Time Out

written by Theresa Hush | August 30, 2018

It’s the last week of August, the run-up to Labor Day, and time to re-energize as we head into a period that promises even more intense health care reform. We at Roji Health Intelligence wish you a relaxing end of summer and a chance to recharge before we’re all back in the fall fray.

For those of you who would like to use a little vacation time to catch up on some reading, here are links to content that will come in handy as CMS continues to ratchet up the pressure on ACOs to assume risk:

Download our free eBook, *How to Achieve ACO Cost Savings: Innovative Strategies for Performance Improvement.*

Brush up on essentials of CMS's Proposed Final Rule for ACOs.

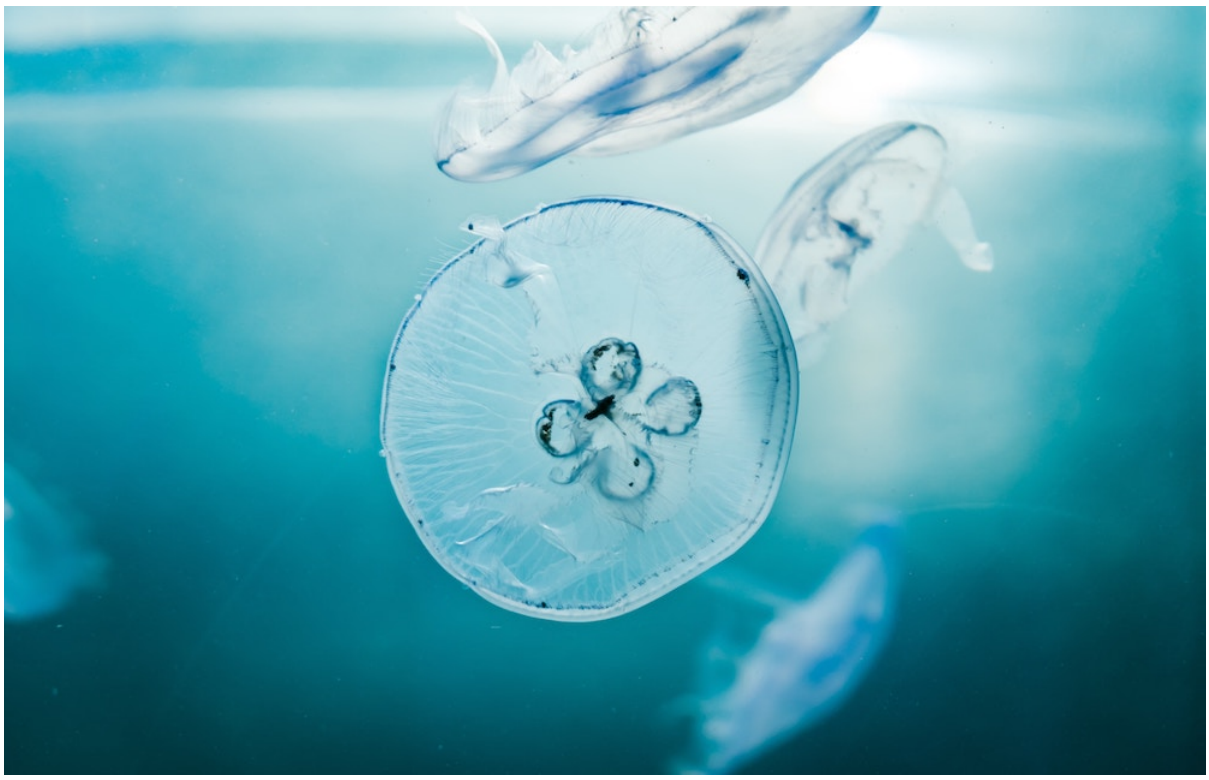
Then again, if you'd rather just watch the sunset, enjoy!

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Vidar Nordli-Mathisen

How ACOs Can Leverage Price Transparency To Create Value for Consumers

written by Theresa Hush | August 30, 2018



Health care consumers are being forced to assume a greater

share of costs for treatment. But how can patients determine the value of health care services if they can't compare costs? Lack of price transparency is a major obstacle to value-based medical decisions. In evaluating treatment options or services by different providers, consumers have no reliable means to monetize their choices. They are powerless to do anything about it—as yet. But that may well change as ACOs adapt to downside risk.

Price transparency is a tool that exclusively benefits consumers, because health plans already, obviously, know the prices they negotiated and pay. Now that ACOs are more interested in ensuring market share and patient choice to stay in the network for services, there's an incentive to make real cost information available through cost clarity.

The consumer's relative power is changing because of two current market forces, both of which affect an ACO's total expenses and bottom line. First, the responsibility for health care payment has been shifting increasingly to consumers. Participating providers who don't implement processes to achieve value-based medical decisions for patients may face higher bad debt burdens after they are surprised by costs. Second, as ACOs and other models with financial risk grow—especially in Medicare where patients have free choice of provider—market share will hinge on consumer-focused practices that create trust. Sharing cost information is essential to that concept.

Why Price Transparency Has Been Stymied

Providers have not only failed to supply mechanisms to create cost-awareness; they have also resisted doing so. Why? It's

complicated, as explained below. But the basic truth is that providers are competing and don't want to reveal pricing.

Most providers still consider the health plan, not the consumer, as the purchasing customer. The provider-health plan arrangements create access to patients, and those prices are negotiated individually by insurer and, even, benefit plan. A multi-layered pricing structure combined with the need to protect negotiated prices overwhelms many organizations.

Transparency is also challenging because of multiple billings and providers. It is difficult to always know in advance the consultants, second surgeons and other clinicians who will be required in care. And each of them, in a Fee-for-Service system, may have separate contractual arrangements with health plans that fix their fees. Even if a cost estimate could be made available to patients, the resulting onslaught of multiple bills would be very confusing.

ACOs Are Ripe for Innovative Consumer Initiatives

ACOs will be under more intense pressure to achieve savings, because the alternative—payback of money by providers—will create warfare among participants. ACOs with downside risk will learn quickly to set up plans to lock providers into set-price service packages. Bundled and episodic payments are well suited to this plan, among other changes.

However, the financial model, alone, is not enough to spur change. Clinicians, as well as facilities, are not nimble enough to alter behavior in response to shifting reimbursements, as has been borne out recently.

An ACO will need to create a distinct personality and operational presence to take advantage of the opportunity of market growth. Consumer discovery of a “hidden” ACO identity under which patients are attributed to ACOs without explicit choice, the *modus operandi* of many Medicare ACOs, would create righteous distrust among seniors, and the plan could boomerang.

Providers who lead and form the ACO must facilitate a transition from Fee-for-Service to financial risk *that translates into how both providers and patients experience the health care process.* For providers, ACOs must temper the incentives that value volume of clinical services and their revenue, and increase the value of patient tenure, clinical and patient-reported outcomes, and affordable cost. For patients, this means improving communication and care delivery to meet patient preferences and implementing value-based medical decision processes under guidance by clinicians.

Cost and Expected Outcomes Are the Holy Grail for Patients—But How?

We know that patients want answers, but we aren’t sure exactly what kind. While providers often insist that patients “ask for” services, this could stem from a belief in medical science generally or specific solutions suggested by a provider. We have never studied how and under what conditions patients will decide value.

We do know, however, that three pieces of information determine value of medical services for the purposes of providers, specialty associations and payers. These include (1) effectiveness (i.e., results of effectiveness from randomized trials, which should be expressed in absolute numbers versus

percentage variation; (2) risks of harms, side effects and death; and (3) cost. We can't answer how important it is that these three are connected in a single discussion about the relative merits of various treatment options, but it makes sense to assume that isolating these individual components is not a good basis for medical decisions.

We also see that consumers do not seem to make decisions based on cost alone. That makes sense. Cost of health care is not akin to retail pricing. Consumers know that there is the relationship between who does a procedure, the outcome and the cost. The formula, however, is a mystery. We also know that in the U.S., medical interventions cost more than in other countries, clarifying that one of our problems is, simply, what providers charge.

Providers cite anecdotal cases that consumers do not act according to evidence. But these are headline cases, not proof. Some research has revealed, on the other hand, that patients will cut back on health care based on patient payment responsibility—including much-needed but costly medical treatments. The fact is we lack a reliable process for evaluating clinical effectiveness, risk and cost in a single construct. While cost information is available on some websites, it is independent of discussions with trusted providers.

Guidelines for ACOs to Implement Price Transparency

ACOs are the only provider-led entities charged with simultaneously saving money while providing quality care and good patient experiences. As such, they are uniquely positioned

to experiment to achieve these goals and to include them in a growth initiative. ACOs that can innovate savings through consumer-focused initiatives and decision-making will also build loyalty among patients to ACO providers.

As most ACOs have likely realized, it is not possible to mandate cost reductions in the long run. Any cost savings initiatives must be inspired by collaboration and education, and be of benefit to the participants, whether providers or patients.

Price transparency unlocks the discussion of value with the consumer by acknowledging its importance in the context of effective solutions. A medical treatment of rare effect is less likely to be chosen by someone without means to afford it. While it is possible to make decisions based only on effectiveness and harms, the inability to afford health care is the real reason that many people don't adhere to treatment plans or pursue medical treatment at all.

ACOs intending to implement price transparency for consumers should consider these guidelines:

1. Analyze data to identify your reputational strengths and why patients choose your providers, as well as your cost weaknesses. It will not be possible to create price transparency tools for all services at once. Providers should understand that this is a strategic marketing endeavor, not administrative.

2. Develop your ACO market strategy and the consumer tools you will use. Price transparency must fit into this, not the other

way around. You will then find a pathway to creating the essential group of episodes that will attract consumers. This gives you the means to engage providers in the effort and build the cost distribution formula for bundled services.

3. Choose one of two basic cost basis options for estimates:

   a. Produce estimates based on average Fee-for-Service *totals* for professional, facility and ancillary costs, or use a standardized fee schedule like Medicare to create such total costs; or

   b. Produce estimates based on established episodic payments for all involved providers.

   Using the latter approach requires that ACOs are able to establish episode groups and negotiate episodic payments with insurers, in addition to organizing such terms with groups of providers. The estimates, therefore, reflect such pre-determined charges.

   The episodic payment approach could be extremely attractive to consumers, because it provides a mechanism for comparisons. But that is only if other ACOs or groups provide similar packages. As financial risk moves forward and Medicare implements more episodic payments, we expect such arrangements to become more common.

4. Make prices transparent based on a package of fees that is all-inclusive, and therefore captures all payments. Providers must appreciate the need to facilitate consumers' ability to see full cost without having to anticipate or navigate the

separate clinician services and charges.

5. Carefully construct packages to ensure that consumers understand the limits of estimated costs. If outliers must be specified, they should fall into unusual circumstances, not excessive charges for ordinary or typical services that vary by small degree.

6. Educate providers on what price transparency means, and how you will go about it. They should be able to pull information easily to discuss cost with patients when needed.

7. Market and message price transparency in conjunction with other consumer-focused initiatives. Don’t make consumers ask—broadcast the initiative.

8. Support cost as a component of determining value, not an independent factor, by creating processes for medical decision-making that also focus on benefits and risks or harms to treatments. Patients need standardized informational materials, and clinicians need education—and your organization also needs a process for collecting patient preferences, establishing and choosing among treatments, and capturing results in the EMR.

Price transparency can be a powerful ingredient for building trust with patients, as long as providers are on the same page. For an ACO fighting to distinguish its unique personality, implementing consumer-focused initiatives generally, and price transparency in particular, can be very successful. Perhaps not for the weak-hearted, these initiatives push change in health care beyond comfort levels for some providers. But enrichment of the trust between providers and consumers—including those

who are not yet patients—will create a robust pathway to success.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Willian Justen de Vasconcellos

Proposed ACO Final Rule: 10 Essential Takeaways from “Pathways to Success”

written by Dave Halpert | August 30, 2018

The Final Rule for the Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) has been released, the first real revision since the program's inception.

Introducing the proposed rule, CMS stated that it is time to put real 'accountability' in Accountable Care Organizations, and this means that ACOs need to accept financial risk. The theme behind Pathways to Success is to end the one-sided risk model.

ACO Savings Success Was Zero-to-Limited Under the Savings-Only Model

Although ACOs were supposed to curb healthcare spending, data released earlier this year showed that CMS actually spent $384 million more, rather than saving $1.7 billion. Further digging reveals that non-risk bearing ACOs accounted for the cost

increases, while some risk-bearing counterparts managed to save money. One-sided ACOs have cost the federal government $444 million from 2013 to 2016, compared to at-risk ACOs, which had aggregate savings of $60 million. As a result of the poor ACO showing, CMS began strongly indicating that the end was near for ACOs that do not bear risk. This proposed rule creates a transition for moving the ACO model with only government risk to a model where both parties share.

When viewing 2016 data (the most recently available) on its own, the savings results reflect poorly on Track 1 ACOs. ACOs at risk saved money, and ACOs that were not at risk failed to generate savings—they actually generated losses. Interestingly, there was a distinct difference between physician-led (low-volume) ACOs and hospital-led (high-volume) ACOs, which has played a role in the proposed rules:

MSSP Track	# ACOs	Saved Money in Aggregate
Track 1 (Non-risk bearing only)	410	No; cost to CMS of $49 million
Tracks 2 & 3 (Two-sided risk)	22	Yes; saved CMS $33 million

Following are 10 key points from the Proposed Rule:

1. ACO participation tracks are revamped to require a shorter time for accepting risk and a longer overall term period.

The proposal calls for two types of ACO participation terms: Basic and Enhanced tracks, each with a five-year term. Basic and Enhanced tracks will consolidate and replace Tracks 1, 1+, 2 and 3. The Basic track transitions ACOs from upside-savings only to a model with enough risk to fulfill the Quality Payment

Program (QPP) definition of an Advanced APM. Each year, the next phase of increased risk kicks in automatically. ACOs may elect to advance more quickly but cannot remain at the same level. The Enhanced track starts at the point where the Basic track concludes, with higher levels of risk (and rewards) in each year.

New agreements will start on July 1, 2019. The first "performance year" is actually only six months. However, the initial six months will not count as a part of the initial one-sided risk phase. In other words, those who do start on July 1, 2019 (and who are not existing ACOs) will have a 2.5 year period (through December 31, 2021) before the two-sided arrangement takes effect.

2. There are advantages for new and/or physician-led ACOs.

Based on their previous successful performance, "Low-volume" ACOs (physician-led) will have the opportunity to re-enlist in the Basic track (at the highest level of risk) after completing the first five-year term, rather than proceed to the Enhanced level. This keeps their level of financial risk lower. "High-volume" (hospital-led) ACOs must move into the Enhanced track after completing the Basic track, therefore taking on more risk. This will moderate the level of downside risk that that they must assume. New ACOs also benefit over those that are already in the program. While all new ACOs in the Basic track can avoid financial risk for the first two years of the arrangement, existing upside-only ACOs only have one remaining year that is risk-free.

3. Patients will get more information—including their first "assignment" notice to an ACO.

The Proposed Rule calls for patients to receive a standardized, written notice at the first primary care visit of the year that the patient is assigned to an ACO. How this plays out among seniors will be interesting. Although Medicare patients will have no obligation to seek services in a specific network, many patients may interpret the notice differently, regardless of wording. ACOs have expressed frustration that patients go outside of the network for services, affecting their costs—but it is not clear that non-ACO specialty services are any more expensive. Patients will also have the choice to opt-in to a specific ACO, even before receiving care.

ACOs may choose to give financial incentives to patients who receive primary care services. Providers in an ACO should have a financial interest in patient health status. This proposal contains a provision to entice patients with a financial incentive to receive primary care services, which was a MedPac recommendation.

4. The ACO may offer the patient up to $20 as an incentive for taking steps to improve care.

Although the goal is to engage patients, effectiveness of these incentives will only be apparent by evaluating outcomes for patients over time. Unfortunately, there are no explicit provisions to track outcomes associated with patient incentives.

5. Benchmarking methodology will change, to the advantage of many higher cost regions.

CMS will begin to evaluate ACO benchmarks differently than in previous years, including looking at regional markets when calculating an ACO's expected expenditures. Previously, ACOs with high costs and savings could actually be penalized for their own success. Under that prior methodology, when the ACO was compared to its limited market, it seemed as though the ACO's performance was merely consistent with the community, and did not merit being credited for savings.

This shift in methodology will reduce the weight given to regional spending when calculating benchmarks and then cap the maximum adjustment amount at the value of 5 percent of Medicare FFS per capita spending. Benchmarks that incorporate regional FFS spending have been proposed to commence at the beginning of the ACO's first performance period, which will add additional context to an ACO's benchmark relative to the surrounding community.

6. CMS may remove ACOs from the program.

CMS has proposed a right to refuse ACOs from renewing that had multiple years of poor performance in the previous agreement period, or that could not demonstrate their ability to perform under an existing agreement. For example, an ACO that failed to perform within the first two years of the Basic model may be barred from completing the path. ACOs that are terminated or are not renewed could no longer be considered participants in a MIPS APM or AAPM, and would need to seek an alternative manner in which to fulfill Quality Payment Program requirements.

7. There are provisions to prevent modifying ACO structures and avoiding requirements.

CMS understands that the fear of risk could induce providers to avoid it by reorganizing. With requirements that vary according to previous participation status, structure and more, CMS has taken steps to ensure that ACOs may only enter intended program tracks.

Previous participation is factored into both program availability (Basic or Enhanced) and past performance. CMS will identify “new” ACOs as existing ACOs if more than 50 percent of the providers were formerly in an ACO together. Therefore, an ACO could not simply change governing boards, reorganize or rename the ACO entity. That will prevent ACOs from quitting the Basic track at the point where two-sided risk is required, re-organizing and entering a new Basic agreement. Also, ACOs with two agreement terms already will retain the accelerated timeframe that separates one-sided and two-sided risk.

To further combat any ACO attempts to avoid the consequences of failure under financial risk, CMS has included a provision for recouping losses, even if the ACO disbands before the end of the performance period. If the ACO ceases to exist (either voluntarily disbanded or terminated by CMS), accrued shared losses must still be paid back to CMS.

8. ACO quality measurement will be refocused on core quality concepts.

In the Proposed Rule, Quality is broadly concerned with all aspects of improved patient care and not necessarily related to the ACO quality measures. The number of measures required for

the quality reporting component has decreased to 24 from 31. The CMS message is that less time spent on harvesting data for quality reporting will mean more time for providers to care for their patients. As we've described, these initiatives are intended to move providers toward risk, and away from quality measures as an accurate estimation of performance. More time for patients can only really occur if ACOs begin measuring and rewarding provider productivity.

Other quality-related provisions concern care coordination. At the system level, this is related to interoperability between EHRs. ACOs will need to adopt the 2015 edition of Certified EHR Technology, which will facilitate improved care coordination, as well as the MyHealthEData push. At the practice-level, providers in two-sided risk arrangements will receive higher reimbursement for telehealth services. The hope is that the flexibility of lower-cost methods of patient services will help ACOs balance cost of services and deliver care to more patients, while still ensuring good care.

9. The ACO Restructuring May Affect Provider Willingness to Form and Participate in ACOs.

Eighty-two ACOs will come due for the proposed mandatory financial risk under the Proposed Rule. ACOs started in 2012 or 2013 are coming due for the two-sided risk period. Many of these ACOs have argued that they are not ready to take on risk. In a survey by the National Association of ACOs (NAACOS), 71 percent of those 82 surveys said that if they were forced to take on risk, they would be more likely to drop out of the program than continue.

10. The Rule is still only proposed; Comments are due by October 16.

Despite long-standing hints and the fact that the Rule closely tracks MedPac recommendations, this is still a Proposed Rule and open to comment. The American Hospital Association (AHA) and NAACOS have predictably spoken out against the elimination of the one-sided risk model. With the health of 10.5 million people (and counting) at stake, as well as the infrastructure of 561 organizations and an estimated impact of $2.2 billion over the next 10 years, it's difficult to overstate the importance of this proposal. Voice your opinion at www.regulations.gov.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Chen Hu

Why Randomized Clinical Trials Are Essential to Informed Medical Decisions

written by Robert McNutt, M.D. | August 30, 2018

I am not a card-carrying philosopher, although I did study philosophy as my undergraduate major. What I enjoyed most was epistemology, the theory of knowledge. We debated, hotly, from the standpoints of social interaction and humanism, “What is knowledge? What constitutes knowing?”

But such philosophical debates are not relevant in medical care. Medicine is not a philosophical province. By that I mean that when we are ill, we are philosophically the same; debating differences is a waste of time. We have equal value; have the same rights to the same efforts and same actions to get us better. The essential issue in medical care is not how we treat each other (kindly, for sure), but what we treat each other with when we are ill. Medical care is a science, and science is how we know.

I am talking here about clinical science, not basic science. Our knowledge of the body continues to advance, informed by basic science, which studies our anatomy and functioning, sometimes to microscopic levels. Consider how our knowledge of genetics is altering how we think about how the body functions, disease manifests, and, ultimately, how to harness new basic science facts to make us better.

In turn, clinical science, rather than being the tool or philosophy that derives new ideas for medical care, is a method that compares new to older ideas about how to better care for people. Clinical science provides facts that we use to make reasoned judgments about whether one treatment is better for us than another, and if that amount of being better is worth the potential added harm that inevitably comes from testing new alternatives. Clinical science is the way we learn if our basic

science ideas have merit.

Randomized Clinical Trials Provide Crucial Information for Clinical Decisions . . .

The “epistemology” of clinical science is the randomized controlled trial (RCT). In previous blogs, I warned about some types of comparisons. Treatments spawned by theory only or observational studies are usually wrong and dangerous. The only clinical science any patient should be exposed to is the RCT.

In a RCT, patients are randomly assigned to one treatment or another. This creates two groups to be compared, one getting the new, and one getting the old treatments. The RCT aims to balance personal and clinical characteristics that may unduly affect the outcome of one group. This balancing is the means by which an adequate comparison of the independent contribution of new treatments may be done.

. . . But Sometimes the Results are Misleading

Even as the RCT provides the anatomical and physiological path to clinical knowledge, however, it can be wrong. The method is not the problem; the problem is applying the method. While we do not expect that everyone be versed in the methodological pitfalls of performing a RCT, a brief overview may help.

Troubles with the Population of Patients Being Studied

The first place a RCT may go wrong is with the population of patients studied. Patients with a disease eligible for a RCT must be gathered for study. There are three populations of patients with disease: the population eligible to be studied,

the population invited into the study and, finally, the population who accepts being in the study. This progression can be problematic. I saw a study, for example, where the eligible population numbered 10,000+, nearly 1,000 were invited into the study, but only 90 accepted. It is hard to imagine that the 90 reflect the 10,000.

Next, for any study, there are eligibility and exclusion criteria for patients who wish to be in the study. For example, some patients may be too sick or have too many other clinical conditions besides the one being studied to be eligible and included. If you have any of the clinical conditions that would preclude you from being in the study in the first place, no RCT will help you make an informed medical decision.

Last, the best way to gather a population of patients for a study is by randomly choosing from all eligible patients who could be in the study. This is often, unfortunately, not the case, and many studies use any patient willing to be studied. Studies requiring large numbers of patients may gather patients from multiple countries and sites within countries. It is always unclear in these situations if the population of patients gathered in this way is similar to others who were not in the study. These populations are called “convenience samples,” and these populations limit the gains in knowledge to all other patients.

Imbalance in Important Clinical Characteristics

Again, the RCT is the best method for clinical comparison because it attempts to balance other personal and clinical attributes that may cloud the comparisons of alternatives. This

is where observational studies fail; they do not balance confounding factors. For example, perhaps a new treatment only works in women who smoke. If there is an imbalance in the number of women who smoke in one part of the study and not the other, we cannot know if what we learn is due to the new alternative treatment or the imbalance of important clinical factors.

RCTs are the best method for balancing, but they are not perfect. By chance, some important clinical factors may end up on one side of the study. It is important to count the numbers of patients with similar clinical characteristics for all compared treatments. While researchers have statistical methods to re-balance populations of patients, these are imperfect, also. Imbalance of important clinical factors even in a RCT must be considered.

Masking

A crucial aspect of comparing alternatives is that neither the patient nor the physician should know who is getting what treatment. This should be true both when patients are randomized and entered into the study, and at the end of the study when outcomes are measured. The term used for this is "masking." Unmasking is a major reason why RCTs fail. This is especially important in RCTs that have "subjective" outcome measures, such as pain or satisfaction. If a patient knows what they are getting, they can alter their true feelings in order to support the researchers, for example.

In a powerful demonstration of the need for masking on patients' perceptions of outcomes, patients were randomized to receive a surgical procedure to clean out arthritic debris from

their knees, or to have a "sham" surgery. The sham surgery made cuts in the skin just like those of the actual surgery, but no procedure was done. This study was conducted because people who had had the surgery said they were much better off after the surgery than before, but these patients chose the action and no comparison had been done. Surprising some, the sham performed as well, and even a bit better, than surgery, raising serious doubts about the value of doing the expensive cleaning of arthritic debris. RCTs with appropriate masking are only way to determine truth from fiction about the values of medical treatments.

Missing Data

Every patient who begins a study must be accounted for at the end of a study. Sometimes people drop out of a study, and they do so in non-random ways. For example, some patients suffer more side effects with a new treatment and then drop out of only the part of the study testing the new treatment. If those who drop out are not considered in the final analysis, the results will be flawed.

How to Know if a RCT Is Relevant for Your Medical Decisions

The only philosophy of medical care, in my view, should be that patients make choices, not physicians or systems of care. But, to make an informed choice, patients must be given evidence that is reasonable enough for making those choices. The only clinical science that fits this bill is the RCT.

Your physician can help you determine if the treatment you are offered has been adequately tested in clinical science. The

population studied must be representative, and you must be similar in terms of your disease with those in the study. In addition, important clinical factors that may affect the outcome of the study must have been balanced for all compared treatments, the assessment of the outcome of the study must be made without knowing who got what treatment, and all patients must be accounted for at the end of the study. If these items have been accounted for, the study is likely useful for your decision-making.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: James & Carol Lee

Five Steps for Successful Initiation of Bundled Payments and Episodes of Care

written by Theresa Hush | August 30, 2018

Everything about health care is complicated—its rules, science, service delivery, organizational systems, financing, and the relationship between all participants. So too will be the solutions for measuring and managing its value as determined by quality, outcomes and cost. To imagine that we can simply change one part of health care and effect change throughout the entire system is naïve, even ridiculous.

Nonetheless, a recent analysis of how bundled payments failed to lower costs is being used as an example of why such reimbursements aren't effective in changing incentives for high medical costs. While the analytical results show little difference in Medicare costs associated with bundled payments, that is not the lesson we need to take away. In fact, we must take great care not to erect a straw man argument against bundled payments by assuming that reimbursement alone can change costs and behavior.

Without altering behaviors by providers, facilities and patients, a payment mechanism cannot accomplish much. At the level of health care delivery, most providers—and certainly patients—are not aware of changes in how services are reimbursed, nor what it means for their wallets. How can we reduce the cost outcome if we don't do anything to alter the inputs to care? If there is no reengineering of care delivery, if physician compensation remains the same, if nursing and operational staff are uninvolved, and if patients don't understand or can't see costs in medical decision-making, we cannot expect savings to result.

Bundled Payments Are Economic Vehicles but Require Clinician Involvement to Achieve Savings

To be sure, the intent of bundled payments has always been cost control through creating a package price and putting providers at risk for managing within a global fee. But much more has to take place for it to work.

Bundled payments are built on the concept that care can be broken into time-bound packages of health care services provided to a patient—"episodes" based on procedures, diagnoses or other causative health care elements. But episodes can include services of multiple providers, and this is where the financial concept becomes significantly complicated. To reconfigure both price and quantity of services, the distribution formula must also be negotiated, often across specialty lines.

Unfortunately, episodes of care and bundled payments are rarely

initiated by physicians or clinicians; rather, they are initiated by administrators. And when these approaches are negotiated with health plans or as part of a Medicare or Medicaid initiative, the analytics to identify cost variations, cost drivers and specific clinical issues are often unavailable. Indeed, organizations typically initiate bundled payments lacking significant data on volume, cost and variations of care. The providers can be impacted without fully understanding the implications to their practice of medicine, yet still be held responsible for results.

The successful implementation of episodes as a savings initiative depends on agreement among every care team member, including those not named in the specific episodic arrangement (such as nurses and facility staff) regarding key aspects of service delivery. Issues such as facility scheduling and staffing, waiting time before or after procedures, and technology available at the time of care, all present issues for both quality and cost.

Information about the patient must be shared with all clinicians, who may need to adjust care accordingly. Learning of potential for complications at the time of the procedure can cause delays or revision of care, costing precious time and expensive resources.

Trickle Down Economics Have Little Power to Affect Cost, Unless Orchestrated

Bundled payments are trickle-down economics applied to health care. Business tax cuts are the most well-known example of trickle-down economics, but with positive rather than negative potential. The theory is that cutting taxes will stimulate

spending by businesses and consumers, and thereby create jobs. That end result will depend on specific actions by business to expand their enterprises by reinvesting and hiring more people, as well as passing more money to employees as higher wages.

Politics aside, however, the economic stimulus from business tax cuts is not a given. The organization must have the leadership and confidence in the long view to engage in business expansion strategies. Otherwise it will just return any extra income to its investors, owners and executives. Most importantly, organization leaders must have the desire and existing resources to execute expansion strategies, which are very time consuming and expensive to undertake.

Health care has an even greater challenge to make trickle-down economics work. To achieve real cost savings, providers must address the specific services and elements of care that are driving cost, not the total cost alone. Focus on total costs will result in denying care to patients who can benefit because they may exceed the bundled payment price. That practice was apparent during the height of HMOs, when consumer complaints of denied services peaked and essentially killed the HMO movement. Unless provider organizations can engage consumers in new methods of providing optimal care delivery with fewer inputs into such services—and to voluntarily avoid some care altogether if outcomes promise to be poor—they will not achieve cost savings.

Providers who participate in an episode need historical information that reveals costs associated with historical episodes and how costs varied by type of service. Patient selection must be a part of this evaluation, since patient

outcomes will vary by age and other factors, driving costs higher or lower. Careful design of care to deliver services that are appropriate for patient risk will reduce the perverse incentives of financial risk in episodes of care.

The following five essential steps can help provider organizations get on the right track and develop episode-based bundled payments as a successful growth strategy:

Five Essentials for Making Bundled Payments Really Work for Providers, Consumers and Cost Savings

- Understand the current service mix, volume and variation in costs through analytics. Even specialty-heavy organizations have had little reason historically to analyze their services along episodic lines. But looking at both procedural and medical episodes and estimating costs based on source system data is revealing. This review is the first step toward understanding where to focus, especially if payer-specific data is evaluated. Claims data is valuable, not essential, to this process.
- Share data with providers by specialty or type of care that could be involved in initial episodic payment initiatives. This ensures that, at the very least, a leadership group of physicians participate in the initial cost evaluation of services, and that a few specialties and episodes can be used to delve deeper into the experience of an episode. One caveat: avoid selection of outliers and high cost cases exclusively for the drill-down, since it will be equally constructive to review cases where cost was low and everything went well.

Select a handful of specific episodes across specialties to use as pre-bundled payments. Establish groups that will design optimal care delivery and the changes required to make that care happen. The groups should be representative of the provider-facility-administrative team involved in services, as well as finance department and/or contracting staff (who may also wish to involve health plans for support and/or data at this point).

Identify patient-reported outcomes and quality outcomes to be captured along with the episodes. Rather than traditional quality measures, these should be focused on complications, cost drivers and patient decision-making, so that cost and outcomes can be more easily correlated.

Broadly educate clinicians and administrators on the effort and create ongoing communication tools and events to keep channels open. As most quality directors know, initiatives have a way of "dying" because momentum flags and communiqués become more infrequent, killing enthusiasm. Change always demands a steady supply of rocket fuel, energy and urgency to keep moving.

Episodic Payments Can Differentiate Competitive Providers

Episodic payments offer specialty providers a mechanism for accomplishing two critical objectives in Value-Based Health Care. First, they create a mechanism for reasonably evaluating costs of care according to procedures and medical conditions. It is essential that the inquiry be constructive, investigatory and collaborative with clinicians. Analytics that compare costs across clinicians too early or without assessing risk and cost drivers will doom the effort to failure.

Second, the construction of episodes of care with transparent pricing has market appeal for health plans, employers and patients. This approach will differentiate innovative and customer-focused health systems that are responsive to the latest trends and will help them cultivate the data for further analysis and actual savings in health care costs.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Marc-Olivier Jodoin

The Proposed 2019 Quality Payment Program (QPP) Rule: What You May Have Missed

written by Dave Halpert | August 30, 2018

Whoever said bureaucracy doesn't foster change did not anticipate CMS's Proposed Rule for the Quality Payment Program (QPP), 2019 performance year version, released on July 12. While the familiar overarching structure of MIPS remains, there are a number of revisions that activate newly developed policies. These include "Patients Over Paperwork" and "Meaningful Measures" efforts that CMS initiated in 2018 to streamline the requirements-heavy MIPS program.

To be honest, there are some rough patches within the wrangling of old and new MIPS provisions in the 1,473 page 2019 Medicare Physician Schedule Proposed Rule, set to be published in the Federal Register on July 27, 2018. The new policies also represent a very small part of MIPS and essentially overlay the MIPS structure that remains in place. In Year 3 of the QPP, the program becomes more challenging, but some requirements come with caveats or are less intense than originally proposed.

No doubt you've already seen the first round of "five things to know" posts, so let's examine the implications and impacts of the Proposed Rule, as well as some of its less publicized provisions.

CMS Efforts to Reduce "Check-the-Box" Reporting Will Raise Bar for Performance

CMS has proposed adding 10 new measures that they feel reflect the Meaningful Measures goals, four of which are patient-reported outcome measures. These include:

- Continuity of Pharmacotherapy for Opioid Use Disorder
- Functional Status Following Lumbar Spine Fusion Surgery (Patient-Reported)
- Functional Status Following Total Knee Replacement Surgery (Patient-Reported)
- Functional Status Following Lumbar Discectomy Laminotomy Surgery (Patient-Reported)
- Appropriate Use of DXA Scans in Women Under 65 Years Without Risk for Osteoporotic Fracture
- Leg Pain Following Lumbar Spine Fusion Surgery (Patient-Reported)
- Ischemic Vascular Disease, Use of Aspirin or Anti-platelet Medication
- Shingles Vaccination

The inclusion of patient-reported outcomes is a positive step for a meaningful quality program, but it may not please providers who feel patient input is subjective. Nevertheless, inclusion of a fledgling set of patient-report of outcomes introduces the idea that patients' own results can and should be considered in quality scoring,

CMS has also proposed substantial changes for 23 measures and recommends completely dropping 34 measures they determine are duplicative or do little to improve outcomes. These proposed deletions primarily include specialty care measures. As a result of the deletions, some specialists may have a more difficult time finding relevant measures to meet reporting requirements. A few of the deleted measures will be replaced by new proposed versions, but these will not have established benchmarks and will not be scored as favorably as in the past.

Some specialty providers will be challenged to meet the proposed minimum performance threshold of 30 points, double the minimum for 2018. This substantial change will outweigh the total possible points in either the Improvement Activities or Promoting Interoperability categories. In other words, it will take more than one of those two categories for providers to avoid penalties. The Exceptional Performance Bonus threshold has been raised to 80 points. Not only is it harder to avoid a penalty, but it will take a higher leap to qualify for bonus.

However, those who do qualify can expect the monetary value of that incentive payment to increase, as there will almost certainly be more penalties for failing to meet minimum standards. Since only 9 percent of MIPS-eligible clinicians failed to meet the minimum in 2017, the 2019 positive payment adjustments are comparatively small, maxing out at just over 2 percent. Under this Proposed Rule, it's fair to anticipate that more providers will fail to meet the minimum in 2019, while those who succeed will see higher incentives in 2021. Those who fail will also stand to lose up to 7 percent of allowed charges for Part B professional charges in 2021, up from 5 percent. CMS estimates that approximately $372 million will be shuffled

between those penalized and those rewarded.

MIPS Cost Component Has Higher Weight but Also Reflects Policy Gap

Cost will be scored more in 2019, at 15 percent of the total MIPS score. That is a 50 percent increase, but half the previously planned level of 30 percent. Along with the continued easing of MIPS requirements for quality reporting, the low weight on Cost may indicate that CMS—unlike the previous administration—does not necessarily see MIPS as a regulatory "stick" to push providers toward Alternative Payment Models.

The lower Cost weight takes some pressure off health care organizations for cost increases. That weight will be negotiated in each of the next three years (2019-2021), with the stipulation that Cost may be valued as no less than 10 per cent and no greater than 30 per cent of the total MIPS points.

We hope that CMS will develop strategies within the reimbursement system to promote reduction of health care costs, both within MIPS, Medicare's largest Value-Based Health Care program, and independent of it. But the retrenchment on Cost weight, along with delayed or non-distribution of cost detail to providers, sends a different message. Providers need comparative cost data, cost measures, and a fee model to influence them to control expenses under a Fee-for-Service reimbursement that rewards the opposite. The alternative, a dramatic cut in Medicare and Medicaid budgets, doesn't solve either consumer or provider issues.

New Episodes of Care Will Apply to Some Specialists

For most physicians, the MIPS Cost component will be scored on the basis of two measures: Total Per Capita Cost (TPCC), and Medicare Spending Per Beneficiary (MSPB). TPCC measures all Medicare Part A and Part B costs during the MIPS performance period and attributes them to providers based on who provided primary care or equivalent services to a patient. MSPB, alternatively, calculates episodic costs related to generic inpatient admissions and related services, and assigns these to providers.

But some specialists will have one or more of eight proposed episode-based cost measures based on specific conditions. The episode measures are geared toward patients who have received care for specific conditions or who have undergone certain procedures. These additions are particularly noteworthy, as they may be attributable and scored for individual clinicians, depending on whether they have reported on their own or as part of a Group.

Five episodes are procedural; they will be attributed to each clinician who performs a trigger service, as identified by procedure code. A provider would need at least 10 cases for one of these measures to be counted in his/her Cost score:

- Elective Outpatient Percutaneous Coronary Intervention (PCI)
- Knee Arthroplasty
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia
- Routine Cataract Removal with Intraocular Lens (IOL) Implantation

- Screening/Surveillance Colonoscopy

The remaining three episodes are acute inpatient medical conditions. These are attributed to each MIPS eligible clinician who bills the inpatient E/M claim lines during the trigger inpatient hospitalization, provided that it's billed under a TIN that renders at least 30 percent of the inpatient E/M claim lines for that hospitalization. A provider would need at least 20 cases for one of these measures to be figured into his/her Cost score:

- Intracranial Hemorrhage or Cerebral Infarction
- Simple Pneumonia with Hospitalization
- ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)

More Physicians Get a Break from MIPS Reporting, but Other Professions Now Included

Physical Therapists, Occupational Therapists, Clinical Social Workers and Clinical Psychologists are now MIPS-Eligible Clinicians, assuming that they exceed the low-volume threshold. However, the low-volume threshold will require that, besides a minimum of $90,000 in allowed Part B charges and at least 200 Medicare beneficiaries, a provider must also provide at least 200 covered professional services under the Physician Fee Schedule. Note that a provider meeting at least one of the criteria can opt in to MIPS.

MIPS applicability to hospital-based providers was a gray area in terms of MIPS eligibility previously, and that will change under the Proposed Rule. Instead of having Quality and Cost scores calculated like other MIPS eligible clinicians,

hospital/facility-based providers will be scored in MIPS in conjunction with the Hospital Value-Based Purchasing Program (HVBP).

A provider performing at least 75 percent of services in a hospital or emergency room may be attributed to a facility with a HVBP score and be eligible for facility-based measurement. Scoring will come from the methodology used in the HVBP. To be considered a facility-based group, at least 75 percent of the providers meet the definition of facility-based clinician. No additional data submission is required for Quality and Cost, but those providers will need to submit data for the Improvement Activities and Promoting Interoperability components.

A Soft Sell for Alternative Payment Models (APMs)

CMS anticipates that between 160,000 and 215,000 eligible clinicians will be Qualified Participants (QPs) in an APM, and would be excluded from MIPS. CMS does expect the number of MIPS-eligible clinicians to rise and to continue (for now) to outweigh the number who participate in the Quality Payment Program via an APM.

But the relationship between MIPS and APMs under the Proposed Rule remains connected—and voluntary. There are still APMs in which providers are required to report MIPS due to lack of downside risk, and the 5 percent bonus remains the only financial incentive for APM participation. Note, however, that in addition to this Proposed Rule covering the Physician Fee Schedule and general aspects of the QPP, there is an additional Rule likely to be released later that will focus on ACOs and

other APMs.

However, the Proposed Rule does move forward in enfolding providers in the "APM world" by annexation of providers participating in other types of risk-based reimbursement programs. The key details about this are not mentioned in the high-level CMS Fact Sheet.

Some of the biggest news is related to Medicare Advantage. The separation of MA from the QPP (and PQRS before) has long been a source of confusion; this proposal indicates that CMS hears the call to tie the programs together. There will be a test run, called the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration. Its goal will be to determine whether clinicians who are participating in Medicare Advantage Organizations (MAOs) can be excluded from MIPS and scored similarly to those participating in APMs. The provider would need to have a sufficient amount of Medicare FFS payments coming through a combination of MAO and APM services to qualify, but it may make a difference for those who aren't considered Qualified Participants in one APM.

The Proposed Rule also includes more specifics on the All-Payer Combination Option APM. Currently, all APMs apply only to Medicare patients, and providers get no credit for participating in health plan-negotiated ACOs. The Rule proposes that to achieve Qualified Participant Status, a provider would need to have 25 percent of Medicare payments and 50 percent of total payments coming through the APM, or 20 percent of Medicare patients and 40 percent of total patients coming through the APM, whichever is more advantageous for the provider. These minimum thresholds are set to increase each

year.

Buried within the proposal, capitation is specifically called out as meeting the APM criteria for the All-Payer option, provided that it is a full capitation arrangement. To meet this definition, a fixed payment must be allocated for care spanning a specific time period, and there can be no reconciliation between the health plan and provider organization if the cost of treatment exceeds the cost allotted under the capitation arrangement.

CMS has distributed guidelines to payers interested in being a part of the All-Payer Combination Option.

New challenges will also be applied to Alternate Payment Models (APMs). The Proposal states an APM will need to have at least 75 percent of its clinicians using Certified EHR Technology (CEHRT), rather than the simple majority required now. Additionally, the MIPS-comparable measures required for reporting must now include at least one outcome measure. Financial risk, the remaining criteria of an APM, is largely unchanged, including the 8 percent nominal amount standard.

Qualified Clinical Data Registries (QCDRs): A Higher Standard and Additional Benefits

CMS has proposed that, beginning with the 2020 measurement year, a QCDR must have clinical expertise in medicine and quality measure development. According to CMS, the need has arisen due to their belief that certain QCDRs are too technically focused, without the clinical knowledge to facilitate quality improvement. Measuring and improving performance has always been the focus of the Roji Health

Intelligence QCDR, and we welcome this additional requirement.

Additionally, due to the duplication and scoring concerns with QCDR measures, CMS has also proposed that QCDRs that design their own measures must enter into a licensing agreement with CMS that allows other QCDRs to report the same measure (with the same designation and without modification) for MIPS. This is very good news for those who are interested in QCDR measures, but who had concerns related to a lack of benchmark or who had a greater risk of appearing to have poor performance based on a small number of entities reporting that measure. In some situations, the smallest difference can separate the winners and losers.

Progress for Price Transparency, but Nothing Is Decided

In an interesting inclusion to the Proposed Rule, CMS is specifically requesting input on how to create price transparency for consumers. Bravo!

CMS also states its long term interest in addressing health inequities by addressing risk stratification methodologies, which is positive.

As we've seen in previous years, there can be substantial changes between what's proposed and what's finalized in CMS Rules. However, nothing has surprised us in this Proposed Rule, apart from what it is missing: the CMS plan for cost control.

Your comments may be positive or negative; CMS considers both types of feedback when finalizing a Rule, but will not accept comments after September 10, 2018. Make your voice heard at

regulations.gov.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Erwan Hesry

No More MIPS Cost Score Details? 5 Ways Providers Can Still Take Control of Costs

written by Dave Halpert | August 30, 2018

CMS is urging providers to participate in ACOs with downside risk, but they might be eliminating one of the keys that providers need to prepare. It couldn’t come at a worse time, when providers already stand to lose under risk-based models if they can’t identify where their cost issues lie. That data is only available from claims data made available by payers.

Up until now, practices have had access to indispensable data on costs that are attributed to their providers, showing specifics of where they are above the norm. These were previously part of Quality and Resource Use Reports (QRURs) that have been distributed for years, first under the Value-Based Payment Modifier program and then under its successor, MIPS.

CMS informed providers this month that QRURs were only for PQRS and the Value-Based Payment Modifier (VM), and will no longer

be distributed. The VM was incorporated completely in MIPS, but CMS is clearly moving in a direction that will dismantle MIPS in favor of ACOs or other risk models.

What will MIPS providers get instead? So far, a final score with either an incentive or penalty determination occurring in 2019, without explanation. Although CMS seems to be wavering on whether additional data will come later, this is a big departure from the past. What should providers do when this data is no longer available?

How the QRURs Helped Providers

While the purpose of the QRUR was to provide a VM score, the additional exhibits, containing patient-level detail, were beneficial for practices that were interested in identifying and addressing detrimental utilization trends. The information wasn't actionable on its own, but those who partnered with some advanced Clinical Data Registries (CDRs), such as Roji Health Intelligence, saw their QRURs transformed into meaningful analytics, including the conversion of opaque Medicare IDs into identifiable patient details. By revealing the patient case and individual provider, the data triggered episode-based analytics and identified outliers.

Without these supplementary materials, practices lose the ability to dig into the "why" of their cost score—only the score and high-level information are available. This is significant: although cost was not figured into your 2017 MIPS score or 2019 payment adjustment, it will be worth 10 percent of your overall score in 2018, and 15 percent in 2019 (according to the most recent proposed rule released July 12, 2018). And that's the optimistic scenario, because providers

may well be required by next year to participate in financial risk models like ACOs or direct provider contracting by future administration proposals.

Without receiving the cost data directly from Medicare, providers need alternative means to evaluate and improve cost performance. One way is to involve a Clinical Data Registry to help develop the data and analytics necessary to measure and improve performance in both cost and outcomes.

MIPS Cost Scoring in 2018

So, that's the new landscape. Understanding how your costs will be assessed in MIPS is critical to developing your strategy for success and ongoing improvement. The 2018 Cost Score will be calculated exclusively using two cost measures:

- Total Per Capita Cost for All Medicare Beneficiaries (TPCC), designed to evaluate efficiency of care provided to all patients attributed to a specific TIN.
- Medicare Spending Per Beneficiary (MSPB), designed to evaluate efficiency of care provided to patients, as it relates to a specific episode of care, where that episode has been attributed to a specific TIN.

Other episodic cost measures have been "field tested," but these metrics are still being developed and will not be included in MIPS scoring until 2019 (at the earliest).

CMS scores both the TPCC and MSPB measures exclusively using adjudicated claims data from services occurring during the measurement (performance) year. In other words, unlike other MIPS measures, no information separately reported by the

practice or another third party (e.g. Qualified Clinical Data Registry, Qualified Registry, EHR, Survey Vendor) is included in the scoring process. It is important to note that, although the other MIPS categories include all patients (unless reporting Quality via the CMS Web Interface), because Cost is calculated by CMS, only Medicare patients are included in the Cost component of MIPS.

The Total Per Capita Cost is a standardized dollar value indicating the average sum of Medicare Part A and Part B costs for each attributed Medicare beneficiary over the measurement year. Medicare Spending Per Beneficiary is a standardized dollar value indicating the average spending associated with an MSPB episode of care. An MSPB episode includes the sum of all Medicare Part A and Part B costs for services beginning 3 days prior to, during, and 30 days after an Inpatient Prospective Payment (IPPS) hospital admission.

Prior to scoring the TPCC and MSPB measures, CMS performs risk and specialty adjustment on claims, and standardizes payments to account for variation unrelated to care (e.g. location). This means that the numeric value of the benchmark is the same across the country, but CMS determines beforehand whether a dollar spent on care for an attributed patient in one practice is equivalent to $1.10 at another practice.

MIPS Feedback Reports Are Summaries, Not Tools

The feedback delivered on 2017 cost metrics contributes to creating a value-based strategy, but is not enough information, alone. The reports show only the highest-level details for each measure. You'll see the number of attributed patients or eligible cases, the measure score (in dollars), a measure ratio

and performance (points and decile). There is an additional summary of Emergency Department Utilization showing the number of “associated patients,” the number of those patients who had an ED visit and the total number of ED visits.

Without the breakdown of patient attribution, (primary care services delivered by a primary care provider, rather than a specialist), a window onto the in-network/out-of-network referral patterns has been slammed closed. It will be impossible for your group to know whether you have a significant problem with patients accessing specialty physicians without any primary care coordination, because you won’t see this data. Therefore, you also can’t execute a targeted strategy by specialty for ensuring that patients are connected to primary care physicians.

The same issue is magnified on the inpatient side, as the listing of admitting hospitals (both for episodic care and total per capita costs) is also absent.

Information on care coordination is similarly missing. Groups could formerly see the breakdown by type of care that patients received. Practices that saw lower-than-expected ambulatory and post-acute care and higher-than-expected ED utilization could infer that care was not sufficiently coordinated. Additional emphasis on care transitions after a procedure may mean decreased emergency department utilization or hospital admissions.

Without actionable data, results will be difficult to leverage. There is no way to determine the areas in which you performed well or that need work. In order to lead the field,

organizations will need to use their own data to understand and improve spending and utilization patterns. This is a perfect opportunity to work with a Clinical Data Registry. Why? Because the CDR is specifically designed to assist in performance improvement, integrating both cost and quality performance. The CDR, which blends analytics, performance measurement and improvement activities, is built on data that is aggregated and customized to performance improvement projects.

Five Strategies for Taking Control of Your Costs

No matter how you interpret the recent CMS decision not to release detailed cost data, one thing is clear: Medicare Fee-for-Service, and possibly MIPS, will erode, replaced by a risk-based payment system. Therefore, providers who have focused on maximizing revenues in the past must turn their attention to managing efficiency of encounters, together with maintaining or improving outcomes. That will require major changes in the way providers work now.

What do you need to do to succeed? Start with developing available data and then optimize value. Consider these five tactics:

1. Choose technology to focus on cost and quality performance, or use the services of a Clinical Data Registry as a technology vendor.

Current provider systems are not generally optimized to look at performance and, especially, costs. A CDR that can aggregate comprehensive transactional and clinical data from multiple

data sources and facilities, along with the analytics to visualize what's important, can develop the tools you'll need to measure and reduce spending.

2. Understand your services, costs and inbound/outbound referrals.

A CDR with the ability to ingest years of historical billing data can illustrate the types of procedures provided (and trends) and can identify common conditions and progression. Many groups—even those with EMRs—have been stymied by a lack of basic data on group and provider volume by procedure, as well as costs.

3. Build medical and procedural episodes as the unit for evaluation of discrete costs and clinical quality.

In order to undertake risk, groups must evaluate production statistics from an episodic rather than a by-service standpoint. Episodes allow comparison of variations in services and costs by provider, and offer a mechanism to evaluate what is going right or wrong in the delivery. Additionally, episodes create the mechanism to examine variation, spending by types of procedures or diagnoses. Episodes are more instructive than focusing on total costs in both the TPCC and MSPB measures, because they lead to actions in specific areas. If conservative treatment, or a more minimally invasive (but equally successful) procedure can be utilized, spending can be reduced while improving patients' qualify of life. For example, studies have shown that laminectomy with spinal fusion does not improve outcomes more than the laminectomy on its own.

Lacking payer or Medicare data, your technology can still identify patients who have had a specific procedure and then attach other services delivered within a specified window. Even if the patient has a different MRN at multiple practices, or if different practices use different EHRs, a CDR should be able to track a patient from one location to the next. If all components of the episode (surgery, radiology, anesthesia and medicine) are present and accounted for, it's possible to build a preliminary bundle.

With a CDR, it's also possible to incorporate feedback to examine the reasons why procedures were performed, in a peer review context. With the technology and episodic measurement, you can identify variation by provider and procedure, and begin the conversation on change.

4. Identify out-bound referrals and out-bound patients.

Your technology or CDR should be able to calculate where system outflow is occurring. This is essential not only from a cost control standpoint, but as an indicator of clinical quality or customer service. Since out-of-network services can be attributed to your organization, understanding this will be critical to your cost levels.

5. Pilot and roll out performance improvement projects—best in collaboration with health plans—that incorporate cost and quality and permit practicing cost control.

While participation in the QPP (either through MIPS or an APM) is required, there's no reason to limit your focus. By looking

at procedures by payer (e.g. how many total knee replacements were covered by one health plan) and payers by procedure (the mix of health plans that have covered a specific procedure), you're in a position to negotiate your own arrangement with that health plan. If you are able to obtain patient-level and aggregate-level data related to a certain procedure or population, your CDR can incorporate those claims into its technology to provide you with previously unavailable insights, and then incorporate and track interventions designed to improve performance.

While the MIPS Feedback and Score Reports were very clear and concise, they never gave providers the full information needed to improve cost performance. Translation and integration with other data was always required to identify cost issues. These five strategies will work regardless of data source or data set. The availability of cost data has never been the primary stumbling block to addressing costs, although it has often been used as an excuse.

There is no short cut to creating better cost performance in health care, and the lack of CMS detailed data, while disappointing, should not be a severe deterrent. While claims data will be needed in the future, some health plans are more willing to engage in programs that help providers develop the technology, data and process acumen, and the cost results they need. Providers will have to address their costs across the board, regardless of payer, and it doesn't much matter where they start—it only matters that they do.

To view the CY 2019 Quality Payment Program proposed rule, please click here.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Ryan McGuire

Create Value for Consumers by Leveraging ACO Provider Choice

written by Theresa Hush | August 30, 2018

Medicare and commercial insurers are adamant about moving providers from Fee-for-Service to financial risk for services, and CMS is losing patience over providers' reluctance to embrace downside-risk ACOs. Why are providers so worried about accepting risk? Because, they say, provider choice will ruin their potential for savings.

With an estimated 25 percent of patients seeking services outside the ACO—for 60 percent of attributed total costs—providers argue that they can't control total expenses, yet are on the hook for savings. They blame lack of coordinated care, duplicate tests and differences in the standard of care.

Coordinated Patient Care Inside the Organization: Myth and Reality

Let's examine the facts about patient care coordination. It would be a surprise to most patients to learn that their care

is “coordinated.” That’s because if any coordination is occurring, it is between providers and not with the patient. With the possible exception of post-discharge follow-up to avoid readmissions, “coordination of care” has focused on provider communication and information sharing, without necessarily including the patient.

Provider-to-provider communication about the patient creates a mythical coordination of medical care. If patients are not part of the loop, how can they take an active role in executing a plan of care? The operative scenario assumes that providers are in control and directive, while patients are managed and comply with orders.

The reality of care coordination is this: Typically it’s the patient or a family member/support person who must iron out inconsistencies or gaps of a particular care plan, link communication among providers and prepare for the next step. As organizations have gotten bigger and more bureaucratic, frustrated consumers are increasingly challenged to “work the system”—to get answers from providers, to arrange for services and, certainly, to challenge any objectionable administrative or clinical policy.

Finally, even the degree of provider coordination is overstated. Beyond medical record sharing with central diagnostics tracking, the frequency of collaboration between physicians is questionable in ACOs, even when patients have overlapping chronic conditions. Patients and families are either left to coordinate their own services between providers or respond to multiple coordinators all acting on behalf of different providers.

It is any wonder that consumers want to choose their own providers?

The Appeal of Outside Specialists and Providers to Consumers

Almost all ACOs across the country have met Medicare's ACO quality measures. These consist of 16 measures reported on a sample of several hundred patients, most of which are basic service messages, such as a blood pressure reading taken once per year at a patient visit. Similar MIPS quality measures are criticized by MedPac because the data cannot help consumers compare the quality of physicians. Nonetheless, CMS, MedPac and providers have deemed ACOs successful in delivering high quality care.

Consumers who seek care outside an ACO do so for either positive or negative reasons. Positive reasons include a recommendation from someone they trust about a particular specialist or more familiarity with a group that is well known in the region. Adverse experience of any kind in the ACO, but particularly poor history in the specialty targeted by the patient for care, will negatively affect patient choice and favor care outside the ACO. Lack of communication, difficulty getting services, and extensive time spent working the system are all adverse experiences. Combine that with lack of good comparative data on providers and the lack of transparency in referral policies, and it's clear that consumers are making a completely rational choice to seek providers elsewhere.

Is Outside Care Less Efficient or Poorer Quality?

ACOs argue that when patients get care outside their network, coordination breaks down and care may not reflect ACO providers' agreed-upon quality standards. Here's an important question: how do they prove their case?

Data now emerging on physician behavior indicates that physicians perform the same regardless of ACO participation, even with differing protocol directives.

Health care systems are novices when it comes to measuring cost performance. Without pricing and episodic claims data, not only can they not accurately claim that other providers are less efficient, but also they can barely evaluate their own data.

Better Strategies for Responding to Consumer Choice in ACOs

ACOs are responding to provider choice provisions not as financial risk-bearing entities, but as Fee-for-Service providers. Provider statements and articles that decry "patient leakage" as an issue of revenue loss are essentially admitting that their concern is not what patients are getting when they go outside the system, but what providers are losing.

As a result, some ACOs are deploying strategies to counteract patient leakage and keep specialty services inside, and doing so without revealing their referral system to patients. This dangerous practice, which choked the HMO gatekeeper movement to death, is also unlikely to gain either savings or loyal patients. To have even a chance of succeeding, ACOs would have

to know cost performance of competing providers, which few have programs to do.

But there are two alternative strategies that ACOs should embrace to benefit their patients and their organizations. In tandem, these strategies can help improve performance for specialists as well as add value for patients making decisions within the system.

1. Specialty Provider Strategy

>>Develop and deploy a specialty performance measurement system to use in referral policies. Often, ACOs either refer to their own employed physicians or reinforce historical referral patterns, rather than develop a value-based performance system. Both internal and external participants in the ACO should be included in measurement of key medical and quality indicators corresponding to ACO patients. If available, data should include larger populations or public reporting.

Ideally, ACOs should develop episodes of care, when feasible, for incorporation of outcomes, quality, cost and patient feedback. There will be providers who are unwilling to participate, but the lack of data should be reflected because it is an important indicator for consumers.

>>In referring patients to specialists, ensure transparency of the methodology for recommending physicians. It is important that patients are not directed, but advised, using as objective a process as possible. The ethics of ACO referral practices is already coming under scrutiny and can backfire if not handled appropriately.

2. Consumer Strategy

>>Develop value-based initiatives aimed at the real customers: consumers. Health care is now emerging into a market where purchasing is based on value. Roji Health Intelligence has written extensively on how providers can be more consumer-focused; we've compiled some of our best articles here.

Unlike previous eras, consumers are shouldering a heavier proportion of health care costs and will be the primary decision-makers about their health care spending in the future. It's time to model efforts after retail and other businesses—accepting that consumers make rational choices because of benefits, cost and fit with lifestyle and preferences—and to encourage those choices.

These approaches, not handcuffs, create the way to keep consumers in the system. First, we must build the best provider network using a reliable and objective measurement process. Then, we market and sell those services to consumers using predictable, transparent prices.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Ryan McGuire

Life, Liberty and Happiness Require Good Health: What Consumers Need to Get There

written by Theresa Hush | August 30, 2018

Independence Day reconnects us with our Founders' values that "Life, Liberty, and the Pursuit of Happiness" are our fundamental rights. There is a basic concept underlying this dream: While the country will provide the opportunity, its citizens will act to achieve it. But there's a catch—citizens' potential to realize the dream depends on good health.

Health has never been as threatened as now. The epidemic of chronic disease, exacerbated by poor nutrition and life choices, is overwhelming a system running out of money. We keep paying more for health care and coverage, and getting less in health outcomes. Even worse, the economic burden has now shifted to consumers, more and more of whom cannot afford to pay.

At the same time, consumers don't yet have the means to act as informed purchasers of health care. Nor have they the

scientific information to make truly healthy lifestyle decisions—medical science has not been clear about the link between human choices in diet, lifestyle and resulting disease.

How can we facilitate the opportunity for consumers to achieve better health?

> We can provide the information and tools for consumers to make choices.
> We can establish a real medical decision-making process that helps patients make those decisions in a way that is consistent with their values.

Here are a set of Roji Health Intelligence resources for the health care industry and consumers to foster thinking about creative ways to forge an opportunity-action link for good health:

Redesigning Health Care For The New Consumer
Shared Decision-Making May Be The Next Consumer Health Movement

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Le Kiet

Tech Tools Empower Consumers to Reform Health Care: Will Providers Cooperate?

written by Theresa Hush | August 30, 2018

Health care is ripe for change, but providers have yet to take the lead. Who will push for much needed reform? Investors and technology experts are betting on consumers. Money is chasing health care technology (IT) startups to create consumer tools for everything from evaluating and comparing treatments and related costs, to managing medical conditions. The underlying assumption is that consumers will shop for good, affordable care.

It’s the right time for health care IT to focus on consumers, who are feeling the pain of huge medical costs that were once paid by employers or government health plans. Either through brutal experience with bills that exceed their ability to pay or similar stories of others’ fight to maintain coverage, consumers are grappling with the tangible risk of being unable to afford health care.

Can consumers truly wield the power of these new IT tools to make health care better, more affordable and more accessible? If they succeed, how will providers and payers respond?

The 2018 Internet Trends Report and Consumer Health Care Readiness

Mary Meeker's highly regarded *Internet Trends 2018* documents how the shift in health care financial responsibility from business to consumers is driving technology development. Consumers are starting to understand that they have purchasing options and rights. What do they want? Cost transparency; their own digital health records, customized to their interests; demand-based shopping for health care providers and services; and decision tools.

The development of the Internet, availability of health care data and an explosion of health care applications all combine to induce willing consumers to activism. The likely candidates will be boomers (retiring now with poorly planned finances) and millennials (facing worse prospects than their parents and already refraining from traditional health care). The convergence of cost sensitivity with cultural tendencies to challenge the status quo may be just enough to spur boomers and millennials to demand action.

Let's look at some of the latest applications now being offered to consumers:

- Websites to compare prices between providers;
- E-shopping for treatments once reserved for providers;
- Apple's Health Records, populated by EHRs, but managed and shared by consumers;
- Telemedicine alternatives;
- On-demand prescriptions;
- On-demand health care services;
- Research and efficacy websites to support decisions;

Genetic testing coupled with health care solutions;
Disease management aimed at consumers versus providers or care coordinators.

Health Care Environment Fosters Consumer Health Care Shopping

If you read only health care industry literature, you're likely to believe that the industry is moving toward organized care, larger systems and one-stop shopping for both primary and specialty services. It's true that providers have been rapidly merging, acquiring and building ever-bigger health care enterprises. Health care organizations have pursued consolidation with a vengeance to shore up defenses in competing for market share and power in negotiations with payers.

The problem is that consolidation strategy is only relevant for pre-Value-Based Health Care days, when negotiations with payers required heft and market presence. Now we know that consolidations have actually increased costs, and that health plans and employers are willing to create narrow networks and otherwise guide consumers to lower-cost health care. As the share of consumer expenses continues to increase, consumers will either make value- or cost-based decisions—or fail to pay for services they use. "Big" could be the antithesis of efficient health care.

Most consumers, particularly millennials, do not embrace the concept of one-stop health care. They are shopping by price—using CVS and Walgreens for quick primary care and diagnostic services and avoiding long-term attachments to physicians. Boomers may be slower to transition away from

traditional medicine, but ask them where they got last year's flu shot and how they access specialty physicians, and a similar pattern emerges.

Indeed, we may be experiencing the beginnings of a real market for health care, where price-conscious consumers look for better value.

Whether consumers will use new technology to lower their costs is not in dispute. Health care avenues that produce value will draw consumers. But comprehensive reform is another matter. To prompt providers to increase efficiency and limit excess services and costs, only large scale consumer action can force change.

Consumers may also have to win another, more unexpected battle: the right to choose their health care providers.

Health Care Consumerism Could Be Foiled by Value-Based Health Care and Financial Risk

Health care organizations continue a push-pull response to Value-Based Health Care and other reform efforts, as they challenge the imposition of financial risk on providers. But Medicare and payers remain universally focused on the elimination of Fee-for-Service incentives that reward providers according to service volume.

ACO providers, under threat to accept financial risk in the near term, complain most about patients' ability to seek care outside their system. They argue that they should be able to keep patients from seeking costly non-ACO services, in return for accepting financial risk. However, the argument lacks

evidence. A recent study of ACO specialty services revealed that, regardless of ACO participation, physicians failed to reduce the rate of low-value coronary revascularizations. Nonetheless, Medicare might gamble to reduce consumers' provider choice in order to get more services under risk-based ACOs. Even MedPac, in its latest documents supporting changes for ACOs to influence risk, is floating the idea of gain-sharing for patients if they stay inside the ACO system.

Narrow networks and limited benefit plans, used predominantly in private coverage, also take choices away from consumers to favor budget controls.

What's uncertain about consumers' ability to reform health care is the fact that their power has never really been tested in the health care marketplace. It will be a major transition for health care providers and payers to treat patients as rational decision-makers and as partners, instead of beneficiaries.

Even with the tools for change, consumers will almost certainly need to challenge their providers and payers for the right to decide on value, especially since they need their providers' time and guidance to determine the value of alternative treatment options.

How Providers Can Benefit By Pivoting to Consumers

Historically, health care costs were an employer and health plan issue. Now affordability is no longer just about benefits and access to coverage; it's about consumers' ability to pay. Yet consumers are repeatedly blamed for their excessive use of

health care, while medical technology drives about half of the annual increase in health care costs. That technology, totally outside consumer control, includes:

- Investments made by providers in clinical records, population health systems, and other administrative and financial systems;
- New types of surgeries and treatments;
- Genomic technologies and their related treatments;
- Prescription drug prices;
- High-tech equipment for diagnostics and interventions.

All technologies are incorporated into provider prices, of course. Health care organizations' marketing to consumers still highlights state-of-the-art health care, because cost was less relevant in the past.

But when good financial stewardship of care is rewarded, the messaging to consumers must also change. The success of risk-based ACOs, specialty practices' episodic payments and other financial risk models are dependent on delivery of predictably good outcomes and controlled costs. Providers can appeal to consumers based on these benefits and engineer the delivery of care and operations to actualize them. Why is this essential? Because consumers will be making their choices based on these understood values. Providers who make good on benefits will also create the bond—and future loyalty—between them and their patients.

Six Essential Reforms that Consumer-Savvy Providers Need to Make

Health care organizations have been immune from a market economy for a long time, but those days are over. Consumers armed with information and technology will have no patience for big bureaucracies in large, consolidated systems. Providers who do not pivot quickly to consumers will lose patients who are well, raising their overall cost profile and lowering their appeal.

Fortunately, providers already have the assets to respond to consumers' needs. Their task is to share information and support consumers, not manage them. This won't be easy. A major but necessary culture change is required for these six essential reforms:

1. Supply consumers with information on episodic and service-based costs.

This is where consumers start—there can't be a consumer relationship without cost-sharing information. Over time, providers will need to remove the guesswork involved in pricing built on Fee-for-Service and commit to all-inclusive episodic pricing.

2. Facilitate value-based medical decision-making by consumers, in keeping with *their* values.

Patients are customers who make valid choices based on their own criteria, including life circumstances, finances, ability to maintain commitment and other preferences. Any medical

decision for a serious condition can have a significant impact on any or all of these factors. Providers who are responsive to consumers must make differences between treatment options clear through summary of research and cost data.

3. Help physicians adjust their roles in medical decision-making.

Most physicians feel responsible for their patients' health. They are used to making decisions, taking immediate action, and/or recommending treatment based on their advice. They are not accustomed to justifying effectiveness with numbers or waiting to see how conditions further develop before intervening. Consumers who want answers, data and research will demand evidence. Physicians must shift from only treating patients to providing additional guidance and education. To do that, they will need time built into their schedules (and compensation/productivity plans), centralized data to support patient information needs, coaching and support staff who can help.

4. Open communication channels with patients and consumers.

Providers should create new avenues for consumer communication, making it easy to find a wide range of information. This includes matching available providers with consumer needs; providing access to complete medical records and images in digital format; and reviewing the patient navigation of the system of care to eliminate bureaucracy and conflict.

5. Establish accessibility and approachability across consumer-facing operations.

Large, centralized operations may appear to save resources, but that analysis is often flawed because it fails to account for patient decisions, such as attrition. Some organizations are beginning to experiment with decentralized, small care settings that personalize health care operations and successfully manage costs while improving patient experience. Input from consumer/patient and community groups is essential for successful removal of bureaucratic layers.

6. Support consumer technology.

Technology solutions coming from the industry will require provider cooperation and involvement. Providers should help consumers connect with key applications and respond to questions. Their own efforts to create on-demand scheduling, prescriptions and telemedicine must have high priority in development.

We can’t guess how fast consumers will act to challenge the health care system. But we can expect it to happen. How organizations act to establish trust with consumers will define them as “A-rated” by the only group that can make them successful—their patients.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Javier Mazzeo