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MA Plans Consider Contracting, Quality As MACRA Lays Value-Based Framework

CMS in a recent final rule implementing the provider payment portion of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) unveiled a "pick-your-own-pace" approach for Medicare fee-for-service (FFS) providers that will be subject to new reporting requirements and performance measurement starting next year. Yet despite some new flexibilities contained in the final rule, which was released on Oct. 14 and is slated for publication in the Federal Register on Nov. 4, stakeholders agree that the Quality Payment Program will accelerate the move toward risk-based contracting in Medicare Advantage and beyond. And organizations that must work with providers to achieve their own quality metrics are seeking ways to support their contracted providers as they face new performance measures, according to industry observers.

Introduced in a May 9 proposed rule, the Quality Payment Program replaces the Sustainable Growth Rate model used to pay FFS physicians and allows them to seek reimbursement through one of two paths: (1) the Merit-based Incentive Payment System (MIPS), which consolidates three Medicare physician reporting programs, requires reporting of measures in four performance categories and includes bonuses and penalties depending on performance; or (2) the Advanced Alternative Payment Model (APM), which applies to provider organizations that accept significant downside risk through specific models (e.g., Track 2 or Track 3 of the Medicare Shared Savings Program), includes an automatic 5% bonus and exempts clinicians from the extensive MIPS reporting requirements (MAN 6/16/16, p. 1).

While CMS in the final rule retained the Jan. 1, 2017, implementation date, it included several reporting options for the first "transition year" to help physicians avoid negative payment adjustments and excluded some smaller practices from MIPS. Moreover, since the majority of Accountable Care Organizations in the Medicare Shared Savings Program are Track 1 and therefore do not accept downside risk and would be subject to MIPS, CMS said it is developing a new ACO Track 1+ model with lower levels of risk that would still qualify as an Advanced APM. CMS now estimates that 25% of eligible Medicare clinicians could be in an Advanced APM by the second year of the program.

"We are at a tipping point in both how physicians/providers and payers' systems really deal with quality delivery but also how it gets reimbursed," observes Patrick James, M.D., chief clinical officer, health plans and policy and medical affairs at Quest Diagnostics. "By broadening the opportunities to participate, it's just going to accelerate getting physicians in those APMs and ultimately the transition to value-based reimbursement, opening up more opportunities for risk-based contracting in Medicare Advantage and elsewhere."

Given this great shift to value-based reimbursement, MA plans currently have two main goals: (1) ensure that their star ratings strategies support the performance measures physicians will be tracking through MIPS and (2) ensure that their value-based contracting strategies align with the APM their contracted physicians may choose, explains Andrew Davis, vice president and general manager for Medica, a Minnesota-based not-for-profit insurer with MA membership in several states.

With the star quality ratings program, MA plans are "focused on incenting and rewarding and collaborating with providers to improve those results," remarks Davis. But with MIPS bringing in a whole new set of measures for providers, "stars needs to fit into the context of MIPS. So how do you attempt to over the next three to four to five years align the goals and objectives you have for your MA products and performance through the providers along the same lines of what they're going to be doing to reward their performance for Medicare fee-for-service?"

Shift to Value Will Depend on Market

Moreover, meeting those goals and ensuring the overall success of MACRA will be largely dependent on an insurer's service area, their MA product strategy and the providers in that mix, suggests Davis. "For example, in Minneapolis, we have what may be a disproportionate share of large systems that are participating in a number of the [Center for Medicare & Medicaid Innovation] demos — Pioneer ACOs, Next Generation ACOs, etc. — and we have a lot of the care being provided through these large, integrated systems," he explains. "So we've got high APM alignment, but every market is going to be slightly different around what the provider mix is, MIPS vs. APMs, and where your MA product focus is going to be. This is not going to be a one-size-fits-all approach."

However, physician readiness is a major issue as the transition year approaches, say Davis and James. And Medica is still in the "front-end phase of assessment" when it comes to figuring out how it can support providers, identifying gaps in their technology infrastructure and leveraging the diversity of contracting that it has with various providers.

"For example, how are you going to have the right level of data and analytics to track patient flow, predict risk, [and] assess where you should be putting energies in terms of the risk stratification of your patient population? Clearly that is going to be a whole area of opportunity, particularly on the APM front," suggests Davis. "Everyone has to enable the success around this, and health plans and technology companies can get in a position to support physicians to really get to this new paradigm."

Medica's technology partner, HealthEdge, for example, provides a core administration system that features "dynamic" claims processing — and it's that "range and flexibility" in the adjudication and reimbursement that will be an advantage to providers using the system, he adds.

Speaking first-hand from his time spent working in the field and as medical director of hospital integration for Health Midwest (now HCA Midwest Health), a 14-hospital integrated delivery system in the greater Kansas City area, James points out that "physicians are not typically trained in risk, and documentation often is variable within the practice." New systems such as those established in the Quality Payment Program will require better tools to manage risk, including actionable data at the point of care, he suggests to MAN.

Physicians Need Quality Measure Support

He points to a study released in July by Quest and technology company Inovalon, Inc. in which 74% of hospital-affiliated primary care physicians and health plan executives indicated that quality measures are too complex, making it difficult for physicians to achieve them. And while three-quarters of all respondents agreed that quality measures are useful in improving care quality, only half said that those set under value-based care models are top of mind when physicians meet with patients. Separating that finding out by health plans and physicians, however, the former measured slightly higher at 59% vs. 46% for physicians, suggesting that health plan executives may be unaware of the true complexity at the point of care, observed Quest.

Moreover, 79% of all respondents agreed that physicians do not know the quality metrics that apply to individual patients. And 64% of physicians and health plan executives said that physicians do not have the tools needed to succeed in a value-based system.

Through the Data Diagnostics tool launched a year ago by Quest and Inovalon, physicians can order member-specific data analyses at the point of care that are partially designed to help them stay on top of quality metrics, adds James. The report, which physicians can order through their existing workflow, utilizes all available patient data to determine quality programs for which a patient qualifies (e.g., HEDIS, star ratings, the exchange marketplace Quality Rating System) and to analyze the patient's current status as it relates to each measure set. For example, that report may show when an MA beneficiary with diabetes requires an eye exam, kidney disease monitoring and/or blood sugar control to comply with certain CMS star ratings measures.