Why MACRA MIPS Cost Episodes Make Good Products for Health Care Consumers

written by Theresa Hush | April 13, 2017

Here's a radical idea: What if providers re-envisioned MIPS as a patient marketing initiative, not a regulatory response? Yes, I'm serious. From the beginning of PQRS and Meaningful Use to MACRA, health systems considered these efforts to be merely "compliance" with regulations and not market initiatives. But this view is shortsighted.

As outlined in MACRA rules, all of the MIPS initiatives parallel changes that consumers, employers and health plans have been demanding: lower costs, quality, improvement and value. Analyzing the MIPS component of Cost provides a good way to evaluate how providers could use Medicare data to help remap their care products and pricing.

Cost Control Is a Market Imperative

Virtually everyone in the health care industry agrees (even most providers) that the Fee for Service method of paying providers helps to drive costs. By ensuring payment for every component of care, Fee for Service can insulate providers and patients from considering the full

cost of services.

Those economics spurred the federal effort to transition Medicare to financial risk for providers through Alternative Payment Models (APMs) such as ACOs, and through commercial Medicare Advantage plans. But Medicare is also trying to replicate risk incentives through MIPS Episode Cost Measures, which reward or penalize providers who are participating in Fee for Service.

The Cost component of MIPS involves three different scoring components that compare providers along a spectrum in terms of (1) per capita costs, (2) Medicare spending per beneficiary costs and (3) Episodic costs associated with a number of different chronic conditions, inpatient admissions or procedural episodes. Episodic payments are new to MACRA, but provide the strongest opportunity for providers to design the best consumer health product.

How Features of MIPS Episodes Translate Into Consumer Health Care Products

Medicare has established a huge number of chronic conditions, procedures and admissions for comparing costs between providers. That's the hard part. If you're not paying attention to how your care is generating costs to patients and Medicare, you could end up on the high cost part of the spectrum and lose Medicare revenues.

But here's the good part: Using these episodes providers have a perfect opportunity to build a consumer product that they can market to patients, health plans and employers. Providers can create opportunity to take patients from decision-making to purchasing services, using comprehensive, reliable information about services and costs. Because the patients are engaged in the process, they are also engaged in securing better outcomes for the health care services they receive.

The MIPS Episode Cost Measures create this market opportunity because, for both chronic conditions and procedures, *there are established and well-defined populations built on coded diagnoses and procedures.* These target populations empower providers to customize many of the features that can be used to promote and sell the product:

> Organized services that create predictability and trust for consumers about what will be included in the episode, so that they can make a good purchasing decision. One of the big problems with the current Fee for Services environment is that health care services are provided and paid on a piecemeal basis, creating unpredictability and cutting patients out of decision-making.

Pre-determined provider network and referrals that eliminate the guessing game of who's on the care team. Consumers currently don't know when or if they will be see a bill from a provider who they didn't even realize was involved in their care. Sometimes that provider will even be outside their insurance network, triggering larger patient costs. Being able to anticipate both services and providers that are in an episode package gives patients the ability to make better purchasing decisions. For providers, pre-establishing the networks creates the capability to choose providers who will collaborate and willingly participate in cost control. This also removes the mystery and guesswork for providers about who should get referrals for components of care.

Quality measures and outcomes to help providers and patients assess both the goals and results of the episodes, and to participate in data collection for meaningful performance measurement.

Price transparency of episodes for patients so they can anticipate and plan their share of expenses; this also enables providers to negotiate individual components within the episode price. In addition, price transparency is the key to marketing the episodes as bundled payments, as well as for establishing variations that will reflect patient options and preferences.

Options within the episode package that reflect patient choices, focused on services or extras that are important to patients. This helps the discussion of value and customization to individual patient needs.

Streamlined education and communications with patients on their conditions and procedures. Because episode products can be presented as a package of services focused on a given goal, rather than an *à la carte* shopping experience, the whole episode can be explained by a centralized source. Patients can receive a comprehensive education on the condition or procedure based on the collective consensus of all providers participating in the episode, rather than individual provider interest.

Episode Purchasing Requires Shared Decision-Making and Personalization

Informed purchases of episodic care packages depend on an essential first step—defining the interests and preferences of the patient through a shared decision-making process. This process needs to meet two separate goals:

Ensure that the treatment has value for the patient that outweighs any potential harm. In establishing care packages, providers must not assume that the central premise of the treatment's value holds for any given patient. Each patient must be able to assess the benefit and harm with quantifiable information and be educated on existing research and data.

> Personalize the treatment to the patient. With any procedure or treatment, there are variations of care that must be synchronized to the patient's own circumstances and preferences. Devices that are geared to a 60-year-old patient may not have the appropriate strength and durability for a 30-year-old, and this must be managed through a series of options explained to the patient. Exercise tolerance, lifestyle and other conditions must be considered so that the patient's decision reflects the known facts about the interventions as well as personal appropriateness.

Cost Episode Products Help Providers, Too

In 2017, the MIPS formula doesn't place any weight on the Cost component. Why should providers pay attention, anyway? Because the market is demanding cost control. Getting ahead of other providers on this goal will be key to success in winning patients.

Cost episodes help providers prepare for the inevitable financial risk in the next phase of the Medicare budget. In fact, Cost episodes may be essential for practicing how to survive under the Medicare Advantage plans or APMs.

Providers have demonstrated ingenuity in organizing care through Centers of Excellence to market to consumers. Cost episodes are the next logical step toward creating products that will help those Centers thrive under new economics.

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