CMS Eliminates Episode Groups in MIPS Cost Tracking for 2018—But Providers Should Not

written by Dave Halpert | August 24, 2017

It’s no surprise that Cost is one of the most significant targets of Medicare Value-Based Health Care initiatives, as well as those in the private sector. So it was a real surprise last month to learn that CMS would delay weighing Cost as a component of MACRA MIPS total scoring. Equally significant is the CMS plan to scrap the ten episodic cost measures that were part of the cost calculation for provider groups in exchange for new, “to be determined” versions.

Does this retreat from Cost and episodic costs calculation signal a big shift in the direction of Medicare Value-Based Health Care? In particular, will Bundled Payments based on episodes of care, which have been a major proposed solution to realigning incentives for payments to specialists, be abandoned? Apparently so, according to Dr. Tom Price, Director of Health and Human Services.

An orthopedic surgeon, Dr. Price has previously spoken out

against the Comprehensive Care for Joint Replacement (CJR) model, which has been mandatory in dozens of locations across the country. In September 2016, Dr. Price contended that the CMS Innovation Center is "experimenting with Americans' health" by making the CJR model mandatory. Removal of the MIPS episodic cost metrics (which include hip and knee procedures) is consistent with this narrative.

Cost will count for 30 percent of the total MIPS score in 2019, and new episodes are in development. Regardless of how CMS includes episodes in its cost calculations, however, providers should not be quick to abandon them. Why? Regardless of whether the FFS MIPS Model remains or Medicare transitions to APMs and Medicare Advantage, intermediary ACOs and health plans will likely opt for bundled and episodic payments for most specialty care.

Bundled Payments Can Lower Episodic Costs

Let's start with outcomes. A study published in JAMA indicates that Bundled Payments, which use a pre-determined expenditure for an episode of care, have been successful in lowering episodic costs. In a pool of almost 4,000 patients undergoing a lower extremity joint replacement procedure (the procedures under the microscope in CJR), costs decreased by more than 20 percent over the course of seven years—without impacting patient outcomes. By comparison, expenditures for similar procedures across the country actually increased over the same time period.

Expanded Bundled Payments Model Has Potential for APM Consideration

Medicare may be stepping back from being the industry's change agent, but that does not rule out competition and innovation as forces pushing for improved care. The Centers for Medicare and Medicaid Innovation Center (CMMI) is always on the lookout for new ideas for Alternative Payment Models, and with All-Payer APMs on the horizon, an Episodic Cost-based APM is a solid candidate for CMS review and approval. Bundled Payments are already listed at the Innovation Center, but do not count as an APM—they lack two key requirements:

- Use of Certified EHR Technology;
- Quality reporting on MIPS-like measures.

However, a payment model based on episode groups (like Bundled Payments) does meet several of the Innovation Center's criteria for review, including some supported by the previously mentioned joint replacement study:

- Potential for cost savings;
- Potential for quality improvement, including better coordination and reduction of care disparity;
- Strength of evidence base;
- Number of beneficiaries that may be impacted.

By expanding on the existing Bundled Payments model, an organization has the potential to take control of its own destiny—not to mention the chance to pick up a 5 percent lump sum payment if the project is granted Advanced APM status.

Maintain a Robust Network by Including Specialists

Because ACO quality metrics and cost composites focus heavily on primary care, specialists are faced with a tough decision: Is it better to be left out of an Alternative Payment Model, or to be included, but without the ability to steer? By tracking and evaluating episodic costs, almost every specialty has the opportunity to contribute to a quality initiative, either through the to-be-determined MIPS cost episodes or as an eventual Advanced Alternative Payment Model. This is an excellent opportunity to engage those specialties that have been traditionally left out of Medicare initiatives.

For example, OB/GYN providers have had limited ability to demonstrate performance through PQRS or the Value-Based Payment Modifier, as these programs were driven by Medicare enrollment. Although MIPS does include all payers in quality metrics (unless you're reporting through the CMS Web Interface or through claims), MIPS eligibility is still Medicare-based. However, if your organization is considering an All-Provider APM down the road, analyzing episodes outside of the traditional Medicare population (e.g. childbirth) can bring more specialties into the fold, many of whom are eager to play a more active role in the quality process.

As we saw, the GDP-to-healthcare spending ratio continually demonstrated that fee-for-service was not sustainable. Congress passed one "Doc Fix" after another to prevent cuts, but healthcare spending didn't come down, and it took MACRA to stave off the 21 percent cut that would have been applied through the Sustainable Growth Rate. With MIPS steering towards

risk, and the requirement that more and more reimbursement must come through an APM, creating an APM based on episodic costs can meaningfully bring specialists into the fold and cover their costs.

Patients Will Choose Those With Demonstrable Success

Episodic Payments can help patients proactively budget out-of-pocket costs, which can protect against personal financial catastrophe. They add transparency to a traditionally opaque relationship between dollars spent and quality of care.

Our clients have recognized this, and some have actually posted a fixed cost for an episode. The individual out-of-pocket costs will vary by patient and plan, of course, but the fact that providers are providing this information to be competitive signifies that privatization will not kill Value-Based Health Care. As with any other industry, our clients have recognized that if they can demonstrate that they're able to provide a better product at a lower cost, well-informed customers will seek them out. In this case, the better product is an episode with expected results.

Episodic Cost Metrics Don't Require MIPS to be Meaningful—or Successful

The Episodic Cost model may face an uncertain future through MIPS, but should not be abandoned. An organization committed to lowering cost-per-episode is acting in its own best interests, which are also (as they should be) the best interests of their patients. Both parties can benefit from demonstrable evidence that costs can be decreased without sacrificing outcomes.

Patients will be able to make informed decisions, knowing who has a track record of producing good outcomes, and doing so efficiently. Reducing complications and re-operations should be a great source of pride for everyone in the organization—both providers and administrators—and tying these metrics to reimbursement ensures that those who can produce these results are appropriately rewarded.

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Image Credit: Ja Ma

How to Evolve MACRA MIPS Quality Reporting for Better Physician and Patient Value

written by Theresa Hush | August 24, 2017

Critics are pushing back against Medicare quality reporting, deeming it burdensome and time-consuming to meet confusing quality measures. One survey asserts that barely a majority feel knowledgeable about MACRA or prepared to achieve long-term success. Indeed, CMS is pulling back on program requirements, with the stated desire of making it easier for physicians.

So, here's what should be examined—especially when discussing Value-Based Health Care: Does MIPS Quality Reporting meet the benefit test for the effort expended by physicians and their staff? If the point of Quality Measurement and Reporting is to improve care for patients, can it fulfill that potential?

For Quality Results to Demonstrate Clinical Quality, then Quality Reporting Will Need Redesign

Quality Measurement Results and actual quality are distinct

concepts. For those outside the process, reporting results seem easy to interpret. Good results may appear as clinical excellence, while poor results may appear as if the physician isn't doing a good job. But this interpretation is invalid. The measures themselves, along with variations in practices, populations, and other quirks introduce inconsistencies into reported results. For example:

1. Measures often require single, once-per year values to convey patient status.

The measurement system obtains some good information, but it falls short of achieving a focus on long-term outcomes or improvement over time. Quality Reporting was designed to involve physicians in examining patient data, and we should remember that we are still at an early stage in its development.

2. Reporting is easier for some measures than others because data is inconsistently available.

Actions like the selection of specific perioperative antibiotics are often based on standing orders, requiring little or no effort because collected data almost always includes them. Information systems are designed to drop these CPT Category II codes automatically for these measures and have done so for years. However, there is a downside to this, too—when the clinician's software automatically uses a code that has not been valid for years. The results then appear as if some providers deliver excellent care (when the correct code is dropped), while others do not.

Other measures are written with the assumption that providers have easy access to specific data points. Reports from pathology, radiology and echo labs are often scanned documents, meaning that the EHR cannot simply scoop up the data and transmit it as needed.

For certain measures, it's easier to document the quality action than it is to determine whether the patient is eligible for the measure. For instance, for MIPS Measure #8, used to report whether patients with heart failure have been prescribed beta-blockers, it's easier to document that a patient is on a beta-blocker (and transmit that data) than it is to report that, in addition to a diagnosis of heart failure, the patient also has a left ventricular ejection fraction of less than 40 percent.

These discrepancies are not distributed evenly, and the groups with outdated technology—or none—are forced to commit team members' time and effort to a manual chart review process in order to fulfill reporting criteria.

3. Not all measures account for real life patient scenarios, so reporting negative results is open to misinterpretation.

Measures are designed by different organizations or specialty committees, using different processes, and reporting options may not translate into practice. For example, many measures allow for only two possible responses: a desired quality action was performed or it was not performed. The provider does not have the opportunity to justify the reason for not performing the action—it was either done or not.

Take the case of the measure for pneumonia vaccination (MIPS measure #111), which allows only two responses: patient received/previously received the vaccine (the "performance met" option) or, the patient did not receive it ("performance not met"). Patients who have received hospice care are excluded, but not a new patient who does not recall a November 2017 visit, but brings records to a visit in 2018. Alternately, there is no allowance for coverage by a physician for temporarily treating a patient, such as a patient seeing a provider out of town on a one-time basis, but who plans to follow up later with his or her primary care provider. The temporary provider would not vaccinate the patient without knowing the patient's full history. In both situations, the provider's scores would suffer, while the provider acted appropriately.

4. Performance scoring is based exclusively on reported patients.

Reporting results can be misleading, but performance, even more so. Performance is graded only when the provider reported a measure. So it's possible to have a performance rate of 100 percent based on only one patient, even if one hundred were eligible. That isn't enough to meet MIPS performance scoring requirements, but the discrepancy between completion and performance detracts from meaningful analysis. It's not possible to reasonably compare Provider A's 100 percent performance with Provider B's 80 percent performance, because the proportion of reported patients varies.

To add an additional layer of complication, the same measure may be scored differently depending on how it was reported. For

measures with multiple allowed submission methods (e.g. EHR, Registry or claims), the number of points earned with a 90 percent performance rate on a measure may earn fewer points if submitted through a different mechanism. If the manner in which the information is submitted can affect quality scoring, this rewards the practice for finding the best way to earn the most points through a submission strategy, rather than for meeting quality standards.

While Quality Results are Inconclusive, the Reporting Burden Is Often Exaggerated

The fact is that the majority of practices have EHRs that produce data for reporting either through the direct EHR method or delivery of that data to a Registry or QCDR. There is little actual work—or notice paid—by most clinicians to quality data capture. And, clean-up work is usually handled by staff without involving the physician. It can be argued that the process changes required to ensure that quality measures are met are part of the point of reporting. However, no one can argue that there is no work involved, but it has become easier and significantly less time-consuming.

Accurate reporting, however, does require ongoing review and assessment. Many have fallen into the trap that their EHRs would automatically capture quality data and report it accurately on their behalf, without looking at the details of how the EHR could accomplish this task, and what may be required. As a result, many EHRs have been used differently in practice than the manner intended, with data not captured into the record as data fields. Rather than creating a patient-centric, searchable database, some groups have allowed charts

to include scanned (and not searchable) documents and free-text notes. The data needed for quality metrics is visible to providers, staff and administrators, but does not contribute to measure data or even important clinical data captured in the EHR database. The EHR could store the information, but could not report it.

Specialty-Centered Measures—Intended to be Fair to Physicians—Instead Complicate Reporting

Reporting challenges have been amplified by the vast increase in measure volume. The number of measures in play has significantly increased, especially under MACRA. In 2007, there were only 74 measures for the Physician Quality Reporting Initiative (PQRI), and only three (any three) were required. Since then, we've seen as many as nine measures required, broken down in different categories. Each year, new measures are added, some measures are deleted, and changes are made to others. The process that's being used in one year may not work in the next year, so results can't be consistently compared, either.

If the information needed to report is not readily accessible, the burden falls on those tasked with finding those measure responses: organizations' administrative and technical teams. This drives the process toward finding the information for reporting, rather than improvement. The best performers are the ones who can find the information, since inconsistent EHR use may only shift the burden away from clinicians.

How To Make Quality Measurement and Reporting More Meaningful—and Less Burdensome

Quality reporting can be meaningful, but providers and CMS both have to change how the program works and how it is implemented to make that happen:

1. CMS should clarify and mitigate formulas where comparisons may result from underlying data or measure flaws. If quality measurements cannot realistically compare physician quality through equivalent numeric scores, then formulas that punish providers for not meeting benchmarks should be relaxed. At the same time, however, providers should not get a total pass for failure caused by bad data, without documenting a corrective action plan with their EHRs (or their usage of these systems) to improve quality reporting in the future. Both providers and consumers must get a better explanation of what quality scores represent and how best to use them.

2. Providers must take action to improve their data and systems for performance measurement and improvement. Reported results that assume everyone can provide the same level of detail are unrealistic and will result in inequitable scores. MIPS and Alternative Payment Models give practices the freedom to participate in the manner that they choose, even allowing for variance between groups who are participating in the same program.

3. CMS should bring Cost scoring back into MIPS. Currently, quality reporting accounts for more than half of the total MIPS score, and this overvalues quality scores in a merit-based payment adjustment. By returning Cost to the MIPS scoring algorithm, CMS can combine quality reporting with an alternate

quality determination—expenditures per patient, and per episode of care. This brings balance to quality scoring, by looking at what happened on an episodic basis. Quality can then be measured using a combination of quality reporting and costs. Neither cost/utilization nor quality results, alone, provide a complete picture , but taken together, they help to to identify potential improvement opportunities, which may be achieved through the Improvement Activities portion of MIPS.

4. CMS and Providers should be rewarded more for Performance Improvement. One of the historical problems of quality reporting is that clinicians removed themselves from the process. Thus quality reporting often failed to involve providers in review of data and benchmarks, stifling initiatives for improvement, as well. Providers must recognize that while quality reporting is not going away, the review of outcomes and processes is critical.

Cost data alone does not sufficiently guide improvement initiatives, but the addition of accurate, comprehensive quality information will facilitate the full discussion of value. Population-based care and specialty episodes of care are models of how both cost and quality/outcomes can be measured simultaneously—and eventually compared to others.

5. CMS and Providers should concentrate their quality reporting on a streamlined core of quality measures where improvement is evaluated over time. The overwhelming number of quality measures now in use represents a focus on physicians rather than patients. They also measure single-point-in-time values as opposed to outcomes over time, which present a better view of patient status. Unlike MedPac recommendations in its June 2017

report to Congress, we believe that this data should include clinical EMR data and not just claims data.

6. Providers should focus on creating value from their EHRs through appropriate use, standardization and better education and training. This will mean commitment of resources to investigating how the EHR stores data, ensuring that codes are updated, and that regular education and training are provided to users. Good use of technology will remove reporting burdens from providers. By standardizing what is collected, and how, organizations can shift quality reporting from a burdensome administrative task into a method of quantifying outcomes over time.

7. Consumers and patients must be part of the direct measurement process. Providers need to consider how to incorporate direct patient feedback, as well as outcome data, into quality measurement and reporting. CMS also needs to adopt a strategy that includes these elements in quality measures.

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Image Credit: Robert Lukeman

How to Recognize “Fake” Medical News – And Why It Matters

written by Robert McNutt, M.D. | August 24, 2017

Is coffee good for you? A recent headline suggested that people who drink coffee live longer. Sounds great to me. I drink a lot of coffee, so maybe I will be immortal. But, wait, another

report links coffee to cancer. Dang.

Estrogens were once touted as a life saving elixir for women of elegant ages, until these hormone supplements were linked to increased cancer risk. Wine will either add to your life expectancy or increase chances of breast cancer. But if you are married and have cancer, your outcome is better; you live longer (and can drink more wine?). Eggs either kill you (dropping the value of egg futures) or do not hurt you at all, (prompting a financial rebound in chicken-by-product).

Each study and report alluded to above is erroneous. Indeed, these claims are what I call fake medical news. My definition: if a medical report is either wrong or not provable, it is fake.

When Is Medical News Fake?

Fake news is a hotly debated topic regarding national political reporting. There is a reason I am extending this concept to reports of wrong or not provable medical information: it is imperative that you begin to look askance at most of the medical information presented to you in news reports.

If you Google "how to tell fake news" you will find enough reading material for the rest of your life and will also find, likely, that some of those articles are fake. Some say fake news is defined by intent to deceive; but this is not sufficient in my view. Some industry folks will tout a study on coffee or wine, for example, to boost sales of each; their intent is no less reprehensible than bald, bare, bold-face lying. Time to call a spade a spade.

But, how do we know what medical news is fake? That is a crucial question. Those worried about fake political news have offered suggestions for identifying “fakeness.” Most of this advice focuses on validating sources, verifying claims, determining if the information actually comes from expert sources, discerning if quotes are legitimate or lifted out of context, and researching origins of any visual images to see if they’ve been doctored.

These “rules” from the political news world are not helpful, however, if you are reading medical news. Some of the most faulty and not provable information comes from legitimate medical journal sources or academic centers, include quotes from those excited about their wrong and not provable “research” findings, and provide distinctive, original pictures of their data.

Three Rules For Uncovering Fake Medical News

To uncover fake medical news, we need better rules. Here are three:

> Is the item being reported measurable? (Measurable means that the item is quantifiable and will be measured the same by all, and that the finding is reproducible).
> What additional human traits or actions may cloud or confound the relationship between the item being studied and the outcome being touted?
> How was the study done?

Let’s try out these rules on the issue of whether coffee is good for us or not:

1. Is the item and outcome measurable?

What is “coffee drinking”? Is it drinking coffee black, or with cream and sugar? How is coffee imbibed; at one sitting, over the entire day, gulped or sipped? Is it Folgers in a Can or Starbucks? How much is a lot of drinking? Was the amount of coffee consumed observed by researchers or self-reported? *Science is about measurement, and if you can’t define a measure, you don’t have science.*

2. What additional human traits or actions may cloud or confound the relationship between coffee consumption and life expectancy?

Who is rich enough to drink coffee these days? Is coffee part of a better diet? Was the entire diet/drinking history of each person known and universally recorded? Did the imbibers ride their bikes to the coffee shop, or drink it at home? Are they new to drinking coffee, or have they been drinking all their life? *People vary in many ways; a report isolating one thing from many things about an individual is sure-fire fake medical news.*

3. How was the study done?

Coffee consumption was not randomized to users. The study was observational (people who drank or did not drink were observed and not assigned to being a coffee drinker or not). *Observational, non-randomized studies are nearly always fake, as observational studies cannot prove an independent contribution of the item being studied to the outcome of interest. In other words, if they happen to be true, we can’t*

prove it. Hence, they are fake.

You can repeat these three steps every time you hear a medical report. Estrogens appeared helpful, for example, because the women who took them were healthier than average (confounded; second rule). The same is true about being married and cancer survival; married people are healthier. There is no proof that wine or eggs do anything to improve or harm our health, as all information on wine and egg consumption and their health benefits comes from observational studies, not randomized scientific experiments (third rule).

Bottom line: if any of the three rules identifies a problem, you are reading fake medical news. I find that the first rule—is it measurable—busts many medical news reports.

I am being tough on medical news. I don't apologize. Your care is too important to be left to the chance of un-measurable, confounded and poorly studied information (Rules 1, 2 and 3).

If I were forced, however, to offer a recommendation, it would be that you should not read or watch any medical news. Instead, you should partner with your physician when you are ill and focus on knowing the best information for your medical choices. That is how you will learn and how you will more likely get the best medical advice.

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Why Real Improvement Pays in Your MIPS Improvement Activities Strategy

written by Dave Halpert | August 24, 2017

What separates MIPS from its quality program predecessors? On the Quality Payment Program website, the only component that isn't a reincarnation of a previous program is the Improvement Activities (IA) category. Although the IA category has a smaller weight than the Quality category, it has the potential to be just as important, if not more so for your composite MIPS score.

How can 15 points compare to 60? The answer lies in the way in which those 60 points are earned. It also derives from a fundamental flaw of CMS quality reporting initiatives, to date.

The Problem: The Focus On Reporting Has Led to "Flat Line" Outcomes

A long-term emphasis on reporting has marginalized the importance of performance—specifically, outcomes, adverse events and disease progression. CMS began utilizing the AMA's

CPT Category II codes for tracking quality metrics more than a decade ago, as a part of the Physician Voluntary Reporting Program (PVRP), which morphed into the Physician Quality Reporting Initiative (PQRI). PQRI started small, encouraging providers to report on quality metrics. Those who did were rewarded with incentive payments, and those who do not were simply passed over.

Performance and improvement were not factored into incentives—these early iterations were the building blocks of an eventual risk-based program. Improvement came from providers' intrinsic desire to get better, with a little bit of the Hawthorne Effect (knowing that you are being observed is often enough to change behavior) thrown in for good measure.

As PQRI transitioned into the mandatory Physician Quality Reporting System (PQRS), those of us who would become Qualified Clinical Data Registries developed analyses and tools for benchmarking quality data across practices, providers and networks, as well as tracking outcomes over time. With our clients, we created programs from quality reporting results in order to improve outcomes, close gaps in care, and identify at-risk patients before those patients incurred high costs.

The challenge was this: Without a requirement to enact additional quality improvement projects or a penalty for maintaining the status quo, not all quality departments could make the financial case to their leadership for the necessary resources. This was particularly true when resources were committed to activities for private health plans, which were tied to performance.

As expected, those who put their efforts into fulfilling requirements have been successful reporters, but have not seen the improved outcomes and decreased costs experienced by those who have focused on outcomes and successfully intervened. In MIPS, flat-line outcomes have put organizations in a bind—they are hard pressed to find an outcome measure with superior performance, and have discovered that a disproportionate number of their long-standing process measures are "topped out" and worth only a fraction of the possible total. In short, a long-term reporting strategy has put the MIPS category worth the most points in jeopardy. Without a plan to stop the spiral, your group will continue looking for superficial fixes that will not address the problem—and the bill will come due.

The Solution: Leverage the Improvement Activity Requirement to End Stagnation

Maintaining consistent year-to-year reporting and performance may have served groups well in previous years, but is no longer sufficient. Demonstrating exceptional performance under MIPS is far more challenging, and those who have been living by the "report, repeat" philosophy will find that performance deciles and "topped out" measures have deflated previous results when scoring performance.

At first glance, the IA category may not contribute as much to the MIPS score, but only if you consider it in a vacuum. When reviewing Improvement Activities as they relate to patients' health and providers' MIPS scores, understand this: Without strategically selecting and performing your activity, MIPS will continue to be a yearly jump through administrative hoops. There will be no benefit to your patients, and the same year-

to-year results will eventually lead to penalties, as the playing field becomes more competitive. Although CMS may only be looking for a “Yes” when it comes time to attest that you’ve done your Improvement Activity, you should view this as more than a “check the box” program requirement, and should avoid taking shortcuts (i.e. attesting for an activity that you are already doing). This is an opportunity to use this requirement as a stepping-stone toward improved outcomes.

The Plan: Use a QCDR to Identify Opportunities, Track Results and Earn IA Credit

Your goal should be to ensure that your Improvement Activities meaningfully contribute to your performance, rather than simply drain administrative resources. To that end, the first step is to select an activity that addresses an issue you’ve identified—and to recognize that it may be a challenge.

Finding the Right Patients, Helping the Right Way

A Qualified Clinical Data Registry can help identify these deficiencies. For example, you should be able to view your current measure performance on demand, and be able to view any measure with a Registry Reporting option, and, if your QCDR is ONC-Certified, see EHR-based measures, as well. Grouping all of the outcome measures together, you’ll clearly see where to focus your efforts. Do patients with hypertension have controlled blood pressures? Do patients with diabetes have controlled Hemoglobin A1c? If your performance in these measures is in a high decile, that’s great news, and an indication that you should focus your efforts on another set of patients. If performance is low, you’ve identified a population

that can benefit from intervention.

Reports from CMS and CAHPS Survey vendors are also helpful when identifying potential areas for improvement. QCDRs can pinpoint opportunities here, as well. Analyzing your Quality and Resource Use Reports (QRURs) against your practice's data, a QCDR can help you identify which patients are contributing to higher episodic costs, ambulatory care sensitive condition admissions, and more. A QCDR can also utilize CAHPS Survey data by creating customized templates for collecting and trending patient feedback and comparing results.

Once you have identified your target population, the next step is to identify actions that you plan to take and define how these steps will fit into your workflow. Start with a small subset of patients before full deployment. Your QCDR can track the results on this group and provide you with a mechanism to record what has worked and what has not, either logistically or clinically. If the results are favorable, more providers and patients may be added to the activity. If there are no changes (or things get worse), examine the results with your QCDR to determine what changes are necessary prior to expansion.

With a QCDR, Your Activities Translate Cleanly into IA Points

Of the 92 available Improvement Activities, QCDR use is a required component for 13 of them. That isn't to say that you cannot use a QCDR for others, but that some have been explicitly designed for practice-QCDR collaboration.

The key is to track the results and learn from them, rather than merely to carry out a project for the sake of an

attestation. In the previous examples, the goal is to bring hemoglobin A1c and/or blood pressure under control. Not only will these improved intermediate outcomes bring you up into higher performance deciles for two challenging outcome measures, but they also reduce these patients' risk of complications, hospitalizations or worse.

This is what makes the Improvement Activities so valuable—the point value of the activity may be comparatively small, but the effect the activity has on Quality and (eventually) Cost will be what separates those who do well from those who reach the "Exceptional Performance" Category. More importantly, IAs have the potential to affect the lives of the people behind the MIPS points—the patients. Lowering blood pressure or hemoglobin A1c can slow (or curb) disease progression, reduce hospitalizations and cut patients' out-of-pocket costs. Strategic selection of activities with a well-defined purpose and plan can tighten the bond between better scores and better care.

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Image Credit: Michael Prewett

It’s Not What We Don’t Know That Hurts Us: It‘s What We “Know” That Isn’t So

written by Robert McNutt, M.D. | August 24, 2017

Making a decision is a—or really—“the” fundamental activity of

life. The decisions we make, the consequences of those decisions, our feelings about the consequences, our interpretation of whether we made a good or bad decision based on those consequences, in total, form the basis of our life's experiences, and, often, how we decide the next time.

My children used to say, "Duh," to my muttering an obvious observance like, "It sure is hot today," because the temperature just hit 100 degrees. The opening sentence of this blog may seem so obvious that it may trigger a similar response.

Making a decision in medical care is, however, not a "Duh" experience. It is a difficult, sometimes grueling experience. In fact, it is so grueling, that many people resign their responsibility for choosing to others, like their physicians. Making a decision is tough, for certain, but the process for making a decision should be routine, or, at least, "a" routine.

The routine is this: when you are ill and a diagnosis is made, you will have options for treatment. The options must be compared in terms of how much benefit they impart and how much, simultaneously, harm they produce. The key word in this last sentence is, "compared." Medical decision-making is a routine of comparing one option for your care versus another.

We Must Understand the Real Tradeoffs Between Treatment Outcomes and Doing Nothing

Medical researchers study the outcomes of diseases. There are consequences when you have a disease. For example, your disease may threaten your life expectancy or your quality of life. Medical care aims to reduce the chances of those detrimental

outcomes. Some treatments may be better at reducing the chance of the disease-related outcomes than another. There will be, hence, a difference in the percent chances of outcomes. You must know how big that difference is.

But, here's the rub: a treatment that reduces, compared to another, the chance of detrimental outcomes associated with disease almost always produces added harmful outcomes caused by the treatment. When a patient learns the differences in both the outcomes of disease and treatment, she can assess if the value to gain in terms of disease outcomes is worth more than the value to lose from treatment outcomes. That trade-off is the essence, the routine of medical decision-making.

A brief, classic example may clarify—treatment for early stage prostate cancer. Surgery, compared to no surgery, reduces from 8 to 6 percent the chance of dying of prostate cancer over the next 10 years. The benefit is the difference, or 2 percent. On the other hand, surgery increases the chance of being impotent from about 10 percent to 60 percent; a 50 percent added difference, or harm. That is a 2 percent (benefit): 50 percent (harm) trade-off, or 1:25. In other words, harm is 25 times more likely than benefit with surgery, but benefit outcomes are life/death, and harm outcomes affect quality of life, not length. That is a tough balance choice to make, but the numbers of added benefit and harm inform the value debate for a patient.

No Medical Choice Should Be Made If Nothing Is Known

These trade-offs, in fact, are a requirement for making a medical decision. The marginal differences in outcomes of

disease and treatment are based on science, hopefully appropriate for an individual's choice, and required in order to balance one option versus another. Without those known differences in outcomes, no choice can be made, as no appropriate routine for choosing is available.

That is a radical statement in medical care, so I will say it again; no choice can (should) be made if nothing is known. Physicians often ask me, "What if I don't have the data?" By this they mean that they do not know if there is a difference in disease outcomes because definitive studies have not been done. In that situation, no comparison of treatments can be made and, hence, no decision. This includes doing nothing versus doing something for a patient. Before any decision can be broached, there must be knowledge about how much better is doing something over nothing, for instance.

It is said that only about 20 percent of medical interventions have been studied in rigorous randomized scientific designs for us to know the numbers of benefit and harm. I don't believe this number. First, we don't really know how many possible interventions or combinations there are; any given disease may have only a limited set of options available and many treatments don't require a randomized controlled trial to know they work. For example, the effectiveness of the polio vaccine was so obvious, we did not need a randomized study. Some treatments provide obvious benefits because they are nearly 100 percent effective. My point is that, in reality, we know more about the benefits and harms of treatments than just what the randomized trials tell us.

However, some use the 20 percent number to legitimize the need

to suggest untested choices for the other 80 percent of the possible options for care. Some assume, even, that they can "intuit" what is better and offer based on beliefs. Belief-based decision-making is not new; but it is a different routine. It only uses values without knowing anything about the marginal differences in numbers of outcomes, much like the debates regarding health care in Washington, D.C.

If the title to this blog is correct, it is better to not know and not act than to act. Medical care must be a science. Patients must be the decision makers but it is our job to make sure they have evidence upon which to base their choice. So, if we don't know what is best, it will always be better to study our ideas rather than treat based on our best guesses. Perhaps, one of the reasons medical care is so expensive is that many of the things being proposed are assumed to benefit when they do not. When we don't have a known trade-off, we can't inform patients, and making decisions without knowing leads to valueless care.

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Image Credit: Cindy Tang

The Future of MACRA: Will MIPS Survive?

written by Theresa Hush | August 24, 2017

Will MIPS survive as Medicare’s overarching performance measurement and improvement program for physicians? That’s the question as providers finalize their plans for meeting requirements in 2017 and beyond.

MIPS Is in Adjustment Mode

MIPS is undergoing a significant transition.

How do we know? First, the ink is hardly dry on the huge rewrite of various Medicare Value-Based Health Care programs combined and streamlined through the MACRA Final Rule in October 2016. That rewrite replaced PQRS, the Value-Based Payment Modifier and Meaningful Use with a Merit Incentive Pay System (MIPS) for physicians. Yet, while MIPS is still in its initial implementation period, the new administration has floated a 2018 proposed rule with relaxed requirements.

That was just the first signal. This week, CMS announced a proposed 50 percent retroactive reduction in penalties for providers' failure to meet previous year PQRS and VBPM standards. Keep in mind that the time period for activities are long past completion, so the CMS action forgives providers for what they didn't do. That is a clear sign that CMS believes providers were treated unfairly and intends to rebalance the program.

CMS has also pledged future changes in the MIPS quality reporting program to reduce the burden for providers. In a period where there is a clear political desire to reduce regulation and the size of government, the complex Value-Based Health Care carrot-and-stick program is likely to undergo big changes.

Can MIPS as Originally Designed Meet Its Goals?

Regardless of the political agenda, there are legitimate questions about whether all the requirements of MIPS track to

the achievement of benefits in Value-Based Health Care. One question is whether the Quality Reporting program can produce good information to compare provider quality. There are many reasons why this has proven more difficult than planned, not the least of which is the fact that QR is founded on an idealistic assumption about the quality of data.

MedPac, a nonpartisan agency that advises Congress on Medicare and has promoted Value-Based Health Care efforts, agrees that MIPS quality reporting as it stands may not be meaningful for consumers. The organization recently released a report on why the quality program will not meet the goals of identifying high value providers by comparing physicians. Among its charges: too many quality performance measures make it impossible to compare physicians, all of whom have freedom to choose different quality metrics. The truth of this is irrefutable.

To be clear, however, there was never a CMS claim that physician quality results could translate into meaningful comparisons between all providers. As both provider systems and commercial carriers have adopted programs to incentivize providers or to create narrow networks, they have often turned to quality or cost scores as part of incentives and compensation. They did this because they needed some objective measures to distinguish between providers. Likewise, the CMS Value-Based Payment Modifier included comparisons of group quality scores and cost attribution, implying that the use of scores in provider rankings was a credible practice—even as it has proven flawed.

The Cost component of MIPS also has potential issues with achieving its intent. Without adequate definition of key cost

drivers, Cost becomes an non-actionable comparative mechanism that does not promote change. CMS correctly removed episodes of care for this reason; each actual episode type did not align well with significant cost drivers in health care. But much more will be needed in the Cost area to facilitate provider understanding of how they drive cost, what part they play in the total delivery of health care to their attributed patients, and how costs associated with patient populations differ.

One of the key expansion areas under MACRA and MIPS was to include all patients (including those with private coverage) in quality reporting and to prepare the way for all-patient ACOs and universal quality measures. These are positive directions that must be pursued—eventually. Currently, however, these initiatives suggest an overly idealistic view of the integrity of existing data coming from clinical and claims systems—and the capture of essential outcome data at the point of care.

Is Provider Engagement in MIPS the Best Goal for Achieving Value?

MIPS Quality Reporting and Cost components reflect an ambitious effort to get spending under control and hold providers' feet to the fire to do it. The concept of "Value" is still not thoroughly defined as a concrete formula by CMS or any other insurer. We know that better outcomes and processes and lower costs come from getting more for the health care dollar, but what we are measuring and how to tally up the value of individual providers remains elusive.

Not elusive, however, is the MIPS process. Providers were disengaged from the details of PQRS reporting and calculation of their costs under the CMS Value-Based Payment Modifier. As a

result, there are little if any benefits from these programs. The MIPS program is so much more robust, placing performance rather than simple scores front and center. Perhaps the real benefit of MIPS—and its ultimate goal—is the engagement of providers in the process of measuring and improving performance.

Performance Improvement Activities—Instructed or Guided by Financial Risk?

New to MIPS is the significant push for providers to make systematic improvements to cost and quality performance. In Fee for Service (FFS), there is no built-in incentive for providing less costly care. The fact that such improvement efforts must be part of a scoring system says a lot. This approach can also push the Quality and Cost measures into a better context; they should be used to start the dialogue for improvement, not reward or punish providers.

It also is interesting that CMS has gone to the effort of categorizing and assigning points to various activities. To some it's a bureaucratic burden. But to others, it demonstrates a lack of trust in providers to launch significant performance improvement activities on their own. CMS took its lesson here from private health plans, which have defined incentives and delivery requirements in the name of lower costs for years.

While the de-regulation agenda may well result in changes to the Performance Improvement component, the question at that point is really the survivability of MIPS as a whole. There are other ways to accomplish a program that motivates providers to achieve improved cost and quality performance. The strategic incentive that underlies MACRA as well as MedPac

recommendations: financial risk.

The dismantling of MIPS provisions, if they continue to occur, will be followed by a program that moves swiftly toward financial risk. That financial risk may occur through increased provider ACO development and participation, or through Medicare Advantage plans. Under either scenario, providers will rapidly need to embrace quality and cost measurement along with performance improvement to survive. What's the best way to go about that? Hmmm, let's see . . . through a strong and full-fledged MIPS effort.

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: Romain Peli

Narrow Networks and Rationed Health Care, Version 2017

written by Theresa Hush | August 24, 2017

For decades, our nation’s health care system has been highly valued for its bounty. Access to the most advanced technology, surgery and expertise has been a point of pride.

The concept of rationing health care, by contrast, has been taboo. We accused the British of rationing in their universal health system when people had to wait for care or couldn't get specialty services. We proudly counted the number of Canadians crossing the border to get cardiac surgery in this country. Oregon was accused of rationing when it released a list of prioritized health services under its health system, and the label of "death squads" was attached to attempts to evaluate medical effectiveness in the original Affordable Care Act (ACA) proposals.

But that was before health care became impossibly expensive for business and consumers.

Health Care is Now Being Rationed by Default and Obscure Design

Today the health care system's bounty is in process of contracting. That's because rationing has slipped in under the radar. Not all rationing is understood by providers in the industry, and much is hidden from consumers and employers.

At one level, most of the public is waking up to the debate about consumer access to affordable coverage. Repeal of the ACA could effectively ration services based on the individual's ability to pay. But at least (in theory) a public forum will determine the outcome of the Congressional debate. Consumers essentially voted in favor of this policy shift, whether they fully understood it or not.

Less clear is how services will be rationed as a result of limiting benefits and loosening requirements for health insurers to cover pre-existing conditions. This issue is not

limited to individuals seeking health insurance coverage through exchanges, since employer-provided insurance coverage is subject to ACA rules. But if that insurance excludes certain benefits that the employee suddenly needs, the employee no longer has access to those services.

Narrow provider networks also represent rationing, and this is largely invisible to consumers. Invented by health plans to exclude certain providers solely on cost, narrow networks, by definition, include lower cost hospitals and physicians. But we shouldn't mistakenly confuse this with value—by defining the network on the basis of cost alone, many academic systems and specialty providers are excluded.

Narrow networks are accomplished by negotiations between health plans and provider networks, which are consummated throughout the year. Consumers may be caught unaware that their choices are being limited in the process, or may not understand the implications of limited provider choice in their benefit plan, especially since they can't always predict future service needs. A health plan may also change its benefit network after a company's consumer benefits choice period is completed. There is often no easily available information for consumers to compare provider networks, and no guarantees of care for those whose needs change outside of benefits choice periods.

New Narrow Networks Limit Providers More Severely

Under the ACA, Health Plans' narrow networks became more prominent as a way of creating lower premiums. Employers were quick to identify potential savings by adopting them, since ACA plans are sold to employers, too. Significantly, the majority

of plans offered in exchanges are now associated with “narrow networks,” or lower cost providers. In fact, 75 percent of ACA plans in 18 states were projected to have narrow network plans in 2017. According to one study, however, 26 percent of those who purchased coverage from the exchange policies *did not understand that they were purchasing coverage with a narrow network.*

The trend has its proponents. Blue Cross plan officials support the shift toward narrow networks because research does not demonstrate that high-priced hospitals score better in quality measures. However, quality measures reflect only the most basic data and do not adjust for vastly different populations across providers. Performance measures historically do a poor job of realistically differentiating between results for highly complex patients and poor socioeconomic populations.

Nonetheless, the push for narrow networks appears to be gaining momentum, at the expense of access to specialized care. A recent study by University of Pennsylvania researches indicates that narrow networks may drop coverage of providers at National Cancer Institute Designated Cancer Centers in order to control costs. Academic and specialized hospitals with higher cost structures are also often on the chopping block as narrow networks are created. The survival of research and teaching institutions will be called into question if solutions cannot be found in the system or these organizations.

For employers and consumers alike, one of the most confounding problems is comparing networks and benefit plans during the annual insurance renewal process. As mentioned earlier, the provider list is hard to obtain and it is almost impossible to

compare the full scope of coverage. Narrow networks implicitly limit services because not all services are available from all providers; furthermore, in many cases, the need for certain subspecialty services can't be identified ahead of time. Insurers do not track providers at this level—and actually would prefer that their networks not be so attractive to patients who would need very costly care.

Best Provider Strategy for Managing Network Participation

Providers must have not only a negotiating strategy, but also an underlying cost and quality performance strategy for your market. The days are gone when any provider can command network participation simply because you offer unique services, such as pediatric specialty care. Most employers require employees to choose between a tightly constricted plan or a higher price plan—and will offer both. But that ensures a sicker population of patients for higher cost providers. If you are that provider, you will also have a harder time achieving attractiveness to narrow networks in the future, since your costs will go up.

How to respond? Create a systematic plan that will improve your long-term position in a market that is quickly distinguishing providers based on cost:

- Establish cost performance measures for both facility and professional costs.
- Increase your quality performance by a broad system of quality measurement and improvement—you need your profile to reflect not just cost, but also the full spectrum of your efforts to improve outcomes.

Negotiate with health plan to capture full claims information on primary patients whenever feasible, as well as other comparable cost data, and populate this data in technology for analysis.
Participate in the full MACRA MIPS suite using a QCDR, for maximum flexibility and power to target quality and cost performance. If a provider does particularly well, this success can be leveraged in negotiations with commercial payers.
Establish marketable bundles of care to consumers who are price-conscious and looking for information, such as care and procedural episodes, provision of price and cost data.
Engage and solicit consumer input and develop shared decision-making processes. Help your patients ask questions and participate in the process on their terms.

How Can Consumers Navigate Network Choices?

Consumers have a much more difficult task because you must make decisions among predetermined coverage options. But you should be vocal about what you need both before and after the choice process. Become more active in both coverage selection and managing health care choices after coverage:

Organize or participate in health plan selection processes.
Request information in detail about network providers, access to highly specialized services, and options in the event you need essential care that is not available under the plan.
Become knowledgeable about your health care status and conditions. Ask providers to be involved in a dialogue about tests and treatment that will lower costs.
Request quality measure data, including specifics on quality

measure results that apply to you. You should know how your major health outcomes compare to other patients—and what you can do about them.
Ask for cost information and prices. You have a right to know what you will have to pay, and what might not be covered.

Providers and consumers can work together to create benefit plans that focus on both quality and costs. Unlike the previous era of managed care, where data was sparse and increases in health care costs were more willingly borne by employers, there is a clear possibility that both groups of stakeholders will have greater motivation to collaborate on solutions that will achieve lower costs and greater flexibility to achieve better outcomes for patients.

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Image Credit: Paul Dufour

Who Will Fill the Leadership Void in Health Care Reform if MACRA Rolls Back?

written by Theresa Hush | August 24, 2017

Amidst the political cacophony over health care coverage for American consumers, a fundamental question has been relegated to a soundbite: How can we control cost? Everyone (in the industry or participating in the debate) knows that cost drives our health care system problems, including affordable insurance coverage. The fallacy at the heart of all the wrangling is that we can address coverage affordability without confronting cost.

But doing something about cost in a de-regulation environment is exceptionally difficult. That is why we are finding ourselves in the midst of both a MACRA implementation and a likely MACRA Rollback. And no leader has yet to emerge to get us out of this mess.

Is Reducing Cost of Health Care Too Hard to Do?

Reducing the cost of health care has proven to be staggeringly hard. No one has been willing to step into the leadership

vacuum, because the actions required to fix health care affect business, providers and patients, and carry huge political risk. Just examine this list of various experts' health care reform requirements to reduce cost, and you can see what's at stake:

> Revise educational financing for the physician workforce to reduce their debt burden, prompt better distribution of primary care and specialty physicians, and lower costs;
> Address oversupply or maldistribution of facilities that result in higher usage, including hospitals, outpatient surgery and diagnostic facilities, and emergency/urgent care;
> Control the supply and use of medical technology;
> Shift provider compensation and reimbursement away from fee-for-service, to realign incentives for appropriate care and better outcomes;
> Limit malpractice liability and limits;
> Reconfigure funding and conduct of medical research and clinical trials to create a provider- and consumer-accessible knowledge base on treatment effectiveness;
> And (lest we forget that the beneficiaries of the system are also affecting cost) create financial incentives for lifestyle changes, prevention and cost conscious decisions by health care consumers.

Government as Leader in Controlling Costs?

In the 1990s, the private sector—both insurance carriers and providers—spearheaded change in health care policy. This included efforts to control costs by negotiating rates with cost-conscious providers, developing models such as HMOs and PPOs to create risk for providers, creating utilization control

mechanisms, and instituting benefit plans that included health care spending accounts and well-care incentives. At best, these market-based initiatives slowed the increase in costs.

But the private sector, alone, couldn't fix the problem. Supply grew and costs continued to rise. HMOs became hugely unpopular, and capitated plans disappeared. Large employers self-insured their plans, so insurers transitioned to administrators rather than medical managers.

In response to projected budget deficits, the federal government, namely CMS, and some states' Medicaid programs began to assert more leadership in changing the health care system. CMS took on the Value-Based Health Care discussion and regulated PQRS quality reporting, Meaningful Use, and other reimbursement incentives, such as the Value-Based Payment Modifier.

The Affordable Care Act was a further attempt to evoke changes in the health care system. ACA programs included Accountable Care Organizations, incentives for quality and cost performance as well as interoperability, and measurement across all providers. Many provider systems scrambled to form ACOs, despite the high initial capitalization and uncertain payback.

MACRA cemented the focus on moving Medicare to a risk-based program through APMs, such as Advanced ACOs. Now in its first year, that program is already being revised for future periods, as competing drives for regulatory relief and health care reform clash in Congress.

Did Flaws in the CMS Approach Inhibit Effectiveness?

Even under strong CMS leadership for Value-Based Health Care, ambiguities in the approach and design flaws persisted. Implementation included new guidance and concessions to stakeholders that undercut the program's meaningfulness.

The most significant problem that resulted from the CMS approach, however, was the unintended perception of the programs as regulatory- rather than outcomes-oriented. PQRS Quality Reporting, despite much emphasis on specialty-approved measures from the then-AMA's Physician Consortium for Performance Improvement (PCPI), was viewed by providers as a check-the-box exercise rather than a serious quality program. Few outcome measures, too much focus on number of measures, new categories of measures every year, annual changes in measures—all reinforced the sense that PQRS was about meeting requirements rather than providing better care. This perception was compounded by organizations levying unfair penalties on providers with poor PQRS scores, with no risk adjusting or data validation.

The Value-Based Payment Modifier (VBPM), which compared cost and quality of each provider group with peers, was barely known by the entire provider community. Even though VBPM affected provider reimbursement, the fact that CMS acted alone in creating the formula limited provider awareness—and program effectiveness—even as it was arguably the strongest component of the overall Medicare VBHC.

MACRA Starts and Stops

MACRA is, undeniably, both ambitious and complex. Overall, it achieves a better integration of programs that leads to a better match to the goal of VBHC, a higher focus on improvement, and some excellent long-term planning for all-patient ACOs.

MIPS quality reporting, however, is even more complex than PQRS, making it difficult to comprehend quality reporting success criteria. This is one of the factors that led to MedPac's recent paper suggesting a redesign of the MIPS program.

Yet MACRA has more problems than just quality reporting complexity. Before the ink was dry on final regulations, CMS essentially relieved providers from meeting requirements in the program's first year, designating 2017 as "Pick Your Pace." Although most providers had ramped up technology and spent years in quality reporting and various improvement programs, the retreat was justified as "too much, too fast" due to fourth quarter adoption of rules.

This June, CMS has relaxed regulations for 2018, as well, on several fronts; most importantly, the Proposed Rule excludes a number of providers and indicates that further streamlined quality reporting is on the way.

Swinging the pendulum on requirements never bodes well in health care. Uncertainty creates inaction, which will have serious consequences for cost reduction.

Who Will Step into the Leadership Vacuum?

Recent CMS action indicates a major redefinition of how it may approach VBHC in the future. Rather than a strong regulatory approach, we will see more responsibility shifted to the private sector. CMS may not establish a health care reform policy direction; more likely, it may retreat to its more traditional role as a governmental insurer of health care. In other words, we will see a more constrained CMS.

So who will fill the leadership role to make health care affordable?

Health care consumers.

The reality is that, instead of addressing health care costs directly, all current or proposed programs in Medicare and the private sector are looking to the consumer to bail them out on costs. Common to all proposals are fewer required benefits; less available coverage; higher deductibles, copays and premium costs; topped off by more emphasis on "patient responsibility." Let there be no doubt. Short of a drastic change in policy and political will, the consumer will be paying health care bills in the foreseeable future.

And that means those consumers will become smarter and much more demanding. Their needs and ability to pay will be driving and restructuring the health care marketplace. In response, forward-thinking providers should be organizing their services in packaged episodes to market and better deliver value.

Providers who hope to wait out the uncertainty should consider this: Consumers will be a much stronger force than government

regulation, once they get their bearings. Here's my list of what you should be doing instead of rolling the dice on your organization's economic survival.

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Image Credit: Jason Rosewell

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10 Takeaways from the Proposed Rule for MIPS and APMs Year 2

written by Dave Halpert | August 24, 2017

We are already more than halfway through the initial year of Medicare's new Quality Payment Program, which includes MIPS and APMs. Yet already we are seeing some changes from the new administration that will relax requirements for providers, eliminating the need for some to participate and making quality reporting, in particular, easier.

Regardless of how Medicare plays these rules, top providers should maintain a strong strategic focus on Value-Based Health Care initiatives that emphasize performance improvement in cost and quality. Even as Medicare may step back from the leadership role it has taken in this arena, private insurance and employers still consider VBHC the top solution for getting the most value for the health care dollar.

How will the Proposed Rule for Year 2 of the Quality Payment Program affect you? Here's what you need to know:

1. Participation methods are largely unchanged, but more flexible (especially MIPS APMs).

There are still two tracks for success (MIPS and APMs), and for those participating in MIPS, you still have the option to report individually or as a group, and to do so through a third-party intermediary (such as a QCDR or Registry). Additional proposals continue to promote flexibility, allowing groups to submit QCDR and EHR measures for their Quality score.

If you are in an Alternate Payment Model (APM) that doesn't meet the Advanced Alternate Payment Model requirements (for example, Track 1 ACOs or the Oncology Care Model without downside risk), you may still bridge the gap by participating in a MIPS APM. Your MIPS score is partially fulfilled by participation in the APM, but also requires some MIPS-specific efforts. The Proposed Rule would make it easier for MIPS APM participants to fulfill requirements and eliminate some of the existing confusion related to MIPS APM scoring.

2. Increasing the "Low Volume Threshold" will mean fewer individual MIPS-Eligible Clinicians.

In 2018, in addition to the previous exclusions (e.g. clinicians who are new to Medicare), CMS is proposing only to hold clinicians or groups accountable for MIPS if they exceed $90,000 in Medicare Part B allowed charges (this is triple the 2017 amount) or see more than 200 Medicare Part B beneficiaries (double the 2017 volume). As in 2017 (and as was the case in PQRS), a clinician is defined by the individual NPI/TIN combination. However, even if certain clinicians are not MIPS Eligible on their own, they still may want to participate in MIPS, either as a Group Practice or in a new method, called a

“Virtual Group” (see #4).

3. There are advantageous reasons to opt in, even if you may not need to (spoiler: bonus points and incentive payments).

Even if you are not MIPS-eligible on your own, there are few reasons to consider going in with your group or creating a Virtual Group:

- Improve your patients’ health. The purpose of this program is to quantify performance in order to improve. While the program is certainly not perfect, if you are not measuring your performance in some other manner, it’s impossible to see whether your actions are having an impact (good or bad) on your patients’ health.
- Earn incentives for year-to-year MIPS improvement. The Proposed Rule has established incentives for improving MIPS Quality and MIPS Cost performance year over year. The catch is that, unless there’s a “year 1” to compare, you can’t improve.
- Get a head start on bonus points for exceptional performance. Bonus points are awarded to small practices and for caring for complex patients. By joining in, you give yourself a head start. The bonus points will help you clear the 15 points needed to avoid penalties and increase your opportunity to earn the 70 points needed to qualify for exceptional performance.
- Enhance competitiveness on Physician Compare website. Data submitted for MIPS may be publically reported, and that includes Quality measures, Improvement Activities and Advancing Care Information. You may choose to sit out this

round, but that information will be missing from Physician Compare, which will put you at a competitive disadvantage as patients become familiar with the Physician Compare site and resources.

4. Clinicians may participate in MIPS as part of "Virtual Groups."

A Virtual Group is a group of clinicians (all of whom must be in practices with 10 or fewer providers) who come together to participate in MIPS as a single entity, even though their practices have separate Tax Identification Numbers.

Those who understand that early participation is the key to demonstrating (and being compensated for) improvement, but who are in a small practice, should consider a Virtual Group. This provides an opportunity to pool resources to partner with a QCDR that can get everyone on board, and then flex its data integration muscle to help you track outcomes for your shared patients and improve performance –even if the clinicians in your Virtual Group use different EHRs.

5. MIPS categories have the same effect on your overall score in 2018—even Cost.

As was the case in 2017, MIPS categories are weighted as follows:

Quality: 60%
Cost: 0%
Improvement Activities: 15%
Advancing Care Information: 25%

Yes, you read that correctly. Although the Cost category was supposed to represent 10 percent of your 2018 MIPS score, this has been rescinded. However, CMS has requested feedback on whether to include cost or not, knowing that it *will* be 30 percent in 2019. Why eliminate Cost weighting? CMS plans to eliminate the episodic care measures that were originally planned, and to develop new episodic cost measures. Since there will not be an opportunity for providers to preview their results prior to scoring, CMS will not weigh them.

Nevertheless, there are still cost measures that could be incorporated. If Cost is re-assigned its 10 percent weight (which would bring Quality down to 50 percent of the total score), it will be based on the Per Capita costs for all Medicare Beneficiaries and the Medicare Spending Per Beneficiary (MSPB) measures, which have both been retained.

6. Changes to Quality, Improvement Activities and Advancing Care Information are minor.

Quality: Reporting requirements remain constant—individuals or group practices must report on six measures, one of which must be an outcome measure, for at least 50 percent of the eligible denominator, and that denominator includes all patients. There are a few new challenges, though. Measures that don't meet the data completeness requirement will only be worth one point, rather than three. In addition, the proposal limits "topped out" measures to six points. You can make up for this with bonus points for reporting additional high-priority measures (as you can this year) and by earning points for improving from year to year.

Improvement Activities: Scoring requirements are unchanged:

40 points are required for large groups, and 20 points are required for small ones. Points are earned by completing activities worth either 10 or 20 points. This will still be based on attestation, and, if reporting as a group, a single provider may complete an activity on behalf of the entire group. Participants in Patient-Centered Medical Homes are still exempt from this category (as are CPC+ participants, which is a new provision), but now, at least half of the practices in a TIN must be PCMH certified to exempt the TIN from this category.

Advancing Care Information: The biggest surprise is that the Proposed Rule still allows clinicians to meet objectives through EHRs that have only been ONC-Certified through the 2014 edition, although those who use exclusively 2015 CEHRT earn bonus points.

7. Reporting to a Clinical Data Registry gets more emphasis.

In the Advancing Care Information category, a subtle, but important change has been proposed: rather than reporting to an Immunization Registry, you may earn additional points by reporting to Clinical Data Registries and Public Health Registries. Clinicians may earn 5 percent per reported registry in the ACI performance score (up to 10 percent), and a 5 percent bonus for each additional registry reported that was not already counted in the performance score.

8. Financial Risk for Medical Homes as APMs will be eased in gradually.

Medical Homes that have been created through the CMS Innovation Center may be considered Advanced Alternative Payment Models,

meaning that participants are excused from MIPS, but are still part of the Quality Payment Program. The Proposed Rule walks back some of the previously provisioned financial risk. Rather than an estimated 3 percent of average total Medicare Part A and B revenue in 2018, only 2 percent will be at risk. An additional 1 percent will be added in each consecutive year.

9. It's time to start thinking about All-Payer APMs.

Although this provision will not come into play until 2019, the Proposed Rule lays the groundwork that will enable providers to become Qualified Participants in Advanced APMs (exempting them from MIPS) by participating in a combination of Medicare and Private Health Plan APMs. For those who want to participate in APMs but do not have the required financial risk thresholds (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), or who don't meet the nominal risk standard (at least 8 percent) on the Medicare side, an All-Payer APM will vastly open your options, and enable you to control your own destiny, without creating different standards of care.

10. This is a Proposed Rule—your voice can shape the Final Rule.

None of this is final, so whether you loathe or like what you see, you have until August 18, 2017, to comment. Submit comments electronically (refer to "CMS-5522-P" in your comment), or in writing (CMS will not accept faxes or phone calls). Please see the Rule for instructions on how to comment in writing:

Download the Unpublished Version.
Download the Published Version (scheduled for publication on June 30, 2017).

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Image Credit: Web Donut

The Doctor Will See You Now, But Don't Stay Long or Ask Too Much

written by Theresa Hush | August 24, 2017

DECEMBER 26, 1906.] PUNCH, OR THE LONDON CHARIVARI. 451

FORECASTS FOR 1907.

IV.—DEVELOPMENT OF WIRELESS TELEGRAPHY. SCENE IN HYDE PARK.

[These two figures are not communicating with one another. The lady is receiving an amatory message, and the gentleman some racing results.]

Something has been happening with physician medical visits. Maybe I'm just noticing it because my doctor quit and I had to find a new one, which put me on a treadmill of repeat appointments—because, as my new physician told me, she was out of time for our visit. But here's the rub: Apart from seasonal allergies, there is nothing wrong with me.

I am, thankfully, extraordinarily healthy. I have no hypertension, diabetes, cardiac issues or auto-immune diseases. My lipids are normal and my weight hasn't changed since I was 21. The only meds I take are for allergies.

Yet so far, in this new medical relationship, I have had two primary care visits but no exam except for a quick check of my throat and ears, bunches of blood tests and a chest x-ray.

After the first visit, my primary promised that the second appointment would give us enough time to deal with “all my issues.” Okay, there are none. But trying to play the catch-up game, I went with it. At that second visit, she virtually scolded me when she ran out of time again, because somehow, I had used all of it. Then she asked that I come back for a third visit for the exam.

At the second visit, she also referred me to a pulmonologist because my chest x-ray showed some fibrosis—possible old histoplasmosis—in my upper right lung. That was the same finding as previous tests, but she hadn’t read any of the documents and images I provided. So I went, but first I called that pulmonologist. I told the office about two sets of available images, which I knew the specialist could access. I wanted to make sure that the specialist reviewed those images so that they could be discussed and compared at the visit.

Guess what? The pulmonologist didn’t have time to do this in advance, and would I please schedule a second visit to review the images and all the additional (negative) blood tests.

Cost and Quality Implications of Clinician Visit Time

Physician practices have been purchased or consolidated over the last several years, while at the same the market has moved towards Value-Based Health Care. Practice consolidations have been guided largely by a strategy of leveraging better contracts with health plans and building a stronger patient base. Although many networks have been built with the future of financial risk and ACOs in mind, the incentives currently are still fee-for-service. As a result, visit volume is the key

indicator for both growth and revenue.

Here's why: Physician productivity standards expanded as physician practices were purchased or consolidated in the past few years. However, these metrics make it very clear that physicians are part of a revenue growth objective, as opposed to value. All the indicators drive towards more visits, more revenue, and more downstream services of both physicians and other practitioners.

Fee-for-service benchmarks have put pressure on physicians to produce as many visits as possible within a short time frame, and likewise to cut patient appointments into repeated appointments for revenue recurrence—as I apparently experienced first-hand.

How visits have increased, however—and what that means for quality and cost—is not well documented. In fact, the most interesting revelation from literature reviews is that we continue to measure larger statistics of growth and usage in health care, without measuring the value and trends of usage that may be physician-driven or consumer-driven.

The latest National Health Insurance Interview Survey reveals that a high percentage of people *with health care coverage*, across all age groups, access professionals at least one time per year, and most of those have repeat visits to physicians within six months. Even for consumers between 18 and 44, almost 60 percent had more than one visit to physicians within that time period. Whether those visits represent a trend of care that is divided by financial incentives and productivity standards into smaller chunks of time is unknown.

What is clear, however, is that an average physician visit time of 15-17 minutes is consistently measured. According to one observational study, the average length of an office visit for an elderly person was 15.7 minutes, with a maximum of 5 minutes spent on the longest topic. And, despite a huge growth in total visits, technological changes, advances in science, public discussion on the need for higher patient engagement and more discussion, the duration of the average office visit did not significantly change from 1993 through to 2010. This speaks not only to the pressure of productivity standards on physicians, but also to the need for a culture shift.

How Engaged Can Clinician and Patient Be In a 15-Minute Average Office Visit?

Every day I read censures by providers and politicians of patients who will not "comply" or "engage," and how we need to cut excessive consumer spending on health care. But the reality is that we are *blaming the patient for a system problem.*

Can an office visit of 15 minutes allow for adequate time with a patient? We need to evaluate whether it can accommodate the activities recommended in both quality performance measures and in plans that insist the consumer take a stronger role in making decisions:

- Is 15 minutes enough time for setting patient goals, creating a long-term patient plan and determining patient preferences?
- Does 15 minutes allow for reviewing literature about the benefits and harms of recommended treatments?
- Does 15 minutes allow for enough conversation as well as examination of the patient?

> Is 15 minutes, in fact, enough time for exploring any ideas of promoting patient engagement or building a physician-patient partnership?

The Case for Different Measures of Physician Value

We live in a time when consumers are getting smart enough to demand participation in a system that has been failing them—and now wants to charge them more money for the privilege. At the same time, payers of health care and provider-based ACOs have increased the volume of physician extenders—nurse practitioners and case managers, among other roles—that are providing direct services to patients.

Unless physicians can produce the results of better outcomes and lower costs that a shared partnership with patients is intended to achieve, payers and other health care organizations will expand the use of these providers and minimize the role of the physician. Walgreens, Walmart, Costco and CVS are all capitalizing on the idea that physicians should only perform limited services that warrant their diagnostic and technical skills. In view of a looming physician shortage, it may be a necessity as well as better economics to rethink the roles that physicians must play in the health care spectrum.

Physicians may be unwittingly falling into a trap of providing high-cost hourly services that will be shifted to other personnel in the future. Some industry experts have argued for redirecting physician activity in a way that will focus on outcomes.

Three Steps Health Care Organizations Should Take to Reinvest in their Physicians

What should health care organizations do to maintain the strength and relevance of their physician workforce? Start by accepting the reality that health care is on a trajectory away from fee-for-service, and, therefore, it's time to begin measurement of quality and cost performance, as well as the patient experience, in earnest.

> Redefine the measures of productivity and value. Providers should see quality measures and comparisons with their peers on outcomes over time, as well as by risk-adjusted patient panel volume and process measures.
> Build time and process for physician-patient discussion and shared decision-making. Patients will make decisions in the future, and an organization should make a valiant attempt to keep those patients in-network. Without a dedicated process and training about how to talk to patients in the current environment, those patients will make fast tracks to another provider who can do better.
> Build a care team and construct its roles and responsibility around new consumer attitudes and behavior. For many large health care organizations, this could mean a major overhaul of everything from medical records to patient scheduling and services.

Time is short, and revenues are sliding quickly. Responding to the national debate, many states are engineering state-wide initiatives for health coverage and redesigning the care system. Physicians and health care organizations will need to modify their own operations soon, lest they wake up to discover

that their roles have become marginalized under financial risk, VBHC or state-wide initiatives.

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.

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