ≈+21%	-9% to ≈+27%→						
				Exceptional performers may qualify for additional + adjustment; up to 10% annually 2019-2024									
Option 2: APMs													
				Alternative Payment Model (APM) Adjustments									
				APM providers exempt from MIPS									
				+5%	+5%	+5%	+5%		+5%	+5%			

Responses to MACRA have varied. . .

"If you don't know where you are going, any road will take you there."

The Cheshire Cat

25

So let's get started….

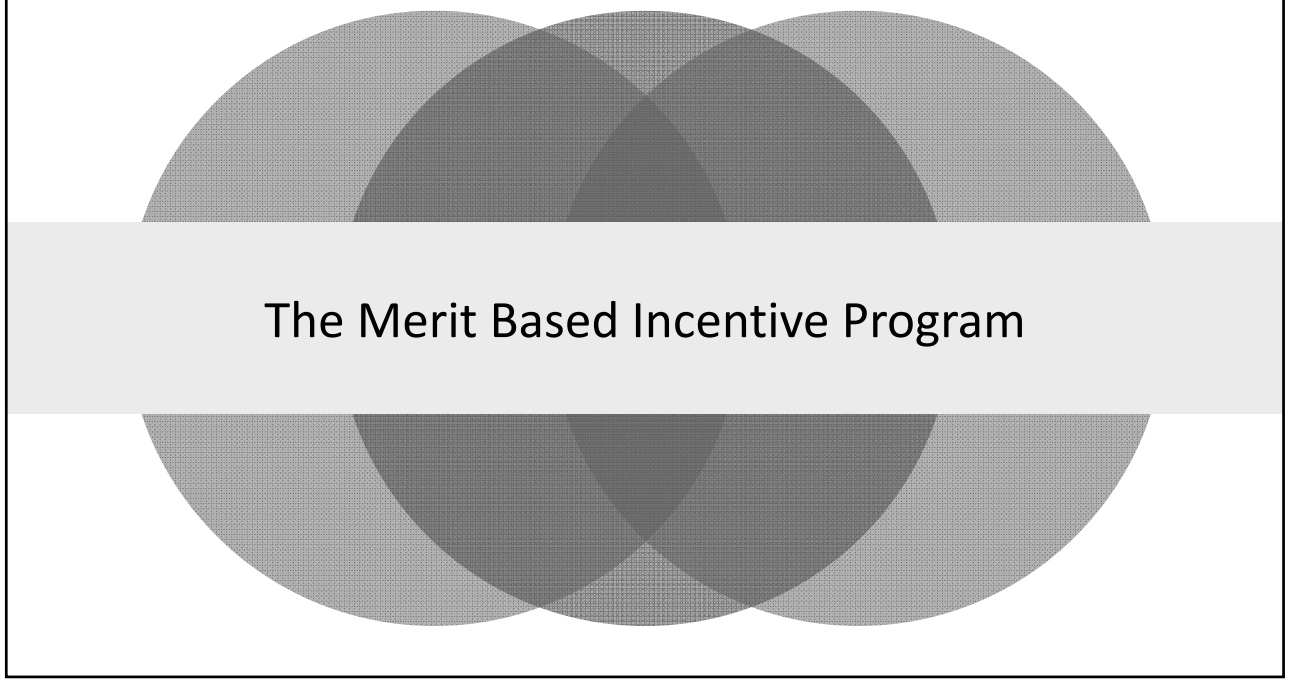
The Quality Payment Program has two tracks you can choose from:

The Merit-Based Incentive Payment System

- Consolidates existing P4P programs including Meaningful Use, Physician Quality Reporting System, and Value-Based Payment Modifier
- Gives providers performance score based on four categories: quality, resource use, clinical practice improvement, and EHR use
- Adjustments reach -9% / +27% by 2022
- From 2019 through 2024, potential to share in $500M annual bonus pool

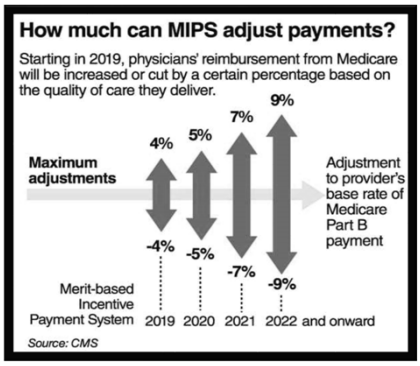
Advanced Alternative Payment Models (APMs)

- Provides financial incentives (5% annual bonus in 2019-2024, 0.75% annual payment increase from 2026 on) and exemption from MIPS
- Requires that physicians meet increasing targets for revenue at risk
- Qualifying APMs must involve downside risk and quality measurement that is comparable to the MIPS



Merit-based incentive payment system will impact physicians who do not participate in Alternative Payment Models.

Source: http://leavittpartners.com/



Who are MIPS eligible professionals?

- **Annual Medicare Part B billings > $30,000**
- **Provide care for more than 100 Medicare Part B patients**
- **Are not in your first year as a Medicare Provider**
- **Are not participating in an Advanced Payment Model**

Years 1–E
;ECDJ – ECDK<

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists

Year 3+ (2019+)

- Physical or Occupational Therapists
- Speech Language Pathologists
- Audiologists
- Nurse Midwives
- Clinical Social Workers
- Clinical Pathologists
- Clinical Psychologists
- Dietitians/Nutritional Professionals

There are four categories in MIPS performance reporting.

Quality	Improvement Activities	Advancing Care Information	Cost
• Replaces PQRS • 60% weight 2017-2019 • Individuals report up to 6 quality measures including outcome measure (TIN/NPI) • Groups use web to report 15 quality measures for a full year (TIN/group mean score) • MIPS APMS (MSSP Track 1, Oncology Care model) report quality through APM	• This is a new category • 15% weight in 2017-2019 • Attest you completed up to 4 IA for a minimum of 90 days • PCMH automatically earn full credit • MSSP 1 and Oncology Care Model automatically receive points • Participants in any other APM automatically earn half credit	• Replaces the Medicare EHR Incentive Program know as Meaningful Use • 25% weight in 2017-2019 • Required measures for 90 days: ✓ Security Risk Analysis ✓ e-Prescribing ✓ Provide Patient Access ✓ and Summary of Care ✓ Request/Accept Summary of Care	• No data submission is required • Calculated from adjudicated claims • Counting starts in 2018

•Cost category will be calculated in 2017 but will not be used to determine payment until 2018 (or later based upon 2018 proposed rule)

•Performance year determines payment

•Weighted scores total to determine Composite Performance Score (CPS)

•Weights will change over time: By year 2022 Quality and Resource Use = 30%

Medical home recognition becomes more important.

- Medical homes receive “full credit” for CPIA score if certified:
  - Accreditation Association for Ambulatory Health Care
  - NCQA
  - Joint Commission
  - URAC
- Medicaid Medical Home or Medical Homes Model
- Specialty Practice that has NCQA Patient-Centered Specialty Recognition

MIPS Improvement Activities are divided into 9 subcategories.

Currently, 92 Activities are listed on the QPP website including:

- ✓ Depression screening
- ✓ Implementation of methodologies for improvements in longitudinal care management for high risk patients
- ✓ Implementation of practices/processes for developing regular individual care plans
- ✓ Use of telehealth services that expand practice access
- ✓ Use of tools to assist patient self-management

33

MIPS: Data Submission

Individual	Group

• **Quality**
  • Qualified Clinical Data Registry (QCDR)
  • Qualified Registry
  • EHR Vendors
  • Claims (No submission needed)
	• **Quality**
	  • QCDR
	  • Qualified Registry
	  • EHR Vendors
	  • CMS Web Interface (GPRO)
	  • CAHPS

• **Resource Use**
  • Claims (No submission needed)
	• **Resource Use**
	  • Claims (No submission needed)

• **Advanced Care Information**
  • Attestation
  • QCDR
  • Qualified Registry
  • EHR Vendor
	• **Advanced Care Information**
	  • Attestation
	  • QCDR
	  • Qualified Registry
	  • EHR Vendor
	  • CMS Web Interface (Group of 25+) (GPRO)

• **Clinical Practice Improvement Activities**
  • Attestation
  • QCDR
  • EHR Vendor
  • Claims (No submission needed)
	• **Clinical Practice Improvement Activities**
	  • Attestation
	  • QCDR
	  • Qualified Registry
	  • EHR Vendor
	  • CMS Web Interface (Group of 25+) (GPRO)

MIPS Math: Composite Performance Score

Quality
50% and 80-90 Points

+

Advancing Care Information
25% and 100 Points

+

Clinical Practice Improvement Activities
15% and 60 Points

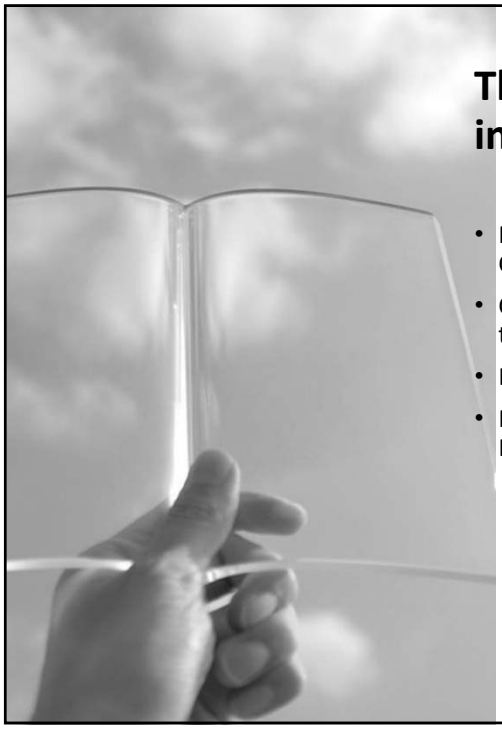
+

Resource Use
10% and Average $ of attributed measures

=

Composite Performance Score (CPS)

- Clinicians can report via multiple mechanisms
- Deadline is 3/31 post-performance year under QCDR, EHR, and attestation
- Report 1 score as a group, all scores are by group
- For facility-based MIPS Eligible Clinicians CMS will consider using their institutes' performance rates as a proxy



The Age of Transparency is here: MIPS information is publically available.

- MIPS scores will be publically available on the CMS Physician Compare website
- Consumers able to view individual provider's score and compare to other providers both regionally and nationally
- EPs may request an "informal review" of their CPS
- Feedback reports available to providers through the Quality and Resource Use Report (QRUR)
  - Information on Quality Measures
  - Claims-Based Outcome Measures
  - Claims-Based Cost Measures

MIPS: Payment Adjustment

- Physicians will receive a CPS expressed as a percentage
  - Scores known before payment year
- CMS will compare the CPS to a "performance threshold"
  - A CPS below the performance threshold results in a negative payment adjustment
  - A CPS at the performance threshold results in no adjustment
  - A CPS above the performance threshold results in a positive adjustment.
- CMS will score small, rural, and "non-patient facing" EPs differently
- The MIPS adjustment is made to the Part B physician fee base rate
- MIPS adjustments are BUDGET NEUTRAL

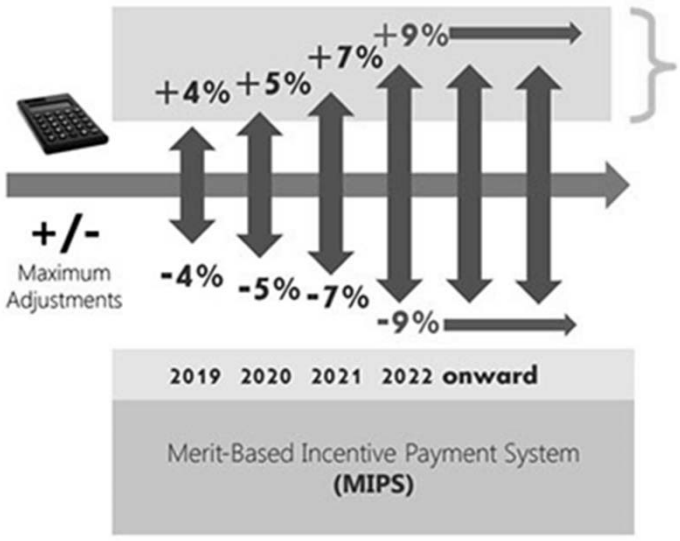
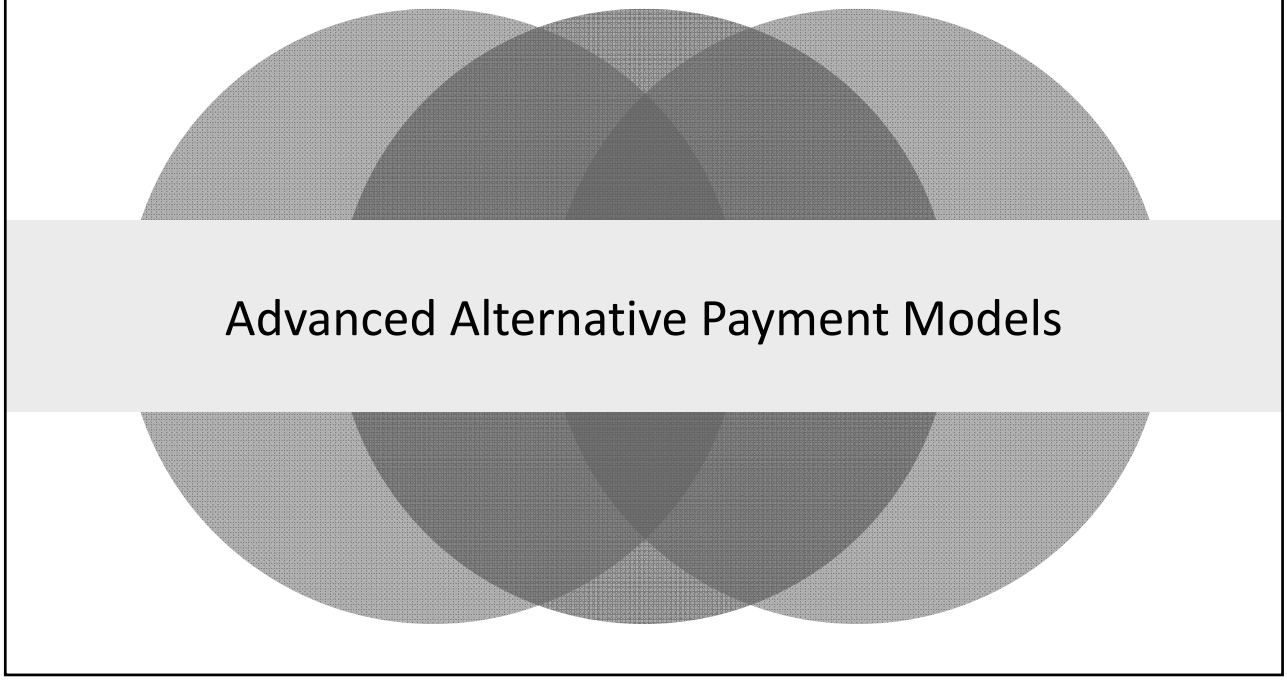
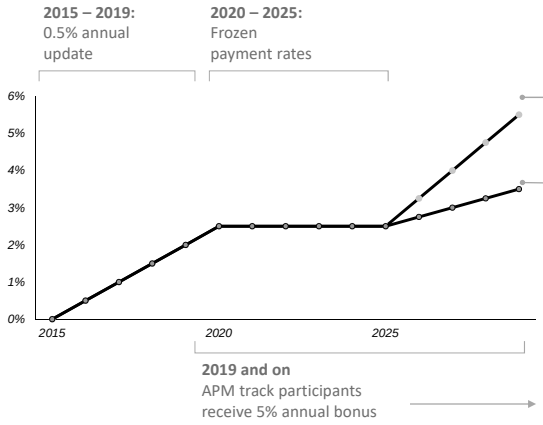


Image Source: https://www.sgo.org/public-policy/macra/



MACRA significantly incentivizes physicians to participate in APMs.

Baseline Provider Payment Adjustments Under Each Track



Advanced Alternative Payment Models: 2026 and on 0.75% annual update

The Merit-Based Incentive System: 2026 and on 0.25% annual update

Annual Bonus for APM Participation

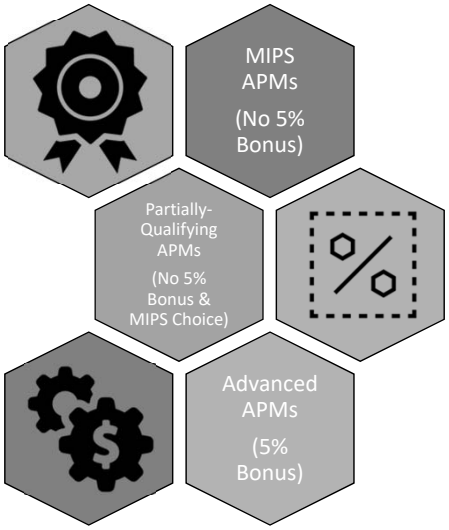
5% Bonus awarded each year from 2019 on to providers that qualify for the APM payment track

Advanced Alternative Payment Models:

- Exempt participating providers from MIPS
- Award them a 5% lump sum bonus for six years
- Give providers a higher annual increase in their FFS revenues
- Must involve "more than nominal risk"
- Use quality measures comparable to MIPS
- Must use certified EHR technology

Image source: https://revcycleintelligence.com/news/cms-announces-new-advanced-alternative-payment-model-options

Not all Alternative Payment Models are "advanced".



Who qualifies for Advanced Payment Models?

2017	2018
• Comprehensive ESRD Care Model • CPC+ • MSSP Track 2 and 3 • Oncology Care Model OCM • Next Generation ACO Model	• 2017 Approved AAPMs • ACO Track1+ • New Voluntary Bundled Payment Model • Comprehensive Care for Joint Replacement Payment Model (CEHRT) • Advancing Care Coordination through Episode Payment Models Track 1 (CEHRT) • Vermont Medicare ACO Initiative (All-Payer ACO Model)

Participation in alternative payment models exempts physicians from MIPS but thresholds increase over time.

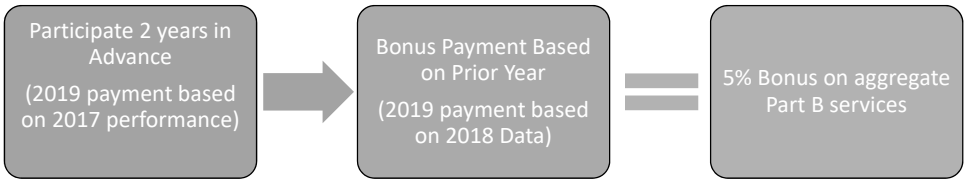
Performance Year	2017	2018	2019	2020	2021	2022 and Beyond
Percentage of Medicare Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Medicare Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

Starting in 2019, the clinician may also meet an alternative standard for Advanced APM that will include non-Medicare payments and patients

	MEDICARE-ONLY OPTION	ALL-PAYER OPTION
	% OF PAYMENTS IN AN ELIGIBLE APM	% OF PAYMENTS IN AN ELIGIBLE APM
2019-2020*	25%	N/A
2021-2022*	50%	25% Medicare & 50% All-payer
2023-2024*	75%	25% Medicare & 75% All-payer
2025 onward	75%	25% Medicare & 75% All-payer

* Under both options, providers receive a 5% bonus from 2019 until 2025.

APMs: Bonus Payments



- The 5% bonus crosses all billing TINS
- Payment is made to the TIN
- Payment made no later than 1 year after “incentive base year”
- Shared savings and other incentive payments excluded from 5% calculation and bonus, in turn, excluded from shared savings rebasing

Physician Focus Payment Models (PFPMs)

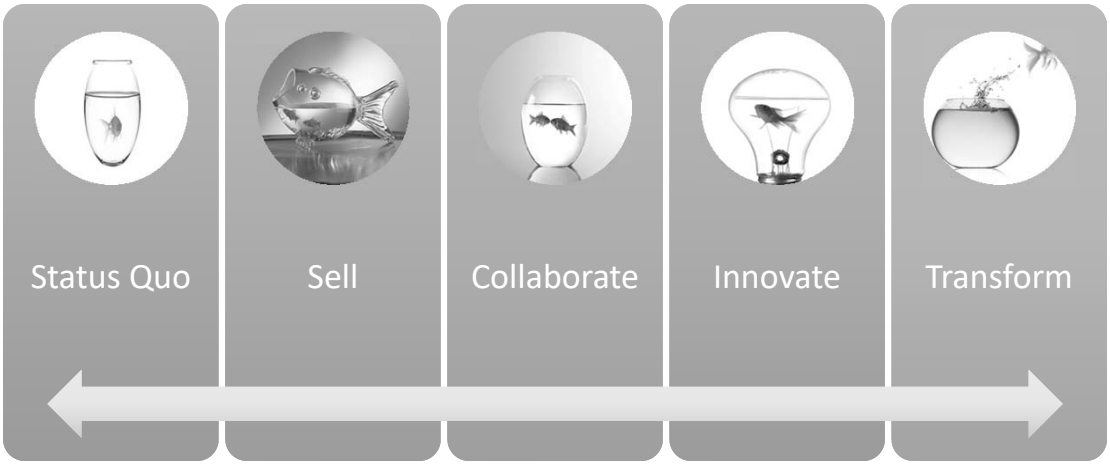
- MACRA created a physician-focused payment model technical advisory committee: P-TAC
- Applications submitted on ongoing basis
- Models test APMs under Medicare along with other payers
- Not limited exclusively to physician care (additional types of entities)
- Criteria includes quality measures, cost reduction, difference from current Medicare payment methodologies, have evaluable goals

Transformation requires comprehensive change to our business models.

	Volume Based	Value Based
Reimbursement	• FFS/DRGs • No payment for readmits, never events, etc.	• Outcomes & Quality Based • Global Payments
Organizational Model	• Departmental	• Populations • Conditions • Focused Factories
Value Drivers	• Volume • Efficiency (on a procedure level)	• Quality and Low Variability • Efficiency (on a population level)
Profit Pools	• Visits • Surgery/Procedures • Outpatient Ancillary	• Wellness and Prevention • Population Management • Chronic Condition Management
Investments	• Capacity • Revenue-Producing Assets • Patient Referrals	• Health IT • Clinical Integration • Commercialization

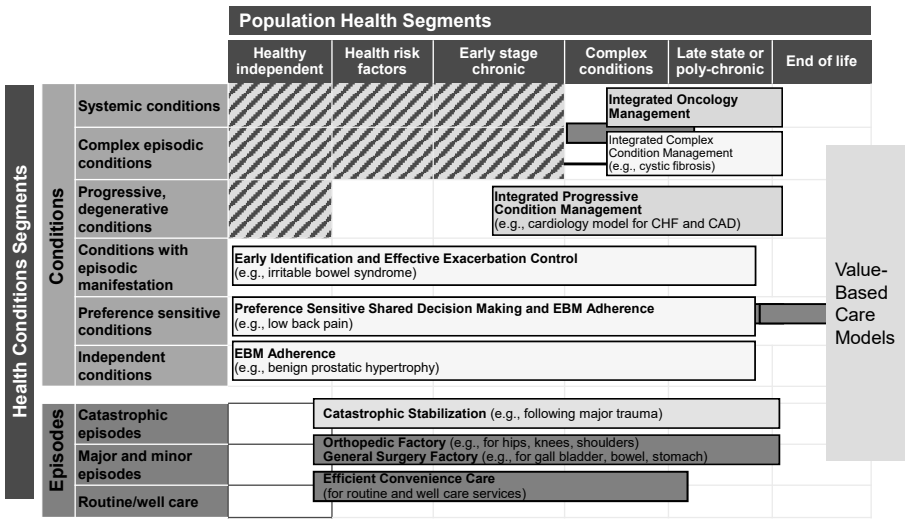
How should we think about all of this?

All businesses have the same strategic choices:

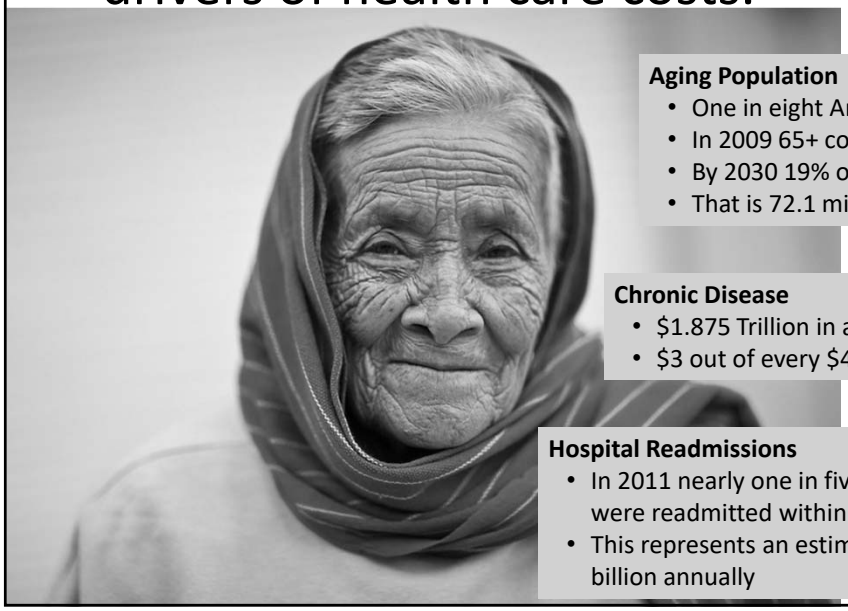


Transformation completely restructures how services are delivered.

Payment methodologies should be evaluated at the intersection of population health segments and health conditions segments.



Success requires an understanding of the drivers of health care costs.



Aging Population
- One in eight Americans are 65+
- In 2009 65+ comprised 12.9%
- By 2030 19% of the population is projected to be 65+
- That is 72.1 million people

Chronic Disease
- $1.875 Trillion in annual health care costs
- $3 out of every $4 spent on health care in the U.S.

Hospital Readmissions
- In 2011 nearly one in five patients admitted to the hospital were readmitted within 30 days
- This represents an estimated preventable cost burden of $25 billion annually

Health care system clinical needs evolve over time.

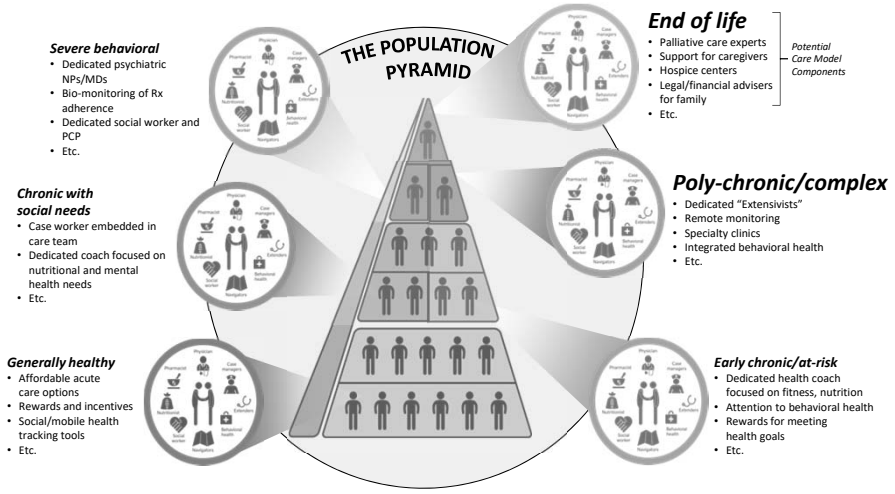
Year	Life Expectancy	Death Rate (per 100,000)	Leading Causes of Death	Clinical Need
1900	47	1,719	Pneumonia Influenza Tuberculosis Diarrhea GI disease	Acute
1950	68	963	Heart Disease Cancer Cerebrovascular	Acute Chronic
2000	77	865	Heart Disease/Cancer Cerebrovascular	Chronic Acute Prevention
2020	?	?	?	Prevention Chronic Acute Integrated Care

Interventions work…but it may take time.

	Activity	Expected Impact	Time to Impact
Effects Within Months	Transitions of care management	Reduce readmissions	3 months
	Case management for high-risk patients with targeted conditions: diabetes, heart failure, COPD	Reduce primary admissions and ED	3–6 months
	Case management for other high-risk patients	Reduce primary admissions and ED	6–12 months
	Pharmacy management	Increase generic use	6–12 months
Effects within 1 – 2 Years	Nursing home management	Reduce readmissions/primary admissions	12–18 months
	More efficient specialists and ancillary providers	Decrease cost per episode of care	12–18 months
	High-end imaging	Reduce unnecessary testing	12–18 months
Effects within 3–5+ Years	Interventions for low-risk chronic disease patients: disease registries, chronic disease care optimization	Improved control; avoid complications	2–5 years
	Preventive care; screening; lifestyle change; wellness	Earlier identification and treatment; decrease incidence of chronic diseases	2–5+ years

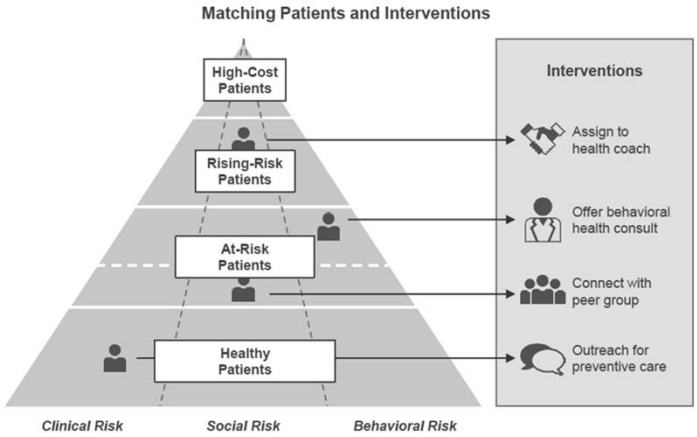
Source: Geisinger

Next generation PHMs will thrive on complex adaptive systems that are highly-tailored to particular segments of the population.



Specialized care models will be supported by new population-specific ecosystems

Whole-person care will integrate behavioral, clinical and social risk into models of care that provide superior value.



55