MACRA, Analytics and the Move From Volume to Value

William Bercik, Global Director of Healthcare Finance Product Strategy
Oracle Health Sciences Global Business Unit

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William, Bercik

Global Director of Healthcare Finance Product Strategy, Oracle HSGBU

William has over 28 years of experience in the healthcare industry and has specialized in enterprise applications and technology solutions since 1992. He provides specialist product expertise and develops and executes solution strategies for the Healthcare Finance market. Prior to joining Oracle, William was a former Chief Financial Officer of a 350 bed acute care hospital.
MACRA: Disruptive by design

MACRA is a new Medicare payment law that will drive the future of health care payment and delivery system reform for clinicians, providers, and plans across their payer mix.

**MACRA is a game changer...the new law aims to fundamentally change the health care payment system and drive the delivery of health care in the future.**

MACRA repeals the SGR formula sets updates to the Medicare Physician Fee Schedule for all years in the future.

MACRA establishes a path toward a new payment system that will more closely align reimbursement to quality and outcomes.

MACRA offers significant financial incentives for health care professionals to participate in risk-bearing, coordinated care models and to move away from the traditional fee for service system.
Payment updates, bonuses & adjustments under MACRA

Although MACRA creates separate paths for payments under the Medicare PFS, these paths are in addition to, not in replacement of, the PFS. Taken together, these paths are referred to as the Quality Payment Program (QPP)

- **PFS** Updates
  - 2016: 0.5%
  - 2017: 0.5%
  - 2018: 0.5%
  - 2019: 0.5%
  - 2020: 0%
  - 2021: 0%
  - 2022: 0%
  - 2023: 0%
  - 2024: 0%
  - 2025: 0%
  - 2026+: 0.75%

- **APM** Incentive Payments
  - 2019: 5%
  - 2020: 5%
  - 2021: 5%
  - 2022: 5%
  - 2023: 5%
  - 2024: 5%

- **MIPS** Payment Adjustments
  - 2019: +/-4%
  - 2020: +/-5%
  - 2021: +/-7%
  - 2022 and subsequent years: +/-9%

*For 2019 through 2024, the highest performing MIPS eligible clinicians who receive a positive payment adjustment will be eligible to share up to $500 million each year for “exceptional performance” payments. This upside is limited by the statute to +10% of Medicare charges.

Source: Public Law 114-10 (April 16, 2015)
Key highlights: MIPS

Timing
The administration proposes using January 1, 2017 as the beginning of the performance period for clinicians for payment adjustments occurring in 2019, leaving less than seven months to prepare.

CMS proposes that the MIPS performance period of one calendar year (January 1 to December 31) for all measures and activities applicable to the four performance categories.

MIPS Performance Categories and Composite Performance Score (CPS):

- **Quality**: CMS proposes that most MIPS-eligible clinicians would be required to report on at least six quality measures, including at least one cross-cutting measure (for patient-facing MIPS-eligible clinicians) and an outcome measure if available.

- **Resource Use**: The proposed rule suggests continuing two measures from the current Value-based Modifier program: total costs per capita for all attributed beneficiaries and Medicare spending per beneficiary (MSPB) with minor technical adjustments. The Administration also proposes including measures based on episodes of care.

- **Advancing care information**: (a change in terminology from meaningful use of certified electronic health record (EHR) technology): The proposed rule indicates that MIPS-eligible clinicians would choose to report customizable measures, with a particular emphasis on interoperability and information exchange.

- **Clinical Practice Improvement Activity**: In the proposed rule, CMS regulators say they “generally encourage but are not requiring a minimum number of CPIAs.” Clinicians may select activities that match their practices’ goals from a list of more than ninety options, including activities focused on care coordination, beneficiary engagement, and patient safety.
Key highlights: Advanced APMs

Requirements for Advanced APMs

- Bear financial risk for more than nominal monetary losses
- Base reimbursements for covered services on quality measures comparable to those used in MIPS, quality, resource use, clinical practice improvement
- Requires use of a Certified Electronic Health Record (EHR)

Proposed Advanced APMs

1. Next Generation Accountable Care Organization (ACO) Model
2. MSSP Track 2
3. MSSP Track 3
4. Comprehensive End-Stage Renal Disease (ESRD) Care (CEC) - Large Dialysis Organization (LDO) arrangement
5. Comprehensive Primary Care Plus (CPC+)
6. Oncology Care Model (OCM) two-sided risk arrangement (available in 2018)

Advanced APM Thresholds

QP Payment Amount Threshold

<table>
<thead>
<tr>
<th>Year Range</th>
<th>APM 25%</th>
<th>FFS 50%</th>
<th>APM 75%</th>
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<td>2019-2020</td>
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<tr>
<td>2021-2022</td>
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<td></td>
<td></td>
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<tr>
<td>2023 and later</td>
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QP Patient Count Threshold

<table>
<thead>
<tr>
<th>Year Range</th>
<th>APM 20%</th>
<th>FFS 80%</th>
<th>APM 35%</th>
<th>FFS 65%</th>
<th>FFS 50%</th>
<th>APM 50%</th>
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</thead>
<tbody>
<tr>
<td>2019-2020</td>
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<tr>
<td>2023 and later</td>
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</table>
### Timeline for MACRA implementation

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deadline for comments on the proposed rule to be submitted to CMS</td>
<td>June 27, 2016</td>
</tr>
<tr>
<td>Deadline for the HHS Secretary to establish and publish in the Federal Register an annual list of quality measures to serve as the basis for the MIPS payment adjustment.</td>
<td>Jul 1, 2016</td>
</tr>
<tr>
<td>Deadline for the HHS Secretary to establish through rulemaking the criteria for physician-focused payment models.</td>
<td>Nov 1, 2016</td>
</tr>
<tr>
<td>The HHS Secretary is directed to draft a list of the care episode and patient condition codes and post them on the CMS website. Secretary seeks for 120 days (March 9, 2017).</td>
<td>Nov 9, 2016</td>
</tr>
<tr>
<td>The HHS Secretary will post an operational list of patient relationship categories and codes on the CMS website.</td>
<td>Jan 1, 2017</td>
</tr>
<tr>
<td>Date for HHS to publish final rule on MIPS. Start of first performance period for 2019 payment adjustments under MIPS/APMs.</td>
<td>Apr 10, 2017</td>
</tr>
<tr>
<td>Deadline to begin providing confidential performance reports to MIPS-eligible clinicians on the individual’s performance on quality and resource use.</td>
<td>Jul 1, 2017</td>
</tr>
<tr>
<td>Codes established for care episode groups, patient condition groups, and patient relationship categories required on all Medicare claims going forward.</td>
<td>Dec 14, 2017</td>
</tr>
<tr>
<td>Deadline to begin including on all Medicare claims the new codes and the national provider number of the ordering physician or applicable practitioner.</td>
<td>Jan 1, 2018</td>
</tr>
<tr>
<td>Codes established for care episode groups, patient condition groups, and patient relationship categories required on all Medicare claims going forward.</td>
<td>Jul 1, 2018</td>
</tr>
<tr>
<td>Date for HHS to begin providing confidential performance reports to MIPS-eligible clinicians on the individual’s performance on quality and resource use.</td>
<td>Dec 2, 2018</td>
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<tr>
<td>Codes established for care episode groups, patient condition groups, and patient relationship categories required on all Medicare claims going forward.</td>
<td>Dec 31, 2018</td>
</tr>
<tr>
<td>Start of first performance period for 2021 payment adjustments, including through Other Payer APMs</td>
<td>Jan 1, 2019</td>
</tr>
</tbody>
</table>

**Source:** Public Law 114-10 (April 16, 2015)
Implications of MACRA across health care organizations

The new MACRA law significantly impacts a number of key areas across health care provider organizations.

**Financial**
Affects future Medicare reimbursement for all clinicians paid under the Medicare PFS

**Operational**
Requires organization-wide collaboration and coordination of eligibility, multiple moving parts and regulatory requirements

**Clinical**
Requires clinicians to change/add incremental workflow and assess and improve clinical quality outcomes

**Technological**
Requires robust clinical data capabilities (data governance, capture, collection, validation and reporting)

**Strategic/Competitive**
Prioritizes strategic Physician Acquisition/Growth decisions related to who (PCPs/Specialties, etc.), where, when, how (types of arrangements)

**Reputational**
MIPS CPS results will be made public and transparency will expose the good and the bad

**Clinician Engagement**
Relationships/Partnerships/Arrangements will need to evolve in order to attract, retain, evaluate and optimize

**Patient Engagement**
Greater coordination of care and two-sided risk for health care providers will raise the stakes for health care providers to foster closer ties with patients and help them actively manage their health
MACRA impact framework

Several categories of enterprise impact will require MACRA response strategies

**Strategic**
- Competitive Positioning
- Transparency
- Consolidation
- Transformation Readiness

**Financial**
- Professional and Facility Revenue
- Fixed Cost Infrastructure and New Investment Requirements
- Risk and Physician Contracting
- Financial Transition Management

**Operational**
- Clinical Engagement & Integration
- Data, Analytics and Reporting
- Process Transformation
- Compliance Management

**Organizational**
- Executive Leadership Alignment
- Talent & Skills Requirements
- Incentive Re-alignment
- Change Management and Culture
What is Triple Aim?

Improving the Health Systems requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations and reducing the per capita costs of health care. Analytics are the key to enabling and achieving the Triple Aim. This Bold Play represents a “start anywhere” approach that aligns with a widely-recognized goal for the majority of health systems and allows us to numerous cross selling opportunities.
Business Analytics provides a path to higher value

Business Analytics enables fact-based decision making with a hyper-focus on value

- Optimization algorithms
- Simulation and modeling
- Quantitative analyses
- Advanced forecasting
- Role-based performance metrics
- Exceptions and alerts
- Slice and dice queries and drill downs
- Management reporting

Increasing business advantage and sophistication

Business Intelligence

Predictive & Prescriptive

Descriptive

Insight

Hindsight

Foresight
Start with the End in Mind — Where Do We Go from Here?

Vision

Your analytic vision represents the end-state your organization wants to achieve or, at a minimum, a near-term goal (3-5 years maximum), that you want to reach with your analytic capabilities across each of the four key analytic domains of market, clinical, operational and financial analytics.

Capability

Before your organization embarks on its analytic journey, it’s important to understand where you’re starting from and the analytic capabilities that your organization already possesses. An inventory of your current analytic technologies, techniques and talent is an important step before beginning.

Value

The value of analytics and having better information faster, can be very clear as in clinical effectiveness and supply chain analytics or very opaque as in market sizing or regulatory compliance. Investing in capabilities that have the greatest impact for your organization’s mission and money are key.

Priorities

Healthcare Providers need to prioritize and allocate scarce resources toward analytics in a way that moves them toward their vision, extends and enhances current capabilities and maximizes analytic investments toward achieving their mission.
The use-case below represents a Medicare patient complaining of knee pain. The patient visits their PCP, is referred to a specialist and then admitted to an acute facility for knee replacement where complications occur. After discharge the patient has physical therapy.
Taking the Big Picture: Key Analytic Capabilities in Aggregate

**Accountable Care and Patient Cohort Analytics**

- What is our margin for all United Healthcare Total Joint Replacements?
- What are the true costs of episodes of care for a population?
- Should I be doing all Total Joint Replacements in an ASC setting?
- Do I have the information to prepare for MACRA and Bundled Payments?

**Regional Comparisons and Institute Analytics**

- Why is there so much variation in margin for the same Disease State across regions?
- What procedures are unprofitable because of indirect allocations in acute settings?
- What is working well in Region A that I could replicate in Region B and C?
- What is the best way to rationalize services across regions?
Getting at the Details: Key Analytic Capabilities when Drilling Down

**Care Pattern Variation Analytics**
- Where are my greatest opportunities for reducing variance? How do I track success?
- How are shifts in volume and mix of services impacting my bottom-line over time?
- How are shifts in volume and mix of services impacting my profitability?
- Are the incidence of complication higher in one care setting vs. another?

**Physician Network Efficiency Analytics**
- Am I getting my fair share of referrals from inside and outside my network?
- What care setting has the highest margin for a given type of procedure?
- Are there efficiencies in scheduling that can be achieved across care modalities?
- How can I “value” the referrals from our primary care physician network?

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DSS combines financial, payroll, supply chain, patient accounting and clinical information from multiple sources. Cost and revenue models are applied to provide powerful information for decision making. Combined with structured analytical tools and processes, change data into actionable information.

Required Data and Sources

- SATISFACTION SURVEYS
- SUPPLEMENTAL PATIENT INFORMATION
- SUPPLY CHAIN
- ERP / GENERAL LEDGER
- HUMAN CAPITAL MANAGEMENT
- EMR / EHR
- SERVICE / PRODUCT LINE ANALYTICS
- REVENUE MODELING
Having a Solid Foundation is Critical

- Complete
- Modular
- Unified
- Flexible
- Extensible
- Enterprise class Platform

Health of a Population
- Patient Cohort Analytics
- Service Line Analytics
- Payor Contract Analytics

Experience of Care
- Care Pattern Analysis
- Patient Satisfaction
- Complication Analytics

Per Capita Cost
- Cost Accounting & DSS
- Rate, Volume, Mix Analysis
- Supply Chain Analytics

Healthcare Foundation

Enterprise Performance Management

Data Management

Clinical Financial Admin Omics

Multi-Structured Data Sources

SECURITY PRIVACY

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The Foundation Must Be...
Complete, Modular, and Fit to Your Purpose

Each module includes built-in core functionalities

**CLINICAL**
- Case
- Intervention
- Order
- Observation
- Specimen History
- Pharmacy Study
- Incident

**FINANCIAL**
- Billing
- Claims
- Cost Allocation
- Accounting
- Charge Master
- Patient Financial Services
- Account Payable
- Account Receivable
- Purchasing
- Inventory

**ADMIN**
- Survey
- Inventory
- Purchasing and Scheduling
- HR and Payroll

**OMICS**
- Omics Database (ODB) Loaders

**CORE**
- Party: All Roles
- Patient, Service Provider, Insurer
- Encounter
- Facility
- Consent and Advanced Directive
- Concern
- Code Repository
- Masters Catalogs, Device
Healthcare Financial Decision Support Solution

**Analytics Subject Areas**

- Financial
- Operational
- Clinical
- Research

**Healthcare Financial Decision Support**

**Cost Accounting**
- Cohort cost of care
- Physician, DRG variance
- Service line profitability

**Financial Modeling**
- Episode of care cost
- Contract scenario modeling
- Net revenue modeling

**Budgeting, Flex analysis**
- Patient volume, utilization trends
- Scenario modeling: case mix, volumes
- Actual vs budget

**Labor productivity**
- Productivity KPIs
- Chargeable, non-chargeable activity
- Capacity analysis
- Nursing and Physicians

**Healthcare Foundation**

Comprehensive, Integrated Healthcare Enterprise Data Management

EMR, ADT

ERP

Contract Management

Metadata

Hierarchy/Management

Data Definitions
Value Based Care Analytics

- PMPM Overall Cost ($):
  - $8,387.40
- Overall $ spent:
  - $1,851,896.80
- Average Cost per Procedure:
  - $2,748.49

- Patient Satisfaction
  - Clearness of Hospital Environment: 80%
  - Communication about Medicines: 82%
  - Knowledge of any new medicines: 82%
  - Communication and respect: 82%

- Risk Score
  - Patients with Risk Score: 121
  - Avg Scoring Events per Patient: 2
  - Avg Days Since Last Scoring Event: 431

- ACO Quality
  - Risk Analysis by Gender
  - Risk Analysis by Ethnicity
  - Risk Analysis by Age

ORACLE
Executive Dashboards
Enterprise Financial and Clinical Metrics Summary

Multiple Sources of information including Patient Accounting, EMR, Contract management, General Ledger, etc.
Direct Cost Choices

[Graphs and tables showing cost data for different months and physicians]
Service Line Drilldown – DRG Profitability

Look at key Orthopedic DRGs..
Population Analysis

Patient Cohorts

<table>
<thead>
<tr>
<th>Facility</th>
<th>DRG</th>
<th>Direct Fixed</th>
<th>Direct Variable</th>
<th>Indirect Fixed</th>
<th>Indirect Variable</th>
<th>Total Costs</th>
<th>Charges</th>
<th>Payments</th>
<th>Net Margin</th>
<th>Net Margin %</th>
<th>Reimbursement %</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Hospital</td>
<td>100: Sepsis w/ MCC</td>
<td>1,966,918.63</td>
<td>22,241,234.42</td>
<td>16,583,382.36</td>
<td>17,755,643.16</td>
<td>58,355,738.57</td>
<td>174,115,416.92</td>
<td>55,017,883.49</td>
<td>38,436,304.92</td>
<td>16.30%</td>
<td>54.57%</td>
</tr>
<tr>
<td></td>
<td>101: Sepsis w/o MCC</td>
<td>354,39</td>
<td>9,304,31</td>
<td>9,659,65</td>
<td>10,333,27</td>
<td>29,651,52</td>
<td>130,262.77</td>
<td>72,514.20</td>
<td>42,866.68</td>
<td>12.02%</td>
<td>55.67%</td>
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<tr>
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<td>102: Headaches w/o MCC</td>
<td>7,442.94</td>
<td>176,035.19</td>
<td>131,975.52</td>
<td>141,447.31</td>
<td>457,502.36</td>
<td>1,377,561.13</td>
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<tr>
<td></td>
<td>123: Neurological eye disorders</td>
<td>37.19</td>
<td>913.50</td>
<td>3,114.03</td>
<td>3,221.13</td>
<td>7,286.74</td>
<td>32,265.22</td>
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<td>52.09%</td>
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<td>125: Other disorders of the eye w/o MCC</td>
<td>12,443.32</td>
<td>252.31</td>
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<td>147: Ear, nose, mouth &amp; throat malignancy w/ CC</td>
<td>3.51</td>
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<td>148: Ear, nose, mouth &amp; throat malignancy w/o CC/MCC</td>
<td>39.96</td>
<td>1.98</td>
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Patient Level Detail (composite) / Patient level Summary

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<tr>
<th>Facility</th>
<th>Department</th>
<th>Code</th>
<th>Procedure</th>
<th>Direct Fixed</th>
<th>Direct Variable</th>
<th>Indirect Fixed</th>
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<th>Total Costs</th>
<th>Charges</th>
<th>Payments</th>
<th>Net Margin</th>
<th>Net Margin %</th>
<th>Reimbursement %</th>
<th>Procedures</th>
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<tbody>
<tr>
<td>General Hospital</td>
<td>Ambulatory Surgery</td>
<td>1001</td>
<td>ADA BATEMAN</td>
<td>11.16</td>
<td>287.36</td>
<td>1,218.53</td>
<td>1,306.53</td>
<td>2,833.58</td>
<td>12,648.96</td>
<td>4,411.54</td>
<td>3,387.86</td>
<td>55.96%</td>
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Patient level Margins
Cost Management Link to Clinical Outcomes

Clinical Indicators as % of Total

*All Other physician volume only on sample of 9 patients
Encounter Drilldown: Care Variability...

Same procedure, later encounters have higher direct costs...

<table>
<thead>
<tr>
<th>CPT</th>
<th>Direct Fixed</th>
<th>Direct Variable</th>
<th>Total Direct</th>
<th>Indirect Fixed</th>
<th>Indirect Variable</th>
<th>Total Indirect</th>
<th>Total Costs</th>
<th>Charges</th>
<th>Payments</th>
<th>Net Margin</th>
<th>Net Margin %</th>
<th>Reimbursement %</th>
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</thead>
<tbody>
<tr>
<td>27447:TOTAL</td>
<td>20,512.00</td>
<td>8,791.00</td>
<td>29,303.00</td>
<td>11,305.00</td>
<td>13,689.00</td>
<td>24,994.00</td>
<td>54,297.00</td>
<td>69,158.16</td>
<td>32,900.00</td>
<td>-21,397.00</td>
<td>-65.04%</td>
<td>47.57%</td>
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<td>KNEE ARTHROPLASTY</td>
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<td></td>
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<tr>
<td>469:Major joint replacement or reattachment of lower extremity w MCC</td>
<td>RICHARD GRIBBIN</td>
<td>PAN37012</td>
<td>20,512.00</td>
<td>8,791.00</td>
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<td>8,791.00</td>
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<td>PAN37047</td>
<td>29,352.00</td>
<td>12,579.00</td>
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<td>30,768.00</td>
<td>21,977.50</td>
<td>31,393.00</td>
<td>106,868.50</td>
<td>-48,118.50</td>
<td>-81.90%</td>
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<tr>
<td>27447:TOTAL</td>
<td>44,028.00</td>
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<tr>
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Service Line Drilldown – Physician Comparison

higher direct costs for these physicians!

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<tbody>
<tr>
<td>Orthopedics</td>
<td>Musculoskeletal System And Connective Tissue</td>
<td>469: Major Joint replacement or reattachment of lower extremity w MCC</td>
<td>RICHARD GRIFFIN</td>
<td>76,153.67</td>
<td>43,160.66</td>
<td>119,314.33</td>
<td>38,986.00</td>
<td>34,468.67</td>
<td>73,454.67</td>
<td>192,768.63</td>
<td>222,102.38</td>
<td>120,633.33</td>
<td>-71,135.58</td>
<td>-59.80%</td>
<td>54.31%</td>
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<td>DENNIS ELOOTS</td>
<td>105,100.00</td>
<td>45,041.00</td>
<td>150,143.00</td>
<td>65,326.00</td>
<td>82,970.00</td>
<td>148,496.00</td>
<td>256,619.00</td>
<td>425,150.33</td>
<td>228,733.33</td>
<td>-69,905.67</td>
<td>-30.56%</td>
<td>53.80%</td>
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<td>ANTHONY B PLETCHER JANICE MILLER</td>
<td>80,782.33</td>
<td>34,623.33</td>
<td>115,403.67</td>
<td>89,490.00</td>
<td>96,767.67</td>
<td>185,766.67</td>
<td>301,170.33</td>
<td>449,776.41</td>
<td>244,866.67</td>
<td>-56,303.67</td>
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<td>54.44%</td>
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<td>INEZ GALVEZ</td>
<td>51,759.00</td>
<td>22,182.00</td>
<td>73,941.00</td>
<td>25,078.00</td>
<td>34,701.33</td>
<td>59,779.33</td>
<td>131,720.33</td>
<td>222,580.19</td>
<td>127,683.33</td>
<td>-6,037.00</td>
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<td>57.37%</td>
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<td>24,739.67</td>
<td>10,601.67</td>
<td>35,341.33</td>
<td>20,999.00</td>
<td>12,131.33</td>
<td>33,330.33</td>
<td>66,761.67</td>
<td>227,462.31</td>
<td>119,050.00</td>
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<td>-42.70%</td>
<td>52.69%</td>
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<td>469: Major Joint replacement or reattachment of lower extremity w MCC Total</td>
<td>67,706.93</td>
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<td>98,828.63</td>
<td>48,015.80</td>
<td>52,149.60</td>
<td>100,165.40</td>
<td>198,994.03</td>
<td>309,414.32</td>
<td>168,353.33</td>
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<td>557: Tendonitis, myositis &amp; bursitis w MCC</td>
<td>LORI L STUSSE</td>
<td>631.90</td>
<td>12,037.97</td>
<td>12,669.87</td>
<td>2,688.21</td>
<td>2,883.31</td>
<td>5,571.52</td>
<td>18,241.39</td>
<td>28,254.24</td>
<td>15,593.10</td>
<td>-2,648.29</td>
<td>-10.41%</td>
<td>55.19%</td>
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<td>557: Tendonitis, myositis &amp; bursitis w MCC Total</td>
<td>631.90</td>
<td>12,037.97</td>
<td>12,669.87</td>
<td>2,688.21</td>
<td>2,883.31</td>
<td>5,571.52</td>
<td>18,241.39</td>
<td>28,254.24</td>
<td>15,593.10</td>
<td>-2,648.29</td>
<td>-10.41%</td>
<td>55.19%</td>
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Where are you in your journey?

- There’s been much buzz around “analytics” in health care in recent years; how would you describe the current state of analytics in health care?
- What impact do you think industry consolidation has had?
- Given that we’re in a time where we have access to more data than ever before, do you think companies are leveraging that volume of data effectively?
- When thinking about the “Triple Aim” of improving the experience of care, improving the health of populations and reducing the per capita costs, what role do you see analytics playing?
- How are analytics changing the way organizational decisions are made and how has the role of finance shifted?
Smart first steps...

- **Begin Internal Discussions** with key enterprise stakeholders (including potentially the Board of Directors) on forthcoming MACRA impacts.

- **Perform a thorough Impact Assessment** to understand how MACRA will impact Strategic, Financial, Clinical, Technological, Operational, and Organizational priorities as well as exploration of strategies to gain access to higher percentage of the premium dollar.

- **Plan and prepare for tactical changes and/or enhancements associated with MIPS readiness** particularly given the Performance Range begins 1/1/17.

- **Make informed, strategic choices around moving in a swift and responsible manner towards Advanced APMs and Other Payer Advanced APMs**.
William Bercik

• Global Director;
• Oracle Health Sciences Global Business Unit