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pulse

# Digging into the New Quality Payment Program

**By Anne Rosso May**

The first performance year for the Quality Payment Program, which was instituted by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), launched on Jan. 1, and healthcare providers that bill more than $30,000 to Medicare Part B and care for more than 100 patients a year should start recording their quality data and documenting how they are using technology to support their practice.

If you are confused by MACRA's requirements—after all, the 2,400-page final rule was only released a few months ago—you're not alone. A study from Deloitte's Center for Health Solutions released just before the final rules were published found that 50 percent of practicing physicians said they had never even heard of MACRA. This is a pretty big deal, because the majority of providers will need to change aspects of their practices to comply and avoid a negative payment adjustment down the road.

Here are five things you need to know about MACRA and what you should be doing right now.

### Starting Out with Training Wheels

The Centers for Medicare & Medicaid Services received more than 4,000 public comments on the proposed rule for MACRA last year, and the federal agency seemingly took many of them to heart. The final rule scales back initial expectations, noting that 2017 is a transition year for providers.

The first performance period runs from Jan. 1, 2017, to Dec. 31, 2017, and during this time providers can pick their pace to report data to Medicare. They can choose to test the Quality Payment Program on a limited basis, participate for only part of the calendar year or participate for the full calendar year. This reduced set of requirements for 2017 give providers time to fine-tune their basic infrastructure and get familiar with what's expected of them.

Eligible providers only need to submit one quality measure in 2017 to avoid a negative penalty. But Steve Daniels, president of Able Health, noted that this year might be a good time to work toward an exceptional performance bonus, which kicks in when you hit a composite score of 70 or above on the 100-point scale.

"We have a lot of providers coming to us to discuss the minimum participation requirements, but if you are ready to participate in the full program, this is going to be the easiest year to outperform your peers and get a nice positive payment adjustment," he said.

### Finding the Right Track

Broadly speaking, MACRA offers two main tracks for healthcare providers: the Advanced Alternative Payment Model (APM), for providers that are already participating in a payment program CMS considers to be strongly value-based, and the Merit-Based Incentive Payment System (MIPS), for everyone else—roughly 592,000 to 642,000 clinicians. Providers that qualify for the Advanced APM track earn a 5 percent bonus in addition to being exempt from MIPS.

But providers don't get to decide which track they will need to follow.

"One detail that's important for providers to know is that the eligibility for the APM track and MIPS exception is dependent on your portion of patients or payments in that track," Daniels said. "That's not something you'll know until partway through the year. So we encourage providers to assume you are going to be eligible for MIPS until you hear otherwise, because if they don't meet those thresholds they'll be stuck being subject to a MIPS payment adjustment without anticipating it in advance."

### Understanding Your Data

MIPS consolidates several older quality-based programs: Meaningful Use, the Physician Quality Reporting System and the Value-Based Payment Modifier. Under PQRS in particular, Daniels noted, providers were only expected to submit their quality-measured data once

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MEDICARE:

# CMS Issues Online Quality Payment Program Tool

Healthcare clinicians now have access to a tool from the Centers for Medicare and Medicaid Services to "share automatically electronic data for the Medicare Quality Payment Program."

The tool is part of the its ongoing projects "to spur the creation of innovative, customizable tools to reduce burden for clinicians, while also supporting high-quality care for patients," according to a news release.

The CMS Quality Payment Program website was released in October. The tool, known as an Application Program Interface, "builds on that site by making it easier for other organizations to retrieve and maintain the Quality Payment Program's measures and enable them to build applications for clinicians and their practices."

In November, CMS reported tens of thousands of clinicians were using the tool.

"An important part of the Quality Payment Program is to make it easier and less expensive to participate, so clinicians may focus on seeing patients," said Andy Slavitt, acting administrator of CMS. "This first release is a step in that process, both for physicians and the technologists who support them."

The Quality Payment Program is "modernizing Medicare to pay smarter for better care" through organized policy and improved technology and operations, according to CMS. "The Quality Payment Program is designed to reduce reporting burden on clinicians so that they can focus on their patients, while also providing useful information to clinicians and other stakeholders, so that overall care quality improves. As the program and its supporting website mature, CMS will continue to release data and APIs to spur innovation and keep participants up-to-date." More information: http://ow.ly/wLGt306ShF4

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a year to CMS—they weren't obligated to understand how they had performed.

"But that's not a process that's going to fly under the Quality Payment Program, regardless of if you are doing MIPS or an APM, because now the payments will be based on your performance on those measures," Daniels said. "It's moving from a reporting- and compliance-based task to a performance- and quality-improvement-based task. That's probably the number one thing providers have to understand."

What does this mean? You will need to start tracking and improving your performance on quality care year-round.

### Size Matters

While some small physician practices may be exempted from MIPS participation due to the threshold exemption, those that are still required to participate will face the tallest obstacles. Where larger practices and healthcare systems may already have a dedicated team in place working on quality-care programs, smaller providers likely don't.

Jim Hammond, CEO and publisher of The Hertel Report, encouraged all providers to designate a point person to learn about MACRA, summarize the information and share it with leadership. "I also recommend that they attend seminars and webinars about the subject," Hammond said.

Some facilities may find it easier to outsource the data gathering and analysis required by MACRA to third-party companies that specialize in helping providers comply. Whatever approach providers choose, looking the other way is not an option.

"A lot of smaller practices took the 2 percent penalty under PQRS because they didn't want to deal with the reporting burden," Daniels said. "But those penalties are increasing every year now, and it's not really an option to ignore this program if you want to continue to accept Medicare payments."

### What Does the Future Hold?

MACRA earned bipartisan support in Congress, but some providers are wondering what will happen to it under a Trump administration. Will the time and money required to comply with MACRA be worth it?

"There's a little bit of uncertainty in the industry with what's going to happen with healthcare in general, and providers might be more hesitant to invest in new infrastructure or take some programs seriously when there is a lot of flux," Daniels said. "But I would warn providers against that specifically with regards to value-based payments and MACRA because all indicators from the government and analysts suggest that it's going to be moving forward at full speed."

In fact, Daniels noted many commercial payers are looking to design an alternative payment model of their own similar to MIPS and other advanced alternative payment models.

"We are seeing MACRA becoming an aligning force in the industry, where other payers want to design programs that either meet CMS's standards or reduce the reporting burden for providers by using similar reporting requirements," Daniels said. "We know that many commercial programs exist and that they are increasing the percent of payments that are on the line."

To read more about the Quality Payment Program, see above.

*Anne Rosso May is editor of* Collector *magazine.*

SURVEY:

# Health Survey Shows Decline in Consumers Having Trouble With Medical Bills

Data from the first six months of this year show a decrease in the percentage of consumers having problems paying medical bills, according to the Centers for Disease Control and Prevention National Center for Health Statistics.

Overall, the percentage of consumers under age 65 in families having problems paying medical bills declined from 21.3 percent (56.5 million) in 2011 to 16.2 percent (43.8 million) in the first half of this year, according to the survey.

Changes in the insured rate also occurred during this time period.

"In the first six months of 2016, 28.1 million persons under age 65 were uninsured at the time of interview—17.8 million fewer persons than in 2011 (17.3 percent) but only 0.3 million fewer persons than in 2015," the NCHS reports.

A family defined in the NCHS survey is an individual or a group of two or more related people living in the same household.

"The effect on families is profound," Lynn Quincy, director of the Healthcare Value Hub at the Consumers Union told National Public Radio in an article about the survey results. "Healthcare costs are a top financial concern for families, far above other financial concerns."

The NCHS also found the percentage of consumers having trouble paying medical bills declined among different demographics, consumers with different types of health insurance and financial status.

For example, the percentage of children in families having trouble with their medical expenses declined from 23.2 percent in 2011 to 17.6 percent during the first half of 2016 and children overall are more likely to be in families with those financial troubles than adults aged 18 to 64.

The NCHS also found that 28.5 percent of consumers under age 65 without insurance, 21.1 percent of those with public health insurance and 12.6 percent of those with private health insurance were in families experiencing problems with medical bills in the last 12 months.

Additionally, 23 percent of "poor," 24.9 percent of "near poor" and 12.6 percent of "not poor" consumers under age 65 were in families with troubles paying medical bills in the last year.

The complete National Health Interview Survey results are available on the Centers for Disease Control and Prevention website: https://www.cdc.gov/nchs/

# NEWS & NOTES

## Healthcare Jobs Increase in November

Jobs in the healthcare industry increased by 28,000 in November, according to the Bureau of Labor Statistics. The growth rate at hospitals declined compared to October, when they added 10,500 jobs, *Becker's Hospital Review* reports. The healthcare industry added 407,000 jobs over the past year.
http://ow.ly/Uff5306SdGX

## Healthcare Professionals Weigh In on ICD-10

Representatives of the healthcare industry recently shared about ICD-10 compliance with *Becker's Hospital Review*. Mary Beth Haugen, president of CEO of Haugen Consulting Group, said, "Our clients that were diligent in their preparation for ICD-10 did not see a significant impact to their processes, systems or accounts receivable, like some organizations."
http://ow.ly/YmtH306SeQm

## Americans Say They Cannot Afford High Premiums

As a result of health insurance rate increases, 52.5 percent of respondents to a survey by HealthPocket said they couldn't afford more than $100 a month in premiums, *FierceHealthcare* reports. "Still, federal health officials have said 77 percent of current Healthcare.gov customers can find a plan for $100 or less, thanks to subsidies. But individuals who don't get subsidies will get hit especially hard," it reports.
http://ow.ly/A1B3306Sfzi

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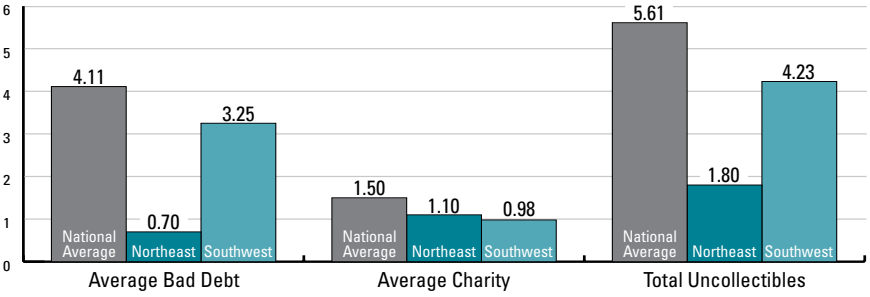
# datawatch

## Two of Six Regions Reach Uncollectibles Benchmark

Two of six regions in the U.S. met the benchmark for charity and bad-debt write-offs, at 5 percent or less of total gross revenue, during the fourth quarter last year, according to the *Hospital Accounts Receivable Analysis Report on Fourth Quarter 2015*. Hospitals in the Northeast reported write-offs for bad debt or charity care at 1.80 percent of their total revenue in the fourth quarter 2015, according to the report. Southwest hospitals achieved the benchmark, despite the fact that their bad debt write-offs increased to 3.25 percent of total revenue in the fourth quarter, because charity care write-offs declined to 0.98 percent of revenue.




Data Source: *Hospital Accounts Receivable Analysis report on Fourth Quarter 2015 vol. 30, no 1.*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