CMS Eliminates Episode Groups in MIPS Cost Tracking for 2018—But Providers Should Not

written by Dave Halpert | August 24, 2017

It’s no surprise that Cost is one of the most significant targets of Medicare Value-Based Health Care initiatives, as well as those in the private sector. So it was a real surprise last month to learn that CMS would delay weighing Cost as a component of MACRA MIPS total scoring. Equally significant is the CMS plan to scrap the ten episodic cost measures that were part of the cost calculation for provider groups in exchange for new, “to be determined” versions.

Does this retreat from Cost and episodic costs calculation signal a big shift in the direction of Medicare Value-Based Health Care? In particular, will Bundled Payments based on episodes of care, which have been a major proposed solution to realigning incentives for payments to specialists, be abandoned? Apparently so, according to Dr. Tom Price, Director of Health and Human Services.

An orthopedic surgeon, Dr. Price has previously spoken out

against the Comprehensive Care for Joint Replacement (CJR) model, which has been mandatory in dozens of locations across the country. In September 2016, Dr. Price contended that the CMS Innovation Center is “experimenting with Americans’ health” by making the CJR model mandatory. Removal of the MIPS episodic cost metrics (which include hip and knee procedures) is consistent with this narrative.

Cost will count for 30 percent of the total MIPS score in 2019, and new episodes are in development. Regardless of how CMS includes episodes in its cost calculations, however, providers should not be quick to abandon them. Why? Regardless of whether the FFS MIPS Model remains or Medicare transitions to APMs and Medicare Advantage, intermediary ACOs and health plans will likely opt for bundled and episodic payments for most specialty care.

Bundled Payments Can Lower Episodic Costs

Let’s start with outcomes. A study published in JAMA indicates that Bundled Payments, which use a pre-determined expenditure for an episode of care, have been successful in lowering episodic costs. In a pool of almost 4,000 patients undergoing a lower extremity joint replacement procedure (the procedures under the microscope in CJR), costs decreased by more than 20 percent over the course of seven years—without impacting patient outcomes. By comparison, expenditures for similar procedures across the country actually increased over the same time period.

Expanded Bundled Payments Model Has Potential for APM Consideration

Medicare may be stepping back from being the industry's change agent, but that does not rule out competition and innovation as forces pushing for improved care. The Centers for Medicare and Medicaid Innovation Center (CMMI) is always on the lookout for new ideas for Alternative Payment Models, and with All-Payer APMs on the horizon, an Episodic Cost-based APM is a solid candidate for CMS review and approval. Bundled Payments are already listed at the Innovation Center, but do not count as an APM—they lack two key requirements:

- Use of Certified EHR Technology;
- Quality reporting on MIPS-like measures.

However, a payment model based on episode groups (like Bundled Payments) does meet several of the Innovation Center's criteria for review, including some supported by the previously mentioned joint replacement study:

- Potential for cost savings;
- Potential for quality improvement, including better coordination and reduction of care disparity;
- Strength of evidence base;
- Number of beneficiaries that may be impacted.

By expanding on the existing Bundled Payments model, an organization has the potential to take control of its own destiny—not to mention the chance to pick up a 5 percent lump sum payment if the project is granted Advanced APM status.

Maintain a Robust Network by Including Specialists

Because ACO quality metrics and cost composites focus heavily on primary care, specialists are faced with a tough decision: Is it better to be left out of an Alternative Payment Model, or to be included, but without the ability to steer? By tracking and evaluating episodic costs, almost every specialty has the opportunity to contribute to a quality initiative, either through the to-be-determined MIPS cost episodes or as an eventual Advanced Alternative Payment Model. This is an excellent opportunity to engage those specialties that have been traditionally left out of Medicare initiatives.

For example, OB/GYN providers have had limited ability to demonstrate performance through PQRS or the Value-Based Payment Modifier, as these programs were driven by Medicare enrollment. Although MIPS does include all payers in quality metrics (unless you're reporting through the CMS Web Interface or through claims), MIPS eligibility is still Medicare-based. However, if your organization is considering an All-Provider APM down the road, analyzing episodes outside of the traditional Medicare population (e.g. childbirth) can bring more specialties into the fold, many of whom are eager to play a more active role in the quality process.

As we saw, the GDP-to-healthcare spending ratio continually demonstrated that fee-for-service was not sustainable. Congress passed one "Doc Fix" after another to prevent cuts, but healthcare spending didn't come down, and it took MACRA to stave off the 21 percent cut that would have been applied through the Sustainable Growth Rate. With MIPS steering towards

risk, and the requirement that more and more reimbursement must come through an APM, creating an APM based on episodic costs can meaningfully bring specialists into the fold and cover their costs.

Patients Will Choose Those With Demonstrable Success

Episodic Payments can help patients proactively budget out-of-pocket costs, which can protect against personal financial catastrophe. They add transparency to a traditionally opaque relationship between dollars spent and quality of care.

Our clients have recognized this, and some have actually posted a fixed cost for an episode. The individual out-of-pocket costs will vary by patient and plan, of course, but the fact that providers are providing this information to be competitive signifies that privatization will not kill Value-Based Health Care. As with any other industry, our clients have recognized that if they can demonstrate that they're able to provide a better product at a lower cost, well-informed customers will seek them out. In this case, the better product is an episode with expected results.

Episodic Cost Metrics Don't Require MIPS to be Meaningful—or Successful

The Episodic Cost model may face an uncertain future through MIPS, but should not be abandoned. An organization committed to lowering cost-per-episode is acting in its own best interests, which are also (as they should be) the best interests of their patients. Both parties can benefit from demonstrable evidence that costs can be decreased without sacrificing outcomes.

Patients will be able to make informed decisions, knowing who has a track record of producing good outcomes, and doing so efficiently. Reducing complications and re-operations should be a great source of pride for everyone in the organization—both providers and administrators—and tying these metrics to reimbursement ensures that those who can produce these results are appropriately rewarded.

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.

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