

Are You Ready for MACRA?

As the healthcare industry moves to a new reimbursement model, here's what you need to know

By Min Matson and John Tu

The Challenge

Is your healthcare organization ready to prosper from the nationwide shift to a provider reimbursement model that rewards value over volume—in short, being paid for cost-effective, quality care over quantity of care? Or do you stand the risk of being unprepared and losing revenue?

For decades, healthcare providers have been compensated based on traditional fee-for-service payment models—the volume of patient visits and services. Now the Centers for Medicare & Medicaid Services (CMS) are shifting the focus away from volume to value-based models, and providing guidelines that link provider reimbursement to measures of cost-effective, high-quality care.

These CMS guidelines are part of a mandatory Medicare incentive program known as MACRA—the Medicare Access and CHIP Reauthorization Act of 2015. MACRA is designed to drive major reforms in healthcare payment and delivery. Most of the U.S. healthcare industry is affected, including millions of clinicians, health systems, Medicare and commercial payers.

Despite all the uncertainties in the healthcare industry, one thing is certain: This major change in provider reimbursement is moving forward, and the impact will be profound. Yet many healthcare organizations are not prepared for the change.

In a 2017 joint survey by KPMG and the American Medical Association, 64 percent of physicians reported being "unprepared" or "very unprepared" to comply with MACRA. Only 20 percent of practices with fewer than 15 physicians say they are prepared, and just 25 percent of practices with 16 to 50 physicians say they're ready to go.

CMS recognizes that some providers, especially smaller practices, are struggling to meet the original MACRA deadlines. As a result, CMS recently announced that it is expanding its original "transition year" from 2017 to include 2018.

Still, there's no time to lose. For most provider organizations, the transition will take significant cultural change, new processes and new technology. This depth and breadth of change won't happen overnight. It takes time, planning, and a clear understanding of your "MACRA gap"—where you are now, and where you need to be—in order to successfully align your organization with this quality-centric system.

Point B's Perspective

Point B's healthcare specialists are working with healthcare organizations across the industry to position them for the changes in reimbursement that come with MACRA. We help them understand their level of MACRA readiness, and close their "MACRA gap" to comply with new regulatory demands. We take a two-phase approach—Impact Analysis and Roadmap/Planning—along with a one year post-implementation recalibration to increase the quality of patient care while maximizing Medicare reimbursements and minimizing risk exposure.

Here are a few recommendations for making a successful transition as you navigate this change—lessons learned in our work with leading healthcare organizations.

Make quality the focus across your organization

Some providers are well on their way to becoming quality-driven organizations. Many are just beginning to understand how deep, wide and interconnected these efforts need to be.

How about your organization? Have you established quality goals for your practices? Do you have tactics for achieving those goals, and ways to measure progress?

We suggest analyzing how high performing organizations achieve high-quality care and setting quality oriented targets in alignment with delivering it.

For example, it is not enough to simply diagnose a condition such as asthma or diabetes. Improving patient outcomes may include taking proactive steps to minimize episodes and complications and connecting patients with healthcare specialists who can keep their conditions under control.

Use data to understand your performance

How will you measure and report value? It pays to establish processes in each department that uses data to provide measurable quality outcomes.

Collecting survey data is only the beginning; you may need to implement adjustments based on that data. After all, data is only as useful as your ability to use it

and act on it. Which brings us to our next recommendation.

Address any gaps in technology and performance

On a regular basis, evaluate where you are hitting and missing the mark on delivering cost-effective, quality care, and make adjustments accordingly.

For example, if your provider network is not measuring up on diabetes management, take a closer look at who seems to be struggling, and why. Then reach out with information and practices that can help them improve.

Many organizations lack the infrastructure to meet more demanding MACRA requirements. For example, under MACRA, providers are required to submit reporting for a much higher percentage of their patients than ever before. Currently, providers are required to submit reporting for 50 percent of their Medicare patients. Under the new requirement, providers must expand reporting to 80 percent of their Medicare population and 90 percent of their total patient population.

In the shift to value-based care, **most organizations will need to expand or upgrade technology along the way. Take time now to address any system limitations or technology challenges as MACRA requirements kick in.**

The Bottom Line

Keep in mind that your organization's transition to MACRA needs everyone to succeed. Improving quality and making the most of value and performance-based incentives takes an "all in" mindset at every level of your organization. It may require new levels of collaboration and integration—new ways of thinking about what really matters, and how to measure progress.

Leadership can do much to ease the transition by sharing meaningful data that keeps everyone informed, engaged and moving toward clear goals for success. If your organization is not yet fully prepared for MACRA, the time to act is now.