Do Centers of Excellence Lose Under New MACRA MIPS Episodic Cost Measures?

written by Theresa Hush | April 6, 2017

Health systems' Centers of Excellence that attract patients through clinical prowess may be heading for an upset. Under the MACRA MIPS program now entering its first year, physicians will be scored for cost performance in some of the same clinical areas that they have promoted to distinguish their care—and compared against their peers. Since Centers of Excellence are likely to be higher cost in comparison with other providers, associated episodic cost measures may possibly be used to penalize their providers. The impact won't be felt immediately, however; in 2017 the MIPS Cost component is scored but not calculated in the final MIPS incentive or penalty tally.

It will be challenging for providers to compete on price in this area and serve patients in vulnerable populations. The MIPS episodes are far reaching, but represent those areas long used as marks of clinical distinction: orthopedics, cardiac and neurological procedures, and specialty care for diabetes, arthritis, asthma, heart disease, and kidney and liver failure. Academic centers offering extensive specialty services will be especially vulnerable. Although the patients will be adjusted for risk, risk adjustment will not account for the demographic and other individual patient attributes that contribute to higher cost and poor outcomes.

MACRA MIPS Cost Scores and Episodes Explained

The Cost component of MIPS is a complex formula designed to rank groups of physicians and other eligible MIPS professionals by cost of services. These costs are attributed to the group regardless of whether they directly performed the services, which means that the professional group is held responsible for referrals, hospital inpatient and outpatient, and tests performed on their patients.

The attibution formula for physicans varies by MIPS cost component and is the subject of much debate. In general, physicians are held responsible for primary care patients if they have provided the plurality of outpatient visits, and for procedural or admitted patients if they were primarily involved in the procedure or admission.

There are three main types of calculation that make up the MIPS Cost scoring, each of which is attributed to physicians: total per capita costs, Medicare Spending per Beneficiary costs, and Episode costs. Episode costs represent a new addition to previous formulas comparing total cost for attributed Medicare patients.

MIPS Episodes are used to compare episode-based costs of Chronic Conditions, Inpatient Stays and Procedures. The details are daunting. A total of 117 episode groups form the basic structure of episodic cost variations, including 39 acute inpatient medical conditions, 16 chronic conditions (with more than 1,300 diagnosis variations), and 62 procedures (with 955 treatment variations). However, the episodes will roll out over time. In 2017, expect to see scores based only on these episodes:

Mastectomy
Aortic/Mitral Valve Surgery
Coronary Artery Bypass Graft (CABG)
Hip/Femur Fracture or Dislocation Treatment, Inpatient (IP)-Based
Cholecystectomy and Common Duct Exploration
Colonoscopy and Biopsy
Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia
Lens and Cataract Procedures
Hip Replacement or Repair
Knee Arthroplasty (Replacement)

Note that the 2017 episode groups are all procedure episodes. Providers should take note of these key facts for the procedure groups:

Episodes are generally triggered by a DRG, CPT or HCPCS code but will often include services prior to the trigger. The trigger does not necessarily "start" the episode, however, since often pre-admission or pre-procedure costs are included in the episode. Once the list of episodes expands to chronic conditions, there are likely to be diagnosis triggers.

Episode groups include direct clinician costs, hospital inpatient or other facility costs, diagnostic tests and the services of other physicians. Pre- and post-acute costs are often included. The exact services to be included or excluded vary by episode and are not finalized yet. Inclusion of drug costs is still be considered.

Risk adjustment of the episodes is performed as part of the scoring process, through an algorithm. How this algorithm accounts for clinical complexity of a case is not known. Also unknown is how groups of patients will be assigned risk, based on other circumstances outside the procedural episode.

Quality and outcomes are measured outside the episode. Although CMS acknowledges the strong link between quality and cost measures, there is no assessment of outcomes in the episodes that will bridge the cost to quality or to outcomes.

Will a Provider Strategy Backfire for Centers of Excellence?

In an economic environment that pays providers on a Fee for Service schedule, Centers of Excellence make sense for providers. Attracting high-risk patients and providing specialty services has no downside, and this creates a market niche or banner under which the health system tries to distinguish its breadth and scope of services. Centers of Excellence distinction is also good for physicians because it tends to attract more specialists who want to work collegially on the same patients, offering the potential for greater clinical expertise and continuity.

Episode groups have the express purpose of examining and holding down costs, and these costs are specifically focused on the same patient populations visiting Centers of Excellence. Further, the 2017 list targets procedural specialists that are often prized by hospitals as heavy admitters.

The MIPS episodic cost measure has the potential to disrupt the current physician-hospital harmony by penalizing physicians for inefficiencies in the hospital services of an episode. Physicians are likely to be more vocal about hospital processes that they have complained about for years, which now will turn up as adjustments to their reimbursements.

In the Centers of Excellence model, there is ideally a synchronization between population-

based care delivery and the care to be delivered to specific patients at risk. The episodic cost measure can be useful in identifying areas where costs are higher, but they also pose risks, such as:

Lost access for vulnerable populations that require more services;
Regimented and controlled care processes;
Less research and innovation in trying new components of care that cost money;
Penalties instead of collaboration with providers to reduce costs;
Lack of focus on outcomes not reported in connection with the episode.

7 Strategies for Making Cost Episodes Effective in Centers of Excellence

Centers of Excellence can make cost episodes work effectively in a long-term strategy, but this will require an ingenious pre-emptive strike: episodic cost measures for internal provider tracking with the potential for future bundled payments.

As part of the Cost component in MIPS, episodic cost measures are calculated retrospectively by CMS. Providers are then left without options to change the prior results and with insufficient development to avoid similar results in the future. However, there is an alternative: decisive independent action.

Health systems and their providers can simulate cost episodes and create a meaningful process to reduce costs with good outcomes. Here's how to do it:

Create health system episodic measures that incorporate cost and quality. This will be most effective if your providers are collaborating on measures, but it makes sense to use the 10 procedural episode groups for MIPS 2017 as a start, since they match your Centers of Excellence services. You should also consider adopting multiple cost episode measures, because this will be more efficient once you design the interface and processing for reviewing episodic costs and quality in tandem. Ask your Qualified Clinical Data Registry (QCDR) to create specifications for these measures and implement them for you as part of you MACRA performance improvement activities. This is one of the areas where a QCDR can benefit you and will give you credit for completing another MACRA activity.
a) Ensure that all the providers that contribute to the types of episodes you adopt are participating in your QCDR efforts and sharing data, including private providers.
b) Your data specifications for this activity will need to meet the scope of the

episodes, capturing claims and payment data in addition to the typical data elements for performance measures.

Establish quality measures and outcomes for each episode. Since these will be internally monitored rather than reported out, you should attach as many quality indicators and outcomes as needed to finesse your model in the future. It is likely that the quality and outcome measures will add as much to your understanding of data sufficiency or problems as to the outcomes themselves, and that is the point of experimenting at this phase.

Develop a process for review and feedback on the care episodes with physicians, identifying and collecting additional data that will help you assign risk.

Ensure that patient-reported outcomes are incorporated in the design of your performance improvement projects.

Once initial review of data is performed, establish interventions that have the promise to show better outcomes and efficiency. Ensure that these interventions are separately measured with the project, so that you can see the results of both cost and quality stemming from each intervention itself.

Consider developing bundled payments for certain episodes to prepare for these in future risk programs, allowing you to market the services to payers and employers.

Episodic cost measures can be positive for health systems that pursue them as innovations in their market strategy, especially in preparation for taking on financial risk under health plan contracts or as an APM. The only way to get ahead of the game is play the offensive strategy.

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: Olga Guryanova