Frequently Asked Questions (FAQs)

What is a Clinically Integrated Network?

A Clinically Integrated Network (CIN) is a group of independent and employed physicians who have joined together to develop active, ongoing clinical initiatives that are designed to control costs and improve the quality of health care services. A properly developed and implemented CIN allows physicians from different organizations to collectively negotiate value-based contracts with health plans and employers without violating antitrust laws.

What is the Medicare Shared Savings Program (MSSP)?

The Medicare Shared Savings Program is a model established by CMS to allow groups of providers to share in savings generated by reducing costs for their attributed patients below their benchmark costs. McLeod Healthcare Network is applying to be in Track 1 of the MSSP which is an "upside only" model and will not assume any downside risk. Participating in an MSSP provides significant visibility into patient utilization patterns through detailed Medicare claims data as well as provides limited legal waivers for Stark Law, Anti-Kickback Statute and the Civil Monetary Penalty which facilitate joint investments in infrastructure.

What is the difference between a CIN and MSSP?

While some people use CIN and MSSP interchangeably, it may be helpful to think of the CIN as the overall physician-led, quality-focused organization that will ultimately pursue value-based with third party payers – such as Blue Cross and self-insured employers – for enhanced reimbursement. Think of the MSSP as the CIN's initial value-based contract with Medicare. The CIN provides the basis for success in the MSSP contract (infrastructure and staff) and will include a more robust and comprehensive quality program than what is required for the MSSP.

What is MACRA?

MACRA stands for the Medicare Access and CHIP Re-Authorization Act which is bipartisan legislation that was signed into law in April 2015. It repealed the Sustainable Growth Rate (SGR) and dramatically changes how Medicare will pay providers:

1. It locks provider payment rates at near zero growth.
2. It placed all provider groups onto one of two new payment tracks– the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APM). Starting in 2019, Medicare payment adjustments to clinicians each year will depend on which track the clinician's medical group falls into.

What are the key differences between the MIPS and Advanced APM tracks of MACRA?

Advanced Alternative Payment Models (APM):

- As a reward for participating in payment models with significant downside risk, providers on this track will earn a 5% payment bump on their Medicare physician fee schedule revenue from 2019-2024. They will also be exempt from MIPS reporting requirements.

Merit-Based Incentive Payment System (MIPS):

- Under MIPS, Medicare has consolidated and expanded three pay-for-performance programs—Meaningful Use, the Value-Based Payment Modifier, and the Physician Quality Reporting System (PQRS) — into a single revenue-neutral program (taking money from low performers and giving it to high performers). Under this program, CMS will score providers on their performance in four categories: Quality, Cost, Improvement Activities, and Advancing Care Information (IT). Starting in 2019 (based on performance this year, 2017), providers will face a range of payment adjustments, starting with potential penalties of -4% and bonuses as high as 12%. These penalties and bonuses will grow to payment reductions as much as -9% and increases of up to 27% after the first few years of the program.

If I participate in McLeod Healthcare Network, which track will I fall under for MACRA?

McLeod Healthcare Network is applying for Track 1 of the MSSP which is considered an APM, but not an Advanced APM because we are not taking on downside risk. While we won't earn the 5% Advanced APM bonus, we will qualify for favorable scoring within the MIPS track through the "APM Scoring Standard." McLeod Healthcare Network will report to CMS as an aggregate entity and all participating providers will receive the same (likely very favorable) score. Under the APM Scoring Standard, MSSP Track 1 participants are not scored on Cost. In 2018, McLeod Health Network's score will be weighted 50% on quality, 20% on Improvement Activities, and 30% on Advancing Care Information. Due to participation in MSSP Track 1, we will automatically receive full credit in the Improvement Activities category and, based on McLeod Health's past performance, will do very well under the other categories. Since MIPS is a competition against all other providers in the country, a higher performance score will result in a more favorable Medicare payment adjustment for participating providers.

What happens if I do not participate in the Medicare Shared Savings Program (MSSP)?

If you choose not to participate in the McLeod Healthcare Network's MSSP, your practice must develop its own MIPS quality reporting strategy and will not access preferential scoring. If you do not join the MSSP by 2019, the cost category will comprise 30% of your performance score (based on your performance managing per capita costs, Medicare spending per beneficiary and costs for several episodic bundles) and you will have to report on Improvement Activities. Additionally, you would not receive the comprehensive data set from Medicare that provides insight into your patients' utilization patterns. CMS will allow practices to join our MSSP on an annual basis and we hope you will consider joining the program at a future date.

What do I need to do and how much time will this require?

To participate in the Medicare Shared Savings Program in 2018, your practice (defined by the Taxpayer ID Number (TIN) that you use to bill Medicare) will have to sign a Participation Agreement by July 25th. If you don't participate in the MSSP, you may still participate in the development of the CIN and join MSSP at a later date. When the CIN is operational, providers will collaborate to develop and share best practices, with a goal of advancing quality and outcomes and coordinating care for patients within the network. To enable individual and network-wide performance analytics, your practice will also share clinical and demographic data with the CIN. The amount of time required will depend on availability of data and your level of involvement in leadership and governance, which is at your discretion.

How will my current reimbursement and/or compensation be affected?

McLeod Healthcare Network will not be involved in your practice's compensation decisions or negotiating fee-for-service arrangements. Decisions and negotiations regarding these arrangements will remain with each practice and employer. However, if you participate in the MSSP, your Medicare payment adjustment under MACRA will be based on the performance of the network as an aggregate. In addition, we plan to pursue value-based contracts with local employers and other payers in the future.

If I currently participate in a different CIN, can I still participate in McLeod Healthcare Network?

Yes, McLeod Healthcare Network is non-exclusive; therefore you may participate in multiple CINs. However, if your current CIN also participates in the Medicare Shared Savings Program (MSSP), there are federal rules that may limit your participation. If you are a provider that is eligible for attribution (e.g. Primary Care, Cardiology, Pulmonology, etc.) you are limited to participation in only one MSSP, but you will still be able to participate in our CIN.

Will McLeod Healthcare Network allow independent physicians to stay independent and keep their identity?

Yes, this is a key element of Clinical Integration. While participation will inevitably bring some changes for providers, it is one of the most effective strategies for helping them maintain their independence. Most of the changes that Clinical Integration will bring (reporting of quality, greater use of technology, exposure to value-based contracts, additional support staff) are in reaction to national trends and not simply a result of clinical integration. Clinical Integration offers many of the advantages of employment (regulatory guidance, MACRA strategy assistance, access to favorable contracts, performance-based bonuses, strong referral networks, and care management resources), but also helps independent physicians gain financial stability and remain in private practice. It should be noted that participating in a clinically integrated network will come with obligations. All clinicians will be held to quality performance standards and will be expected to follow evidence-based medicine guidelines (as adopted by their peers).

Why should I join McLeod Healthcare Network?

By leveraging the stability, support, and resources of a large health system, McLeod Healthcare Network providers will be well positioned for success in the transition to value-based care. Together, physicians can effectively improve the quality and affordability of care while maintaining autonomy over their practice operations. Other advantages are as follows:

Preferential Scoring under MACRA – As part of your participation in the MSSP, you will access preferential scoring under MACRA. To summarize the scoring:

- Cost – will not be scored
- Improvement Activities – full credit awarded
- Quality – Heavier weighting (50% of score) and is primary focus of the network
- Advancing Care Information – McLeod Health has significant experience with IT

Access to Technology and Infrastructure for Quality Improvement – McLeod Healthcare Network will be investing in additional technology to help track the quality of care delivery across the network and to help providers identify gaps in care for their patients. In addition, we will receive a full set of Medicare claims data that will provide insight into patient utilization patterns and allow providers to better coordinate care within the network.

Additional Support Staff – McLeod Healthcare Network will hire dedicated support staff including IT, analysts, care managers, and other care team members, to ensure that providers are adequately supported in their efforts to achieve the network goals.

Improved Patient Satisfaction and Outcomes – By aligning primary care, specialist and hospital incentives around quality and care coordination, patients will receive more holistic care and experience increased coordination across the continuum of care.

Enhanced Value-Based Contracts – McLeod Healthcare Network will be able to leverage our superior outcomes and the size of our network in negotiations with payers. All negotiated contracts will provide positive benefit only.

Potential for Increased Volumes – Since all participating physicians will have the shared goal of improving outcomes for their patients, physicians will want to refer to other physicians in the network because they know they're upholding the same quality standards, have access to shared data, and will be able to better coordinate their patients' care.

What if I decide to leave the network, what are my options?

Our participation agreement only requests an annual commitment to the network and practices can leave the network by providing a written termination notice 120 days before the end of each calendar year.

How is McLeod Healthcare Network being funded?

McLeod Health has budgeted over a million dollars next year to fund the network's upfront infrastructure (in addition to leveraging current McLeod resources dedicated to quality improvement and population health initiatives). If McLeod Healthcare Network was to earn shared savings, those dollars would be reinvested in infrastructure to cover the cost of shared staff, IT, quality reporting, and other resources necessary to support participating providers. Although shared savings will be retained by the network until McLeod's investment has been recouped, the positive adjustment you receive under MACRA will be applied directly to your practice's Medicare Part B reimbursement.

How will McLeod Healthcare Network obtain data from independent practices?

McLeod Healthcare Network is investing in a quality IT infrastructure that will support network analytics and reporting. The requirements to exchange data with independent practice EHRs is critical to the Network. Current project work includes the evaluation of McLeod's current IT systems and capabilities, any additional software that may be needed and the most efficient method of data exchange with independent EHRs. Keep in mind that we will not need to report on quality performance for the Medicare Shared Savings Program until February 2019. While the technical logistics are being developed, CIN staff will be able to utilize chart abstraction / more manual processes to abstract quality data from your practice.

What if my practice does not utilize an EHR?

All providers that see patients in the ambulatory setting must have an EHR to avoid a negative performance impact under MACRA's "Advancing Care Information" performance category (formerly Meaningful Use). There may be opportunities in the future for McLeod to support your practice in implementing an EHR. Please contact Ron Boring at RBoring@McLeodHealth.org if you would like additional information.

How will McLeod's migration to the Cerner EHR impact quality measure reporting?

Cerner is one of the most prevalent EHRs in the country and has significant experience working with CINs participating in the Medicare Shared Savings Program. While we're in the implementation process, there will be a key focus on capturing these measures in our current systems to support quality reporting and making sure new Cerner EHR workflows are optimized for quality measure capture.

What does this mean for my non-Medicare patients?

Our initial focus is on the Medicare Shared Savings Program and our MACRA performance will be based on quality reporting for attributed Medicare beneficiaries. However, as a Clinically Integrated Network, we are focused on improving quality for all of our patients and the McLeod Healthcare Network will ultimately collect quality data on ALL patients in your panel. This is a requirement to be considered Clinically Integrated and will help us prepare for commercial insurers that will follow CMS' lead in the transition to value-based care. In the future, McLeod Healthcare Network will likely pursue other value-based contracts in which we will have similar initiatives for our patient populations outside of Medicare.

How are Medicare beneficiaries attributed?

All Medicare beneficiaries in the country are attributed to a provider or group of providers based on who provided the plurality of primary care services. Medicare uses a two step process that first gives attribution based on visits with primary care providers. If a beneficiary does not have a single visit with a primary care provider during the calendar year, they can be attributed under "Step 2" to certain types of specialist based on office visits. Non-physician primary care providers (Nurse practitioners/physician assistants/ clinical nurse specialists) may are eligible for "Step 1" attribution, but only if the beneficiary had an office visit with a physician at some point during the year. The following list outlines the specialties that can receive attribution under each Step:

- **"Step 1" Specialty Types – Majority of Attribution:**
  Primary care physician specialties used in Step 1 Attribution:
  General Practice
  Family Practice
  Internal Medicine
  Pediatric Medicine
  Geriatric Medicine
  Non-physician primary care providers used in Step 1 Attribution:
  Nurse practitioner
  Clinical nurse specialist
  Physician assistant
- **"Step 2" Specialty Types – Limited Attribution:**
  Specialties Eligible for Step 2 Attribution:

  Addiction medicine
  Cardiology
  Endocrinology
  Geriatric psychiatry
  Gynecology/oncology
  Hematology
  Hematology/oncology
  Medical oncology
  Multispecialty clinic
  Nephrology
  Neurology
  Neuro-psychiatry
  Obstetrics/gynecology
  Osteopathic manipulative medicine
  Physical medicine and rehabilitation
  Preventive medicine
  Psychiatry
  Pulmonary disease
  Sports medicine

Specialties that are not listed above are not eligible for attribution under the MSSP.

What does this mean for providers at FQHCs and RHCs?

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are able to fully participate in McLeod Healthcare Network. Because of FQHC and RHC billing processes, we will need to submit a special attestation listing the National Provider Identifiers (NPIs) that provide direct patient primary care services at each FQHC/RHC. This special attestation is needed to ensure that their claims data is included in the attribution process.

If I'm a specialist ineligible for attribution (i.e. based on specialty code or don't provide office visits), how do I contribute to the MSSP measures and MACRA performance score?

Technically, you may not have a direct impact on the quality measures as they are mostly primary care focused metrics. Therefore, an element of trust is required in that you are relying on the performance of your peers. With that said, specialists play a major role in supporting the network by coordinating care for patients and ensuring that patients are referred back to their primary care provider to receive necessary preventative care.

What if my patients do not comply with treatment plans and referrals?

Providers across the country face similar problems due to patient non-compliance and we will be compared to national benchmarks. There is also a lot we can do to collectively improve patient engagement and care coordination. As a network, our goal is to have shared staff and resources to support participating providers. A priority will be to hire care coordination staff to help navigate patients across the care continuum, ensuring appropriate follow-up visits and self-management. Furthermore, we may hire pharmacy resources who would support poly-pharmacy patients in medication reconciliation and management. Participation in McLeod Healthcare Network provides the ability to leverage the economies of scale of a large organization, avoiding the cost and burden of establishing similar services independently within your practice.