athenainsight

Today's data. Tomorrow's healthcare.

athenainsight.com

CMS gets busy: 4 new announcements to follow now

By Stephanie Zaremba | November 2, 2017

As the world digests the hot-off-the-presses 2018 MACRA Final Rule, let's not overlook other news coming from the Centers for Medicare and Medicaid Services. Over the last week, CMS made several announcements that could have big ramifications for the future of MIPS, APMs, and other performance- and value-based payment programs.

That was the takeaway from a recent survey published in the Journal of General Internal Medicine, which asked patients in a care management program to list their primary concerns. More cited family and financial issues than their own health. And these high-risk patients said the services they most valued from their own care coordinators were those that helped them gain a sense of control over their lives.

But are these announcements really as revolutionary as they are being portrayed? Or is this little more than a rebranding of work carried over from the previous administration? Looking at each announcement in turn, the answer is a little bit of both.

This administration is certainly doubling down on its commitment to simplify and streamline, and it is poised to make even bigger changes than we have seen in past iterations of that effort. But CMS has been working to reduce administrative burden for almost two years, and the challenges to swift and significant reform remain in place.

Here's the lowdown on what went down last week:

CMS wants to put patients over paperwork

CMS formally launched its "patients over paperwork" campaign, the newest iteration of its efforts to reduce the administrative burden on physicians. The goal — to determine which regulations CMS should scrap or revamp — is at least partially in response to an American Hospital Association study that found administrative tasks cost health systems and providers about $39 billion annually.

The cost of the administrative burden in healthcare is increasingly well-documented, but you'd be forgiven if you remain skeptical about the outcome

of this effort. Bureaucracy has a tendency to grow in only one direction: up. What's more, success here will require the private sector to walk hand-in-hand with CMS in a commitment to simplify the healthcare system, whether that be private payers streamlining their operations, health systems more seamlessly exchanging and integrating patient information, or technology vendors delivering on the demand for more usable systems.

We're not there yet, but with gridlock and frustration on the rise, both in healthcare and in Washington, it seems inevitable that stakeholders ready to lead industrywide change will take up this challenge in the near term. Stay tuned.

CMS intends to examine "meaningful measures"

In a similar vein, the agency will launch a review of quality measures to eliminate duplication and focus on judging outcomes, rather than measuring the means of achieving them.

On the one hand, this is exactly the sort of thing CMS should be doing — providers and vendors have long asked for more options that focus on results and leave room for innovation. On the other hand, again, this isn't exactly a new idea. MACRA requires that CMS take on this sort of work. Still, the effort and the specific focus on outcomes over means is worthy of praise.

CMS gives details on info blocking attestation

Also last week, CMS issued guidance on attestations about information blocking that are required of doctors for 2017 MIPS performance.

People seem to be panicking that CMS is singling out doctors while giving health systems and vendors a free pass. It isn't.

What CMS released is simply an in-the-weeds guide for how doctors can comply with the MACRA requirement set by Congress that providers self-attest that they are not knowingly and willfully impeding information exchange. Vendors and hospitals have to make similar representations under different laws; those just aren't covered by this particular guidance document.

CMS takes a major swipe at the Affordable Care Act

The agency published a proposed rule late last week that, if finalized, would give states a lot more flexibility in regulating state insurance marketplaces.

Under the proposal, states would be given much more leeway than federal law currently provides. For example, states could change the definition of "essential health benefits," which ACA marketplace plans must include. States could also alter the ACA medical loss ratio requirements for payers — meaning payers could spend more of their revenue on non-medical costs, provided the change would help stabilize the insurance market in the state.

For those who watch healthcare rulemaking closely, CMS certainly seems to have kicked things into high gear of late. And now that the 2018 MACRA Final Rule has landed, watch this space for more analysis as we comb through 1,600 pages on your behalf.

Stephanie Zaremba is director of government affairs at athenahealth.