3 Ways Proposed MACRA Rules Revive Health Systems' Clinical Integration Programs

written by Theresa Hush | May 18, 2016

Clinical Integration in medium to large Health Systems just received a nice push from the federal government's Proposed Rules for MACRA. Health Systems trying to market quality-based physician and hospital networks systems— especially those with both employed and private physicians—should take note.

This opportunity for Health Systems to bridge Medicare and private health plan quality is one of the best features of MACRA. Why? Look at this triple play of provisions woven through both MIPS and APMs:

> "Other-Payer" Advanced APMs will be allowed in the program's third year to meet Advanced APM status by participating in both Health Plan and Medicare ACOs, thereby having the potential to exempt their providers from MIPS reporting;
> QCDRs, Registries and EHRs must report quality measurement for all patients eligible for quality measures, not just Medicare patients;
> CMS is seeking to align measurement with private health plans and aiming to create uniform measures that will be used by both Medicare and private insurers.

MACRA represent a significant shift in federal thinking about the benefit of collaboration among providers—considering that until recently, Health Systems had to pass Federal Trade Commission (FTC) muster, or be subject to FTC Action. "Clinical Integration," by which I mean the efforts to create networks inclusive of private and employed providers to contract with Health Plans, needed to navigate this safely.

By creating the possibility for integrating private and public rules of engagement in Value-Based Health Care, CMS is creating a path for providers to focus on performance improvement rather than one-off reporting efforts. This will lighten the reporting load on providers as well as Health Systems, while also creating the foundation for consistency and broader application of quality and efficiency efforts across the Health System at large. The effect: reduced perspective emphasis on "compliance" and greater focus on "performance improvement" in Health Systems' activities.

Health Systems, however, may not be so convinced that the complex Rule can be helpful, as it pushes them harder toward risk through heavy financial incentives. Likewise, skeptical providers feel pummeled by the constant evolvement and changing regulations that force them to change more quickly than they often can. But let's take a look backwards to understand how things just might turn out well.

MACRA Corrects the Off-Course of Clinical Integration

Hospital-based systems, PHOs and physician organizations once pursued Clinical Integration to preempt FTC anti-trust action stemming from their Health Plans contracting for networks of competing providers. The FTC rulings created a strict interpretation of what Clinical Integration programs needed to do. The programs had varying degrees of success in engaging Health Plan contracts—and their own providers. With uncertain interest from Health Plans and unpredictable revenues, the programs were expensive and difficult to launch.

Two events changed history. First, the Affordable Care Act (ACA) and ACOs fostered Health System activity, promising solid enough revenue to attract providers into ACO models. The ACOs helped structure the rules of the game and clarify performance measurement.

Second, with the potential for capturing market share, Health Systems began purchasing physician practices and consolidating, while simultaneously implementing EMRs. This reduced the burden of collecting information for performance measurement. Health Plans also saw the opportunity to play in the Medicare ACO arena. By contributing infrastructure and financing, they reduced the risk to Health Systems for starting Medicare ACOs. The arrangement was often extended to the Health Plan's commercial business. The attitude of Health Plans thus also shifted, from being antagonistic to provider networks' efforts to expand networks for

contracting purposes, to cooperative and even solicitous.

The prior Clinical Integration experiments taught us several important lessons about how performance measurement programs work—or don't. One is that physicians do not naturally engage in process measures and will assign staff to manage them. The early programs made mistakes because they were trying to meet perceived FTC-based rulings that emphasized the application of measures to every provider. By so doing, Clinical Integration established itself as a scoring mechanism within Health Systems, thereby often thwarting provider interest and defining the end goal as compliance with measures. Performance improvement and outcomes made little headway.

Second, providers often participated in Clinical Integration programs because they had to, in order to participate in Health Plan contracting. That can hardly be called a successful move toward better value and outcomes, because the providers were not engaged. It is easy to see why early ACO efforts have had such difficulty in reaching savings targets—providers are still lacking the tools and the feedback necessary to go further.

A Better Roadmap for Clinical Integration Under MIPS and APMs

Health Systems will need to become comfortable enough with the Proposed Rules to see beyond all the formulas and requirements. It's easy to lose track of public policy themes in 962 pages. However, at its most basic level, the Proposed MACRA Rules are founded on three key principles:

> Providers will be induced to accept risk to give better care at lower cost, whether by threat of lost revenue under MIPS or by participation in a risk-based organization;
> The key to performing in all efforts is through performance measurement that is then addressed through Clinical Performance Improvement Activities (CPIA), across all patients;
> There are no barriers to creating initiatives across employed-plus-private networks of providers, and, in fact, this integrated approach will be encouraged by CMS.

CMS also has offered some key solutions that incorporate these principles; among the most powerful is the expansion of the Qualified Clinical Data Registry (QCDR). CMS has created the opportunity for QCDR involvement in all MIPS scoring categories and for assisting APMs as well, through performance measurement, population health and performance improvement, and research capabilities. This opens the door for a Clinical Integration program that is facilitated by a QCDR—an excellent way to establish and harmonize the elements of an all-payer quality program, because the QCDR likely has experience in some or all of the key critical areas:

Collection of data from provider EMRs and source systems, plus integration with hospital and other data;
Robust and validated performance measurement capabilities, with experienced CMS reporting;
Population health and performance improvement focused on patient populations and improving outcomes over time, rather than process measures;
Research capabilities to conduct experiments in determining effectiveness of interventions, treatment plans and other performance improvement actions.

Sometimes opportunity lies in the most hidden places. Clinical Integration is no exception. Under the Proposed MACRA Rules, "Clinical Integration" programs, freed of the FTC constraints, can create the private/employed-provider network collaborative to successfully participate in Medicare and commercial plans of value-based purchasing. For Health Systems that want to survive in the newly competitive Value-Based Health Care environment, now is the time to seize the opportunity to re-engineer Clinical Integration.

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