MACRA/Quality Payment Program Financial Impact

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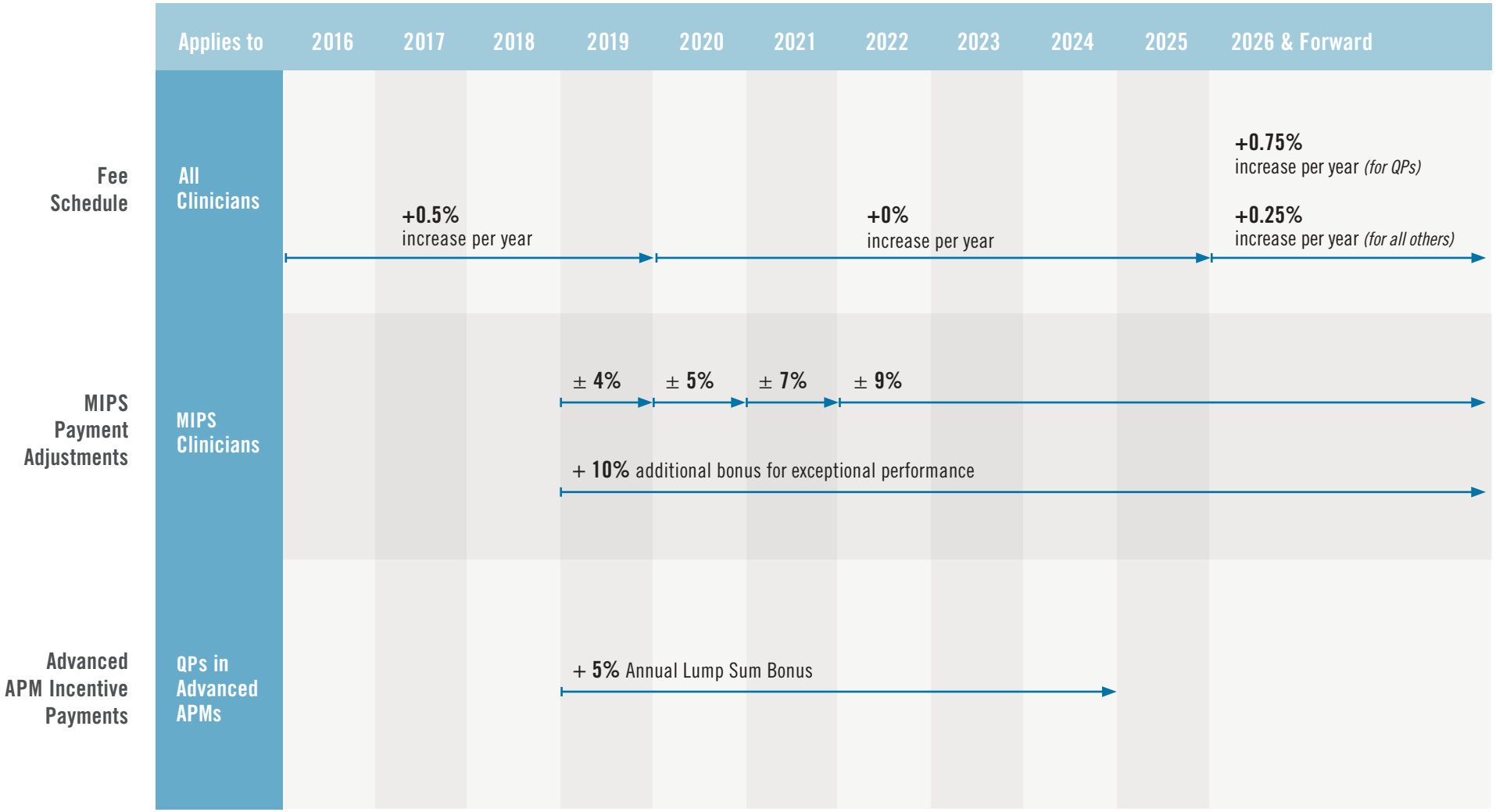
This document summarizes the financial impact of the Quality Payment Program ("QPP"), established under the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"). This page provides a high-level overview of the impact by clinician type. All clinicians receive Medicare Part B reimbursement under the updated fee schedule. Clinicians in the Merit-Based Incentive Payment System ("MIPS") track of the QPP will also receive the corresponding Medicare Part B fee schedule adjustments described below, while qualifying participants ("QPs") in Advanced Alternative Payment Models ("APMs") will receive the bonus described below. Subsequent pages provide more specific detail for each clinician type in the QPP.



MIPS Clinicians

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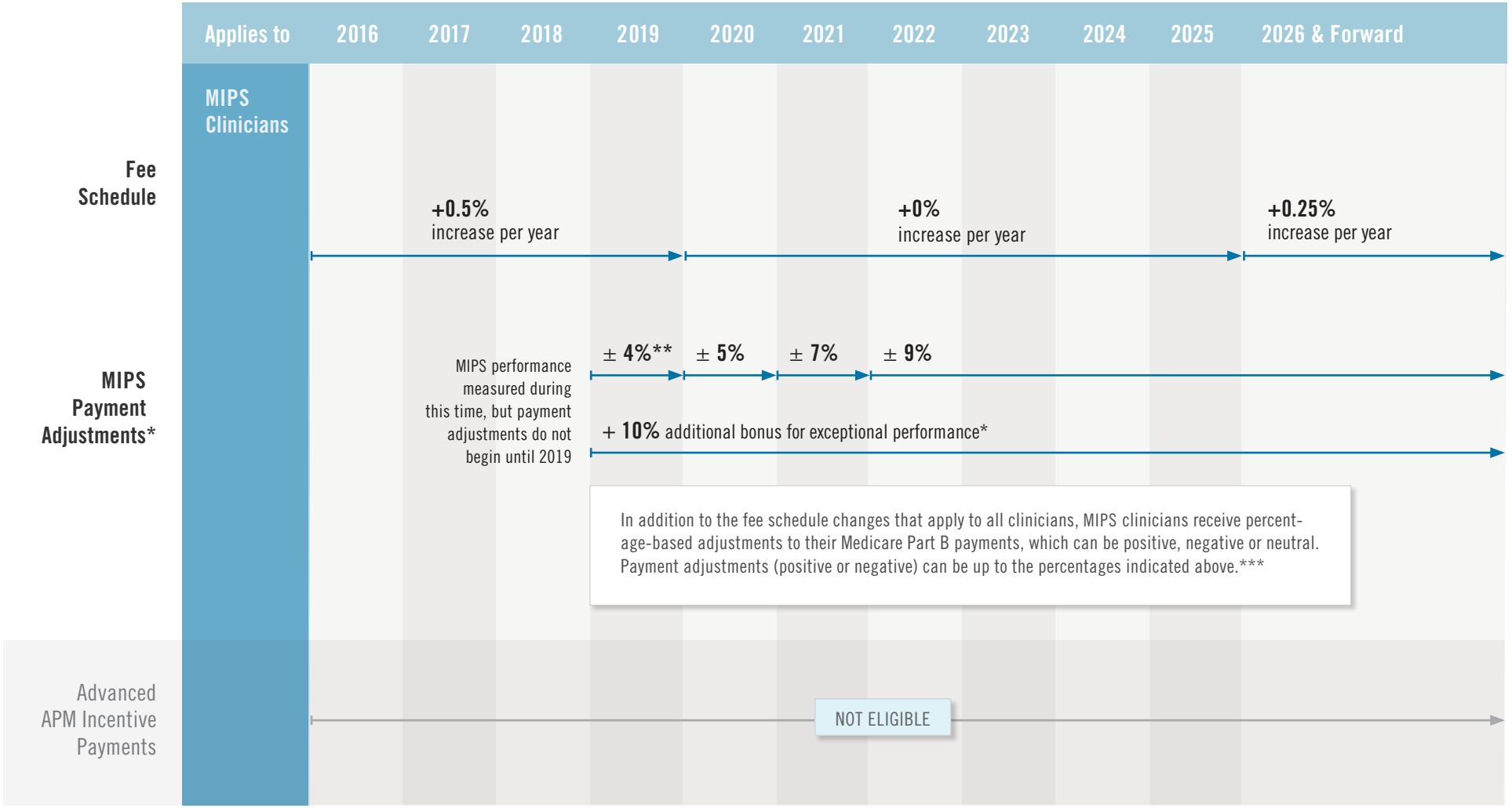
APPLIES TO:

- Clinicians, other than QPs, with annual Medicare Part B billing charges of more than $30,000 or more than 100 Medicare patients in one year
- Partial QPs (see page 6) who elect to participate in MIPS



* CMS will establish and publish the exceptional performance threshold for each of 2019-2024 prior to the start of the performance period. A clinician can receive an additional adjustment ranging from 0.5% (for achieving a final score that meets the exceptional performance threshold) to 10% (for achieving a final score of 100). Additional payments may be subject to a scaling factor to ensure that the estimated aggregate increase in payments will not exceed $500 million in any performance year.

** Refer to next page for additional detail.

*** There is also the potential for an upward adjustment of up to 3x the percentages indicated above, which is tied to the performance of all MIPS providers. The 3x adjustment is based on a budget neutrality policy, so if there is a significant number of underperforming providers, successful providers will receive an additional upwards payment, such that net payments by CMS are $0. However, if there is not a significant number of underperforming providers, the 3x adjustment could be minimal or non-existent.

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MIPS Clinicians *(continued)*

2017 Transition Year Data Reporting Options

Because 2017 is a transition year, CMS has provided several data reporting options to limit the potential negative for a payment adjustment in 2019:

- Clinicians who report all of the required measures for at least a 90-day period (up to the full reporting period) will receive a modest positive adjustment of up to 4%. The amount of the adjustment will depend on the clinician's score.
- Clinicians who submit more than one quality measure, more than one improvement activity, or more than the required measures in advancing care information for at least a 90-day period will receive a neutral or small positive adjustment.
- Clinicians who submit one quality measure, more than one improvement activity, or the required measures in advancing care information for at least a 90-day period avoid a negative MIPS payment adjustment.
- Clinicians who submit no data at all will receive the full downward adjustment of 4%.

QPs Participating in Advanced APMs

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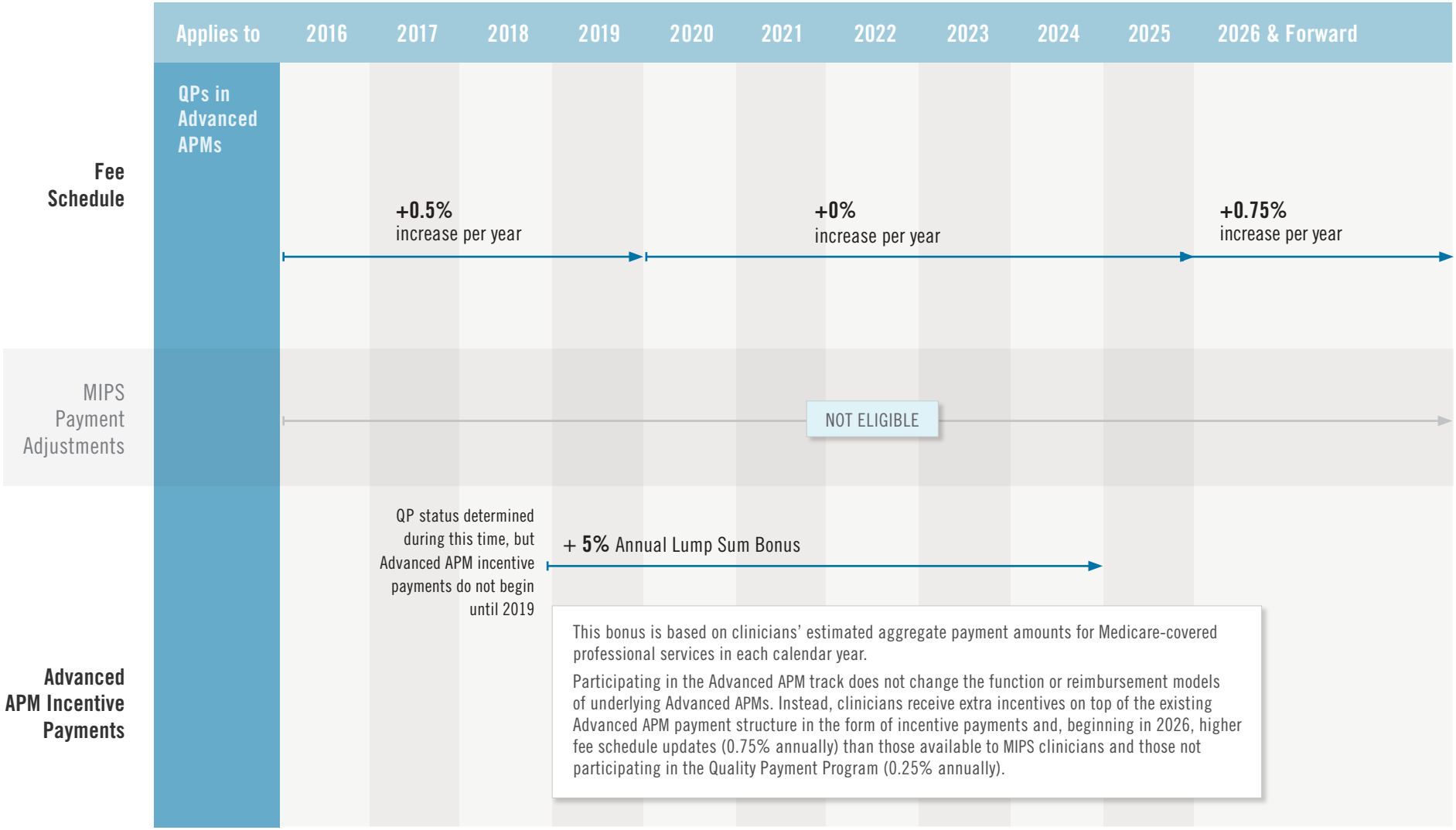
APPLIES TO:

- Clinicians who participate in an Advanced APM and meet the criteria for being a QP*



* Refer to the next page for more detail regarding qualifications.

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QPs Participating in Advanced APMs *(continued)*

To qualify as an Advanced APM, an entity must:

- Use certified EHR technology
- Base payment on quality measures comparable to the MIPS quality performance measures
- Either bear more than nominal financial risk or be an expanded Medical Home Model

CMS will publish a list of models on its website that qualify as Advanced APMs before each performance year, no later than January 1. CMS has published the following preliminary list of Advanced APMs for 2017:

- Medicare Shared Savings Program (Tracks 2 and 3)
- Next Generation ACO Model
- Comprehensive ESRD Care (CEC) (Two-Sided Risk)
- Comprehensive Primary Care Plus (CPC+)
- Oncology Care Model (OCM) (Two-Sided Risk)
- Comprehensive Care for Joint Replacement Model (Track 1 – CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

To qualify as a QP, a clinician must participate in an Advanced APM and receive a certain percentage of Medicare payments or patients through an Advanced APM:

- **2017 & 2018 Threshold:** Receive at least 25% of Medicare payments or at least 20% of Medicare patients through an Advanced APM
- **2019 & 2020 Threshold:** Receive at least 50% of Medicare payments or at least 35% of Medicare patients through an Advanced APM
- **2021 & Forward Threshold:** Receive at least 75% of Medicare payments or at least 50% of Medicare patients through an Advanced APM

Those who do not meet the thresholds are referred to as Partial QPs.

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Partial QPs in Advanced APMs

APPLIES TO: Clinicians who participate in an Advanced APM but do not meet the threshold of payments or patients to qualify as a QP

- Partial QPs can choose whether or not to participate in MIPS
  - A Partial QP who opts out of MIPS is treated as a physician excluded from participation in MIPS *(see page 7)*
  - A Partial QP who opts into MIPS is treated as a clinician participating in MIPS *(see page 2)* and will also receive favorable APM scoring in MIPS
- Partial QPs are not eligible for the 5% annual lump sum bonus or the higher fee schedule updates that QPs receive

Clinicians Excluded from MIPS

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APPLIES TO:

- Clinicians who are in their first year of Medicare Part B participation
- Clinicians who are below the low patient volume threshold (annual Medicare Part B billing charges of $30,000 or less and care for 100 or fewer Medicare patients in one year)
- Partial QPs in Advanced APMs who elect not to participate in MIPS