Can Health Care Stay the Course of Reform Amidst Uncertainty?

written by Theresa Hush | January 11, 2017

With the new year finally here, health care organizations need to know: How should you proceed amidst uncertainty about Medicare policy, including Value-Based and Risk programs initiated by the Obama administration?

In the crosshairs are the new, complex Quality Payment Programs under MACRA, including both MIPS and Alternative Payment Models (APMs) such as ACOs. Although MACRA had bipartisan support in the 114th Congress, it was the Affordable Care Act (ACA) that created the foundation for ACOs and other Value-Based programs. As the new Congress hurtles toward ACA repeal, the landscape for all of health care is murkier than ever.

The significant "Pick your Pace" scale-back of MACRA MIPS requirements for 2017 also makes MACRA seem tenuous. Add to that comments by Tom Price, the appointee for Secretary of Health and Human Services, who expresses weak support for existing Medicare initiatives. As Congressional leadership and the incoming administration brandish promises of large scale

shifts in Medicare, Medicaid and health care finance, all the cards are up in the air. We could be in for a real slowdown.

What Is Health Care Reality Amidst All This Commotion?

Moving forward—even with MIPS—requires an investment in technology and people. You need to know that there will be a reasonable, long-term return on that investment. Also, who wants to stir up the organization with changes to go forward into an uncertain future and use up your political capital without reason? Yes, you already did some of this with PQRS and Meaningful Use, but MACRA is bigger and requires much more of your organization.

Certainly, it's easy get wrapped up in the politics and the difficulties of moving forward. But it's time for a reality check. There are a few facts that will dispel all fantasies about going on with the status quo, or ever (ever!) getting more money from either health plans or government. Dealing with these realities now will put you in a position to be ready for whatever specific models emerge in the months ahead:

> Health costs will continue to rise beyond the level of affordability for employers, government and consumers.
> The population is continuing to age, get more chronic diseases and become higher risk. And potentially not all these people will have the insurance coverage they have now.
> Medicare and Medicaid will run out of money at some point without reform, and if health care costs are higher, it will happen sooner.
> The actions available to employers, health plans and government to stem costs are limited. They essentially boil down to either capping payments for providers or for consumers; likely, both. Even Value-Based Health Care is a temporary strategy on the way to imposing this financial risk.

Along with these issues, there is also a cultural change that is becoming more evident and will contribute to the economics. The disassociation of consumers from traditional institutions, including medicine, has been supported by continual changes in networks by health plans and providers themselves. What this means is that you can't count on your patient base to be loyal. Patients will be using criteria, including cost of care, to determine their choices.

What to Do Instead of Waiting for Definitive Policy Reform

This is the reality. How much time is there to get your health care organization in sync? You won't have enough time to meet the future if you are starting from scratch. If you have only

done compliance-focused PQRS and Meaningful Use reporting, you are pretty much at the start line.

But in this uncertain climate, there is also the opportunity to think differently and creatively about how you will succeed in the years ahead. What will really work to improve the value of health care and to stem the costs? Perhaps the regulatory approach up to now has stymied creative thinking and pushed us into compliance mode. If so, you can jumpstart your plan of action by pursuing three meaningful tactics:

1. Invest in measuring performance and outcomes, both quality and cost.

Performance measurement is no longer a regulatory or compliance process. It's now a strategic exercise. If you used a sample-based CMS interface for PQRS reporting, or if you used EHR direct reporting, you probably don't have the long view of performance. The key is not absolute values or "scores," but what is happening to your patients over time. To improve your organization, your measurement should help you diagnose where outcomes are stagnant and where costs are hiding. These will clarify your strategy and tactics for improvement.

> Are your costs out of line because of a misalignment in your physician network, such as not enough primary care?
> Are costs out of line with others when evaluated by episodes?
> Have you analyzed your outcomes across time to see whether they are improving or worsening for individual patients and populations?

2. Understand and create value for your physician network.

With the rapid shift to hospital-owned practices and consolidation, we often find that health care systems don't understand the activities of their network physicians—aside from their admission statistics and bottom line. To implement real change, you need to involve physicians first, because they have the most to offer clinically and also strategically. The time is now to seriously evaluate the composition of your network, the interest and engagement of your physicians, and the impact that each participant has on costs and outcomes.

> Have you assessed the costs of your network and compared these with other organizations?
> What is the composition of your network in specialties, and how is it affecting your inflow and outflow of patients?

> Do you know the costs of care for patients who are attributed to you but receiving services outside your walls?

3. Begin improving performance with a serious slate of projects.

Everyone is “doing” readmissions, and you are probably also addressing these. But you can also create projects that focus on root causes of sub-optimal outcomes, rather than dealing with problems after the fact. Your performance improvement should be creative and involve physicians, patients and family caregivers in developing solutions with measurable results.

> Do you have improvement projects aimed at improving clinical outcomes and involving physician contributions?
> Are your patients involved in contributing to your strategic process beyond routine satisfaction surveys?

These are big action items, and the assumption is that you already have the underlying technology and support to help you achieve them. If you don’t, that requires correction, and it need not require a massive investment.

Here’s an added bonus: If you begin working on this list, you’ll also make progress on fulfilling the major provisions of MACRA MIPS.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Tim Mossholder