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Medicare, private payers gear up for swift shift to quality-based pay

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Expect your compliance obligations to increase as HHS pushes forward on an ambitious plan to tie up to 85% of its traditional payments to quality or value by the end of 2016.

HHS announced Jan. 26 that it is moving away from volume-based and unnecessary, duplicative care to one focused on paying for value, care coordination and quality and has set measureable goals and timelines to meet this objective. The majority of Medicare payments are expected to come through one of three kinds of quality-based models:

- **Fee-for-service payments with a quality-of-care link.** A portion of the payments will vary based on quality and efficiency. Examples of these payments are the physician value-based modifier program and hospital value-based purchasing.

(SEE **CMS**, P. 8)

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▸ **Alternative models built on fee-for-service programs.** Some of the payment is linked to effective management of a population or episode of care. Examples include accountable care organizations (ACOs) and patient-centered medical homes.

▸ **Population-based payments.** Providers are paid for the long-term management and care of a patient and payments are not directly triggered by services. According to HHS, eligible pioneer ACOs in years three to five will use this payment model.

HHS additionally intends to not only update existing alternative payment models, but also on add new ones, such as new alternative payment models for oncology care.

The agency aims to have 50% of its payments on an alternative or population-based model by 2018.

This is the first time in the history of the Medicare program that HHS has set specific goals for alternative payment models and value-based payments, according to HHS' announcement.

Public-private partnership on initiative

Expect private payers to follow suit and increase their quality and performance requirements, both on their own and in cooperation with the government.

HHS created the Health Care Payment Learning and Action Network so the agency can work with a variety of stakeholders, including private payers and Medicaid agencies, to develop and expand the use of alternative payment models. The Network, among other things, will enable participants to collaborate on projects and create implementation guides.

The private sector already is embracing the change to value-based payments. A coalition of industry powerhouses — including six of the nation's top 15 health systems, four large health insurers and two employer/business groups — announced a new Health Care Transformation Task Force committed to putting 75% of their business in value-based arrangements by 2020 (*MPCA 4/14/14*).

Expect reimbursement, compliance changes

Details of the new and expanded value-based programs are unclear, but physicians will need to meet the goals to be paid. The programs likely will differ from and be more extensive than the current rules for fee-for-service Medicare reimbursement, says attorney Brian Flood of Husch Blackwell in Austin, Texas.

"[This initiative] will further intertwine compliance with finance and with IT. For example, if you are not using an EMR [electronic medical records] system that meets meaningful use rules, you lose 2% of your Medicare profit. If you attest and join meaningful use but attest wrong or false you can be sued or charged as a false claim or lose the money in an audit for failure to comply. If you are not reporting PQRS [Physician Quality Reporting System] or ePQRS [electronic PQRS] numbers you lose another 2% with the same negative consequence possibilities for inaccurate numbers. Under [the value-based modifier], if you are not meeting the requirements and reporting the numbers you lose another 2%. All-in-all that puts at risk 6% gross of Medicare. If you add the [increase in value-based requirements imposed by private payers] then you really up the risk," he explains.

Practices also should expect more obligations to use electronic health records (EHRs) to comply with the new payment programs and earn reimbursement. What was not mentioned in the press release or the fact sheet but what the officials emphasized in a background press call was that the success of these alternative payment models lies in great part on the use of EHRs and the ability of the systems to share patient data. CMS already is pressing providers in this direction in other areas of payment, such as in the new care coordination reimbursement added to the physician fee schedule, which requires electronic data sharing to obtain the reimbursement.

"I see the possibilities for more compliance requirements, very defined loss parameters and likely high pressure to 'meet the numbers.' There has already been one charged case for falsifying them. I bet there will be more," Flood warns (*MPCA 12/8/14*).

RESOURCES:

- HHS press release: *http://www.hhs.gov/news/press/2015pres/01/20150126a.html*
- HHS fact sheet: *http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html*
- Task force press release: *http://www.hcttf.org/releases/2015/1/28/major-health-care-players-unite-to-accelerate-transformation-of-us-health-care-system*