CMS Okays MACRA Flexibility: Standstill or Startup for Providers?

written by Theresa Hush | September 14, 2016

With the CMS announcement last week that the final MACRA Rules will let providers pick and choose activities—or even delay requirements—2017 implementation is now a toss-up. Will providers double down on efforts to meet the MACRA standards in 2018? Or, will eased deadline pressure reverse momentum within health care systems?

There are many valid reasons why the lead-time decision is important. MACRA represents one of the biggest overhauls of the Medicare reimbursement program, and many of the elements have not been fleshed out. Releasing final rules one month in advance of their going into effect surely makes it difficult for even the most advanced providers to prioritize their efforts.

On the other hand, MACRA streamlines and extends existing PQRS, Meaningful Use and Value Modifier programs, and those programs will expire at the end of 2016. MACRA is bigger and has more requirements, but it is not really new. Pick Your Pace seems more a step back than a standstill. How Medicare will control the program's budget under the flexible start scenario is, at best, questionable.

Can Change Without a Crisis Happen in Health Care?

The issue for providers who have been working to develop their quality and cost efforts in keeping with MACRA is how to *maintain* forward momentum. The issue for those who were facing bleak MACRA results, because they have not participated in PQRS or paid attention to performance, is how to *create* that forward momentum. The task is essentially the same.

People hate Change (capitalized to underscore the level of associated fear and hatred)! Maybe because I like a challenge, I've devoted my career to engineering Change and have developed a bucket of Change tools and tactics. Among them, Time is a crucial element. This includes using deadlines, scheduling and external time pressures to create urgency for forward momentum. It's a magic ingredient.

Time as a key driver of MACRA developments has just been sidelined under Pick Your Pace. Parkinson's Law that "work expands so as to fill the time available for its completion" is now in play: committee formation, consultations and heavy analysis of alternatives may look like action, but often serve as delay tactics. The end result is typically a watered-down compromise—instead of a strong effort, the outcome is a pilot or a smaller program that involves fewer people or less Change.

Does a Culture Shift for Health Care Change Already Exist?

Many claim that current Value-Based Health Care efforts by Medicare and commercial health plans have already seeded Change toward performance measurement and improvement. And there are organizations, our best clients, who are talking about or pursuing robust programs.

But in our daily work we also see too many signs that there is no sea change underway; rather, a health-system-by-health-system effort that is dependent upon each organization's leadership and commitment.

A few all-too-common examples:

- Many provider PQRS efforts fall under "compliance" or financial functions. We rarely find clinical leadership involved; it's even rarer to find those focused on performance rather than reporting.
- Physicians almost never get to review their own performance under PQRS, nor do they see performance results. This is delegated to staff because the organization is, again, focused on compliance and not on improvement.
- Population health in most organizations is limited to patient outreach, filling patient "gaps" and getting better patient compliance.
- Few health care organizations coordinate their Quality Resource and Use Reports (QRURs)—the foundation of the CMS Value Modifier penalty/incentives—with their performance measurement or PQRS programs. Many don't even download them or conduct a leadership review of the reports.

There are good reasons for all of these situations, as well as resource restrictions. But when they all co-exist within a health care system, it is likely that the organization has yet to find the

path toward substantial performance improvement. Why? The common factor in all of these examples: physicians and other point of care providers are not engaged.

Making the Most of Pick Your Pace

For 2017 to be a year of advancement rather than standstill or stepping back, the goal must be significant progress toward meeting MACRA requirements. And there's only one way to do that: practice. Talk does not cut it, nor does big data or technology alone provide success. Creating initiatives and interventions, testing results across the organization—these are the necessary steps for performance improvement to take root. This iterative process also creates the fuel for doing more because achieving positive outcomes is inspiring.

Only providers can actually accomplish lower costs and better risk-adjusted quality scores. Administrators play the supporting roles. The best way to achieve high MACRA scores is to focus on tactics that will energize and inspire providers to be involved.

This brings me to the second tactic in my bucket of essential Change tools: promoting Alliance and Affiliation to power interest and commitment for proceeding with MACRA.

One of the clear disadvantages of Health Care's analytics obsession is that it is a negative and uninspiring tactic to promote Change. Handing physicians their scores and expecting them to fix them has had, at best, short-lived advantages—and a load of negatives. Being scored is not fun, as any provider will be certain to tell you. Scoring is perceived as a top-down initiative, not collaborative. And, scoring is often wrong because data are neither perfect nor comprehensive.

What's the best approach to the new MACRA timeframe? Continue your investment in PQRS and Meaningful Use by meeting the requirements for the similar programs under MACRA. Then focus on developing Clinical Performance Improvement Activities (CPIA). Work collegially with providers in groups, departments and specialties to design innovative and collaborative interventions. By so doing, you may find the new MACRA flexibility will provide both the timeframe and the conditions for real Change.

The added time to prepare for MACRA scoring could be squandered, or it could be used to create innovation and dialogue with providers. For example, measuring patient services and outcomes, and scolding or penalizing providers for doing badly, doesn't give a health system—or the provider—positive direction. There are alternatives to the negative approach, and each could qualify as a CPIA under MACRA, depending on final CMS standards:

> Populate limited-patient registries and collaborate with providers to investigate/explain *why* certain high-performing patients succeeded, or *why* poorly performing patients did

not. Sharing information about interventions and determining what obstacles exist for the providers or the patients could be transformative.
Help solidify the information going to primary care physicians and referred specialists by measuring and rewarding the feedback, as a coordination of care initiative.
Support a coordinated curriculum of group education for patients with certain conditions among several practices, with physician agreement on the curriculum. The effort could not only test the effects of social learning, but also lead to collaboration among physicians on experiments with interventions. By bringing physicians along in groups or teams, as opposed to directing activities centrally, you may find less defensiveness and much appreciation for the support.

For 2017, Time and Affiliation can work together to guide providers' transition from the old CMS programs to innovative and dynamic activities to improve outcomes and performance. This Change may actually be exciting.

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