



## **MACRA: Stakeholder Considerations and Next Steps**

**American Medical Association**

**Blue Cross Blue Shield Association**

**Alliance for Health Reform**

**July 11, 2016**

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MARILYN SERAFINI: Okay, folks, we're going to go ahead and get started, so if everyone could please try to find a seat. We do have some more seats up in the front, here.

My name is Marilyn Serafini and I'm with the Alliance for Health Reform. Welcome to today's briefing on the Medicare Access and CHIP Reauthorization Act, MACRA. This is a very complicated subject and, in fact, this is not the first time that the Alliance has called together a briefing on this subject and there is a reason for that. There's a lot to learn about this and we have called together this briefing today, two weeks after the federal comment period for the rule closed. We did that very purposefully because we wanted to give time for the policy community and the stakeholder community, we wanted to give the community time to get its thoughts together and to get their comments in to HHS and then we wanted to bring the stakeholders here to deliver their thoughts to you so that you could understand the considerations, so what they are thinking, and to give you an opportunity to ask your questions to them about what they are thinking regarding the rule, regarding this law.

That's what we're going to be talking about today. We're going to hear from a number of our panelists and before I introduce them I'd like to thank the Blue Cross Blue Shield Association and the American Medical Association for the support of this briefing today. And, as always, I'd like to thank our honorary Co-Chairmen for their constant support of all of the Alliance events, and that would be Senators Ben Cardin and Roy Blunt, for their support of us.

You can live Tweet with us today on Twitter with the hash tag MACRA and you can also submit questions to us using that hash tag MACRA. You can also, once we get to the Q&A portion of our briefing, there will be two ways to ask questions. We do have microphones in the audience so you can stand up and ask a question. You can also ask a question by using the card that you have in your folder. You'll see that you have a green card. You'll be able to write a question on that card and we'll have staff come around and take that card and bring it up to me and I will present those questions to our panel members.

So, without further delay, I will introduce our panelists and you will hear from them and then we'll turn the conversation over to your questions.

To my far right is Lemeneh Tefera, and we will call him Tef, which he allows us to call him since I find it hard to pronounce his name. He is a physician and he serves as a medical officer and policy advisor for the group that runs CMS's value based purchasing programs, and the new merit based incentive payment systems. I think I missed a line there, so let me start again. He's a physician and he serves as a medical officer and policy advisor for the group that runs CMS's value based purchasing programs and the new merit based incentive payment systems. I think I did do that right. Okay. Let's move on.

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To my right is Tom Eppes. He's a family physician at the Central Virginia Family Physicians in Lynchburg, Virginia. He's also Chair of the Governing Council at the American Medical Association's Integrated Physician Practice Section. To my left is Tonya Wells. She's Vice President of Public Policy and Federal Advocacy at Trinity Health, which is one of the largest Catholic healthcare systems in the country. Don Fischer is an independent healthcare consultant who recently retired as the Senior Vice President and Chief Medical Officer at Highmark Blue Cross Blue Shield. And, at the end, is Stephanie Glover. She is a healthcare policy analyst at the National Partnership for Women and Families.

You have full bios, by the way, in your packet of materials. Now, when we get to the question-answer session of our discussion we will also be joined by a couple of folks not here up on the stage, but down at one of our front tables, who will be able to answer questions and join in to provide technical expertise and the expertise of their associations. So, first we have Anshu Choudhri. He's the Managing Director of Value-based Policy at the Blue Cross Blue Shield Association. Anshu, if you could just stand up. And, next to Anshu is Cindy Brown. She's Vice President of Government Affairs at the American Medical Association, so they'll be able to provide more detailed information about the positions of their respective groups.

Without further delay I'm going to turn the mic over to Tef, who's going to talk about what CMS—he's going to give us a little bit of an overview about MACRA and then he's also going to talk about what CMS has heard during the comment period and what he can say about what that means moving forward. So, Tef.

LEMENEH TEFERA: Thank you, Marilyn. And thanks everyone for being here. Happy to represent the Senators from Medicare and Medicaid services and level set and talk through this new legislation and the rule making cycle.

As you know, this legislation was passed last year, April 2015, with a lot of focus on the SGR fix, which took about 17 years to sort out, but although the legislation only spent a few lines on that, the rest of the legislation is actually providing a visionary change for how we pay physicians for the next likely quarter century or more and that's what we'll be focusing on here. I'd like to point out that this is bipartisan legislation. Ninety-two supportive votes in the Senate, 392 in the House. So the idea and principle of changing the existing fee for service landscape has a lot of support and we're working to realize the statutory intent.

So the legislation creates two important programs that we call the quality payment program. I'll be focusing on the merit-based incentive payment system. The second component of the legislation is alternative payment models, some of which are advanced alternative payment models and others are not. But the vast majority of participants in this new quality payment program will be in MIPS, or the Merit-based Incentive Payment System, which is something I would like to emphasize and will be the focus of my remarks.

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Just visually, just to give a sense of where clinicians will land in the quality payment program, this slide here shows that the vast majority of clinicians were eligible to participate in this new program, are not in alternative payment models and will be participating as individuals or groups in MIPS. There are also clinicians designated with the blue bodies there, who are in alternative payment models but they're not advanced alternative payment models, and they will receive benefits specific to that alternative payment model, but they'll also be participating in the MIPS program. A very small portion of clinicians will be in advanced alternative payment models. Those are the folks on the far right. And they will have benefits if they meet requirements for participation in that advanced alternative payment model as far as the number of patients that they see through their advanced APM.

Who are the folks identified by the statute? The statute's very clear and calls out who eligible clinicians are, so those are physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists are all included. Physicians in Medicare speak are a large group. They're identified in the lower part of the slide, but it's also important to note who is not included. So, there are many types of clinicians and specialists who bill to Medicare. They are not all initially included in the MIPS program. They may be added to the program after the third year and that is something for future rule making.

What does the MIPS program do? So the biggest advantage of the MIPS program, and something that we like to emphasize, is that the current existing quality reporting programs, the physician required reporting system, physician value-based modifier, and the medical electronic health records incentive program, they have three different reporting requirements. There's three different feedback loops. There's three different ways to contest the results of that feedback through informal review. And what MIPS does is thoughtfully consolidate them into a single program where clinicians will have a single place to enter their quality reporting. On the back end, we will apply them to newly identified performance categories. Those performance categories are the quality performance category, the resource use performance category, clinical practice and proven activities performance category, and the advancing care information performance category. Quality is based on the physician required reporting system. I'd like to note to clinicians who are concerned about reporting that if they are successful in reporting for the physician required reporting system we expect they'll be successful in reporting for the quality performance category.

Resource use, based on the physician value-based modifier, is a claims-based performance category, so there's no reporting required. It will be done by the agency based on the Part B claims of the clinicians. Clinical practice improvement activities is the new performance category. It's not based on an existing program and this category provides an opportunity, based on statutory intent, to provide metrics, which are called activities in the statute, that drive improvement of the clinician's experience of their practice but also the beneficiaries' experience and the subcategories of this new category

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include expanded practice access, beneficiary engagement, care coordination, and one other category to note is that if you are a clinician who has chosen to participate in an alternative payment model, you also receive credit in this new category, just by nature of your participation in that APM. The last category is the advancing care information category, and that is based on the infrastructure of the existing AHR incentive program.

How do we put this together to develop a MIPS composite performance score? Each performance category is weighted based on the measures or activities for each category. You'll see, for the first year, resource use, which is based on the value-based modifier, has the smallest weight of 10%. Clinical practice improvement activities has a 15% weighting. Advanced and care information has a 25% weighting. And quality has the largest weighting at 50%. This was designated because we acknowledge, and Congress was aware, that there are deficits in some of our measure gaps, we call them. And, as we continue to develop resource use, for example, measures for the future, we will rely more in the early years on the existing measures we have in the quality category.

When you get the composite performance score, that score will be based on the weighting in your performance, in those particular categories, and then you'll get a score and then there'll be a performance threshold which needs to be designated in the final rule. And if you are above the performance threshold in the first year, for example, you'll receive a positive payment adjustment of 4% or higher. If you're below the performance threshold your adjustment varies. If you're in the lowest quartile, which is the darkest red on the slide, you'll receive a maximum minus 4% reduction. If you are between the lowest quartile on the performance threshold, however, there'll be a linear sliding scale. This is another important point to emphasize. Having policy cliffs is not particularly effective and we want to incent improvement at all levels of performance and we think by having this scale throughout the program will drive quality improvement.

On the top end, for those who are already excellent performers, for those who are already doing well in the existing performance programs, we don't want for them to regress to the mean. We want them to continue to excel and we have an exceptional performance threshold for those clinicians who are already doing well. And that, by statute, is about 500 million dollars per year for 6 years. So we're working to incent quality performance from the best performers to those who are still working to improve their performance.

Take away points. MACRA is about Part B payments and that's important because some folks will think that it will affect other parts of our program and it doesn't. And, although the payment year starts in 2019, the performance year, as proposed in NPRM, is 2017. And with that, I will turn it over to my colleague, Thomas.

**THOMAS EPPES:** I want to thank you all for the opportunity to be here today. I always like to talk about my biases. I'm a family practitioner of almost 35 years in the trenches. I'm not a policy walk even though I do things through Medical Society of Virginia and AMA, it is important to understand that the real wheelhouse that I love to do is in the exam room every day. I still do house calls.

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The physician community, in general, supported MACRA and we really are united in our wish to have it succeed and succeed well. When MACRA was being discussed in Congress, a bipartisan vision looking into the future, said such comments as greater freedom for physicians to practice medicine, to give more focus to their patients. It's important that the final policies that CMS does achieve this vision.

General observations. Physicians are a wide diversity of the way we practice. I am very different as a family practitioner from a neurosurgeon. An important goal of MACRA was to simplify administrative burdens, and while there are many improvements that are in the initial regs, the sweet spot is yet to be hit, and I think there are things that we can do to allow flexibility in choice. To help us get there, AMA, my specialty group, the American Academy of Family Practice, and many others have sent very large, lengthy proposals about what could be done.

A big concern that we have for MACRA in general is small rule and independent physicians. Of the initial page 64 pay cuts, showed pay cuts for a high percentage of people in small practices. This table was developed based on 2014 data, even though many small physician practices and healthcare professionals did not report the quality measures at that time. Some of the most high valued care is delivered in these settings by small physicians, independent physicians, the single and solo guys that are out there. It's important that rule are written that we make sure that the new MIPS program doesn't hurt these physicians and that means it'll hurt their patients.

We have some solutions that we may do and that's increase the low volume threshold to accept more physicians from MIPS. A very important thing is the initial proposal was \$10,000 of Medicare charges if you had Medicare of less than and less than 100 patients. If you do a Medicare wellness exam, the cheapest Medicare wellness exam is the subsequent exam, which is about \$125 a year, that the new ones are \$150 to \$160 per year. If you're almost at the threshold of 100 patients you don't allow any room for those people to get sick during the year or they rotate up into a MIPS program. We would like to see peer to peer, so the group size doesn't really make a big difference. We want to allow participation for virtual groups, maintain hardships exemptions for meaningful use when they're replaced with the advanced care information. We would love to see further reduce the amount of small practices' need to report.

I visited a physician in Chase City, Virginia. He sees patients at 6 o'clock in the morning and continues the full day. Why does he start at 6? He lives in a rural community. People want to get to their factory job. People want to get out to the farms and he doesn't have time to do all this stuff. We want to use consistent definitions for small practices so people who don't qualify for one accommodation but not for others, that from the practical standpoint, we've just got to keep track of what accommodations are allowed.

There are also solutions to help physicians in general that currently see them as have a 50% report threshold for quality. We want them to maintain that. CMS is planning to

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move episodes to reduce resource costs but it's not yet ready to do that. We want them to be very clear when it happens. A few clinical practice improvement activities should be required for those who have developed patient centered medical homes and gone through the expense of doing that and the time and the effort of doing that. We don't want to have to go through that process again. It's laborious and very expensive to meet that thing.

Advancing care information programs should grant a credit for each base measurement to truly eliminate the pass-fail. If people are doing a good job but they miss the mark, you don't want to miss the mark totally if you're in a pass-fail situation, especially in smaller groups. The first performance period is supposed to start January 1st. We would love to see that moved back to July 17th. It takes time to implement and respond to multiple new programs that you've got to put in place.

We also have recommendations for the APMs. They are policies that we think need to be modified. The hospital world is a very expensive world to be in charge of and that being able to take more than nominal risk should be a small percentage of practice revenues. If you have some very sick people you could end up in a very deep hole where you do not want to incentivize people not to take care of complicated patients.

Many more APMs do not qualify as either MIPS or advanced APMs than those that do. This needs to be fixed. Medicare has set many rules in the past. Many of us have tried to get to that point but the vast majority of ACOs, 95%, don't qualify in the new paradigm.

The policies for medical homes qualifying as APMs need to be changed. The number of 50 is arbitrary. Groups get smaller, get larger. That becomes a problem as you recruit or lose physicians. CMS should understand that medical homes that focus on Medicaid and dual eligible are already incurring monster significant financial risk by doing so and I think doing more for those people that are sticking their necks out there would be a big mistake.

Finally, the other recommendations for APMs, CMS should offer those developing APM proposals a very clear pathway with predictable guidelines and options of how to go about doing it and then, APMs need to be a meaningful option. That's what the law was about—providing opportunities for physicians to be a little bit different and developing new things.

A couple of personal closing comments. I want to remind you and emphasize to you that this is a quantum shift for physicians. We have lived in a fee for service world forever. Quality care is what we're about. Patient experience is what it's going to become about. At the best cost it's what it's about. That's the triple aim the physician community will adapt. Why? Because it's about our patients and the care they receive. This will be the focus physicians will do. At the same time, a fourth goal has to be maintained and that is physician satisfaction because physicians burn out when they hit the clickim [sic] here. When you see old people like me doing this, every change is a struggle. You young guys out there do real well because you live with the computer. I don't. I wasn't raised with

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one and I don't have it at my bedside every night. At the same time, that each of you that's seen a physician and had them looking down at the computer while they're seeing you, that's not what you want. You want it to be simpler and easier. That's what EHR's have done. You make it too complicated, you're going to lose physicians, especially small groups, solo practices, older docs. They'll either quit, they'll quit taking Medicare-Medicaid, they will opt out and go non par. They'll do concierge. That's not what you want. You want physicians seeing all people.

And, then, because what we love to do is in the exam room, and getting lost in the acronyms of MACRA over an arbitrary two months starting at November to the end of the year is going to be really tough. That is too short a time frame to get people to respond to do it right, do it right the first time, adjust to the new paradigm in this bold new world that we're heading into. And I implore you to remember the wisdom of one of our founding fathers, Ben Franklin. Haste makes waste.

TONYA WELLS: Good afternoon. I'm starting with a couple slides about who Trinity Health is because I think it really provides context for our commitment to alternative payment models that we've made both with intention as well as with operations. So we're in 22 states and we're not just a traditional acute care health system. We're very committed to the continuum of care. We employ almost 4,000 physicians and we have clinically integrated networks that include almost 14,000 physicians.

I included this slide, too, because we have made a commitment along with some other members of an organization called the Healthcare Transformation Task Force. This task force includes payers, providers, purchasers, and patient or a consumer voice, and this group is committed to have 75% of all payments coming from alternative payment models by 2020. My president and CEO at Trinity Health, Richard Gilfillan, is the Chair of this task force, and he also happens to be the initial director of the Center for Medicare Medicaid Innovation. This is where we're striving to go and you can see we have a long path ahead of us.

This map will just quickly give you a sense of how many Medicare shared savings programs were in '14 and we have one NextGen ACO. All of those MSSPs are Track 1. Beyond this commitment to the ACO alternative payment models we have a significant commitment to bundling. We have 43 hospitals participating in model 2 and we have 13 skilled nursing facilities in model 3. We have 2 facilities in CJR. So the commitment is both in the ACO and in the bundled space.

A couple things that I wanted to add. I know Tom really covered the need for an extension related to MACRA and we would certainly agree with all of the remarks that he made, is we talked to the physicians that we have across the 22 states that we're serving. We heard the same concerns that Tom shared. This is a big change. Another comment that we wanted to make related to this is, you know, there are a lot of deadlines related to those advanced payment models for CMS and the Innovation Center that could be adjusted to allow expanded participation in those APMs so we would recommend that

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some tweaking be done to ensure that as much participation as possible, recommending that the ACOs could start midyear. There's precedence for this. It was what was handled the first year they were put into place. And we would also ask that consideration be given to shortening the time frame for when participants can sign up.

Moving into how the definition of an advanced APM impacts physicians and facilities who are participating in those programs, the definition of an advanced APM is really new in this proposed rule. It wasn't something that we saw in the statute. And in the proposal, it was defined such that monetary losses need to be tied to the performance under the model as opposed to the indirect losses related to financial investment. And as a system that is sponsoring more than a dozen MSSP programs, we have seen that there are significant inherent risk and loss associated with making these programs work, and we request that CMS consider that as they finalize the rule. These investments look like care managers and patient educators, new population health management tools, appointment systems that allow the access that's necessary to be a population health model and expanding the access to care givers after hours to meet the patients' needs. All of these add up to dollars and all of these dollars are part of the losses that we're incurring in Track 1. We estimate that this costs, annually, about 1.5 million dollars, and that's consistent with a survey that was done by the National Association of ACOs, or NAACOs.

So we would really encourage CMS, as they finalize the MACRA rule, to include investment risk as part of nominal risk and also, in doing so, that would allow the track 1's to be included as an advanced APM. If there's a concern about, you know, how do you really assess what those investment losses could be, we recognize that this could be handled via attestation and an audit process.

And if you look at the number of ACOs that are currently participating, you know, Track 1 is the large majority of those and so it really is an indication of where folks have been able to feel comfortable dipping their toe into this world of population health models without moving as aggressively into assuming risk as you need to do in Tracks 2 and 3 in NextGen. And we have real concerns that if Track 1 is not included that this will really dampen enthusiasm for participation in the programs altogether. In a survey NAACOS recently did of its members, they asked if the Track 1 is not included as something that counts as an advanced APM and the 5% bonus won't be available, 56% of their members responded that they would leave the MSSP program. So we really are cautionary about the impact that that decision could have.

We also would ask, that if the decision can't be made to fully include Track 1, that there'd be some sort of glide path that Track 1 be included for a transitional period and then require that the providers move into downside risk in a 2-year time frame. We would also ask that consideration be given to rules that allow ACOs to move into a risk bearing program within their existing contract and not require a whole new contract or waiting for the remainder of the 3-year period, so allowing to switch Tracks at the beginning of a performance period. And then we would ask that consideration be given to a proposal

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that's been brought forth that's a Track 1.5 of an MSSP program which mitigates the amount of downside risk but still includes downside risk in the program and we'll be happy to talk more about that later.

And then, finally I would add that, as I have described to you the commitment our organization has made to bundles and what we've seen from the LAN as far as the inclusion of bundles and its categories of advanced payment models, we strongly encourage that the adjustments be made such that contracts can be amended to allow both the BPCI program to qualify as an APM and then the Cert obligations be included in the CJR program to qualify them.

And then, the final point I would make related to that is, the overlap policy, which determines how bundles and ACOs interact when they're both in the same market, we think some additional work needs to be done there and we would like to see a policy that doesn't subject ACOs to target pricing and it would better support continued participation in ACOs.

As we have said here already today, I'll just say that the goal of advanced APMs, it's really a means to an end. The intent is higher value care. The intent is a healthier population that gets better care at better cost and we strongly encourage that MACRA final policy be developed with that in mind.

DON FISCHER: Good afternoon. I'm Don Fischer and my background might be helpful to understand. I was a practicing pediatric cardiologist for almost 25 years. During part of that time, had become the Medical Director of the Children's Hospital in Pittsburgh. So I had experience from the hospital administration standpoint before I went to the health plan world, and initially started there as a Quality Medical Director, working with practices, many of them for the first time, seeing data that suggested that there were opportunities for quality improvement, and then became the Chief Medical Officer for Highmark, which is one of the 36 Blues plans. Highmark has about 5 million members in multiple product sectors and the Blues, as you know, about 36 plans nationally with about 100 million members. So I've seen this from a variety of perspectives and can say that the Blues have been very, very supportive of eliminating the SGR and moving to a program that really fostered a movement from fee for service payment to a pay for value opportunity.

In the health plan world, you're dealing with commercial products, very often self insured clients who are demanding value for the dollars they're spending, and we had been very involved early on in the efforts to do pay for value at the behest of those kinds of accounts. We don't want to lose that work that we've done and if you look at what are the potential impacts on the private sector, despite the fact we're very, very supportive of moving in a different direction, we need to be aware of unintended consequences. What are the things that we need to pay attention to that we don't get another problem as a result? And there are four areas that plans have potential problems with. One is will this impact the future ability to innovate? We want to continue to innovate. We don't want to

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require a cookie cutter approach but to be able to align CMS programs with those that are happening in the private sector. We also are very concerned about viability of small independent practices. I think Tom spoke to that in his comments, as well. If they throw up their hands and say I can't do it this way, their choices are, many of them, onerous for the country and for plans.

Medicare Advantage has been particularly bringing value to members and to CMS and I can tell you, in western Pennsylvania about 60% of the Medicare eligibles are in a Medicare Advantage plan. We don't want to blow that up. We want to add to that and, in fact, there are pay for value programs happening in Medicare Advantage that we feel that those practices who already have Medicare Advantage members would like to be able to see them counted towards these advanced APMs. And there's a risk, as there always is, of cost shifting to the private sector. When practices find that their payments aren't as robust as they were, they come to the private plans as do hospitals, you know, can you make to keep us in the black?

So in our priority comments, which I think you had access to, four major areas: support flexibility, insure a level playing field for Medicare Advantage, protect against unintended consequences, and begin with a quote soft launch of MIPS, and I'll talk about each of those in turn.

Plans have been very flexible and have been able to innovate and find out what works and what doesn't work. We've been able to jettison things that don't work and we can continue to learn from that. If the ability to innovate is hampered by a rigid one size fits all model we're concerned that we will lose traction. And I can tell you, having worked in physician practices with quality improvement, back when they had no EHRs and we were the source of their data, basically healthcare claims are a poor man's EHR. We could bring out claims that said thus and such wasn't happening and it was tough to get them to change, to recognize that processes had to change in their offices to bring value. We don't want to lose that work. And that's part of the last bullet there, was standardization of APMs. If we can capitalize on what we're already doing and add that to it we think that would be an asset.

As I said, Medicare Advantage has brought a great deal of value. Members see that. There's care coordination involved. There are a variety of comprehensive benefit programs. When you have 60% of Medicare eligibles choosing to go into Medicare Advantage, we don't want to lose that. We want to be able to make fee for service Medicare move in a direction of pay for value and not lower the standard of what's happened with Medicare Advantage. If, in fact, then, too, one of the dangers is that people are more highly compensated in the fee for service Medicare world they'll stop taking Medicare Advantage members, perhaps, and that could be a risk, shifting out of Medicare Advantage.

Unintended consequences—one of the issues here is, if I look back at the practices that we helped train to do process improvement and succeeded pay for performance and then

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pay for value, they've done very well and they will continue to do well whatever program you put in front of them because they figured out it's not just about I'm smart and I'll remember, it's about you have a process in place to succeed. And what we don't want to do is have the rich get richer and the poor give up and some of those practices who are small practices who have not done this kind of work, their incentive now is to say okay, I'll be bought by whatever the large network or large system is and we're the poster child in western Pennsylvania for what happens with consolidation that's pretty ugly. There's price control – I shouldn't say controls – there's the ability, from a pricing standpoint, the large systems are able to get a price point that's higher. Prices do get out of control when you have very few large consolidated networks and we want independent practices to still be able to succeed, whether it's in a virtual practice where you align multiple small practices together to be able to succeed—we don't want them all to retire, to quit, to say okay, I give up. I'll go with a large consolidated network.

And lastly, around soft launch. Even practices that are pretty astute and have, you know, been able to build processes, have to be able to turn around that new process very quickly once final rules are promulgated. Very hard to do. And being able to either push out the start date for the measurement period or to stagger some of the domains within the measurement could be very useful to assuring people are successful and are able to play. You know, I personally have been frustrated over the years with the slow pace of physician adoption of doing new things, but I recognize it's hard, especially when you've got people of different vintages, people who have different experience with using computers, and I must say, Tom, you used an iPad for your presentation. That was very impressive. Yeah.

TOM EPPES: Thank you.

DON FISCHER: Yeah. [Laughter.] But, you know, it is hard. There are those who are early adopters, there are those who are laggards, and we do have to recognize that it takes time. They're trying but I would give the concession of a softer launch to this program.

There's one last slide in there. These are some of the other additional considerations that we're thinking about, concerned about. I think we speak to this in the letter, but I think enough said for now. Thank you.

MARILYN SERAFINI: Actually, before I turn this over to Stephanie, I want to remind you that after Stephanie speaks we're going to open the floor to your questions so please be getting your questions ready. Again, you'll be able to ask your questions at the two microphones in the room. Also, you can write your questions on the green cards in your folders and our staff will be coming around the room to collect your question cards and bringing them up to me. There is a third way to send in your questions. You can Tweet them to hash tag MACRA and speaking of hash tag MACRA, we are live Tweeting the briefing, so if you want to join the conversation via Twitter please feel free to join at hash tag MACRA. And so, now, Stephanie, who's going to give us the perspective from the consumers.

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STEPHANIE GLOVER: Great. Thank you. Thank you and good afternoon. I'm with the National Partnership. We are dedicated promoting fairness in the workplace, access to quality healthcare, and policies that help women and men meet the dual demands of work and family. I personally lead our policy advocacy work to ensure that health system transformation meets the needs of patients and their families. I also manage our coalition for better care, a broad-based coalition of consumer organizations with a direct stake in improving the health and quality of life of patients and their family care givers.

I will just start by giving some background on consumer priorities for health system transformation and then transition into some more specific comments around MACRA. Like other stakeholders today, we strongly support the movement away from fee for service toward a health system that better rewards quality and value over volume, and MACRA is an important first step in driving that needed health system transformation.

We do think that alternative payment models, APMs in particular, have the potential to provide the well coordinated patient and family centered care that can also drive down costs. And, as others have noted, APMs should enable us to achieve all three tenets of the triple aim—better health outcomes, better experience of care, and lower costs, but we feel strongly that they'll only do that if they engage and meet the needs of patients they serve and improve how care is delivered. Indeed, reduced spending, excellence in quality and genuine improvement in care delivery are inextricably linked. And I'll note throughout that cost savings and payment changes alone cannot be the only focus of health system transformation, whether that's in the context of MACRA implementation or other reform efforts.

I included here just a quick list of some of the key priorities for consumers and patients as we move towards a transformed health system and those include meaningful patient and family engagement, high value quality measures, use of an effective clinical care model, robust HIT use, and consumer protections. I'll walk through each of these and sort of give a quick assessment of how they fare under the Quality Payment program under MACRA and, as a preview, it's certainly a mixed bag. I think MACRA does advance a lot of these priorities for consumers and patients but, in our comments at least, we did urge CMS to go further in many areas.

I included this slide just kind of as a background on some of the MACRA requirements, but we've gone through those at length so I'll just skip through that and begin with patient engagement. And this is definitely a key priority for consumers. Patients and families should be viewed as partners in all transformation efforts, from point of care to governance, as well that collaboration with patients and families should be built into design, quality improvement, and governance activities as well as meaningfully engaged at the point of care, but point of care is not the only place where engagement can occur. And under the Quality Payment program, particularly under CPIA, is the Clinical Practice Improvement Activities, we do see many activities generally aligned with these priorities but we do note some areas for improvement particularly with respect to

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engaging patients and families beyond the point of care. So, for example, a specific example is that we did support the inclusion of beneficiary engagement activity that encourages practices to regularly solicit feedback on patient experience of care through surveys and advisory councils and we absolutely strongly support that as a CPIA, but we also note that practices can go beyond working with patients and family advisory councils to just identify problems or solicit feedback, but can also work with patient and family advisors to develop solutions and quality improvement plans that are based upon the feedback they receive from consumers and patients. So we did encourage CMS to better define this activity as well as others.

Consumers also want high value quality measures. Quality measurement in reporting should be meaningful, actionable, and transparent to consumers, patients, and family care givers. MIPS and APM sets, measure sets, should prioritize patient generated data including those that address both care experience and patient outcomes, and we did see that the quality performance category includes some of these key measures, including patient experience, outcomes measures, patient safety, care coordination—all those are important to patients and their families and we also do think this is a good step forward. It certainly moves us much further along towards some of the quality measurement that consumers and patients would want to see beyond the PQRS system.

We did urge CMS to make some changes as well. We did advocate for moving toward a core set of measures by specialty or subspecialty that would allow consumers to make direct comparisons across providers and help them answer questions such as, “Should I expect to receive excellent, average, or poor care?”

And then I will move into advanced APMs also. Advanced APMs, we believe, will only be as successful as the models of care delivery that they support and produce, however, their proposed rule doesn’t include any requirements here. But, as I noted earlier, APMs should enable us to deliver on all three tenets of the triple aim in cost savings and transition to value-based payment alone cannot be the sole focus of healthcare transformation. So we did recommend to CMS that they add a fourth requirement for advanced APMs in addition to tying quality to payment, EHR use in risk bearing, we recommended that advanced APMs should also demonstrate that their payment approach will reinforce patient and family centered care with a strong primary care foundation.

Consumers also value and need robust health IT throughout our healthcare system and robust use of health IT and health information exchange is essential for high quality efficient practices, coordinated care and improved health outcomes. So what this means for consumers is that health IT can be used to engage them as equal members of their healthcare team by equipping them with the tools to work in partnership with professional care team members, better understand and manage their own health, and even care for loved ones. So the requirements for health IT adoption and use for both MIPS and advanced APMs must accelerate patient centered uses of health IT which provide really a foundation to our health system transformation and specifically MACRA should advance patient and family care givers’ ability to access, contribute to, and use

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their own health information if we want to achieve high value care as well as healthier people.

In the ECI category of MIPS, particularly through metrics prioritized in the performance score, do promote some of these objectives of interoperability, care coordination, and patient and family engagement. Of course, I won't get into them here, but we did recommend additional changes into that, as well. And I'll just note, finally, that encouraging payment models to bear risk is an effective strategy to incentivize clinicians to practice medicine and deliver care in innovative resource effective ways while they also improve patient experience, quality, and efficiency; however, all APMs, but particularly risk bearing APMs incentivized under MACRA, should be built upon a strong foundation of robust consumer protections that ensure patient's needs are met and that they have ready access to care, so we did urge CMS to ensure that consumer safeguards are keeping pace and that, importantly, CMS monitors for continued access to care as more providers move into advanced APMs.

So I look forward to continuing this conversation and this is just a highlight of the many things we put in our comment letter to CMS. I did include my contact information but I know we'll be having a discussion now and I'll be around afterwards as well.

MARILYN SERAFINI: Great. Thank you to all of our speakers. I invite you to the microphones now and to write some questions. I'm going to kick off the question period by directing our first question to Tef, and I'm going to ask you to try to give us something of an overview, if you can, of the comments that you've gathered at CMS during the comment period. Give us an idea of some of the most common themes, some of the themes that you've heard throughout the comment period. What are some of the most common comments that you've heard, perhaps some of the most important kinds of comments that you think you've heard; and, as a part B to that question, are there areas that you all are already talking about where you may be able to move forward?

LEMENEH TEFERA: Thanks, Marilyn, and thanks for the feedback from the panelists here, unique perspectives.

Just as a background, since the release of the MPRM, the agency has had over 200 unique outreach events and we've been able to include over 64,000 clinicians to do what we're doing here today, which is discuss the legislation and also discuss how we're implementing the legislation.

Regarding the MPRM, we've received nearly 4,000 unique comments that we will be responding to. Some of those comments are included here today, and there certainly are themes. One of the themes is concern about the performance period. An important point that I like to make when we talk about the proposed performance period, which is 2017, is that the performance period is a window to report activities. January 1st is not a deadline, it is the beginning of when eligible clinicians can report throughout that particular performance year. So although the performance year starts January 1st,

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clinicians can report March 15th and July 17th, depending on which metrics they are reporting. And as is proposed in the different performance categories, some have unique time frames. Many of the clinical practice improvement activities have 90-day participation requirements, others have longer. So it really depends on which measure and which activity when you talk performance period. But, again, January 1st is not a deadline. It is the beginning of a window to report.

Another theme that's come up in comments is concern about the performance of small practices and groups, which, in the statute, is defined as less 15 clinicians. As was mentioned earlier, because the analysis that we conducted in the NPRM was based on 2014 physician quality reporting system data, and during that year there was a large number of non reporting. The modeling that's in NPRM shows a high percentage of small group, individual practitioners, receiving a negative adjustment. We think that moving into this new era of quality reporting that there will be a much higher participation of quality reporting for several reasons including A) it's not a new thing; so, PQRS started 4 or 5 years ago gently, but it was new, and the idea of reporting was new to clinicians and, year by year, the number of participants increased and we're benefiting from that in the MIPS program and we expect clinicians who have been successful in the PQRS program to be successful in reporting in the Quality Performance Category.

The other big thing to note, although I'll only mention the incentives for reporting for 2019, which is an upward adjustment of 4% or higher, from year to year the adjustment jumps rather dramatically to 5% up to 9% in 2022 onwards. That is a significant incentive to participate in the quality reporting program and to be successful in the quality reporting program. We think the statute is well thought out and is trying to drive quality improvement with focus on beneficiary care, but also understanding the impact of the work that clinicians do to improve their practice environment—the infrastructure requirements for that—and if they're successful in doing that and they're successful in reporting, the MIPS program has a very generous incentive package.

MARILYN SERAFINI: Great. So, let's start over here. If you could please identify yourself.

DANI PERE: Hi, sure. My name is Dani Pere. I'm the Associate Executive Director of the American College of Preventive Medicine. Thank you all for such great presentations today. My question is for Mr. Tefera, CMS. Looking at the clinical practice improvement activities under the care coordination, you list use of telehealth, and our understanding is CMS only reimburses for telehealth in very limited circumstances depending on where a patient lives, and I'm wondering if this means, since you've listed it here, that you're looking at expanding reimbursement for telehealth beyond kind of the rural or other communities that you've currently set the reimbursement standards for.

LEMENEH TEFERA: Thanks for the question, Ms. Pere, and we have received questions about how to encourage use of telehealth along the lines that you've mentioned. There is already language in Medicare policy about what constitutes and doesn't

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constitute a telehealth engagement for reimbursement. That is actually a completely separate program from the MIPS program. We understand that, as we encourage it in the MIPS program, we'll need to engage our colleagues in the Center for Medicare to come up with options that will make sure that we're incenting the care coordination and beneficiary engagement that we seek to and that stakeholders, like yourself, clearly want.

DR. CAROLINE POPLIN: I'm Dr. Caroline Poplin. I'm a primary care physician. I was not one of the 64,000 physicians that was invited to talk to CMS, and I'm afraid this is going to have a devastating effect on primary care, already one of the lowest paid groups in the medical community. But my question is simple. I've seen the pie chart with the five categories, 50% quality, 10% cost—all of that. That's 5% of what – will I be getting a capitation payment for each Medicare patient I have? A monthly capitation payment that you add on 5% or subtract 4%? What's the base?

LEMENEH TEFERA: Thanks for your question, Dr. Poplin. This is all focused on your Part B services, so the adjustment will depend on your Part B services for the prior year, and there's also additional, like I said earlier, depending on how each clinician performs. With the composite performance score they may be eligible to get higher payments.

DR. CAROLINE POPLIN: I get that. It's a higher percentage of what? It's not a fee for service payment, so is it a monthly capitation payment?

LEMENEH TEFERA: Well, so, it's based on your fee for service activity in Part B. So perhaps the question you're touching on is that fee for service and the background of fee for service payment continues on. The quality payment program and the MIPS program are an incremental step to move away from clear fee for service, but that infrastructure will impact this new program in how payment adjustments are made.

DR. CAROLINE POPLIN: So I will get a low fee for service payment and then it will be moved up and down depending on how well I do on the 100 points? Is that it?

LEMENEH TEFERA: I think that's vaguely in the ball park, but I'm happy to chat more after. It will be easier.

DR. CAROLINE POPLIN: Okay. Because I've heard many of the same presentations and they never, per se, 5% of what?

LEMENEH TEFERA: So, the one thing I'll mention is—

DR. CAROLINE POPLIN: Or 1% penalty on what?

LEMENEH TEFERA: When you mention 5%, that's often tied to the advanced alternative payment model benefits. That is going to be a very small sliver of actual clinicians in the first year—

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DR. CAROLINE POPLIN: I get that—

MARILYN SERAFINI: Okay, so let's follow up with this question afterwards since it's a very specific question. Okay, so let's take a question from the cards. Two speakers have suggested including Track 1 ACOs for eligibility for APM bonus payments. Where is CMS on this issue?

LEMENEH TEFERA: So, I think that the challenge of extending the definition for advanced alternative payment models is that the statute is pretty clear on what constitutes what an advanced alternative payment model is. It asks for advanced alternative payment models to have more than nominal risk, use measures comparable to the EMR-based incentive payment system, MIPS payment program, and also have certified EHR technology. So we are working based on that statutory guideline to come up with a rule and the NPRM gives an overview of the direction we're going towards on how to make that work. If the question is how can we expand on that statutory guidance, that may be a better question for Hill folks than the agency because we're working on clear direction from the statute.

MARILYN SERAFINI: Do any of the other panelists want to weigh in on this? And I want to remind Anshu and Cindy to weigh in where they would like.

Okay. So let's turn to another question at the mic.

TOMMY RATLIFF: Good afternoon, and thank you for holding this. I'm Tommy Ratliff from Evolent Health, a member of the Healthcare Transformation Task Force, as well, with Trinity. I would kind of just reiterate, and this is directed toward Tef, what the other panelists have said. I think most physicians and hospital groups were excited to see SGR go, and now, with kind of understanding what will happen with MACRA, there's a lot of hesitation to move to value-based care for a lot of different reasons—risk, monetary risk probably being one of the leading ones. And we've heard about an MSSP Track 1.5 including bundled payments. It just feels like we're coming to a head where we want to see their support for this transition to value but only if it's feasible, and I know we've got a final rule on the way and you've spoken to some of those components that may or may not be in there, but just in general, I mean, I'm trying to specify exactly, I guess, what my question is, but in the private sector, that is the main roadblock that we're experiencing is these groups want to take the steps toward value but if it's not feasible or will end up in plans being shut down or not being able to serve the patients, what is to be done?

LEMENEH TEFERA: I appreciate that feedback and it's fair to say we've heard a lot of concern and anxiety about what this new payment program is and when I hear comments like yours what I like to emphasize is that we've already been on a path to value and transitioning for fee-for-service for several years. Clinicians who have been working over the last 5-6 years are already familiar with quality reporting to the PQRS program, are familiar with the value modifier program, are certainly familiar with electronic health record reporting. And all these programs individually have incrementally been bringing

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clinicians to the fold and accustomed to not only quality reporting but coupling that reporting to payment adjustment. This MIPS program and the quality payment program is another step in that direction. It is not a whole new bag of worms. In fact, if you are successful in the physician quality reporting system this year, you will be successful, most likely, in the MIPS quality reporting program. If you're successful this year in reporting electronic health records and incentive program you will be successful in reporting advanced care information in the MIPS program. And there are new opportunities, which I think is also really important to emphasize. Clinicians often express concern, and that's certainly true for the doctors I work with, about all the work that they do that's not seen, that's not captured by measures which have clear limitations not being included in their performance assessment, nor their payment. The clinical practice improvement activities is this new performance category that we've been working to include all the small things that clinicians do that have huge impact for their patients, for our beneficiaries, and improving their practice environment. So we think there's a lot of new opportunity for improvement in the MIPS program and that this MIPS program, in a fair look, is just a transition that we've been underway for some time now. And I think our work, which is clearly challenging, is to work to verbalize, express, explain what we're doing, why we're doing it, and making it understandable. And we're trying to do that.

TOMMY RATCLIFF: Thank you. Can I – a quick follow up?

MARILYN SERAFINI: Sure.

TOMMY RATCLIFF: I don't disagree with that. I think one point I'll make with MIPS, it's my understanding that it is those payment adjustments will be budget neutral, so while the opportunity of a plus 4, plus 5, up to plus 9% positive payment is quite enticing. The downside of that is, you know, it could be detrimental, especially in the instance of a rural or independent physician.

LEMENEH TEFERA: So, it's true that the statute makes the payment program budget neutral. The maximum negative adjustment is for the lowest quartile of performers below the performance threshold. That is the clinicians who've done worse in reporting the quality. Again, the aim here is beneficiary health, improving care, and we think it's important to do that. It's true that the payment adjustments may vary because of the budget neutrality, so depending on how many negative adjustments are in one year versus positive adjustments, the amount paid out will change. And, again, this is all required by the statute. This is not something that the agency could change even if it wanted to.

TOMMY RATCLIFF: Thank you very much.

MARILYN SERAFINI: So we have a question directed to Tonya about bundled payments. But we've had a number of questions in the cards regarding bundled payments and a number of our panelists have also addressed bundled payments. I'm going to read

the question that's specifically directed to Tonya, but I think some of our others will want to weigh in on bundled payments and how they fit in to MACRA and just how it applies.

So, the questioner is asking about a slide that you had in your presentation, Tonya, and with regard to bundled payments, do your recommendations, in particular, imply that these models are excluded on the basis of a lack of contractual obligations rather than a true lack of usage; and also, can physicians qualify as individuals under advanced payment model Track? I think that's a little – okay.

TONYA WELLS: Sure. So, I'll take the first part of the question. So in the proposed rule, CMS very specifically teed up the issue related to the bundled, the BPCI program, and said, you know, we believe that BPCI is missing sort of the specific cert and quality requirements as part of the contractual agreement and asked those providing comments to offer feedback as to how a solution could be reached. And so our comments really suggested that we think that this could be handled through an adjustment to the contract. And so, to answer the question, I believe that BPCI really is using the certified electronic health records, just that the contract doesn't require it to do so and, arguably, is also doing the quality requirements as well. So I believe that in practice it's happening, it's just a matter of what are the specific requirements in the contract and does that allow them to qualify as an advanced APM. And, as far as can an individual physician qualify, this might be getting a little more technical than I can do, but my understanding is that there's an eligible APM, and so you qualify for being an advanced APM at that alternative payment model level and not one by one.

DON FISCHER: I just wanted to comment on the bundled payment, and this may be outside of MACRA to some extent, but bundled payments are beginning to be explored in innovative payment models by plans. And one of the advantages to moving in that direction is that you facilitate a team approach. So we've got to get away from thinking of individual physicians doing thus and such, and that's what fee for service really requires, that the doc does it all and then it seems like the rest of the team is just an added expense. If you move towards bundled payments where you're paying for some sort of episode over a period of time, then it doesn't matter if you're using telehealth for part of that, you're using the right skill for the right service at the right time, and you're able to, frankly, free up time for physicians if you have other people as part of that team getting the bundled payment. Because what you're ultimately interested in is a better result. You want to see the outcome improve and if you do that in a novel way as a practice then you're rewarded.

The other thing I wanted to comment on, and maybe I got this wrong, but one of the first questioners asked about what a percent of what? My sense is that the chassis is still fee for service and it's the total payment over that period of time, fee for service, that then gets a percent increase. You're not moving to a capitation. I mean, that may be the eventual goal, that you shadow price and get there someday, but I believe a lot of the innovations that are happening, from a payment standpoint in the private sector, can eventually be adopted and some of those sit in the bundled payment world.

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MARILYN SERAFINI: We're going to move back to our questions at the microphones, but I want to remind you—we hope you stay with us for the next 15 minutes of Q&A, but if you have to leave, please fill out the blue evaluation form. It's really a big help to us in knowing what you want to hear from us in future briefings and what you liked and what you'd like to see differently from us. So, yes.

DR. JOEL BRILL: Good afternoon. I'm Joel Brill, a gastroenterologist in Phoenix, and here on behalf of the American Gastroenterological Association. Here's the question. Many of our practices haven't just developed models, they've actually implemented bundled payments and episode payments with a number of Blue plans and other payers. One of our models, for example, has demonstrated a 50% reduction in ER visits and inpatient hospitalization with an overall decrease in annualized cost for children and adults with inflammatory bowel disease. Why aren't specialist driven models being viewed as eligible by Medicare as advanced APMs? Why are advanced APMs, with the exception of the oncology care model right now, really being restricted to primary care practices? If we're demonstrating what you're asking for, upside and downside risk, decrease in unnecessary care, improvement in patient engagement and overall decrease in cost, what else do you want from us for an APM?

LEMENEH TEFERA: Dr. Brill?

DR. JOEL BRILL: Brill. Yes. IRS knows where I am. [Laughter.]

LEMENEH TEFERA: Thanks for that. First, kudos to the work you're doing. I think the answer in the statute is that, for innovative work like your group's, we certainly wish to bring them into the umbrella of alternative payment models, and the vehicle for that is the physician focused models that will be considered by the Innovation Center. So the Assistant Secretary for Planning Evaluation has a technical advisory committee. The members of that committee were announced, I think around April or so. There's a whole website outlining the steps it takes for specialists and clinicians who are doing work like you describe, to submit proposals for an APM, have vetted through this process and those selected by the committee will be considered. It's not a guarantee, but will be considered by the Innovation Center. Your larger question of, you know, why doesn't it count now, I think touches to the fact that I know a lot of our work is incremental. I'm pleased that you mentioned the work we're doing on the oncology care model, but we have not reached as many corners in the house of medicine as we'd like to, but we will work to do that.

DR. JOEL BRILL: Thank you.

LEMENEH TEFERA: Thank you.

PAUL COTTON: I thank you. Great panel. I appreciate everything you all said. My name is Paul Cotton, I'm with the National Committee for Quality Assurance and my question is for Stephanie Glover. Stephanie, on your slide you had a note about how

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measures need to be actionable, transparent, and meaningful for consumers. I agree with that completely. That wasn't in the proposed rule which said measures had to be only scientifically evidence based and valid and reliable. Can you explain why you think it's so important for them also to be meaningful and actionable and transparent for consumers.

STEPHANIE GLOVER: Yes. Thanks for your question. Yes, you're right. That is certainly not explicit in the proposed rule, although I think they are moving towards having more measures reported on physician compare which, ideally, would be presented in a way that consumers can assess the value that they would get from different providers or practices. But, right. I do think the meaningful and actionable part is where, you know, that's what consumers and patients need to make decisions about where they're going to go. And in a Medicare context where you're less likely to be making a choice based on price, quality really is your biggest driver in how you make that decision. So I think that that's absolutely key for both patients, but also care givers who may be assisting in some of those choices, and we often recommend that the language used around quality measures when they're presented are consumer tested, that patients and family care givers can be engaged in the process of how measures should be presented and described so that they do have meaning and that patients can use that to choose the provider that might be right for them or for, you know, the treatment that they're going to be seeking. Thank you.

LEMENEH TEFERA: If I can just add to that, it's absolutely our focus that the measures that we propose have meaning to clinicians, can be actionable in their practice and, as Stephanie mentioned, with their posting on Physician Compare, we seek to post this information in a way that patients, their families, care givers, can interpret it to make thoughtful decisions about the care they seek. So it's an absolute priority that measures have meaning for clinician improvement and for overall beneficiary care.

PAUL COTTON: Thank you.

MARILIYN SERAFINI: Okay, great. We have a questioner who is talking about the lack of small group reporting data and concerned about the way the data on Table 64 is fitting an overarching trend favoring larger and larger practices and wants to know, is concerned that the MIPS, isn't it an inherently zero sum game where small payers will be funding the big practices? Anybody like to comment on that?

LEMENEH TEFERA: That's a touch question. Thanks.

MARILYN SERAFINI: It's a tough question.

LEMENEH TEFERA: Throughout the statute there's clear concern that small practices, rural practices, are fairly treated and the statute calls on the agency to offer options in reporting and offer support for reporting. The statute also has funding to support the

agency. There's funding for technical assistance to help clinicians speed up and improve their reporting practices so they can be successful in the MIPS program.

The larger comment about consolidation of smaller practices into larger practices, I think that same comment can be made at the hospital level and clinics and the forces that are driving that are in healthcare at large and not necessarily specific to the quality payment program or the MIPS program, but we are working and explicitly focused on making sure that all our policy decisions have a unique discussion about the implications as for small group practices and any unintended impacts of our quality decisions for small group practices. And it's fair to say that, of the nearly 4,000 comments we received, making sure that we were aware of this concern for small groups and solo practitioners was a common thread.

MARILYN SERAFINI: Yes.

MARA McDERMOTT: I have a comment and a question. One comment is that there are physician organizations that are out there—I'm Mara McDermott with CAPG and we represent physician practices across the country.

MARILYN SERAFINI: Could you step a little closer to the mic please?

MARA McDERMOTT: Yes. Is that better. Yes. That's better. I'm Mara McDermott with CAPG. We represent physician practices across the country, and I just wanted to offer a comment. We represent many physician organizations that are ready to go with MACRA on 1-1-17 and I feel like that perspective hasn't really been brought out, but for our groups that look at the current landscape with the value modifier and meaningful use and PQRS, and they see even for solo and small practitioners who have a potential penalty under that existing law today of 7, 8, 9, 10 percent, MACRA, with a maximum potential penalty of 4%, seems like a much better deal. And so I just wanted to offer that.

And I wondered, one question, on Table 64 I wonder if anyone has modeled what those cuts would look like without MACRA? So if you have the value modifier continuing to increase over time instead of MACRA, which sort of cuts is off, right, what would it have looked like? I think it's an improvement.

LEMENEH TEFERA: Thanks for the question and singular positive feedback so far. [Laughter.] It's always good to note. And you are right. If you actually look at the cumulative potential penalties in 2018 if the existing payment quality reporting programs had not sunset, those cumulative penalties would actually be higher than the potential minus 4%. That is a true statement. But again, once the program starts relatively quickly over a few years, 2022 and onward, it will be at that 9% upward or downward. And I think it's with the long term view that we think it makes sense for clinicians to really focus on enhancing their quality reporting and strengthening their participation downstream because that's when the big benefits kick in.

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MARILYN SERAFINI: Yes.

CHRISTINE GROSSMAN: One more question. So, Christine Grossman from Heart Health Strategies. I was wondering, not from a policy side, but more from an implementation side, what CMS has been doing in terms of increasing and improving outreach? You mentioned that you guys have been holding a lot of discussions and presentations, but specifically, in terms of maybe improving the help desk resources or potentially improving the feedback reports that will be provided for the MIPS, what CMS has been doing in terms of implementing all that?

LEMENEH TEFERA: Thanks, Ms. Grossman. So there is work on the back end. Obviously, a lot of our focus is the public facing aspects of the legislation. Currently, as I mentioned before, there are three different help desks, there are three different feedback reports and working to unify that. The first MIPS feedback report is slated for summer of 2017 and the hope is to have information about the various quality reporting programs within that single report available through an online portal and, using that same portal, a clinician to be able to ask questions about the report. And there's ongoing work now in focus groups and things of that nature trying to identify what will improve our help desk functionality. I think it's fair to say there was a lot of frustration about having an issue in PQRS and calling Help Desk 1 and then being told it's actually something that has to do with the value modifier and being told to call Help Desk 2. Again, we're working on a thoughtful consolidation that will make the experience of the clinician understanding quality reporting and helping understand how their reporting will impact their future performance much more streamlined.

CHRISTINE GROSSMAN: Great. I would like to say, too, specifically what we've heard from some groups that they've thought it helpful in terms of past or current programs, to provide kind of comparisons by a specialty and group practice. I know some of the programs, such as PQRS, are a little more mature than, for example, the reports provided in the value modifier because PQRS has been around for longer. So if you could incorporate more of those, you know, specific comparisons that would be great.

LEMENEH TEFERA: Noted.

MARILYN SERAFINI: Yes, at the microphone.

MARK DANN: Hi. My name is Mark Dann, I'm the Federal Affairs Director for Compassion & Choices. We're the end of life rights folks. And my question is what impact do you see MACRA will have on end of life care?

TONYA WELLS: I'm happy to take a stab at that. Trinity Health is an organization that's very committed to palliative care, including end of life care, so thank you for your work. I believe that alternative payment models and incentivizing physicians and all providers to move toward alternative payment models is very beneficial to those who are suffering with chronic conditions and at end of life. And to the extent that you're creating

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an accountability model where you're providing, really focusing on the patient in a more people-centered manner, and you are cognizant of the cost implications as well and the balance that all of that can create, I think really does result in a better outcome for those patients. So overall, I think directionally, it's a very good thing and I think that the more that we can get folks to move into alternative payment models and the more open MACRA is to the acceptance of those the better off those folks will be.

MARK DANN: Thank you.

LEMENEH TEFERA: Just to follow up there. In addition to alternative payment models, just regular participation in the MIPS program is encouraging the use the electronic health records. There are multiple clinical practice improvement activities that focus on care coordination. And regarding end of life issues, among the hardest challenges for clinicians—I'm an emergency physician—is seeing someone in dire straits and not knowing what you need to know about their past history and engaging in duplicative care, duplicative testing, potentially engaging in treatments that are not the will of the patient, the family, their care givers, not knowing if there's actually an existing plan for end of life—all these things will hopefully be improved by the type of electronic health records that clinicians want, which is cooperative, involves meaningful information data sharing, and gives you the needed information at the right time. So, again, downstream, the hopes of the MIPS program and certainly participating in alternative payment models, will hopefully improve the care for end of life.

MARILYN SERAFINI: So we're going to just do one more question that comes from the cards, which actually expands a little bit on that question. So we were just talking a little bit about electronic—the question is about electronic medical records and interoperability and there have been passing references to that today and the timely exchange of data as being an important part of clinical practice improvement.

So the question is, is anything happening here? Is there anything envisioned that will require or significantly encourage data standardization to make it easier for health professionals and consumers or patients to create better, more effective information, use of information. Are we making progress in this area? And I think it would be great to hear both from Tef and also from some of our other stakeholders in this area, because we continue to hear about this as a challenge and a barrier to moving forward.

DON FISCHER: I'd be happy to comment to start off. I believe one issue, and there are several, one issue is that people use HIPAA as an excuse not to share data and fall back and, perhaps it's a misunderstanding, perhaps they just don't want to share data. But we need to be able to have full information at the point of care and that means that systems need to share data; that there needs to be a way that's facilitated by interoperability and rules that are clarified that data and it's in the best interest of the patient, that's truly patient centered, that and I used to tell my team, "No data left behind." We need to have all the information because you can't make a wise decision without interoperability. So anything that CMS can do to help foster that would be an asset.

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STEPHANIE GLOVER: I absolutely agree and would just add that I think that patients and consumers really are looking for access to their data. They want to be able to logon and see test results. They want to be able to take data from one provider to another if it's not exchanged, you know, through the EHR. So I think we are making progress and I think that there's still work to be done and patients and consumers really do want to be a part of the measures that move forward to ensure that there is interoperability, better coordination, etcetera, but that does have to include coordinating and exchanging data with patients as well.

THOMAS EPPES: I would say that was the great hole that was never addressed when EHRs were started. That I can be an independent practitioner 10 miles from the hospital and struggle to get in there and get enough information in a timely fashion. And they never have access to my chart. So the ER physician that is seeing somebody at the end of life that shouldn't be resuscitated, shouldn't have multiple things done, regrettably, that information is never passed unless we've had the time to sit down and have the forethought and the chance to talk with that patient, give them the information, tell them not what to do, tell them not who to call because that's going to be, ah, the ER physician is stuck. The EMS people are stuck. They've got to do, because saving the life is what they're commanded to do unless the patient and the family has sat down and said we don't want that. And there are countless other opportunities for cross pollinating information to other specialists and I agree that patient needs to be portable and engaged enough to do that. You young guys out there are that way, but the people that I see that have either no hair, gray hair or dye enhanced hair, they don't do so well from that standpoint.

LEMENEH TEFERA: I think it's fair to say, again, that among the nearly 4,000 comments we received on this proposed rule, there was significant attention paid to the importance of interoperability. As most of you know, our acting administrator is very focused on improving electronic health records and making sure that this policy is a huge step forward for the merit based incentive payment system. We are happy for the feedback we've received and we are well aware that an EHR that doesn't have that type of functional interoperability does not provide meaningful information and it's important that we are providing clinicians the information they need to make the right decisions.

MARILYN SERAFINI: Thank you. Tef, while you have the mic, could you please just wrap up? Tell us what happens next on MACRA. What is the timeline?

LEMENEH TEFERA: Sure. So, the final rule will come out in the fall of this year. We're currently reviewing the comments, as I mentioned, and will be working to incorporate those comments into the final rule. I think the important part of the quality payment program, the future role for alternative payment models, and how clinicians will participate in the merit based incentive payment system, the thing to remember is that the majority of physicians will be in the MIPS program. Participating in the MIPS program does not exclude one from participating in alternative payment model. Clinicians can

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participate in alternative payment model, receive the benefits related to that alternative payment model, and still participate in MIPS and be successful in MIPS. The clinicians who will be participating in the advanced alternative payment models, this is a much smaller band of clinicians and they will receive the benefits outlined in the statute as well. But the vast majority, and you know, we're estimating greater than 90%, will be in the MIPS program and those clinicians will be able to be in APMs as well and they'll receive all the benefits of being in that alternative payment model.

MARILYN SERAFINI: Great. Okay, again, if you haven't filled out a blue evaluation I'd like to urge you to do so, and I will thank you again for being here and please help me to thank our panelists for a great conversation to help us to understand this very complex issue.

[Applause]