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Implementing MACRA: The AMA's Keys to Advancing Opportunities, Avoiding Pitfalls

Narrator: You're listening to ReachMD, and this is Inside Medicare's New Payment System, produced in partnership with the American Medical Association. This podcast was produced before final regulations for the quality payment program created by the Medicare Access and CHIP Reauthorization Act (MACRA) were released. Visit the AMA website for the latest news and more details on Medicare's new quality payment program.

BIRNHOLZ: The Medicare Access and CHIP Reauthorization Act, or MACRA, has entered a critical phase of development as the Centers for Medicare and Medicaid Services responds to feedback from clinical stakeholders across the country. At the AMA, efforts are fully underway to update CMS, and the physician community alike, with their latest recommendations to maximize MACRA's opportunities while avoiding potential pitfalls. My guests today are here to provide updates on this organization-wide mission. This is ReachMD, and I'm Dr. Matt Birnholz. I am joined today by AMA Executives, Richard Deem and Michael Tutty. Richard Deem is the Senior Vice-President for AMAs Advocacy Group, where he directs this organization's Federal and State advocacy efforts. Michael Tutty is the group Vice-President of Professional Satisfaction and Practice Sustainability, where he manages AMAs efforts to identify, support and grow sustainable models of care delivery and payment. Gentlemen, welcome to the program.

DEEM: Hello.

TUTTY: Hello. Good to be with you, Matt.

BRINHOLZ: Great to have you both with us. So, Rich, my first question is to you. We know that the physician community strongly supported MACRA's passage, but how has MACRA proven to be a better path for patients and positions.

DEEM: Well, first it eliminated the payment formula that subjected physicians to double-digit cuts every year for over a decade. It also revamped some separate reporting requirements ... and has better aligned them and created new opportunities for physicians to receive bonuses or have a greater upside. And we are also hopeful that this will allow physicians to spend more time practicing medicine and more time focusing on patients and less time on the reporting.

BIRNHOLZ: Now, Michael, on the subject of the physicians, how would you say individual physicians are feeling about MACRA at this point, in your estimation?

TUTTY: Well, there was some research done this past summer by another organization that showed about 50% of physicians in the marketplace are unaware of MACRA. So I think there is a lot of unawareness in the physician community. We've got our job to do to make sure that physicians are aware of the new rules and offer them suggestions on how they can succeed under MACRA.

BIRNHOLZ: With respect to awareness, obviously the larger payment environment is quite aware of MACRA, but are the payers following suit to the directions of MACRA? Michael, what do you think?

TUTTY: Well, I think if you look at nationally, we are seeing a larger move to value and a lot of experimentation by the private payers, and I'm sure MACRAs implementation by Medicare will also influence the private payers to continue this exploration of the move to value. What we're seeing though is large variation by market. It's really market-specific, payer-specific, but overall we are seeing general trends to more move to value more experimentation with episode payments, bubble payments, and other basic reimbursement models.

BRINHOLZ: And Rich, coming back to you, there are obviously a number of positive aspects of MACRA. Can you illuminate some of those aspects for our listening audience?

DEEM: First, under the old reporting system, there were overlapping penalties that basically subjected physicians to a double jeopardy situation so that if you missed your quality reporting measure matrix, that would cascade and also subject you to penalties on your health information technology side. Also, what the new system does with MIPS is that it creates an opportunity for you to pick and choose from over 90 clinical practice improvement activities to meet some requirements. And these are activities that the physician may already be doing to improve practice and access for patients. Also, it moves away from a pass/fail electronic reporting system under the Meaningful Use Programs where physicians can get partial credit for some of the elements. It's not all or nothing.

BIRNHOLZ: And Michael, adding to Rich's line of thought here, how do you see MACRA's intended changes in payment impacting practices?

TUTTY: Well, last year we did a study with Rand Corporation to understand the effects of healthcare payment models on physician practice. Obviously, this was pre-passage of MACRA, but we did study practices who are moving to value. Obviously changing the payment model and incentivizing quality care at controlled costs is what these changes in payment models do. But our research shows that changing the payment model alone, while it is an important factor, is not the only factor for success in the move to value. Physicians need better information, understanding their patients and the cost of care. That information can come either come from the pair, and that information comes out of the electronic health record and population-based reports. In both cases, there's opportunity to increase the quality and time limits of that information. The second thing is there's a lot of quality metrics. Many of these payment programs have different quality metrics and as a healthcare system, we need to start to align these healthcare metrics so that physicians and the practices are measuring reasonable metrics that really measure high quality care. And finally, I think the thing we need to do is help physicians with this transition because it does mean practicing medicine differently – from a fee-for-service environment to a value-based environment where you're thinking about the population health and controlling costs, and we need to help practices with that information and resources to really understand and succeed in this transition.

BIRNHOLZ: And, Rich, coming back to you – Michael just outlined some of the needs that physicians have as this moves forward, which brings up the concept of concerns that some things might lag behind. You know, looking at the proposed rules, are there any concerns that you have about how CMS is proposing to implement MACRA?

DEEM: One of the big concerns was the timeline between when a final rule comes out sometime this fall, maybe late October, and then a start date for the program. Now there was good news – recently CMS announced a plan in which physicians can pick their pace for the reporting required under this program. One option is to simply test the program so that you would be subject to minimal reporting. You would be held harmless from any penalties. Another option would be if you wanted to report for the whole year, you might want to do that. For example, for outcomes measurements, to make sure you have a number of cases to meet your metrics. You could do that. That would be your choice. Another option would be that you could participate for part of the calendar year. Your reporting might

start later than January 1. And then a fourth option would be if you want to participate in the Advanced Alternative Payment Model program, which has a different set of requirements. This shows responsiveness from Andy Slavitt, and I think that he and his team deserve a lot of credit for trying to be flexible, trying to give everybody a fair shot at success. Now there are some other things that we want to see in a program when the final rule is issued, and understand we have a proposed rule which is just a draft. The final details come out, like I said, in mid-October. One of the things we want to see is further reduction in administrative burdens. We provided detailed comments on a number of things that could be improved to make things easier for small practices, make sure that there is fair comparisons of practices.

BIRNHOLZ: Well, if you're just joining us, this is ReachMD and I'm Dr. Matt Birnholz. I'm speaking with Richard Deem and Michael Tutty about the AMAs ongoing efforts to make the MACRA initiative a success for physicians and patients. So Rich, one emerging concern that you alluded to a little earlier is that small physician practices may be left by the wayside, or worse, penalized, specifically by the MIPS program moving forward – and you had mentioned the MIPS program. Can you tell us about the AMAs recommendations to protect these small practices from MIPS penalties?

DEEM: First, let's recognize that peer-reviewed research has found that high-value care is provided in independent, small practices and we want to preserve access to those practices for Medicare patients. What we have recommended was that number one, CMS increase low-volume threshold. This would be a threshold for exempting practices that have a low volume of Medicare patients. The threshold we proposed would be if you receive less than $30,000 in total Medicare charges or have less than 100 Medicare patients. Another way we can level the playing field here is to have good peer-to-peer comparisons, so group size does not become a determining factor in success. So let's compare the small groups to small groups, not some large, integrated system that might have advantages with respect to infrastructure and IT capabilities. Also, this was not in the proposed rule, and we are pressing hard for it to be implemented – this is something that is in the statute is it calls for virtual groups so that different small practices could link together and, therefore, possibly meet their metrics through a virtual group option. Another area is there is going to be continued need for some hardship exemptions. For example, with your electronic reporting programs, if for some reason the physician has done everything they can to meet the requirements, but the vendor, your person who supplies your electronic medical record product, they've fallen down on the job, the physician shouldn't be held accountable in that case and should receive an exemption. And we will be looking at also trying to reduce the minimum requirements for both quality and the clinical practice improvement reporting that should be further reduced for small practices.

BIRNHOLZ: Now, Rich, just to carry this forward for another minute or two, I understand that in addition what the AMA has recommended to help small practices, there are solutions that your team has suggested to CMS to help physicians in all sizes of practice succeed. Can you help summarize some of those solutions?

DEEM: One is in the quality reporting area. Currently, physicians have to report quality measures for 50% of their patients. The proposed rule proposes to take that up to 80 or 90%. We think 50% is an adequate measure. If you're doing it for 50% of your patients, that is proof of what you're doing from a quality perspective. We also have raised come concerns about the resource use measures; that these are things that are really not ready for prime time. Resource use should be based upon episodes of care, not the total cost, and some of these episodes are just recently been developed and need further testing and, therefore, we think the resource measurement should be an optional category for reporting in the early years of the program. We think that there should be fewer clinical practice improvement activities required. We think that the time involved in some of these is maybe greater than some of the proposed rules suggest, and also medical homes – if they are operating, they've been certified, for example, by a local Blue Cross/Blue Shield association, that they should be accepted in a program. They shouldn't have to spend a lot of money for a new certification to get into the Medicare program as a medical home. As I said earlier, you want to totally eliminate the sort of pass/fail approach in terms of the medical record. Clinical information is required for your electronic medical records and you should get a partial credit for what you're doing and not have a pass/fail piece to that. And then finally, as I said earlier, we were concerned about the start date, and with the recent announcement from Medicare, it looks like they are giving physicians a number of options so that we will have adequate time between when the final rule comes out and when there is reporting requirements.

BIRNHOLZ: Now, Michael, it's clear that they are – based on everything that Rich has discussed – there are many recommendations,

many solutions here to impart to physicians nationwide. What is the AMA doing specifically to help physicians and physician practices prepare for MACRA.

TUTTY: There are opportunities to get prepared, even though, as Rich said, we are still in the proposed rule and waiting on the final rule and this measurement does not go into effect until 2017, but there are opportunities for practices to understand, particularly MIPS and the components that you're going to be measured on – your quality reporting, your resource use, your advanced care information or how you're using technology, and your clinical practice improvement activities. These are the four ways that you'll be measured or a mixed program. So understanding what you're doing today in your quality metrics, are you reporting quality metrics? Do you use a qualified clinical data registry? How is your quality metrics being reported? Are you doing it? Understand that use of the work. Or your research – you can get your Medicare Quality and Research Use reports. Understand how that is being measured currently. Leverage your EHR – talk to your EHR vendor and make sure that they're tracking with appropriate clinical support tools and that your EHR is certified. And finally, look at some of the Quality Improvement Activities – there's over 90+ Quality Improvement Activities proposed that would be approved under MIPS and many of those you may already be doing. One of those programs is AMA's Steps Forward program which are activities to help improve ambulatory practice efficiency to eliminate some of those administrative burdens. All of his information is available on the AMA website. We have those checklists of activities that you can do today. And in the coming weeks, we are going to be roling out some more comprehensive educational tools that allow you to answer 10-12 questions about your practice and get some more education about how MACRA will impact your practice, and some more specific steps to get ready. But this is a long opportunity to get ready. Practices should start working on it, but there is time for practices to continue to work on these, understanding the quality reporting research use and the like, and continue to work on them over the coming years. Even though we start reporting next year, financial impact isn't for a couple of years out, but it does allow practices to really understand how they are going to be measured and start taking some steps to make sure they're ready for that in the coming year.

BIRNHOLZ: Rich, Michael just gave us a sense of, through the tools, what's coming forward in the weeks ahead, and even years ahead, but based on the advocacy work of your team and the recommendations for CMS, what changes do you expect to see in the final rule?

DEEM: One of the changes we hope to see in the final rule deals with the advanced payment models in terms of the alternative payment models. These are thing – it could be a medical home, it could be an ACO – and we think the risk threshold there in the proposed rule was way too high. We think that physician's should not be held accountable for the total cost of care, cost of care that they don't control. That should be limited to the physician revenue portion there. Physicians have to make a substantial investment to have an alternative payment model that's approved. They have to hire additional staff. They have to secure additional data analytics, and that cost is incurred well before they're going to receive any revenue from the Medicare program. So if they move it to the model that they have or the threshold they have for medical homes, we think that is a better one, which is just a physician revenue portion, and we want to see also many more options in the alternative payment model sector right now. It's medical home, some bundle payment – there are many specialties that don't see a pathway. We think this is something that needs to be expanded, create more models for all specialties to participate. These alternative pay models offer greater upside. There's a lot of value that physicians provide that extends well beyond the care provided in the four walls that are practiced. If they have savings downstream, they'll end up in reduced admissions into the emergency departments if they have lower post-acute care cost. Physicians can capture some of that savings back and we think we want to create those opportunities. Probably not as many alternative payment models in year-one participation as we would like, but we want to keep the pressure on to expand that avenue.

BIRNHOLZ: Well, with those thoughts looking ahead, I very much want to thank my guests, AMA Executives, Richard Deem and Michael Tutty. We've been talking about the AMA's ongoing efforts to ensure a successful implementation of MACRA for physicians nationwide. Rich and Michael, it was great having you on the program today.

DEEM: Thank you.

TUTTY: Thank you.

BIRNHOLZ: To access this interview, and other related content, visit reachmd.com or download the ReachMD app. I'm Dr. Matt Birnholz, as always, inviting you to be part of the knowledge.