Will “Value” Help Consumers Choose?

written by Theresa Hush | September 5, 2019

In the emerging days of Value-Based Health Care (VBHC), “value” was defined by quality, cost, and experience of health care for patients—the “Triple Aim.” The movement’s initial defining goal: patients should be able to access high value health care services that improved outcomes, to get value for their dollars. Likewise, employers and other purchasers deserved

similar value for their share of investment in health care benefit plans.

Because incentives inherent in insurance and Fee-for-Service (FFS) payment systems reward volume over value, however, VBHC has also had a subagenda to make value pay for providers. But to reward better value instead, we must first measure it and then provide incentives that will either replace or overcome the disincentives under FFS.

Quality measures—first under PQRS and then converted into MIPS—developed into a complex performance measurement and reporting system. Patients' Consumer Assessment of Healthcare Providers and Systems (CAPHS) survey responses measured satisfaction and patient experience. Cost measures—the most difficult because prices, actual costs, and drivers (such as patient risk) don't easily lead to a cost "standard"—emerged, including monthly/annual cost-per-person and episodic costs of care.

As Value-Based Health Care goes full throttle, it's time to examine whether these intended goals are intact and how providers should set the correct path. Why now? Because evolving VBHC initiatives have the potential to redefine value and create unintended effects. Let's examine the key trends.

Quality Initiatives Are Simplifying and Scaling Back

Quality measurement expanded to more measures and complexity, but never progressed to a much broader focus on health outcomes. Quality performance under VBHC has been more concerned with the inputs and processes that may lead to better

health results, but the outcome itself is neither measured nor trended to see if improvement results. So we can't answer whether the product of health care is improved outcomes.

That very unanswered question is the issue behind the outrage over our health care spending nationally, and what we are getting for it—declining life expectancy, high maternal death rates, and health inequities.

In its most recent rule, CMS is proposing scaling back quality measures and easing the reporting burden for providers. There is little argument that the current quality measurement is more complicated and less meaningful than necessary—and doesn't help consumers choose (once a key reason for Physician Compare and quality reporting in general). But we also need to answer the basic question: How do we know that our VBHC will produce a better system for patients, if we are not measuring that in any meaningful way?

Transition to Provider Risk in ACOs and Primary Care Models

The objective to eliminate or modify FFS has become a stronger part of the VBHC agenda for Medicare. The ACO Rule in December 2018 now requires ACOs to adopt downside risk for expenses over targets. Provider Direct Contracting with CMS, introduced this year, will pilot partial or global capitation payment systems, and will expand to include a population-based capitation.

The goal of these programs is to cap costs and ensure that providers are more conscious of the cost of services they are providing.

Cost Transparency Is a Bigger Part of Initiatives

Under Medicare's Quality Payment Program (QPP), including MIPS, Cost was always intended to grow in importance for achievement of incentives. But concurrent with revision of quality initiatives and more models with downside risk, Cost is taking on an added importance.

Besides pressuring providers to keep costs down, VBHC has placed price transparency as a high priority. But price transparency is not equivalent to enabling consumers to choose among options based on cost, because health care pricing is extremely complex and opaque.

Cost should, in fact, be a front-and-center issue. It's why the VBHC efforts were invented, and we must address the driving issues behind cost that make health care unaffordable.

As we usher in an era of new provider risk and cost disincentives, however, we should also ensure that we protect consumers and patients from the denials of legitimate care, as well as from the bureaucracy that once plagued previous risk-based models of health care. And, we should freshly examine how we should structure cost to help consumers make wise choices.

Asking Essential Questions to Ensure VBHC Will Help

Over the next few posts, we will analyze the direction of current VBHC efforts, and whether those programs can be expected to lead to better value. We will suggest methods for providers to navigate a path to value when regulations seem to

be shifting the focus.

- Will consumers be able to identify and access high-value health care services?
- Do quality, cost, and patient experience reflect the current criteria for value?
- Are measures adequate to reflect the criteria, and to see performance?
- What should ACOs and providers do to meet consumer needs for value?
- What are the critical tools providers need to enhance value?

Stay tuned!

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Image: Dominik Lange

How Should Primary Care-Centric Physician Practices Choose A Path to Risk?

written by Theresa Hush | September 5, 2019

It’s an urgent question for most practices: How should physicians participate in value-based reimbursement? Traditional Medicare is moving assertively to physician payment models that include capitation and ceilings on spending, with revenue risk tied to patient care costs. Without a doubt, primary care practices are bearing the brunt of risk-based reimbursement.

With the exception of specialty-aimed Bundled Payments, most payment models are primary care-centric. Patient costs are grouped and then attributed to their primary care physicians—regardless of whether the services were provided by those physicians or by specialists and hospitals—and those PCPs are then rewarded or penalized under various risk arrangements.

Under Medicare Value-Based Health Care programs, elimination or

modification of Fee-for-Service (FFS) has become a stated priority. CMS is also rewarding physicians to participate in other plans, like Accountable Care Organizations (ACOs) that must include downside risk under CMS rules. Again, while the dollar risk may be spread throughout the ACO network, the reality is that the PCPs are compared based on cost, and those whose patients drive ACO cost overruns usually feel the brunt of criticism.

A five-year trajectory to risk-based reimbursement is likely for most physicians, whether they accept government or private insurance. Commercial health plans have been, so far, slow to readopt capitation because they can achieve savings by directing patients to network providers who negotiated lower rates. But incentive payments tied to spending are common. If Medicare succeeds in transitioning to risk-based reimbursement, Medicare Advantage and private insurance plans will undoubtedly follow suit. Capitation will be necessary under competition with traditional Medicare and other MA plan.

Let’s examine both the options and decision-making criteria that practices must weigh as they contemplate options for participating in Risk, especially primary care and multi-specialty practices with a primary care base of services.

Risk Models for Physicians Come in Many Varieties

There are five Risk models for participation in Medicare or commercial health plans. These include three options for practices and two for networks. Practices may directly participate in the following:

- Medicare's Primary Care First (PCF) model (small groups), which is a 5-year pilot that would allow physicians to "practice" for more substantial risk initiatives;
- Medicare's Direct Contracting (DC) model, also a 5-year initiative targeted to larger groups with infrastructure to manage populations;
- Health plan options like Medicare Advantage (MA), which already claims about a third of Medicare beneficiaries and is expected to grow beyond 40 percent within a decade.

Additional options can be leveraged with locally-organized physician or hospital-physician networks. These choices include:

- Accountable Care Organizations (ACOs) directed either by hospital networks, physicians, or combined, for Medicare and/or commercial health plan participation;
- Provider networks such as a Clinically Integrated Network (CIN), or Independent Practice Organization (IPA) /Physician Hospital Organization (PHO) acting as a CIN, for commercial health plan participation.

Some options are mutually exclusive, so the real range is limited. Each practice will have to make a choice between direct Medicare options, and may also decide to participate in Medicare Advantage. Depending on the size of the group, the decisions now look more limited:

- PCF or ACO/CIN, with or without MA

Or

- Direct Contracting or ACO/CIN, with or without MA

Each option also often has variations that will affect level of risk and payment type.

Decision Criteria for Risk Participation

Realistically, any primary care or multi-specialty practice cannot predict which risk arrangement will be safest or most financially viable. Why? Because the data simply won't be readily available for them to calculate how the future final metrics—cost of patient care and practice revenues—will turn out under each model. Their decision criteria will necessarily be subjective. Here are four key questions:

1. Seminal Decision: Is Practice Independence or Interdependence the "Safer" Route?

Each direct Medicare option above is a choice of independently engaging in Risk, or working with other providers in an ACO or CIN. That decision will ultimately be determined on the basis of whom the other providers are—and any history of trust issues. But there is a basic preference in every practice for independent or group action that overrides logic. Nevertheless, it pays—quite literally, under financial risk—to perform due diligence of other providers in the network.

Partnering practices should ideally share a variety of information that would demonstrate their cost status, such as Medicare scores on cost-per-beneficiary-per-year, and their cost scores relative to targets. While this type of data sharing has been rare in the past, the financial partnership under Risk creates an imperative for transparency and knowledge

based on solid data. That exercise builds trust and makes it possible for providers to create a group process of change.

2. Are Data and Infrastructure Established—with Ongoing Investment?

Every risk model will require actionable data to change the cost curve. The best practices will calculate patient risk and track costs against predicted expenses, so that intervention can be timely. There must be systematic processes to reach out to patients and to improve the knowledge of risks, barriers, and experiences of patients. Then, applications and analytics must put that data to use in a way that will be clear to physicians.

Infrastructure is expensive, and the economics of Risk help make a strong case for spreading that cost over a larger number of providers. Physicians who are engaging with ACOs or CINs should make their participation decisions based on the necessary investment in infrastructure and staff to support the practices. Otherwise, physicians will be scrambling and blindsided by questionable analytics. Data and infrastructure are logical selection criteria. If present, the organization is a safer bet. If not, participating brings a higher risk to the practice.

3. Is There a Learning Approach for Physicians and Patients?

Providers are just beginning to understand the requirements of value-based care, and how motivational conversations and joint medical decisions can help physicians and patients create a collaborative plan. But this is a departure from traditional

roles. Research is beginning to highlight good results coming from positive physician learning processes as well as use of coaches to participate in patient goal-setting.

Physicians need to feel engaged and valued in their practices and/or in larger groups like ACOs. Both in reviewing their data in patient cases, as well as in leadership of the organization and actual patient care, there must be a learning environment that contributes to building skills that will help physicians succeed at Risk. When these learning processes are coupled with changes in productivity criteria that emphasize time with patients rather than churning appointments, physicians will be more willing to engage in Risk because they find it doable.

4. Is the Commitment to Quality and Evidence-Based Medicine Evident?

With Medicare reducing requirements for quality reporting, many are concerned that Risk will usher in old problems associated with HMOs, like patient dumping, difficult pre-authorization processes, and so on.

Physicians should question how the organization is conducting its outcome and quality reviews. Sticking to Medicare's bare minimum and calculating quality only at the annual review period on a sample of patients should be a red flag. Practices and ACOs should be harvesting data from EMRs so that it does not affect workload, and use that data to populate quality information on all patients.

ACOs versus CINs and other Networks

Physician practices, in some areas, may have a choice between

ACO participation and various CINs in the community. ACOs are more structured, often better funded, and generally more mature than most CINs. But the wide range of ACOs, Risk adoption, and success levels make the distinction between the two categories somewhat arbitrary. Nevertheless, they are used here as part of a continuum of Risk-oriented networks. If ACOs mature and achieve their savings goals more universally, CINs are likely to disappear.

An ACO is the only network model that has flexibility under Medicare and Medicaid to participate as a Risk entity. The only real reason for participating in a CIN instead of, or in addition to, an ACO is if the CIN is the only network available for commercial health plan contracting.

Medicare Advantage—Competing Risk Model or Not?

While MA plans are at risk with Medicare, that risk is not directly passed on to network providers. MA negotiated rates may first appear to practices as non-risk-based. MA plans often pay physicians on rates synced with traditional Medicare. However, in FFS under Medicare Advantage, claims may be denied for lack of medical necessity (more common in MA HMO plans). Therefore, physician revenues are at risk but the criteria are different—they are assessed at the level of individual medical decisions, rather than global cost targets.

Medicare Advantage participation also does not compete with Medicare programs offered directly to providers, such as Direct Contracting—for now. Because patients enroll in MA plans and thereby remove themselves from the traditional Medicare structure, providers can participate in a direct program from both Medicare and Medicare Advantage. Over time, however, MA

will attract patients that would otherwise be attributed to the provider ACO, or the provider may be part of a Direct Contracting organization and decide that the dual processes are not sustainable. Ultimately, the models will compete for patients and for revenue.

To sum up, to navigate Value-Based Health Care, physicians should apply criteria that are already within their assessment capabilities. In a contest between independence and interdependence, physicians can investigate four key parameters to determine how well they can integrate their practice into a group like an ACO, or whether they have the resources to benefit more by going it alone.

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Image: Rick L

AI May Be the Future, But It's Not (Yet) the Future of Clinical Research

written by Robert McNutt, M.D. | September 5, 2019

Good medical practice depends on good clinical research. Without rigorous, replicable, reliable research findings, we cannot trust that our medical decisions are based on truth. To put it bluntly, flawed research leads to bad medicine. It's essential that we get it right.

In this series, I have argued for a more rigorous approach. The present model of clinical research is expensive, slow, studies insufficient populations of subjects—making generalizability difficult— and lacks power to examine important variations in clinical and personal characteristics of individuals. In my biased view, study design determines if research is being done. Without an appropriate design, we cannot prove if there is an

independent contribution of some “input” to some “output,” nor can we adequately surmise the size of that contribution. The only designs that allow for research are the randomized controlled trial (RT), or full population research.

This is not just armchair analysis or ivory tower argument. The need for accurate clinical research is crucial for patients who need reliable medical information, for providers whom patients depend on for that information, and for our society, with its growing distrust of institutions, in general, and the medical profession, in particular.

Research Is More Than Inquiry

To be clear, I am redefining the word “research.” The dictionary definition is broad and lacks context; “investigation into and study of materials and sources in order to establish facts and reach new conclusions.” This, to me, is so nondescript that it allows everything we do to be called research; are we not constantly investigating to learn and reach new conclusions? We seek Yelp to find food places, we ask our partners questions to understand their moods, we put our hands out of the window to feel the temperature.

Everything in our lives is inquiry of some sort, but this is not research; research has to have an element of seeking assured truth. And truth requires a representative group of subjects, a controlled comparison, and an accurate measure of differences. Yelp does not assure I will like the food, my questions to my partner do not assure I will know their mood, and I can find the temperature more accurately with a thermometer.

Observational Studies Are Unreliable Predictors of Medical Outcomes

Observational study (uncontrolled data collection on people who, unplanned, do something while others do something else) and secondary analyses of RTs are not research, either. Yes, there is inquiry. Yes, they seek new insights. But those studies do not assure truth, and truth means that if we act on the new insights, things will get better. Too many observational/secondary "research" studies have led us astray (estrogen therapy, radical mastectomy, high dose chemotherapy and bone marrow transplant for breast cancer, length of time needed to take anticoagulation after a stent, and many other bad ideas arising from bad study designs).

I apologize to many of my friends and teachers for the above paragraph, as many are masters at doing observational studies. In fact, much of training in epidemiology and statistics is learning how to do observational studies, since those studies are easy to do in comparison to RTs or full population research; just get some data and explore connections between independent (input) and dependent (output) variables, and hope you have the variables on the appropriate side of the equation. Observational studies fill the pages of tens of thousands of publications. So, they serve a purpose, just not the purpose of best research for individuals who are ill.

AI is Just a Sophisticated Form of Observational Study

Which brings me to the newest, rapidly growing, highly touted form of medical inquiry, artificial intelligence (AI). And a question: Is artificial intelligence (AI) clinical research? A

recent review highlighted 32 examples, including faster and better diagnoses, improved radiology and pathology interpretations, novel materials discovered in yeast, new drugs found for rare diseases, better supply chain management, and robotics for surgery. According to one blog on AI, Google Analytics had over 2,400 projects using AI; one in five companies added AI capability; some estimate that AI will be a $150-billion-per-year industry. Investors in AI are brilliant leaders in information sciences, far more advanced in AI than me, and they consider AI to be a burgeoning research field. It, however, does not fit my definition of clinical research. AI is sophisticated, but, still, observational study. It's an important distinction. For all its power, AI has yet to evolve to a point where we can rely on its findings for generalizable medical decision-making.

When the discipline began in 1956, AI was defined as the simulation of human cognition. AI has expanded to include not just cognitive models, but emotional and social models, and their data, as well. AI programs, are, basically, statistical programs. "Machine learning" is essentially regression models and "if-then" statements (algorithms) looking for correlations between inputs and outputs, which make sense only in comparison to known relationships between those inputs and outputs. The last part of that sentence is key; computers are remarkable, but AI programs need structure, and instruction. The output of an AI model uses some internal representation of associations. Certainly, the statistical models and programs are advancing, but the conceptual idea remains similar to statistical modeling.

What makes AI different is that there are now new sources of

input variables. Computers can capture optical data, size/volume data, spoken/written words, pixels of radiology data, data in any sort of unstructured format. Some programs, even, create variables to study on multiple layers of the variable, not just its existence (neural networks). For example, a cancer cell can be modeled by color change, change in the volume of the cell, or growth rates, and all of these can be combined into a new variable to correlate with known examples of cancer cells. Some AI, called "deep learning," relies on machines to capture, self-refer, and reinforce learning without any human external input (some define machine learning as requiring human tweaking, while deep learning is supposedly on its own, but even that needs a target, or reference to aim at).

More Data Doesn't Mean More or Better Knowledge

All this new, or newly formed, or newly reconfigured data, however, does not assure we will learn more. It will depend on how distinctly independent the new input data will be in comparison to older, known relationships (you may now have data to identify the make of my car, but the only thing that needs knowing is that it starts and gets me where I want to go).

Clinical research must demand a planned comparison of AI versus human judgment in a representative, random sample of people to see if AI insights are generalizable. AI may bring ideas to test, but it can't be the tester. Why? Because AI is working with observational data, gathered for a purpose other than the purpose of the AI program. This is a big problem; this is not research.

I'm willing to concede that I may eventually be proved wrong.

Some people even go as far as to suggest that clinical research funding should end until we see what the machines can do. But the machines were made by us, and the rules and data collected are biased by human input variables.

It will be fascinating to see how the focus on AI plays out. I hope we will not see another "AI winter" (no AI funding) by overselling the tool until we figure out how to use it. My hope, also, is that we study AI just like we study other things, with random samples of full populations, or full populations, with really smart study designs. Only then will we truly know both the strengths and limitations of AI for good medical decision-making.

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Image: Franck V.

Five Actions ACOs Should Take Now: Takeaways from Proposed CMS Rulemaking

written by Theresa Hush | September 5, 2019

Last week CMS released a proposed rule addressing revisions in

the Physician Fee Schedule (PFS) and the Quality Payment Program (QPP), along with a few other matters. Of 1,704 pages, only about 20 addressed ACOs issues directly. But ACOs should take a holistic approach to reading this proposed rule, as well as the proposed Outpatient Prospective Payment System (OPPS) rule.

Competition Among Risk Models Will Strongly Affect the Course of Change

With so many CMS programs and models now in flux, the whole is more than the sum of its parts. It's worth the effort to pay attention to the systematic interweaving of proposed changes throughout the various programs. That's because CMS's position is clarifying the direction and makeup of Medicare's Value-Based Health Care program. ACOs, once considered "the" direction for Medicare Value-Based Health Care, will be just one of several options for new Medicare risk-based models. Medicare Advantage (MA) plans—the option that is repeatedly praised by CMS—Direct Contracting (DC) physician practices, Primary Care First (PCF) practices, and various types of ACOs will be competing for both physicians and patients.

When the "Pathways to Success" ACO rule was finalized in December 2018, providers did not wholeheartedly embrace a regulatory path to Risk. New Primary Care Models were announced as innovations, yet it was clear to everyone that CMS had failed to create protective boundaries for ACOs; the same providers form the foundation for both types of models and can't realistically participate in both at this time. ACOs may still not appreciate that CMS's intent was not to protect them, but to stimulate them (and other providers) through

competition.

To Regain Superior Positioning, ACOs Must Increase the Pace of Change

The new competitive landscape creates new urgencies for ACOs to ensure that physicians and patients see the advantages of a provider-built model of delivery. Here's how we tally the key takeaways for ACOs from the PFS/QPP and OPPS rules, and actions that ACOs should take now to ensure a strong showing against the other models:

1. Adopt an "implicit" capitation system by showing comparative analytics for PCPs with actual spending results against per-member/per-year targets.

None of the ACO models, even Next Generation ACOs, is comparable to the simple Direct Contracting capitation model. Despite the fear factor of capitation, ACOs will find themselves at a recruitment disadvantage if primary care physicians positively view capitation as predictable revenues they can depend on, yet see downside risk in Medicare Shared Savings Plans (MSSPs) as a surprise retroactive rate cut. ACOs must now, ironically, argue for capitation with CMS. But they also need to create internal capitation-based reports and projects to engage physician in reviewing variations.

The quest for better cost performance tracking should inspire the need for better mechanisms to understand variations in cost, and to improve data itself (including patient risk data and social determinants). This should become an important segue for involving physician in a learning and contributory process

using patient data and costs, rather than the all-too-often negative process that penalizes physicians for higher costs.

2. Redesign ACO quality systems to include all patients in quality measurement, even when reporting requires less.

Most ACOs, understanding that the current ACO system provides a low bar for quality by using a sampling approach, gamble by waiting for the sample and then running their data. After all, why track quality on 100 percent of your patients when a small number can create eligibility for savings, especially given that the new PFS/QPP rule allows physicians to use their own MIPS scores if ACO scores aren't high enough?

The dissenting argument is that without understanding how each physician actually is performing, the ACO has little ability to guide and achieve the value that the ACO hopes to provide. The strategy also fails the ACO by making it impossible to connect quality results with cost data.

Limiting the ACO's quality reporting to regulation-only requirements actually encourages physicians to perceive the ACO as tangential (and not helpful) to their own efforts to perform good care. The ACO should evaluate ACO participants' MIPS scores so that it can actually understand how each physician is really doing against the standard for every patient, as well as their real performance for their patients. That effort should also compare quality using the new set of 23 measures as well as MIPS measures.

3. Embark on a primary care recruitment campaign that outlines the ACO agenda to help primaries do better than PCF or Direct Contracting, or Medicare Advantage.

CMS is probably correct that many groups who are not willing to join ACOs are willing to directly contract. But if that is the case, it reflects the likelihood that the ACO has either organized itself to be un-beneficial for larger physician groups, or has not done a good job of conveying its message.

To compete properly in risk models, the ACO will need to identify its benefits to core physicians—by asking them. If the ACO benefits are not strong enough compared to the other models, its future options will be very limited, assuming those physicians were good candidates for ACO participants. That's something else the ACO should now realize is necessary: a recruitment process that collects data and information that properly evaluates its participating providers' practices, attitudes, and costs.

4. Pursue price transparency measures to attract patients.

MA plans and other models will have the ability to tighten the formal bond between patients and the practice, just short of restricting choice. The PFS/QPP rule is very revealing in its attempts to simplify and streamline the complex pricing of physician services, and at several points specifically refers to the benefit of comparisons. CMS has been forcing the transparency of pricing for all health care providers. ACOs have the capacity to weigh in and potentially manage this transition internally, and create an advantage by making it a

part of the medical decision process. Price transparency will happen one way or the other in health care, and ACOs should recognize this as an opportunity that could help them compete now.

5. Be involved in visible public health and patient initiatives—be more than a financial or functional mechanism for providing care.

The ACO has had little separate identity to date, unlike either its individual practices or Medicare Advantage plans. Its administrative functions are not strong enough to be relevant to either providers or patients.

ACOs in competition will need to mature beyond getting attributed patients and invisibly developing processes to do better care. As administrative entities, they have no marketing oomph in an environment where the competitors do. In short, they need to be aspirational and appeal to both consumers and physicians.

An obvious option is for the ACO to be a more visible enterprise, and this will prove an advantage both competitively and to achieve better outcomes. ACOs must be able to take on the issues of opioids—a major feature of the proposed PFS/QPP rule—women and minority health inequities, vaccinations, and other significant public health issues.

Between the lines of the Medicare initiatives in Value-Based Health Care as outlined in the proposed PFS/QPP rule, the ACO is still maturing. Some ACOs have become very important to their stakeholders, even if their “brand” is primarily known

only to their participating providers. For successfully performing ACOs to continue to make gains against competition, they will need to broaden their influence internally and with patients. Still-evolving ACOs must aggressively battle to compete for patients and physicians, offering much more than many first entrants in their markets had to do. The strategy for ACOs on both ends of the spectrum must be to become relevant, not by scripting their actions from regulations that depict the minimal requirements, but by competing as customer- and physician-focused businesses.

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Image: Mitchell Orr

Risk Payment Models Will Fuel Growth of Equity-Backed Physician Practices

written by Theresa Hush | September 5, 2019

Risk payment models present a daunting challenge to the very cultural of medicine—for most physician practices. Physicians identify their practices as clinical enterprises more than businesses, although some have managed to achieve success solely by being excellent clinicians in their fields. Patients, however, are quick to see the flaws along with higher costs—hence complaints about customer service, poor billing practices, and difficulty communicating. But clinical practice success, up until now, has been measured by the yardstick of Fee-for-Service reimbursement: higher incomes through patient volume and services.

Hospital purchasers of physician practices adopted the same benchmarks of success. Even as hospital systems introduced modernizations like technology and improvements in clinical flow and patient billing, however, they often focused on the physician practice engine to achieve more productivity and greater volume of services.

That reliance on volume-driven revenues accounts for the fear of Medicare risk models. While many physician groups and health systems see the possibilities, they are slow to adopt risk. Even ACOs have struggled with the concept of downside risk.

But there is one rapidly growing physician practice model that will actually be fueled by the expansion of risk: Equity-backed physician practices. Let’s examine how equity purchasers are influencing the landscape of health care providers.

Equity-Owned Specialty and Multi-Specialty Groups are Booming

Equity investors have been flocking to health care because of high revenues and opportunities to create efficiencies and growth. Another appeal is the recession-resistance of the health care industry; medical emergencies can't be deferred, and utilization tends to rise as workers use up benefits before they expire.

More recently, those deals have increasingly involved physician practices. Dermatology and ophthalmology, followed by other specialties such as urology, gastroenterology, and orthopedics, have the highest number of equity investor purchases. Also targeted are subspecialty and emergency medicine practices, including urgent care. Some specialties have higher number of purchases because of a centrally active acquirer, such as EmCare's acquisitions of emergency physician practices. In other specialties, multiple private equity firms are active acquirers.

According to *Bloomberg Law*, there have been 107 combined dental and physician practice transactions in the first half of 2019, alone, a stark increase over 2018. While many purchasers have consolidated smaller practices, two recent transactions may lead the wave of major group purchases. The recently closed purchase of DaVita Medical Group by Optum/United Health Group, along with that of Summit Medical Group by CityMD announced in June 2019, are both well positioned to play in the emerging value-based reimbursement environment. Warburg Pincus equity investment firm characterized the purchase by its CityMD partner as "creating the leading physician-centric and

consumer-oriented integrated delivery system in the largest US healthcare market."

Consulting firms active in practice acquisition forecast major increases of equity investment in physician practices, along with consolidation of equity companies and expansion into areas of specialization, such as ophthalmology into optometry.

Equity Deals are Perceived as Good for Practice and Physician Future

For some groups, selling to equity investors has distinct advantages over hospital sales. One advantage is maintaining ownership and a voice. Ophthalmologists and dermatologists, who have navigated a high number of practice acquisitions to an impressive volume of separate equity firms, share stories broadly of their experiences. These identify several key benefits of equity purchases:

- Physician ownership maintained, although with some loss of control;
- Investment in infrastructure;
- Practice value monetized immediately, so physicians financially benefit;
- Route to expansion and growth;
- Better physician incentives;
- Helping physicians practice medicine by off-loading practice burden.

Equity practice purchases are not without controversy among physicians, however. Just last week, an editorial in the *Journal of the American Medical Association* (JAMA) by two dermatologists portrayed the trend as possibly leading to the

demise of medical practices in response to the urgency of cutting costs.

How Can Equity Investors Make Money While Squeezing Costs?

Many industry experts believe that the trend toward physician equity purchases will raise costs, not lower them. In a Fee-for-Service environment, there is little doubt that any purchaser will take advantage of the opportunities available for revenue.

But in the coming environment of risk reimbursement models, especially capitation or bundled per-case payments, there may be an advantage for risk-savvy companies: predictable revenues. Direct Contracting and Bundled Payments, in particular, offer practices opportunities to achieve guaranteed revenues and benefit from additional savings.

With good analytics and infrastructure, it is possible to target and moderate variations in cost of individual cases. It takes end-to-end flow of collecting risk data from patients, use of an efficient and effective clinical pathway that leads to the discussion and adoption of a treatment regimen, and execution of the regimen by the physician and patient. It is a job of technology, infrastructure, and process.

Of course, that is a glib summary of steps to accumulate savings. Most of those steps are not routine in the typical practice. Risk data are not always collected, and do not inform patient treatment plans, which are usually designed by the physician. The physician and patient don’t have agreement on what is possible in the patient’s life, or financially.

But that’s the point. Physicians don’t have the time to guide the development of a process toward risk, and practice staff are often not experienced enough to take on the task with confidence and power. Equity investors have the imperative to focus on business and its risks. They may be instrumental in helping businesses move toward profit in their markets, with the right relationships and incentives.

Business-focused practices are more likely to pay attention to consumers/patients as medical purchasers, delivering better customer service during service delivery and better outcomes to lower costs. That’s rational decision-making for most businesses who understand that their customers have choice of providers. But under the current medical system, consumers are recipients of service, while payers have the purchasing power.

Purdue University could be an example of how the staunchest of enterprises, a university, adopted innovation through an equity investor mindset. That experiment resulted not only in frozen tuition for six years, but an investment program that helps fund students’ education.

Physician Equity Will Leave a Mark on Medicine, Good or Bad

Experience will teach whether equity-purchased practices will indeed be consumer-focused and also help physicians realize their goals as clinicians. There are good reasons to question what will happen to clinical innovation and pushing the envelope of medical research and discovery, should health care enterprises privatize.

But business is finally coming to health care. It’s not coming

in the way everyone expected, through adoption of modest changes in business-like practices and modernizations, and more responsiveness to purchasers and patients. While those changes are also happening, the whole nature of the business of health care is changing.

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Image: Quino Al

A MIPS Rewrite is Certain: CMS Proposed Rule for the 2020 Quality Payment Program

written by Dave Halpert | September 5, 2019

The CMS Proposed Rule for the 2020 Physician Fee Schedule and changes to the Quality Payment Program picks up where the "Pathways to Success" ACO rule left off. This time, the "Pathways" shake-up is aimed squarely at MIPS, in the form of "MIPS Value Pathways." We've described the growing frustration with MIPS, specifically MedPAC's report to Congress on its concerns that MIPS is overly burdensome and complex, and doesn't translate into better care. That theme repeatedly shines through the 1,704 page proposal.

CMS is using this rule as an initial salvo indicating that MIPS as we know it is headed for reform, to be replaced by MIPS Value Pathways (MVPs). The four pillars of MIPS (Quality, Cost, Promoting Interoperability, and Improvement Activities) will continue to be measured, but requirements and methodologies will be new (and, in fact, are up for debate). The aim is to reduce clinician burnout by aligning the four components and reducing reporting burden.

CMS states that they will facilitate this transition by providing additional administrative claims data and enhanced performance feedback. What's left unsaid is how practices will need to continually measure and monitor performance, ensuring that their 2021 Feedback Reports promise incentives in 2023, rather than penalties.

How Did We Get Here?

A restructuring of MIPS was inevitable. CMS's cheers for high participation were also a warning that the penalty pool and corresponding incentive payments would be minimal. In fact, pending huge changes from Targeted Reviews, the maximum incentive payment based on 2018 performance is actually less

than 2017, the “Pick Your Pace” year. Of the eligible 2018 MIPS Eligible Clinicians, 96 percent of 2018 participants avoided 2020 penalties. In other words, fewer clinicians were penalized under the full-implementation year of MIPS than in the year in which providers needed only to report a single measure or activity.

The zero-sum nature of MIPS seems benign until one factors in the Congressional requirement that, beginning with the 2022 performance year, the performance threshold (the point at which penalties begin) must be set at the mean or median of the final scores from prior years. In the “Pick Your Pace” year (the 2017 performance year) the mean score was 74, and the median was 89. It is estimated that, when all Targeted Reviews conclude, the 2018 mean score will be 80, and median score will be 91. Those who achieved the touted “Exceptional Performance” designation in one year could suddenly find themselves penalized in the next, even though they continued to score well in MIPS. In essence, CMS has inflated the MIPS grade curve.

MIPS Value Pathways (MVPs)

To alleviate concerns related to clinician burden and indistinguishable performance, CMS has developed a new phase of MIPS called MIPS Value Pathways (MVPs). As described, MVPs are a CMS construct for putting providers into a more targeted initiative—one with a strong resemblance to an APM. There are four key components to an MVP:

> MVPs should be built from smaller sets of measures and activities, and these should be meaningful to clinicians. The measures and activities should make it easier to compare performance data, be it for scoring or to enable patients

and caregivers to make informed healthcare decisions. Measures should be clinically relevant and encourage improvement.
MVPs should include measures that are also used in APMs so that clinicians will have an easier time transitioning into an APM.

Conceptually, MVPs follow the model that we've long advocated: providers should develop a cohesive MIPS strategy designed to encompass each MIPS component, as this will be more efficient and successful than devising four separate strategies. For example, a group may choose Improvement Activities specifically targeted at certain quality measures, particularly outcome measures in which an improvement can reduce expenditures (e.g. controlling intermediate outcomes for patients with chronic conditions or reducing re-admissions and/or complications following surgery). Breaking the "flat line outcome" trend can elevate the group's performance, improve the group's quality score, and decrease costs, while simultaneously fulfilling the IA requirement. This should coincide with education and training to maximize EHR efficiency; providers will need to spend less time documenting and more time caring for patients.

Nevertheless, there will be differences between MVPs and the MIPS we know today. This will be particularly true in the Quality component. CMS states a desire to incorporate administrative-claims-based measures, which would reduce clinician burden. The measures would have a specified focus, be it chronic condition management, procedural outcomes, or cross-cutting population health issues. This streamlined measurement would make it easier for CMS to identify "high value" clinicians and would be more easily understood by consumers

utilizing the Physician Compare website.

To facilitate this model, CMS has indicated that they will provide more comprehensive and timely feedback reports, as well as claims data. Whether these measures or a greater focus on administrative claims measures proves more reliable than other measures remains to be seen. Of important note, one of our major criticisms of MIPS measures is that they represent a single value of performance, rather than show improvement or trends over time. As a single performance indicator, they are subject to change from year-to-year and provide no understanding of whether the practice is improving results for patients, or not.

It is critical to note that very little about MVPs is actually defined in the Proposed Rule. In fact, CMS has created the "Transforming MIPS: MIPS Value Pathways Request for Information (RFI)" to give stakeholders an opportunity to weigh in on the logistics. Questions include (but are not limited to):

- Which conditions and procedures will be included in the eventual MVP catalog?
- Once created, what measures and activities should be included in each MVP, and how will they be scored? Will clinicians have the opportunity to pick from a limited set?
- How should MVPs be assigned to clinicians? What if the clinician practices in a multi-specialty setting?
- How should patients be attributed to MVPs?
- What feedback will clinicians need from CMS (and how often) in order to be actionable?

Although MIPS Value Pathways would not take effect before 2021,

CMS encourages all stakeholders to comment prior to September 27, 2019. Comments may submitted electronically through the regulations.gov website.

Immediate Proposed Changes

The biggest QPP-related news in this Proposed Rule may be MVPs, but there are more immediate changes proposed for 2020. CMS intends for these changes to facilitate the transition to MVPs, and they may. What is certain is that these changes will address the universally high MIPS performance over the last two years. Should these changes pass as proposed, those who have succeeded in MIPS before may not have such an easy time in 2020.

These new challenges begin at the highest level. First, the minimum number of points needed to avoid a penalty has been proposed to increase from 30 points in 2019 to 45 in 2020. Along with the higher scoring requirement, the corresponding magnitudes of the financial incentives and penalties have also increased. A MIPS failure in 2020 will cost clinicians up to 9 percent of allowed Part B charges in 2022, with those penalties being re-distributed amongst the MIPS winners. CMS has proposed to raise the bar again for the 2021 performance year; providers would need 60 points to avoid penalties in the initial MVP year.

In this Proposed Rule, CMS continues to increase the weight of Cost on MIPS scoring, at the expense of Quality. In the 2020 performance year, CMS has proposed to decrease the weight of the Quality component to 40 percent, while increasing Cost to 20 percent. CMS further proposes to continue the value of Cost at 5 percent through 2022 at the expense of Quality, with both

Cost and Quality counting for 30 percent of the total MIPS score in the 2022 performance year. As CMS hinted during Measure Field Testing in 2018, the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (now MSPB-C) within the cost component have proposed revisions, along with the addition of 10 new episode-based measures.

CMS has proposed a new definition for QCDRs, one which requires specialty-specific measure testing and development in addition to providing the infrastructure and experience to help improve outcomes. The result is that the majority of QCDRs will be comprised of specialty societies and similar organizations.

In addition to raising the bar at a program level, the Proposed Rule includes more stringent proposals for individual MIPS components. In the Quality component, the data completion threshold has been increased from 60 percent to 70 percent. Practices who have not adjusted workflow and/or documentation guidelines in prior years will have a more difficult time meeting that threshold, and for 2020, a measure below the data completion threshold will not earn points. (Previously, it was still possible to earn one point for measures reported below the data completion threshold.)

Stronger requirements are also found in the Improvement Activities section. In prior years, when reporting as a group practice, if only one provider in the practice needed to complete an activity for the requisite time period, all clinicians in that practice would earn credit. As proposed in 2020, at least half of the providers in a practice need to have completed the activity for the practice to earn credit for that activity as a whole. For those who have earned IA credit in the

past through limited pilot projects, now is the time for a roll-out.

CMS Continues the Push to APMs

Despite the introduction and eventual rollout of MVPs, make no mistake—CMS wants providers out of MIPS and into APMs. This has been a cornerstone of the Quality Payment Program since its inception, continues to be a pervasive theme, and is openly stated as one of the MVP goals.

In fact, one of the few proposals that will make things easier for providers in 2020 allows MIPS APM participants to report on MIPS quality measures, rather than the APM's quality measures. Clearly, CMS isn't hung up on which measures are reported—they are focused on getting providers into financial risk arrangements. If you have reservations about a re-defined MIPS program with rapidly dwindling margin for error, now is the time to consider your APM transition strategy.

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Image: Lopez Robin

Can ACOs Survive the Complicated New Landscape in Medicare Risk?

written by Theresa Hush | September 5, 2019

What a difference a year makes. In Spring 2018, many Accountable Care Organizations (ACOs) pondered a walkout over Medicare plans that included downside risk in ACO financials. Nonetheless, CMS finalized its plans to make provider risk a

reality for all ACOs in its Pathways to Success overhaul of the Medicare Shared Savings Program (MSSP).

ACOs' lukewarm reception to the goal of compelled savings, however, was not forgotten. Fast forward to April 2019, when CMS announced five Primary Care Models to propel physician groups to adopt risk-based reimbursement directly—including capitation. Those models are now under fast-paced implementation, with application deadlines approaching.

CMS is determined to impose cost caps and hold providers at risk. We are not surprised. Long before Department of Health and Human Services Secretary Alex Azar revealed this week that it had plans to boost Medicare Advantage (MA) plans, we predicted that CMS would deploy a multi-prong strategy, including direct contracting with physician groups and expansion of Medicare Advantage. Why? Providers were moving too slow with risk-based models, avoiding participation in ACOs, or choosing the lowest risk path in ACOs as well as other risk initiatives, like Bundled Payments for Care Improvement (BPCI). In addition, ACOs had limited success at achieving savings and an aversion to risk.

More careful with words this year, ACO representatives are writing letters to CMS supporting the Primary Care Models and making helpful suggestions for mitigating the overlap. Yet behind the scenes they seem puzzled. Why is there a frenzy to create overlapping models, all of which put providers at risk?

Risk Models Overlap by Design

Let's put one issue to rest. CMS did not underestimate the competition between the models of ACOs and primary care for

winning provider participation in their communities. The agency also did not forget to address overlap of features that may cause ACOs problems in recruitment of physicians who may be more interested in dealing with Medicare risk independently through a Primary Care Model, or confusion in the market among providers and patients.

The overlap benefits CMS. How? First, the message to providers shows the absolute certainty of risk-based reimbursement and the death of Fee-for-Service. That clear message speeds up the transition and lowers resistance. Second, the overlaps force an election among providers to choose their best options for risk, without CMS having to mandate a program. There is no doubt that a period of competition will effectively demonstrate how providers prefer to participate in risk, and which model will be most successful financially for Medicare. As someone who also tried many big changes in health care via government, I have to acknowledge that the strategy is brilliantly conceived to meet the administration's goals.

CMS has also carefully paired its financial initiatives with policy goals. The Medicare Advantage boost is not only a payment hike, but a "strategy to tackle maternal mortality rates, social determinants of health and rural healthcare access." Primary care models "will reduce administrative burdens and empower primary care providers to spend more time caring for patients." Whether the policy goals can be achieved by payment models alone can be debated. But the message seems to be working.

Will Downside Risk Kill the ACO Golden Goose—and Why Does it Matter?

ACOs were conceived as the solution to Value-Based Health Care. But they proved hard and expensive to establish, and more difficult, still, to succeed. Small physician-run ACOs have achieved better savings, yet have a higher drop-out rate, a clear demonstration of the conflicting organizational and financial issues involved in risk, especially for lower income organizations.

Despite the success of small physician-run ACOs, however, ACOs are so varied in structure, participation, and goals that there is no sure model of success. Some larger organizations have achieved savings. And it is possible that larger ACOs with a genuine interest in care redesign and coordination simply require more time to change cost trends, align providers effectively, and better collect and use data and technology required to improve patient care. A premature push to risk may lead some ACOs that could be successful to fold the tent rather than risk financial failure.

CMS actions put higher emphasis on capping costs through risk than on a long-term fostering of the ACO concept. Perhaps the desire to move quickly away from Fee-for-Service outweighs the perceived benefit of an ACO model of care delivery. Or, that the ACO program is too complicated and too varied to prove manageable. Government may see no advantage in fostering better efficiencies through provider-led delivery systems, and may see Medicare as health care insurance. Whether the design of health care delivery is established by payers or providers may be unimportant to decision-makers.

For now, there is a small group of 41 Next Generation ACOs that form the core of providers that are willing to accept downside risk. If that number dwindles, or if MSSP ACOs fail to mature into successful risk-bearing organizations, CMS patience will certainly diminish. No doubt the realization of an uncertain future has compelled ACOs to request that Next Generation ACOs be deemed a permanent model—a request to which CMS has not yet responded.

ACO Model Survival Depends on Being Equal to or Better than Medicare Advantage

Considering that ACOs and other models compete for the same providers and patients, ACOs have a very difficult road ahead to define their advantages to either group.

Direct Contracting and Next Generation ACO offer similar perks to providers, including extra benefits and services for patients who align with providers. The payment and savings reconciliation under each model are substantially different, with partial or global capitation in Direct Contracting and a more complicated All-Inclusive per beneficiary rate for Next Gen ACOs. However, these are technicalities and the manner in which revenues return (or not) to ACOs and Direct Contracting groups will not affect immediate sustainability.

In some geographic areas, ACOs and Direct Contracting or Primary Care First groups cannot co-exist. Low physician supply of primary care or specialty physicians will affect the ability of ACOs to achieve effective physician coverage in such communities. In larger urban areas, we can expect a patchwork quilt of ACOs and DC practices. It may indeed be difficult for ACOs to recruit premier physician groups who could remain

successfully independent under capitation.

But the key threat to ACO survival does not come from Direct Contracting or Primary Care First. While these models could impair ACO ability to form solid provider networks, such situations will most likely be rare.

What matters more is whether ACOs can achieve same or better results than Medicare Advantage plans. MA is the real competitor to ACOs. Concerns over selection bias that favor MA seem to have disappeared, and CMS is clearly pushing for expansion of MA. To call MA the privatization of Medicare would not be an overstatement, and it is a strategy that could appeal strongly to an anti-regulatory, fiscally conservative government.

The Strongest Strategy for ACOs to Compete: More Risk!

ACOs have tread cautiously toward adopting risk, but financial risk must be a “sink or swim” proposition. Without alignment of payment systems that encourage efficiency over volume, ACOs and their provider groups have trouble unraveling the incentives for productivity, admissions, and referrals of their physicians. Those incentives kill success under risk.

An ACO’s best advantage is that its network and infrastructure can serve multiple purposes for a variety of payers. Then clinicians can be consistently focused on interventions and efficiencies for all patients, not just Medicare patients.

ACOs should build their capacities to negotiate commercial health plan contracts for risk-based reimbursement, if they

aren’t doing so already. They will require identified claims data to understand their per-member/per-month costs for covered patients as part of these negotiations, and to segment risk by patients and create interventions. Without claims data, ACOs are blind to the leakage from their systems and preventable costs. Participation agreements with physicians and hospitals should be flexible enough to permit narrow networks within the ACO for particular contracts, if warranted.

Financial risk can enable the development of pathways toward positive results, as well as predictable cost and outcomes to patients and payers. ACOs must be the engine of change rather than the administrative contracting entity.

Energy Is the Antidote to Noise and Distraction

The imperative for would-be and existing ACOs is to overcome a paralysis that can arise from noise and distraction. Until (and unless) CMS allays ACO concerns by managing the overlap of various risk models, coexisting risk arrangements—Primary Care Models, Medicare Advantage, ACOs—will be the norm. So, too, will be the permanency of ACOs, in general, and the Next Generation ACO. Uncertainty is the rule.

Many ACOs have been working to achieve goals, but most still lack the tools to predict risk and stem costs. The inability to better organize their networks through negotiated arrangements with physicians and hospitals is an issue that they need to overcome. Data, for many ACOs, is limited to CMS claims and does not include the risk factors necessary to help guide patient care plans. ACOs must raise the resources to fulfill these gaps.

ACOs have the possibility of fulfilling their promise, but they must seize the day.

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Image: NRKbeta

How the Stock Market Models a Path to Better Research.

written by Robert McNutt, M.D. | September 5, 2019

The better clinical research is, the better medical care will be. It is so crucial to the future of best medical care that I have highlighted deficiencies of the present conduct of randomized trials (RTs) in previous articles to suggest ways to improve. A system of better research must accommodate studies on any intervention aimed to improve care, including interventions such as a change in practice, any quality or safety plan, or an economic principle such as fee-for-service versus capitation—not just studies of new drugs.

In my last article, I coined the term "Gallup Research Medicine" as a model to improve the generalizability of RT studies by

- using random samples of full populations of disease registry patients, and
- increasing the number of people in RTs with variable

prognostic characteristics.

Here I propose a second model for better clinical research: a stock-market model.

Random Sampling Is Not Always Random

A criticism of random sampling of even full populations of people is that not all people sampled agree to participate in a study. Gallup, for example, uses a full population of phone numbers and randomly calls those numbers. However, Gallup cannot control who accepts their call (as few as 35 percent of those contacted). The problem is that the variable "accept a call" is not necessarily randomly distributed. For example, some area codes are inundated with spam calls, which may make people less likely to participate by accepting Gallup's call. This introduces error, and Gallup accounts for this variable, and others, as best it can. However, as soon as accounting or adjusting is needed, randomization is compromised. (Of course, who does/does not accept entry into a study is a problem for any study design).

If random sampling is problematic due to non-random reasons to participate/not participate in a study, studying a *full sample of patients* would circumvent the problems. Full sample research presents its own challenges. But before throwing the idea out at first mention, let's consider what situations might be compatible with this idea and what measurement concepts would need to be followed.

How a “Medical Stock Market” Model Could Benefit Research

The stock market serves as an example. First, the stock market is a *full sample* of selected companies (more later), and, second, it uses a standardized, uniform measure for the value of all companies.

The stock *market* is a compilation of stock *indexes*. Each index (e.g., Dow) reports the performance of all companies in the index. An index’s measure is the weighted average of each company’s stock price times the number of shares.

The stock market is also a transparent measurement system. We see daily reports of an index’s outcome value (dollars). The presentation of the measure is a run-time chart, the measure is the average, weighted index value over time. *In summary, the stock market includes a full sample; a sensible, stable, uniform measure of value; and transparent presentations of data.*

Not all companies are in stock indexes, but each index has a defined and full set of companies representing a type of business (e.g., technology). Clinical research might follow this model. Each “index” could be a defined entity such as a hospital, a group of hospitals, or an ACO. Alternatively, an index might be a disease registry. All patients in those entities would be included in the index.

The stable measures in clinical research would not be as simple as stock price times the number of shares. Clinical conditions have multiple outcome measures. Disease conditions, however, share standard measures used by researchers. For example,

diabetes research may measure blood sugar, A1C values, or creatinine clearance. Breast cancer outcome measures include stage, treatments given, recurrence rates, life and death. In any research study, a limited set of measures are defined and followed. If a parsimonious set of measures were followed over time, a stock-market model would fit.

Measuring Hospital Safety with Medical Indexes for a Full Patient Sample

An example might help. When I was the safety officer for our department of medicine, we measured 20 variables on every patient admitted to our department. The index “fund” was all patients admitted to our medical wards.

We spent several months deciding measures for our “index fund”; some were disease specific, some measured utilization. For an example of a disease measure, we tracked blood sugar values on admitted diabetic patient and presented a run-time chart at our monthly department meetings. The chart showed the average blood sugar value and range of values. This means we knew the percent of patients with low or high blood sugar values as well. Another clinical measure was percent of patients with pain scores higher than 6 (out of 10). An example of a utilization measure was the percent of paired orders for amylase and lipase. Since they are redundant, we hoped to show we could reduce the tandem use of the tests.

These clinical and utilization stock-like measures showed the functioning of our hospital. With stable measures presented monthly, it was easy to note if any of the measures changed. For example, one month we noted a marked change in the percent of patients with pain scores over 6 and learned that nursing

had altered rules for how the pain score was measured.

The observation of this change in both practice and pain scores suggested a research avenue. It was easy to show differences in the pain outcome measure as a consequence of the systematic change in nursing practice because the *entire population of patients* had been intervened on. Given the standard and stable measure, we noted the change in a single month's report.

This observation, in fact, was clinical research in action; nurses *intervened* on all patients and *outcome measures* changed. We easily noted *how much* the percent of patients having a pain score over 6 changed with the intervention; comparison was obvious. The change was so dramatic that statistics were not needed to show a significant difference, but we did do statistical testing if needed.

Following the observation of change for full population interventions, we then intervened on the entire population of patients getting laboratory tests with amylase and lipase for presumed pancreatitis. After the intervention—an educational plan involving all ordering physicians— the percent of paired tests was reduced from over 90 percent to less than 10 percent, a statistically and clinically significant difference.

We conducted full population research studies for many of our outcome measures. We reduced the percent of patients with hypoglycemia by raising the target level for blood sugar during a patient's hospital stay; we reduced the use of chronic medications for non-life threatening or altering conditions; we eliminated dangerously high potassium levels by imposing restrictions on the amount of potassium supplementation.

We were just one hospital, but the model is transferable to any other, and groups of any other hospitals. This model would not work, perhaps, for introducing new drugs, but for any quality/safety/policy intervention, intervening on full populations after establishing baseline measures for outcomes would allow for generalizable and locally responsive advances in care.

Other Applications of Full Population Sampling

To recap, random sampling of full populations is ideal, but difficult. Research on entire populations is equally valuable, but there are limits on interventions that may be tested. Stable, routine measures for outcomes is paramount. Our hospital chose what we wanted measured, but our government research agencies could encourage similar measures for all covered patients in our country. If organized, we could test multiple interventions on full samples of patients across the entire country to see what might be best. The key, again, is full samples, not non-random portions of full samples.

This model is also useful for learning how local environments of care may alter what interventions are possible or useful. The results of studies in this model are tangible and readily shared. The cost of doing research will be relatively low as this model *makes research part of the day to day care of patients*. We watched our "stock index hospital fund" monthly and changed actions when needed.

Research efforts can get better, and I propose two models. There are likely others. The stock market analogy is not perfect for clinical research, as medical care will be more systematic when asking questions and planning interventions.

The stock market, on the other hand, is a sometimes capricious animal that reacts, rather than plans. Yet, the conceptual model of information management works as a platform for clinical research.

In the next blog I will address logistical considerations in hopes of spurring discussion about how to change the organization of clinical research.

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Image: Aditya Vyas

Can Medicare Primary Care Risk Models Work in Today's Practice Environment?

written by Theresa Hush | September 5, 2019

There’s now no doubt that Medicare is eager to move forward with Value-Based Health Care and risk-based reimbursement. CMS has rolled out major changes to make Accountable Care Organizations (ACOs) risk-bearing and add attractive benefits to capitated Medicare Advantage plans. Add to that two new classes of Primary Care Risk Models that introduce risk-based reimbursement into the general provider population, which, CMS says, are designed to stimulate primary care: Primary Care First (PCF) and Direct Contracting (DC).

But we also know, from early CMS statements on direct contracting, that it intended to find other mechanisms to move physicians into Value-Based Health Care in light of tepid adoption of ACOs. At the same time, existing and future ACOs are depending on recruiting from the same dwindling pool of primary care physicians to achieve success.

Given the reality of consolidated health care organizations and primary care physician practices today, will these models actually work?

In prior articles, we've described the two programs and the variants of each model, and laid out how groups need to examine their likelihood of success. For large groups considering direct contracting, we've outlined key steps to preparing for the challenge of partial or global capitation.

Here we examine how the Medicare Primary Care Risk Models fit the evolving delivery system and the goals of Value-Based Health Care. What are the potential effects of these models on adoption and success for providers?

Can Primary Care Physicians Take on More?

Let's take a look at what is happening to physician groups, in general, and to primary care physicians, particularly.

It's a well-established fact that the capacity of primary care physicians falls short of need in the U.S., and that there is a maldistribution of physicians, to the detriment of high-need areas. Observational data links reduced capacity by county to increased mortality and specific higher causes of death. Although there has been a recent rise in number of practicing primary care physicians, the per capita benchmarks are declining.

Primary care physicians are being driven to take on more volume, while at the same time the population health processes envisioned by Medicare Primary Care Models require more work and time per patient. Physician thought leaders are asking

legitimate questions about how pressure to see more and spend less time per patient can result in better care—and whether incentives to focus on primary care management of expensive chronic illness can actually result in worse outcomes.

Primary Care of Yesteryear is Not Same as Today

There is nostalgia regarding primary care that does not seem to reflect the reality for most practices and patients. In a departure from the past, less than half of physicians are in physician-owned practices, which tend to be smaller in size.

According to the American Medical Association's (AMA) Physician Practice Benchmark Survey of 2018, more than half of physicians are employees in a practice. Ownership and partnership of practices declined from 75.3 percent in 1983 to 45.9 percent in 2018. Along with this trend is a significant shift in practice size, with just over one-third of all practices having five or fewer physicians. More of the smallest-size groups tend to be physician-owned and single specialty practices. This will be a significant obstacle for ensuring the resources and technology required to manage risk in small primary care and specialty practices.

In both Family Medicine and General Internal Medicine, the majority of physicians are employees, and in both areas the number of physicians operating in physician-owned single specialty groups is obscured by the combined total of physicians in multi-specialty practices and hospital-owned settings. The traditional small general medicine practice is fading and being replaced by larger multi-specialty groups. Primary care physicians have exited solo small practices, and practices with fewer than 5 physicians are dwindling. These

smaller practices, along with the next tier of 5 to 10 physicians, are the target of Primary Care First.

Private practice is also declining, as hospitals have acquired or established joint-venture practices with physicians. The AMA Survey reveals that just 54 percent of physicians are in private practice, down from 61 percent in 2012, but the rate of decline is slowing. Hospital investment tends to produce multi-specialty groups of larger size.

A second survey of physician practice trends, morale and perspectives paints a markedly bleaker picture of the numbers, with only 31 percent of physicians as owners or partners in practice (different results due to a different mix of responding physicians, including more primary care physician responders).

Primary Care Models Favor Larger Practices and Prominent Multi-Specialty Groups

Physician practice trends will have a significant effect on the adoption and success—from both provider and patient standpoint—of Medicare Primary Care Models.

> Primary Care First will face the greatest hurdles to adoption on a large scale, and less success in achieving incentives for practices. Its focus on a waning number of small and under-resourced practices will be a natural deterrent to adoption, and perhaps this is intentional. CMS cannot exclude such primary care physicians from the game and has understandably set a low bar for incentives. But stronger and trended outcome measures are necessary to ensure that patients are improving. Rewarding practices

based on reduction in hospital utilization, while depending on MIPS measures for quality, is an insufficient formula for value.

Direct Contracting should appeal to certain larger groups, especially if they are negotiating other risk-based agreements. Targeting large groups with guaranteed per-beneficiary payments—with beneficiary alignment advantages an extra plus—creates strong incentives for groups that have invested in expansion. However, we should recognize that consolidated systems with physician practices are in the best position to capitalize on direct contracting, since their providers can participate in a closed system of care, including ambulatory, outpatient and inpatient services, as well as post-acute arrangements. Nonetheless, note that these organizational assets will be offset by the attitudes of employed primary care physicians in such groups—being overworked, with little autonomy and power—lessening their leverage and interest in controlling costs. While the group's top hierarchy may be keenly interested in a committed patient volume, rank-and-file physicians are unlikely to be the change agents needed to generate better care or savings.

Participation of physician multi-specialty and single-specialty primary care groups is unlikely to be very advantageous to any but the most prominent multi-specialty physician groups. While partial capitation is available, there are shared savings associated with costs that are often outside the control of the primary. Medicare has established cost of care as the primary indicator of value, because the only real measure of success is savings against capitated revenues or total expenditures. Like PCF, DC lacks key trended outcome measures and safeguards to protect

attributed patients from denials of care or inadequate treatment.
Capitated payments planned under Direct Contracting have worked in the private sector to produce savings, and Medicare Advantage plans have also been successful. But all capitated arrangements benefit groups by the influx of younger, healthier patients that balance the costs of older and more ill patients. Medicare Advantage plans have already siphoned off many lower cost patients from traditional Medicare, and those who remain will represent more difficult and expensive patients to serve and still generate returns for providers.

We have presented a rather pessimistic forecast of Medicare's Primary Care Models, but not because of their inherent design. There is little doubt that stimulating primary care relationships may be helpful for many patients, and could result in better outcomes and lower costs. The question is whether this result could take place on a large scale in the current health care environment. We may have passed the stage where existing vertical organizations can reimagine and reinvigorate primary care and specialty care to become a real continuum of accountable care. In fact, is not that vision what ACOs are intended to do?

The question of ACOs and the competition for primary care physicians we will leave for another post. CMS seems to be indicating that where ACOs have failed to achieve the goals of value, a less cumbersome regulatory structure for providers may succeed. Or, the larger CMS goal may be simply to steer physicians toward fixed or capitated fees, rather than to remodel the delivery system. Stimulating the supply of primary

care physicians could be better accomplished through a payment system other than capitation or risk-based incentives.

In either case, there is a nascent but growing group of providers who recognize the potential for fulfilling the CMS goals: private-equity-backed physician practices. Lacking the history and baggage of physician-owned as well as hospital-owned practices, these companies are eager to fill the void and make health care a business.

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Image: Reki woo

Follow the Pathway to PCP Success In Medicare Direct Contracting

written by Theresa Hush | September 5, 2019

Primary care physicians were sitting on the sidelines as

Medicare developed financial risk models in various generations of ACOs. At best, they could only hope to participate in Medicare Advantage and/or join a larger ACO. But potential for financial gain was elusive when the physicians' success depended on the actions of others to achieve savings.

Now Medicare is offering a carrot to large primary care practices with its new Direct Contracting (DC) models, luring them with the possibility of capturing higher and more predictable revenues as well as shared savings.

CMS recently announced an initiative to test risk-based reimbursement models for primary care practices over five years:

> Primary Care First aimed at small practices, which we've reviewed in a previous post, and
> "Direct Contracting" (DC) models that target larger practices with infrastructure to manage services and distribution of money to other physicians.

Direct Contracting is Reminiscent of the "Good Old Days" in Managed Care

DC builds on past experiences of Independent Practice Associations (IPAs) and Physician-Hospital Organizations (PHOs), where primary care physicians played the central role in managing their patients' services, costs and referrals. Those models and DC share a philosophy that patients need a primary care home to guide their health care and avoid unnecessary use of emergency care and avoidable hospital admissions.

Payment differs under the three DC models, with a Professional Per Beneficiary Payment (PBP) option comprised of a PCP capitation plus shared savings/losses based on performance, and a Global PBP option that allows partial or full capitation plus sharing of shared savings/losses. A third DC option, not yet configured, will establish a regional geographic model.

But there are major differences from the 1980s primary care-centric model of services and capitation, the biggest being that patients are free to use other providers freely without authorization. DC lacks the restrictions on patients that were viewed as essential elements to financial success.

As a result, Direct Contracting physician groups must control the full spectrum of patient care costs to achieve savings. DC requires a considerable shift in the core expertise of most group practices. They must significantly address cost drivers, generate patient loyalty and cooperation, and make it easy for patients to choose and follow therapies.

PCP Group Structure Is Contingent upon the Choice of DC Reimbursement Model

DC practices must actively manage their patients' services—whether they are directly providing that care or not. For a Global PBP capitation model to financially succeed for primary care groups, PCPs must already be aligned with specialists and hospitals who are reliable partners and can ensure that the PCP continues to be part of the medical decision-making process. They will need to provide the benefit of shared savings to other physicians as well as to PCPs, and use strong tactics to steer patients to facilities that cooperate with their needs. Only the best situated independent

primary care groups or primary care-centric groups with some specialists will have the leverage to accept Global PCP payments.

Even with partial capitation, however, DC will demand that primary care groups use their leverage to arrange a referral network that can facilitate their coordination efforts. DC groups are still subject to downside risk if they cannot manage patient utilization of services beyond the PCP setting.

All DC groups must therefore identify and proactively manage patient risks, especially those more likely to be admitted under emergency situations. That will require analytics and data that are not typically used by PCPs, and population health and other functionality that may not be available in their current systems.

Three Guideposts for DC Success

As primary care physicians enter the fray of provider risk, they must engage in the three processes that determine their ultimate success:

1. Assessment of patient needs;
2. Adoption of a plan of care with the patient in a joint process of medical decision-making; and
3. Arrangement of specialized services that will help manage services beyond their walls.

Let’s take a closer look at each, in turn:

Pathway to DC Success Starts with Patient Needs Assessments

A key differentiator for PCP groups cost management will be the use of pro-active rather than retroactive tools to identify and coordinate patient needs. Since events associated with chronically ill patients drive as much as 90 percent of total patient costs nationally, the focus for PCPs will naturally be to avoid hospital and emergency care.

But PCPs should not be misled by industry statistics for chronic illness to then simplify the problem. Included in chronic disease are cancers, mental illness, auto-immune disease and other genetic conditions for which the causes are unknown. Similarly, some population health efforts attempt to go after “high users” with chronic disease, on the premise that patients’ poor lifestyles are the central problem. That fails to address financial and physical circumstances that must be addressed for patients to get better.

The more realistic and compassionate approach is to help patients achieve success through various supports that are targeted to their circumstances. But this requires PCP practices to gather patient data in a reliable and connected way through patient meetings or interviews, and to use this data to identify functionality issues, social determinants of health, and barriers to patient treatment.

DC provides the opportunity for practices to rebuild the primary care relationship with patients. By talking to patients and collecting the associated data, a needs assessment process can build the clinical foundation for patient care coordination while also improving patient communication, engagement and

loyalty. This should recharge primary care and can help get patients and physicians on the same page for planning care and engaging in shared decision-making.

PCP practices will need to invest in technology to help them store data and connect it with the EMR patient history, and to roll out defined and customized population health initiatives.

A Pro-Active Medical Decision-Making Process Is Key to Aggregate Cost Trends

Total patient costs are aggregated by thousands of events associated with individual patients. What drives the cost of those events? Individual medical decisions made by patients and/or providers. Ultimately, reducing costs always must involve altering the decisions—not just altering the front end of the process of establishing the treatment plan.

Changing the front end of the process is the needs assessment and the development of a plan that can be achieved by the patient. But that plan, and its execution, has to stick. What makes it work? One solution is a process between the provider and patient to discuss and agree on the goals and plan of action.

PCPs who are unwilling to work with patients to understand concerns and achieve consensus will be unlikely to succeed in lowering costs long-term. Patients will simply do what they want—which could be nothing.

In addition, there will be surprise events and medical crises that occur despite best intentions of PCPs and their patients. These situations are unexpected and unavoidable, and each will

undoubtedly come with options for aggressive or conservative treatment, or none at all. In each circumstance the resulting medical decision is also a cost decision, and the patient and PCP should engage in a discussion of cost and benefit based on reliable data.

Physicians are not trained in the art of motivational interviewing as applied to health, or in shared decision-making. But PCPs in DC will find that learning these skills could be as important as the plan itself. They should seek resources to educate physicians in these new skills.

Partnerships with Specialists and Hospitals Will Be Essential to Successful DC

No matter how excellent the PCP care, most patients will need specialized services at some point. Some patients will rely on specialty services more than primary care. It is unavoidable, and PCPs must ensure that the choices of specialty services align with their DC cost goals.

While PCPs are unable to strongly steer patients in Medicare and deploy prior authorization practices of the past, they are not powerless to help direct patients to good resources. They must establish preferred referral arrangements, and do so by evaluating cost and outcomes as much as possible. In short, they will need to have a different recruiting process in the future if they want to achieve savings, and to make arrangements mutually beneficial for specialists.

Specialty groups have, in the past, been averse to sharing data or episode-based cost profiles. But CMS has reinforced the need for price transparency, most recently upping the ante through

an executive order. In addition, there are more initiatives that foster bundled payments for specialty procedures and medical episodes. Many specialty practices are now experimenting with creation of episodes and could be eager to engage with primary care physicians in ventures, rather than health plans or even ACOs.

PCPs should work with specialty practices that are willing to establish shared initiatives like cost per episode tracking. PCPs and specialists can share the cost of technology or outsourced vendors that will create episodic shadow pricing, and assist in tracking the results of intervention to bring the cost trend down. Over time this will enhance both PCP and patients' ability to compare costs of various specialty procedures and medical episodes.

Relationships with hospitals are more complex, because PCPs have largely given up inpatient management of patients to hospitalists, especially in populated areas. But PCPs should develop a process to establish relationships with hospitals that ensure communication upon emergency department or inpatient admission, and communication with attendings and PCPs during the event, so that the primary care practice can manage the transition back to home or post-acute settings.

In sum, coordination of care cannot, by itself, fuel the achievement of good outcomes at lower cost. Value is attained by matching patient needs with interventions that are both achievable and implemented. It's a tall order to turn the ship around and put primary care in a central role. Practices with the energy for change will do well if they work hard to rebuild the trust and engagement of their patients, and work

collaboratively with specialists.

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