A Systematic Approach to Performance Improvement Under MACRA's Quality Performance Program

White Paper

Coker GROUP
Business Advisors for the Healthcare Industry

ELLIS "MAC" KNIGHT, MD, MBA
Senior Vice President/CMO

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CONTACT

For further information about Coker Group and how we could be of assistance, call 800-345-5829 x2021 or visit www.cokergroup.com.

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Abstract: The Medicare Access and CHIP Reauthorization Act (MACRA) is perhaps the most significant change to healthcare in the last half-century. Though the proverbial and long-anticipated volume-to-value shift in the industry has not yet materialized in most markets, MACRA will make this change real as CMS, the country's largest payer, dramatically changes the way they pay participating providers.

The question, then, becomes how Medicare providers should prepare to operate successfully under MACRA? What must be done to optimize ones' chances of receiving payment enhancements, as opposed to payment penalties, by 2019?

This paper outlines a step-by-step approach for providers both to prepare for and to thrive within the MACRA payment models of the future.

Key Words: MACRA, Medicare Access and CHIP Reauthorization Act, value-based reimbursement, volume to value, Merit Incentive Payment System (MIPS), Alternative Payment Models(APMs), physician quality reporting system(PQRS), value payment modifier program (VPM) meaningful use program (MU), clinical practice improvement activities (CPIAs) quality review and utilization report (QRUR), CMS, Medicare payments

INTRODUCTION

As many providers are now realizing, the roll-out of the Medicare Access and CHIP Reauthorization Act (MACRA) is becoming one of the most significant changes to the healthcare reimbursement system to occur over the last 50 years. MACRA will move providers of all types toward a value-based, rather than a volume-based payment system and will have significant ramifications across the industry.

One ramification is that providers now have to re-tool their delivery systems at the frontline level to move the dial on the performance metrics included in MACRA. This change in bedside practice patterns will not come effortlessly since provider behaviors are well entrenched and geared toward producing volume rather than value. Nevertheless, if MACRA participants wish to "win" under this model (i.e., receive CMS payments that are adjusted upward rather than downward based on their performance), they need to establish a strategic and systematic plan prior to January 2019 when the MACRA payment adjustments begin.

This paper outlines an approach that can serve as a step-by-step way for providers to not only prepare for, but to thrive within the MACRA payment models of the future.

MACRA: A BRIEF REVIEW

The MACRA legislation was passed in 2015 with overwhelming bipartisan support in the United States Congress. Notably, this law was separate and distinct from the Affordable Care Act (ACA),

and even if the latter is repealed, MACRA will remain in place as the reimbursement mechanism by which CMS pays physicians and other providers.

MACRA replaced the sustainable growth rate formula (SGR) through which CMS had previously calculated provider payment adjustments required to hold healthcare cost inflation in check. Unfortunately, the SGR never proved to be a viable methodology. For several years prior to 2015, Congress passed a "doc fix" bill that pushed off the adjustments called for by the SGR. This bill provided doctors and other providers with a reprieve from what some felt were draconian cutbacks in provider reimbursements.

The initial rules for MACRA were released in April 2016 and finalized in November 2016, just two months before MACRA data reporting started in January 2017. The basic rules of MACRA call for two distinct payment models:

1. The Merit Incentive Payment System (MIPS)
2. Alternative Payment Models (APMs)

Under MIPS, each provider group or individual provider is measured across four categories of performance (Quality, Cost, Advancing Care Information, and Clinical Practice Improvement Activities). Performance in these areas is then quantified via calculation of a composite score for each group or individual practitioner. The composite score determines payment adjustments or penalties based on the providers' performance over the previous two years. The adjustments are designed to be budget neutral, i.e., payments are shifted from low performers to high performers, and no additional dollars are put into the system by CMS.

APMs encourage providers to band together into groups focused on improving quality, cost efficiency, and other practice improvements. Simply being an eligible participant (EP) in an advanced APM results in each provider receiving a 5% increase in Medicare payments for each year between 2019 and 2022. The APM, however, must meet certain eligibility criteria. Specifically, it must measure performance down to the individual provider level across the same categories used in MIPS; it must utilize a certified electronic health record technology (CEHRT); and, most importantly, the providers in an APM must be "at risk" for both upside and downside payment adjustments based on their collective performance within the APM.

Currently, very few organizational entities meet the criteria necessary to serve as an APM; and, therefore, most providers will fall under the MIPS portion of MACRA, at least for the first couple of years of MACRA's roll-out. Going forward, more APMs will become available, and providers should be encouraged to move into this model since it provides less individual risk. For now, however, providers will need to use the following approach to optimize their performance under MIPS.

MAXIMIZING MIPS PERFORMANCE: A SYSTEMATIC APPROACH

STEP ONE:

The four categories of performance under MACRA include three historic voluntary CMS performance improvement programs that are now being rolled into two new involuntary payment programs (MIPS and APMs).

The three historic programs that have now been woven into MACRA include:

1. The physician quality reporting system (PQRS)
2. The value payment modifier program (VPM)
3. The meaningful use program (MU)

Each of these programs incentivized providers to work on quality (PQRS), cost efficiency (VPM), and to adopt the use of electronic health records (MU). In addition to these programs, CMS has added a further category of performance, clinical practice improvement activities (CPIAs), which is to encourage providers to change frontline practice patterns and workflows. In later sections of this paper, we will explore more fully how to utilize CPIAs to enhance a provider's performance score and to improve performance across all categories.

Step one in our approach is to utilize past performance on two of the historic programs now included in MACRA to determine areas of focus for improving performance under MACRA. This data is best looked at by downloading a provider's quality review and utilization report (QRUR). These reports can be downloaded from CMS's website and are available to all who have previously participated in the PQRS and VPM programs.

STEP TWO:

Critical information to glean from the QRUR are the specific metrics related to quality and cost performance. Any of these measures that are not currently two standard deviations above the benchmark average should be targeted for improvement initiatives. Relevant providers and their support staffs (clinical and non-clinical) should be assembled into performance improvement teams and tasked with doing the following:

1. Isolate those care processes or procedures that are critical to the improvement measures.
2. Map the key steps in each care process using a modified Lean process mapping technique where squares are key steps and diamonds are decision steps.
3. Specify the services provided in each key step to include evaluation and management (E&M) services, imaging services, lab testing, pharmaceutical prescribing, specialty referrals, hospitalization, and post-acute care service referrals.

4. Design or redesign the care process map to ensure that it follows evidence-based best practices, as informed by the literature and the performance improvement team's internal knowledge and experience.
5. Select outcome measures (quality and cost) that can be used to monitor performance on a regular basis. NOTE: The quality and cost metrics need to match those used to measure performance under MIPS and within APMs.
6. Utilize outcome data to refine care processes and procedures over time to maximize the value equation where value = quality/cost.

As an example, a care team (physician, medical assistant, appointment clerk, and biller) from a primary care practice might come together to look at their office care of diabetic patients and explore how to improve metrics related to diabetic care for MIPS. First, they might decide to focus on routine office visits for diabetic patients. Next, they would map out this process and determine the average costs related to these visits (costs to Medicare) by adding up the billable services included in each step. Next, they would redesign their diabetic office-visit care process by deciding to implement group visits for diabetic care. Next, they might select outcome measures such as Hemoglobin A1C levels and average billings per patient to follow as they refine the care map through an iterative process over time.

Step Three:

In due course, further initiatives would be added to the provider's overall improvement plan with the goal to improve performance on MACRA measures as quickly as possible to ensure optimal performance is achieved by the time MACRA payment adjustments begin in January 2019.

It should be noted that each of these performance improvement initiatives can serve as a CPIA, of which there are over 90 to select from CMS. As outlined above, setting up each of these ongoing performance improvement initiatives can serve to improve both the provider's composite quality and cost scores, while also improving care delivery at the front lines of patient care.

Case Study: MACRA preparation for a PHO

The organization is a large physician-hospital organization (PHO) located in the Southeastern U.S. Over 200 physicians across most major specialties and a community hospital with over 400 beds were members of the PHO. About half of the physician participants were employed by the hospital, and the other half were private, independent practitioners.

Coker Group was engaged to help the PHO and its members prepare for MACRA. We began by requesting quality review and utilization reports for each practice in the PHO. Twenty-two

separate practices were reviewed, and all the practices were found to be "average" in their quality and cost performance compared to benchmarks in CMS' PQRS and VPM programs.

Next, the QRUR reports were used to recommend specific CPIAs that the practices should initiate to improve performance around the quality and cost metrics related to their practices. As an example, an internal medicine practice was tasked with improving performance around pneumonia care. Specific recommendations were made to this practice as follows:

1. A multi-disciplinary team from the practice should be assembled to work on care process improvements related to pneumonia prevention and acute care.
2. The care of patients seen by the practice with pneumonia should be mapped, and best-practice, evidence-based care guidelines should be implemented within this care map.
3. Quality and cost outcomes, e.g., admissions for simple (aka community acquired) pneumonia or the percent of eligible patients receiving pneumonia vaccinations should be tracked, and this data shared with front-line providers on a real-time or near real-time basis.
4. The above data should be used to guide refinements in the care processes used for pneumonia in the practice.
5. The care practice improvement activity described by these recommendations should be submitted to CMS for credit under the CPIA category of MACRA's QPP. Note: This would be classified as IA_PSPA_18 under CMS's CPIA Activity ID classification methodology; the subcategory would be Patient Safety and Practice Assessment.

All practices in the PHO have been given customized recommendations regarding CPIAs that should help improve performance over the next two years and result in upward payment adjustments under MIPS. Progress on these initiatives will be monitored, and remedial efforts will be applied to those practices that fail to engage in this massive performance improvement project.

CONCLUSION

MACRA is perhaps the most significant change to hit healthcare in 50 years. The proverbial volume-to-value shift in the industry has been expected for some time, but as of today has not materialized in most markets. MACRA will make this shift real as CMS, the country's largest payer, dramatically changes the way they pay participating providers.

The question, then, becomes how Medicare providers should prepare to operate successfully under MACRA? What must be done to optimize the chances of receiving payment enhancements, as opposed to payment penalties, by 2019?

The above described step-by-step approach, whereby past performance as measured by the QRUR is used to guide practice improvement, and performance improvement initiatives will

serve as a model through which provider organizations of all types (small to large physician practices, hospital-owned physician networks) can optimize their success. Producing high quality at low cost in an industry as complex as healthcare is no simple task. Those who can do so will be rewarded in the approaching value-based healthcare economy, and those that cannot implement the necessary changes may get left behind. Hopefully, the method outlined here will be of value to those who must assume this enormous challenge.