MACRA: Not just for Providers

HCCA

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Speaker introductions

Todd Gower is a Senior Manager in the EY Advisory Services practice and EY’s Health Lead for compliance technologies. He is also one of EY’s compliance operations subject matter resources. Todd has 17 years’ experience in healthcare leadership, focused in governance and compliance management, compliance technology enablement, finance and accounting, program management, data analytics, claims systems, and risk management. He has worked in public, commercial and academic markets. Todd is also engaged by senior management and audit committees to conduct compliance and risk assessments for their hospital, pharmacy, IT, internal audit, compliance, and finance departments. Prior to joining EY, Todd served under agency with Center for Medicare and Medicaid Services (CMS) as the Leader for Region A of the Recovery Audit Contractor Program, covering 13 states and respective hospitals in the upper northeast of the United States.

Lisa Alfieri is a Manager in the Risk Transformation – Health Compliance sector of Ernst & Young’s Advisory Services practice. Lisa’s experiences include operational process improvement, risk management and mitigation and major platform transformations for both commercial and government programs in the public and private sectors. Projects include but are not limited to Provider/Network operational readiness, Claims processing implementation, the design, development and testing of operations reporting, ICD-10 readiness and 4010 to 5010 readiness.

Lisa has her J.D., from the Massachusetts School of Law and her B.A., Political Science, The University of Rhode Island.
Agenda

- Objectives
- MACRA is challenging health systems
- Create or enhance VBC offerings
- The complexity
- Who else is concerned
- Getting ready
- FAQs

Objectives and what participants will learn

- Participants will learn:
  - MACRA, though provider focused has downstream impacts into Payers and ACO's.
  - The process to look at enhancing their relationships and contracts with providers.
  - Having the right infrastructure will be critical
MACRA is challenging health systems, forcing new discussions: MACRA’s scale looms large

As the House and Senate look at the American Health Care Act (ACA), we think the Medicare Access and CHIP Reauthorization Act (MACRA) has the potential to be equally, if not far more, transformative to our health care system in terms of improving access to high-quality and lower-cost health care.

MACRA is already shifting dialogues with health care leaders:

1. Will the government reduce payments with a new administration?
2. Are the criteria too restrictive?
3. Will the shared risk really improve care?

As it stands, MACRA will impact many Medicare stakeholders. Not just providers, but also the nearly 50 million beneficiaries, the caregivers who serve them, the medical device manufacturers, the pharmaceutical companies, and the health insurers.

The main goal is to improve the quality of care delivery across the health spectrum.

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Due to MACRA, now is the time for payers to create or enhance VBC offerings

By 2019, the most-advanced (typically higher-quality) providers will seek to partner and align commercial payers to support and offer “Other payer Advanced Alternative Payment Models (APM)” in order to maximize incentives for transitioning to Value-Based Care payment models (VBC).

- Between 2017–2019, providers will look to payers and health systems to support and collaborate to achieve MACRA’s objectives. During this time, many providers will assess which payers are best to partner with for AdvancedAPMs.
- Payers can offer clinical decision-support tools, access to data, better integrated care teams, additional CM/DM services, and share knowledge from past experience predicting risk to show value-add services and maintain/grow market position.

Operational quality data model to lookat VBC

Program Management Office support, leading practices, co-support readiness activities
Advance Alternative Payment Models (AAPM): An example of complexity of MACRA

How do eligible clinicians become a Qualifying AAPM Participant (QP)?
- They must have patients or payments through an Advanced APM (see table 1)
- QP’s will be excluded from MIPS and receive a 5% lump sum incentive bonus - (applies in 2019-2024; then QP’s receive higher fee schedule updates in 2026)

Source: CMS.gov

How do eligible clinicians (EC) become a QP?
- Determinations are made at the AAPM entity level
- CMS calculates their score and the score is compared to the QP threshold
- All ECs in the entity become QP’s for the payment year

Who else is concerned?
Accountable Care Organizations (ACOs)

“ACOs are extremely concerned about the direction the CMS is going not only in the proposed MACRA rules but also with the conflicts created by its other value-based payment programs such as bundled payment, and when you add that to how much it costs to run an ACO, there’s a significant number of ACOs ready to leave the [Medicare Shared Savings Program, MSSP] program.”

Clif Gaus, President and CEO of NAACOS, said in a public statement.
Why are ACOs concerned?

Needing to help serve their community, and there is a shortage

- ACOs participating in the Medicare Shared Savings Program (MSSP) will be allowed to:
  1. Participate in an Advanced APM
  2. Obtain 5% payment boost
  3. Other providers can participate in bundled payment models instead

- **The impact**
  - ACOs will need to show their coordination of care, such as with social service agencies. All focused to improve population health management. *Examples include:* Employing community health programs targeting chronic disease management, health care coordination, and patient education.

- **The risk**
  - With a desire to support community health systems, less than 25 percent have enough staff members available to meet behavioral health needs of their patient population. This is where cost management will be key.
  - Most ACO leaders see funding as a barrier to connecting their providers with social service programs. They feel they are in a Catch-22.

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Note:
1. Based on findings from the Robert Wood Johnson Foundation and the Premier Research Institute
2. From the novel "Catch-22" – a phrase used to describe a type of unsolvable logic puzzle sometimes called a double blind.

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Getting ready

*Infrastructure*

**Payers and provider infrastructure:**
Referring back to our article in the HFMA, payers and providers entering and renegotiating value-based contracts will likely need robust infrastructure and dashboards to track the three Ps (Patient, Procedures, Performance). This will relate to the following:

1. Patient treatments
2. Patient outcomes
3. Provider follow-up and med/treatment adherence

**Life sciences and path to influence care and cost of care:**
To support improved patient experiences, care and cost management, life science companions should consider focusing on the outcomes most important to the patient, from interactions with the pharmacy and/or medical devices.

**Research and clinical trial organizations**
Academic, private and commercial institutions should work closely with their stakeholders to determine a definition of value that they can attribute to the drug therapy or device.

*Example*:
Speed to trial on less-invasive treatments and protocols.
FAQ’s

1. Question: What effect does MACRA have on payer and provider cooperation?
   - In our discussion with clients, the various measurement criteria are similar for health plans and providers, especially in regards to the clinical quality metrics. Med Management departments will need to be more attuned to their case management reviews. The call for improved infrastructure to include dashboards for analytics and workflow will be added to capital budgets.
   - Smaller providers may not have a capital budget to allow for enhancements of their EHRs. However, payers can leverage what providers send in data (unstructured and structured) to help providers meet MACRA requirements.
   - As health plans review their provider contracts, they will work to identify high-performing providers and health systems to facilitate data sharing with each other should be part of a value-based care contract.
   - Per MACRA, health plans should also be able to help providers educate their patients on the costs of care and the treatment options. In summary, the drive for collaboration between payers and providers will be critical.
FAQ’s

2. Question: What is the impact of risk-sharing between payers and providers?
   MACRA is about managing risk in patient populations and financial risk through the reimbursement process. Our health plans clients are preparing to see how they can be able to support providers on their network.

3. Question: As a follow-up on payer and provider collaboration, what is the impact of exchanging data between the two?
   The care continuum and the exchange of data for interoperability is going to become important under MACRA. The impact can be the formation of ACOs and other ventures with payers and providers. As this is the first year, the outcomes of these ventures is too early to tell. If anything, helping improve interoperability will be a positive result.

Conclusions on getting ready for MACRA

► For non-provider groups, establish a MACRA steering committee
► Actively involve stakeholders within your organization, so that the considered processes and systems addressing MACRA are compliant
► Align to the risk management process required for MACRA
► Document and keep decision-making rationale for changing processes with providers
► Just because you are not a provider, this does not mean MACRA can not impact you
Questions and answers

► Q&A
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