



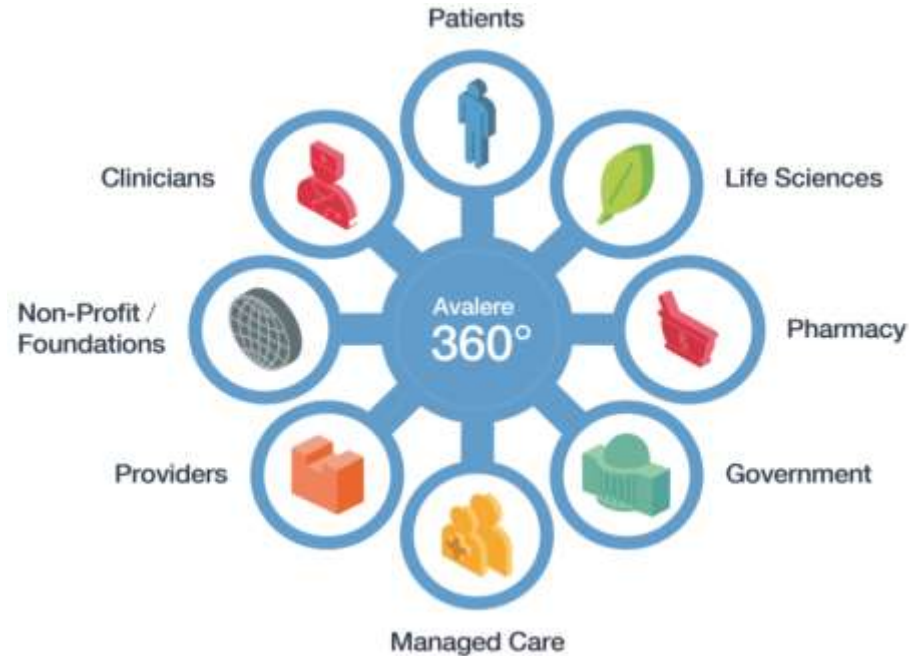
MACRA/MIPS: Implications for Health Care Data

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Avalere Health | An Inovalon Company

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About Avalere Health



Reach and Influence

- Extensive Fortune 500 client roster
- Sought-after by national and trade outlets for our independent voice and analysis
- Featured speaker at national industry conferences and webinars

Company Overview

- Presently 250+ employees
- Singularity focused on healthcare
- Wholly owned subsidiary of  **inovalon**[™]
healthcare empowered
- Founded in March 2000

Inovalon is the Nation's Leader in Quality Outcomes Measurement

Inovalon provides enterprise-scale data integration, analytics, and intervention platforms that deliver precise accreditation measurement, detailed clinical performance insight, improved quality outcomes, and accelerated reporting for government and commercial entities while improving gaps in care, utilization, and financial performance.

11.7B medical events inform Inovalon's analytical insights

65% of the nation's clinical quality outcomes measurement analytics are performed using Inovalon platforms

15 years certified for NCQA HEDIS® measures



Avalere Analytics Produce Data-Driven Insights for Clients

<p>MEDICARE AND COMMERCIAL CLAIMS ANALYSIS</p>	<ul style="list-style-type: none"> • Trends in/patterns of care delivery, utilization, and outcomes by patient characteristics, provider type, payer type, geography, etc. • Relationship of benefit design/formulary to medical/drug utilization
<p>ECONOMIC IMPACT</p>	<ul style="list-style-type: none"> • Budget/cost impact on a provider/payer of using/covering a new service/product • Provider gain/loss on a type of Medicare patient/procedure
<p>PUBLIC POLICY IMPACT</p>	<ul style="list-style-type: none"> • Cost/savings to federal government from a legislative proposal • Eligibility/enrollment/cost/utilization impact to individuals/providers/payers/manufacturers from a change in public policy
<p>PROGRAM EVALUATION</p>	<ul style="list-style-type: none"> • Are new alternative payment models resulting in higher quality outcomes and lower costs?
<p>BENCHMARKING/ COMPARATIVE ANALYTICS</p>	<ul style="list-style-type: none"> • How does a provider/payer/manufacture compare to their competitors on cost, quality, utilization, access, and risk mix,
<p>PREDICTIVE/SIMULATION MODELING</p>	<ul style="list-style-type: none"> • Estimating sources of insurance coverage for individuals with a specific medical condition over the next 10 years • How would changes in a bundled payment model impact costs/revenue for payers/providers/manufacturers
<p>ACTUARIAL ANALYSIS</p>	<ul style="list-style-type: none"> • What is the anticipated cost and risk range of a particular population and what level of shared risk should a provider consider accepting? • How do changes in benefit design impact consumer decision making, utilization, spending, and premiums?

How We're Supporting Our Provider Clients

Interpret Policy

- Summarize and quantify the impact of proposed and final regulations
- Assess the economic implications of payment changes
- Define the financial opportunities and challenges for new payment models
- Support clients in responding to proposed rules

Develop Models

- Inform the design of new delivery models through financial modeling
- Assist clients in engaging with public and private payers on payment reform
- Evaluate clinical and financial performance of pilot programs

Create Platforms

- Customize Inovalon's data-driven intervention model to support care redesign and payer contracting
- Create dashboards to monitor performance in bundled payment, other initiatives

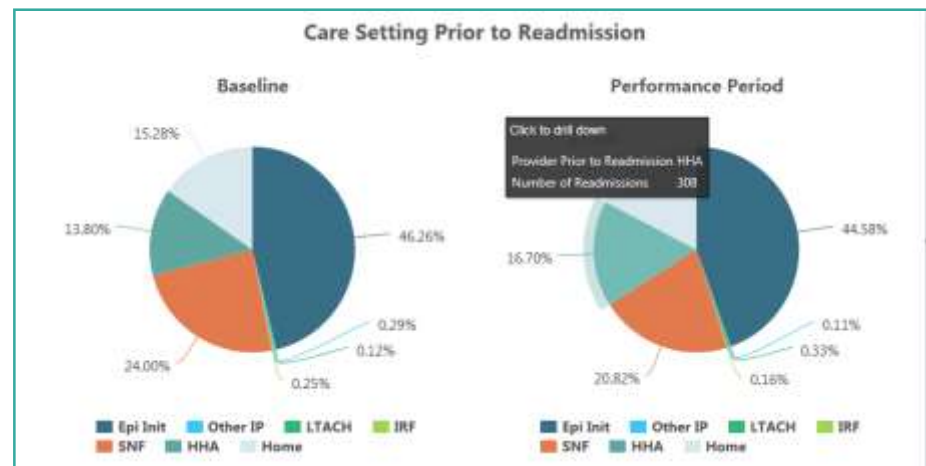


Avalere helps clients to make data-driven decisions to guide their strategic direction

Case Study: Transforming Data Into Meaningful Insights

AVALERE CREATED A PLATFORM FOR BPCI PARTICIPANTS TO TRACK AND MONITOR THEIR PERFORMANCE IN THE DEMONSTRATION

- Methodology
 - Entered into data use agreements with CMS and BPCI participants
 - Accepted data feeds from BPCI participants
 - Assessed data to recommend episodes for which to go at risk
 - Translated data into dashboards to monitor clinical and financial performance



Case Study: MACRA Impact Assessment

Challenge: How to enhance impact of MACRA and influence client's engagement with customers

Qualitative Assessment

through performance gap analysis and interviews

- Pre/post-knowledge assessment
- QPP introduction and high-level implications

Quantitative Assessment

of the impact of QPP through analysis of data

- Impact of quality performance, cost, advancing care information, and improvement activities performance categories

Strategy Workshop

with cross-functional team

- Dialogue on optimal strategies for engaging providers

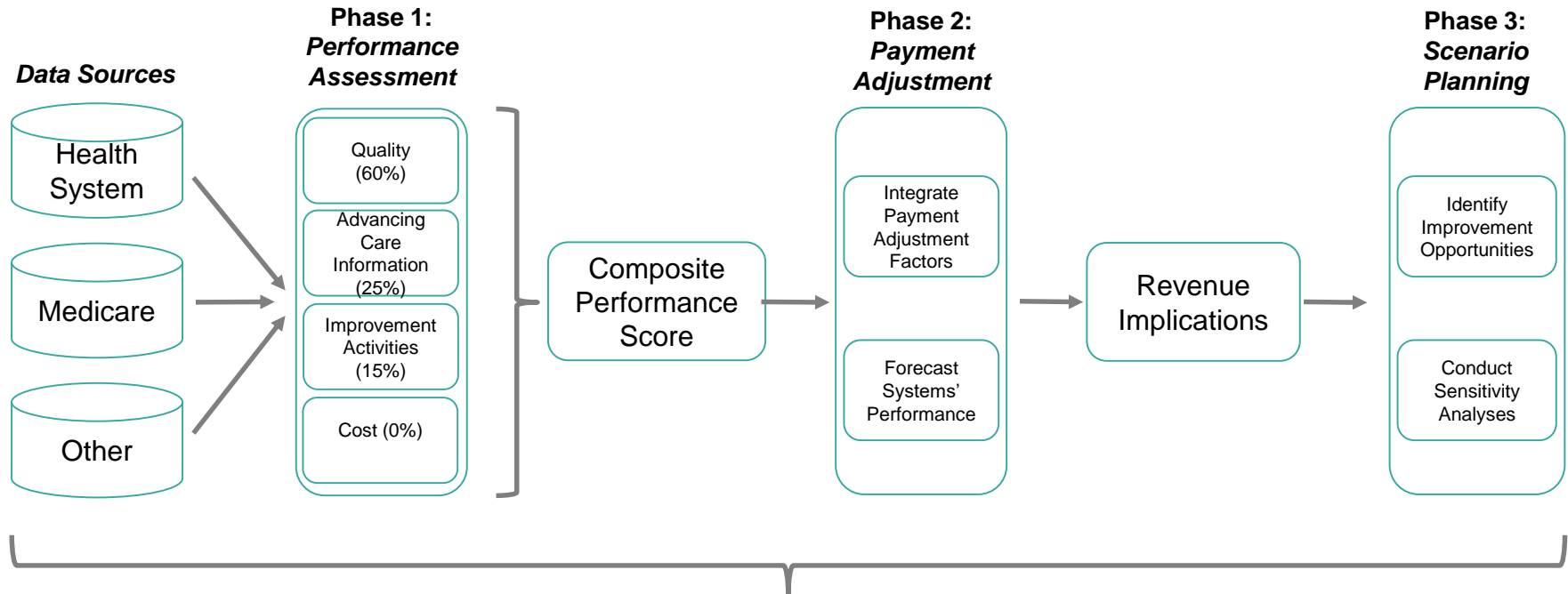


Improve provider engagement and performance to improve patient care and outcomes



Case Study: MIPS Financial Modeling

CONDUCTING IN-DEPTH ANALYTICS TO IDENTIFY OPPORTUNITIES TO ADVANCE CLINICAL CARE AND IMPROVE FINANCIAL PERFORMANCE



Key Outputs

- ❑ Deep insight into the performance of a health system's physician network on quality and efficiency measures relative to other providers
- ❑ Revenue implications associated with a shift to MIPS
- ❑ Areas for quality enhancement, clinical practice improvement, and resource use

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Appendix: Key Features of the MACRA Final Rule

Beginning in 2017, Physicians Will Have Two Options for Moving To Value-Based Payments (2019 Payment Year)

MACRA outlines two tracks for physicians

1

Merit-Based Incentive System (MIPS)

- Fee-for-service payments with annual payment adjustments based on physician performance on quality measures, resource use, EHR use, and clinical practice improvement
- Existing reporting programs (PQRS, EHR meaningful use, and VM) will be replaced by MIPS
- Up to +/- 4% reimbursement in 2019
- Up to +/- 9% reimbursement by 2022
- Budget neutral, so there will be winners and losers

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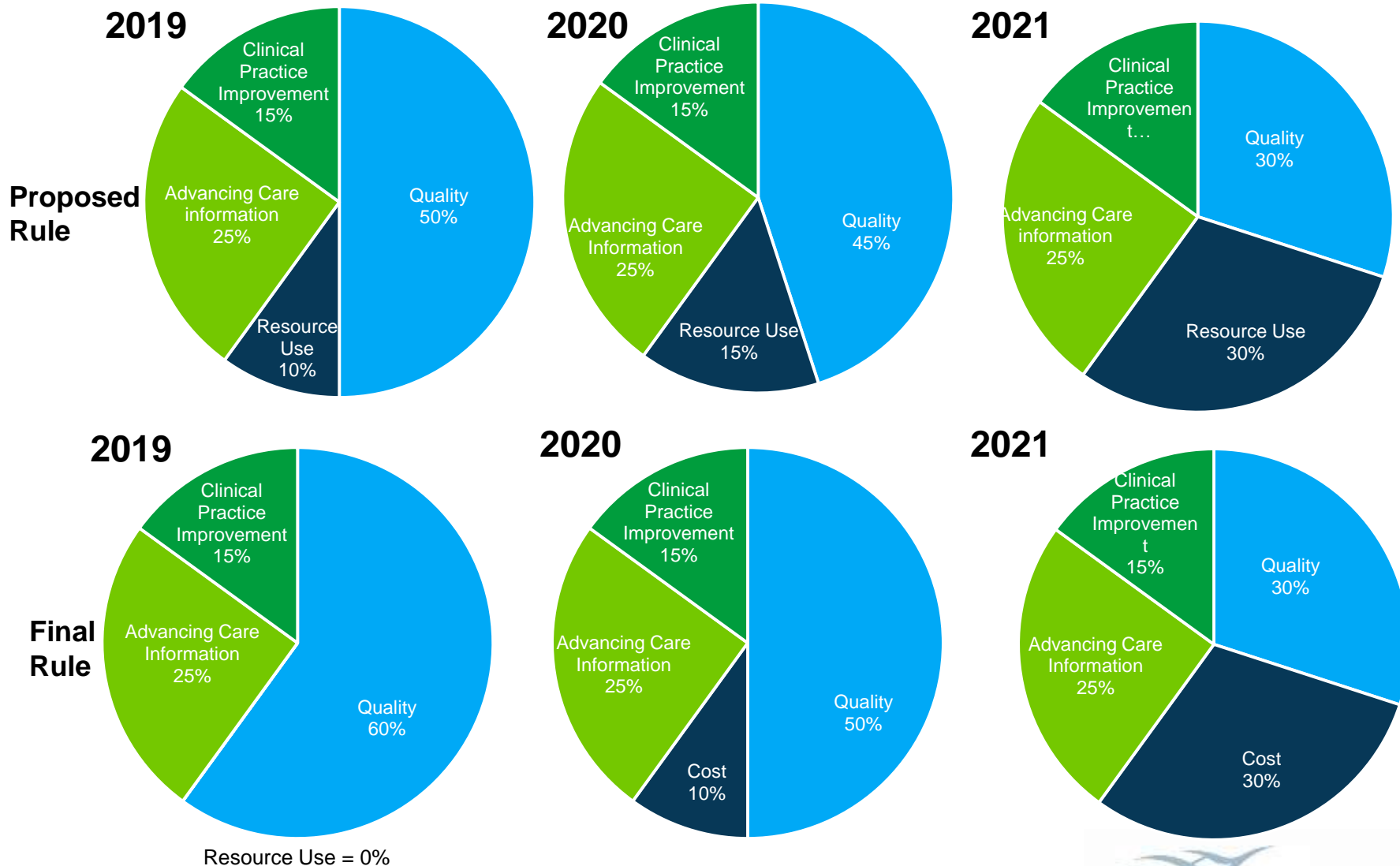
Alternative Payment Models (APMs)

- 5% lump-sum bonus will be paid annually from 2019-2024
- Physicians must meet increasing APM revenue thresholds to qualify for bonus payments
- Beginning in 2021, APM revenue can be calculated using payments from both Medicare and other payers

Key Features of the MACRA Final Rule

- Quality performance category rated higher for the 2017 performance year (2019 payment year)
- Resource Use performance category renamed “Cost” and zeroed out for 2017 performance year (2019 payment year)
- Clinical Practice Improvement Categories renamed “Improvement Activities”
- Reduced quality reporting thresholds within each category
- Allows flexibility for providers to participate in MIPS
 - Three MIPS reporting options, which provide for no negative adjustment
- Increases low-volume threshold that excludes clinicians from MIPS
- Modifies Advanced APM eligibility criteria; announces future models
- Invites additional public comment for a period of 60 days

MIPS Weighted Performance Categories for Composite Score – Proposed vs. Final Rule



Source: MIPS/APM Proposed Rule. Available [here](#); CMS. MIPS/APM Final Rule. Available [here](#).

The Final Rule Creates Provider Flexibility Under MIPS

No participation

- Automatic 4% negative payment adjustment

Submission of minimum data

- Requires at least one quality measure
- Neutral payment adjustment

Partial year reporting option

- Providers may submit 90 days of data
- Potential for small positive or neutral payment adjustment

Full MIPS participation

- Potential moderate positive payment adjustment

Increased threshold for providers to be excluded from MIPS

- Less than \$30,000 in Medicare Part B charges or less than 101 Medicare patients
- Represents 32.5% of clinicians, 5% of Medicare spending

MACRA Allows Providers Participating in Advanced APMs to Opt Out of MIPS

Incentive	<ul style="list-style-type: none">• MACRA establishes a 5% lump-sum bonus payment, provided annually from 2019-2024 to qualifying APM participants (QPs)
Qualifying APM participants (QPs)	<ul style="list-style-type: none">• To qualify as a QO, participants must meet minimum thresholds for the percent of Medicare revenue received through the Advanced APMs or number of patients provided care through the Advanced APM• The law creates two categories of eligible participants: qualifying APM participants and partial qualifying APM participants
Qualifying APMs	<ul style="list-style-type: none">• MACRA establishes three criteria APMs must meet to qualify under this track:<ul style="list-style-type: none">– Includes quality measures comparable to those under MIPS– Uses certified EHR technology– Bears more than a “nominal” amount of financial risk for spending above established benchmarks (or target price)

MACRA Establishes Two Categories of APM Participants: Qualifying and Partial Qualifying APM Participant

- The statute distinguishes between QPs and Partial QPs, both of which are exempt from MIPS, key differences include:

QUALIFYING APM PARTICIPANT (QP)

- In 2019 and 2020, participants must receive at least 25% of their total Medicare payments or treat at least 20% of beneficiaries through an Advanced APM
- Eligible for the 5% incentive payment
- Beginning in 2021, the percentage of thresholds can be met through a combination of Medicare payments and other payers (Medicaid, private)

PARTIAL QUALIFYING APM PARTICIPANT

- Thresholds are lower for Partial QPs: In 2019 and 2020, participants must receive at least 20% of total Medicare payments or 10% of beneficiaries through an APM
- Not eligible for the 5% incentive payment, but may opt out of MIPS
- Partial qualifying APM participants may also incorporate a combination of Medicare and private payer payments beginning in 2021

Qualifying APMs

- Under the final rule, the following would qualify as Advanced APMs:
 - Comprehensive ESRD Care Model (downside risk)
 - Comprehensive Primary Care Plus Model (CPC+)
 - Medicare Shared Savings Program Tracks 2 and 3
 - Next Generation ACO Model
 - Oncology Care Model (downside risk, beginning in 2018)
- CMS indicates it may broaden eligibility in the future to include:
 - A new MSSP Track 1+ ACO model
 - Comprehensive Care for Joint Replacement
 - Episode payment models (EPMs) for AMI, CABG, SHFFT
- CMS estimates that:
 - 70,000-120,000 of providers will be qualifying APM participants in 2017
 - This range is expected to grow to 125,000-250,000 in 2018