ACOs, You Probably Think Cost Transparency Isn’t Your Problem. Think Again.

written by Theresa Hush | September 24, 2020

ACOs have largely sidestepped the cost transparency dispute raging between Medicare and medical providers, especially hospitals, due to CMS rules requiring providers to give consumers coverage-based cost estimates. If you're an ACO, you probably assume that cost transparency is not your problem.

So you probably won't like to hear that your ACO should be helping your patients manage costs via cost transparency. Moreover, doing so will benefit you as much as your patients.

Let's examine why this makes sense.

Lack of Cost Transparency Disables Discussion of Value for Consumers

Cost transparency really means giving advance price information to consumers so that they can make good decisions about diagnostics and treatments. If consumers are blind to the actual cost of services, their incentives to keep those costs down are minimal. Value is at the heart of transparency efforts. And for consumers, who now shoulder a much larger portion of costs—if not all, if insurance coverage ends—cost transparency is also a matter of fairness.

The definitions of “prices” and “costs” in health care are convoluted, but that confusion benefits providers. Since “prices” are rarely paid because of insurance-negotiated fees and governmental fee schedules, there is no agreed-upon public response to cost transparency.

But Providers Feel Financial Risk in Transparency of Negotiated Rates

Negotiated rates reflect the competitive status of the provider and the health plan. Large providers can negotiate better deals with insurance companies than small health care organizations, and therefore patients of some practices and hospitals will pay more than others.

Medicare’s provider fees are a fraction of those paid by private insurers. But Medicare has interests beyond controlling its direct payments. CMS is considering adjusting prices for Medicare Advantage plans, which also pay the higher rates. The difference? Private health plan payment rates to providers can be as much as two to three times Medicare’s provider fees,

which has benefited providers until now.

Cost transparency could also create a benefit to employers and their employees. Revealing costs paid to providers can stimulate employers and their covered employees to challenge and reduce disproportionately high payments. By lowering cost of provider payouts, there is a potential to achieve expanded coverage.

Why Would ACOs Want to Go Crosswise to Providers' Transparency Disputes?

CMS Rules require hospitals to divulge to consumers the prices they negotiated with insurance companies. In response, hospitals have challenged CMS 2019 rules in court, arguing both that consumers don't pay these total prices so that the rate is irrelevant, and that the negotiations and revealed rate information would damage them financially.

While your ACO isn't subject to those rules, you'd be well advised to adopt cost transparency to succeed under Risk through your own modified approach. As your organization establishes mutually beneficial relationships with providers, you can't avoid the choice to achieve savings by prioritizing strategies to focus on cost variations and areas of excess costs. To realize those goals, you'll need to navigate the battleground of cost transparency by involving patients and physicians in discovery of costs.

ACOs Can Offer a Consolidated Approach for Participating Providers and Specialists

The final CMS requirements for cost transparency may be settled

by congressional legislation or the courts; in the meantime, ACOs have an opportunity to chart their own course to involve physicians and patients in costs. This path does not need to adopt the methods of the CMS rule, as ACOs are not directly targeted by the regulations. But the following key components offer the best method for your ACO to successfully begin transparency efforts and weave them into a larger strategy of physician-involved cost control:

Ensure that cost transparency is organized around how consumers experience health care services—associated by time and episodes of treatment or conditions, rather than individual services. Use technology to create episodes of care to establish the most common procedures and patient cases for targeted episode costs:

- Bundled services like procedures and any post-procedure follow-up;
- Annualized cost of serious medical condition, such as chronic COPD, heart failure, diabetes, and end-stage renal disease;
- Treatment and monitoring costs associated with cancer.

Establish total estimated payments, rather than patient share of costs, as the goal of cost

transparency efforts. Patient share calculations do not help the patient determine the value of the treatment, nor compare alternatives. A patient's share, in absolute dollars, could be affected by a variety of factors, including location, treatment type, and the patient's other existing services. Express cost estimates for episodes according to *payer category*, such as an average of private health plan negotiated rates for the providers in your ACO. This permits you to protect competitive, precise insurance rates while achieving approximate and reasonable accuracy. Exclusions and clinical considerations that may have an effect on actual costs must be listed. Your ACO needn't produce a detailed cost commitment for treatment or services for patients; rather, you need to provide a fair estimate based on a range of costs dependent on certain conditions.

For ACO negotiations with private health plans, ensure you request claims data with financial detail is a precondition to the agreement, so that you can use this information to calculate costs in episodes. Medicare claims will be available for you to develop episode calculations for that population, as will your providers' EMR data.

Support processes that introduce cost transparency into physician-patient discussions about initial treatment plan decisions, annual reassessments or new diagnoses, surgical consults, oncology treatment reviews, and so on. These conversations depend on predetermined generation of cost estimates for various episodes and bundled services that are

initiated as part of a clinical pathway and routine work-up prior to a visit or consult.

Your ACO can improve cost management by navigating transparency, but your leadership is needed most in determining how patients and physicians examine and discuss prices in health care. Lost in all the discussion of politics and protection is this simple fact: at the heart of cost transparency is the conversation between patient and physician, how they explore treatment options and the value of those treatments using concrete estimates of costs and outcomes. Establishing robust shared decision-making based on cost transparency is how ACOs can truly meld business and clinical opportunities to make health care more affordable.

Founded 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.

Image: Jan Canty

Video: Create Effective Partnerships with Physicians for Value-Based Reimbursements

written by Theresa Hush | September 24, 2020

Physicians were trained to be scientific problem-solvers. Reach your potential under Risk by tapping into their overlooked talent to find the balance between best practice and costs. Learn *Three Fixes for ACOs' Physician Engagement Strategies* here.

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Three Fixes for ACOs' Physician Engagement Strategies

written by Theresa Hush | September 24, 2020

ACOs know that reducing costs is the key goal for Value-Based reimbursement. But strategies on how—or even whether—to engage

physicians in that goal have not always been successful, to the detriment of all involved.

Part of the problem is that provider revenues still stem from Fee-for-Service payments. Physicians are still rewarded based on meeting volume of patients and revenues. Even if participating in an ACO, your physicians get very clear messages about meeting volume and revenue targets. Hospital and health system-based practices survive by ensuring that volume is maintained—especially in these times.

As health plan capitation and new Value-based risk payment models emerge, however, you should reassess your strategy for involving physicians. If your history involves using administrative tactics like coordination of care and population health as your main cost control strategies, you are curtailing opportunities to address the central cost drivers: decisions made by physicians (diagnostic or treatment choices) and patients (health and treatment choices). Don't avoid that terrain if you plan for success under Risk.

Frustration about physician involvement has worn out some provider organizations, including ACOs. Years of reliance on a few physicians willing to attend steering groups or attend sessions takes its toll. Physicians, for their part, complain of burnout and excessive documentation and hours. They see administrative meetings as irrelevant and data as untrustworthy. And, they want to spend their time with patients and doing what they were educated and trained to do. One result: ACOs adopt a "we'll do it without them" approach, which will limit success.

Let’s examine physician engagement and how three overlooked strategies promise greater success for your ACOs and participating physicians.

1. Create the Clinical Language for Costs

It is rare that physicians ever see cost data that is rich enough for them to believe, let alone understand, why higher costs occur with some of their patients. The point of providing data to physicians is to provide actionable information that can segue into a process to reduce clinical costs. The data they get, and how it is organized, is the essential element that must be changed to make engagement possible.

The current usage of “physician engagement” implies that clinicians are off in a different world and must be herded into an organizational lockstep march. While not always intended as hierarchical processes, these efforts often connote compliance and the need to meet expectations.

Your review of many ACO physician engagement strategies will no doubt reveal that they often focus on communication, not involvement. They tout the need to disseminate information through different channels, and reach out broadly to carry the organization’s message. It may be good advice, but passive messaging is not a foundation for physicians to be involved in costs.

The key to physicians’ investment is creating a connection between costs and clinical practice. When the adoption of Risk drives cost discussion to be more serious, many COs resort to a common strategy of releasing comparative physician scores. The idea behind scores is that physicians will pay more attention

to where they fall on the curve and gravitate to the mean. Scores include comparisons of annual per-patient costs by primary care physicians, as well as comparisons of attributed emergency room or inpatient admissions. Most of this data isn't actionable: it lacks the detail necessary for clinical evaluation of the events. As a result, scoring comes off as a shaming mechanism, if there is no recourse or intervention process for physicians to actually improve. Measurement, alternatively, can be positive if it is presented for feedback as part of a process that involves improvement.

Measurement must be structured so that physicians can make sense of cost data. Physicians can benefit by seeing individual episodes that are constructed as a comparison of inputs to care and total costs, plotted along a cost curve or displayed with outcomes. Those data illuminate variation in the costs across patient cases, as well as the distinct ingredients—imaging, tests, procedures, and therapies—that contributed to higher costs in each case.

For primary care physicians, even annual per-patient costs can be displayed as patient episodes and show the conditions/factors in individual patients that led to higher annual costs. And it may be even more valuable to review episodes according to populations with single or multiple conditions.

Unless physicians can see the costs related to their own clinical decisions or those of specialists made during the diagnostic or treatment phases, how can they be involved in improving cost performance? Stripped of important clinical information, data is not enough to examine whether costs are

excessive or not.

2. Help Physicians Review Common Variables that Influence Costs

Highest cost patient cases have something in common: they often result from major medical issues or trauma, but there is little opportunity to define future savings. In the middle and lower part of the cost curve of patient cases, however, lie your opportunities.

An ACO-facilitated initiative could generate a physician review process based on small samples of patient cases, with the purpose of investigating both clinical services and costs. This kind of review, with the right data, will be revealing and important to physicians, especially if they have never seen their own patient data in sufficient detail. Again, the key to comparing costs between patient cases is to construct clinical episodes that standardize what services will be included in each episode and over what time frame.

Even examination of low cost cases has enormous value. The episodes may explain the circumstances of the patient or the process that contributed to lower cost, yet good patient outcomes. A shared process over many physicians could provide avenues for broader adoption through review of diagnostics, drug therapies, devices, and the physician-patient communication.

Patients with average to above-average annual costs can reveal common variables to address through discussion and review. The only “magic” is the construction of patient episodes and cases to reveal the important clinical information.

3. Introduce Cost Transparency to Support Physician-Patient Decisions

The real truth about costs is that physicians, patients, and the clinical environment are collectively responsible for making the medical decisions that drive costs. Incentives matter, as well as physician practice style and clinical expertise. But so do patient preferences that are influenced both by their belief systems and what they have been told by medical professionals.

All the parties have been operating without the necessary information to guide medical decisions based on cost and outcomes. The reason? Providers do not consolidate data into patient events and episodes, so that the ramifications of decisions—down to specific drug therapies, diagnostics, and treatment plans within care plans—can be discussed with patients. How many times are diagnostics with little value to ultimate treatments requested, but patients end up paying unnecessary costs? How often are patients given side-by-side comparisons of therapies with both expected clinical outcomes and their relative costs, so that they can make real decisions?

ACOs are in a unique position to help physicians engage in better patient care by using patient episodes for cost transparency in physician-patient decision-making. With episode costs that reflect various options for treatment or other services, physicians are empowered and invested in care that will be both affordable and important to the patient's health.

Physician engagement means investing physicians in a process that will lead to better care as well as better performance. Create the foundation for trust and analysis among your

physicians. You will need technology to organize the clinical and claims data and then customize applications to fit your improvement processes, so that you can facilitate the conversation.

Physicians were trained to be scientific problem-solvers, not cogs in the wheel. Reach your potential by tapping into their overlooked talent to find the balance between best practice and costs.

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Image: Mitchell Luo

Video: The Right Data for Value-Based Success

written by Theresa Hush | September 24, 2020

Claims data isn’t all you need to succeed under capitation. Here’s why provider EHR clinical data should be added to identify variation in care and engage providers.

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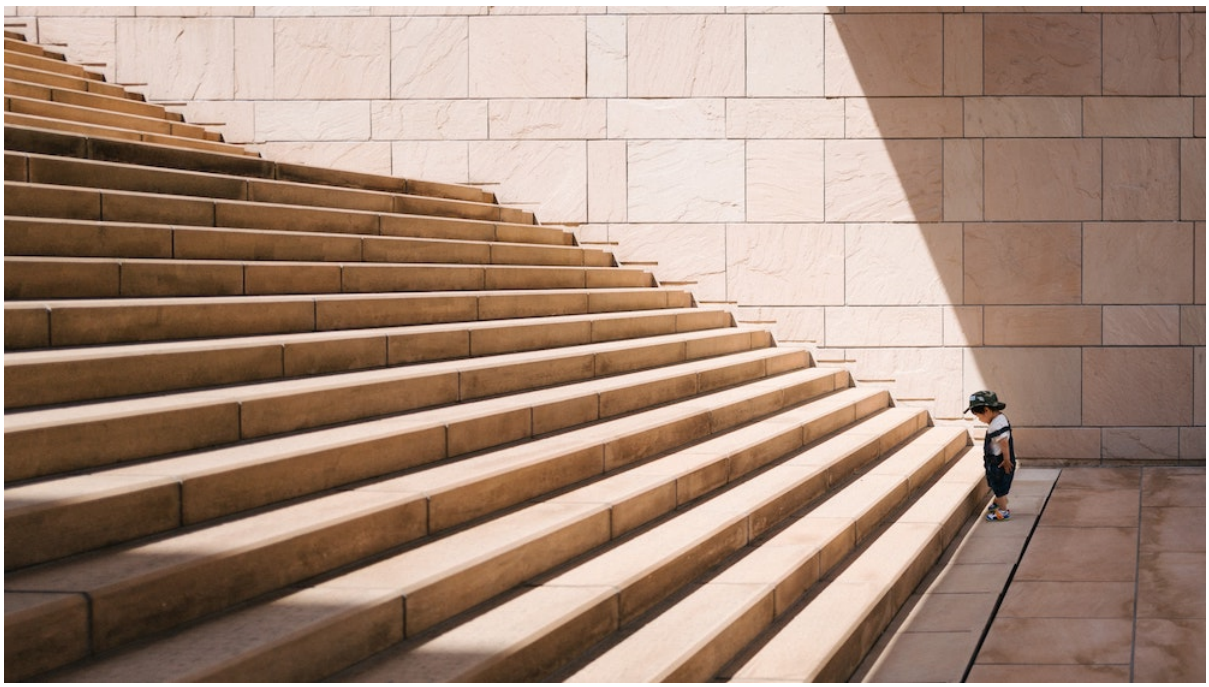
Straight Talk for Providers Adopting Capitation: Don’t Fly Blind Without the Right Data

written by Theresa Hush | September 24, 2020



Value-Based Reimbursement—once focused on incentives and shared savings—now more often means capitation. Whether adopting Medicare Alternative Payment Models (APMs) or contracting with health plans, physician groups and health systems have signaled greater willingness to adopt these new Risk payment models with their guaranteed payments for attributed patients.

But here's the problem: If you don't have good data on your costs, you are flying blind.

Let's look at the myths and realities of what you really need both to measure your success under global capitation and to ensure that your Risk program is on track to be successful.

Do You Need Claims Data for Calculating and Evaluating Costs?

The short answer is that the more open your system, with patients using practices and facilities outside your own, the more claims data is necessary for calculating key cost

indicators. The most important of these indicators is your Per Patient Per Year Costs. That is a key benchmark that you can compare against global capitation levels. While that number may indicate you have a problem, however, it won't tell you what that problem is.

Your status with payers currently dictates whether you get claims data. ACOs receive claims data from Medicare, and so will provider groups that are Direct Contracting Entities under the Medicare Direct Contracting program. But groups contracting with commercial carriers rarely—if ever—have access to full, patient-identified claims data. That includes Medicare Advantage plans, covering over a third of Medicare beneficiaries.

Organizations that intend to provide care to patients under a global capitation payment, particularly under private insurance plans or employer-direct contracts, must negotiate provisions for regular claims data feeds. For ACOs, Independent Practice Associations (IPAs), and similar Clinically Integrated Networks (CIN) that include many private practices, this data is critical for you to understand how patients are flowing into your system and where they are going for specialty care.

Having claims data is a big advantage in two critical areas: you can calculate the cost of services that have been generated by your patients and your providers, and also see services patients have used from other providers outside your organization.

But, Is Claims Data Enough?

Here's the other problem that people rarely acknowledge: if you

aren’t already in Value-Based reimbursement like capitation, you won’t get claims data until after you’ve signed the agreements and services are flowing. So your retrospective view of patient costs has two flaws. First, it won’t help you decide whether you can survive under global capitation, and second, it can’t help you enough to manage costs prospectively.

A lot of ACOs have built their shared savings strategies on claims data alone; others have simply dug into strategies that seem to make sense, without really focusing on data at all. That may work when no downside Risk is included in the arrangement, but it’s a mistake when real revenues—which pay for provider salaries, rent, record systems, and direct services to patients—are on the line through a fixed fee structure like capitation.

Let’s examine what you *can’t* see with claims data. Especially if your view of cost data is based on annual costs reflected by claims data, your view of these cost drivers is obscured:

- Longitudinal view of patient conditions, services, and costs;
- Problem lists from the EHR that indicate patient issues with diagnoses outside the claims data parameters;
- Clinical patient data such as lab values, functionality scores, other critical outcome information;
- Referred versus non-referred, or patient choice, services;
- Diagnoses that are filtered out by the payer because they are not primary to the service;
- Quality measure data;
- Trended outcome data.

While claims data may be more comprehensive because it comes from all sources of services (theoretically, which we will address next), the quality of the data is poor from the standpoint of engaging in activities to improve cost performance. In fact, the poor substance of the data virtually limits these improvement activities to service elimination, prior authorization, or coordination of services.

Over-dependence on claims data leads to the perspective that costs are high because of "patient overuse." This explains why ACOs have focused their attention on limiting post-acute services and emergency room services, and have over-relied on coordination of care activities for patients with high utilization. *Claims data is not helpful in engaging providers in a longer-term focus on improving care design, medical and patient decision-making, and clinical cost control, because it lacks the clinical data needed for providers to engage.*

ACOs and groups often bemoan the lack of provider engagement in cost, while, in fact, meaningful cost data is rarely provided to physicians at all, especially data of value for clinical improvement.

Collecting EHR Clinical Data Is Feasible for Providers Going into Global Capitation

Years ago, the aggregation of data from provider systems was a big challenge. As a pioneer in such efforts during the early 2000's, Roji Health Intelligence modeled data using the backup databases of many clinical record systems to create a common for collection of data. Additionally, more private practices used cloud-based or low price EMRs that made data exports almost impossible. Aggregating data from networks having over

300 different clinical data systems, we were able, even then, to integrate all patient transactional and clinical data into a patient-centric database for evaluation of cost and quality.

Now, health systems are bigger and more consolidated, with fewer EHRs. But those clinical systems have interoperability capabilities and are also supported by dedicated staffs of the health systems, enabling reporting of the data. This has supported easy and more current collection of data from Epic and other large systems.

Current data collection from providers is seamless and fast, rarely taking more than a few days for providers to create reports using Roji data specifications, and to submit securely to us. When FHIR v4 becomes more broadly adopted, data sufficiency will continue to improve.

Analytics and data aggregation vendors should be able to easily support clinical and transactional data collection from providers either anticipating or participating in global capitation. Even if not all participating providers have easily accessible systems, the capability to include clinical data from the majority of providers and supplement other data feeds is indispensable.

But Data Does Lie

Aggregating provider data, however, is not enough to support global capitation cost management. The data needs a full vetting and restructuring for clinical engagement.

Anyone who espouses the catchphrase “data doesn’t lie” hasn’t looked at clinical data as it comes from EHRs. Data does lie

because it depends on human delivery via both technology implementation and actual data input. Data goes missing, is not collected or entered, is miscoded, uses local generic or outdated codes, or is not coded at all, and is not reported into the export files because it is hiding in some unknown table of the database. Data can also lead people astray, creating inconsistencies in the timeline of the patient—such as diagnoses that are coded after a procedure that imply a complication rather than a preexisting condition.

Data also can be false at point of original capture. The variation in blood pressure values is an extraordinary example of wildly variable values over a single episode of care. Some blood pressures are taken incorrectly by staff, some reflect patient “white coat” syndrome, fear, pain, differing equipment, and practices used in taking the measurement.

When aggregated, such mistakes in data are amplified. That’s why data must be reviewed and validated. But it is only when patient histories are combined in episodes that mistakes come to light. This is a critical function for providers while they review and draw conclusions about cost data that is built on clinical diagnoses and other aspects of the patient. Again, episodes facilitate that analysis by creating the sequence of patient history and events in a way that illuminates what happened and what should be questioned.

The truth of cost data cannot be revealed through claims data because it lacks the robustness needed to create the story. Clinical decisions require supporting clinical data to make sense.

Facilitating the Clinical View of Costs

We have previously addressed several mechanisms that help groups analyze cost information in a way that illuminates clinical processes and treatment decisions. Patient and procedural episodes are just one way to evaluate patient outcomes and costs in the context of such clinical decisions, but they are essential to the development of an effective and efficient specialty network.

Specialty physicians will drive most of the downstream costs for patients attributed to the globally capitated entity. If those physicians cannot see their own procedures and medical episodes along a cost curve, their ability to change that curve is diminished. Episodes have the power to illuminate how medical decisions—such as overlapping multiple procedures in a single patient event—have affected costs and outcomes for individual patients. That can and should lead to internal discussion about best practices that will optimize affordability and produce best outcomes.

There are no shortcuts to successful participation in global capitation. You will need experts to aggregate and structure data for you so that your clinical expertise is not wasted on reviewing false or insufficient data. As providers, only you can create better clinical care design and physician-patient decision-making to produce better outcomes at an affordable cost.

Don’t fly blind into Risk without a clear view of what you need to work on to make your health care achieve more.

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Image: Jukan Tateisi

Video: Specialists and Value-Based Reimbursements

written by Theresa Hush | September 24, 2020

With specialists driving a significantly large share of ACO costs, consider how to use episode-based inquiries in your ACO strategy. The higher the financial risk for ACOs, the more critical it is to incorporate specialty episodes and other features effectively. Read more here.

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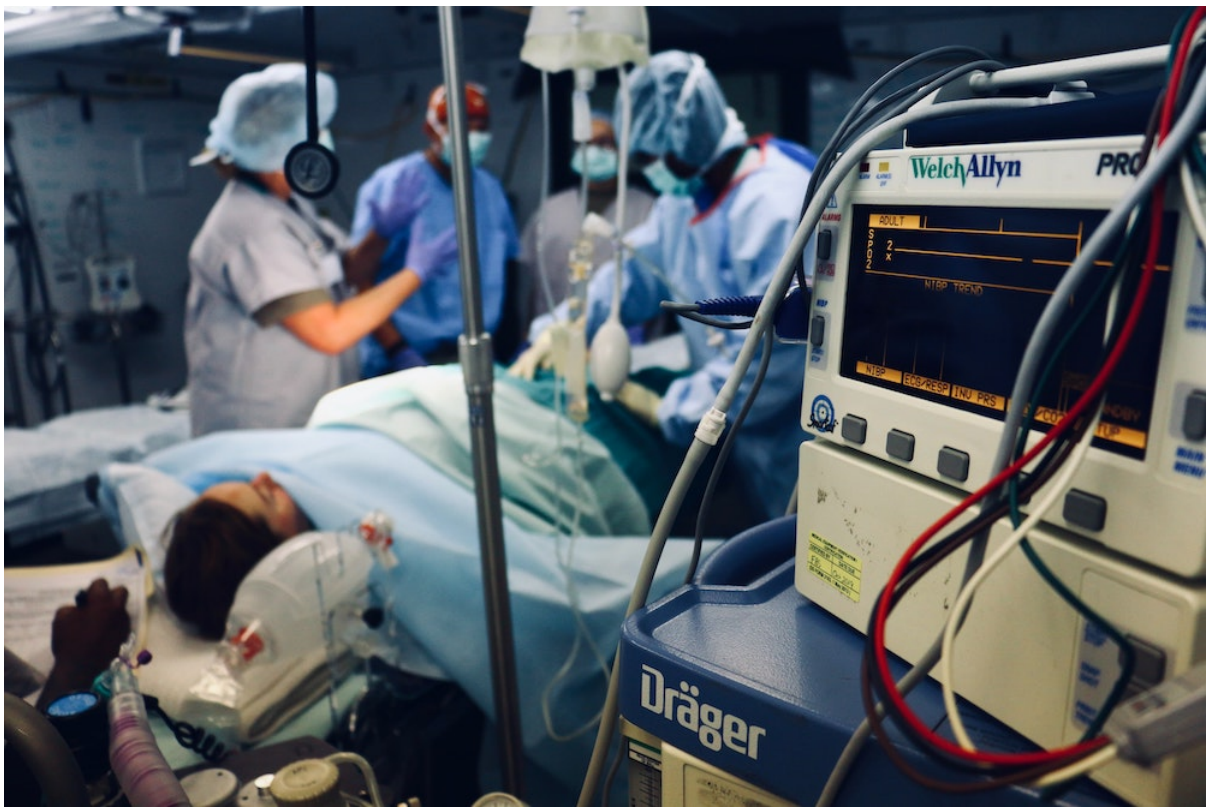
How ACOs Can Control Costs with Physician Help, in 3 Steps. Really.

written by Theresa Hush | September 24, 2020



Health care has been drained emotionally and financially by the COVID-19 pandemic. Yet, in a surprising twist, that trauma has accelerated providers' willingness to adopt financial Risk.

You may be one of many providers who have suddenly realized the value of predictable revenues like capitation. Receiving continual payments for attributed patients is appealing, especially when deferral of routine care has led many practices to the brink of failure.

That's why many providers are specifically considering capitation. For Groups with previous experience in managing risk pools, it's an easier decision. But if you represent an ACO that resisted CMS Rules to inject downside Risk into the model, or a Group still tiptoeing toward Risk, your path may be longer. Ask these questions: Can you prepare quickly for real Risk like global capitation? And if so, how will you protect

yourself from costs you don’t directly control?

There’s a subtext here. Candid ACOs will express the reservation, “If only I could engage physicians.” That’s why it’s essential to address these questions together: How can you achieve cost control through physician engagement?”

Here’s a synopsis of the steps needed to do just that, using solutions that Roji Health Intelligence has successfully piloted with our clients.

Step 1: Correct the Lack of Data Essential for Clinicians’ Engagement in Risk

Many ACOs and Groups use claims data to establish their cost savings strategies, as well as analytics, population health, and provider comparisons. CMS has promised Direct Contracting entities will receive such claims data to help them with global capitation.

While claims data is adequate for aggregating total billed services by patient into annual Per Beneficiary Per Year (PBPY) Costs and identifying out-of-network services, it only gives you information that highlights and categorizes your costs. *It doesn’t tell you why your costs or higher or point to what you can do.* That’s because it misses a key attribute for ACO success: clinical patient status information.

Patient status includes discrete bits of patient clinical information stored in EHR problem lists, lab and other values, blood pressure readings, medication lists, and other clinical or demographic information. Unless you are able to harness relevant clinical information and connect that data with costs,

you aren't in a position to help your clinicians engage in clinical solutions—or, for that matter, to even engage in the problem.

This is why Roji Health Intelligence first collects provider data to support their services. Correct the problem by collecting data from provider EHRs that can supplement transactional encounters as well as claims.

Step 2: Create Patient Episodes with Clinical Integrity and Interest

Patient clinical data lets you review what is actually happening to the patient before the ER visit, before and after procedures, and admissions. You can plot patient risks against outcomes, and track how patient symptoms were validated (or not) through diagnostic tests. As you connect all of these patient experiences through episodes of care, the enriched data will help your clinicians become involved in identifying issues that drive costs.

But to accomplish episodes, data must to be organized into comparable units that make sense to physicians. The best method to normalize patient experience is with patient episodes by various categories, such as procedures, conditions/condition combinations, and patient risks or populations. Adequate data integrity and volume can generate the data needed for comparing episodes along key vectors: cost, outcomes, and diagnostics or treatment plans.

Payer episodes of care that support payment models have little "clinical" integrity; they are a mix of included and excluded procedure and diagnosis codes, and those inclusions or

exclusions respond to either payer or provider financial or administrative issues. *By contrast, provider-developed episodes should be more inclusive so that they can illuminate more about the patient cases and engage providers in conversation.*

Step 3: Engage Physicians in Clinically-Based Cost Inquiries

After resolving data insufficiency and organization, you can create a process for your physician engagement. That process must not resemble scoring and similar cost comparisons if you want physicians to approach it positively.

Scoring turns physicians away from an active inquiry process and raises defenses. It's also unfair. The data does not tell the full story, and, is often inaccurate. There can be missing pieces of information, such as the patient's long-term history or services beyond the scope of data. Or, a full picture cannot be determined without data about patient risks, social determinants, or the extent of other conditions—none of which is always present in a single provider's EHR, especially when patients see multiple physicians.

A more effective approach is, first, to coach physicians on what data is saying about their cases and costs. The objective is awareness, not scolding. The cases could well be in the lower cost range, and the inquiry focused on what happened that could help ensure similar cases with good outcomes. Or use cases across the spectrum of the physician's patients, asking for feedback about what contributed to the variation in cases.

There are so many substantive threads to follow that where to begin is not really important. One could be the path from

symptoms to diagnosis, evaluating the diagnostic services for consistency, duplication, and best practices— or the lack of a diagnosis related to presented symptoms that could signify a patient left stranded. Another could be cost variation spurred by different patient risks or by treatment approaches. Or, costs illuminated by patient age and risk category.

Can You Engage Your Specialty Referral Network?

With specialists driving a significantly large share of ACO costs, also consider how to use episode-based inquiries in your ACO strategy. The higher the financial risk for ACOs, the more critical it is to incorporate specialty episodes and other features effectively.

Contribution of data and episode review could be part of referral discussions and agreements. Episode analysis is positive for specialty groups and helps them on the path to competition as well as financial recovery, but initial reactions could also be defensive. Both your ACO and the specialty practices will need to approach data sharing and solutions in a way that will be mutually profitable.

Another bonus: In review of episodes, specialists can play a vital role in identifying and attaching key risk factors and diagnoses to the patient for primary care management.

In short, yes, it is possible to engage physicians in costs and discussions, so long as the language and subjects of those discussions are neither preempted by blame nor predetermined by scoring. Your ACO Administration must give credit to physicians for their clinical expertise—after all, that is why they are valuable—and use that talent instead of algorithms to pave a

path to value.

For Medicare-focused ACOs, using clinical approaches to focus on long-term trends has an additional advantage. Only episodes and review of patient cases can reveal choices and decisions about treatment, patient selection, and alternative therapies—decisions made by both patients and physicians.

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Image: Richard Catabay

“Push-Pull” for Providers in Medicare’s Proposed 2021 Rule for Physician Fees and Quality Reporting

written by Dave Halpert | September 24, 2020

The newly published 2021 CMS Physician Fee Schedule and Quality Payment Program (QPP) Proposed Rule reflects our harsh reality: Operate under the constraints of the COVID-19 pandemic, while moving toward uniformity and Risk. That tension is palpable in the Proposed Rule's "push-pull" of CMS trying to continue to advance a Value agenda while stuck in the mud of the pandemic.

Rather than launching the next step of integrating CMS quality improvement activities, the Proposed Rule stays the current course for MIPS Quality Reporting to avoid additional stress on providers during the COVID-19 pandemic. But the Proposed Rule also continues to clear the path toward a common system of quality measurement for all providers, and toward financial Risk.

CMS explicitly declares that a public health emergency is not the time to make big program changes, delaying the MIPS Value Pathways (MVPs) model until 2022. However, the Proposed Rule—

which also covers Physician Fee Schedule (PFS) modifications for 2021—includes provisions for new, permanent telehealth codes.

COVID-19 has led to a massive upswing in telehealth; in turn, the Proposed Rule provisions for new telehealth codes include adjustments for complexity and prolonged services, along with other changes. They also allow flexibility to use these codes in new settings, including home visits. In the Merit-Based Incentive Payment System (MIPS), many quality and cost measures will be adjusted to reflect the increased use of telehealth codes.

While there has been an attempt to maintain QPP consistency for the sake of the COVID-19 pandemic, the 1,353-page Proposed Rule covers a lot of ground. Reading between the lines, it's clear that CMS remains committed to moving providers from a fee-for-service system into Value-Based reimbursement models. Specifically, they want providers out of MIPS and into Alternate Payment Models (APMs), which are the most significant ways that CMS is advancing this agenda.

Forfeited to the Pandemic in 2021: MIPS Value Pathways (MVPs)

The clearest example of "give" to providers in the Proposed Rule is the delayed release of the MIPS Value Pathways (MVPs) model. MVPs were previously scheduled for implementation in 2021, as finalized in the 2020 Final Rule. However, as we are in the midst of a pandemic, organizations have had neither the time nor the resources to prepare for these changes, so CMS proposes limiting disruptions to MIPS. Nevertheless, CMS has updated the MVP Guiding Principle and the Proposal provides

insight on how MVPs will be used to move providers into APMs.

In particular, organizations will have greater control over their scoring than previously understood. First and foremost, CMS "envisions" (this is a Proposed Rule) that MVPs will be optional for providers when a set of measures and activities align with their practice. Organizations will need to formally submit their MVP as a candidate to CMS, using a to-be-defined template. The submitter will propose the measures, Improvement Activities, and cost measures to be included in the MVP. This may help alleviate concerns among practices that CMS would arbitrarily hand down pre-defined MVPs, without regard to the specific types of care they provide.

To earn MVP approval, organizations should tie the 21st Century Cures Act and Patient Protection and Affordable Care Act into their MVP framework. This will obviously include a link to the Promoting Interoperability category of MIPS, but should go much further.

On the Quality side, CMS has proposed an additional guiding principle of MVPs, which is the use of "Digital Quality Measures" (dQMs). These are rooted in digital data sources, ranging from the mainstays like EHRs, HIEs and Registries, down to newer sources, including assessment data and even wearable devices. This signals CMS's desire to amplify the patient voice in the measurement process. In fact, CMS advocates through this Proposed Rule the belief that patients should be involved in the MVP development process itself, in order to ensure that the measurement is meaningful to them.

CMS has made no secrets about its desire to move providers out

of MIPS and into the APM world, and this MVP process will give organizations the chance to develop their own “APM-Lite” structure, enabling them to succeed in MIPS in 2022, while spring-boarding them into APM readiness.

Simplified QPP Scoring for APM Participants: Introducing an APM Performance Pathway (APP)

This Proposal introduces an APM Performance Pathway, intended to standardize participation options among MIPS and APM tracks, while simultaneously facilitating APM participation. As proposed, the APP is only available for MIPS APM participants, but it does allow reporting at the individual, group (by TIN), or the APM entity level.

The APP is structured in a similar manner to a Medicare Shared Savings Program (MSSP) ACO. Those who volunteer for the APP would be able to report a single set of measures and receive an Improvement Activities credit. The cost performance category would be re-weighted, as providers are already scored on cost within the context of their APMs.

The integration of the APP marks the end of the “APM Scoring Standard,” which will substantially simplify QPP scoring for APM participants. The proposed measure set is primary-care centric, with one measure each for patients with hypertension and diabetes, a depression screening measure, performance on Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, and two administrative claims-based measures.

The APP will shake up MSSP ACO scoring, as ACOs will need to report via the APP process, rather than the CMS Web Interface. *In fact, the CMS Web Interface is being retired altogether, for*

both MIPS and ACO quality measure submission. The number of measures that the ACO (or APP participant) will "actively" submit (as opposed to being calculated by CMS or the survey vendor) will be reduced from 10 to 3. While this is a clear signal that CMS is focusing more on costs and patient feedback than scoring a multitude of quality measures, it is also *a warning to ACOs that they will need to find an alternate method of quality data submission.*

Uncertain MIPS Quality Scoring: Providers Who Don't Aggressively Push for Success, Beware

While the category itself may not undergo massive changes, that's not the case with the specifics. As we know, "the devil is in the details."

The majority of the Quality scoring system will remain intact. MIPS measures will still be graded on a 3 to 10 point scale, provided the measure has a historical benchmark, at least 20 eligible cases, and a response for at least 70 percent of the applicable denominator (although CMS anticipates using a 1 to 10 point system for MVPs). Measures with fewer than 20 denominator-eligible cases or without an assigned benchmark will continue to earn 3 points, provided that at least 70 percent are reported eligible cases. In a change of course that providers should appreciate, CMS has proposed that points will continue to be awarded for those reporting additional outcome and high-priority measures.

Things get complicated when looking further, though, starting with the measures themselves. Of the 206 proposed quality measures, 112 of the 2020 measures will undergo "substantive changes." While many of these changes relate to the inclusion

of telehealth services, providers would behoove themselves to review updated specifications before beginning in 2021—additional updates are scattered throughout. There may be more to these changes than meets the eye. *A measure with substantive changes may lose its historical benchmark. This means that the measure may only earn a maximum of 3 points, even though the prior-year iteration of that measure could earn up to 10 points.*

The benchmark issue is further compounded by the COVID-19 pandemic. CMS has raised concerns that the pandemic will compromise the integrity of benchmarks, as they are calculated based on the prior year. For 2021, that would mean measures reported in 2020—as we know, this is far from a normal year, and benchmarking based on 2020 data is suspect. Therefore, CMS will calculate 2021 benchmarks based on what is actually submitted in 2021. As a result, clinicians will not have the ability to track their performance against an established standard during the year, which has been a feature of MIPS in prior years (with the right partner).

While this may create a scenario where additional measures receive benchmarks (potentially earning more points), the overall impact will be challenging to providers. They will not be able to track comparative performance at a program-level and will not know how a measure will impact MIPS scoring—and future reimbursement. CMS has stated that they are seeking feedback on potentially using the 2019 performance period to calculate 2021 benchmarks, but the official proposal is to calculate performance after the fact (comments—through regulations.gov, code CMS-1734-P—are due by October 5, 2020!).

Complicating things further, two new administrative claims measures have been proposed. One is global (Hospital-Wide 20-Day All-Cause Unplanned Readmissions), requiring at least 200 cases in the denominator, and one is episode-specific (Risk-Standardized Complication Rate Following Elective Primary Total Hip and/or Knee Arthroplasty), requiring 25 cases. CMS Feedback on prior episode-based cost measures has been sparse, and the same type of information (i.e. the relationship between costs and re-admissions and surgical complications.) would have been useful for preparing providers for these two measures. Unfortunately, the details provided by legacy programs' (PQRS and the VBPM) feedback reports have historically not been included in MIPS feedback reports.

Both Give and Take for Providers: Maximizing MIPS Penalties (but Limiting MIPS Rewards)

MIPS is a budget-neutral program, meaning that (with the exception of Exceptional Performance bonuses), CMS cannot distribute incentive payments beyond what CMS has recouped through penalties. If most providers meet the minimum performance threshold, the penalty pool is relatively small, and so is the corresponding incentive.

In the 2018 performance year (the 2020 payment year), 98 percent of MIPS participants earned a positive incentive payment in 2020. Unfortunately, that means the incentive was funded by the mere two percent who did not meet the minimum requirement—a thin incentive spread for the 98 percent of successful participants. CMS is still calculating 2019 results, as the submission period was extended due to the pandemic. However, with the opt-out opportunity and extension, given the

trend (a similarly high success rate was achieved in 2017), it is likely that the 2021 incentive payment (based on 2019 performance) will be equally modest.

For 2021, CMS has proposed that the Performance Threshold will only be increased to 50 points, rather than the 60 points that were established in the Calendar Year (CY) 2020 policy. Nevertheless, CMS is standing by the increase to the Exceptional Performance Threshold; it remains at 85 points. The result will likely be a large percentage of providers who avoid penalties, with fewer earning the Exceptional Performance bonus.

Furthermore, in keeping with the proposed APP framework and end to the APM scoring standard, CMS has adjusted its scoring hierarchy, such that, should a provider have more than one type of data submission (i.e. Virtual Group, APM, Group Practice, Individual), as long as the provider is not in a Virtual Group, CMS will assign the provider the highest possible score—even if that provider is in an APM. That means more opportunity for providers to exceed the 50-point threshold and claim a sliver of the incentive pie.

Even though the penalty is staggering (9 percent in 2023, if failing to meet 2021 requirements), having a comparatively small group in this contingent will mean that incentive payments will be nominal, especially when compared to successful APM participants.

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succeed in Risk.

Image: Vidar Nordli-Mathisen

Episodes Are More Than Payment Models: They're Key to Improving Care

written by Theresa Hush | September 24, 2020

For many health systems and groups, episodes are esoteric. Providers often think of them only in context of risk-based payment models like bundled payments and capitation. Navigating Value-Based Health Care contracts, providers analyze and model performance under Fee-for-Service and episode-based payments to decide their course of action. Or, if already in Value-Based reimbursement, they use them as targets for costs to pinpoint physicians who exceed the targets.

These strategies are shortsighted and limited. Even at best, they do nothing to address what is actually driving cost of care. By using payer-constructed episode specifications, such strategies potentially obscure valuable clinical and cost information from evaluation. These are lost opportunities for providers to direct their own clinically driven cost control initiatives. Analyses of patient care episodes are tailor-made for providers to conduct inquiries of costs and cost drivers, resource use, patient outcomes, and inequities in health care. But to do that, we need to look at them differently than payers do.

Episodes Were Created by Payers as Risk Vehicles

Episodes are a methodology based on capturing all costs, resources used, outcomes, and other data for a given patient-capsule of health services. Typically, that capsule is defined by a patient, timeframe, and services specific to a type of care. Here’s the hidden benefit: Capturing data in this way allows for comparison of costs, outcomes, and other metrics of health care for defined populations of patients—for example, those having certain procedures or those with conditions and risks.

But episode-based *payments* were designed to eliminate volume-based incentives for delivering more services and to establish fixed fees. Fixed health care fees, like capitation and episode-based reimbursements, are moving into the mainstream. Value-Based payment models are using more aggressive risk models than shared savings. Medicare signaled the shift from shared savings to fixed fees when incorporating global or

partial capitation in its Direct Contracting program. In specialty services, procedural or treatment-focused episodes of care are forming the basis for cost measures—and for bundled payment reimbursements to specialists and other providers.

Episodes in Payment Models Can Be Artificial and Arbitrary

Building payment models based on episodes introduces other factors designed to make the payment more palatable to providers or easier for payers to administer. For example, Medicare and other payers will narrowly define a capsule of specialty care, so that diagnoses or factors that could lead to outlier costs are excluded from the episode altogether. That makes it more acceptable to physicians.

However, to make a single bundled payment work across a larger group of procedures, such as multiple spinal procedures, related procedures are combined. The episode that determines a bundled payment—constructed with multiple exclusions yet accumulated across multiple procedures and approaches—is no longer related to clinical care or outcomes in the same way.

Capitation Is an Episode-Based Reimbursement, but More Broadly Defined

Some might argue that capitation is not episodic because all care is included. But capitation is simply a person-episode with the episode time frame set to a year (and then paid out monthly). The same methodology of data capture exists in both capitation and episodic payments to specialists. The time span of the episode and types of services to be included have simply been lifted in capitation to make it more inclusive.

Capitation may also have variations in the capsule of services to appeal to providers, just as specialty episodes have these features. Providers may be able to choose global or partial capitation, respectively including everything or limiting fees (and risk) to professional services. Medicare's Direct Contracting model allows providers to elect either global or partial capitation. Capitation may also be risk adjusted, or age-adjusted.

Three Huge Benefits of Episode Analysis

Despite the financial disasters experienced by providers during the pandemic, Medicare and health plans have given no indication that they will let up on plans to expand financial risk in health care. In fact, it's quite the reverse. Medicare is clearly proceeding with plans for Direct Contracting and Medicare Advantage plans to continue moving toward the most aggressive vehicles of Risk, prospective risk-based payment. At least one health plan has offered recovery payments to primary care physicians with the stipulation that they accept capitation in the future and remain independent.

To live under fixed fees, small progress in achieving savings and cuts in "elective" services won't be enough. That's where episodes can help:

1. Episodes can illuminate costs by revealing patient stories of care for given diagnoses, and resulting costs and outcomes.

Populations organized by higher risk or serious conditions can form the basis for special episode analyses, to facilitate reviews of potentially higher risk patients. Likewise, higher cost patients can be used as a unique population to explore common factors.

2. In a physician-driven environment where physicians have latitude to create clinically-relevant episodes rather than artificial constructs, they can more enthusiastically engage in evaluating cases and patient stories.

While coaching may be used to introduce the data and analytical approaches, it is essential that physicians see their own data and visual results. They are much more likely to be interested in contributing to the environment if there are clinical practice benefits and exchanges with other physicians.

3. Evaluating symptoms, diagnoses, and treatment results across conditions or patient attributes can also help to reveal a variety of other important aspects of care.

Inequities from racial, gender, or cultural bias for further study. These are topics that will be important for providers to address for ethical, consumer, and cost reasons.
Unexpected events, particularly following procedures. Including complications as well as problems or costs in post-acute care, unexpected events can be more clearly and fairly evaluated in the context of the episode as part of a learning process.
Evaluation of treatment modalities and areas where better patient information or shared decision making processes are indicated.

Episodes create a real opportunity to put the focus on value of health care. While it is not easy to construct episodes of care with data, making the effort will give providers a crucial advantage—to better understand how their decisions and services translate into costs, and how data reveals the clinical process from beginning to end.

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How to Start Redressing Racial Bias and Reducing Health Care Inequities

written by Theresa Hush | September 24, 2020

In recent weeks there have been many cries for the health care system to finally address racial inequities. Now is the moment to harness that energy toward a process of substantive change.

Value-Based Health Care is not achievable without addressing racial inequities that drive costs and poor outcomes: patient disengagement, higher risk factors, greater admissions, and emergency room usage. Fully acknowledging the issues is the

first step. Creating better methods to evaluate how race affects decisions and to innovate change is the next.

Racial inequities in health care in the U.S. are well documented, including:

- Higher maternal mortality, with Black women three to four times more likely to die in childbirth or from its complications than their white counterparts;
- Evidence of dismissal of pain symptoms for Black women (this bias runs across all races and ethnicities) and men; likely misdiagnoses of women with cardiovascular disease;
- Higher incidence and more deaths from cancers of almost all types;
- Across many conditions, diseases caught later, with greater progression and associated risks, and higher mortality;
- Much shorter life expectancy in the Black population;
- Disproportionate number of deaths from COVID-19 .

Racial Inequities Result from Racial Bias

Health outcomes and mortality across all medical conditions are poorer for people of color. Socio-economic disparities—lack of access to quality health care, lack of adequate health insurance, lack of resources to pay for health care—account for some of these disparities. A disproportionate percentage of high risk factors such as obesity and hypertension within this population also leads to poorer outcomes.

But addressing financial coverage and access to care won't correct disparities. These inequities are driven by racial (and gender) bias in the provision of care itself. That's the hard part for providers—and health system administrators—to address.

Physicians go into medicine to help people and earnestly believe they are living up to the Hippocratic oath. But racism is invisible and misunderstood. Unconscious and unintended racial attitudes bias risk assessments, diagnoses, treatment algorithms, and continuing care for patients of color.

Racial bias in health care has also created a false narrative about race and health care, especially to the detriment of Black Americans. That narrative includes using race as a proxy for genetics and biological differences that in reality do not exist. For example:

> Allegations that hypertension in Black Americans is a completely different disease, referencing more severe clinical status and a widely-touted (but debunked) "genetic salt-sensitivity," even involving ocean crossings into slavery, among other contributing theories. The fact is that many humans, regardless of race, have a higher sensitivity to salt. If Black Americans present later with disease due to other barriers to care, the health ramifications will be greater.
> Racial bias in diagnoses of mental illness. Black Americans are disproportionately diagnosed with schizophrenia and are overrepresented in state psychiatric hospitals. Yet such diagnoses represents interpretations of symptoms and not, necessarily, real schizophrenia. A number of studies indicate significant racial bias in diagnosis, with Black people three to four times more likely to be diagnosed with psychotic disorders than whites. According to one recent Rutgers study, clinicians performing assessment of symptoms for severe depression were more likely to diagnose Black patients with schizophrenia while attributing white

patients' symptoms to severe depression, by overlooking mood symptoms.

Characterizations that Black patients are non-compliant, unreliable, late, neglectful of their health, and fail to control their own risk factors, by physician practices, health administrators, and even politicians arguing for higher consumer share of health care costs. For example, in a study of provider decisions to recommend total knee replacement (TKR) as a cost-effective treatment of severe osteoarthritis, providers were more likely to assume that white patients would be more medically cooperative than African American patients. Although those implicit biases were not predictive of treatment recommendations in the study, the researchers concluded that those attitudes "may have influenced treatment decisions."

Inclusion of race in specialty treatment risk assessments and algorithms that problematically use race as a proxy factor for genetic risk, a practice called out by a recent *New England Journal of Medicine* article. Despite a wealth of data proving that race does not confer distinct genetics, these methods result in restricting Black patients' eligibility for certain courses of treatment, and raise risk assessments.

How Do We "Fix" Racial Bias?

Because we perceive our feelings as reality, informed by experiences and the influence of others, unconscious bias is almost inevitable. Whether that bias is racial, cultural, or gender-based, providers are not immune. Biases enter into the exchange with the patient in ways that determine belief about the patient's reliability, symptoms, and behaviors, and

influence diagnosis, treatment options, and ongoing care.

But a critical, punitive approach to addressing racial attitudes will only put clinicians on the defensive. Such attitudes are often unconscious and unintended, and are not exclusive to clinicians. Solutions must be directed throughout the health care organization to help providers and administrators alike. Every industry should be doing work to promote self- and structured education, conversations, and activities to bring racism to an end.

Health care, however, cannot reach accountable care goals without measuring its performance. Quality and cost measures warrant expansion to incorporate equity of care criteria. Since both race and gender have substantial evidence of disparities, key decision points should be illuminated through data that focuses on medical decision processes to reveal those disparities, such as:

- Constellation of symptoms and the resulting diagnosis for patients by gender and race;
- Diagnosis and prescribed/fulfilled treatments by gender and race, including pharmaceutical, surgical, and other types of interventions;
- For high risk individuals, volume, cost, and variety of care inputs by gender and race;
- For high risk individuals, intermediate and long term outcomes in relation to care provided.

Episodes of care may be a helpful model that can help to provide a method to fairly assess these issues. In a future article, we'll examine how we might use episodes to create the

building blocks to evaluate care to patients in populations, not just as individuals.

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