MACRA and Care Quality Improvement

Why All the Fuss?

Let Medicare's preventative and coordinated care services lead the way

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The Age of MACRA is upon us.

Most clinical professionals will be measured against their peers in their ability to improve overall health outcomes and reduce claims for wasteful and unnecessary services, with contracted payments hinging on the results. Many of these professionals – some of whom are still unclear of the Quality Payment Programs and/or their requirements – find themselves stressed over a perceived lack of direction, skills, tools and resources to address the regulation and its measurements.

What they may not recognize, however, is the value supplied through numerous CMS-sponsored prevention, wellness and care management programs, which directly correlate to promoting interoperability, practice improvement activities, and progress in the quality of care provided to patients. These programs require minimal overhead and provide an added (and relatively important) advantage – each program follows a fee-for-service payment model, allowing doctors and their supporting clinical cast to be **paid for activities upon which they'll be graded and further incentivized.**

While the Chronic Care Management (CCM) and Annual Wellness Visit (AWV) programs lead the charge, additional preventative, behavioral health and transitional care services play a key role in easing the pains introduced by MACRA and quality improvement initiatives in general. In the sections below, we'll outline several challenges/areas of concern introduced through the regulation, and discuss the opportunities provided by these services in addressing them. We'll also review the crossover of fee-for-service programs with alternate payment models (i.e. Next Generation and Shared Savings ACO initiatives) and identify next steps in the introduction of these highly valued programs to your group's operations.

What is MACRA?

- MACRA is the Medicare Access and CHIP Reauthorization Act
- It aims to provide the public with better care, healthier people and smarter spending of Medicare dollars.
- For years, providers were reimbursed through the volume of services they provide. *(fee-for-service)*
- Gradually that model has shifted toward reimbursement for the value of services provided. *(fee-for-value)*
- MACRA is the major move to true value-based healthcare and physician reimbursement.

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Provider Challenges

Lack of Expertise and Strategic Direction

Medicare's preventative and care management services do not require advanced analytics or complex workflows. They simply require a process to:

- engage patients;
- assess their well-being;
- identify barriers to improved health (including social determinants and behavioral issues);
- develop a comprehensive and preventative personalized plan of care; and
- monitor and document progress as needed, including updates to the personalized plan.

The plan of care summarizes the patient's current health status and includes a list of goals defined through a combination of the patient/clinician engagement and standard clinical criteria (e.g. Diabetes goals should include a preferable HbA1C reading). In terms of the latter, clinical goals can be directly linked to the electronic clinical quality measures (eCQM's) defined per the Quality Payment Program and leveraged by the Merit-based Improvement Performance System (MIPS) and many other alternate payment models (including Next Generation and Shared Savings ACO models) – at least 33 eCQM's, 22 of which are defined as high priority, can be targeted through CCM and BHI participation. These goals can then be compiled in aggregate and evaluated for performance, allowing providers to easily assess which items to report, which require more attention, etc.

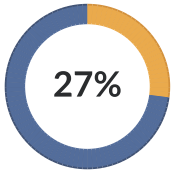
Again, no complicated analytics, no challenging operational workflows. Additionally, by implementing these procedures and documenting/sharing the information, many of the four required Practice Improvement Activity goal measurements can be achieved.

The Cost of Quality Reporting

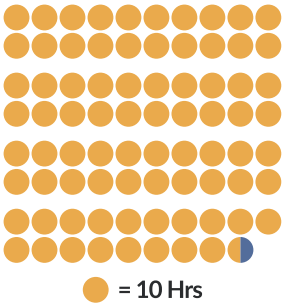
A March 2016 Health Affairs report identified that physicians spent, on average, only 27% of their work day engaged in face-to-face engagement with their patients. A significant amount of their time, approximately 785 hours per year (about 38% of the average 8-hour work day) is consumed by efforts related to clinical quality reporting requirements. Physicians need solutions that respect the limited amount of time available for direct patient interaction, while ensuring that patients receive the appropriate care services that address their clinical conditions and overall quality of life.

Practices and health systems can offset costs by directing efforts toward the administration of programs such as Chronic Care Management (CCM). This allows providers to leverage reimbursable services to directly address quality measures associated with any chronic condition, within a patient segment amounting to over two-thirds of the entire Medicare population.

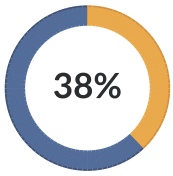
Reminder – the quality payment program introduces performance incentives that reward value and improved outcomes through payment increases. By establishing successful care management and wellness programs, **clinicians will get paid to provide the services that can result in increases to future Medicare payment amounts.** It almost sounds too good to be true, but if administered correctly, these programs can positively affect revenues on both ends of the reimbursement spectrum and allow additional dollars to be earmarked toward resources that further promote health improvements for a group/practice patient population.



Physicians Spend 27% of their work day engaged in face-to-face interaction with their patients.



Physicians spend about 785 hours per year addressing efforts related to clinical quality reporting requirements.



That's 38% of the average 8-hour work day.

Staffing

Physicians are hard-pressed for time. The hours directed toward quality reporting (as shown above) notwithstanding, an Advisory Board study observed that physicians are spending, on average, less than 30 percent of their time in the office on patient engagement. **"The value of programs like CCM are unequivocally clear – CCM improves care and in some cases it even saves lives"** states Jeff Ward, CEO of Tristan Medical, headquartered in Massachusetts and a provider of primary care services to thousands of patients in the New England area. **"Unfortunately, when combining administration, resource coordination and revenue management activities with the delivery of in-office patient care, our doctors and their staff are left with no bandwidth to take on new initiatives".**

With limited staff availability acting the part of inhibitor, it is important to note that the bulk of the services can be provided by clinical staff under the direction of the physicians, and these resources can be contracted through entities who provide qualified nursing assistants and health coaches, most if not all of whom are familiar with the issues associated with common chronic conditions. Through a combination of care coordination training activities and the workflow discussed above, physicians are supplied with additional resources to assist them in accomplishing overall quality goals and improving clinical outcomes.

The application of the CCM program at Tristan Medical delivers a case study for the successful introduction of a third-party consulting firm in providing comprehensive care management and care planning services to patients on behalf of a physician group. Recognizing the value provided through non-face-to-face care services, Tristan staff began enrolling patients into the CCM program in 2016, but quickly acknowledged the challenges in assisting their chronic population. In 2017 they partnered with CareThrough Inc., a value-based healthcare services provider and subsidiary of HealthChannels Inc., to guide their chronic care management operations. The improvements were immediately realized, and within 12 months the number of monthly CCM claims increased by over 1000% (from less than 40/month to over 400/month).

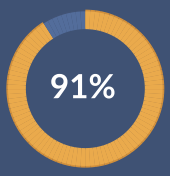
"Our successful application of the CCM program is directly attributed to our partnership with CareThrough and addition of their care team assistants to our operation. Overall patient health and quality of life is improved, and the additional revenue generated from CCM allows us to explore new programs to manage and enhance care beyond our Medicare population."

— Jeff Ward, CEO, Tristan Medical

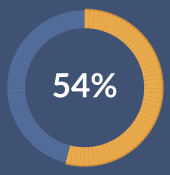
Patient Engagement

The shift to value-base payment model brings with it the seemingly continuous concern of patient adherence – many doctors stress concerns about being held accountable for behaviors that are beyond their control. The results of a 2017 care delivery survey provided to members of the NEJM Catalyst Insights Council demonstrated the following:

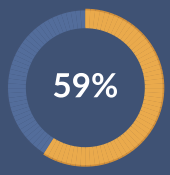
of the 555 survey respondents believe that successful patient engagement positively affects the quality of patient care



of the respondents believe that patients play the most important role in designing patient engagement into the care delivery process



of the respondents feel that patient adoption is the biggest challenge in designing patient engagement into the care delivery process, with 59% of clinician respondents acknowledging the challenge of patient adoption



In addition, through a survey conducted by PLOS ONE, 59% of providers identified patient pressure as a driver of overtreatment and the delivery of unnecessary/low-value services

The details here are not surprising – clinicians communicate the importance of patient accountability yet view it as the largest hurdle. To this, we offer the introduction of Medicare's prevention and care coordination programs in promoting the necessary behavior changes that result in improved patient activation measures.

Care Coordination and Preventative programs that are built around the patient's individual needs demonstrate that this type of engagement is a doorway to greater prevention and wellness and a reduction in excessive treatments and tests that amount to approximately $200 Billion per year – driven by a flawed generalization in that more hands-on care is better care.

Programs focus not only on the chronic medical conditions, but also the patient's quality of life, social determinants and health goals as they define them, allowing for the realization in that people aren't problems but rather have problems and play an important role in solving them. The activities that are shared and discoveries gained are numerous and accrued, and over time the patient can build a relationship with an individual who is wholly focused on his or her choices, desires and unique motivations.

It might take training, but it is something you can accomplish, and prevention and care management workflows can provide a framework for doing so. Patients engaged regularly in-between visits are said to be more engaged with their doctor and the entire care team, and an activated patient takes greater care of his or her health and works with the care team toward better health outcomes. In addition, these patients are more educated and can help in better determining which treatments are most appropriate vs. those which are unnecessary. This helps reduce utilization and assists providers in improving their Cost-based performance measures (amounting for 10% of the total MIPS score in 2018 and up to 30% of the total score in future years), while demonstrating increased customer satisfaction levels. As any good behaviorist will tell you – change behavior from within and the patient changes their behavior for a lifetime.

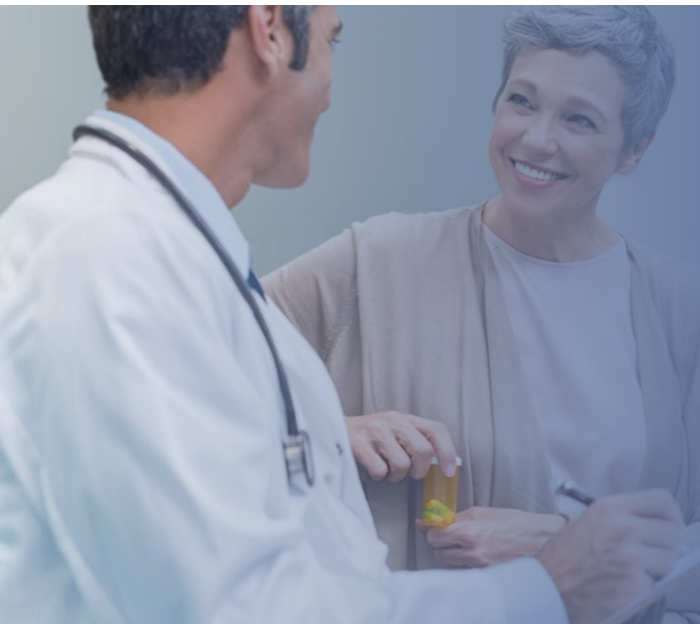
Prevention and chronic care management programs provide a viable opportunity to engage the neediest patients at times when, without regular communications, a patient might stray from treatment plans, finding themselves in the emergency room or even the hospital.

The process of successful engagement generally boils down to a few important characteristics:

Start with the patient in mind, realizing that they can't be tricked. They do know when you really care or if you have an agenda. At that moment in time no one else matters but that patient;

Focus on where that patient is right at that moment and meet the patient at that need;

Expect good results because that is what they are hoping for as well, and hope is very important! This means you must check your own disbelief at the door and put your own needs and biases aside.



"Having someone to talk to every month keeps me on track and accountable to my individual goals that I set for myself. It helps me stay on track and when I see my doctor, I am prepared to explore the ways we can work together for me to stay healthy."

— Warren, Portland Oregon

Provider Specialization

Many clinicians/groups experience challenges with care coordination operations and most believe that the introduction of fee-for-service care coordination programs and services is limited to primary care providers. While only one clinical professional is permitted, during a calendar month, to provide support and receive reimbursement for care coordination activities – particularly CCM, Behavioral Health Integration (BHI) and Transitional Care Management (TCM) – this is not restricted to one category of specialization. Many specialized (non-PCP) care providers can take advantage of an absence from program participation by a patient's PCP by providing preventative services and enrolling patients into care management and wellness programs, with focus often applied to conditions affected by their area of concentration. If the specialty practice receives consent from the patient, the specialist's involvement in care coordination activities is validated.

MetaPhy Health has focused on working with their specialist partners to manage specific chronic conditions through the available programs. MetaPhy is a premier physician services company focused on leveraging telehealth-based technology and empowering Gastroenterologists to provide better care to their patients through the provision of disease management services. They are seeing that patients with multiple chronic conditions are concentrated in the GI practice. They have been referred to the Gastroenterologist by the PCP for a reason, and most, if not all, are not offered the opportunity to engage with clinicians through the care coordination and wellness programs.

By focusing on specific chronic conditions which include and/or stem from GI-related issues, their people, processes and platforms are designed to provide services that are, according to Chris Oubre, President and Chief Operating Officer at MetaPhy, **"two inches wide and two miles deep" as opposed to "two miles wide and two inches deep".**

"The typical 'bricks and mortar' environment doesn't lend itself well to the types and frequency of touch points needed to manage these conditions for these patients. Telehealth technology and CCM services allow us to manage and monitor these patients outside the walls of the physician practice. We are excited to be a part of a fairly unique situation in healthcare where everyone wins. As we continue to execute on our plan we are seeing that physicians can better manage their patients, patients have an exceptional experience and feel better, and payors save money through the reduction in hospitalizations and improved clinical outcomes."

— Chris Oubre, President and COO at MetaPhy

Participation in Alternate Payment Models

While physicians enrolled in a Comprehensive Primary Care Plus (CPC+) program are not eligible to take part in certain fee-for-service care coordination programs and services (such as CCM) to their attributed population, physicians who participate in Accountable Care Organizations – Shared Savings or NextGen ACO models – take on no restrictions in providing these services. In fact, a survey of healthcare providers found that practices/groups participating in ACOs have introduced a CCM program (46%) more often than those independent practices (41%). The results from program participation have been positive.

National ACO, with offices in Beverly Hills, CA and Nashville, TN, quickly realized the benefits of these Medicare programs in addressing the quality performance benchmarks required for shared savings eligibility. They have recently required the establishment of a CCM program for each of their 400+ contracted provider groups, with formally defined (per patient) goal measurements for both program enrollment and clinical staff time and will soon expand their care coordination and wellness operations to include additional Medicare programs including BHI, AWV and TCM.

The results thus far have been positive – program enrollment and CCM claims submission increase each month, and most importantly, overall patient quality is improved. Table 1 below outlines achievement of several eCQM-based goals by CCM-enrolled vs. non-CCM-enrolled patients:

Measure	Goal Achievement (CCM vs. non-CCM)
Depression Remission at 12 months	**27.7% greater**
Screening for Depression and Follow Up	**17.56% greater**
Screening for Future Fall Risk	**14.3% greater**
Colorectal Cancer Screening	**11.4% greater**
Pneumococcal Vaccination	**9.38% greater**
Breast Cancer Screening	**7.27% greater**
Influenza Immunization	**5.21% greater**
Controlling High Blood Pressure	**3.2% greater**

The metrics above indicate the success of the programs in improving care quality. Sabrina Martin, Director of Provider Network Management at National ACO, states the following: **"Since starting the Chronic Care Management program, we have made many positive impacts. We have increased our quality measure scores and reduced hospital readmits, resulting in a decrease in overall spend. Our providers are much more engaged with their patients overall care team. Through the CCM calls we have found that patients are more likely to be open and honest about social deterrents and their ability to get needed resources. Many times we are the only call these patients receive that day. We build a trusting relationship and can provide feedback to providers on new issues or much needed resource challenges these patients maybe facing."**

As the introduction and rollout of programs expands, and patient engagement levels increase, quality goal and outcome achievement will continue to improve collectively.

Call to Action

From process improvements to increased revenues to – most importantly – improved health and wellness of patients, there are many incentives provided through the care management, prevention and wellness programs. As demonstrated above, these incentives are opposed by minimal (and avoidable) resistance in the form of "barriers to entry" and are further complimented by helping providers address requirements defined in the MIPS/APM Quality, Improvement and Promoting Interoperability (formerly titled Advancing Care Information) categories, with successful performance contributing to even more revenue for regulated providers/organizations.

If you have not considered the introduction of these invaluable programs to your organization, there are numerous resources within the healthcare community to help you create a vision and define a strategy for their implementation. Moreover, there are many experienced clinical support groups and technology vendors that provide the necessary tools and resources that minimize overhead, shorten production lead time, and maximize both revenue and clinical-based outcomes.

About The Authors

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Earl Hutz is a senior healthcare IT executive and value-based healthcare advocate, with 20+ years of Care Management Operations experience, including 15+ years leading Software Development, Product Management and Professional Services teams. He is currently the Chief Operating Officer for ThoroughCare, Inc., a leading provider of cloud-hosted software solutions supporting numerous Medicare care coordination, care management, wellness and prevention programs.

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Virginia Burchett is a healthcare professional with a proven ability to build relationships through collaboration and partnerships within and outside of the healthcare industry. With over 25 years of experience working for Kaiser Permanente, she has a deep knowledge of managed healthcare centered around value-based care and shared risk programs with expertise in the areas of patient engagement and behavior change. She currently holds multiple roles, including CEO of Eiger Healthcare, Inc., a global healthcare technology and implementation company based out of Washington DC, founder/CEO of VBurchett Consulting, a healthcare consulting firm, and strategic partner and healthcare implementation lead with multiple technology and consultant firms.

ThoroughCare

About ThoroughCare, Inc.

ThoroughCare presents healthcare providers and accountable care organizations with software solutions that simplify staff workflow, increase provider revenue, support healthier outcomes and assist with the transition to the value-based model of care.

Our platform includes capabilities that support numerous Medicare preventative and care coordination programs such as Chronic Care Management, Behavioral Health Intervention, Annual Wellness Visits, Screening and Counseling Services and Transitional Care Management, along with support for Medical Home-based care delivery models including Comprehensive Primary Care Plus.

Our features are designed with clinicians in mind and driven by our passion to improve the quality of life for every person we can. For more information, visit us at www.thoroughcare.net

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