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On Healthcare

MACRA, MIPS, AND MORE

Announcer: Welcome to Navigant On Healthcare, offering insights for healthcare leaders striving for success in an evolving industry.

Host: Welcome to Navigant On Healthcare. I'm your host Alven Weil. Today, we are joined by Chris Stanley M.D., a director in Navigant's healthcare practice with more than 25 years of health system and payer executive leadership experience. Dr. Stanley most recently served as system VP of population health for Catholic Health Initiatives, where he successfully led pop health efforts for more than 100 hospitals across 17 states. This included one of the country's largest health system-based Medicare bundled payment initiatives. Medicare shared savings program, Medicaid and commercial payer participation across 10 ACOs, serving as chief medical officer for CHI's employee benefit plan (to include management of a seven state, clinically-integrated network), and initiating MACRA education and participation among 10,000 physicians.

If that isn't enough, Dr. Stanley is a trained pediatrician, retired U.S. Army major, and he recently completed the Boulder, Colorado, Half Ironman. And now, for those of you keeping score at home, that's a 1.2-mile swim, followed by a 56-mile bike ride, topped off with a 13-mile run. And all that at a very high altitude.

Dr. Stanley, clearly, we are not worthy, but thank you for joining us today.

Chris Stanley, M.D.: Thanks very much, Alven. Really appreciate it. Look forward to connecting today.

Host: Let's start with a question I'm sure everyone will want the answer to: Which was the hardest, the run, the swim, or the bike?

Dr. Stanley: All of them are a bit challenging, especially for me because I have only fairly recently gotten into triathlons. But for me, the swim is the toughest. It's basically an absolute sport, you're either sinking or you're swimming. Bike and run you can always stop if you need to, but swim is all or none. So, that probably my most challenging part.

SPEAKER

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Host: Well, speaking of challenges, on to an equally as challenging topic, I think for many: MACRA. What's the latest from MACRA implementation timeline standpoint and general information about the rules, requirements, regulations for MACRA?

Dr. Stanley: First of all, we're currently in the first performance year of MACRA for both the MIPS, as well as the alternative payment model tracks. This is a reminder for folks, is going to affect Medicare payment rates for physicians in 2020. Actually, it's going to affect hundreds of thousands of physicians with their payment rates in a couple of years from now.

Many may know that there was a proposed role released several months ago that would apply for 2018, and beyond. Relatively minor aspects of the law that would be shifted or changed, and I'll probably highlight a little about those in just a moment, but it is really important to know that the law is still in effect. In fact, as of just a few days ago, October 1st, physicians, if they are on the MIPS track or the merit-based performance approach, they have to actually start collecting data for the fourth quarter starting October 1st, in order to avoid a penalty in 2020. So again, the implementation timeline is progressing for this year. We are in the current performance year and there's going to be some modifications and changes, quite likely, for 2019, affecting payment year 2021.

Host: So, I think we've also learned that there's a fair amount of uncertainty around MACRA. In your opinion, what are some of the unanticipated, or poorly understood, implications of MACRA for providers that you believe are essential to their understanding as soon as possible?

Dr. Stanley: Sure. I think there are a few things that pop to mind for that, Alven. First is, many providers still believe that -- with all of the uncertainty coming out of Washington D.C., the administration and Congress, until potentially fairly recently, the uncertainty for whether the Affordable Care Act was going to be maintained -- they were hoping that MACRA would either be stalled, would go away...in some situations some providers even believed that MACRA was directly tied to the Affordable Care Act, so if the Affordable Care Act was modified, then MACRA would go away. That, by the way, is absolutely false. The two of them are not directly linked, especially in law. So MACRA is definitely continuing.

The other uncertainty, to a degree anyway, that's coming out of Washington, D.C., at this point, is what will be the modifications or the changes to the program such that, for example, where mandatory bundled payments coming out of, at the time, Secretary Price's, leadership has been suggesting that mandatory bundles or mandatory alternative payment models would be going away. Some read the tea leaves, meaning that they felt that value-based programs overall were going to be going away, at least being driven out of CMS or health and human services. Our reading of the tea leaves, my reading of the tea leaves, is that's not correct. We believe that value-based programs are sizable, significant, in the marketplace right now, both in the Medicare, as well as Medicaid and commercial space. But we also believe they're going to grow in size, grow in number, and importance. We just believe that the shift from mandatory programs to voluntary programs is an important and a welcome shift for most providers, and therefore, there's more opportunity for innovation and for working with payers and others from the physicians' side to drive change.

So again, just to reinforce that, we don't believe that value-based programs are going to go away, we don't believe that MACRA at all is going to go away. How they're designed, how they're driven, and how they're implemented, though, is going to be much more of a free market type of an approach under this administration, as opposed to being driven out of Washington D.C.

Host: Dr. Stanley, obviously your time at CHI you were heavily involved with educating a large amount of physicians on MACRA. And, based on that experience, how can household executives engage and educate physicians, whether employed or affiliated, about the law?

Dr. Stanley: Sure, great question. And first I would say, there's no simple or easy answer for this, Alven. It is important for everyone to realize that physicians are really, primarily focused on providing excellent patient care for their patients and their community and that administrative and business programs, such as MACRA, are really not what is at the top of their mind. So, they really, overall, need things to be as simplified, tailored, and personalized as possible for them.

So, what we tried to do at CHI was a few different tactics. One was that we provided basic education, if you will, a MACRA 101, for all of our physicians. Why did they need to know about it, and how did it directly impact them and impact their patients? Number two is we tried to tailor it for their specific situation. So, in many of our markets, as you mentioned before, we had accountable care organizations. If you, as a physician, are part of an ACO, you don't have to worry about submission of data, or any other key decisions, because the ACO takes care of all of that for you. Again, we tried to tailor it in that way. Lastly, is we tried to personalize it for providers, such that if they were on the MIPS track and they did need to submit their own clinical, quality, and other type of data, performance improvement data, because they were part of MIPS, and not part of an ACO, then we tried to provide them with educational sessions, webinars, onsite meetings, PowerPoint decks, that could be passed around and distributed frequently through some physician champion, either in the physician group, or through the hospital, that would allow a primary care physician, versus a cardiologist, versus an ophthalmologist, to understand what their decisions were, what data or information they would need to submit and how it would be different than other physicians. So again, we tried to personalize it for their specifi,c specialty type.

I would lastly mention that programs as complex and as multi-year and changing over years as MACRA, there's not a single point in time where you say, "Okay now a provider or other individual is educated." We really saw this as a campaign and really part of a larger push to value initiative that all of our markets were working toward. So, we also tried to make sure that MACRA wasn't seen as a standalone governmental program, but rather, a fundamental shift and move from volume to value, and that MACRA was just a program to help administer and help for individuals to focus on.

Host: And, finally, Dr. Stanley, here's one that's kind of out of left field for you, but interested in learning more; healthcare and the military are among the country's top expenditures. Now, as a former officer, is there a lesson healthcare leaders can learn from the Armed Forces on aspects of efficiency, cost, or other topic areas?

Dr. Stanley: That's an interesting question, Alven, I'll admit I've never been asked that before. So, what pops to mind are couple of things for me. First is, I'm actually a leader in population health because of my time in the military. When I was in the military I learned from the very beginning, during my training as a pediatrician, and during my time as a physician, that health is more than healthcare. Healthcare I define as taking care of sickness, illness, or conditions. Health is really how the individual feels about their health and well-being, which includes physical health, mental health, financial, social health, connectedness to the community. So, the military was very focused on health, not just healthcare. And especially we were very focused on maintaining the health of our soldiers, in order to allow them to focus on their mission. And, in fact, one of the elements within that is, if their families back home, or otherwise, in a deployment over in Europe, for example, if their families were not healthy, then the soldiers were not able to focus on their mission. So, we were all about community.

In fact, I did not need to see more patients, or do more things, do more procedures, in order to get paid. I was on salary. And I've really sort of brought all these core principles and these core beliefs to all of my roles since that time, as pediatrician and other clinical leadership.

Secondly, the military taught me the importance of being very focused, being solution oriented, but also being flexible and ready to modify or shift or change if and when one was not able to get the results that they were striving for. There's a German military strategist, one time, who said that, "No battle plan survives contact with the enemy." Meaning, that you can make a great plan on paper, you as a hospital system can develop a great strategic plan, but as soon as you start to implement you realize that the decisions that were made or the competitive market that you need to be…make modifications.

So, I'm always looking for ways to improve, ways to tweak, ways to modify, because as one encounters, in the military, the enemy, or in the civilian world, encounters the open market, the best plans don't always play out the way that you think that they will. And that's what, frankly, I love about both my clinical and my business roles, is identifying those areas of weakness and improvement and working collaboratively with others in order to improve. So that's a couple of the things that I've brought away from both my healthcare and my military time.

Host: Outstanding. Thank you so much, Dr. Stanley, for your time today.

Announcer: That concludes today's episode. Be sure to check in with us for future installments of the Navigant On Healthcare podcast series on Navigant.com/healthcare podcast. Navigant On Healthcare is a podcast series produced by Navigant's healthcare practice. If you enjoyed this episode, please share with friends and colleagues on social media. Learn more at Navigant.com.