The 2018 Quality Payment Program Final Rule: What You Need to Know

written by Dave Halpert | November 9, 2017

Halloween may be over, but CMS has given us one more scare—a 1,653-page Final Rule for Year 2 of the Quality Payment Program.

The Proposed Rule represents the next phase of the transition into a full-fledged Quality Payment Program. For eligible providers, more is required to avoid penalties, but CMS has defined the process to favor those making efforts to avoid penalties. Of course, the program is designed to facilitate improvement—not just to meet a minimum participation threshold. Success will not be quantified in terms of avoiding penalties but, rather, by demonstrating exceptional performance and improvement.

With these guidelines established for 2018 and beyond, CMS's intent is clear—2018 marks the end of the transition period. If your strategy involves "getting by" in 2018, you'll find yourself in a heap of trouble when 2019 rolls around. Here are ten keys to success in 2018 that will help you achieve an optimal position in 2019:

1. A "Test Submission" Will Be a Failed Submission

In 2017, clinicians can avoid penalties by submitting data on a single measure, even if the data completion threshold isn't met. For the current calendar year, the minimum participation requirement is to earn 3 points. With each quality measure worth a minimum of 3 points, even if only one response is provided, it shouldn't be challenging to avoid a penalty. Similarly, performing an Improvement Activity or meeting base Advancing Care Information requirements will also protect against penalties. In 2018, however, the minimum threshold rises to 15 points, meaning more (or better) reporting will be required.

2. The “Low Volume Threshold” Has Been Increased, but Consider Your Options (Especially Small Practices)

As proposed, providers will not be considered “MIPS-Eligible Clinicians” unless that clinician (as defined by the combination of Practice Tax Identification Number and Individual NPI) has at least $90,000 of Medicare Part B charges or has more than 200 Medicare Part B beneficiaries. If you are reporting as a Group Practice, these same standards are applied at the TIN level, which will make it possible for some practices to participate.

Why participate in MIPS as a group if you’d be able to skip as an individual? First, while it may be possible to opt out now, Value-Based Health Care is here to stay, and it’s easier to build momentum now than to start from scratch during full rollout. Furthermore, if you are in a small practice (15 or fewer providers), you will be scored more generously than larger ones, giving small practices an opportunity to earn incentive payments. Small practices will receive outright bonuses of 5 points at the end of the year and can earn full credit even if they complete fewer Improvement Activities.

3. Clinicians May Participate in “Virtual Groups”

The 2018 Rule allows multiple practices with 10 or fewer providers (note that this a smaller practice than those referred to throughout the remainder of the Rule as a “small practice”) to join together and submit data as a “Virtual Group.” The group is scored as if it were one group practice. The “Patient-Facing” criteria that contribute to eligibility in

the Advancing Care Information component is applied to Virtual Groups in the same manner as Group Practices: at least 75 percent of the individual clinicians must be “Non-patient Facing” for the group to be considered as such. Providers and practices wishing to participate in Virtual Groups must self-nominate by the end of the preceding year, so if you want to take advantage of the Virtual Group method in 2018, don’t wait to register! Deadline is December 31.

4. Quality Component Challenges, Part 1: More Reporting, Over A Longer Timeframe

For several reasons, earning points for quality reporting will be more difficult in 2018 than it was in 2017. First, the reporting period itself has increased to a full year. In 2017, a measure could be scored against a benchmark with only 90 days of reporting. In 2018, the reporting period will go from January 1 to December 31, similar to PQRS in prior years.

Furthermore, the amount of reporting required to earn full scoring on a measure has also increased, from 50 percent to 60 percent. Under PQRS and in the 2017 year of MIPS, a measure met the “data completeness threshold” if at least 50 percent of the denominator-eligible cases were reported. For example, you could score performance on a measure with 50 eligible instances if at least 25 of those cases were reported.

In 2018, CMS has ruled that the data completion threshold has increased to 60 percent. Measures reported for fewer than 60 percent of cases will only be worth a single point, which is also a decrease from 2017, when these measures are worth 3 points. However, small practices will continue to earn 3 points for measures with fewer than 60 percent of eligible instances

reported.

5. Quality Component Challenges, Part 2: “Topped Out” Measures and Measures Without Benchmarks

As is the case in 2017, every measure reported to the minimum data completion threshold will continue to earn at least 3 points. While this may provide some comfort, those striving to demonstrate excellence face continued challenges related to measures that are “topped out” (measures universally performed well) and measures that CMS has not benchmarked.

In 2017, it is still possible to earn 10 points on a topped out measure, although performance must be perfect. In 2018, this will not be possible for certain topped out measures, as CMS has finalized its plan to phase out several. There are 6 measures on track for removal, and for these measures, a maximum of 7 points may be earned. This will be particularly challenging to surgeons, as two of these are the remaining perioperative care measures (Measures #21 and #23, related to perioperative antibiotic selection and VTE prophylaxis, respectively).

CMS maintains its stance that if a measure cannot be benchmarked, it cannot be reliably scored and may only earn a nominal number of points. Therefore, non-benchmarked measures will remain capped at 3 points.

6. The Big Surprise: Cost WILL Be Weighted, Making Up 10 Percent of Your MIPS Score

Despite the proposal to weight Cost at 0 percent for an

additional year, CMS has decided to reinstate Cost in the final MIPS composite, worth 10 percent of the total. This 10 percent will come from the Quality Component, which will be worth 50 percent of the MIPS composite score in 2018.

Only two measures will be used to calculate this score: the Medicare Spending Per Beneficiary (MSPB) and the Total Per Capita Cost (TPCC) measures. These are global measures, calculated by CMS using its claims data—no submission is required.

MSPB looks at costs associated with hospitalizations and procedures, specifically, charges in the days immediately preceding the index admission, inpatient care and the care following the procedure. TPCC is based on all patients attributed to a practice, looking at any costs associated with those patients (regardless of who provided the care).

The Cost composite will be the average of these two measures, unless one of them does not have sufficient data for CMS to calculate. In that case, the remaining measure will make up the entirety of the Cost composite. It is expected that additional episodic cost measures will be introduced in future years, potentially including the measures that CMS has field-tested this year.

7. Improvement Activities and Advancing Care Information Are Largely Unchanged

These two categories largely carry over as is. Improvement Activities will continue to be worth 15 percent of the total MIPS score, which may be earned by completing 40 points worth of activities (between 2 and 4 activities for large practices

and 1 or 2 activities for small practices, depending on activity weights). An additional 20 Improvement Activities have been added to the possible selections.

Advancing Care Information retains its 25 percent portion of the MIPS composite score, again requiring that clinicians meet EHR standards by earning a base score and selecting from a variety of other measures to earn the remaining score. There are more bonus points available in 2018 for reporting to Clinical Data Registries and Public Health Registries. Clinicians may also earn a bonus for using exclusively 2015 Certified EHR Technology (CEHRT), although 2014 CEHRT is still allowed.

8. There Are More Opportunities to Earn Bonus Points (Including IMPROVEMENT)

There are already opportunities to earn bonus points in MIPS. Providers can increase their Quality score up to 10 percent by reporting (and performing well) on additional outcome and/or high-priority measures, in addition to the one that is required. Additional bonus points can also be earned in Advancing Care Information by performing EHR-related Improvement Activities or reporting to other entities. These provisions will continue in 2018.

In addition to what's carrying over, there are additional opportunities to earn bonus points in MIPS. Most telling for CMS's long-term goals: CMS is offering a bonus of up to 10 percent for significant year-to-year improvement. *Bonuses will also be granted to those who take care of particularly complex patients, based on Hierarchical Condition Category (HCC) score*—a big break for Academic Medical Centers and others whose

patient pools include a larger proportion of high-risk patients. This is a huge signal to practices that the game has changed from quality reporting to performance improvement.

9. Provisions for MIPS APMs and Advanced APMs Remain Consistent

The biggest change to MIPS APMs is that a new determination period has been added, ending December 31. For some providers in ACOs, this will mean the difference between being considered as a part of a MIPS APM (and scored according to that standard) and being scored exclusively in MIPS. There are also additional clarifications to the MIPS APM scoring methodology.

On the Advanced APM front, CMS has extended the standard for nominal risk for the next two years: at least 8 percent of average estimated Medicare Part A and Medicare Part B revenue must be at stake. However, the Medical Home nominal standard will be eased gradually, as proposed. In terms of structure, APMs must continue to meet the same three standards for APM considerations (MIPS-comparable measures, CEHRT use and financial risk).

10. All-Payer Advanced Alternative Payment Model Roll-Out Continues

The Final Rule continues to lay the foundation for an All-Payer Advanced APM. The proposed risk standards (marginal risk of at least 30 percent, a minimum loss rate that doesn't exceed 4 percent, and a total risk of at least 3 percent) were approved. For All-Payer APMs defined in terms of revenue, CMS approved an 8 percent nominal amount standard, meaning that at least 8 percent of expected revenue must be at risk. CMS states that

the nominal standard cannot be used in place of the expenditure-based standards, but recognizes that it may be the only viable option for certain All-Payer APMs.

Qualified Participant determination is also similar to traditional advanced APMs and will be performed on three snapshot dates (March 31, June 30, August 31); the QP or Partial QP threshold must be met by one of these three dates, maintaining a timeframe consistent with Medicare APMs.

An Additional Note on "Extreme and Uncontrollable Circumstances"

Also present in this rule, but not applicable to all, is a provision on "Extreme and Uncontrollable Circumstances." Over the last several months, we've seen Hurricanes Harvey, Irma and Maria wreak havoc on portions of the country; CMS addresses these in the Final Rule by re-weighting (either automatically or through an application) some or all components of MIPS, both in 2017 and 2018.

A Final Note: There is a Comment Period, and CMS Reads Your Comments

Although the Rule is considered "final," it is still possible to comment. CMS states that they have attempted to make it easier to participate by reducing the burden while maintaining flexibility. Over 1,200 people have commented on proposals, and many of the finalized rules are made on the basis of those comments. If you do not believe that the program's measures or activities are relevant and meaningful, if your burden has increased, care coordination has not improved, or your path to success is not clear, let CMS hear your voice.

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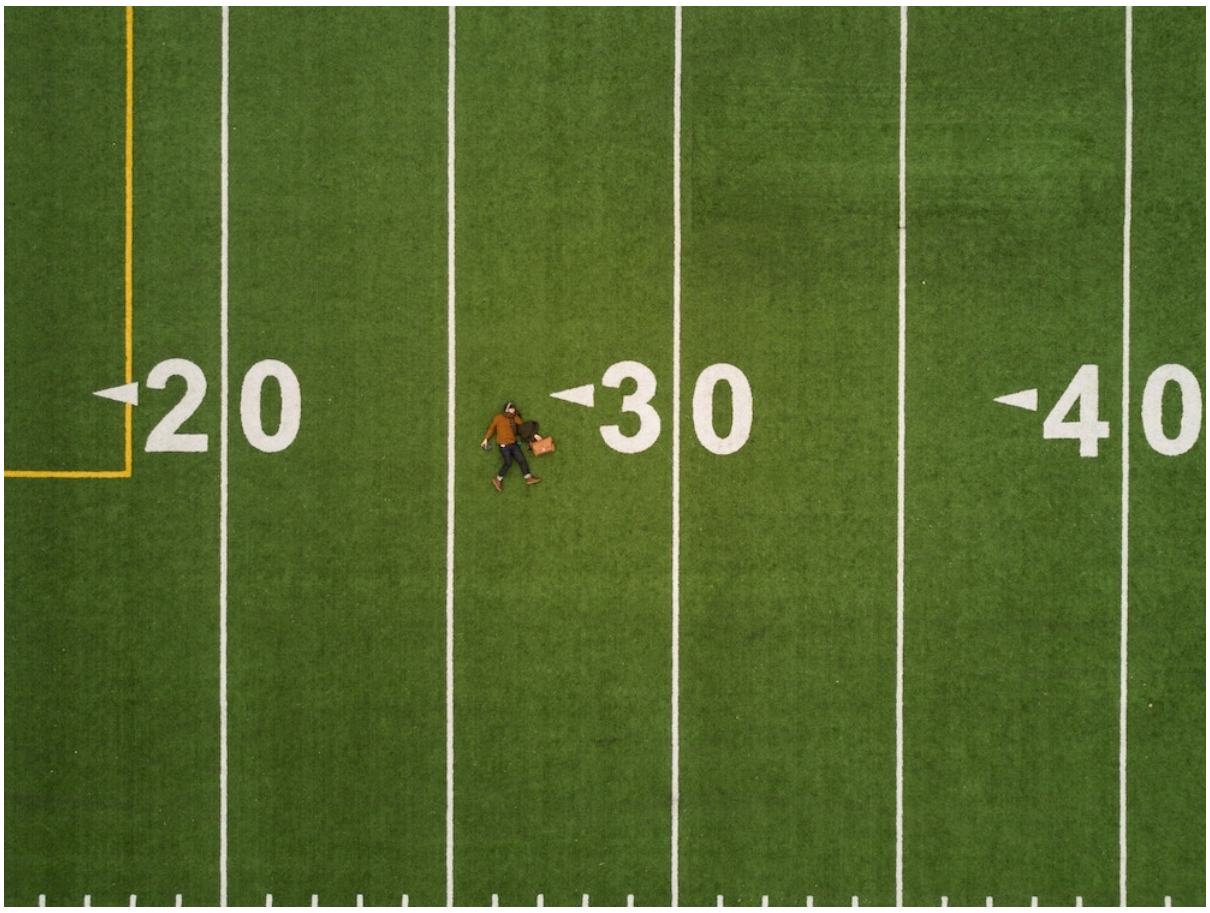
Providers Should Believe in Health Care Cost Control Now—If They Want to Stay in Business

written by Theresa Hush | November 9, 2017



Despite MACRA and other Value-Based Health Care efforts, many health care providers believe that controlling health care costs is impossible to do. They cite lack of comprehensive data about their patients and where they obtain services, and lack of control of patients' decisions.

But the real issue that providers have with cost control is much simpler: Why give up revenues under Fee for Service by reducing volume of services? That system has rewarded them well, fueling the growth of consolidated health systems, technology expansion and purchase of physician practices by ensuring a patient base. Controlling costs is now a relatively low priority. Under Medicare MIPS, it has zero weight in scoring. In ACOs, there is only a minimal incentive. Patients in private health plans often still have choices beyond severely limited provider networks.

So what's the rush? The future of more narrow networks and financial risk might seem a long way off to providers focused only on the present.

Major Changes May Not Be Obvious, But Are Planned

The problem, of course, is that this strategy will rob providers of the precious time they need to manage some of the big changes coming – or here already – in health care economics. Consider some of these key trends:

A major shift to increasing the financial burden of consumers is underway. While this relieves pressure on employers and/or health plans, it increases bad debt for providers.

Benefit plans have higher deductibles and copayments every year, with many employers now opting for high deductible plans guaranteeing coverage only after $2,500-6,000 in expenses.

Medicare Supplement Plan F, the most popular Medicare supplement option, will expire for new enrollments after 2020. To save money and allow for higher physician fees, Congress decided that consumers should pay more in deductibles and copays.

Coverage is being limited and even disappearing. Some version of the ACA repeal will likely pass, and Medicaid will receive cuts. More people will have less money for health care.

Medicare and other payers are moving to financial risk, believe it or not! Even though this intent is spelled out in MACRA rules, the transition is likely to move at an even

faster pace because of the push to decrease the regulatory burden on providers. Financial risk plans like Medicare Advantage are the logical replacement to MACRA and ACOs, with less government costs in administrative approvals, management of claims, and associated costs.
We will see growth of narrow networks of lower cost providers and benefit plans tied to small provider networks or employed providers, both of which will lower revenues for higher cost providers serving patients most at risk.

It's hard to imagine a scenario under which health care systems can continue their current level of profitability, given these trends. The providers that attract patients will reorient their services, marketing and value toward ensuring that consumers are protected from excessive costs and can make responsible decisions.

Health Care Systems Can Get the Cost Data They Need to Act

While the payer side of health care – including Medicare, Medicaid and most health plans – has robust data that reveal a comprehensive picture of each covered patient's expenses, providers are limited to data within their own systems. If the patient goes elsewhere, providers don't know. In fact, even within a system, it can be hard to aggregate cost data to provide a view of services utilization or leakage from the system.

The advent of Medicare and health-plan-provided data is changing that. Medicare data sets, such as the Quality Resource and Use Reports (QRUR), provide annual plus supplemental data that offer some excellent information for provider analysis,

and some of that data is patient-identified. In particular, episodic cost data that provides detailed patient and services data can be a model for providers to construct their cost performance system.

What are the data types that could be of value to providers?

Identify Aggregate Costs, Per-patient Costs and Comparisons

- Cost per Medicare beneficiary (CMS Quality Resource and Use Reports, or "QRUR")
- Cost per covered individual, generated by primary care physician (health plans)
- Costs per Episodes of Care/Procedure (QRUR, some health plans)
- Comparative Medicare costs generated by attributed physician (QRUR)
- Comparative costs generated by primary care physician (health plans)
- Cost per covered individual, generated by primary care physician (health plans)
- Comparable Medicaid cost data (State Medicaid programs)
- Claims and reimbursements by episodes of care and by specialty/provider (provider source data)
- Billed and reimbursed cost per inpatient, outpatient, ambulatory (provider source data)

Search for Excess Cost Drivers

- Ambulatory Sensitive Admissions (QRUR)
- Emergency, Diagnostic and Anaesthesia costs, aggregated and grouped by diagnosis/procedure (health plans)

- Out-of-system referrals (health plans)
- Diagnostic technology episodes by patient/diagnosis (provider source data)
- Emergency visits by patient/diagnosis (provider source data)
- Outbound referrals by physicians, by specialty/reason (provider source data)

These two groups of data create the baseline for the most important analyses of cost: overall cost of care by condition and procedure; leakage from the provider system to outside services (and why); generation of costs for technology and other key cost drivers.

Data Should Prompt Health Care Systems to Start Questioning

If the data are enough to identify areas where costs are high, many people outside the health care organization assume that this is enough to go after problem providers and areas of cost excess. This is naïve at best, and could be damaging to providers and patients.

The goal for addressing costs is to measure and then improve performance through an ongoing and evolving process. Measures of cost performance are key indicators, but they don't tell the full story. Data could be missing or incorrect, patients could have higher or lower risk, and different protocols with variability in services could be required for the patient's condition.

Relying solely on quality measure results to accurately represent quality at face value is inherently flawed; so is the use of cost measures as scores or benchmarks for care. There

are hundreds of reasons why variation can and should occur. The task of determining why that variation occurs should be part of the feedback from clinicians. Higher cost in individual cases is often completely justifiable. High aggregate costs across all providers or individuals should raise questions. In both cases, further inspection is needed.

But Is Data Enough for Action?

It all depends on what “action” means. Improving cost performance is a complex process that will take more time than initial measurement. It should be both iterative and collaborative. The means or “interventions” for cost performance improvement are rarely clear-cut. Improving cost performance involves a process of targeting and testing interventions that have potential for cost reduction, and exploring how and why that reduction can be achieved through a measured improvement project.

Action is difficult not because of resistance; rather, this is due to lack of knowledge. For example, reducing the cost of excess radiology through multiple serial procedures sounds reasonable, but the contribution of each procedure to the final diagnosis or treatment is not always understood until retrospectively reviewed. The review of such data is new to physicians and relevant to how they make future clinical decisions. Reviewing cases of patients is likely to result in physician adjustment, due both to Hawthorne effect and physician learning. But only through measuring impact of the case review intervention can we tell exactly how effective that process will be and whether results will diminish over time.

Cost Is an Outcome; Innovation and Time Are Essential for Success

Excessive costs are an outcome, and that outcome is often shared by both physician(s) and patient. Failure can come from either or both parties.

One goal of cost performance measurement, therefore, is to identify the point at which an outcome has become a failure and create interventions to avoid it in the future. Time and an environment of collaboration – not punishment – are essential for this effort to succeed.

Ultimately, the most innovative cost performance strategies will address how providers and patients share information, and will generate effective means to help patients understand treatment alternatives and how to choose wisely. That effort will require both performance improvement technology as well as an organizational shift to refocus priorities toward meeting needs of patients over providers.

The message to health care systems that are banking on time to achieve more growth in size and revenues before addressing cost performance: time is not on your side. Even after investing in a significant, lengthy effort to obtain and analyze data, providers must be prepared for the reality that developing initiatives and allowing for participants' learning curves will take years, not months. To remain viable for the long run, begin efforts now to improve cost.

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Medical Treatment Should Be Based on More Than Just “Doing Something”

written by Robert McNutt, M.D. | November 9, 2017

Memory is malleable. This was made quite clear to me at my recent 50th high school reunion. Despite my fallacious recollections, I could not dispute the data of my forgotten activities, awards and foibles captured in pictures and written comments in my high school yearbook. Then there were the comments about my behaviors “back then,” interpreted or misinterpreted by my former high school comrades. These conversations reinforced for me how difficult it is to correctly intuit the motives and thoughts of others, when my own are occasionally tarnished or refurbished.

None of us can truly read another’s mind. Even if we could, the information gained would be a confusing jumble without deep context. Nonetheless, when it comes to making the most important decisions we encounter, it would seem beneficial to understand what’s going on inside the minds of those advising us. Which prompts me to consider the motives and thought processes of physicians regarding how they recommend treatments or validate their diagnoses. Do spoken motives expose a truth,

or are they constructed in the moment to justify actions or outcomes?

Why is this important? Because most current processes of performance measurement hold physicians accountable, retrospectively, for decisions made in health care.

What Motivates Physicians to Recommend a Given Treatment Plan?

These reflections lead me to wonder why physicians do what they do. I do not, I must confess (despite my years of practice as an oncologist), believe much of what they say about their justifications for decisions they promote and present to patients. This is not an indictment, just an observation informed by my own imprecise thoughts that may, without conscious awareness, be occasionally injudicious.

Two examples illuminate how precarious justifications can be:

An acquaintance of mine opined that she could not come to grips with the treatment plan for her breast cancer diagnosis. The plan was onerous and would demand energy, time and entail certain compounded complications. When she asked her physician to explain the value of the proposed multi-pronged treatment plan, she was told that her "case" had been presented to a "tumor board," and there was complete agreement that she was getting the best treatment possible. In fact, she would be getting the "standard of care." The final justification came from her surgeon, who stated, "I would treat a family member the same".

Another friend of mine told me that she had been offered a new

therapy to protect her “bones” and given a prescription. After leaving her appointment, she began to wonder about the new treatment and researched the drug on the Internet. She determined that there was not enough information about the drug’s benefits and harms, and decided not to take it. When she later told her physician of her decision, the physician acknowledged that the drug really did not work well and that she would not offer it to her “family member.” My friend asked why she had suggested the drug in the first place, to which the physician responded that she thought my friend would want anything that might help; she added that it was the physician’s “job” to offer treatments so patients feel they are getting something from the visit.

“Doing Something” Is Never Good Justification for Treatment

The physician’s motives for providing an onerous treatment plan in the first story are unclear. What, after all, does “standard of care” mean? Does it mean every patient will get the same plan given the same context? If this is what the physicians were thinking, they were unambiguously misguided. Individual patients vary too much for uniformity to be a justifying principle in the minds of any physician for any clinical situation.

And what did her surgeon mean about doing the same for a family member? I doubt that situation would ever arise, since that physician would not be on the tumor board of a family member, so I wonder what the surgeon was really thinking. Ironically, in the second story, the physician used the same reference to family members to justify *not* offering the bone medication.

In both stories, neither patient received tangible information about the added benefits and harms of recommended treatments or comparable alternatives. The patients wanted that information, but did not get it. The multipronged plan for breast cancer and the new drug for “bones” were proposed, but never explained. Were the physicians simply offering treatment plans because they were trained to “do something”? The justifications and motives were confused and confusing, at best; lazy or inane, at worst.

Patients Must Understand Real Benefits and Harms of Any Treatment

Truthfully, it doesn’t matter what is in the head of a proposing physician. What they say may not be what they mean. You will never be sure, and, I offer, that they are incapable of being sure in their own minds, when they propose and justify their decisions. Conflicting memories, intents, pressures and expectations that lead to vague thoughts with indeterminable links between thoughts and actions besiege physicians.

Hence, you (we) should forgo listening to explanations and instead demand information. And, most importantly, we should not care what physicians think about their decisions, as it is not really their job to decide. It is their job to inform; it is the patient’s job to decide.

The only mind that matters in medical decision making is the patient’s.

It may be that patients will, given that they, too, may misremember and misinterpret their own thoughts, struggle with making medical decisions. But at least it is their struggles

that will influence their choices rather than the misrepresentations of others, even if others think they mean well.

The only path out of ambiguity for a patient is to know the absolute benefits and harms of the choices they face. Tangible information about the consequences of one treatment plan versus another is all that matters; reliable facts will allow patients to reframe their own stories and not suffer from irrelevant stories of others.

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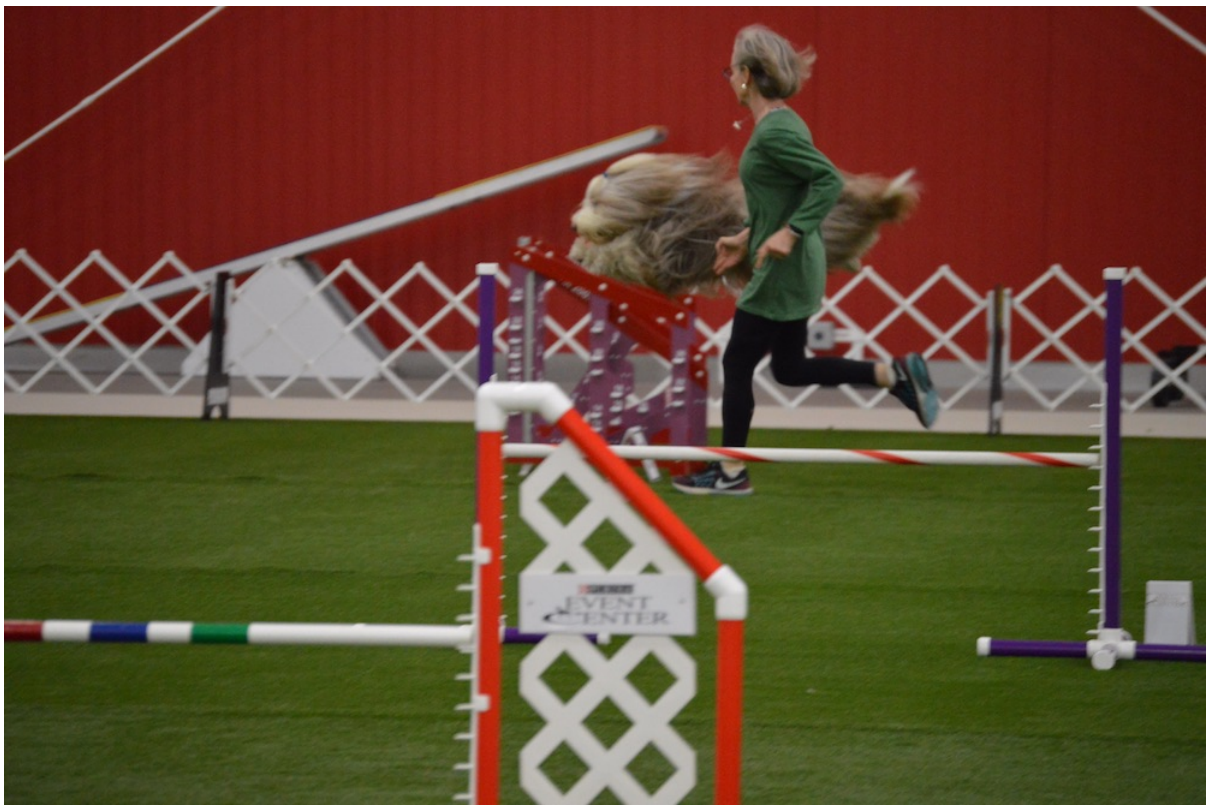
What the Dog Show Taught Me: Performance Improvement Is Not Just Science, But Art

written by Theresa Hush | November 9, 2017



Last week I attended the Bearded Collie Club of America National with my two highly energetic and driven dogs, along with about two hundred other competitors. A calm vacation it was not. My dog athletes enjoyed multiple days of performance competition, capped off by show competition.

For people who believe dogs are pets and don't have emotional lives, let me introduce you to my beardies. They have goals. It's my job to help them achieve those goals. To do that I need to understand how to get performance, and to improve it.

I have learned a lot about meeting goals of others from raising dogs as well as children. With my own goals, I now have the flexibility to determine my time-frame and criteria for achievement. When performance is judged for my dogs, that flexibility disappears. We are judged only on the outcome, and we get scores that are compared with others. Prizes are

awarded, or not.

Excellent Performance is Propelled by Both Data and Engagement

I don't want to imply that training dogs for performance is anything like tackling the complexity of health care performance. But sometimes it's instructive to step back and look freshly on performance from a different perspective. Why? Because in both cases, although there is a quasi-scientific process to master performance, there is something else propelling the achievement of results—the art of making it happen.

In both venues, there is a common performance framework: a science of measurement, performance measures, the challenge of meeting performance amidst distractions, and interventions for improvement.

There is also data. Data in dog performance? Absolutely. When a dog is experienced in jumping, he knows the exact distance from a jump obstacle for takeoff and landing that will scale the height of the jump. He also knows, by "reading" the line of the agility course, that if the next jump is at an angle to the first and not straight ahead, he must make the first jump by collecting and not extending his body. In other words, he will jump short instead of long. These are measurements he must learn through practice, data that he imprints on his memory.

But data is only one piece of the puzzle. In dog performance, both participants, human and dog, are fully engaged, which affects our results. My impact on my dog's results is as important as my dog's ability to run the agility course. I can

be the deciding factor in success or failure. Nervousness or overexcitement on either part can fail us. We are a team.

Instilling Performance Requires Involvement

There is a baffling yet common process in health care organizations to issue quality measure or cost results to physicians as scores, and then expect them to fix performance. Instead, they rebel. The data is wrong, the patients are sicker, the patients weren't compliant, the system was problematic—any number of reasons are categorized by executives as excuses, even if true. The real problem is that the physician wasn't engaged in the first place, had no input into the process nor agreement with the criteria.

If I am running my dog in agility or performing in obedience trials, I know better than to work with a dog that doesn't care if she is there. I spend a lot of time coaching her along the way. If she doesn't trust the teeter-totter, I teach her that it's not scary. I make games that reward fast weave-pole performance, and I whoop it up at the end of a good run. Most of all, I have to teach that it is fun, and that we are doing this together. If there is no partnership, there is no team, and we can't possibly succeed. Yes, agility is a game (for us); for the dogs, it is their work.

A few weeks ago, I was involved in a performance improvement project with a health care client. It was novel and was focused on improving outcomes for difficult patients. I was so struck by the excitement of the physicians, by creative thinking about managing aspects of the project, and by input into the criteria and the process. Physicians want contribution. If they are passive in the process, we cannot meet the goals.

Performance Can Only Improve Over Time—And Slowly

I spent six weeks this summer trying to eliminate foot movement in a dog's Sit. Prancing feet (which bearded collies do by nature) indicate that the dog will break the Sit and move off. If I want to get to a good performance on the ensuing command, a Stay, I must break performance into steps. First I must get the dog to understand that he is moving his feet, which is very difficult because it is emotional—he is expressing his excitement. Then I must be able to look away or move around the dog without foot movement, and then add distractions, like toys.

Each part of performance is a separate step, and the process is iterative. It takes patience, calmness and, yet, a fun attitude to keep my dog engaged. I work alternative positions to get better results; I add new elements of a game. And because it is enjoyable and not a huge amount of work, we succeed. That's how I got my first Rally Obedience Stay at the National and the first leg of our next title.

Performance Improvement Can't Be Blame and Shame

When I think about how performance improvement is undertaken in health care, I am struck by how often organizations can be quick to point blame at physicians based on limited data and poor measures. In many organizations, administrators provide only aggregate reports to physicians, permitting no feedback on individual patient results or establishing a foundation for real improvement. If a process of improvement is organized, it may include physician executives but not always rank-and-file

practices.

When compensation is linked to the achievement of measures, do physicians take away any value from performance measures? Are they more or less inclined to become involved in long-term improvement of their patients? What support do they get for improving individual patient results, if only aggregate scores matter?

Improvement in outcomes is driven by emotion in addition to facts. Both the physician's leadership and compassion and the patient's confidence and emotional status will play a part in getting good results. Achieving success is a process that cultivates the creation of a scientifically-based clinical plan yet also nurtures physician leadership and patient confidence, while supporting the emotions of those participants.

Performance improvement is not solely scientific; it slowly unfolds under circumstances that allow it to succeed. It is an iterative, step-by-step, creative process that involves far more than data, one that depends on a true connection between all parties who actively and enthusiastically own the process. That is the art of making it happen.

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Image Credit: Jim Cayo

If Federal Policy Can’t Improve Health Care, What’s Next? 5 Trends to Track

written by Theresa Hush | November 9, 2017

Health care has been extraordinarily resistant to change. Escalating costs have been at issue since the early 1980s—think about it!—but continue to rise unabated. Ask anyone participating in the system, be they physicians or other health care providers, payers or patients, and you will be inundated with complaints about health care economics, outcomes or processes. If you ask most health care executives about the future, chances are you'll be met with a shrug.

The fact is, however, that an undercurrent of change is already beginning to transform health care. It is gaining momentum, but the health care system and providers are still behaving as if the status quo is immutable. Nothing could be farther from the truth.

Here are five trends emerging throughout health care delivery and health care financing that are reshaping both economics and

treatment.

1. Consumers will assume a greater and greater financial responsibility for health care.

With revived proposals of vouchers for health care, limitations on benefits, as well as outright loss of coverage and restrictions in access from everyday to only catastrophic health care coverage, the cost for consumers will continue to rise sharply. This is significant not only because the cost burden is shifting to those who may be less likely or able to pay, but also because it sets up a quid pro quo: if I'm responsible for paying, I should have more say in it.

Health care systems, which have consolidated into huge bureaucracies, should not be surprised by a consumer revolt on pricing, nor by millenials avoiding health care institutions altogether. They should prepare by understanding, first of all, what costs consumers are facing, and then by establishing solutions for consumers who cannot afford services they need to purchase in order to stay healthy. The time for simply verifying coverage of patients is gone.

2. Consumer-patients will demand more information and shared decisions.

Shared decision-making has become a new buzzword in health care, replacing "patient engagement"—outdated code for providers' desires that patients comply with physician directives. Patients are pressuring for facts about effectiveness, for price transparency and for access to information. They are motivated by financial vulnerability as

well as a reliance on Internet-based information. They are willing to challenge bureaucracies and are taking more personal responsibility for health.

Health systems are not used to sassy consumers, especially younger adults, but they should pay attention. Insurance plans that constantly change provider networks have killed patient loyalty. Providers must engage patients with better customer service, helping them make intelligent choices, and giving them the tools to do it.

3. Individualized care will take precedence over population health.

At its best, population health is only a way of making sure that patients with chronic disease receive essential health services. Measurement of outcomes using populations or treatment of patients in a population, however, will always fall short.

Research and genetics have already clarified that people do not respond the same to drugs, treatments or other interventions. Population-based health care may help keep track of the overall status of health and of general processes, but it is not magic. It cannot identify how an individual will get better. Individualized care is emerging as patient data become richer and more specific, and intervention results are evaluated against those patient characteristics.

Providers should prepare by working with a clinical data registry or other technology to capture and evaluate patient information, garner patient feedback and create opportunities for broad based research on interventions.

4. Cost measures will be essential tools for health care management.

Most health care organizations are focused on prices and revenues, not cost. They are not tracking what it costs for an intervention or the overall cost of care per patient. In part they are limited by the data inside their walls, but the larger issue is this: As long as providers are paid fee-for-service, they won't perceive a need to know about cost.

Medicare introduced types of cost measures a few years ago for primary care, and episodes of care for specialists. As data becomes shared more widely (as under MACRA plans) for all payers, measures of cost will become more universal and shared publicly.

Health systems need to prepare by establishing programs to calculate and create ongoing measurement of their costs—pronto. They can then strategically plan how to use their resources in a market that measures cost comparatively and address cost outliers collaboratively with their providers.

5. Performance improvement will take the place of quality measurement.

Measuring quality through standardized measures has many flaws. Measurement problems, missing data, measure limitations such as annual outcomes—for all these reasons, quality measurement fails the test of accuracy and fairness. That's why physicians never bought into the concept, but health systems have found it difficult to move away from the simplicity of scores.

Performance improvement, however, is beginning to take hold

through discrete initiatives that focus not on annual measurement, but on outcomes over time. This is how measurement will occur in the future. As quality measurement becomes “streamlined” and deregulated, but data becomes more available, payers and consumers will demand better measures of quality. That test will be one of effectiveness, measured over time.

Performance improvement in the future will be less generally applied and more condition- and outcome-specific. Old “disease management” programs are beginning to re-emerge and may well replace generalized process improvement.

To succeed in the future, health systems should focus on real performance improvement over quality scores. Performance improvement must differentiate process improvement from outcome improvement. Health systems have historically focused on process rather than outcomes. Outcomes improvement, however, will be of greater interest to clinicians and engage them, and will have greater value to patients. A trend line of patient health status provides the basis for asking why variation occurs and why improvement is or is not happening. It creates curiosity and engagement.

The Federal Government Will Not Fix Health Care

The most comprehensive plans for changing the health care system in recent years have come from the federal government and, to a lesser extent, from private health plans. Change did not come from inside the system. That is an important point, because federal policy inadvertently fostered passivity for creating solutions to the health care system itself; instead it put a premium on compliance.

It was federal policy that proposed major solutions for measuring quality and controlling cost, building on private insurers' quality incentives for primary care. The Affordable Care Act, various budget bills and, later, MACRA attempted to engineer deep changes in the system. Providers got into action to comply with regulations but largely did not adopt initiatives that would change the health care system's profit center—fee-for-service reimbursement.

Expect to see continued action by Medicare and private health plans to take down fee-for-service and replace it with some kind of fixed fee. That could mean risk models like Alternative Payment Models or risk-based ACOs, Medicare Advantage and various capitation and episodic payment models, or a blend.

Regardless, there will be no solution for a new, effective health care system that emerges from Washington. Instead, we will face one of two realities: a system that implodes under increasing consumer debt or failure to pay, or a system where most providers begin to engineer change and improvement. The choice is obvious. The question is whether providers have the will to take the initiative.

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Image Credit: h heyerlein

Physician-Patient Interaction: Where We Should Begin to Measure and Improve Medicine

written by Robert McNutt, M.D. | November 9, 2017

Data is not always the path to identifying good medicine. Quality and cost measures should not be perceived as “scores,” because the health care process is neither simplistic nor deterministic; it involves as much art and perception as science—and never is this more the case than in the first step of that process, making a diagnosis.

I share the following story to illustrate this lesson: we should stop behaving as if good quality can be delineated by data alone. Instead, we should be using that data to ask questions. We need to know more about exactly what we are measuring, how we can capture both the physician and patient inputs to care decisions, and how and why there are variations among different physicians.

Our measurement and improvement should focus on both parts of the equation: physician and patient. Why? Because the physician

and patient interaction determines the path for both diagnosis validation and treatment. When data is limited only to claims and clinical values, it does little to elucidate the options for lowering costs or improving outcomes.

A Tale of Two Doctors

“As soon as I start swimming, my chest feels heavy and I have trouble breathing. It is a dull pain. It is scary. I swim about a lap of the pool, and, thankfully, the pain goes away. This is happening every time I go to work out in the pool”.

Her primary physician listened intently. With more than 40 years of experience, the physician, a stalwart in the medical community, loved by all, who scored high on the “physician compare” web site listing, stopped the interview after the description and announced, with concern, that she needed to have a cardiac stress test. The stress test would require walking on a “treadmill” to monitor her heart and would include, additionally, an echocardiogram test to see if her heart was being compromised from a lack of blood flow.

“But, I have had three echocardiogram tests in the last year as part of my treatment for breast cancer and each was normal. Why would I need another”?

“Well, I understand your concern about more tests, but the echocardiograms were done without having your heart stressed by exercise. The echo tests may be normal under those circumstances, but be abnormal when you are on the treadmill. You still need the test, unfortunately. I want to order the test today and you should get it done in the next week”.

The patient had other ideas. She refused the stress test and, instead, sought a second opinion. The second physician (another experienced, well respected, multiple-board-certified physician) asked more questions than the first. The complaint was queried for the context of the pain. When did it occur? Did it occur only with swimming? How long did it last? What made it better? What made it worse? Any associated symptoms? What was its course—gradually better, or suddenly better? Were there any other medical issues in her life?

The pain abated as she exercised; it did not worsen as she swam and was gone in less than a minute. The pain never occurred in any other circumstance. The patient offered that she worked out daily and never had the problem when she ran or exercised robustly. She worked out faithfully for one hour, seven days per week and in a strenuous fashion. Her symptoms only occured during swimming. She had tried nothing to improve it, but since it had been occurring regularly, she sought help.

The physician asked about how she started her swim; she anxiously jumped in the pool, and, since she hated the sudden blast of cold water, she tensed and then swam vigorously to warm up. After listening to her lungs and her heart as part of a brief physical exam, the physician asked her to try a common sense solution, while not offering a cause. The physician advised her to enter the water slowly, perhaps, even, walk in the pool for a bit until she warmed up before swimming.

Approaches to Diagnoses Fall Outside of Data Analysis, With Huge Impact

What is going on with this person? Is she having trouble with her heart? Could this be her lung? Could she have asthma? The

differential diagnosis for the cause of her symptoms is filled with worrisome conditions—or not. This is a diagnostic dilemma. What would you do? Which approach seems most reasonable to you?

This anecdote, like a TV program, is based on a true story, and I will tell you the outcome.

But, first, think about how varied were the responses of the physicians. One directed the patient to testing; the other performed no tests other than the history of the complaint and a focused physical exam. One physician's care will be expensive, but will the stress test ordered by the first ease the worry of both the patient and the physician? Why did the first physician focus on the most serious cause and the second on the most likely cause?

The differences in approaches to this same patient are huge. Many quality improvement efforts aim to assess variations in physicians' practice patterns. But these efforts of comparison are hampered on many fronts; foremost, that different patients, cared for by different physicians, vary in clinical context and disease burden. This blog's story differs, pointedly. The patient variation is gone; the patient is the same, the variation is in the physicians' responses to the patient's complaint.

There is little information about the variations in how physicians approach a patient's diagnostic dilemma beyond aggregate costs of care. This is a deficiency since physicians' variation may surpass patients' variation, as in this situation.

Variations in Care Are Not Fully Explained by Utilization in Care

A search for a diagnosis requires appropriate context. The complaint of “chest pain” has myriad causes; the complaint of “chest pain when jumping into a cold pool that abates as exercise progresses” has a much smaller list of causes. Too often, medical care improvement, safety and science truncate the discovery process regarding important aspects of a patient’s condition when a concerned physician fails, for whatever reason, to capture the nuance that is essential to medical care for an individual.

The second physician teased out the nuances of the complaint via questions and a physical exam appropriate to the contextual clinical situation. While we know, for example, that the physical exam done routinely will likely yield nothing of significance, a physical exam that aims to test a hypothesis based on the full “picture” of the patient’s complaint will bear more fruit.

More information about the value of a physician-patient encounter will always be found in the content of their communication than in what they ultimately do. The difference in these physicians’ behaviors will not be found in any database, electronic medical record, or machine-learning algorithm. I have yet to see data on the contextual information from a history of the present illness in any data set or quality improvement initiative.

Performance Improvement Must Include Both Physician and Patient Communications

We keep insisting on bland, poorly conceptualized ideas about how to improve care. We keep insisting on non-contextualized "data," as if, somehow, that data includes something of value about what is going on between patient and physician. Medical care is a cottage industry of two and can be nothing else. It should be measured as such.

And now, the outcome: The patient followed the advice of the second physician. She changed her routine and now warms up before swimming; her complaint is gone and has not returned. She also changed physicians.

How Focus on Communication Informs Better Care

We assume that current outcome and cost measurement is better because it is informed by objective data—utilization, clinical values, dates, procedures, medications. But this is just a bias toward what we can count and does not describe how medical decisions are really made or how the patient acts.

We need to begin to improve our understanding by soliciting patient and provider feedback, asking specific questions, such as choice of diagnostic tools,and preferences or choices made by the patient. Our process of assessing quality and cost should be iterative and individual-focused rather than just seeking the average outcome.

Likewise, communications should play the central role in how patients choose providers who are a good "fit" for them, and who guide them appropriately through the diagnosis and

treatment of their concerns. That is clearly the direction that patient responsibility—for financial as well as lifestyle decisions—is headed.

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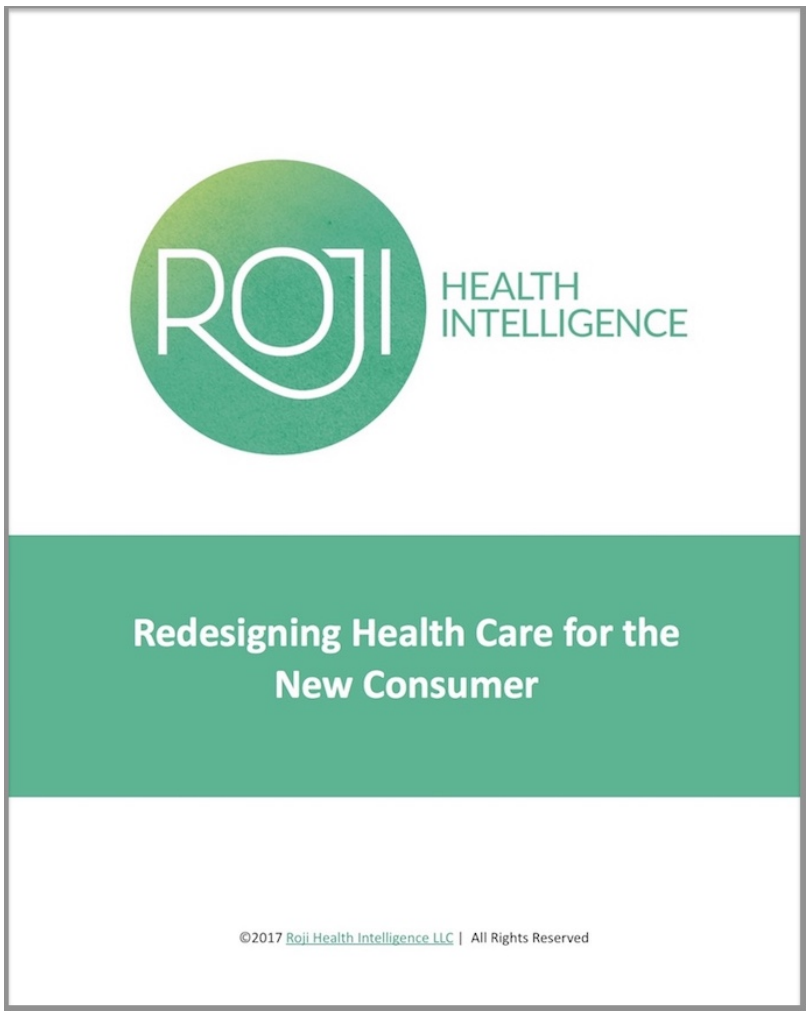
Image Credit: Margot Pandone

Redesigning Health Care for the New Consumer

written by Theresa Hush | November 9, 2017



A consumer-driven culture shift is emerging in health care that will change the dynamics of health care purchasing decisions and impact providers' bottom line.

It is being fueled by policies that are increasing the share of health care expenses paid by consumers. Benefit plans with higher deductibles and copayments, choices narrowed to providers who demonstrate lower cost, restriction of medical services, and higher percentages of premium sharing are just some of the tactics used to control and redistribute costs from health care payers to consumers.

Much of the discussion focuses on the need for consumers to be "better purchasers" of health care. They need to make wiser

choices about lifestyle and health care, and be more engaged in their treatment. All of this makes sense.

This shift also raises a major challenge: Can we provide consumers with the tools they need to make these smarter decisions? Do they have that information now, and, if not, how can we fairly put them in the driver's seat? Are physicians and other health care providers really ready to respond to consumers' needs to direct health care spending—and if so, how?

Health care systems have a lot to worry about if they don't help consumers and share responsibility for good health care decision-making. Failure could result in increased bad debt or, worse, financial loss.

Roji Health Intelligence experts give you the intel on how to prepare for the challenges ahead in our new 65-page e-book, *Redesigning Healthcare for the New Consumer*.

- Find out how consumers are impacted by Value-Based Health Care.
- Understand consumers' key concerns about how to make wiser healthcare decisions.
- Discover what consumers want from providers to help them act responsibly.
- Learn strategies for delivering services that will encourage consumers to engage with you.

Click here to find out more and download your free copy.

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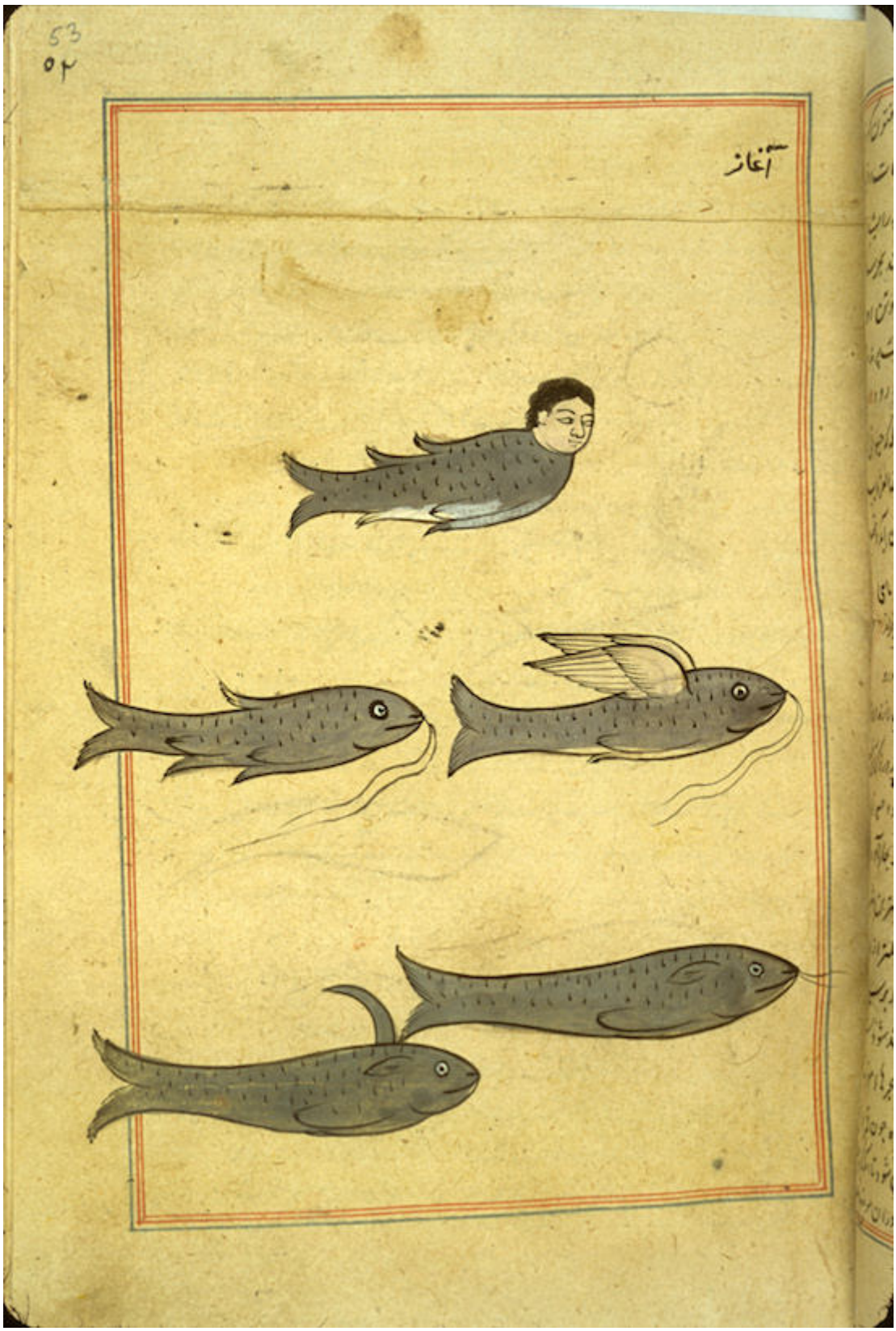
better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Physicians Aren't Engaged in Performance Because Measure Results Aren't Real

written by Theresa Hush | November 9, 2017



According to management guru Peter Drucker, “If you can’t measure it, you can’t fix it.” Quality measurement and reporting have been rooted in similar reasoning. The idea is

that we find out what's wrong, and then we launch programs to improve it.

That's the linear route mapped out by Medicare starting with Meaningful Use, PQRS quality reporting, Value Modifier comparisons, and moving into current MACRA MIPS and APMs.

But physicians have known something for a while that others have been unwilling to accept: quality reporting measures don't give you a foundation for improving outcomes. Why? Because performance measurement does not tell them what they need to know.

Performance Results for Outcome Measures Can Paint the Wrong Picture

When providers are launching improvement projects to gain Medicare MIPS dollars or APM savings, they see that something is missing from the current measurement system. That missing something is enough good information from measure results to show them where the problems lie and where outcomes must be improved.

CMS made compromises in implementing PQRS (that were transitioned to MIPS) to include outcome measures with clinical significance, but that don't go far enough to achieve real value. This is especially true of typical outcome measures for primary care. Look at any intermediate outcome measure, such as blood pressure, and you will see that a once-a-year reading of blood pressure will not tell you anything about the patient's control level.

In fact, blood pressure performance is a perfect case in point.

A review of values across time, even of a single patient, reveals a remarkable variation—often as much as 60 points between high and low values that could have been taken a day or a week apart. The cause could be the method of taking blood pressure, devices or misrecording of data—but the effect is uniformly unreliable outcome data. That same individual patient, depending on whether the value chosen is 125 or 176, could be classified as either well-managed or high risk.

Understand that this happens over hundreds of patients for an individual physician, and thousands for a group. It means that results accumulated for both are inaccurate. Also know that this happens over many outcomes with repeated values, although blood pressure illustrates one of the worst cases of variation. Therefore, improvement activities based on patient outreach, shared goal setting, or even clinical interventions based on such data, is problematic, if it is based on quality measure reporting results.

Outcome data is also the most frequently missing data in retrieved EMR data files. Pain scores, disease staging and complications are among those most frequently absent from much structured EMR data. As a result, the final performance numbers are not complete and not reflective of real provider performance. Real performance is unknown.

Doing something with such performance data to improve outcomes is shaky, at best. Since data is missing or incorrect for individual patients, there aren’t any criteria to assign them correctly to higher risk groups for focused interventions.

Process Measures Rely on Data Capture and Do Not Represent Provider Excellence

Non-outcome, or “process” measures have generally been perceived by physicians as “administrative” measures and assigned to staff to complete. These are measures that simply report that a patient received some service: a diabetic foot exam, in the case of a patient of a primary care patient, or administration of certain drugs within a certain timeframe of a cardiac event. Physicians are almost never responsible for recording results for process measures. They also don’t always see them as legitimate quality measures, for good reason: these measures are usually less a result of performance than of data availability.

Process measures, which are the most common quality measures, usually assume the collection of various procedure codes to indicate the completion of the process defined by the protocol. Since procedure codes are included in claims data, the assumption is that these results are more available—and reliable.

This may be unfounded. Claims-based codes are not universally applicable to all process measures, requiring manual or other forms of retrieval to complete. All process measures are subject to data capture limitations that impair their performance results. Even claims procedure codes can be wrong or missing.

Also, a patient could report to her physician that an exam or test required by a quality measure was performed by a previous provider. If this data is not verified and captured in the record, the current physician will have a lower performance

score. The performance reflects how the state-of-art of data is facility or group-centric, and not patient-centric.

Data That Will Facilitate Physician Engagement—and Propel Performance Improvement

Physicians want to know that their patients have done well and are getting better. Information about patient status must be presented in a way that is valuable for *learning* and *improvement*.

Make no mistake about this: once-a-year outcome values can only be interpreted as scores, and this is how they are used not only by CMS and health plans, but also by physicians' own health systems. Measure results are invariably used to show physicians how they compare to others, regardless of whether that comparison is valid.

With a new anti-regulatory environment in Washington, and MIPS in its first year of implementation, proposals are already percolating to make it streamlined and simpler. Unfortunately, the focus appears to be on easier reporting alone without achieving better value.

But both goals can be achieved: *focused performance measurement, yet smaller external reporting requirements.* That happens by measuring and reporting improvement efforts instead of ineffective quality metrics.

Performance improvement must come from a review of current patients and their outcomes, but it requires a more focused emphasis to be visualized by physicians. Since data is almost always coming from EMRs, especially for the large groups that

will be participating in these endeavors, there is little burden to actual data collection beyond data integrity efforts.

Outcomes and not Process Measures. Process measures should be monitored internally to ensure the use of clinical protocols and evidence-based medicine, but unless they are associated with targeted outcomes or problems, should be separate from performance improvement.

Measurement over time. Since improvement in outcomes should be the real focus, continuous values (blood pressure, BMI, HbA1c) can only be properly evaluated through trends.

Measurement of interventions. Performance improvement by necessity consists of one or more interventions. This could include patient education, shared decision-making, changes in medication, and similar initiatives. Physicians need to be able to see what is producing results beyond anecdotal information by their patients and peers.

Selected representative patient results for learning and investigation. Physicians need both aggregate and individual patient results, but we cannot overwhelm them with data. They should see outcome variations for small numbers of patients who are improving, or not, and those who may have frequent variations.

Data integrity issues in patient information. As in the blood pressure example, physicians should see samples of such widely variant values in their patients, because this likely represents a process that is not working and must be corrected by practice to provide better care. They should also be exposed to conditions where outcome information is missing in the data, so that they can support efforts to improve.

Risk adjusted patients and performance and comparisons with

peers. Physicians want to know how they are comparing with peers, but the underlying data point should be fair. Comparison of the aggregate improvement trend for any outcome and comparison of a physician's trend with the organizational trend are valuable information. But that performance data should have been risk adjusted and should allow or require physician feedback on the results.
Per patient and episode costs. Providers should always negotiate for patient-identified claims data with payers, so that they can use per-patient cost reports and episodic care costs. The aggregate costs should be able to identify in- and out-of-network costs, referral volumes and types, diagnostic tests including imaging, emergency services, and facility costs including inpatient and outpatient services.

The years of focus on reporting measures have discouraged many physicians from performance measurement. Fortunately, MIPS and APMs, along with many health plan initiatives, reflect movement toward performance improvement in both quality and cost.

Providers can adjust the fundamentals of performance measurement and get better data to begin improvements. By evaluating the issues revealed through outcomes and cost, they can launch better future efforts—with physician support.

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Image Credit: Illustration from *Ajā'ib al-makhlūqāt wa-gharā'ib*

al-mawjūdāt (Marvels of Things Created and Miraculous Aspects of Things Existing) by al-Qazwīnī, Islamic Medical Manuscripts from the National Library of Medicine.

Can Academic Medical Centers Be a Force for Health Care Reform?

written by Theresa Hush | November 9, 2017

Can Academic Medical Centers (AMCs) survive Value-Based Health Care and its metamorphosis to financial risk? That’s the question many industry watchers have been asking for several years, as margins have slimmed and some university-based programs have sold off their facilities and physician groups to private interests.

But a number of economic and policy impacts are generating greater urgency regarding the status of AMCs, threatening their ability to continue their historical three-part mission of teaching, research and specialized patient care. While AMCs have been targeted as “high rollers” by those seeking to control health care costs, we should be very concerned about their future status. Why? Because the failure of many AMCs would be a hit for the whole health care system.

Solutions to creating better Value in health care must also include how to evaluate and reimburse the role of AMCs in their specialized endeavors. AMCs themselves also need to learn how to adapt to the economic environment while fulfilling their roles. They must become a *force* for health care reform, not passive participants, if they want to succeed as leaders in their geographic networks. Here’s a plan to achieve that:

AMCs Are an Economic Powerhouse—And an Economic Hot Spot

Recognition of the role that AMCs play is critical to defining their future role. AMCs are economic powerhouses in their communities. They provide a major source of employment for both clinical and administrative staff. They are also a significant player in the medical care system, often the largest provider of charity care as well as specialty services. They are unique because, while their services often overlap with other specialty networks, they often serve patients at higher risk or with fewer financial resources.

AMCs include both hospitals with and without medical schools, each with a separate set of issues. The large institutions with medical schools are research- and resident-heavy, with a

patient mission driven by specialty care. Once at the top tier of the health system with heavy tertiary care capabilities, university-centered AMCs have scrambled for a number of years to recover their "cash cow" market status; their higher cost and lower margins are now a liability. Some hospitals have been sold to health systems or spun off independently, and others have developed alliances within their regions to maintain survival.

AMCs have a special role in the health care system:

> They form the infrastructure for educating and training physicians. This is significant in light of the consensus that a future physician shortage is looming.
> AMCs are the primary conduits for clinical trials and medical research needed to advance medicine and determine cost-effective choices of treatment. They are large recipients of pharmaceutical firm money as well as federal funds for research.
> As tertiary centers, AMCs deliver specialized medicine that cannot be easily transferred into mainstream healthcare institutions—treating rare and orphan conditions, offering highly specialized procedures and treatments, and providing higher end technology. These are also expensive and long-term pursuits, not easily transferred to organizations without large resources or academic structure.

Each of these aspects of AMCs is under attack either by health care reform efforts or directions in modern health care and technology. In patient care, AMCs are perceived by insurers as high cost generators. They generally attract poorer and sicker patients and offer services that others do not; as a result,

superficial comparative data does not always present a positive picture of AMC outcomes in relation to their costs. There are some reasons why these comparisons are unfair. Regardless of these misconceptions, however, large groups such as AMC-employed physicians will remain vulnerable to payers until they make progress on cost reduction.

AMC patient care is also often characterized by fragmented specialty services, lack of coordination among physicians (even if employed by the same entity), and the necessity of the patient to act as his or her own care coordinator. Patients often must fight the "system"—struggling to get access to their records and images, arranging their own care, scheduling their services, and fighting for reimbursement when payers have segmented the AMC into areas that are covered benefits, or uncovered because of costs. These patients must often wade through the resident and attending caste system before reaching the right attending for answers or to make preferences understood. The bureaucracy of AMCs is often unkind to patients.

In addition, AMC research is under increasing public and professional scrutiny for its failure to focus on well-designed studies of treatment efficacy. There are also frequent allegations of collusion in AMC-run clinical trials funded by Pharma and device manufacturers, as well as conflict of interest in papers that promote publication over content. But an even more significant challenge to AMC research is the growing potential for practice-based research as data becomes more available for evaluation of outcomes and efficacy, as well as the development of stand-alone research operations that can facilitate precision medicine fueled by greater genetic

information. Unless they embrace such totally new directions in data-facilitated research, AMCs risk irrelevance.

Finally, the AMC education and training mission has caused concern by its overemphasis on hospital-based training rather than ambulatory, and specialty care over primary. While these are appropriately the domain of professional Boards, because the AMCs realize the value of residents through higher admission volume and fees, the AMC bears the brunt of criticism.

Value-Based Health Care Will Have Impact on AMC Viability

Value-Based Health Care has arrived for both Medicare and Medicaid—heavy contributors to AMC revenue. As a result, the health of AMCs—especially those with medical schools and university hospitals—is under question. With MACRA, the relatively high cost structure of AMCs will make it difficult for them to achieve the best comparative scores among Medicare providers, triggering penalties that could reduce Medicare revenues as MACRA is fully implemented. Similar efforts among commercial insurers to restrict provider networks to lower cost physicians and institutions (the majority of Exchange policies include narrow networks) further isolate academic institutions so that patients can’t use them without paying a higher price.

Affordable Care Act repeal, if it happens, will cut sharply into AMC patient care revenues in addition to support for teaching and research. On top of these pressures are targeted budget reductions, including federally funded research dollars, funds that researchers at university-based AMCs use to subsidize their academic mission.

Past AMC Strategies Fall Short of Needs

AMCs have deployed several strategies over the past few years to unburden themselves financially:

- Spinning off university foundations and being sold, such as University of Arizona to Banner Health, and Vanderbilt University. This moves financial responsibility without necessarily changing the underlying economics.
- Participating in broader clinical integration networks for the purposes of quality reporting, cost reduction and better contracting.
- Developing ACOs, most of which have not generated savings.
- Focusing on the infrastructure rather than governance through purchase of primary care practices, or employing such physicians to build a large patient base.

None of the strategies is sufficient for meeting Value-Based Health Care or preparing for financial risk. Instead of a focusing on concrete performance improvement initiatives, they simply move the problem down the road. Over the long run, the costs associated with AMCs are either distributed across a larger population or absorbed by other providers.

AMCs Can Lead Real Health Care Reform—But Culture Must Change First

AMCs have all the assets needed for regaining a leadership role in creating Value in health care. But it will take work. Here are some opportunities:

- Create Physician Leadership Throughout the Organization for Engaging in AMC Transformation. In hospital-heavy AMCs where

rank and file physicians believe they have become “cogs” in the machine, there must be a turnaround that engages physicians in the future of the organization. That engagement can only happen if clinicians play the dominant role in clinical performance and development of coordinated care programs. Physicians across the organization should be cultivated as leaders and involved in the development of solutions to AMC issues. They will make time for it, if they are inspired and believe that they will be able to contribute.

Ask the Patients and Consumers. The time is past for simple surveys and rote responses to patients and consumers. The biggest transition going on in health care is toward consumer cost sharing and patient decision-making. If AMCs are to succeed financially, patients as well as physicians will make that happen.

Lead the Community in Value-Based Health Care. AMCs should adopt programs to organize VBHC in their communities and help to define appropriate measures of performance and improvement models. By leading the discussion, AMCs can open the conversation with payers and referring groups about issues needing resolution, and create solutions. Lacking these initiatives, AMCs will find themselves on the fringe of regional discussions and be cast as the high cost/specialty center.

AMCs can become ACOs or develop them, but they should do so only if they have the ingredients to make it work, especially an adequate primary care physician base. Without that, the only value to being an ACO is access to Medicare claims data to see how badly they are leaking patients to other providers. With a primary care base, however, AMCs

have all it takes—with physician engagement—to create real continuity of care and care teams that work to resolve patient issues.

Adopt Cost Measures as Well as Quality. AMCs should face the charge of high cost head-on by measuring cost through a variety of tools and across all points of care. One good strategy is to work with a QCDR that can access AMC—and other providers'—clinical and claims data to create metrics and risk-adjust patients. The objective is to investigate the elements that are going into the higher cost of care per patient by condition or procedure, arranged by risk. But this is only a beginning to determine whether there is overuse of services, and this is why a QCDR with cost measurement expertise can be valuable.

AMCs must adopt defensive cost strategies as smaller and more nimble providers offer fringe services in the market. For example, the establishment of freestanding MRI and other radiology services in the community will provide lower cost options to the higher costs that are charged for similar services at AMCs, because of higher overhead.

Use Performance Measurement to Look at Data, but Focus on Performance Improvement. With the overemphasis on reporting quality to Medicare and health plans, there has been an overemphasis on measure results as "scores" of quality. This is a real misuse of data, especially for outcomes that are reported once per year. Instead, AMCs should work with QCDRs to evaluate outcomes over time and determine how to create pilot initiatives that engage physicians and patients in shared responsibility for better long-term outcomes.

Be the First to Create Specialty-based Episodic Treatment Packages, with Pricing. With their concentration of

specialties and other resources, AMCs can realistically develop episodic care packages for building referral business. The coordination of care and communication under these packages is key, as well as the pricing. Episodic packages will alleviate the concern among primary care physicians and others about sticker shock. Additionally, they will facilitate the process of developing interdisciplinary care teams for complex cases, establishment of appropriate quality and outcome metrics, and fair pricing.

Align Teaching Mission with Value-Based Health Care. AMCs have a role in the teaching of shared decision-making processes, care plans that are organized with the patient and caregivers, and an ambulatory-focused approach. Clinicians in training must be made more aware of the costs of health care services.

Pursue Practice-Oriented Research. AMCs are notoriously poor at measuring quality and performance in their own patient populations, and only partly from lack of data from other providers. To remain relevant amidst the tide of new data and new organizations that analyze such data—including Artificial Intelligence ventures—AMCs will need to reconceive their mission to be more targeted on cost and efficacy and more focused on patient care. It is likely that National of Institutes of Health funding will diminish over time and clinical trials will move to different models to test efficacy as well. AMCs that want to continue research must do so because it brings value to their physician researchers and patients.

AMCs can navigate and even lead the way for their communities on Value-Based Health Care. But the deeply ingrained, history-

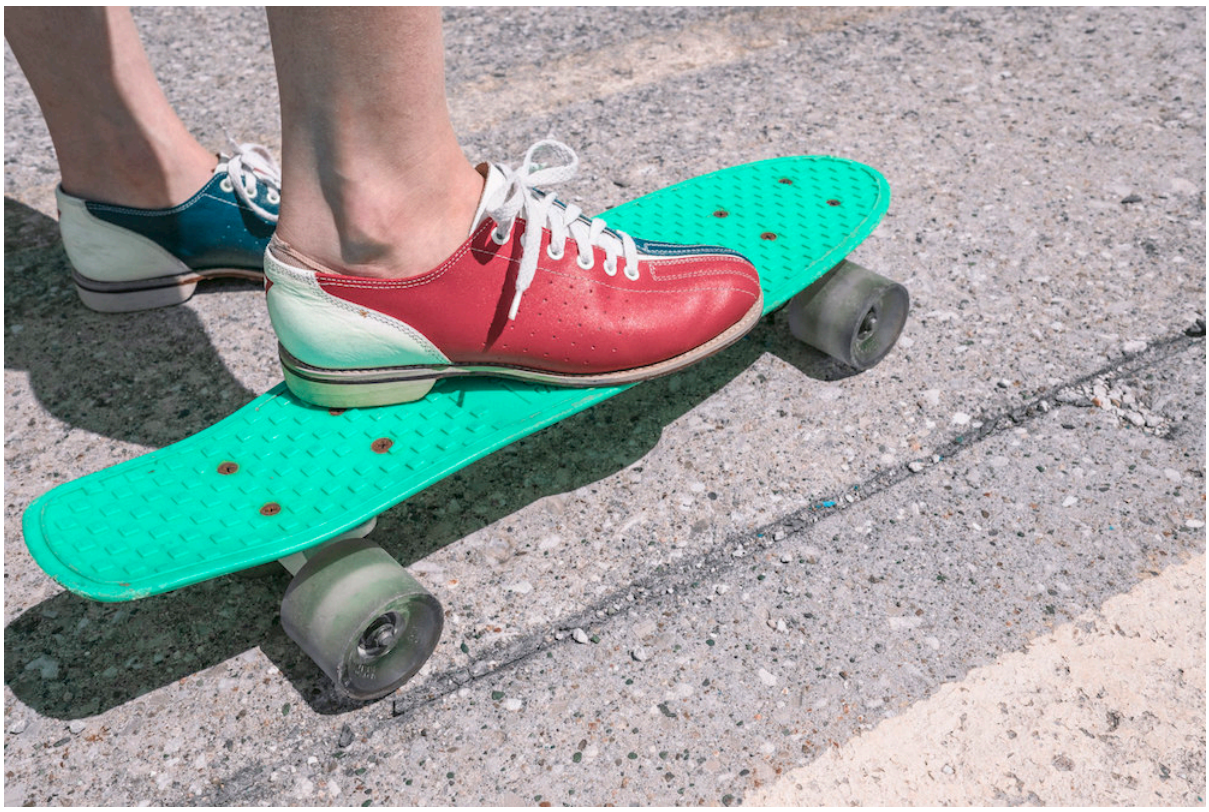
steeped culture in academic medicine must first shift. Currently the three missions of AMCs are in conflict with each other, as well as with external forces. The survival of AMCs will depend on the successful navigation of the unique expertise of AMC physicians as well as the significance of their role *for their communities and their patients*. Like every other part of health care, AMCs are still rooted in their locale. Lead rather than follow, or risk irrelevance.

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: Leio McLaren

October 2 Is Almost Here: Are You MIPS-Ready?

written by Dave Halpert | November 9, 2017



Calendar check! October 2, the last chance to start your continuous 90-day participation in MIPS, is nearly here. Those who meet minimum standards in the “Pick Your Pace” transition year will avoid a whopping 4 percent penalty on their 2019 Medicare Part B reimbursements. Those who exceed these requirements and perform strongly in MIPS stand to earn incentive payments on top of the regular reimbursement schedule.

To make sure that you’re among those who will earn incentives (or at least avoid penalties), take an opportunity to review MIPS requirements, assess what’s in place and close the remaining gaps.

What Do You Need to Report?

There are four components in MIPS, but in 2017, only three will be used to calculate your MIPS composite score. The pieces (and

contributions to the MIPS score) are:

- Quality (60 percent)
- Improvement Activities (15 percent)
- Advancing Care Information (25 percent)
- Cost (Not weighted; feedback will be for informational purposes)

Certain components may be re-weighted when calculating your final score. This will depend on participation in other programs, the type of care provided or the setting in which care is delivered.

Group Practice and Individual Reporting

Providers may choose to report as individuals, or as a Group Practice.

If you are reporting as an individual, you are defined by CMS as the combination of your individual NPI and Practice Tax Identification Number (TIN). Your 2017 MIPS score and 2019 payment adjustment will be applied to anything billed under that combination of numbers. Each requirement is your responsibility.

If your practice reports as a group, you will be scored at the TIN level, meaning that everyone bills under the TIN is scored together, in one composite score. Some providers will play a larger role than others, but in the end, it’s a team effort. If someone in the practice performed an Improvement Activity, the entire practice earns credit. However, this also means that if a practice is submitting a quality metric, that measure’s numerator and denominator must incorporate data from all

charges under that TIN.

In prior posts, we've recommended Group Practice Reporting over individual reporting. The Group Practice Reporting Option (GPRO) is easier to administer, is patient-centric and can help you narrow your external focus. Partnering with a QCDR that can help you report as a group while maintaining individual accountability is the best of both worlds.

Luckily, there's no sign-up required this year to report as a Group Practice, if you're reporting through a QCDR, Qualified Registry or EHR.

Quality

The Quality component of MIPS is scored according to your performance in quality reporting. This is the new look for what was formerly PQRS and a portion of the Value-Based Payment Modifier. The full reporting requirements are that an individual or group practice (reporting through a Registry, QCDR, or an EHR) must report on at least six different measures, and at least one of those must be an outcome measure. If no outcome measures apply, CMS has instructed that another "high-priority" measure is allowed.

To earn maximum points for a measure, participants must provide data on at least 50 percent of the eligible patients. Points are awarded for each measure according to performance thresholds calculated by CMS. A measure can be worth up to 10 points, or as little as 3 points. The latter will occur if a measure has not been reported to the required 50 percent, if performance is poor or if CMS has not benchmarked the measure.

With so many measures missing benchmarks or being “topped out” (performance points are capped by CMS), you should make sure that you have as many reporting options as you can. Avoid finding yourself pinned down to a small set of measures that are “performance prohibitive” by partnering with an ONC-Health IT Certified QCDR.

Improvement Activities

The purpose of Improvement Activities is to demonstrate that your group has actively gone beyond quality reporting or utilizing Health Information Technology, making additional efforts to improve patient care. Improvement Activities are new for MIPS—they weren’t scored under a previous program.

To earn the full 15 percent for your MIPS composite, you must complete between two and four Improvement Activities for a minimum of 90 days. Activities are classified as “medium” and “high,” with the former being worth 10 points, and the latter worth 20. If you are in a group with 15 or more providers, your goal is to earn 40 points (e.g. four “medium” activities, two “high” activities, or a combination). Groups with fewer than 15 participants only need 20 points to earn the full 15 percent for their MIPS score (one high-weighted activity or two medium-weighted activities).

Providers who are engaged in MIPS APMs or who are in accredited Patient-Centered Medical Homes (PCMH) may be exempted from having to attest for additional activities. One of the goals of the Quality Payment Program (specifically MIPS) is to reduce duplicative efforts needed to satisfy multiple programs. In other words, if you are in a PCMH, you have already demonstrated that you’ve performed several of the Improvement

Activities, over a longer period than 90 days.

Remember, Improvement Activities are attestation-based, and you must only answer that you did the activity. If it wasn't successful (i.e. outcomes did not improve), you will not be penalized. For that reason, these activities are an ideal opportunity to pilot a new program. Even if your results aren't what you'd hoped, you're still earning credit for the program and can learn from your experience. Knowing that something did not work is valuable information and can provide insight for future programs. If your efforts are successful on the first try and you're able to improve outcomes or reduce costs, so much the better. You'll see impact in future quality and cost measurements and, more importantly, in your patients. Here's a novel idea: look at specific areas where you've come up short in the past and develop an IA strategy that facilitates meaningful improvement.

Advancing Care Information

Meaningful Use has been repackaged into MIPS, constituting the Advancing Care Information (ACI) category. Like Improvement Activities, these results are also calculated through attestation, but performance will factor into your ACI score.

Depending on your EHR version, you can attest (either with a yes/no or with numerator and denominator results) to performing specific tasks using certified EHR technology. Whether you use the ACI measures (advanced ONC Certification required) or the ACI Transition measures (for those whose systems are certified to the 2014 edition), credit is earned by achieving a base score, worth half of the ACI score, and then by earning a performance score to make up the rest. However, participants

must earn that base score to earn anything in the ACI category. Without the base score, ACI will be zero, regardless of how many performance or bonus points were earned.

Some providers, notably hospital-based clinicians, may be automatically exempted from this category. The 25 percent is reassigned to the Quality score. Therefore, these providers should be especially cognizant of their quality score, as it will be worth 85 percent of their total MIPS composite score.

Is It Too Late? Not with a QCDR

One of the most important benefits of reporting through a Registry or a QCDR is that it is not too late to start. However, as we approach the Fourth Quarter, remember that, just like football, there will be a point where it's too late to stage your comeback.

Since Quality will account for most of your MIPS composite, let's start there. Advanced Registries with the technology to retrospectively collect and process data can still glean a full year's worth of results, even if we're starting later in the year. In other words, even if you don't have an agreement in place until after October 2, it is still possible to create a comprehensive Registry and submit a full year's worth of data.

Improvement Activities and Advancing Care Information are less forgiving, but still feasible. Each must be continuously performed/calculated over 90 days, so if you have not started before October 2, a Registry cannot help. However, if you have been performing these activities and tasks (but have not engaged a Registry quite yet), you're still in the game. Certain QCDRs and Qualified Registries can submit the final

results on your behalf, even though they've not been involved with the process.

The future of MIPS is uncertain, but it most assuredly is the rule of the day. As October 2 looms, do your practice's short-term bottom line a favor, and hustle to get your strategy in place, if you haven't already done so. Do your practice's long-term bottom line and, more importantly, your patients a favor by creating a strategy that avoids "hoop jumping." Build your strategy on improvement, focusing on outcomes and costs over time. By maximizing performance, you'll optimize success in any quality initiative, and will do so by making your patients healthier.

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