MACRA Helps Position Home Health Services to Impact Physician Compensation

by Cory Rutledge
Home health providers take great pride in their ability to achieve quality health outcomes at a low cost relative to hospitals, skilled nursing facilities (SNFs), and other sites of service. Many of those home health providers believe they could play a larger role in working with physicians to manage high-risk patients. Can home health services play a role in reduced overall Medicare spending for frail older adults, individuals with multiple chronic conditions and comorbidities, and rehabilitation patients? If physicians were financially incented to manage their patient populations by providing the best outcomes at the lowest cost, would physician referral patterns change? If so, home health providers should understand and care about the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).
What is MACRA?
As the health care payment mechanism evolves, one common theme is aligning incentives so that good outcomes that come at a reasonable cost are rewarded. One such payment reform program that influences the physicians and medical groups is MACRA. While there is much discussion about how MACRA will impact the physician world, its effect on home health providers is seldom discussed. It is our opinion that MACRA provides a substantial opportunity for the home health industry to elevate its prominence in the health care continuum.

MACRA in brief
The details of MACRA are incredibly complex, but the main components of MACRA are focused on the following issues:

1. Repeal of the sustainable growth rate (SGR) formula, often referred to as the “doc fix”
2. Extension of Children’s Health Insurance Program (CHIP) and graduate medical education (GME) funding
3. Definition of goals for interoperable electronic health records by 2018
4. Establishment of physician payments for 2015 – 2025
5. Revision of physician value-based purchasing
6. Regulatory reporting of data and public availability of quality results

The physician payment mechanism under MACRA is the Quality Payment Program (QPP). The QPP moves Medicare payments from the fee-for-service model to value-based payment models. As part of the QPP, eligible clinicians must follow one of two payment paths: advanced alternative payment models (APMs) or the merit-based incentive payment system (MIPS).

Advanced APMs provide incentive payments to physicians for high-quality and cost-efficient care. It is possible to earn an additional 5 percent incentive payment if clinicians participate in one of the advanced APMs. There are additional risks associated depending on which advanced APM they choose to participate in.

Eligible clinicians that participate in MIPS earn a performance-based payment based on information submitted in four different categories:

- Quality
- Improvement activities
- Advancing care information
- Cost (Medicare defines cost as the amount of Medicare “spend” per patient per annual period by provider service.)

Quality and resource use report (QRUR)
Regardless of whether a provider chooses APM or MIPS, their reimbursement, and ultimately their take-home pay, will be impacted by their ability to provide good outcomes at a low cost. The quality and cost will be reported on the quality and resource use report (QRUR) and the physicians’ compensation will be directly impacted by their ability to improve their relative position in comparison to peers.

Whether free-standing or hospital-based, MACRA provides home health agencies an opportunity to communicate their value to the physician community. If an agency can convince clinicians that it can play a meaningful role in managing the health of a Medicare beneficiary through both Medicare-certified home health services and non-skilled services, physicians gain an incentive to change referral behavior.

Source: The Centers for Medicare and Medicaid Services 2015 Annual Quality and Resource Use Report
Demonstrating savings: a case study

In exploring the financial impact of MACRA on the Medicare system as a whole, CLA created a model that assessed the financial ramifications on a community health system (System X) that included a hospital, a physician group, a nursing home, and a home health agency. Using System X’s actual performance data from its 2016 QRUR, CLA determined that the Medicare beneficiaries associated with System X had a total cost of care (TCOC) of $14,356 per member per month (PMPM), which was more than $2,000 greater than the national average TCOC of $12,326 PMPM.

The improvement strategy of System X began with an increased focus on primary care. System X believed this focus would result in higher physician costs due to more patient visits and chronic care management costs, but would be offset by fewer emergency room visits, hospitalizations, and SNF admissions. Using 1,000 Medicare beneficiaries as the System X population, its strategy assumed the following:

- Primary care productivity could increase 10 percent (as measured by work relative value units)
- Physicians would increasingly use chronic care management (CMM) codes and CMM services for 40 percent of their Medicare population
- Successful management of the Medicare population would reduce inpatient hospitalizations by 30 percent
- SNF days would drop by 50 percent, and 60 percent of that reduction would be attributed to using home health services instead of SNF care

The chart below shows the financial impact of the above assumptions on each component of System X, as well as the payors:
In a risk-sharing payment model, System X would benefit from the $1.57 million reduction in cost, which is driven by reduced hospital and SNF utilization. While this economic outcome is intuitive and not a new concept, the take-home pay of primary care physicians is now directly and positively impacted by the TCOC of their Medicare population because of MACRA. The QRUR impact of the reduced TCOC and improved quality is modeled in the graph above. As depicted, System X improved its relative position by both increasing quality and reducing cost. This improved QRUR positioning directly increases the compensation of the System X physicians in this case study.
Opportunity for home health providers

MACRA will prove to be a financial burden on physicians who are not willing to manage their Medicare population at a lower cost. In other words, status quo is detrimental to the income of many physicians. We believe that the changes MACRA dictates will provide an opportunity for home health providers to engage in conversations with physicians on how home health can be a low-cost solution to manage chronic conditions and reduce the likelihood of an expensive health episode. Moreover, when an episode does occur, home health providers can demonstrate their ability to manage post-acute services at a lower cost. As shown in the table below, the post-acute costs of various episodes for five sample hospitals demonstrate that home health agencies (HHA) can provide outcomes at a much lower cost when compared to SNFs.

Cost of Post-Acute Services for Five Sample Hospitals — SNF versus HHA

As agencies engage with physicians in this conversation, this type of data is critical. By knowing their relative cost in comparison to other providers — both home health and SNF — agencies can position themselves as the key partner for physicians who want to reduce cost and improve the health of Medicare beneficiaries. And while this is reason enough to seek change, the impact on compensation provides additional incentive for physicians to have these conversations.

Data Source: Definitive Health Care (defhc.com). Derived from 2014 and 2015 Medicare FFS SAF data
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