[Chris Keller]

Thank you for joining us today and welcome to the webinar. This is the 2016 Health Catalyst® Webinar Series. As a quick introduction, Health Catalyst® is an outcomes improvement company focusing on healthcare data warehousing in analytics. My name is Chris Keller and I will be your moderator today.

Our webinars are intended to be educational opportunities to explore the many facets of healthcare transformation, culminating in our annual Healthcare Analytics Summit this September 6th through the 8th in Salt Lake City. Those of you who attended our webinars in the past couple of years may remember that we held summer registration giveaways at the end of some webinars leading up to the summit. We will be doing that again today.

Now, let us begin with today's webinar. Making Sense of the New MACRA Announcement presented by Bobbi Brown, Vice President of Financial Engagements with commentary from Dr. Bryan Oshiro, Chief Medical Officer at Health Catalyst®. Throughout our presentation today, we encourage you to interact with our presenter by typing in questions and comments using the questions pane in your control panel. We will be answering questions at the end of the presentation during our questions and answers time. We are recording today's session and shortly after the event, you will receive an email with links to the recorded on-demand
webinar, the presentation slides with the poll results and the names of the summit giveaway winners. We will be providing this transcript to this webinar and we will send out a notification once this is available. Also, you can follow us on Twitter. Our handle is @HealthCatalyst.

Before I turn the time over to Bobbi, we have two poll questions. Let me go ahead and load that first poll question right now.

What is your primary functional area of expertise? We have five options, clinical, finance, IT, executive, or other. We will give people a few moments to answer that question.

Are we good? We will close that poll question and show the results.
Alright. We have got a nice mix of people today. Fewer in finance than typical. 21 percent clinical, 8 percent finance, 19 percent IT, 25 percent executive, and 27 percent other. Thank you.

Now, onto our second poll question that pertains to today's topic.
Poll Question #1
How ready are you to participate in MACRA?

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<tr>
<td>Somewhat</td>
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364 Total Responses

How ready are you to participate in MACRA? Five options. Not at all, somewhat, unsure, ready, or very ready. We will give you a few more moments to answer that question.

Very good. We've got great response here.

Okay. We will go ahead and close that poll and share the results.
What do you think about that, Bobbi?

[Bobbi Brown]
Wow! We can see a lot in the unsure category. We do have a couple people, 1 percent are very ready. So that's great. Hopefully they can share some feedback with us today as we are going through this. And the not at all, I'm glad you're here. That's why we are here, to try to help out. And the somewhat category, we will get to there.

[Chris Keller]
Very good. Thank you, Bobbi. We will go ahead and turn the time over to you now to present.
Making Sense of MACRA [03:30]

[Bobbi Brown]
Okay. Making Sense of MACRA. It's a great day here in Salt Lake. We have this cute little boy up on the screen. He is ready to take on anything, just like we are ready to take on MACRA.

Question
Who reads 962 pages of regulations?

Remember all these slides reflect PROPOSED regulations

Question: Who reads 962 pages of regulations? [03:38]
So the first thing that happened, I think it came out maybe two weeks ago, the regulation, the proposed regulation came out and I just, I don’t know. I wish I could ask a poll of how many people read the 962 pages of regulations. I hope not a lot of you. It is an interesting scenario of people. When I have been in this business awhile, as you can probably tell if you read the write-up about this webinar, and we used to have a fight between some partners at our instance and partners at [04:12] to try to see who could get the federal registered the fastest and read it and then interpret it and get it back out to our clients quickly. We didn’t have to do that anymore. It's all online which means you can stay up all night and just dial in and look at them. But I’m a pretty calm person and I’m pretty calm through all this and I have to say I went through the regulations once and then I had to go away and come back. So the coming back is what you are going to see as I went through and figured out what is going on.

**Purpose of HR Bill 02**

**Physician Fix Passed in April 2015**

- Offer multiple pathways for risk/reward
- Minimize additional reporting burdens
- Streamline multiple programs
- Reward clinicians for value over volume

The whole point of this, it was House of Representatives Bill 02. It was passed last year in April of 2015. And I want to come back to this at the end. They want to offer multiple pathways for risk and reward, they want to minimize reporting burdens and streamline multiple programs and then reward clinicians for value over volume. As anyone will tell you when they read these, these are great. The devil is in the details.
So let's talk a little bit about those details. But first, when you read this, you kind of think what is this and you are never sure whether to say, M-A-C-R-A or MACRA or SGR or MIPS or how to say it. We kind of developed our own little language around this. But MACRA is the Medicare Access and CHIP Reauthorization Act of 2015. It did pass for another two years, the Children's Health Act, which is always great, but we are not going to focus on that. The Sustainable Growth Rate is what got replaced by MACRA. And MIPS is a Merit-based Incentive Payment System. APM is Alternative Payment Models and they snacked a little something in on us in this. There are alternative payment models and there are advanced alternative payment models, which we are going to talk about. And Eligible Professional became the Eligible Clinician. So if you were an EP, you are an EC now.
So again, overall goals for CMS, I think it's just great that they put these out there last year. They said by 2018, we want to be 90 percent based on quality and we want to have 50 percent based on alternative payment. Right now, just in context, 22 percent of the payments that Medicare makes go to physicians. So that is the segment that we are talking about and they are talking about overall on the slide on the right but now we are going to be focused on this 22 percent of payments, approximately $138 billion a year. And of course, Medicare wants to get the private sector commercials to match this and I do not know if too many commercial payers will get in and have this level of regulation around it but there are some things that they can do, definitely tying to quality, using some of the same metrics, which would be wonderful, and see where we go from there.
Goals of CMS [07:20]

Again, these goals, cannot argue with these, we want better care, smarter spending and healthier people. And they are going to go that via incentives, the care delivery, and the information sharing.

Reactions [07:32]

“Most profound change to physician compensation in more than 25 years. There is going to be a lot of anger and frustration.”
Steven Stack, M.D., President of AMA

“Make policies simple, flexible to allow providers to make choices to meet their needs and outcomes-oriented.”
Patrick Conway, M.D., Chief Medical Officer, CMS

“Feedback mechanisms are too removed from the performance year.”
Anders Gilberg, Senior Vice President of Government Affairs, MGMA

“Quite frankly, the rank-and-file physicians aren’t paying attention.”
Chet Speed, JD, LLM, Vice President of Public Policy, AMGA
The reactions, I'm going to let Dr. Oshiro speak a little bit about this when, like I said, it was kind of a frenzy when this stuff first comes out, and what do we think about it. And I put some up on the board and let Dr. Oshiro.

[Dr. Bryan Oshiro]
Yes, thank you, Bobbi. You know, it's quite interesting when you go and talk to physicians. I talk to many of them and they really do not understand what the actual changes are. There is a misunderstanding that because of the new MACRA OS and payment schedules and so forth that are proposed to be changed, that they thought that meaningful use even was going away. So there is a lot of confusion. But for the most part, it is interesting to me that although Steven Stack, the President of AMA, says, "This is the most profound change to physician compensation in more than 25 years and there is going to be a lot of anger and frustration." I think a lot of that stems from the fact that people just do not understand it and they are really not paying that much attention to it. So it is just quite an interesting environment in which we live.

[Bobbi Brown]
Okay. So just a few, you know, trying to make it simple, and this one, I want you to think about, "Feedback mechanisms are too far removed from the performance year." Again, let's come back to that one.

Performance Year

2017

Performance Year 2017 [08:55]

The performance year, it's 2017. And guess what? How many months away is that? Seven months away and we are going to start into a performance year. So, one thing that potentially
could happen with your feedback and particularly with this being election year is maybe some delays, maybe it will not start January 1st. I don’t know. We should take a poll on that and see when it is going to actually start. But again, if I get across anything today, 2017 is around the corner and that is when the performance year is going to be. You do not get paid this way until 2019. So you tend to think, huh! I can go to sleep for a while. No, you cannot because the performance year is going to be 2017.

Additional Aspects

- $100M of technical assistance for small practices (under 15 professionals)
- $75M for physician groups to improve quality measure development

Additional Aspects [09:38]

Some additional aspects of this, CMS has agreed to give $20 million a year technical assistants for small practices and there also, they put in $75 million to have physician groups get together to improve the quality of measurement development, which is good. Both of those are good things. We will have to figure out how to tap into them.
Two Tracks of MACRA [10:00]

There is a million different charts out there. And I need to say, CMS, if you just go to cms.gov and type in MACRA, there is a really good information out there. They are doing really good webinars. It tends to be a lot of repetition of regulations them self which I used to love to do, just sit there and say, 4 percent, 5 percent, 7 percent. So you need that piece of it and then you also need the piece of what you are going to do with all this.

So again, there's two tracks in MACRA, MIPS or the APM for qualified providers. And if you go into the MIPS track, which is where most – you don’t really get to choose. Medicare is going to put you probably in MIPS. And we'll talk about which track and how you get into the different tracks. And then again, I mentioned the performance year is 2017. Then starting 2019 for MIPS your payment can go up or down by 4 percent, 5 percent, 7 percent, 9 percent, then it stays at 9 percent, and you can either be plus or minus those numbers, you can be neutral, get nothing increase on your fee schedule, and then there is also a potential for a bonus, which we will go into.

So they did actually give out regulations past this date, but to me it was just too much. I thought, well who cares in 2026 if I am going to get 0.75003 percent increase. I want to focus on today. So I did not even put those in here.

On the value-based side, 5 percent bonus and at first I was thinking, ah yeah, if everybody go into the value-based side, but it is not going to be as easy that it ends up in that track.
Cross Over Between the Tracks

MIPS participants who participate in APMs would receive credit toward scores in the Clinical Practice Improvement Activities category.

Certain Advanced APMs participants, who fall short of the payment or patient participation requirements for the incentive payment can choose whether they would like to receive the MIPS payment adjustment.

The proposed rule aligns standards between the two parts of the Quality Payment Program in order to make it easy for clinicians to move between programs.

And there is some cross-over between the tracks. If you are in the MIPs and you are also in an alternative payment program, you will receive credit for some of those things. If you are in an advanced payment and you fall short, you could still get the MIPS payment and they have tried to align the quality payment program between the two so that the measurements are the same.
Proposed Rulemaking

Public commentary until June 27, 2016
Final regulations published in November 2016

Comments may be submitted electronically to CMS:

Important part, proposed rulemaking. The public commentary, we have from now until June to give our commentary, and then the final regulations will be published in, again, November 2016, and that's not a lot of time period until January, from November to January. So again, we will have another frantic reading of all those regulations when the finals come out. I gave you the web address here to submit any comments that you may have to CMS. They are really listening to people and trying to take into account everybody's feedback.
The reporting period will be once a year and you are only going to see results once a year. So hence, that comment there that was made earlier. The first feedback period will be July 2017, which will be data from previous two years. Your second feedback report will be in July of 2018, which will be on the actual data. And just to remember, all of this data is going to be made public and it is going to be on Physician Compare. When Medicare first started putting all this data out there, I was working at a system, I'm a finance person, and my boss, obviously he was a finance person but he said, "Get out there and find out everything that is on the web about us because I don’t like this, and make sure that the data is correct." So you will want to be thinking along the same way. You want to make sure that reports that Medicare sends you, you look at them because they are going to be made public.
Okay. Let us talk about these two tracks now. We have this MIPS, Merit-based Incentive Payment System. I have to say I like MIPS. I like saying that. This will be the default.
And who is eligible for this in years 1 and 2? It's physicians, physician assistants, nurse practitioners, the clinical nurse and the CRNA. And then they are proposing an expansion in year three. So for additional PT, OT, social workers, and the nurse midwives.

[Bryan Oshiro]
Bobbi, let me insert a question that an audience member asked, which is, what does base year mean?

[Bobbi Brown]
Base year will be 2017 generally. And sometimes I'm interchanging the word base year and performance year and I really should not. It really is the performance year, which is 2017, because in the other program, there is also a base year of payment to be based on 2018. So it is generally 2017 and I will try not to use the word base and performance year.

[Bryan Oshiro]
The other, I think you are going to talk about exceptions but there is an exception for low volume providers that do not charge more than $10,000 and provide care for less than hundred Medicare patients in one year. So they do have that provision there too.

**Exceptions for MIPS**

- First year of Medicare participation
- Low volume threshold
- Participants in advanced APM

[Bobbi Brown]
Yes, and the screen right now, we have exception for MIPS. If it is your first year of Medicare participation, you will not be, and then this low volume threshold that Dr. Oshiro talked about.
So a hundred patients or $10,000. And then if you are participating in the advanced APM, you will not be in MIPS. But it has to be the advanced APM, not just APM advanced.

Measurement
Composite Performance Score (CPS) [15:59]

Okay. So when you are in MIPS, there is a composite score and it's weighted and that's probably the most important thing you need to know. I am going to drone on about a few more things but it is quality, cost, this is a new one, clinical practice improvement activities, and advancing care information, which is the old meaningful use. And then the weight is over there and these do change by year. Eventually, cost goes up higher and quality goes down lower and the other two seem to stay constant over the time period.
Quality – Weighted 50%

- Six measures with no domain required – select from over 300 measures (last 200 pages of regulation)
- One cross-cutting and one outcome measure required

Cross cutting measure example

Care Plan: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed.

Outcome measure example - CMS defines

Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

Quality – weighted 50% [16:33]

So if we talk about quality, the quality metrics were, if you are used to PQRS, you are used to submitting what is nine measures, with the domain now, it is down to six measures, and they are giving you a selection of over 300 measures and they are actually in the last 200 pages of the regulation, if you want to look at them. You do have to have one cross-cutting measure and one outcome measure. Example of a cross-cutting means that it impacts a lot of different practices. So a care plan – do I have a care plan.

At outcome measure, again, CMS actually defines what is a process measure and an outcome measure. So for an outcome measure in this case is cataracts. After cataract surgery, I have better visual acuity within 90 days. So again, this is going to be weighted 50 percent.
The stakeholders that they went to, they talked to 6,000 people. And there is what they called a measurement document out there, it is 80 pages long. So if you like documents. This is not as long as the regulation, but it does give you their basis for how they develop some of these measures and who they talk to and what their criteria were.
Initial Priorities for Measure Development
Clinical Care
• Measures incorporating patient preference and shared decision-making
• Cross cutting measures (more than one specialty)
• Outcome measures
• Focused measures for specialties that have clear gaps
Safety
• Measures of diagnostic accuracy
• Medication safety related to important drug classes

And just talking about criteria, I think it is interesting to always start out with what were they trying to do, trying to have outcome measures, as I mentioned. On the safety measure, I cannot imagine we are not going to see more on opiates, just everything that's in the news to important drug classes safety related to important drug classes.
Continued- Initial Priorities

Care coordination
- Assessing team-based care (timely exchange of data)
- Effective use of new technology such as telehealth

Patient and caregiver experience
- PROMs (Patient-reported outcome measures)
- Additional topics important to patient/family/caregivers

Affordable care
- Overuse measures

Care coordination, telehealth, PROMs. No, you are not going to the prom but those are Patient-Reported Outcome Measures. I personally was sick last couple years ago. I actually had sepsis and I had to go back to my doctor and they gave me a little laptop, a little iPad, and made me fill out how I was doing, and I thought, oh this is the stupidest thing in the world, and I could tell a lot of patients in the waiting room were having a lot of difficulty doing this. But my friend, who is a nurse, she said, no, that's extremely important, your patient-reported outcomes, how far you can walk, if you can pick up your shopping bag, that's extremely important for her to know and make sure that I'm making improvement in those areas. So it was more important than what I realized. So I'm learning something new every day. Affordable care, where are we overusing areas, the high imaging, are we overusing anything.
Continued – Initial Priorities

Population Health and Prevention

- Developing or adapting outcome measures at population levels to assess effectiveness of promotion and preventative services
- IOM Vital Signs topics
- Detection or prevention of chronic disease

And finally our population, we know we want to really get into population detection and prevention of chronic disease. So again, all of these things went into the quality metrics and how, which ones they pick.
Resource – Weighted 10%

- Compare resources used to treat similar care episodes and clinical condition groups across practices
- Can be risk-adjusted to reflect external factors
- CMS will calculate from claims

The resource, this is the cause one. It's just weighted 10 percent this year and they are going to compare resources used to treat similar care episodes and clinical conditions across practices. They will risk adjust and they will calculate this number for you, and I do not know if that is a good thing or a bad thing, if you like somebody calculate numbers for you. But they have the information from claims and they will calculate it for you.
Right now, there is a thing called the Medicare Spend from Beneficiary, another acronym, MSPB, and it is public information. You can get it right now for all the hospitals and it shows you what they are looking at and looking at three days prior, the hospital and then 30 days out and they could change any of these and looking at your hospital compared to your state compared to your nation. So, the data is there. They are going to start – they also want to start doing it by conditions, like for heart failure, for COPD. So they are part of this regulation, had some groupers in it of how they might potentially group 40 to 50 different conditions. So that is coming down the pipe and that is going to be part of the piece on the resource use.
Clinical Practice Improvement Activity (CPIA) – Weighted 15%
Areas: (Not yet defined in detail but there will be 90+ activities and selection of one)

- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessment
- Participation in an APM

The clinical practice improvement activity, CPIA, it's 15 percent. It is not a lot of detail but they do have 90 plus activities, things like expanded patient access. So for things like do you have weekend hours, do you have hours at night, do you have 24-hour access. For the care coordination, have you implemented practices that document this care coordination. The beneficiary engagement, we talked about tools where the beneficiary is involved. Obviously, patient safety. There are different programs you can participate in that will count as this. You only have to pick one. What I could not find out from the regulations is how long you have to do it. It looked like they were proposing that you do it at least 90 days but hopefully in the final regulation, that will come out and we will see how long we have to do some of these things. But again, all of these are things that are beneficial to the patient and the beneficiary.
Advancing Care Information – Weighted 25%

- Former Meaningful Use
- Use of certified electronic health record (EHR) technology in day-to-day practice
- Emphasis on interoperability and information exchange.
- Not all-or-nothing EHR measurement and no quarterly reporting.
- Removes reporting for CPOE (Computerized Provider Order Entry) and Clinical Decision Support

The final advancing care information, weighted 25 percent. This is what used to be called Meaningful Use or MU. So you are going to have to use a certified EHR in your practice. There is going to be emphasis on interoperability and information exchange and there is not anymore quarterly reporting and it is not an all or nothing and they took out the CPOE and Clinical Decision Support.
Meaningful Use [22:18]

So, in the beginning of the year, we had a lot of flurry because the acting administrator of CMS, Andy Slavitt wrote, "Meaningful Use, as it existed, will be effectively over and replaced with something better." And it was a great tweet. I think we all got excited. It is not over. We still are going to be reporting measures. But again, the focus is towards the use of technology and the outcomes they are going to give our patients.
So again, what criteria are we looking at in this advancing care information – protection of the information, patient having electronic access, the electronic prescribing, coordination of care, and information exchange and public health and clinical data registry. They eased back on some of these registry requirements and some of the public health as you go through the regulations.
Technology

For period of January 2017 to December 2017

1. Use 2014 or 2015 edition certified EHR
2. Report eight Stage 2 or six Stage 3 advancing care information measures/objectives
3. Attest that clinicians have cooperated with the surveillance of certified EHR technology under the ONC Health IT Certification Program
4. Attest to statements related to health information exchange and information blocking

What are you going to have to do starting in January of 2017. Again, the certified EHR report eight, if you are in stage 2 or six in stage 3, and you are going to have to attest that you have cooperated with the surveillance and that you have cooperated with health information exchange and information blocking.
Okay. Now, all of these go together. The quality, the cost, the clinical practice improvement, and the advancing care, and you get points, and then you get scored on each one. And the advancing care is interesting because there is 60 points for this, the performance is 10 points and a bonus score. I put all this up here just to let you know it is a little complicated. It is not going to be something that we are going to be able to do in three seconds.
More about scoring

- Converts measures/activities to points
- Eligible Clinicians will know in advance what they need to do to achieve top performance, targets will be communicated
- Partial credit available
- MIPS composite performance score in 4 weighted performance categories on a 100-point scale
- Option to do as a group

More About Scoring [23:58]

Then they take all these measures and convert them to points and they are going to let you know in advance what the targets are going to be, which is good. So we are going to know ahead of time. So if I want to be in that top performance, I know what I have to do. You can also submit. These measures can be done as a group. And that is an interesting one because consumers want to know about individual physicians. Individual physicians want to report as a group. So it is just an interesting dichotomy that we have there. And again, this MIPS, we are going to have those four areas on a zero to 100 percent scale and put them together and you will get a score for each one and come up with, of course, a CPS.
So in case you hear a CPS, that is your Composite Performance Score for all of those four areas. And in the first five years, there is going to be $100 million extra each year, or $500 million over the five years, as an additional performance bonus that is exempt from budget neutrality for exceptional performance. So if you really are an exceptional performer, you can really get some extra money in here.
Okay. So, when we boil this all down, they are going to adjust the payment then based on that score. It is a budget neutral program. So whoever goes below, then that can go to the people that are above. And what I put on there, the 46 percent is what CMS has put in the regulation as what they think the number of people that are going to be below. And the interesting thing is that really varies by practice size. For the small practice size, it was up to in the 80 percent that they thought were going to receive a negative adjustment. For overall practices, all sizes, it is 46 percent, and then obviously the inverse of that is 54 percent saying that that will be performance above and you can either be neutral or performance above and you have a potential for a bonus that will not exceed 10 percent, and they are also going to do some scaling in this. So they are not going to scale on the downside. And remember, I said, the first year, it's plus or minus 4 percent, and if they do some scaling, if there is a lot of people below, if their number is not right and it is more people below, then they are actually going to let the people above earn more money to make a budget neutral. So what goes out will be, like I said, a zero sum gain. So, interesting. Good way we can forecast.
The other track is the Alternative Payment Model. Really this is where the Alternative Payment Model, as you saw on the beginning, is where CMS wants us to go as an industry and the Congress wants us to go there. The current administration wants us to go to these alternative payment models, which are things like ACO-bundled payments. We have a couple of bundled payment models. So that is where they want us to go.
MACRA does not change any existing APM programs or incentives

Now, MACRA, it is not for hospitals, it is only for physicians and it does not change any of the existing programs that are out there. So if you are in an MSSP ACO, nothing is changing there. Some of the quality measures that you are reporting will count towards MACRA but generally there is no change in those programs.
And as I mentioned, you have to not just be in an alternative payment model, you have to be in an advanced alternative payment model. And right now, there are five different types of models that qualify for that advance. I put them up here – the ESRD, the Medicare Shared Savings Program Track 2 and Track 3, Not Track 1. So if you are in Track 1, you are probably still in MIPS. The Next Generation ACO Model – 21 participants. The CPC model, which has right now just came out. This Comprehensive Primary Care Model just came out and right now Medicare is asking for payers to participate and they are going to ask for your participation, I believe, starting later in, I believe it is going to be in about July they are going to start asking. They are going to pick 20 regional areas in the country. And if you do participate in that, you will be considered an advanced APM. And then there is another model that is going to be available in 2018, which is the Oncology Care, which is a Two-Sided Risk Model.

So what they are really looking for here, it is the risk that they are talking about, how much risk are you taking, and that will qualify you into an APM model.
Advanced APM Eligible Programs

Criteria to meet:

- Payment based on quality (measures similar/comparable to MIPS)
- Use of certified EHR technology- at least 50% of providers
- Bear financial risk and risk must be at certain magnitude or be part of Medical home model expanded under CMMI

It WILL be difficult to qualify for Advanced APM.

So, advanced APM, how do I qualify? Payment has to be based on quality, at least 50 percent of my providers have to be using a certified EHR, and I have to bear financial risk and the risk has to be at a certain magnitude. And this changes again every year. The first year, I believe, it is 30 percent risk. I cannot have a stop-loss that covers the risk. It has to be true risk and they have three different formulas that you have to run through. And then they also have this medical home model, which is again several pages of regulation that you have to fill to be able to qualify. So therefore it is going to be difficult to qualify for an advanced APM. So we can probably make some assumptions that MIPS is going to be the big deal.
Expanded Criteria

Not only do you need to be part of an advanced APM, but you also need to be a QP (Qualified Provider).

- Based on advanced APM entity scoring and done for payment year
- % of payment and patients under advanced APM-based on 2017

CMS Calculates Threshold Score

Use most favorable score

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<td>2019 Partial QP 20%</td>
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**Partial QP can choose MIPS**
So how do I score in that. Then they are going to use whichever score is the most favourable. For you, it is either a patient count or a dollar amount. So of the people that I treat, how many of those were in a risk-based model. So for the dollars, 25 percent to be a qualified professional and 20 percent on the count, if you are just counting. Then there is thing called a partial qualified professional. And if you have ever read a regulation and then you realized at the end, oh I do not know what a partial qualified professional is...So I did go back and it is someone that does not quite fit the category of the advanced APM. So you can choose MIPS, so you would at least get some potential at getting some upside on your payment.

**Met all criteria**

Now QP in advanced APM

- Do not participate in MIPS
- Get 5% increase in fee schedule

Now, if you have met all this criteria, if you are an advanced APM and you are a qualified professional and you do not have to participate in MIPS and you will get an automatic 5 percent increase in your fee schedule.
Impact Projected by CMS [31:23]

I mentioned earlier, CMS, we have approximately 761,000 professionals and they are estimating only 30,000 to 90,000 are going to fit in that advanced APM model. So that is about 12 percent. They are also saying that the cost for implementation is, they admit, could lead to higher operational expenses but they believe that the combination of the payment adjustments and the overall gain in efficiency will offset those initial expenditures. And they also believe we are going to have a positive impact on our quality and value of care. And I looked at one. There is a chart in there by specialty on what is the plus and minus and sometimes they put the dollars in very big dollars. When I did it per physician, this is their estimate in one year, that first year, internal medicine. You could either lose -$1,100 or be up $1,900. If you actually go into the bonus, then you could triple that. So it is on the plus side.

They also mentioned, which I thought was interesting, that they think the hours to do quality should take six hours of an analyst type person and one hour of the physician, that the advanced care requirement should take four hours and the CPIA should take four hours and I multiplied this all out. So they are saying at a high end that this should take $1,700 in a year and they were not considering that overly burdensome. So, just interesting to impact projection that CMS did on this.

So I am going to stop now and see if Dr. Oshiro has any comments that he wants to add before we talk about readiness.
[Dr. Bryan Oshiro]
I think, Bobbi, all of this really pertains to the fact that in order for practices to really benefit from this, remember, it is a zero sum game. And so, if there is no preparation well ahead of time, just looking over the eligible programs that are there that your organization or your group can participate in and think that you can make meaningful impact, is so important for all of the physician groups to actually go out there and actually read these rules and so forth to see what the eligible things are that they can do because it is going to take time to gear up for that. So, there should not be a lot of delay. And I have to emphasize that CMS actually is very interested in hearing about the public comments. So, I know we stressed that before but it can overemphasize that as well.

[Bobbi Brown]
Okay. I sat down and thought about some things that I would do.
Poll Question #2
How optimistic are you that the April 27th proposed regulations will produce the results that CMS is expecting from MACRA? [34:42]

Oh, we have a poll question.

[Chris Keller]
That is right. We inserted this there. We will go ahead and ask that to the audience. This will give you a good sense of what they think about all this. How optimistic are you that the April 27th proposed regulations will produce the results that CMS is expecting from MACRA? Five options. 1) Not at all; 2) Somewhat; 3) Unsure; 4) Optimistic; and 5) Very Optimistic.

We will give the audience one more moment to answer this. And some people are asking questions about the slides. We will give those to you after the presentation today. There will be an email with that information.

Okay. We will go ahead and close that poll and share the results.
So the results are 20 percent said not at all, 39 percent said somewhat, 29 percent said unsure, 13 percent said optimistic, and zero percent said very optimistic.

[Bobbi Brown]
Again, remember what they were trying to do is offer multiple pathways for risk and reward, minimize the reporting burdens, streamline multiple programs. So we are not getting rid of but we are streamlining Meaningful Use PQRS in this value-based modifier, and then rewarding clinicians for value over volume. So that is what we are responding to.

Dr. Oshiro, any comments from you about the poll?

[Dr. Bryan Oshiro]
I think that that is what I would have expected from what we are hearing and so forth. So yeah, I think that that is about right.

[Bobbi Brown]
HFMA Comments

Goals
• Set predictable updates for physician fee schedules
• Encourage physicians to participate in new payment models
  • Both cost and quality
• Adopt interoperable electronic health record

Is this encouraging consolidation?
This is not cheap or simple.

Joseph J. Fifer, FHFMA, CPA, President HFMA

HFMA Comments [36:22]

HFMA, I am a member of the Healthcare Financial Management Association. And their president, Joseph Fifer, said, well, you know, we are going to see some predicable updates for fee schedules. It is not a hundred percent predictable because it will depend on your performance. So there is an encouragement to get physicians in these new payment models and also to adopt the interoperable electronic health record, which is something that our nation does need to do. He also asked the question, are we encouraging consolidation and he also made a statement, this is not going to be a cheap or a simple participation agreement.
Reaction

May push independent physicians to a breaking point [37:01]

And another reaction, may push independent physicians to the breaking point. I predict more physicians are going to seek employment and let the health system worry about all these measures and having the certified EHR. I just want to practice medicine.

So again, Dr. Oshiro, any comments on that?

[Dr. Bryan Oshiro]
I think that this is the whole apathy – well not apathy but I guess the issue that we are all struggling with as physicians and so forth that just the rules and regulations are becoming so burdensome and onerous that we feel that we cannot practice medicine. It is more about the business in medicine. But given that, it is so important that we are engaged in this because it is part of our everyday lives. So going forward, I think it is so important for us to be engaged in this process and really understand the rules and regulations because it is not just going to stop, I do not believe, with just CMS regulations and requirements. Many of the other insurance companies are soon going to follow. Medicaid will soon follow as well. So, the second grouping there was kind of interesting where, you know, I think while there is not a whole lot of pregnancy-related issues and yet with sort of nurse midwives in that second group of providers. So I anticipate because of majority of the government funded programs for pregnancy are through Medicaid, that it is not going to stop with just Medicare.

[Bobbi Brown]
Yeah. Great. I did not even catch that. Yeah, whenever you think Medicare, you do not think nurse midwife but yes, great.
Financial Impact

Take Medicare Part B revenue and annualize – adjust for volume and fee schedule increase of .5%

• What is impact of 4% reduction under MIPS?
• What investments do I need to participate?
• What is impact of 5% under APM?
• Have we explored these options and know investments?

$25M of revenue has potential for negative impact of ($1M) – adjust for point scoring on MIPS

Okay. Real quick. I love to do financial impact. So just take your revenue, multiply it times 4 percent and that is your potential reduction. That is probably not going to happen. So if you had $25 million worth of Medicare revenue, you have a potential negative impact of a million bucks. Then you can adjust up from that as to where you think your scoring is going to be. You also have to think about what investments do you need to participate in this. And if I am under advanced alternative payment and I am a qualified provider and I can get 5 percent increase, should I explore that option? What investments do I need to make to go into that? So those are things you need to be thinking about.
Outline a Strategy [39:37]

And this was my to-do list. I outlined a strategy. I had a deadline of quarter 4 and I switched it to quarter 3. But let us make it somewhere between quarter 3 and quarter 4. By quarter 4, we are almost close to 2017, that is Christmas time. So we want to go quarter 3.

Do I know which track I want? Again, like I said, it is not like you can pick, but if you could pick, which one would you pick? And what is the impact on my practice? And what do I need to do? What happens if I do nothing? And am I already moving to some value-based model? So what is going on, what have we been looking at as a practice, and what have we been doing.
As far as with value-based, you may think, okay, yeah, I want to go be an ACO. Good luck. The letter of intent is due May 20th and your application is due May 25th for next generation. For MSSP, you could probably make it. I could write a letter by May 31st and your application is due July 29th. I do not know if I could do the application by July 29th because you really need to go through the application process and figure out, you know, there is a lot that goes on into deciding if you want to be an ACO. But I just put these up here to let you know, for Medicare, that there is just a lot going on right now and it is right around the corner. So you may just say, okay, we are going to go in MIPS for 2017 but then in 2018 I want to know, so I am prepared next year, so I can make a letter of intent by May and an application that will be applicable in the following years, 2018.
Educate and communicate. Provide clinicians with summarized documents. Dr. Oshiro was very kind to say, you know, really read the regulations. There is a lot out there. There is a lot of webinars out there and I think it is important to get a basic understanding than dig a little bit deeper. And I am not sure everybody has to dig a little bit deeper but some people do need to dig a little bit deeper. Make time in your current meetings to talk about this. And I think if you stay informed, it will ease the stress.
The professional societies, like I mentioned, CMS, they have done an outstanding job. The family physicians, they have a MACRA-ready program out there that you can just – and I gave you their websites and you can just get on. AHA has been good. AMA, very good. Again, and sometimes the way I think, I cannot just hear one person explaining to me. I have to hear a couple different people explaining to me and especially on some of those areas like am I going to be an alternative payment model or not. Some of those are a little tricky and you want to work through a decision tree and there is just so much good information on all of these websites and they really are trying to represent the physicians and do the right thing for their physicians and make sure that voices are being heard.
Identify thought leaders and discuss [43:03]

I like to talk to other people whenever I am against, and I have a person in the room that I always ask. Chris is in the room with me. He is our marketing VP here and I always look out to him and ask, well how should I show this or give me some ideas. And I would say, go outside of your field. Ask other industries who have faced this kind of a challenge what did they do, what ideas can you get from other people, and just put that into your discussion mode.
Look inward and know your strengths

- What do you think you do well?
- Where do you have data that shows you do well?
- Which measures show how well your practice performs?
- Do you have an performance plan in place to improve?
- Who has accountability for performance?

Look inward, know your strengths [43:39]

Look inward and know your strengths. Now, you might say, why in the world did this lady put that? That is one of my paintings by the way. And I have to tell you, I take all these painting classes. I have not in a while but I go to the painting classes and I buy everything. And if they tell you you need three paints, I buy 10 paints. And I go to the class and all my stuff is new and I have new paper or whatever and then I cannot do anything. So, I know that I think I can paint but I have not been in any shows. I cannot measure anything with my painting but I do have fun with it. But you need to look now within your own practice and say, what do you do well? And then look at that data that shows what you do well and look at measures and you have a performance plan in place. Who has accountability for this performance? Making sure that someone has accountability is just key to everything. So, anytime I am working on a project, I do not like project management, I hate when I get those emails from people, but I know that it is something that someone has to have the accountability to get this done by X date and this is very true in this case because it is going to be here and you are not going to have anything done.
Review your QRUR and Meaningful Use Submission

- Talk with the individuals that completed the work in PQRS and MU.
- What can you learn?
- What applies to MIPS?

Look at the quality reports and your Meaningful Use Submission. Who in your organization did this? What can you learn from that person? It is often we did a lot of interviewing and talking to people who submitted these reports and I, myself, have had the joy of submitting some meaningful use reports, and it is interesting just to talk to the people about how they got the data and how it did and how is that going to impact MIPS.
QRUR Report [45:26]

This is just a quality report. Again, the reference guide, I am giving you the reference guide that is out there for Medicare. I cannot access your reports. You need your own passwords to get into your reports, but just to let you know.

Evaluate readiness/Execute [45:40]

You now have a plan and can do a quick check on reality based on your practice. You know where you have penalties and where you need to change.

You need data, best practices and an adoption methodology to succeed.
Finally, we have looked at our readiness, now we are ready to go. You have a plan. You know where you can potentially get some penalties and where you need to change. You have data, you have best practices, and you have an adoption methodology. You are going to be able to diffuse this throughout your organization and have outcomes improvements. Outcomes improvements will lead to better quality scores which will lead then to higher potential bonuses in the MIPS program and also can lead you to some quality scores that are better in your alternative payment programs which will be positive for you as well from a financial standpoint.

So Dr. Oshiro, do you have any more comments that you want to make about readiness or just in general about this?

[Dr. Bryan Oshiro]
I think that you have stressed it enough but again overemphasizing the need for planning. Planning, planning, planning. You have to get a team organized at your practice, that whoever has been working on meaningful use and reporting requirements and get them really engaged and start planning as soon as possible and do not forget to make comments because unless you actually understand this program, it is going to be very difficult to make meaningful comments that would be favourable as far as changing some of the requirements or so with the program itself. So just a lot of planning and this year is going to be critical.

[Bobbi Brown]
Yes. Remember my slide 2017, get in there fast. Okay.

[Chris Keller]
Very good. That was a tremendous amount of information, Bobbi. Thanks for sharing that, and Dr. Oshiro as well. Before we move to questions, we have three items of quick business.
Healthcare Analytics Summit 16 [47:35]

First, thank you for showing that slide, Bobbi. Some of you know about this and I mentioned in the beginning, we have a Healthcare Analytics Summit that will happen on September 6th through the 8th. We have two giveaways today. I am going to offer one giveaway right now, which is a single registration giveaway.
Are you interested in attending the Healthcare Analytics Summit in Salt Lake City? (single registration) [47:50]

If you are interested in attending September 6th through the 8th, go ahead and fill up this poll right now. There is an expiration to this registration giveaway, which we will notify you in the email. So you will have to act quickly.

We will go ahead and leave that open for another moment. And then we have a second poll question for a team of three. The opportunity there is for you to bring you and two other people.

Alright. We will close that poll. Thank you. We will follow up with the winner there.
Are you interested in attending the Healthcare Analytics Summit in Salt Lake City as a team? (team of three registration) [48:20]

And then the second poll offers our giveaway team of three. So if you take one more moment there. If you have questions, please ask those in the questions panel. We will get to that in just a moment.

Bobbi, we have probably 40 questions. So we are going to shift through those and you can direct some to Dr. Oshiro as well.

Okay. Let us close that poll.
How interested are you in someone from Health Catalyst® contacting you about a demonstration of our solutions? [48:40]

Last item of business, our webinars are meant to be very educational. We hope you feel that today. Some of you have asked for a follow-up and we try to be very educational about our follow-up. If you are interested in having someone from Health Catalyst® provide you with a demonstration of any of our solutions, please answer this poll question. We will leave this up for a few more minutes.
Questions [49:02]

Let us go ahead and move on to questions and I am going to present those to you, Bobbi, and you can look through those with the help of Dr. Oshiro. We have got a bunch here.

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| Who would you direct within an organization? Dr. Oshiro spoke to this briefly. Who would you direct to be the point person to understand this information you just talked through? What kind of profile would you expect for that person? | [Bobbi Brown] It has to be somebody who likes digging and likes getting into regulations, and there are people like that. I happen to have someone that works for me. He is a data architect but he really likes these regulations. And so, finding someone, like it is interesting that that will pop up in your organization sometimes and I would say talk to people in your organization. Sometimes in smaller initiations it is going to be really tough. Many times there are physicians who like doing this type of work.  
Dr. Oshiro, do you have any comments on that?  
[Dr. Bryan Oshiro] Yeah. So this is not going to be something that you may be used to doing and particularly with an office practice. So if you have a multi-specialty group, you usually have a billing department. I usually have an office manager, per se. But you cannot relegate this to just the billing and coding people. You cannot just relegate this to the office manager. You may have some nurse care coordinators and nurse managers...
and so forth that are in your practice as well. Because this is a combination of quality improvement, cost efficiencies, and practice changes that are going to go across your entire practice, it is important that you have a multi-disciplinary team actually working on this. So I would advise for physician practices, no matter how small or large, that you have somebody that knows about the billing and submitting payments, somebody that knows about the practice management, physicians, nurses, and well but I think it has to be a group effort.

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<td><strong>[Bobbi Brown]</strong></td>
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<td>They are not right now. The providers that practice under a hospital, they will go into MIPS, but in some cases they do not have their own certified EHR. They use the EHR of the facility. So no for hospitals right now. Yes, hospitals will have to submit for providers just like they do on PQRS.</td>
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<td><strong>[Bobbi Brown]</strong></td>
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<td>Cross-cutting means that a measure can apply to a lot of different specialties. It is not just something that is like only for an obstetrician or only for internal medicine. So these are measures. That way, they can get a good cross set. They try to get measures that are specialty specific and then a lot of these measures that could be what you call more generic.</td>
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| [Dr. Bryan Oshiro]                        |
| Some of the cross-cutting measures that they asked about earlier, Bobbi, you sort of mentioned, is care coordination may be one of those. The other thing is access to care. So extending hours and so forth. So those are some cross-cutting measures. So if you can think of office practice and efficiencies that go across specialties, no matter what they are, risk stratification, adjustment issues, and so forth may be part of those as well. |

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<th>Will CMS change in measures over time?</th>
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<td><strong>[Bobbi Brown]</strong></td>
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<td>Oh heavens, yes, they are going to change. My guess would be, like I said, the last 300 pages or 200 pages of the current regulations, and it is in table format, are actually all the measures and you can pick from six of those. And I expect them to change. Some of those will change by the final regulation. Probably not a lot but I expect that over the year, they top out on some measures. Whenever we are doing all A on giving aspirin within so many minutes of coming into the emergency room, that measure tops out and they pull</td>
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| Do you think MACRA might result on a lot of independent physicians getting consolidated or independent doctors first to merge, change management issue for the eligible clinicians? | **[Bobbi Brown]**
I go to an independent physician. My primary care is independent and I love him. When I grew up, my dad owned a small drug store, and he eventually sold that to Walgreens. But I like independent practice. I like small business. I hope this does not happen but there is some reading on the wall here.

Dr. Oshiro, any thoughts on that?  

**[Dr. Bryan Oshiro]**
Yeah. Actually, several of my friends are in primary care and they have solo practices or two-person practices and they are just waiting to retire. They say that this is a very onerous condition. Some of the other ones that are still a little bit younger are looking for employment models because they say that they cannot practice and do the business side of it. It is just getting too complex for them. So I think that that is a correct assumption. At least, that is the way that I am reading the tea leaves, is that people are not going to be able to practice independently. I think the exceptions are going to be in small rural areas where you have low volume providers and so forth that they cannot go out of business. They need them in those rural areas and small markets and so forth. So I think that there is going to be exceptions based on the volume issues and stuff and they are excluded anyway. So there will be some accommodations made for that.

**[Bobbi Brown]**
I had made a comment about the dollar amount, the financial impact is tiny, so why should I care. And I believe right now, under PQRS, I think CMS that only about 32 percent of the eligible providers are participating in that program. So again, you could be part of MIPS and just go along with like you are normally doing. You will have to submit requirements and there is not a penalty. I have not seen any penalties in there yet. Eventually, it is just like PQRS. That will happen, penalties for not participating at all if you did not turn in any measures. So eventually I would say that will happen. It is not there right now though.

Why the regulation does not address HIPAA or compliance or security?                                                                                                                                   **[Bobbi Brown]**
The regulation says you have to attest to security, that you are doing your best to meet security
requirements. So there will be an attestation in there and I would assume over time that this is one that we will see more regulation on.

Again, any comments on that, Dr. Oshiro?

**[Dr. Bryan Oshiro]**
No, that is right. I think it is part of it. It has incorporated into it but it is not a major focus of the program.

**[Bobbi Brown]**
Yeah. So yeah, they are bringing in the meaningful use and trying to make it not too onerous for people.

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The 300 measurements, are there up...

**[Bobbi Brown]**
Right now, we do not have upper limits, lower limits. Again, 2017 will be the performance year. And so, what is in 2017, and they are going to try to get through a report by July of 2018 and that will all have to be – we cannot take vacation. We cannot have vacation then. But we really want to look at when those reports come out in July of 2018, where we are. They are going to put some reports out in July of 2017 that will be based on history and again probably not that much movement in the measurements. And probably what you are reporting now for PQRS, you can, like I said, look at your own PQRS and see what is going on and then you can go from there.

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Will PQRS no longer be the standard?

**[Bobbi Brown]**
Yes, PQRS will no longer be the standard and be integrated in the MIPS. Yes. That is the whole point of MIPS. So you will do PQRS in 2017 and in 2018 and then in 2019, good bye.

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Can you compare and contrast the impact of MIPS on specialty physicians versus primary care physicians? Can you also compare and contrast the impact of APMS on the same? How does MACRA participation relate to bundles?

**[Dr. Bryan Oshiro]**
Yeah. So that is kind of an interesting question and it is unclear as to what the impact is going to be. So we will have to see going forward. So that is something that I, myself, being a subspecialist, we are going to be impacted on that as well. So I am going to have to take a look more carefully as to how it is constructed but it is the overall, through the care coordination aspect of it that is what is going to look like as far as getting into our practice. But there are performance measures for individual subspecialties. And so, that is going to be an area of intense focus for me personally as well.

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**[Chris Keller]**
Okay. Very good. Thank you, Dr. Oshiro, thank you, Bobbi, for a tremendous webinar with lots of information. I wish we could have gone a little longer. There were still probably 35 questions. And by the way, we have had an incredible attendance. We had 1,200 people registered for this and we have had a great turnout today. So thank you for everyone who joined today. Shortly after this webinar, you will receive an email with links to the recording of this webinar and the presentation slides and the poll question summary results. Also, please look forward to the transcript notification we will send you once it is ready.

On behalf of Bobbi Brown, Dr. Bryan Oshiro, as well as the rest of us here at Health Catalyst®, than you for joining us today. This webinar is now concluded.

[END OF TRANSCRIPT]