Preparing a Physician Practice for MACRA Participation

White Paper

Coker GROUP
Business Advisors for the Healthcare Industry

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

BRANDT JEWELL
Senior Vice President

September 2018

CONTACT

For further information about Coker Group and how we can be of assistance, call 800-345-5829 x137 or visit www.cokergroup.com.

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Abstract: The date is rapidly approaching when providers who are participating in MACRA will be subject to adjustments in payments from Medicare. However, many providers may not be ready for the significant changes that will soon occur. This paper presents a step-by-step guide to preparing for MACRA participation.

Key Words: Alternative Payment Models, APMs, Medicare Access and CHIP Reauthorization Act, MACRA, MACRA Implementation, MACRA Preparation, Merit Incentive Payment System, MIPS, Quality and Cost, Value-Based Reimbursements, PQRS, Value Payment Modifier, VPM,

INTRODUCTION

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015, and becomes effective January 1, 2019. There is a 12-month Quality performance period starting in January 2018 (January 1–December 31, 2018), which will be the basis of reimbursements. A report of a full year of quality data gives a more comprehensive picture of a physician's performance. Providers will have a greater chance to earn a higher positive payment adjustment, but the inverse may also occur. Participants will see either an increase or decrease in January of next year based on their past performance. (A Centers for Medicare and Medicaid Services (CMS) Fact Sheet is available at https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Quality-Performance-Category-fact-sheet.pdf.)

All providers currently active with Medicare and those planning to become Medicare providers should have a plan for MACRA. In working with many groups across the country to assist in preparing for the dramatic change that MACRA initiates, we have developed a step-by-step framework to refine the process. Following is a roadmap designed to serve this purpose for most providers.

STEP 1: CHOOSING A PAYMENT MODEL: MIPS VS. APM

The MACRA legislation created two payment models, the Merit Incentive Payment System (MIPS) and Alternative Payment Models (APMs). Those providers who are members of a level 1+, 2, or 3 accountable care organization (ACO) or who are specialists participating in the Oncology Medical Home (OCH) or End Stage Renal Disease Care Program (ESRD CP) should strongly consider going the APM route. The ACO, Medical Home, or ESRD care program can off-load the burden of data gathering and reporting required by CMS for MACRA. Additionally, eligible providers in APMs qualify for a 5% increase in reimbursements for the next six years, which is not at risk for performance. While all of the APMs do involve some inherent level of financial risk related to their ability to generate shared savings, we believe that the risk in these models is less than the risk with MIPS, and thus all providers should eventually plan to move into an APM.

Step 2: Studying Your QRUR and MIPS Data

For those practices or individual providers who participated in the Physician Quality Reporting System (PQRS) and Value Payment Modifier program (VPM), the Quality Review and Utilization Report (QRUR), which reported performance in these programs for 2015 and 2016, along with the MIPS quality data for 2017 (either submitted by the individual, the practice, or the APM) can be valuable in terms of planning for future MACRA participation.

At this time, most practices are required to report six quality measures to CMS. We strongly suggest that providers try to optimize their success in this program by choosing six measures on which they have performed well under PQRS or MIPS. Ideally, these would be six measures that the practice or provider would be able to improve and thus receive higher reimbursements from CMS for clinical services. At the very least, this method should avoid providers having to take a penalty (decreased payments) for poor performance.

Further, MACRA will be scrutinizing costs both at the provider level and across the Medicare system for patients attributed to individual providers and practices. Therefore, providers would be well advised to look at their costs in each of these categories compared to their peers to determine where they might institute cost reduction initiatives to improve performance. While MIPS cost or resource use performance data is not yet available, cost efficiency was reported via the QRUR reports for 2016 and 2017. This information can be beneficial in determining where costs for a specific provider or group exceeded the norm and should be addressed.

Step 3: Developing Quality and Cost Efficiency Initiatives

As outlined, those participating in MACRA should develop formal initiatives that are designed to move the dial on performance metrics going forward in the MACRA quality payment programs. While this may be easier to do in a small practice operating in MIPS, an APM may have more resources, e.g., performance and process improvement experts, who can assist in developing such initiatives for its participants. In either program, the standard "Plan, Do, Study, Act (PDSA)" quality improvement cycle should be used to ensure that providers at all levels are continuously working to improve performance over time.

Note also that quality and cost initiatives can give providers and practices credit under the third category of MIPS, which measures participation in CMS Clinical Process Improvement Activities (CPIA). There are over 90 CPIA to choose from, and it is relatively easy to find those that fit the metrics and areas of performance providers are most interested in improving. For instance, if a practice or provider is focusing on improving the control of blood pressure and diabetes in their patients with diabetes mellitus and hypertension, they may want to develop an initiative that fits the criteria for Activity ID IA_PM_13 - Chronic care and preventative care management for empaneled patients. Again, this will accomplish two things:

1. It will improve the care of patients with these conditions, and
2. It will satisfy the criteria for the CPIA category within MIPS for the participating providers.

Step 4: Estimating Additional Revenue Gains or Losses and Return on Investment

There is no doubt that participating in a significant pay-for-performance program such as MACRA is an expensive undertaking. All potential participants should estimate their expected gains or losses under this program and compare them to the expected costs of participation. While CMS has proposed several mechanisms by which small or rural providers can avoid some of the costs and hassles of MACRA participation, most providers or group practices will not qualify for these program exceptions. Thus, they should assume that as of January 2019 they will either:

1. Be subjected to a 4% increase or decrease in their professional reimbursement rates from Medicare, or
2. Have no change in their reimbursement rates.

When calculating this 4% at risk, providers should look at their historical professional fee charges to Medicare (such as the last three years) and then average these charges to find an average for the three years overall, which are then multiplied by .04 to determine the amount at risk. (Note, it is Part B charges and not reimbursements which need to be measured and only professional fee charges, not Part A facility fees, Part C Medicare Advantage payments, or Part D pharmacy fees.)

For future years, the 4% at-risk calculation will rise annually (5% for 2020, 7% for 2021, and 9% for 2022), and these increasing levels of risk over the next five years should be estimated.

Finally, against the dollars at risk, as calculated above, the potential MACRA participants should estimate their costs of participating in this program by determining the expenses related to the following items:

1 The cost of collecting and reporting the data required by CMS for the MACRA payment programs. This amount may involve the purchase of new qualified clinical data registry (QCDR) systems, which many organizations do not have, or adding features to current EMR systems so that they can be used to report quality, CPIA, and ACI (advancing care information) performance data. (Cost data is captured from claims and does not have to be reported by providers or provider groups.)

2 The cost of setting up any care management programs (care coordinators, chronic disease managers, social workers, and others) that are needed to ensure the success of care process improvement initiatives.

3 Any other staffing costs--analysts, business managers, IT staff, and additional clinicians—required to operate effectively within MACRA.

4 Opportunity costs that may arise by pulling clinical staff away from patient care responsibilities to manage quality, cost, and ACI initiatives under MACRA.
5 Consulting costs for those utilizing outside consultants to help develop their MACRA activities.
6 Legal costs to ensure that MACRA reporting and other aspects of participation are compliant with all relevant statutes and regulations.

In the end, some hospitals may find that the return on investment for participating in MACRA is not worth it and opt to bow out of this large-scale value-based reimbursement program. We would caution those tempted to do this, however, to remember that CMS is usually the pacesetter for changes in the healthcare reimbursement system. It is likely that more and more payers (commercial insurers and self-insured employers) will follow suit with similar programs in the future. Many large commercial payers (BCBS, Aetna, United Healthcare, and others) are rushing to roll out value-based reimbursement (VBR) models.

CONCLUSION

MACRA is ready for full implementation in 2019 and Medicare participating providers will see their reimbursements, from this largest of all payers, either increase or decrease in January of next year based on their past performance. It is not too late, however, to set up a MACRA participation plan that will mitigate the risk of penalties to providers going forward. While no method is foolproof, the step-by-step approach described in this paper should benefit most providers or groups of providers as they plan for MACRA.

There is no reason to ignore this major change in the reimbursement system, and plenty of help is available from CMS, consultants, and others who wish to make the transition from volume-based to value-based reimbursements as safely and effectively as possible.

We encourage every provider to have a plan and to stick with it as the healthcare marketplace evolves. Significant change is at hand, and those who best plan and prepare will be most likely to succeed.