Medicare Paths to Value-Based Health Care: Which Way is Up?

written by Dave Halpert | June 14, 2018

If you're scratching your head about the direction of Value-Based Health Care (VBHC) in Medicare, you're not alone. The current mix includes a swirl of separate initiatives, some new and others recently re-labled.

As CMS pushes toward VBHC, providers may feel confused and frustrated as concepts emerge that will affect multiple programs. Within the last several months, the Patients Over Paperwork and Meaningful Measures initiatives have shaken up CMS value-based care programs, particularly:

Merit-Based Incentive Payment System (MIPS)
Medicare Shared Savings Program ACOs (MSSP ACOs)
Direct Provider Contracting (DPC)

Even more confounding, CMS is taking a non-linear development path for each—from idea inception to initiative and program, and from scope to quality and efficient care delivery. Each component is its own piece, complete with its own quirks and jargon.

But all is not lost! Providers that assemble a cohesive strategy from the component parts stand to win in the CMS VBHC arena. While the programs may appear disconnected, common themes link together target priorities. Achieving those targets creates the "win" for providers. Those who can't establish a path to the right targets will remain stagnant and fall further behind their peers each year.

With so much at stake, let's see how the pieces fit, and how to set priorities.

How the Pieces Were Supposed to Fit Together

Let's review: The Quality Payment Program (QPP), created under MACRA, gives providers two options for transitioning from Fee-for-Service (FFS) payments to VBHC:

> The Merit Based Incentive Payment System (MIPS)
> Advanced Alternative Payment Models (APMs)

MIPS is the amalgamation of three legacy programs: (1) PQRS, (2) the Value-Based Payment Modifier and (3) Meaningful Use, plus an Improvement Activities participation component. Quality, Cost, participation in Improvement Activities and Promoting Interoperability (formerly Advancing Care Information) are scored, and that score is tied to future reimbursement.

Advanced Alternative Payment Models are initiatives in which providers band together to provide quality care at a lower-than-expected cost. An APM needs to meet three requirements: (1) two-sided risk, which rewards those who spend less than a target amount and penalizes those who spend more; (2) quality scoring based on established measures; and (3) EHR usage. Savings (or losses) are shared among the participants, but qualified participants will earn a 5 percent bonus payment.

For those who aren't ready for two-sided risk, there are MIPS APMs, such as Track 1 ACO Shared Savings Plans—they don't qualify for the APM bonus payment, but do protect against penalties. Failing to participate in MIPS or another Alternative Payment Model may lead to penalties; incentives are awarded to those who demonstrate high quality care.

The original goal of CMS's Quality Payment Program was to move providers into value-based reimbursement, but halfway through the second year of the program, it's clear that pieces are

missing. In addition, recent feedback has brought uncertainty to both MIPS and APMs, specifically the MSSP ACO.

MIPS Quality Scoring Is Failing the Validity Test

We've previously described how MIPS is under fire from MedPac for being too burdensome, and that MIPS will not serve its purpose of bringing providers from FFS to Value-Based Health Care. MedPac has gone so far as to say that MIPS should be scrapped.

Since that report, providers and health care organizations have increased criticisms of MIPS quality measures.

To improve care, quality must be quantified. The abundance of MIPS measures means more options for more providers. But that's not necessarily a benefit. A large measure library also leads to more choices for providers on reporting. When one primary care provider reports on chronic condition management measures and another reports on preventive care and screening measures, there's no way to compare the two providers. Although one of the original assumptions in quality reporting was that it would lead to better consumer choice, the lack of a core set of reporting measures makes that infeasible.

Furthermore, dozens of MIPS measures are not benchmarked to statistically valid results. If two providers reported on the same measure, it's not accurate to claim that one provider outperformed the other, even if the numeric scores are different. This leads to the charge that the program cannot be used to accurately quantify quality of care. With providers' Quality score accounting for half of the total MIPS score, concern over the validity of that component strikes at the core of the MIPS program itself.

Additionally, MIPS has failed to achieve its originally intended breadth. Raising low-volume thresholds means that fewer providers are required to participate. Special scoring provisions are in place for providers in small practices, as well as for providers in rural and other underserved areas, meaning that those providers do not need to meet the same standards as others. Without the pressure of a looming financial penalty, these exemptions and exceptions enable providers to maintain their FFS course.

ACOs Are Failing the Participation Test

There is similar concern regarding an ACO's ability to shift the delivery model. CMS Administrator Seema Verma has strongly implied that the end of risk-free participation in ACOs is around the corner. Nearly three quarters of respondents stated they would leave an ACO if

downside risk became mandatory. Consider the numbers: In 2018, 82 percent of the MSSP ACOs are in a non-risk track. In terms of future participation, the NAACOS survey indicates that less than half of the ACOs in 2018 would continue in a risk model.

It's easy to understand ACO participants' concern, since MSSP ACOs significantly missed the expectations of the Congressional Budget Office. In 2010, the CBO anticipated that ACOs would generate $1.7 billion in savings, but in actuality, spending increased by nearly $400 million. Disappointing results and a potential mass exodus certainly cast doubt on this model, as well.

With MIPS and ACOs taking a public beating, providers and organizations are scrambling to find the missing pieces for their VBHC puzzle and fit them together into a cohesive picture.

How Will CMS Fix Medicare Costs Without MIPS and ACOs?

If the main Medicare VBHC programs to save money fail, what happens? Let's assume that CMS will not gather its marbles and stop playing, because that will drive the budget over the brink. The imperative to save money, in fact, is reaching new levels. Far from stepping back, providers will be forced into even more aggressive programs to cut costs. They just might be structured differently:

> Medicare may indeed attempt to force ACOs to adopt downside risk, as threatened by CMS in May. However, the recent disappointing news that ACOs with down-side risk actually did worse, along with poor ACO results, may temper Medicare's enthusiasm for expanding the ACO program at all.
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> Other APM alternatives for providers might gather steam. While other APMs will have the same two-sided risk requirement, they may provide attractive options for those interested in teaming up with a more defined group of providers to care for a more focused population. Primary care practices may find that the Comprehensive Primary Care Plus (CPC+) program fits the bill, while specialists may target specific episodes of care under the Bundled Payments for Care Improvement Advanced (BCPI Advanced) Initiative.
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> Medicare may use a different approach to directly reduce costs. CMS recently floated a Direct-Provider Contracting (DPC) model for providers seeking a primary-care-based APM, but who are not interested in ACO and CPC+. In this scenario, payers would contract directly with primary care or multi-specialty group practices in traditional Medicare (Part B), Medicare Advantage (Part C) and Medicaid contracts.
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> CMS could also move to privatize Medicare, either through increasing Medicare Advantage plans or via another, broader program. Patients would choose to participate in one of these programs with the expectation that care would be readily accessible, high

quality, but without compromised efficiency. If there is a greater emphasis on patient choice—such that patients select their practice and are provided with tools to facilitate engagement and active participation in their healthcare—such a program may be acceptable to beneficiaries. Providers would have the opportunity to get into a two-sided risk arrangement without incurring additional administrative burden on the billing side.

Providers Have Even Greater Urgency to Develop A VBHC Strategy

Alas, "the best made plans of mice and men often go awry." Though carefully planned, MIPS is not producing enough results within the timeframe needed, especially since budget-imposed deadlines will undoubtedly be shorter. The flexibility that CMS touted has become a tangle of regulations that providers are struggling to unsnarl.

Patients Over Paperwork and Meaningful Measures initiatives allow CMS to justify an exit from the MIPS arena, telling providers that their concerns have been recognized, while preserving intentions to move providers into APMs or other risk arrangements. The concepts are not without merit, but clearly aimed at driving APM participation. For example, Patients Over Paperwork emphasizes EHR interoperability and patient rights to health data. This is critical for an APM, as it enables clinicians to track a single patient across the spectrum of care. Avoiding gaps, identifying potential risk and empowering patients to be their own healthcare advocates are all tactics for achieving APM success.

To succeed, providers need to step back and address a fundamental goal: cap costs without sacrificing patient care. Rather than developing a "MIPS strategy" or an "ACO strategy," it's time to develop a real VBHC strategy. In the short-term, that strategy looks like this:

Begin the APM journey. If your organization has a sufficient primary care base, it's time to start an ACO or CPC+, and do so before rules change. Although the first ACO agreement period is less likely than the second or third to require mandatory two-sided risk, CMS rulemaking can be a surprise. In any case, the goal is to get claims data and begin the process of practicing ways to reduce costs. For organizations without a primary care base, consider BCPI Advanced—a small primary base will lead to an abundance of unmanaged, untethered and potentially high-cost patients.

Squeeze the value out of MIPS. Although not perfect, measure reporting is still required, so make the most of it. Even if the results aren't valid for comparing providers and organizations, they are valuable for comparing your own results this year compared to last. Narrow your organization's focus to a key set of metrics for group reporting, but retain individual provider accountability. Outcome measures can help you identify trends

likely to lead to high costs; developing strategies for improving results will be beneficial once you are in two-sided risk. In other words, don't ignore the issue, even though you may choose to focus on a different outcome measure for MIPS.

Invest in *Intra*operability. Remember that *intra*operability is as important as *inter*operability. It's critical that providers are able to transmit and receive patient records across the system in order to provide appropriate care and consultation. However, this does not replace the need for development of internal metrics that enable participants to track costs and outcomes. A Clinical Data Registry designed to integrate, aggregate and visualize a variety of data sources and types gives you the flexibility you'll need to identify trends and measure the effects of your interventions.

Despite the haze of confusion, the pieces are there and fit cleanly together—patient-centered outcomes, tracked without constraint across the spectrum of care, quantified through valid and visible measurement. A program built on top of these three pillars will help you succeed in any VBHC initiative, but therein lies the challenge. With so much at stake, and so little certainty, knowing what's out there now is not enough. Your plan must be nimble enough to successfully adapt to different programs, but robust enough to effectively provide efficient and high quality care

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: Braden Jarvis