New payment system incentivizes a team approach to improving chronic disease outcomes

For those who view the Medicare Access and CHIP Reauthorization Act (MACRA) as an administrative and reporting distraction, it’s time to take a second look. It is the most profound change in the physician payment model since 1965, the year Medicare was enacted. The program offers physicians a variety of choices, but all those choices are designed to change care delivery by moving reimbursements away from traditional fee-for-service reimbursement and toward pay for performance. Most physicians with an active Medicare patient roster will fall under the Merit-Based Incentive Payment System (MIPS). While MIPS is a fee-for-service arrangement, beginning in 2019 the amount of payments will be based on performance reported in 2017.

MACRA is intended to use the payment system to fundamentally change the way care is delivered, especially for patients with chronic diseases or who need complex medical management. In this paper, we take a look at what MACRA requires, how care will be affected and how physicians, health systems and health plans should respond.
**MACRA and you: The new system will change more than just your revenue**

The MIPS pathway requires proof of value

MACRA offers a big benefit to physicians, in the form of eliminating the yearly risk of cuts from the Sustainable Growth Rate formula, but it also increases pressure on physicians to practice “high-value care.” While most physicians believe that they are already providing high value to their patients, the MIPS path will require them to prove it, using criteria set by the Centers for Medicare & Medicaid Services (CMS). The ultimate intention of MIPS is to incentivize practice patterns that result in better health outcomes at lower cost.

There will be four performance categories, which will be weighted and rolled up into the MIPS final score. The weights of each category shift over the course of the program (see Figure 1).

<table>
<thead>
<tr>
<th>Performance category</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>Resource Use*</td>
<td>0%</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Advancing Care Information (ACI)</td>
<td>25%**</td>
<td>25%**</td>
<td>25%**</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Figure 1: Category weights for MIPS program

*How Resource Use will affect scoring is still under consideration. Percentages shown may change.

**If the Secretary of the U.S. Department of Health and Human Services (HHS) determines the proportion of eligible clinicians who are “meaningful users of electronic health records (EHRs)” is estimated at 75% or greater, the weight of the ACI category may be reduced. The remaining performance categories will be increased by the corresponding number of percentage points. The lowest weight the ACI category can carry is 15%.

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**Tip: Pay attention to accurate coding.**

To ensure a fair comparison, physicians should pay close attention to accurately coding for the condition and socio-economic factors of their patients. This will help prevent a situation in which a physician who is serving a population that is largely older, poorer or sicker than average is compared to physicians with healthier, easier-to-treat patients.
Bonus and penalty amounts go up over time
Because MIPS is a revenue-neutral payment change, some physicians will see increases of as much as 4%, rising to 9% over time, while others will see equal decreases (see Figure 2). For physicians who score well, MIPS will be a big boost in income. Those who struggle with the measures will be the losers under MIPS.

Not surprising, many physicians are not pleased by the change (one blog on kevinmd.com was titled “MACRA must die!”) and few are happy about increased reporting requirements. But the system has built into it several factors that are hard to argue with. Instead of being measured against an objective standard, physician performance will be measured against their peers. That means that physicians will be judged, not by what healthcare regulators believe might be possible, but by what other physicians have proven is possible.

To stay independent or join a larger organization? That is the question. Group reporting is much easier.1 Small independent practices will face challenges in complying with MIPS. Reporting data takes resources, and many small practices are operating on very thin budgets now. Where will they find the time and money to meet the criteria?

How MIPS will affect care
If your practice is paying close attention to outcomes, has adopted characteristics from the Patient Centered Medical Home model (such as care coordination and shared decision-making) and has participated fully in the Meaningful Use measures, your model of care won’t change much. You may have to pay closer attention to the cost of services and treatments you prescribe for patients, but you most likely have the pieces in place to score well on quality, care coordination, patient engagement and EHR use. And you are likely already involved in practice improvement activities. But if you are practicing episodic care, with little time spent on patient engagement and care coordination, MIPS will require radical changes in your operations.

Reporting will be easier under the Alternative Payment Models (APMs) pathway
Not all physicians will fall under the MIPS requirements. CMS will exempt the following physician practices:

- Those with less than $30,000 in Medicare charges or fewer than 100 unique Medicare patients per year.
- Physicians who are on the APM Participation List as of December of the reporting year, who will fall under the APM requirements, which are different from MIPS.

The APM list includes physicians in Accountable Care Organizations (ACOs) and Next Generation ACOs, the Shared Savings Program, Comprehensive ESRD Care, Comprehensive Primary Care Plus and the Oncology Care Model, among others. To be certified as an APM, an organization must require use of a certified EHR, tie payments to quality measures and either be a Medical Home Model or bear more than a nominal amount of financial risk.

Physicians who participate in an APM will report data through their APM organization, which will aggregate and average the scores and report the resulting data to CMS. These physicians will also be exempt from the “use of resources” measurement category, as their payments are already tied to quality and costs.

If you are participating in a Medical Home Model, you will automatically receive the full score for the MIPS improvement activities performance category.

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1Physician Frustration and Fear of MACRA, NEJM Catalyst, August 4, 2016
MACRA and data: Data extraction and analytics will be challenging, and using the data to improve care will be critical

This year is focused on data reporting …

In 2017 CMS requires physicians to report at least some of the required data, and those that fail to report will receive a score of zero, automatically reducing their payments by 4% in 2019. Some physicians may decide that they’ll take the hit rather than participate, though most who would be tempted to do that will be exempt anyway, due to the effect of a few outliers, while a few bad numbers in a small population can bring down scores.

For example, if you care for a lot of patients with diabetes, choosing to report on the A1C performance measure is appropriate. Your large denominator will mean that a few outliers who are not in good control won’t skew your rating downward. If you have a comparatively small size of their Medicare population, the vast majority of eligible physicians will report data.

That is easier said than done. While all certified EHRs should be able to report out the necessary data, it’s not a task for the novice or the faint of heart. Beyond extracting the data (which is no simple task), physicians will need sophisticated analytic tools to ensure their reporting choices will enable the best scores. In choosing quality measures, both performance and population size matter. Larger populations will mitigate the small population of patients with diabetes, however, your stellar work with most of your patients won’t be reflected in your scores if you have even a few patients who are not doing well.

… but how you use the data matters, too

While your main task in 2017 is to report data, it is only the first step in this program. Practices that are planning ahead will be reviewing their data and auditing their operations to look for opportunities to improve. This will help meet the requirements to engage in practice improvement activities while actively improving the quality of care and improving quality scores, and will have the added benefit of positioning you for maximum reimbursement.

This is also your opportunity to examine how well your practice is doing in meeting the triple aim: better outcomes and better patient experience at lower cost. While the data you report for MIPS, commercial insurers are increasingly moving toward value-based contracting models, and the data can help you prepare for that eventuality. In fact, it may come far sooner than many physicians expect. A 2014 study predicted that by 2020, two-thirds of all payments “will be based on complex reimbursement models with value measures.”2 This is an opportunity to make the practice changes that will help you be successful with all payers, not just Medicare.

Know what the costs are and be careful with resources

Many physicians believe that they have relatively little control over the cost of care beyond what they themselves provide. But that’s not necessarily true. In a study done by Stanford Medicine and Peterson Center of Healthcare, researchers found 11 primary care practices scattered across the nation whose patients had significantly lower total healthcare costs, while achieving better outcomes, than patients of other, similar practices.3

Tip: Bigger may be better for chronic care.

Smaller practices without the resources to meet the MIPS reporting criteria will want to give serious consideration to joining an ACO or merging with a larger organization. An aging population with a high incidence of chronic diseases requires a complex, coordinated team of caregivers. While a solo practitioner can deliver excellent episodic care, improving chronic care outcomes requires a focused, multi-disciplinary approach and a depth of resources that few small practices can tap. While the loss of independence may be hard for some physicians, both public and private payers are moving toward team-based, high-value care and the day of successful small practices is ending.

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2New Value-Based Reimbursement Models to Eclipse Fee-for-Service by 2020, Healthcare Informatics
3America’s Most Valuable Care: Primary Care
These primary care teams affected the overall costs in several ways, including a judicious use of referrals to specialists. These teams had identified specialists who achieved better outcomes at lower costs and directed their patients to those practices. And they were careful about ordering tests only when the data would affect treatment and about using generic prescription drugs whenever clinically appropriate. They also worked in teams, with more routine patient needs directed to physician assistants and advanced practice nurses, allowing the physician time for more complex medical management. This meant that, compared to practices which did not use physician extenders, the physicians had more time to focus on complex needs, resulting in fewer patients being referred out to high-cost specialty care.

Tip: Get help with the data and analytics.

Unless your organization has staff with deep experience in data extraction and analytics, spending the money to get outside help will likely offer a large return on your investment. A lot of vendors are ready to help, but you should look for one who has all the pieces in place to complete the project. That means not just the technology for the data extraction and analysis and not just the consultation piece, but a complete offering with the people, processes and technology you need. The last thing you want is to buy technology you don’t have the expertise to use, or work with consultants who can’t bring the needed technology to the project. You’ll want a vendor who can do the whole job or who is partnering with other strong players in this space to offer a complete solution. Look for a vendor who brings proven technology and processes, plus consultants with deep experience in EHR technology, analytics and data integration.
The engaged patient and care coordination: The blockbuster therapy of the century

A groundbreaking 2009 pilot project by Kaiser Permanente Colorado proved that coordinated cardiac care, supported by technology to engage patients outside of the care setting, reduced the risk of dying of a cardiac-related cause by 88% within the first three months after a heart attack and overall mortality by 76% during the same time period. That project prompted Leonard Kish to call patient engagement the blockbuster drug of the century, because it improved overall mortality without any new drugs or new treatments. Instead, the blockbuster improvements were achieved with comprehensive care coordination and patient engagement.

We’d modify that statement to say that the combination of care coordination and patient engagement is the blockbuster therapy of the century.

Moving the needle on chronic disease outcomes requires an immense effort, and, as noted earlier, it is a team effort involving a cadre of caregivers and an engaged patient. It is also a data-driven effort that is more effective when supported by the right technology.

With a free flow of information, all caregivers can align their efforts to a common treatment plan. Without that free flow, there will be duplication, miscommunication and wasted effort.

Technology can help you organize and share data

As we all know, current EHR technology is less than ideal when it comes to interoperability. Having a common platform for all caregivers is ideal; lacking that, you’ll need a good data integration strategy and a way to easily share that data as needed.

Technology can extend care beyond the exam room

Since patient engagement is critical to success, using tools that increase patient engagement matters. These tools should include a robust portal with a secure messaging function, which allows patients to easily book appointments, ask questions about their care and get same-day responses. Beyond portals, telehealth and remote monitoring can increase understanding by both caregiver and the patient as to the real-time status of the patient’s health. If you can integrate the monitoring data with the clinical record and set automatic responses to the data (such as a text message like “Call the office about...”)

Tip: Ask health plans to provide data on your patients’ annual health expenses.

While resource use will not affect the composite score in the first year and possibly not the second, it will likely affect the score beginning in the third year and will grow each year. Physicians will need to pay closer attention to holding the line on costs. Private health insurers are starting to do the analytics to identify “high-value” providers and will reward those who keep costs lower. At the very least, you should become aware of whether your patients are accruing larger expenses than patients in other practices and figure out why that is happening. Ask the health plans and health systems you work with for any data they can provide on annual costs for your patients.

MACRA and technology: Using advanced tools for insights, engagement and better outcomes

While EHRs may be problematic, there is other technology that can help fill the data gap. Customer relationship management (CRM) platforms can act as a common meeting ground for caregivers and patients. These tools, designed originally to help companies offer superior customer service, can aggregate and coordinate all the personal information that is important in good chronic disease care.

4Kaiser Permanente Pilot Helps Reduce Cardiac Deaths by 73 Percent
Information Technology Supported Care Teams Significantly Improve Care for Patients with Heart Disease
5The Blockbuster Drug of the Century: An Engaged Patient. Leonard Kish, August 28, 2012
adjusting your insulin dose” or “Your data indicates you might have forgotten to take your medication”) both caregivers and patients get actionable feedback that can head off a crisis.

Analytics and risk identification/stratification can improve care and payments
Since accurate condition coding is crucial to appropriate comparisons of patient populations, it is important to identify and stratify the health risks in your patient population. If your patients have big risks that neither you nor they know about, your quality and cost data could be negatively impacted by poor outcomes and unexpected costs. A patient who is increasingly glucose intolerant, but not yet diabetic, could easily be missed. That same patient could, over the course of several months, have rising glucose levels that lead to a crisis and require hospitalization. That would turn this seemingly low-risk patient into one that not only drags down your quality data but increases resource use.

That’s where population health analytics plays an important role: identifying patients with rising risk who are not obvious in the day-to-day flow of patient care. And that is an important reason for physicians to be aligned with larger organizations (such as health systems or ACOs) with the resources to aggregate a wide variety of patient data and apply sophisticated analytic algorithms to that data. Lacking that, physicians may be able to get risk data from health plans, which are increasingly using analytics to identify patients who need more intensive care to avoid big health bills.

A new technology that is just coming into use, imaging analytics, promises to provide accurate, quantifiable and actionable results in the area of health risk. Using both past and current imaging studies, this technology can analyze images to identify previously unnoticed markers for disease. The technology can also quantify the level of disease, which can increase the accuracy of your condition coding and provide useful documentation.

Tip: Use your CRM to coordinate community services.
A CRM can also act as a communication bridge with outside caregivers and social services, allowing the care team, with the patient’s permission, to share data with others who may be critical to improved outcomes. A CRM can also provide a way for other helpers to report data back to the care team. And they can be used by patients to provide information about their circumstances that may affect their care plan.
Health systems: Benchmarking for quality and cost
While hospitals and health systems are not part of the MIPS programs per se, unless they employ physicians, they have a huge stake in helping their physicians do well under the program. As noted above, by 2020 value-based reimbursement contracts will be the norm, with fee-for-service rapidly dying out. To do well under value-based models, hospital and health systems will need physicians who can deliver high-value care. Hospitals should consider MIPS as a fitness program to get their physician networks in shape to perform at a high value, and you can help coach them toward that goal.

The major advantage you have is data and analytics. You should work with the physicians in your networks to benchmark them against local, regional and national peers on both outcomes and cost. Share this data with the physicians, so they can see where improvement is needed. And you can use this data yourself as you create ACOs, choosing to work with physicians who are effective and cost conscious.

Health plans: Become a partner with your high-value providers
MACRA provides multiple opportunities for health plans to increase and improve collaboration with their provider networks. Many of the clinical measures for MACRA are the same or very similar to the measures health plans report under the Medicare Advantage Stars rating system and the Health Effectiveness Data and Information Set (HEDIS), so better performance by your physician network under MIPS or the APM pathways can translate into better performance for your plan. Help providers and health systems meet MACRA requirements, whether it be under the MIPS or the APM pathways, with the following:

- Enter into agreements with your provider networks to supply support and services in areas where they may not have as much expertise, such as advanced analytics and risk identification and stratification.
- Provide input and support to providers on the clinical measures that would be most beneficial for them to monitor and report, based on predictive models and analytics most health plans use but which are not readily available in the provider environment. Remember, their performance under MACRA can affect your Stars and HEDIS ratings.
- Use your more advanced technical infrastructures to facilitate data exchange and enable providers to access a full 360-degree picture of a member/patient. This will lead to "opportunities to offer tailored consulting and data support" that can improve performance for your providers.
- Give providers regular reports on the total costs for your members under their care. This will help them understand how their choices affect resource use. Benchmark costs so your physicians can compare their data to peers.
- Help providers educate their patients (your members) on the costs of care and their healthcare options. As the number of high-deductible plans increases, there is a rising need for open and effective communication and feedback loops between all parties in the healthcare continuum.
- Partner with your network. Providers will be seeking strong partners with the necessary skills, experience and knowledge to ensure they do not take on risk greater than they can support. You should actively strive to be that strong partner through:

Tip: Use telehealth and remote monitoring.
Studies have shown that telehealth and remote monitoring, when used together, can reduce the use of expensive resources, such as the ER and hospital inpatient days. This combination can increase the likelihood that a patient will take responsibility for their own care and can give them access to caregivers when they need it. This reduces use of the ER and gives caregivers advance warning of an impending crisis, reducing hospitalizations and 30-day re-admission rates. Since ER visits and hospitalization are two of the biggest cost drivers in chronic care, this will help you score well on both quality and cost measures.

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6Health Plans: Top 5 Steps to Prepare for MACRA, Health Lavoie, October 18, 2016
74 things plans need to anticipate from MACRA, Burcu Bozkurt, Advisory Board, August 25, 2016
8Are you ready for the new world of value-based reimbursement? Marla Pantano, July 11, 2016
Tip: Identify the risks in your physicians’ patient populations.

Even if you aren’t currently treating some of your physicians’ patients in any of your facilities, you need to understand and stratify their risks. These patients will likely show up in your populations under future risk-sharing arrangements, and you will fare better financially if you guide these patients into early intervention programs. You might even boost fee-for-service revenues in the short term by treating these patients now, improving their health and reducing your future costs.

- Enabling robust data analytics that support quantitative action plans in the areas of quality and clinical care gaps, medical cost and trend analysis, population health, and member risk management.
- Staying flexible. Be ready to address changes to provider payments as the pay-for-performance model(s) mature over time.
- Learn how to identify high-performing providers and enter into risk-sharing relationships (such as value-based contracts) with them.9
- Be aware of the financial considerations that result from increased value-based contracting. The first of these is the potential for increased costs. Smaller providers are more likely to experience hardships under MACRA, which may result in additional provider consolidation. As Medicare payments shrink, these providers will be looking to shift costs to other payers, making contract negotiations more difficult and potentially increasing unit costs for some services. Large physician groups or those located in markets with progressive healthcare systems will look to negotiate even higher reimbursement rates due to the potential for increased competition. Some physician offices may become reclassified as hospital outpatient departments as a result of integration with a hospital or other care delivery network. Services rendered by providers in these locations could result in facility fees as well as increased professional costs to the health plan.

You should also be aware of potential impacts beyond Medicare fee-for-service, which is the initial focus of the MACRA legislation. During a round table discussion held in June 2016, participants identified items with the potential for broad impact, including:10

- Pay-for-performance is likely to extend beyond Medicare fee-for-service into other health plan lines of business, such as Medicaid or commercial plans. As noted earlier in this paper, health plans are proactively engaging in risk-sharing contracts in their other lines of business and by 2020, fee-for-service will be the exception, not the norm.
- Health plans will need to build brand loyalty amongst their younger and lower-risk members by demonstrating quality results for this population. Being able to view members holistically, with an eye toward the long term, will be critical to support brand loyalty.
- Ensuring access to healthcare services while attempting to work with highly rated providers, and thus a narrower network, will create a delicate balancing act for health plans to manage.

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9Identifying High-value Primary Care Teams through Analytics, Karen Way, February 14, 2017
10Exploring Implications of the MACRA Rule with Health Plan Executives, Harry Merkin, July 25, 2016
Conclusion: Focus on coordinated care to get the scores you need

MACRA is the most profound change in the Medicare physician payment model since 1965, the year Medicare was enacted. While physicians may be tempted to view MACRA, MIPS and APM track requirements as just another reporting exercise, doing so would be a huge mistake.

MACRA is intended to use reimbursement pressures to fundamentally change the way care is delivered, especially for patients with chronic disease or those who need complex medical management. This is the first large-scale program to actively reward U.S. physicians for the outcomes of their patients. If you view this as a path toward improved reimbursements and better outcomes for patients, and take the steps to actively achieve better outcomes, you will likely be rewarded. If, however, you spend your time objecting to being measured for something that you can’t directly control, you will lose revenue under MACRA.

Key concepts to keep in mind to help you stay on track toward success include:

- Value-based care relies on integrated teams, so identify the strengths and weaknesses in your team and take steps to fill any gaps.
- Technology can enable you to extend your resources, and connect with others who can help improve outcomes and increase patient connection and engagement.
- Collaborate to succeed. Health plans and health systems have a huge stake in the MACRA success of their physicians, and can offer help in the transformation of care. Seek help with:
  - Population health risk data for your patients
  - Technology
  - Cost and outcomes data to help you benchmark your performance
  - Access to data that can provide a 360-degree view of your patients

Finally, if you need guidance, get help. For small practices, without the resources to hire consultants, seek out advice and counsel from your professional organization and from the hospitals, health systems and health plans with which you are affiliated. For larger practices, engaging an expert to help you navigate the first stages of MACRA can be well worth the cost.

Tip: Monitor your data and act on it.

Even if your practice currently is doing well on the measure you choose, be aware that other practices will be actively seeking to improve their performance. What is good today may be below average in the near future.

And that is exactly where CMS hopes this approach will lead. By using comparative data to set rates, CMS has put physicians in competition with each other, to see who can help patients reach better outcomes (or at least better immediate measures that are associated with better outcomes).

If you see patients who are struggling with control of a chronic condition, focus more attention on those patients and learn their challenges. Often, more help at the right time and place can make a big difference in chronic care outcomes. Consider telehealth coaching and other high-touch strategies that are enabled by the abundant technology available to enhance patient engagement.