MACRA

Reinventing the Structure of the Practice of Medicine

EBOOK

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The Stakes Just Got Higher – How Will Your Practice Respond to the MACRA?

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THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) HAS FINALIZED ITS PLANS TO IMPLEMENT THE SWEEPING PAYMENT REFORMS CALLED FOR UNDER THE MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT (MACRA) OF 2015.

In addition to repealing the Sustainable Growth Rate (SGR) formula, the MACRA creates the Quality Payment Program that rewards physicians and clinicians for giving better care, not just more care. With 10,000 people entering the Medicare program every day, CMS Acting Administrator Andy Slavitt said that it is essential that Medicare continue to support physicians in delivering high-quality care by focusing on patient outcomes and reducing obstacles that make it harder for physicians to practice good care. CMS says that by changing the way physicians are paid, the Quality Payment Program incentivizes quality and value of care over quantity of services.

Despite the Trump administration's promise to repeal major aspects of the Affordable Care Act, Slavitt says he does not expect any changes or slowdown to implementation of the Quality Payment Program. The MACRA replaces the SGR, which was a deeply flawed reimbursement formula that was largely viewed as bad for patients, bad for physicians, and bad for the Medicare program. Slavitt says that by replacing the SGR, the MACRA puts the Medicare program on more sound footing. In addition, the law passed with very strong bi-partisan support with just three senators and 37 congress members voting against the legislation.

Implementation of the MACRA puts new pressure on physicians and the organizations that employ them to document and report performance and quality metrics. The changes called for under the MACRA will have a significant impact on physicians and the hospitals and health systems with which they partner. For example, hospitals that employ physicians directly will likely bear the cost for compliance with the new reporting requirements, as well as be at risk for any payment adjustments. And there may be more pressure on physicians and their employers to participate in alternative payment models, such as accountable care organizations or bundled payment programs, given the financial incentives to do so.

Who is in the Quality Payment Program?

Medicare Part B physicians and clinicians will be subject to the Quality Payment Program if they are in an Advanced APM or if they bill Medicare more than $30,000 per year and care for more than 100 Medicare patients per year. For MIPS, clinicians include:

- Physician
- Physician Assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist

THE QUALITY PAYMENT PROGRAM

Prior to implementation of the MACRA the Medicare program gathered performance metrics on physicians and other clinicians through a patchwork of programs, including the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and the Medicare Electronic Health Record (EHR) Incentive Program. With the new MACRA law, Congress has streamlined elements of these programs through a framework called the Quality Payment Program. The new program offers clinicians two paths for participation:

1 The Merit-based Incentive Payment System (MIPS)

or

2 Advanced Alternative Payment Models (APMs)

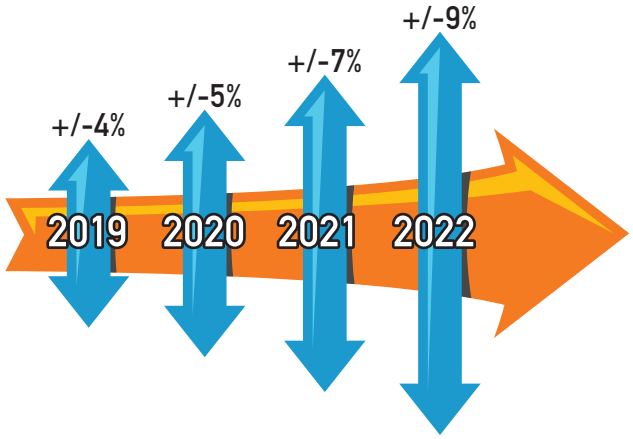
Most Medicare clinicians will initially participate in the Quality Payment Program through MIPS, which will include components of the existing PQRS, VM, and EHR Incentive Program. As an alternative, CMS has established incentives for clinicians to participate in Advanced Alternative Payment Models (APMs). Under this pathway, providers who take on significant financial risk through entities such as accountable care organizations or bundled payments programs can bypass MIPS and become eligible to receive consistent 5% annual payment increases. At least initially, few physicians will qualify to participate under the Advanced APM path, which requires that Medicare comprise 25% of their payments or that Medicare recipients be 20% of their patients through the APM in order to receive the incentive payment.

Regardless of the path, CMS has set 2017 as the performance period for the first payment adjustment in 2019. Payment adjustments under MIPS will be based on performance on measures and activities in four categories, as summarized below.

MIPS Performance Category	Replaces	2019 Percentage of MIPS Score	2020 Percentage of MIPS Score	2021 Percentage of MIPS Score
Quality	PQRS	60%	50%	30%
Advancing Care Information	Medicare EHR Incentive Program	25%	25%	25%
Clinical Practice Improvement Activities	New	15%	15%	15%
Cost (Resource Use)	Value-based Modifier	NA	10%	30%

MIPS clinicians stand to receive a positive, negative, or neutral payment adjustment of up to 4% in 2019. That percentage increases to 9% in 2022. The positive adjustments will be scaled up or down to achieve budget neutrality, meaning that the maximum positive adjustment could be lower or higher than 4%. In the first five years of the program, CMS has also allocated $500 million in an additional performance bonus that is exempt from budget neutrality to reward exceptional performance. This bonus will provide high performers a gradually increasing adjustment based on their MIPS score that can add up to an additional 10%. In addition, CMS has allocated $20 million per year to small practices to provide technical assistance on MIPS performance criteria or assistance transitioning to an APM.

Payment Adjustments Under MIPS



OPTIONS FOR 2017 PARTICIPATION

Recognizing that physicians are in various stages of readiness for the new reporting system, CMS has outlined several options for reporting during the first year of the program. The options are:

1. **Don't Participate.** If you don't submit any 2017 data then you will receive a negative 4% Medicare payment adjustment in 2019.
2. **Submit Something.** With this option, as long as you submit some data to the Quality Payment Program you will avoid a negative payment adjustment.
3. **Submit a Partial Year.** If you submit 90 days of 2017 data, you may earn a neutral or positive payment adjustment.
4. **Submit a Full Year.** If you submit a full year of 2017 data, you may earn a positive payment adjustment.

PREPARING YOUR PRACTICE FOR VALUE-BASED CARE

We asked Lance Hebert, Vice President of Medical Group Credentialing and Provider Enrollment at Echo if there are things physicians should be doing to prepare for implementation of the Quality Payment Program. First, Hebert recommends that practices not delay. "With your Medicare reimbursement at risk based on your participation in the Quality Payment Program this year, it's critical that you start now. Don't leave money on the table by failing to prepare." Hebert offered a few additional recommendations:

- **Understand the requirements.** CMS and a host of others have offered numerous training materials to help educate physicians about the new requirements. Become familiar with the MIPS reporting requirements and the Advanced APM concept.
- **Choose your path.** Decide if you will participate in MIPS or an Advanced APM. While most clinicians will initially participate in the Quality Payment Program under MIPS, confirm whether you are a participant in any of the risk-based models that are exempt from MIPS reporting and automatically eligible for a 5% payment incentive.
- **Decide how you will participate.** As summarized above, CMS has outlined options for participation that allow clinicians to choose the pace at which they will participate in the first year of the program. Review the options and decide which you will pursue.
- **Dedicate resources and explore platform solutions.** Surround yourself with talented resources for technology, clinical quality, and regulatory compliance. Whether your own staff or contracted experts, you need dedicated resources tasked with ensuring compliance with the new reporting requirements. Platform solutions can help you capture, analyze, and submit the new reporting requirements. Further, prioritize training initiatives that can help optimize your results. Best bet—find a partner who can help with both!
- **Have a plan and mitigate risk.** Create a detailed roadmap for your team to follow and an action plan for each reporting requirement. It is also important to understand the potential pitfalls and to have a concrete plan in place to mitigate those risks. The transition to reporting under the Quality Payment Program is not a once-and-done project. It will require a long-term vision and flexibility along the way.

The Quality Payment Program will require physicians, hospitals, healthcare organizations, and medical groups to support the heavy burden of data collection and the associated cost necessary to survive in the world of Quality Payment Program reporting. Additionally, this new payment system will most certainly accelerate the shift in hospital-physician relationships. Some physicians, especially solo practitioners and those in smaller groups, may find the stability of hospital employment more appealing. And given the significant incentives to participate in Advanced APMs, there will likely be more pressure to participate in risk-bearing relationships.

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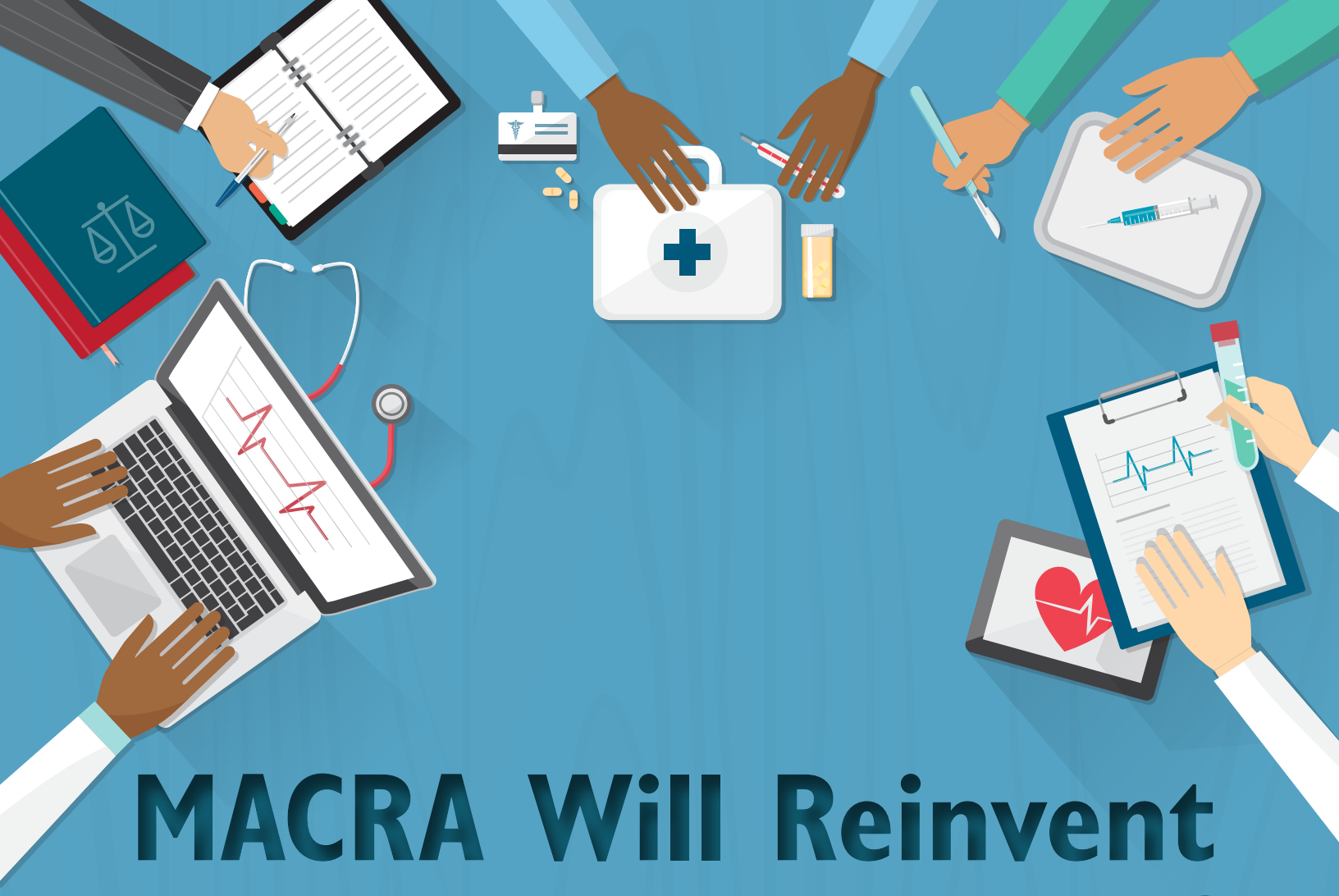

MACRA Will Reinvent the Way the Practice of Medicine Is Organized

An Interview with Dr. Miles Snowden,

Chief Medical Officer, TeamHealth

"The MIPS Program is the greatest change I have seen in healthcare. Traditionally, physicians might practice perhaps into their 70's, and about half would do so in small groups with high levels of satisfaction. That's not a model for practicing medicine that will be sustainable in the world of MIPS. The most important change with MIPS is not the introduction of new quality measures, new incentives, or new penalties. It is the fundamental reinvention of the structure of the practice of medicine that causes it to be the most impactful change in healthcare during my time in medicine from the 1980s to the present."

I'm Miles Snowden. I am the chief medical officer of TeamHealth, a group of largely facility-based physicians. I oversee some 19,000 clinicians, two-thirds of whom are physicians and one-third are advanced practice clinicians. We cover 47 states, and we are in the business of enabling physicians to have a sustainable and rewarding practice in medicine.

I would suggest that we probably represent a typical group practice in about a decade or two, but we are certainly not typical today. A large group practice today is probably 12 or more physicians. Tomorrow practice size will be measured in the hundreds. Eventually I suggest there will be many groups in the thousands and a few like ourselves in the tens of thousands. It will take groups in the hundreds to thousands to sustain the investments in technology necessary to be fully successful in any value based reimbursement model, whether it be MIPS or bundled payments or ACOs.

HSTM: Dr. Snowden, some have said MACRA and the new quality payment program will result in sweeping changes not only in physician reimbursement but also in how physicians practice. What are your observations about this?

Snowden: I think the market place as a whole has dramatically underestimated the impact of MACRA to the practice of medicine going forward. While there has been a great deal of focus on MACRA, it has not been seen as the catalyst for a dramatic change in the organization of physicians to practice medicine, so I'm going to give you some context around that. Today, based on the most recent available data, some 47% of physicians still practice in groups of five or fewer physicians. A group of that size will find it essentially impossible to be able to aggregate data, report results, and improve upon quality performance status sufficient to avoid very large penalties under the MIPS and MACRA program.

So, if you think about half of the 880,000 physicians in the United States today being in groups of insufficient size to survive this change, you can begin to understand that this is not just about an additional burden of reporting. This is a fundamental change in how physicians organize themselves.

It's also interesting to look at the demographics of those physicians in the groups of five or fewer. They are much older on average than the physicians that constitute the larger group practices. You have half of the country's nearly one million physicians in very small groups, and they are older approaching retirement. You have half younger and large groups. The larger groups will most likely be somewhat successful in the program; the smaller groups will be the peer group contributing the funds (through penalties) that will allow those in larger groups to receive incentives. As you can imagine, if you have half of the population creating a pool of money to be given to the other half of the population, there's going to be a push to move from one side to the other side of that situation.

HSTM: How would you say the changes that MACRA will cause compare to other changes you've seen over time in the practice of medicine?

Snowden: I don't recall any circumstance where a program has had the potential for a swing of up to 9% either favorable or unfavorable to the baseline. That is a make or break level of change. I don't believe that it is possible economically for a physician to sustain a practice in the face of consistent penalty payments under MIPS.

That then takes us to an additional consideration. In essence, the program will drive all physicians to seek the shelter of a better performing group in the program. So, I believe the program has a limited lifespan of a decade or less because eventually you will be assessing serious penalties on individuals who are actually performing at a very high level. The program may not be limited by regulation and rule but limited by the practical application of always measuring a group of individuals on a scale that's rapidly rising as a whole.

HSTM: What are some of the short term results we will see under MACRA?

Snowden: Going into the program, I see two major events occurring. The first is a dramatic decline in physician availability. We are already in a critical shortfall with many specialties. We are going to drive out a good portion of those older physicians in those smaller groups that I've mentioned that comprise almost half of our physician population in the US. We will significantly worsen the physician availability problem that we have today.

Secondly, we'll see a dramatic consolidation around larger group practices. As a lower-performing physician begins to pull their own individual performance forward, they are in essence undoing their own economic viability year after year. Since a physician can't sustain more than a couple of years of pulling forward unfavorable performance, they'll have to act fast. Thus, I think the consolidation of the physician practice market place into large groups is going to happen very quickly.

Physicians are a little slow on the uptake on some of these programs, so for two years or so, there'll be relative silence. At the end of the first two years of reporting, after 2018 being the first full year of exposure to the penalty, my expectation is 2021 will be a major year in the consolidation of physicians and in the decrease in the available physician manpower in the US. I foresee 2021 as a real time of fundamental change in the market place for physicians.

HSTM: At the end of the day, do you think MACRA will improve patient satisfaction and the quality of patient care?

Snowden: Physicians generally are dubious that the accountability for aggregating data and reporting on what they would call arbitrary quality metrics improve patient outcomes. What I would say is the promulgation of arbitrary quality metrics in the application of incentives and penalties on those metrics gets physicians attention, placed in an area that they would not otherwise have placed that attention. Although it may seem an inefficient way to do so, that inefficiency is probably necessary, as today we simply don't have the infrastructure in place that would allow a much more efficient aggregation of quality metrics by specialty.

At the same time, I am not at all certain that patient satisfaction with care will be improved, and I think there is a reasonable argument to be made that satisfaction may diminish a bit under MIPS and MACRA. The quality metrics are very narrow and they result in a very narrow focus, and this narrowness of the quality measures are inconsistent with the holistic relationship that patients seek for full satisfaction.

While patient satisfaction probably won't be significantly improved under the program, clinical outcomes, particularly longer term clinical outcomes, I suspect will be improved. I would say, for the next two or three years, there aren't going be many patients that are going be thankful for the promulgation of the final rule for MACRA. However, over the next decade or so, I think people will be able to point back and say, "Outcomes, particularly amongst chronic illnesses, did get impacted favorably."

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HSTM: What impact is MACRA likely to have on hospitals?

Snowden: Hospitals will be a very important component of the MACRA program. For hospital-based physicians, some 30% to 40% of their reimbursement is provided by Medicare and so immediately affected by CMS regulation and rule. I think it's reasonable to expect that the commercial payers will do as CMS has asked and quickly adopt these same quality metrics. So, you can expect that

most of a hospital-based physician's reimbursement will be subject within the next few years to the same or similar incentives and penalties as we are currently seeing in the final rule for MIPS.

If you think about the hospital-based physician or the hospital-focused physician (proceduralists, surgeons, anesthesia, hospital medicine, emergency medicine, etc.), they are going to require the assistance of the hospitals in which they are working to be successful in these programs. Hospitals should expect that for owned or affiliated physician groups, MACRA will become their burden to bear as hospitals will take on the responsibility for collecting the required data, improving physician performance over time, reporting that data, and then deciding how to distribute incentive payments or penalties to individual physicians. That's a significant challenge and burden for hospitals. But even for hospitals who have no owned or tightly affiliated physician groups, it's fairly easy to see that if they don't collaborate with the physician communities that are mostly practicing in their facility, those physicians will then be set up for failure in the program and by default will have to seek shelter with another group practice which, more likely than not, is experiencing success by virtue of the collaboration they are getting with the hospital or facility in which they are doing work.

So, I think it's important as you think about the hospital's role in physicians' ability to navigate through the new MIPS and MACRA program to think about it in two ways. First, you have the community- based physician for which there will be only modest impact for the hospital. Second, you have the hospital-based or hospital-focused physician for which the hospital's focus on this program will be differentiating and may make it the place of choice to work going forward.

HSTM: Will the use of new technology be an outcome of the MACRA program?

Snowden: I've talked about the fact that we are going to lose a good portion of the half of our doctors that are relatively older and practicing in very small groups. So, if you lose a significant portion of your physician population in short order due to the complexity and the risk associated with MIPS, that naturally produces several outcomes.

One is the rise of new technologies. In the past, what we've had is enthusiastic entrepreneurs looking ahead accurately and predicting the need for physicians to procure a clinical data warehouse or clinical analytics. In response, community physicians have largely said, "I'm not buying that because no one's making me yet."

Well I think the 'making me yet' time has arrived with MIPS and MACRA, so by the time we get to that watermark year of 2021 when the physician community has felt in 2020 the full impact of a 2018 full year exposure, we are going to see a lot of uptake in technology, data warehousing, and analytics.

Technology may even be differentiating for hospitals who are willing and able to create secure HIPAA-compliant data feeds from their EMR and the physician's proprietary system for regulatory quality reporting. The ability to facilitate that in an effective manner may be an important differentiator for hospitals by about 2020.

HSTM: How will the industry respond to the shortage of physicians that will occur because of MACRA-induced retirements?

Snowden: We simply aren't producing sufficient numbers of physicians today to backfill the hundreds or thousands of physicians who'll likely leave the workforce or diminish their work time over the next several years. We must find ways to provide healthcare that is not

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physician-centric in its focus. Obviously, there are many proceduralist physicians for whom you can't replace their work with an advanced practice clinician. But for most physicians, it is possible to contemplate a time where much of their work burden can be assimilated by advanced practice clinicians (i.e., nurse practitioners and physician assistants). The physician can then be the supervisor of care as required by state regulations and as dictated by the prudent practice of medicine.

I think we'll see the acceptance of advanced practice clinicians by state and health insurer regulation, by general hospital medical staff bylaws, and by physicians themselves rapidly increasing in the near future. I can tell you that in our own experience in using advanced practice clinicians, patient satisfaction scores are higher than with similar situated physicians, and the quality of care is every bit as good.

HSTM: Given so much change, are you optimistic about the future of healthcare?

Snowden: It's easy to take a glass half empty approach to MIPS and MACRA as a physician myself who is in the latter half rather than the first half of my career. I don't feel that way, and I don't see that among the physicians who make up our 19,000 clinicians. I see for the most part physicians who are energized and enthusiastic about their practice. I see physicians who are comfortable with the use of EMRs now, who are comfortable with being measured against peers, who are comfortable with being required to improve quality outcomes over time, and who are comfortable supervising advanced practice clinicians.

The physicians who are unhappy with the practice of medicine and are pessimistic about the new MIPS burdens are generally those who frankly will be gone with this change. Now that's not a good thing because of course these are highly experienced physicians. They will be terribly hard to replace, but when you think about the remaining physician workforce, these are younger physicians who never knew what it was like to practice medicine in the 80s and 90s. They don't have the context the older physician has who is bemoaning the loss of the practice of medicine as it used to be. If you don't have the context of what the practice of medicine used to be, you don't miss it.

I think we have a generation of physicians who are actually very comfortable with a more regulated, more peer comparison-based practice of medicine. I like that. I think that having more of a team-based approach and more of a willingness to accept measurement against peers are bound to improve the quality of medicine over time. And as we migrate out a generation of physicians who were called in the 80s and 90s and migrate in a generation of physicians who are comfortable with technology and EMRs and don't know how to use a pen on a paper chart, we'll see that general group satisfaction will rise. And with that, outcomes and patient satisfaction should rise similarly

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HSTM: What advice do you have for other Chief Medical Officers?

Snowden: For chief medical officers who are responsible for large physician groups or large health systems of various types, I think my focus as someone who's in a similar circumstance, is on technology. I know that our physician leaders and our clinicians are well-qualified and well-positioned

to develop best practices around the practice of medicine, to hold each other accountable to those best practices, and to enforce a sense of stamping out unfavorable variation in healthcare. What I don't believe our physicians can do of their own accord is procure, deploy, and adopt the technology necessary to be successful. I would submit that the physician leader of larger groups or systems probably needs to accept the burden of the technology plan around MIPS. It's a core goal. There's an adequate focus on care pattern improvement but insufficient focus on the technology necessary to hardwire and scale that change in care.

The investment in technology will be substantial. The business cases and the returns on investment will need to be robustly developed in conjunction with various other partners, operators, and financial leaders. I can tell you that for ourselves, being a 19,000-clinician group, the technology investment required for us to be successful in MIPS is very material to our business, and it is a fundamental focus for me as a physician leader in ensuring that that investment is well placed, well planned, and results in a highly robust deployment and adoption. A technology platform to scale the practice improvement that most physicians can see their way to achieving is what's necessary. It's fine to create improvement with a focus in a short period on a small group of physicians. But how do you do that on a national scale over a decade of time in a manner that can be reported consistently and accurately to CMS? That takes a technology investment. So, that's where I think a core focus of the chief medical officers of large organizations needs to be applied.

HSTM: How will physicians respond to the opportunity to be compensated based on differentiated performance?

Snowden: I think the practice of medicine will be more satisfying because of opportunities for physicians to experience differentiated reimbursement for differentiated performance. Underlying some of the dissatisfaction of physicians with their practice is the failure of the market place to provide a means by which a better performing physician can be better compensated. This is the core source of a good deal of the dissatisfaction with the older generation of physicians.

Fundamental to programs such as MIPS, accountable care organizations, bundled payments for care improvement, and any of the various other iterations of value based reimbursement is the ability to compensate differentially for differentiated performance. So, I think MIPS is a fundamental change for introducing higher levels of satisfaction for physicians. There are very few professions which attract knowledge-based workers in which, through the course of their career, they can largely not expect to be compensated better for higher performance. Physicians have perhaps been uniquely in that position in the past. This is a great way to begin the process of compensating physicians like we compensate other professionals.

One can't help but wonder whether physicians will be taken aback or be surprised by how they perform under the MIPS Program. It would be reasonable to argue that having already participated by necessity in the PQRS Program and the Value Modifier Program, physicians have great insight into how they would perform in the new program. But the data shows that a fair portion of physicians never even attempted to report on the PQRS

Program. CMS has suggested that about one-fourth of those physicians with smaller practices are almost certain to experience meaningful negative payment adjustments or penalties and that up to 87% of physicians in the first year or so who are solo physicians will experience penalties.

I do expect there'll be great surprise among physicians as they discover their performance is lower than where they see themselves. Most physicians subjectively see themselves as high performers. It will take a little time for the realization to set in, and I've suggested that 2021 may be the year of reckoning--2018 being the first full year of exposure to the MIPS program, 2020 being the first year of financial impact, and 2021 being the 'aha' moment to have understood what happened to my pay when we got to the annual calendar year payout of extra funds. The year 2021 will be a time of great surprises for physicians and a catalyst year for retirements, for movement to larger groups, and for various other changes that will be forever in the practice of medicine.

The physicians that won't be surprised are those who have been active, successful participants in the Value Modifier PQRS Program. There are many of us who have benefited significantly by working hard to report accurately, comprehensively, and in a manner that allows transparency among our physicians to allow them to improve their performance over time. I would argue that these individuals will be well-prepared for the MIPS program. By virtue of the fact that you have two cohorts, a well-prepared group that's moving into 2017 very purposefully and are ready to advance their performance against a group that has ignored PQRS, a bipolar distribution is created and is the perfect set up for a large transfer of penalty dollars to incentive dollars in 2018 and beyond.

HSTM: What advice might you give to the generation that follows you?

Snowden: I have actually had the opportunity to do that with one of my daughters. My advice to her, who was someone who was very anxious to go into healthcare, is that it is a fabulous place to be and will remain a fabulous place to be. My daughter chose to do neonatal care and is highly rewarded in her work. I think that our ability to step out of our own context and view the entry into healthcare from the eyes of someone coming in new without the historical biases that come from years of practice is very important to consider.

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To hear Dr. Snowden's recent podcast on "A Big Change Is Coming for Physicians," go to:
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