

The Fallacy of “Relief”: The Dangers of MIPS Extreme and Uncontrollable Circumstances Applications

written by Dave Halpert | June 26, 2020



Under the banner of “relief,” CMS has announced that clinicians will have the opportunity to file an Extreme and Uncontrollable Circumstances application to qualify for re-weighting in some or all components of the Merit-Based Incentive Payment System (MIPS). This possibility may sound intriguing, but don’t be fooled—those who take this route are overlooking the longer-term consequences of maintaining and expanding MIPS efforts.

MIPS Is Not Going Away

The day before releasing 2020 MIPS flexibility guidance, CMS announced the creation of the Office of Burden and Health Informatics, which has grown out of the Patients Over Paperwork initiative. In this notice (released less than 24 hours prior to the Extreme and Uncontrollable Circumstances guidance), CMS cited MIPS as one of its key accomplishments in reducing

burden, as it reduces the number of quality reporting programs from three to one.

Similar to [CMS's approach with ACOs](#), this guidance should not be seen as a reprieve, but as safety net for a limited number of clinicians. In its announcement of the application process, CMS uses bold lettering to emphasize that “no qualifying events” have been identified as extreme or uncontrollable circumstances that are appropriate for an automatic re-weighting of MIPS components, even the COVID-19 Public Health Emergency (PHE). You should not expect a pass on MIPS in 2020, nor should you expect a delay of the MIPS Value Pathways (MVP) rules, set to be released later this year.

Although some may be tempted to file one of these applications, the reality is that this is actually a more dangerous tactic than maintaining full MIPS participation. Here's why:

It's easier to move forward than to stop and re-start.

Those who practice in larger organizations, especially those in multispecialty or academic settings, are continuously engaged in projects with EHR teams, quality departments, and providers in order to ensure that the care that's being delivered is being reflected downstream, whether it's for MIPS, a value-based care contract, or a clinical study. Participants understand that once the plug is pulled on a project, resuming that project is never as simple as “plugging it back in.” Previously-assigned employees may be re-assigned to other projects (meaning that you're either short-staffed or need to bring others up to speed) and day-to-day processes are forgotten (costing you time and progress). Maintaining momentum

is critical to succeeding in any value-based care program, particularly one as complex as MIPS.

By submitting quality data, you give yourself a better chance to succeed in future years. Submitting quality data to CMS is going to contribute to measure benchmarking in subsequent years.

This is critical for success in the future. There has been a substantial decrease in the number of available measures, and newer measures have yet to be benchmarked. In practical terms, there are fewer opportunities to earn more than 3 points out of 10 for a measure, and the only way to improve your chances are to give CMS the data required to fully implement additional quality measures. Quality measure development is an expensive and laborious process, and so even though new measures are coming out, it will be years before the measures that have been removed are replaced and benchmarked. In the 2020 [Measure Development Plan Annual Report](#), it is noted that CMS spent more than \$26 million over the course of three years on agreements that yielded 32 new measures. By comparison, 42 measures from 2019 were deleted for 2020, with only three measures added. By putting your data into the mix, you give CMS the information it needs now in order to develop a fair benchmark for the measure in subsequent years.

By following our past advice and succeeding in MIPS strategically, you'll be able to succeed in any quality initiative.

CMS continues to reiterate its commitment to moving providers

into Alternate Payment Models, and MIPS is the last stop on the path to two-sided risk. Your successful (and continuous) participation in MIPS will be critical to ensuring that you can meet this challenge. This means utilizing all components in order to meet a comprehensive goal. Undertaking an Improvement Activity (IA) with corresponding quality and cost measures, recorded through optimal methods using your EHR, will lead to better scoring across the board without leaving your organization scrambling for resources. CMS has also pushed this methodology and actually intends to require it through the implementation of MIPS Value Pathways (MVPs).

Your decision (and your competition's decision) will be visible in CMS's Physician Compare website.

If a category of MIPS is not scored, that will be publicly visible in CMS's patient-facing Physician Compare site, which scores clinicians and group practices, using (among other things) MIPS scoring. Potential patients will see that one entity succeeded in a quality initiative in spite of a Public Health Emergency, whereas another did not. Patients will not see the rationale behind the "relief," and will infer for themselves why one organization was able to proceed and another was not. This extends directly to COVID 19, as CMS has created an Improvement Activity focused on clinical trials. Clinicians can participate in this IA (and be recognized for it on Physician Compare) by participating in a clinical trial, or by submitting patient data to a [Clinical Data Registry](#) for future study.

The deadline to submit the application is not until December 31, 2020.

With an opportunity to earn additional incentive payments, it's against your best interest to settle for "neutral."

Furthermore, your application may be denied, or only partially accepted. Those who immediately file an application and pump the brakes on MIPS risk finding themselves at a dead end, finding that their participation is required, but that it's too late to fulfill certain requirements (e.g. continuous 90-day performance in Promoting Interoperability or Improvement Activities). In other words, the application itself comes with its own risks. Those who choose to control their own destiny are the only ones with the potential to earn incentives by demonstrating excellence.

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Image: Thomas Vogel

Is Telehealth Bridging or Widening the Health Care Gap? We Need to Find Out.

written by Theresa Hush | June 26, 2020

ROJI Health Intelligence CEO Theresa Hush frames the questions we need to ask about the future of telehealth in this [3:37 minute video](#).

Telehealth has become the go-to solution for health care during the COVID-19 pandemic, enabling providers and consumers to remain in contact for routine and non-emergency visits while brick-and-mortar spaces have been closed. Now that health care is reopening, however, telehealth remains a preferred communications medium, and many providers plan to expand it much more going forward.

So, it's time to ask: Are the services we are offering through telehealth really delivering the best health care possible? And, are there unintended consequences to our telehealth delivery?

If we are going to expand the use of services through a telehealth delivery, we should figure out how to make telehealth a tool for achieving transformational care, not just stopgap medicine. We must also be very careful to avoid creating unintended consequences of reduced health care services for those with limited Internet access or other obstacles to telehealth.

Understanding Telehealth in Context of the Pandemic

COVID-19 has and continues to extract a huge toll on the public and our health care industry. Telehealth provided an extremely important outlet for continuing medical care when it was not safe to visit health care providers. I would even go so far as to say that without telehealth, many patients could have had died for lack of medical input.

We know that COVID-19 will continue to have surges and distancing will be the norm until a vaccine or good therapies are available. And, patients who have had COVID-19 will require continuous monitoring in the months and years ahead. Dr. Anthony S. Fauci, the nation's leading infectious disease expert, said this week, we're only at the very beginning of understanding the immense, long-term health consequences of the novel coronavirus.

We also know that people of color have been affected to a much

greater degree by the virus, with a disproportionately higher number of deaths, and at younger ages. Racial issues don't stop with policing, and inequities extend throughout our social institutions, including health care—a factor that contributes to the racial disparities in COVID-19 outcomes.

Telehealth services can have the unintended consequence of contributing to health care inequities. We need to ask questions as we develop its future:

1. How can we ensure that telehealth does not sideline people

- without access to their own computers and high speed internet?

- who don't already have connections to a primary care physician?

- who lack privacy for confidential conversations?

2. How do we avoid distancing high risk individuals by limiting telehealth to treat only those who reach out to their providers, rather than using this tool to proactively reach out to those at higher risks of severe COVID-19?

3. How can we avoid actually breaking continuity of care—links with community services and service coordination—because we did not tie them into the clinical flow for delivery of telehealth services?

Let's Ask Questions of Our Telehealth Data

The best way to examine telehealth is to investigate the

results of the past few months. We can see where it worked effectively and with the desired effects, and identify where we can improve. Here is a framework to begin that assessment:

1. What telehealth services were delivered during the pandemic?

What are diagnoses and reasons for those diagnoses?

How have visits differed between video and audio telehealth?

What referrals to other physicians, providers, or community settings resulted?

2. Who receives telehealth?

Examine population groups by risks, race, age, gender, zip codes, and SDOH.

Investigate services to patients with high risk and chronic illnesses versus episodic care.

Reveal whether telehealth provided access for people who speak a language other than English or have issues with hearing.

Determine who did not receive telehealth, but are at the highest risk or accounted for high volume of visits previously.

3. Who provides telehealth?

Did patients see their regular primary care providers and specialists, or other medical staff, as a rule?

What proportion of care was delivered by clinicians unknown to the patient?

4. What are the results?

How have outcomes for key risks changed in association with telehealth (or lack thereof)? What do we see in behavioral health? Did patients who called for COVID-19 get tested, and, if so, does the record reflect the results?

Do we see a difference in level of patient engagement as evidenced by actions or outcomes after the visit?

Was the visit patient-initiated or provider-initiated?

Is there any difference in depth of data collected during telehealth versus personal visits?

What do clinicians observe that was not known before by seeing patients in their home environments? How does that increase/decrease information about treatments?

Create the Future of Telehealth as Transformative

Telehealth deserves its important role in health care delivery. But we should make it more than a different venue for care. It should fulfill its potential to do more by connecting with patients in their home environment and in the company of their support network.

As providers, you can deliberately define the future place for telehealth across your services, and ensure that episodic use of telehealth doesn't hijack that agenda. Envision a future in which telehealth can be the vehicle for other patient-focused efforts, such as:

Consider using remote diagnostics and other reporting tools to enhance telehealth appointment information.

Envision a telehealth-based population health strategy that

can help high risk patients.

Examine the possibility of using a video platform for goal setting and shared discussions on risk.

A combination of retrospective and forward thinking will place telehealth in the best perspective for delivering health care that can be convenient, lower cost, and high quality. And by reaching into the homes of your patients, it can be even more.

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A Pandemic Recovery for Health Care Means Addressing Racial Inequities

written by Theresa Hush | June 26, 2020



Health systems, eager to bring patients back, are using new methods to reach out—mass emails to reassure patients of clean and safe facilities, targeted phone calls to reschedule cancelled appointments and procedures, broadcast television announcements and social media ads that strive to convince patients not to defer care any longer.

Providers hope they can recover by encouraging their patients to return. But the pandemic has changed the landscape in health care, in ways that health systems didn't expect. Significantly, it has laid bare the fact that Black Americans are dying in far larger numbers from COVID-19, driven by more severe risk factors.

The current moment demands that we reflect on this evidence about disparate health care outcomes, and solutions for it. We know that racial biases are present in all aspects of our

culture, not just policing. Now is an opportunity to honestly look into health care and determine how we can rid the system of these biases to provide better health to Black Americans, and to alleviate pain.

In the near and far future, bringing down the costs of health care will require reducing risk factors for Black Americans, both because it is the ethical thing to do and also because doing so will lower patient costs and pandemic spikes. That financial reality will become clear to providers as well as payers, employers, and consumers as health care losses mount under the pandemic.

There is overwhelming data that shows that people of color, especially Black Americans, suffer poorer outcomes, including death, across all conditions. And all too often, those outcomes are blamed on the patient. Health care is full of language that implies that Black women or Black men, depending on the medical condition, are not able to “manage” their conditions. In other words, we are blaming these patients for getting worse, for their diabetes progressing to kidney failure and amputated feet. We blame Black women for their higher maternal mortality by implying that they didn’t take care of themselves. We blame Black women for higher deaths by heart attacks by assuming they didn’t do anything to address health risks. The truth is that we don’t always know the reasons for poorer health outcomes, or how genetic and biological factors create more serious risks.

Differential Risks and Inequities in Health Care Have Come Under Strong Light

COVID-19 created the first widespread realization, finally, about how inequities in health care contribute to a tragic

death rate for Black Americans, well beyond their proportion in the population. Despite also having significantly higher medical risks, black and brown workers provide many of the essential services that are keeping the rest of the economy and country going, and are paying for it by getting sick. Those of us who are fortunate enough to work from home and continue to get groceries delivered and garbage removed are enabled by the mostly Black and Latinx workers who put themselves at risk. The heartless murder of George Floyd by police last week is not just the most recent, flagrant example of racism against black men, but an atrocity that is the culmination of months of pandemic deaths of Black Americans, with roots in the same racial discrimination. And it should incite a change in health care as well.

The data on COVID-19 deaths clarifies who has not been helped by our health care system. Vulnerabilities to the virus are supported by a strong body of data about chronic health risks for people of color: higher rates of heart attacks, deaths by metastatic breast and other cancers, maternal mortality and reproductive system disease and cancers, autoimmune disease and chronic stress. Likewise, risk factors like diabetes, hypertension, and obesity are significantly higher in black communities.

Racial disparities in health outcomes may be a frequent subject of studies and many health initiatives, but there has yet to emerge an urgent commitment to real change that addresses systemic racial bias as a root cause. Health care providers must confront attitudes that blame Black Americans for their own conditions and risk factors, while failing to address lack of insurance, income, access to healthy food and primary health

care, and educational opportunities. In the last decade, evidence emerged that a genetic hypersensitivity to salt may be influencing outcomes specifically for Black Americans with hypertension. Yet there is a tendency to assume that unhealthy habits and noncompliance lie at the root of poor outcomes, rather than our system's failure to tailor clinical and administrative strategies. Black Americans are set up to fail in health care, and then redlined when they need care—either by coverage that is not accepted or lack of community facilities.

The Reopening of Health Systems Could Lead to Further Inequities

As health systems balance risk and patient flow while they reopen services, they continue to look to telehealth to fill the gap in care. Many consider telehealth to be a permanent fixture in health care and want to vastly expand it.

But there are dangers to a telehealth expansion strategy. We haven't yet calculated who has benefited from telehealth during the shutdowns and related outcomes across race, ethnicities, and language. If we are committed to reducing disparities in health care, we can't target delivery strategies that work for some groups—e.g., people with high speed internet—and not others, like people less likely to have computers or who have inadequate internet service. We need to measure outcomes to ensure that we are not reducing access and worsening health conditions. We simply cannot afford risking further restriction of access to care for Black and Latinx Americans, without first assessing and resolving these issues.

Use of Social Determinants and Risk Stratification Can Be Helpful or Negative

Understanding that there are health risks as well as obstacles to treatments is a positive step that helps connect patients with needed behavioral health and community services. But collecting and building population health strategies using Social Determinants of Health (SDOH) is not enough to make health care equitable. Nor is it always used for good.

In fact, SDOH can also be used negatively to tag patients as noncompliant or brand them as high risk. Similar labels were used to dismiss patients from practices under financial risk in HMOs. The collection and use of SDOH data must be guided by ethics and accountability in health care, and closely monitored to ensure that discriminatory systems are not set up to eliminate patients.

Likewise, risk stratification and risk factors themselves are double-edged. Not understanding the underlying genetics or biology leads to assumptions about consumers' choice of maintaining risk over health—particularly for women of color. Obesity, for example, is commonly attributed to choices in diet and exercise, when the reality is much more complex and medical knowledge is still at an early stage.

The current state of medical science does not have all the answers to why certain risk factors exist, why patients simply cannot reduce their risks. But we do know that there is more than choice at play.

The Opportunity for Health Systems to Address Racism and Inequities Is Now

If the pandemic created an opportunity to revisit how health care is provided to communities of color, this past week kicked that door wide open to reveal how racial biases influence health care. But there is also no environment better equipped to address these issues of quality and equity than health care. Doing so builds on systems that articulate values and measurement of results, where values are explicitly articulated and measures of quality are woven into the culture.

Doing so is also necessary. Providing better health outcomes does not happen if we don't listen to people and tailor solutions to their circumstances. There is overwhelming data that shows that Black Americans experience some diseases differently, and that they are dying in greater numbers than white Americans. Those numbers can no longer be ignored.

Responsibility for outcomes is beyond what physicians and health systems once believed their "job" to be: provision of strictly medical care. The accountable care movement and Value-Based Health Care have specifically focused on a much larger context for health care outcomes. The time to fully embrace that new accountability is now.

Where to begin? Let's take a lesson from all the voices on the streets and start listening. There are stark messages that speak to health care as much as to any circumstance where human dignity and pain are at stake:

"Can you hear us now?"

“My color does not make me a risk.”

“Privilege is when you call it untrue because you don’t experience it personally.”

“Black lives matter.”

We can see patients for who they are and what they are telling us. We can quit assuming that uncontrolled chronic disease is their fault, and that they are not complying with treatment. We can perceive the pain expressed by Black women as a real symptom, and accept that something is wrong. Failure to listen or understand patients leads to misdiagnoses and inappropriate treatments that can prove fatal.

Rooting out racism and inequities requires conversations within organizations that are stark, emotional, and far-reaching. That discussion needs to happen in health care, with both health care professionals and patients involved in the dialogue.

There are more than enough clinical and administrative areas with glaring disparities in outcomes to choose from in order to concentrate efforts to reduce inequities. We just need to follow the ample data. The familiar process of using data, analytics, and measures of quality to evaluate health care processes and outcomes sorely needs to include race, ethnicity, and gender.

The real guts of this effort involves refining approaches and interventions to change outcomes. Science and health systems cannot determine or impose these; there is too much history behind experiments based on race that has wreaked harm on many

racial groups, including Black Americans.

Instead, transparency and inclusion of people of color—patients, communities, researchers, and physicians—are essential to bringing about change. And they must comprise the leadership of such efforts.

Change is hard and has come slowly to health care. This is the moment to catalyze profound transformation of health outcomes for people of color in the United States. Our health care system won't recover unless we work it out.

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Image: Julian Wan

Size is Now a Problem That Large Hospitals and Health Systems Must Solve

written by Theresa Hush | June 26, 2020



For two decades, consolidation in health care has been a strong industry trend. Championed by hospitals and hospital-organized systems, care is now less independent and more centralized, especially in urban settings. Widespread acquisitions of physician practices and towers of specialty services, diagnostics, and treatment seem to have forever changed the health care landscape. But in the era of COVID-19, that configuration of big health care is proving to be a problem.

Large systems started turning off the spigot of specialty and non-essential services almost immediately once the community spread of COVID-19 became apparent. As these organizations now try to entice patients back into services, big bricks and mortar may present an obstacle. Both consumers and providers have gone through a transformative process in a few months, one that perceives large, populated spaces as a threat.

The Vulnerability of Health Care Will Weigh into Patient Decisions To Return

Patients have witnessed the tragic shortage of PPE in health care facilities and heard countless stories of health care workers falling ill in the very places where they are being asked to return. COVID-19 cases are still increasing in the population, and physicians and nurses are often still isolating from their own families. The majority of Americans also understand that cases will rise even higher as state economies reopen, a dire warning trumpeted by public health experts.

If news accounts weren't enough, being told in no uncertain terms by your own health care providers to stay away to avoid infection certainly is a red flag. "Don't come to see us unless it's an emergency" is a necessary yet somber message that health care facilities are dangerous.

Patients Who Disregard Warnings Pose Different Risks to Large Hospitals and Health Systems

Out in force are virus deniers and anti-vaccine groups, protesting all measures to moderate infections. Providers should expect a subset of patients who are not afraid to get care—and yet who will also refuse to observe social distancing measures and wear masks. More exposed to infection, these patients will represent a risk to other patients as well as to the administrative and medical staff of their hospitals and health systems.

Large systems will need to consider severely limiting patient flow into all settings, changes to physical spaces, advance preparations for security of personnel and buildings, and

arrangements with their local jurisdictions and police to reduce harm.

Physical Layouts and History of Patient Flow, Once an Advantage, Are Deterrents

The physical layout of large, centralized facilities necessitates close human interactions. Parking in attached garages often involves touch screens for tickets. Visiting requires use of elevators, standing or sitting in crowded waiting rooms that may not be well ventilated, and short-distance interactions with staff. And now there is evidence that exposure time to an asymptomatic infected person can assemble viral loads that are enough to infect people well beyond six feet.

In the past, the flow of services in facilities did not favor an in-and-out experience. A physician specialty visit might involve significant waiting times; side visits to imaging, lab, or other diagnostic spots in a large health center; or a return to complete tests that were ordered.

While there are organized patient flow tracks for some treatment-specific care, like chemotherapy visits, patient services can be iterative and take hours to complete. Preparation for visits in large health centers often takes place in the actual exam room, with a nurse or coordinator going through basic questions. Even for routine visits to review existing conditions, diagnostics are ordered at the visit, rather than before. Physicians may come in cold to the exam room, without even enough time to review the medical record or set the visit agenda.

Huge Lost Revenues from Deferred Services

Patients who once had priority-level access to services have been forced to defer care, including those chronically ill patients who previously were targeted for Value-Based Health Care efforts to improve outcomes and patient costs. Cancer patients awaiting surgeries and chemotherapy, people in the middle of clinical trials, patients going through diagnostics to determine their cardiac issues, and most other non-emergency care have been sacrificed or funneled into telehealth visits.

That loss of services has cost hospitals and health systems a staggering \$200 billion in revenue. About 1.4 million jobs have been lost across the industry.

These revenue losses will most impact hospitals and health systems with a high volume of employed physicians and specialty centers of care, outpatient facilities, and large or extensive diagnostic services. Even as health care restarts routine services or patients return for rescheduled services, large centers will face obstacles in attracting patients back because of size and density.

Special Strategies for Large Hospitals and Health Systems Overcoming Obstacles

Simple messaging to patients that services are now open may work for patients receiving some treatments, or for patients in severe pain, but is a system-wide hit-and-miss method of restarting patients. It will be more productive to strategically target patients in need of services, connect with them, and make special provisions to get them into care.

Identify patients and instances with care disruption and high risks associated with care deferral. Using various technologies to identify prior scheduled procedures and diagnostics will be important to restarting patient care. Knowing which patients are at high risk due to missed appointments plus other risk and time-based analytics will be useful in targeting efforts to bring patients back. Create a clinical flow for patients in each treatment or appointment category, so that communication to patients is clear as they are recruited back into the system. The clinical flows should determine which patients will receive telehealth services and who will need physical exams, and how imaging or laboratory services will be handled to safely address patient time and access to services. Use population health technology to target patients by risk level for services and deferral reason. Patients who actually were infected with COVID-19 should be indicated and targeted for services, since this calls for additional surveillance of new risk factors associated with the disease. Contact patients for pre-appointment discussions prior to actual telehealth or personal visits and services. Identify data to collect from patients on symptoms, social determinants, and concerns about health care or COVID-19 infection so that patients can vet their concerns and that upcoming discussions with physicians can be more informative. Re-imagine the role and functions of some specialists. Because specialty practices tend to be located in close proximity to many diagnostic services, primary care physicians, who tend to be off campus, can provide initial services in a low-density setting and leave the procedures

to specialists.

Consider aligning with smaller or more localized services for diagnostics, or provide wearable devices that capture needed clinical data.

If feasible, consider whether physical access to some care locations should be redetermined in the short or mid-term, for patient ease of access.

For physical visits or treatments, adjust scheduling to accommodate patient and staff density in clinical or waiting areas.

Involve specialists in care and space redesign, as well as designing risk criteria. Every specialty will have unique issues that should be accommodated in the design of restarting services.

Many patients have been adrift and isolated, in addition to being physically away from medical care. Providers should consider that these patients have gone through a process of reassessment, rapid education about health care (and possibly science), and adjustment of priorities. Planning to improve and strengthen personal connectedness in patient-care team communication—harder in larger health care operations—will go a long way toward helping patients gain confidence to return to services during this phase of the pandemic.

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Image: Huang Yingone

The Interim ACO Rule Explained: A Pause, Not a Reprieve

written by Dave Halpert | June 26, 2020



As the coronavirus pandemic continues to upend health care in the U.S., pressure has mounted on CMS to adjust its efforts to drive providers to adopt risk. In response, at the end of last week CMS announced a carve-out of COVID-19 patient expenses

from certain reporting requirements. In this round, ACOs were on the receiving end, being largely excused from remaining 2019 reporting and 2020 enrollment obligations.

True to our predictions, this will slow, but not reverse CMS's ultimate agenda to push providers to manage under risk. Those who interpret the Interim Rule as a reprieve will do so at their organization's peril. Here's what you need to know about the reporting adjustments and planning ahead.

How ACO Reporting and Cost Calculations Are Being Modified for the Pandemic

For several weeks, ACOs and stakeholders had become increasingly concerned that a sudden influx of high and unexpected costs throughout the country could upset scoring and payment methodologies for ACOs. In a letter dated April 17, 2020, the Medicare Payment Advisory Committee (MedPAC) urged CMS to take steps proactively to ensure that ACOs were not harmed by the global pandemic.

In the face of mounting concern, and given the opportunity to be held harmless for failing to report data for MIPS, it was inevitable that Medicare Shared Savings Program ACOs—the largest Alternate Payment Model on the other side of the QPP reporting track—would receive similar treatment. The primary provisions addressed the following concerns:

Shared Losses Calculations: CMS has updated its methodology when calculating expenditures against its target to account for COVID-19. This will apply to all ACOs regardless of the extent to which an ACO's patients are affected. An update to the Extreme and Uncontrollable Circumstances policy will

factor the duration of the Public Health Emergency (PHE, the term specified in the policy), and will prorate losses accordingly. In other words, should the PHE continue through June, shared losses would be reduced by half to account for the six PHE months.

Quality Reporting: Although the reporting deadline was extended to April 30, ACOs who do not complete quality reporting requirements will be held harmless, and assigned the mean quality score. Those who do report will be assigned either the mean quality score or their own score, depending on which is higher. This is similar to the policy CMS adopted for the 2019 MIPS program year.

Participation: The 2020 application cycle for the 2021 performance year is being deferred. An ACO with an agreement term ending on December 31, 2020, will have the opportunity to extend their existing agreement by one year. Those in the BASIC track will be able to defer their previously required transition to an increased level of risk for one year, resuming advancement in 2022.

Financial Methodology: CMS is also attempting to avoid penalizing (or rewarding) ACOs based on the prevalence of COVID-19 in the assigned population. All Part A and Part B spending related to COVID-19 treatment will be removed from benchmark calculation and performance year expenditures, in addition to other payment methodologies designed to “level the playing field” amongst ACOs.

Beneficiary Assignment: Because of the enhanced use of telehealth services to treat patients (either because they are exhibiting COVID-19 symptoms or in order to provide ongoing care while sheltered safely in place), CMS will use telehealth services in its beneficiary assignment methodology.

Plan Ahead for Managing Risk or Risk Falling Behind

Although these provisions provide a temporary reprieve from an immediate and crushing blow, ACOs must recognize that this will not be a long-term pass from responsibility or risk. CMS has long expressed its desire to move providers into Alternate Payment Models, and as we all work our way through an unprecedented disruption to the health care system (and life in general), it behooves ACOs to begin planning for what comes next:

Proactively reach out to patients with underlying conditions. Patients with poorly managed conditions, particularly diabetes, hypertension, and obesity, appear to be at the greatest risk of experiencing the most severe complications of COVID-19. Ensuring that these patients are well managed now will be essential to preventing catastrophe down the road. Furthermore, some patients will be more receptive to treatment options and care than last year. Investigate strategic partnerships with entities that can facilitate alternate methods of contact and care, and for measuring the efficacy of your efforts. We do not know if the next wave of COVID-19 will be better or worse, or to what degree. However, we can anticipate the return of social distancing guidelines, shelter-at-home orders, and the fact that patients will still need care.

Continue striving for improvement and excellence. The Interim Rule provides relief for ACOs, but the provisions are decidedly targeted at COVID-19-related issues. In other words, expenditures will continue to be weighed against benchmarks, and the result will be shared savings—or losses.

ACOs should continue to maintain their goals of delivering efficient, high-quality care. The Interim Rule gives ACOs the freedom they need now to ensure that patients receive the right care at the right time. The rule does not give ACOs a free pass, and those who make that mistake will fall behind their peers.

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Image: Annie Spratt

Restarting “Regular” Health Care Will Be Hard: How Providers Can Prepare Now

written by Theresa Hush | June 26, 2020



As states across the country begin to loosen restrictions for the coronavirus pandemic and return to a modified version of normal life, how will our health care system get back to providing regular care? In particular, how can providers pivot from the scale and aftereffects of COVID-19, and bring their patients back? In hot spot areas, that task will also require healing their own organizations.

COVID-19 has upended traditional care delivery and revised priorities for patient care. It has changed status of providers and foisted enormous stress on front line staff, to the point of serious trauma and even suicide. With an enormous death toll of over 51,000 in less than a few months, models' higher predictions, sadly, seem reachable.

The virus has revealed huge gaps in the public health system, emergency preparedness, and health care capacity. It has

overwhelmed medical staffs and facility capacity—as well as capacity of nursing homes, rehab centers, and funeral homes. But COVID-19 has also unveiled widespread innovation, fierceness, and collaboration in health care. By many accounts of industry experts and medical staff, it has also opened opportunities for change. That change will be good for providers, health care systems, and future patients.

But here's something else that the latest data is showing: at least one-third of Americans have postponed routine health care during the pandemic. *Modern Healthcare* cites several recent studies of hospital claims, emergency room cases, and consumer polls that show double-digit declines in use of regular health care by consumers. And that is bad news.

Hidden by the Pandemic: Patients with Real Emergencies like Heart Attacks and Strokes

Back in March, CMS provided for expansion of telehealth services in lieu of personal medical visits, and then recommended delays in elective and other non-essential medical and dental services. Many state governments have used insurance and medical/hospital licensing authorization to reinforce these actions for private insurers as well as medical facilities.

Within weeks of the first COVID-19 surges in New York, these regular patients stayed home. Hospitals across the country furloughed employed physicians and other hospital clinical and administrative staff. Private practices were left without patients and are now financially threatened. Pediatricians, oncologists, surgeons, cardiologists—and other physicians dependent on physical exams and office or hospital procedures—have been sidelined.

There is a surprisingly sharp decline in the rate of reported STEMIs (the most serious kind of heart attack) and strokes during the pandemic—in Europe as well as in the U.S., from hundreds of cases to single digits. Independently, the Minnesota Heart Institute Foundation reported data that shows a 38 percent decline in cardiac catheterization lab activations for STEMIs across nine centers. *The New York Times* reported an informal survey of an online community of cardiologists on Twitter this month, estimating a 40 to 60 percent decline in admissions for heart attacks, with some reporting more than 60 percent.

So far, the reasons are unclear, but patients' fear of seeking care is suspected, along with financial concerns. There is also speculation that these medical events went undiagnosed during hospitalization of patients for COVID-19, because crisis management prevented taking full histories and the management of COVID-19 obscured other symptoms. And in some cases, COVID-19 has precipitated cardiac arrest or stroke.

While telemedicine has been effectively deployed in some areas hard-hit by COVID-19, use of telemedicine appointments has often been triggered by patients seeking medical attention and not, as a rule, by providers reaching out to high-risk patients. Those with cardiovascular symptoms who fear being told to come to a hospital may be unwilling to even schedule a telemedicine visit. Complicating the situation, provider continuity cannot be always maintained as physicians are reassigned to help on the front line, or furloughed, so that patients may lack trusted relationships during telemedicine appointments.

Cardiac experts expect a deluge of patients discovered to have had STEMI heart attacks at home as well as other heart emergencies. They fear that they will find advanced disease, damaged vessels, and organs that cannot be repaired.

Sidelined by the Pandemic: Patients with High Risk Factors

Beyond emergencies, almost all non-urgent care has been put on hold for two months. Measles vaccines have declined by 50 percent, and well child and regular visits for high-risk individuals have been postponed. Access to care under COVID-19 has been significantly reduced by a combination of factors, some patient- and some provider-driven, in order to preserve resources needed for fighting the virus.

Lack of access to care is strongly connected with negative long-term outcomes. In one recently published study on hypertension, loss of access to health care after Hurricane Sandy was associated with uncontrolled hypertension levels that persisted two years later.

Other studies also point to steep, dramatic increases in hospital admissions for diabetes and other chronic conditions that occurred after SARS between 2002 and 2004. The lack of ability to deal with highly complicated diabetes, behavioral health, intestinal issues such as Crohn's Disease, and other illnesses may deluge providers reopening services after COVID-19 moves into another phase. Delays in laboratory services, alone, have put blinders on physicians' ability to understand what is happening to these patients.

Cancer care has also gone on hold during the peaks of COVID-19.

Planned surgeries have been delayed, along with [start of chemotherapies or other treatments](#). According to the Cancer Action Network, half of cancer patients have delayed or interrupted treatments. About a quarter of patients responding to surveys have delayed the start of treatment caused by closed access to care, along with 27 percent of patients who were in active treatment and have had to pause their care. Many have not learned when their treatments will be rescheduled. Oncology groups have issued guidance to clinicians to delay cancer care to avoid exposure of patients to the virus.

In addition to lack of access to treatment, cancer patients are stressed financially, [having difficulty affording treatments](#). Thirty-eight respondents said that COVID-19 is financially affecting the affordability of treatment due to reduced job income.

How to Restart Health Care: Strategically Deploy Population Health and Other Tools

Regardless of how much we all want to get back to normal, it will not be easy to manage restarting regular health care, especially with COVID-19 cases still on the rise. State public health agencies have begun to issue guidance and directives to providers regarding how to restart actual services. [California](#), for example, has defined the process of examining both when it is feasible to begin reopening care, dependent on the volume and curve of COVID-19 cases, and how those services should be delivered initially through telehealth rather than personal visits.

Beyond these parameters, however, we must answer the question of how to approach the sea of patients needing care now. We

suggest four steps:

Use patient data to identify risk severity and stratify need for appointments and lab services. Identifying risk factors as well as uncontrolled clinical conditions will be essential to differentiate the effects of deferred care. Prepare patients for return to care with outreach. Patients will not have an understanding of what providers' process will be for reopening, or how safe that will be for them, unless it is clearly conveyed. To encourage patients to come, this communication should preferably come from their physicians. It will also be necessary to inform patients about how providers plan to communicate with them, especially if it will involve using the patient's portal into their systems.

Use population health technology to facilitate scheduling of patients' telemedicine and lab services, prioritizing according to risk. This will enable analytics that show responsiveness, analytics by population segment, and effectiveness of outreach.

Create analytics that tie deferred or delayed care to clinical status and outcomes. We know that COVID-19 will persist and go through waves; providers will need data that can be used in future planning and risk stratification to mitigate patient downward spirals caused by delayed care.

Providers will need to restore balance to regular patient health care while still battling COVID-19. The cost of deferral will be too high for patients, in the same way that a long-term economic shutdown is proving to be for the country. The use of telemedicine is a major feature that helps maintain some continuity of care and will remain a permanent fixture in

healthcare. But other ongoing elements of care must be now integrated to avoid catastrophic damage. Industry providers have shown remarkable courage and determination to fight COVID-19, and their technology vendors must rapidly develop data and solutions to help them breach the next front of the crisis.

To that end, Roji Health Intelligence has launched a population health registry to help providers track and communicate with patients at high risk for COVID -19 and other conditions that have been sidelined during the pandemic, at no charge to existing clients. [Please click here for details.](#)

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: [Evgeni Tcherkasski](#)

Stretched to the Limit by COVID-19, Will Providers Get Relief from Medicare Value- Based Programs?

written by Theresa Hush | June 26, 2020



This article originally appeared in the April 2020 edition of [Accountable Care News](#) [PDF download].

COVID-19 continues its inexorable, exponential spread here in the U.S. Hospitals in New York City, now accounting for more than 7 percent of confirmed cases worldwide, have less than a quarter of the critical equipment and supplies needed to serve an [overwhelming surge of patients](#). Our health care providers are facing impossible choices, even considering universal [Do Not Resuscitate](#) orders for patients with COVID-19.

Less than one month ago, CMS was closing applications from providers willing to be part of a major movement to adopt financial risk as a new type of payment model. Under Direct Contracting, providers would face per-patient spending limits under a capitated payment scheme. Now that movement could be in question, along with other provider Risk programs, as total and

per-case spending soar under COVID-19.

With the public health crisis upending life everywhere and provider capacity already stretched to the limit, will Medicare continue its full court press for providers to adopt financial risk? Conversely, how will CMS loosen efforts to control health care costs when its own expenses for the highest risk group of coronavirus patients will overrun the federal budget?

Already, those costs are estimated to increase exponentially.

The National Association of Accountable Care Organizations (NAACOS) estimated that Medicare would be hit by COVID-19 claim costs of between \$38.5 billion and \$115.4 billion in the next year, depending on pandemic expansion and hospitalization rates.

In addition, the \$2 trillion stimulus plan—not likely to be the last—will expand the already mushrooming federal deficit.

One thing is certain: No matter what the trajectory of the outbreak, it will result in future budget cutbacks on spending. The only question is when those will begin. Let's look at some of the possible scenarios ahead for providers, consumers, and Medicare.

Scenario 1: Medicare will implement Risk Payment Models for providers, including Direct Contracting and ACOs, as planned.

Depending on economic pressure, CMS could stay on the current risk track with its Value-Based Health Care programs. [NextGen](#)

ACOs could be allowed to expire, and Direct Contracting could proceed toward a performance year and its capitated payment mechanisms. Shared Savings ACOs could remain on the “glide path” scripted by current regulations, and be under risk.

The problem is that this effort could induce some ACOs to leave the program, if there are no concessions on COVID-19. Depending on which provider ACOs exit, their departure may be important enough for CMS to be more lenient. It's too early to tell how CMS will view its options, especially as it has been less forgiving with ACOs than with direct providers, especially physicians, or with Medicare Advantage plans.

Scenario 2: Risk Payment Models will continue, but adjust Risk to carve out COVID-19 costs.

Medicare could continue to roll out payment models that drive providers to adopt risk, but create carve-outs for costs associated with COVID-19, especially for hospitalized patients. While this scenario addresses vulnerability for providers, it does not recognize the rising health care costs borne by consumers through premiums, copayments, and other provisions. Millions of Americans have struggled to meet high deductibles and copays under the best of circumstances, and with months of lowered or no income during this period, many will hardly be able to afford higher insurance costs going forward.

Nor, if the emergency magnifies into a long-term recession, will many companies be able or willing to pick up a bigger share of coverage costs. Medicare has ensured first dollar testing coverage, but consumers will still face a much

different “risk” environment for their own budgets because of higher medical costs, the problem of “out of network” coverage when COVID-19 care cannot be provided in all settings, and the threat of frequent viral re-emergence.

If there is a longer term recession, it may not be possible for CMS to address provider cost concerns without also dealing with the impact on consumers. That makes this a much more costly scenario—and more unlikely.

Scenario 3: Providers will remain in Implementation Year stages, with CMS delaying the start of Performance Year payment models.

Some hospitals—even some regional health systems—could collapse under the surge of severe COVID-19 cases. The spending ability of hospitals and local health systems is not infinite, nor is their expansion capability. Despite the overwhelming numbers right now, we are at an early stage in the surge. Whether there will even be enough hospital beds to handle the volume of patients, an urgent question now in New York City, is a question that is likely to be repeated throughout many areas of the country. The fact is that we don’t know whether we can prevent local hospitals and health systems from collapsing.

CMS will, no doubt, have to reckon with the prospect of adding financial risk to an already-overextended health system. Delay in the actual instruments of risk, like capitated payments or paybacks of over-expenditures, could be allowed. But because of its own budgetary pressures, CMS may not want dismantle reforms too easily.

There could also be negotiated solutions, such as longer-term payback or more reinsurance of risk, to assuage providers, while CMS keeps mostly on track with payment models.

Of course, given that the COVID-19 outbreak is still surging upward, it may be that Scenarios 2 and 3 could be consolidated into a complex carve-out/temporary push back solution.

Scenario 4: CMS will expand and encourage Medicare Advantage while scaling back regulations for provider Risk programs.

It is also conceivable that CMS will look to further privatize Medicare through Medicare Advantage plans and create a buffer for the direct costs that will hit the traditional Medicare budget. This scenario would be in keeping with CMS's favorable view of Medicare Advantage as well as the commitment to working through the private sector in other federal programs— like current efforts to increase the supply of personal protective equipment via private manufacturers.

Surviving the Pandemic Will Be a Long-term Effort that Extends to Post-Pandemic Surveillance

COVID-19 will be with us well beyond the next few months. Until there is an effective vaccine and proven treatments to lessen the virus's severity, vulnerable individuals will remain vulnerable. As routine care is severely reduced to free up resources for the sickest among us, those with chronic conditions who do not receive regular check-ups will get sicker, as well. There is already evidence of virus after-effects on liver function and cardiovascular disease in some

patients. In other words, the pandemic will not end entirely, but create a new set of criteria that health care providers must be ready to address.

How the health care system will weather the existing crisis and prepare for the future under scarcer resources will be an issue that both government and providers must address in the months ahead. Only one scenario is clear right now: The flush days of health care—and the time for playing cat and mouse with health care funding—are over. Now may actually be the time when we figure out how important health care is to people, and how we're going to pay for it.

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Image: [darkroomsg](#)

Best Online Resources for Understanding and Responding to COVID-19

written by Theresa Hush | June 26, 2020



As Roji Health Intelligence focuses on how our business can support the heroic efforts of health care providers in the front lines of the pandemic, I'm spending hours researching and reading the best science and public health information about COVID-19. Here are resources that I've found to be indispensable, as well as significant research to date, and some other articles and videos worth your time. I hope you find these useful as we all work to flatten the curve and plan for the long-term health effects of this insidious virus.

[Johns Hopkins University Center for Systems Science and Engineering: !\[\]\(1fc3c61bf7e7d704c9e331cb11a264d8_img.jpg\) Map of Coronavirus COVID-19 Global Cases](#)

The essential resource for reported confirmed cases, by country/region/sovereignty, updated throughout the day.

[Semantic Scholar COVID-19 Open Research Dataset \(CORD-19\)](#)

A partnership of the Allen Institute for AI and leading research groups to prepare and distribute a free resource of more than 45,000 scholarly articles, including more than 33,000 with full text, about COVID-19 and the coronavirus family of viruses for use by the global research community. Updated weekly.

[World Health Organization Global Research on Coronavirus Disease \(COVID-19\)](#)

A database of the latest scientific findings and knowledge on COVID-19, updated daily.

[“A Science Reader for COVID-19,” JSTOR Daily, 3-27-2020](#)

From spill-over to virus mutation, this collection of free-access readings gives scientific context to the pandemic.

[“Substantial undocumented infection facilitates the rapid dissemination of novel coronavirus \(SARS-CoV2\), AAAS Science, 3-16-2020](#)

Research based on data from China estimates that 86 percent of all infections were undocumented prior to January 23 travel restrictions. Per person, the transmission rate of undocumented infections was 55 percent of documented infections; however, due to their greater numbers, undocumented infections were the infection source for 79 percent of documented cases. This explains the rapid geographic spread of the virus and challenges of containment.

[“Vaccine designers take first shots at COVID-19,” AAAS Science, 4-3-2020](#)

Report on the first small clinical trials of COVID-19 vaccines and the global collaboration among researchers to develop a

vaccine.

[“How Does the Coronavirus Behave Inside a Patient?” The New Yorker, 3-26-2020](#)

Medical researcher and physician Siddhartha Mukherjee, author of *The Emperor of All Maladies: A Biography of Cancer*, examines how level of exposure to COVID-19 may be a critical factor in severity of the illness.

[“False Negative: COVID-19 Testing’s Catch-22—And the consequences of being wrong,” Medpage Today, 3-31-2020](#)

Testing depends on identifying the reverse transcription-polymerase chain reaction (RT-PCR) caused by the virus. However, because of lower viral load following initial infection, RT-PCR’s sensitivity is low in early illness and even lower in asymptomatics—raising the probability of false negatives. While no test is perfect, a negative test in the presence of COVID-19-like symptoms is not a get-out-of-jail-free card.

[“The Workers Who Face the Greatest Coronavirus Risk,” The New York Times, 3-15-2020](#)

An interactive graphic of risk levels to employees across the workforce, in terms of exposure to the disease and infection, proximity to others during an average workday. Data also includes data on average income and access to paid leave benefits.

[“Nonwovens at Frontline in Battle Against Coronavirus,” Technical Textile](#)

How the demand for disposable Personal Protective Equipment is driving a surge in demand for nonwoven textiles around the

world.

Dr. Jeffrey VanWingen's tips for how to apply sterile techniques to grocery shopping and take-out food. YouTube, 3-24-2020

The ultimate guide for how to avoid bringing COVID-19 into your home after shopping at the grocery store or buying restaurant take-out.

"Lightfoot Shares Hilarious PSA Urging People to 'Stay Home, Save Lives,'" NBC 5Chicago, 3-31-2020

A light touch for a serious message in this PSA from Chicago Mayor Lori Lightfoot.

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Image: Jeremy Bishop

Roji Health Intelligence Launches Population Health Registry for Patients at High Risk for Severe COVID-19

written by Theresa Hush | June 26, 2020



To assist the health care provider community's heroic efforts to combat COVID-19, Roji Health Intelligence has launched a new Population Health Registry for Patients at High Risk for Severe COVID-19.

Our goal is to help providers track, monitor, and communicate with patients whose underlying health conditions will make them more vulnerable to the virus, particularly as resources are reallocated away from routine medicine to meet the exceptional demands of the pandemic.

The program is being offered to current Roji Health Intelligence clients at no additional charge.

To learn more, please contact us at info@rojihealthintel.com.

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Image: [Siarhei Plashchynski](#)

Value-Based Care Defined: Know the Vocabulary of Health Care Reform

written by Theresa Hush | June 26, 2020



Today, as we confront a viral threat that is challenging our health system, its capacity, and how care is financed, it seems appropriate to review some fundamentals. Health care reform has been speeding down a particular track, changing how health care is covered, paid, delivered, and organized. These reforms may seem to be about health care financing, but will make a future difference in health care access and patient outcomes.

Medicare is driving the train with its huge budget and rulemaking capabilities. But insurance companies, in lockstep, are rapidly implementing similar changes.

Understanding all those changes is no easy task. The bureaucratic jargon of health care reform continually expands and morphs, as words and phrases change meaning or are spun by marketing gurus. Many practicing physicians are too busy to pay attention to the business end of health care; most consumers are too busy at their regular jobs and caring for loved ones to research what it all means for them.

As we test the prowess and stability of our health care system in its evolved modern state, we should also evaluate the impact of crisis-fueled demand. So, let's start by defining the vocabulary of health care reform. As we continue our examination of how providers can take financial risk for the costs of patient care, both providers and consumers can benefit from a common understanding of the basics.

1. What is Value-Based Health Care?

Value-Based Health Care, or Value-Based Care, is a reform movement that grew out of efforts by private health plans to incentivize professional providers for quality care, called Pay for Performance.

By focusing on Value, the movement's goal was for purchasers—including consumers—to expect good quality and patient experiences from the health care dollars they spend. As the effort progressed, Medicare took the lead under the Affordable Care Act and, later, under MACRA legislation and rules to make Value-Based Health Care an umbrella for many initiatives to contain health care costs while maintaining or improving quality care.

In the last two years, Medicare has made significant changes in its Value-Based programs and put greater emphasis on cost control and changes in reimbursement systems.

2. What is a health care payment model?

A health care payment model is a system for paying providers that determines fair rates and defines the basis on which providers will receive reimbursement for services.

Fee-For-Service (FFS) is one payment model, as are a variety of others under Value-Based Health Care, including Bundled Payments, Capitation, and various Alternative Payment Models (APMs).

3. What is Value-Based Reimbursement, also known as Value-Based Payments?

Value-Based Reimbursement and Value-Based Payments refer to several payment models for health care providers that include incentives for cost controls or quality, and usually include both.

There are two main categories of Value-Based Payments in Medicare: one focused on individual providers or their group practices participating in Traditional Medicare, and one focused on organized groups of providers who are working together to lower cost and achieve quality under an APM such as an ACO.

Individual/group providers under Traditional Medicare are still paid via Fee-for-Service, but the provider or group is scored according to a point system for meeting cost and quality criteria. The results of that score are applied to the traditional FFS payments as a reward or penalty.

Organized entities participating in an APM will have a unique payment method associated with their particular model, but most of these models include a target or ceiling on expenses for patient care, and incentives or penalties for being under or over such targets. Value-Based Payments

can also include prospective payments like Bundled Payments or capitation under [Direct Contracting](#).

Medicare has recently emphasized the inclusion of some provider financial risk for patient care costs in its Value-Based Payments.

4. What is Fee-for-Service?

Historical payment of all health care providers, including doctors, hospitals, and other providers, was based on a Fee-for-Service method. Most facilities are now on a different type of payment system, but FFS remains the payment system for physicians and other professionals.

FFS allows physician groups to bill Medicare for each type of service, including office visits, consultations, procedures, administration of vaccines, and so on.

Since most Value-Based reform efforts now focus on reducing costs, the FFS payment system has been targeted for change.

5. What are Risk-Based Payment Models?

Risk-based payment models refer to any of the Value-Based APM payment structures under which some component of provider fees is under financial risk if patient care costs exceed the expenditure target. Under these models, risk means that the provider must live within the target expense level and aggregate capitation payments or face financial losses—while also making a required repayment to Medicare. According to Medicare rules, physicians must bear some of the risk of the APM. These models include:

Medicare Shared Savings Plans (MSSP ACOs), which are on one of the tracks to Risk, as all will be in the future;

Next Generation ACOs, which have a payment model engaging their providers at a higher level of risk, up to 100 percent of costs.

Direct Contracting Entities that will receive a global or partial capitated payment per beneficiary, and also be held to total-cost-of-care limits. Direct Contracting is just beginning, with providers recently completing applications for the implementation year. Performance year will begin in 2021.

Primary Care First is a small practice payment model that is also risk-based, with a partial capitation payment and total cost targets.

6. What is Partial or Global Capitation?

Capitation is a payment model under which providers receive a monthly rate per beneficiary who has chosen to align with that provider for primary care and coordination of other health services. Capitation was a popular payment model used by HMOs in the 1980s and 1990s, particularly in certain markets such as the West Coast, Chicago, and Boston.

Partial capitation is the payment associated with primary care services and related costs, but not inclusive of payments to specialists, hospital care, or other costs.

Because the other more expensive costs are excluded, partial risk may not represent as high a risk to providers. However, that risk also depends on other parts of the payment model.

For example, there may also be a total expenditure limit that requires payback to Medicare; in the case of private insurance or some Medicare models, the expenditure limit may involve a front-end withhold as collateral for keeping within the expenditure limit.

Global capitation is payment associated with primary care and all downstream medical costs, with the exclusion of drugs and other defined expenses. Global capitation represents the highest risk but also the highest opportunity for financial gain. In order to achieve the gains, providers will most likely negotiate payments or set up payment models for their specialists and other providers.

The vocabulary of Value-Based Health Care makes it clear that Medicare is promoting payment models that provide leverage for change in health care. Cutting costs is a top priority, and CMS's preferred models reflect an underlying belief that putting providers at financial risk is the key to engaging them in that effort.

Risk may produce provider engagement, but producing results will depend on how providers work with patients to improve health status, while preventing as many intensive services as possible. Innovation and drive for clinical excellence, provider enthusiasm, and respectful relationships with patients will be key ingredients for their success. That's the agenda and vocabulary we all need to succeed in reforming our health care system.

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Image: Lorenz Stoer, *Geometria et Perspectiva*, 1567, University of Tübingen collection [via Public Domain Review](#).