How to Manage Your Health Care Costs – Beyond Just Coverage Costs and Gaps

written by Theresa Hush | November 14, 2019

Consumers are rapidly becoming aware that costs for health care coverage extend well beyond premiums, copays, and deductibles—costs such as additional charges for out-of-network physicians and facilities. There is also a growing understanding that different providers charge varying costs for services—and that other hidden variables can increase the final bill for treatment.

But consumer health care costs are not only a price issue. The cost of health care is the final sum of many decisions that are—at least partly—controllable by consumers or providers. Unfortunately, most consumers don't know all the factors that make up health care costs, and why those costs differ so broadly across treatments and providers. And they often feel that they don't know enough to question their doctors to get answers or explore alternatives.

That must change, quickly. Unexpected costs have put consumers at risk of bankruptcy and lawsuits. Let's examine four ways that you can be empowered to lower your health care expenses:

1. Evidence: Question the Evidence and the Case for New or Continued Treatments

The *British Medical Journal* recently published an analysis of randomized clinical trials—the gold standard in determining clinical value—for more than 3,000 medical treatments and procedures and found, shockingly, that for half of those studies, treatment effectiveness was unknown. Only 11 percent had proven benefit; an additional 24 percent were "likely" to be beneficial. Treatments identified as harmful, unlikely to be beneficial, or where the potential harm equaled the benefit, made up 15 percent of all those examined.

The fact is that medical practice still often relies on theories and preliminary findings based on other known facts. Once treatments get into the mainstream, belief systems of both providers and patients make them hard to break. The effectiveness of aspirin in preventing heart attacks, vitamin D supplements to help bones, joint injections for arthritis—the list goes on of popular treatments that have since been challenged by studies that have identified suspect evidence of benefits at best, and potential harm, at worst.

If our culture promotes quick and technical "fixes" to many problems, including medical issues, the health care system under Fee-for-Service was complicit in promoting interventions with questionable merit. By contrast, Financial Risk will introduce incentives to avoid treatments without clear value. But it will take time.

As a health care consumer, you can and do influence the pace of change, and can become a better steward of your body and wallet. Here's how:

- Ask your physician to provide published articles of trial results of both benefits and harm, in numbers rather than "improvement percentages" (which inflate the positive effects). These articles are usually not directly available to consumers.
- When reviewing trial information, request how similar the trial population is to you and/or your condition, how large it is, and how the trial results dealt with patients who did not complete the trial. Discuss with your physician how these issues affect the validity of results.
- Discuss how your treatment will vary from the treatment in

trials, and the basis for that variance.

2. Excellence: Request Information About Your Providers

Under Valuer-Based Health Care, providers are being tracked. There is data on their volume, costs, quality processes, and outcomes. You don't need to be satisfied with seeing just education and training credentials. Nor should you automatically accept providers' self-marketing as centers of excellence, without knowing the facts.

Here's the reality: How providers practice affects consumer costs. For surgical procedures, volume is highly associated with expertise and better outcomes in many cases. The tests that surgeons order, their decisions about type of anesthesia and location of treatment, the drugs they prescribe—all have both clinical and cost implications for consumers.

But how should consumers find good information about their doctors? Most information is currently private, but Medicare does provide some information on its Physician Compare site, and there are other emerging sites that are beginning to compare costs.

The first rule is to ask the physician or practice. A pushback may signal that the practice is still struggling with empowered consumers, and that alone is important feedback. Consumers must perform due diligence on the provider suggesting treatment. These are questions to ask:

- Request the physician's history of treating patients like your cohort.

Ask which quality measures are being tracked in the practice, and where to find information about quality performance.
Ask questions about how the physician responds off hours, and within working hours, to important health care needs.
Ask about the physician's communication practices, including systematic use of the Electronic Health Record portal, telemed, phone calls, and emails. Ask how test results are released to your digital record, and whether it is the physician's policy to talk them over with you first, prior to release.

3. Experience and Respect: Question What Doesn't Seem Right

This includes respect for your own time, which costs you money. Health care professionals have the same biases as other people, so you should push back if you feel symptoms are being dismissed or that treatment plans ignore your preferences.

Health care providers have been slow to embrace the consumerism movement in health care, because it is a big change. Value-Based Health Care is pushing providers to be more responsive and accountable for the services they provide to patients. Medicare, health plans, and employers are pushing providers to engage patients in care so that patients can do better.

At highest risk are vulnerable groups like minorities and women, people with behavioral health issues like addiction, and others with socio-economic challenges. Care for people with psychosocial issues—with significant overlaps between depression and other mental health concerns and employment, access to housing and food—is a major concern that is just now

being acknowledged.

Consumers must be advocates for themselves and their families. Here's what to consider:

> It is important for older consumers, in particular to involve and bring family or another support person to appointments. Any patient, however, benefits from the support and extra eyes and ears of a trusted family member or friend. You should note whether the physician is treating that person as an asset and trusted advisor to you, or as someone who doesn't belong.
> If the physician keeps you waiting for 35 minutes or more, you should question whether the practice is understaffed. Understaffed personnel make errors, including medical ones. Minority, female, and patients with psychosocial or economic problems need a physician who is a partner in health. If symptoms are dismissed or there are other barriers to treatment, the conversations about effectiveness, quality, and cost cannot take place. It's legitimate to question whether this is the correct "fit" of provider.

4. Transparency: Ask for Costs and Validate Coverage of All Services—and Providers.

Broadcast news has recently spotlighted many cases where consumers proceeded with emergency health services, only to discover later that there were problems with costs and coverages. One common root problem is that not all providers in a physician's referral network may actually be "in network," generating thousands of dollars in out-of-network costs for unaware consumers. As employers and health plans continue to narrow their networks of providers, consumers who believe they

have coverage are being caught, unaware, in serious financial crises.

Imaging, anesthesiology, and specialists are the trouble spots for potential conflicts. So, too, are referrals to specialists by an “in-network” provider to another who is outside the network. Nor is it safe to assume that in a large multi-specialty center within the same walls, that everyone is under the same network. It is virtually guaranteed that they are not.

Nor can you assume that once you purchase coverage in which your provider is in-network, that this is permanent. Continue to validate your provider’s position just as your provider’s office requests insurance validation at every patient visit or service.

In addition to network issues, comparing costs between providers is very difficult. Consumers cannot use providers’ price lists to tabulate their expected costs, counting services and prices. You need to be vocal about demanding the cost of a surgical episode of care, and what is covered before, during, and after services within a time limit for any procedure.

Price transparency is getting a big push from Medicare, which first insisted that hospitals post prices, but later discovered that the price lists were not useful. Hospitals continue to push back on these reforms for competitive reasons, but, ultimately, cost transparency will prevail. In the meantime, however, here is what you should ask:

- Request episode-of-care costs associated with any medical or surgical procedure. You might get them.

Validate coverage and costs for every referral from the primary care physician.
Get second opinions whenever feasible, and if appropriate to the situation, seek opinions across specialties—for example, orthopedics and neurosurgery for issues of the spine.
Ask the health plan for comparable cost information of providers.
Before deciding on treatment, check for general cost information, like the Fair Health consumer site.

Consumers Can Direct Costs, But Much Is Still Driven by Providers

While managing health care costs begins with wise choices about personal lifestyle like diet, exercise, sleep, we know that "living the healthy lifestyle" is not enough to eliminate health care costs. All of us will face increasing challenges of vulnerability to disease and dysfunction as we age, as well as the impact of underlying genetic and environmental issues. These are mostly out of consumers' control.

The key is to break down the mystery of health care and learn to control its use. This is a learning process, and not all consumers are yet prepared for the task. If not, they must ask for the support of family or friends to help

The most important advice: research and question, and then verify findings as much as possible. Ultimately, medical decisions are those made by patients under the guidance of physicians. It is a consumer's job to insist on the facts and assess research, as well as enlist support when too overwhelmed or incapacitated to manage the task.

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Image: Jeffrey Hamilton

The Final 2020 Quality Payment Rule: Playing It Safe with MIPS No Longer Works

written by Dave Halpert | November 14, 2019

The common refrain within the 2475-page Medicare Final Rule for the Physician Fee Schedule and Updates for the Quality Payment Program (QPP) is “we are finalizing our policy as proposed.”

This Rule follows the formula CMS adopted in its “Pathways to Success” ACO Rule: Propose a shake-up, reply to concerned commenters, and finalize policy without significant changes. CMS’s desire to move providers into Alternate Payment Models (APMs) comes through loud and clear, both in terms of its vision for MIPS 2.0 and in its more stringent scoring policies.

As it stands now, MIPS has not evolved into the program CMS envisioned under the previous administration. Most importantly, the MIPS measures never developed into outcome performance measures that could allow for accurate comparison of providers.

Performance requirements are clunky and confusing, and the number of choices for reporting measures and activities prevents consumers from making meaningful comparisons between providers and groups. Most providers avoided financial penalties, and although the incentive payments have been small, risk-averse organizations have seen no need to rock the boat and move toward APMs.

Nonetheless, higher performance thresholds were implemented in the 2019 performance year. These are expected to translate into increased penalties in 2021, which will fund larger incentive payments.

The Rule Raises Challenges for Providers to Remain in MIPS

The 2020 Rule continues to toughen MIPS requirements in order to separate the winners and losers. There is a persistent push to move providers into financial risk, both through increased APM participation and by removing "safe" status from MIPS. Here are the seven biggest challenges this Rule will create for future MIPS participants:

1. Uncertain Parameters for Future MIPS (Medicare Value Pathways, or "MVPs")

This rule brings CMS closer to its vision of an integrated payment system, rather than a series of siloed efforts. As we have described, CMS has created and finalized the concept of Medicare Value Pathways (MVPs), which are based on four key components:

- Smaller sets of outcome-based quality measures;

- Use of measures and activities that facilitate performance-based comparisons among providers;
- Measures that are clinically relevant and encourage improvement;
- Utilizing measures currently employed in APMs, in order to promote the transition to APMs.

Providers will fulfill MIPS requirements by engaging in a specialty-specific "Pathway," which will include a small selection of Quality and Promoting Interoperability measures that will dovetail with applicable Improvement Activities and relevant cost measures. While MVPs have been finalized as a concept, the details are still to be determined, including whether participation in an MVP will be mandatory or voluntary. Multi-specialty clinics should pay particular attention to MVP requirements, as they have the potential to profoundly complicate reporting. For example, since MVPs are specialty-specific, a 20-specialty organization could conceivably be required to monitor a "small" set of quality measures, but would need to do so for all 20 specialties. Even if only two to three measures are required, that group would need to report on 60 to 90 measures, as opposed to today, wherein a multi-specialty clinic may choose six measures across the practice when reporting as a group.

2. More Difficult Performance Requirements to Avoid Penalties

The biggest determinant in the MIPS payment adjustment is the Performance Threshold. Depending on the minimum number of points necessary to avoid a penalty, CMS has the power to "pass" providers almost universally, or to create a more

challenging baseline that will ensure that some providers "fail." Since MIPS is budget-neutral (penalties finance the incentive payments), the former scenario leads to a very small payment adjustment, even for the top performers. The latter scenario generates a greater financial swing.

In the first two MIPS Program years, the Performance Threshold was low, giving providers an opportunity to get acquainted with the program. Incentive payments were frequent, but nominal—less than 2 percent of allowed Part B charges. In 2019, some providers who squeaked by in 2018 will not make the cut. For 2020 and 2021, CMS has finalized their proposals to continue increasing the Performance Thresholds. For 2020 and 2021, CMS has finalized Performance Thresholds of 45 points and 60 points, respectively. As we approach 2022, the minimum Performance Threshold will be based on prior averages—if that were in effect today, the minimum Performance Threshold would be 74.

All MIPS participants, take note! Many of the comments advocated for a higher-than-proposed Performance Threshold. Commenters stated that they wanted to ensure that enough providers were penalized (and at a high enough rate) to generate a penalty pool large enough to create a meaningful reward for successful participants—one that covers the cost of investment and encourages continued improvement. Those who pick the "do enough to pass" strategy will soon find themselves penalized at the expense of those who strive for excellence.

3. New Obstacles Within Individual MIPS Components

Even if the minimum threshold remained constant, changes to the scoring of the individual MIPS components would have made it more difficult for providers to fulfill minimum requirements. The combination of a higher Performance Threshold and more stringent guidelines for MIPS component parts will drastically change MIPS scoring distribution.

Let's start with Quality. For 2020, CMS has once again increased the data completion threshold. A measure must be reported in at least 70 percent of all denominator-eligible instances for it to be considered for performance points. This is approaching the PQRS-high of 80 percent, and in that context, only three measures were required. MIPS will still require six measures, at least one of which must be an outcome measure (or high-priority measure, if an outcome measure is not available). Furthermore, clinicians will need to pick from a smaller set of measures—in an effort to remove duplicative or "low-bar" measures, CMS has dropped a whopping 42 measures from the program.

4. New MIPS Quality Reports That Create Competition for Incentive Pool

There will also be a new cohort of MIPS Quality reporters—MIPS APM participants. CMS finalized its policy to allow clinicians in MIPS APMs to report on MIPS Quality measures under the MIPS APM scoring standard. Medicare Shared Savings Program (MSSP) results have shown that those who have taken on two-sided risk continue to outperform those who play it safe. Therefore, MIPS participants should expect to see steep competition in quality

measure performance from the MIPS APM crowd, particularly in outcome measures.

5. Higher Bar for Improvement Activity to Qualify for Points

The Improvement Activity component is also undergoing change. The most daunting challenge is for those who are reporting as group practices. In this Rule, CMS has finalized its proposal that at least 50 percent of the clinicians billing under the TIN must participate (for at least 90 consecutive days) in the Activity that the group is attesting. In prior years a single clinician could carry an entire group by performing a given activity. For those who have been piloting programs with a limited set of clinicians, it’s time to roll them out.

Additionally, and similar to what happened in the Quality component, CMS is removing several Improvement Activities deemed as duplicative, or not appropriate, particularly within the set of QCDR-based Improvement Activities. The new QCDR definition prioritizes specialty-specific measure testing and development over infrastructure and guidance for improving patients’ health. In the wake of the new QCDR definition, CMS removed seven of the prior QCDR-based Improvement Activities, as they were duplicative of existing activities. Previously, clinicians could achieve the necessary points in this category by working with a QCDR for purposes beyond quality reporting. That will not work in 2020—providers will need to look beyond QCDR-based activities in order to succeed.

6. Revisions and Additions to Cost Measures Mean Uncertain Scores

Surprisingly, CMS finalized that Quality and Cost will be weighted at 45 percent and 15 percent of the total MIPS score in 2020—the same weights as 2019. This may seem like a reprieve, but by law, Cost and Quality must be equally weighted at 30 percent by the 2022 performance year. By deferring a gradual shift in 2020, CMS has made future transitions much more abrupt. The challenge here is that, by the time clinicians have their 2020 MIPS feedback scores, we will be well into the 2021 performance year, meaning that there will be less time to take action on prior feedback AND the same issue will cost you more than in the prior year.

Although still weighted at 15 percent of the total MIPS score, the introduction of new measures and substantial changes to existing measures will test providers' ability to demonstrate quality through reduced costs. An influx of 10 new episodic cost measures means that, for the first time, additional specialists will be evaluated on specialty-specific measures, rather than just global measures. These measures have been "field tested," and the fact that they're in their inaugural scoring year means that the results are inherently uncertain. Case minimums are relatively low (10 episodes), and so there is the potential for a small number of patients to substantially affect a provider's cost score.

In addition to the new cost measures, the once-familiar global measures (Total Per Capita Cost—TPCC, a total cost of care measure; and Medicare Spending Per Beneficiary—MSPB, a global episodic cost of care measure) have also been revised. Those

who built strategies based on attribution methodologies and other fine print within the Measure Information Forms may find themselves adrift following these updates.

In the TPCC measure, patients were previously attributed to clinicians based on a two-step methodology to determine which clinician should be deemed the patient's primary care provider. The methodology, borrowed from the Medicare Shared Savings Program, could result in faulty attribution scenarios (e.g. an orthopedic surgeon tagged with all of a patient's downstream costs because the patient saw the orthopedist in the office and never saw a primary care provider). TPCC has been revised to look at "candidate" events, which include services surrounding an office visit that indicate a primary care relationship (e.g. routine chest X-ray), and also exclude clinicians who are unlikely to be "primary care providers," based on the clinician's specialty.

The MSPB measure has also undergone revisions. Like TPCC, the biggest change to MSPB is related to patient and provider attribution. The new methodology will differentiate medical episodes and procedural episodes, making MSPB consistent with 18 MIPS episodic care cost measures. An additional update reflects that certain services occurring during an admission may be out of the attributed provider's control, (e.g. an orthopedic procedure during an ophthalmologic admission).

As is the case with the new episodic care measures, these new versions of TPCC and MSPB have been field tested, but this is the first year in which these versions' scores will count for providers' MIPS scores (and potential payment adjustment).

7. More Difficult to Achieve “Exceptional Performance”

Although incentive payments are required to come from the penalty pool (keeping the program budget-neutral), there is an alternate source of funding for those who achieve “Exceptional Performance.” An additional $500 million has been earmarked for this group.

In the 2020 Rule, CMS took an additional step to differentiate between those who succeed and those who get to share in the $500 million. This has been a problem in prior years—previous results indicated nothing “exceptional” about Exceptional Performance. The 2017 mean score was actually in the Exceptional range! The 2017 MIPS Experience Report [PDF download] provides more detail, notably that 71 percent of MIPS participants achieved the 70-point threshold to earn the “Exceptional Performance” bonus. As there were relatively few penalties, the Exceptional Performance bonus made up almost 90 percent of the total incentive payment.

When “average” equals “exceptional,” there’s a problem with the equation. CMS is attempting to remedy this by increasing the minimum threshold from 75 points in 2019 to 85 points in 2020. This change is understandable, and interestingly, CMS had only proposed a five-point increase in 2020, with a subsequent five-point increase in 2021—they increased the threshold more than they’d initially proposed. So, providers will have more difficulty earning a piece of the $500 million set aside for Exceptional Performance, but those that do will be a more exclusive group, and will enjoy a larger portion of the reward.

Bottom Line: New MIPS May Make APMs with Risk More Acceptable

Throughout this summary of challenges for 2020 and beyond, we've described several reasons that the same year-over-year effort will lead to diminishing MIPS scores. Whether stemming from a reduced set of quality measures and improvement activities, competition in quality reporting from MIPS APM participants, new cost measures, or preparation for MVP implementation, the bottom line is that MIPS is becoming more difficult.

When combined with the larger financial swing (providers may be penalized up to 9 percent of all allowed Part B charges in 2022, depending on 2020 performance), there's more at stake in 2020 than in any prior year. MVPs and uncertain logistics on the horizon, juxtaposed with immediately increasing performance requirements, means that providers and organizations should recognize that MIPS is no longer the "safe" route for succeeding in the Quality Payment Program.

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Image: Waldemar Brandt

Is Patient Lock-In the Next Step in Value-Based Care?

written by Theresa Hush | November 14, 2019

Hoping to safeguard survival under financial risk, health care providers are courting a contentious issue: how patients select primary providers. During the HMO heyday , health care risk

economics depended on patient selection of primary providers as part of coverage selection that “locked” them into those PCPs and their referral networks. PCPs operated as gatekeepers to the rest of the health care system, authorizing services (or not) for specialists and other care.

It’s well known that the HMO’s Primary Care gatekeeper model generated a backlash among private sector consumers. In fact, the gatekeeper was so unpopular with patients that it was partly responsible for the demise of the HMO model in favor of more open-ended PPO networks. Patients complained about the bureaucracy and constraints on resolving their health issues, and refused to choose HMO coverage when there were options. Their employers listened.

Despite that history, the language of “patient attribution” in governmental Value-Based Health Care is now morphing into “patient alignment.” Along with care coordination and other changes in both ACO and Direct Contracting models, VBHC is moving toward active choice of provider. In the private sector, this means that employers and health plans are narrowing networks that automatically exclude providers from the menu for consumers.

Do these efforts signal that a return to restricted patient choices is the next step in Value-Based Health Care? Providers and ACOs are converging on the position that primary care physician selection by the patient is key to making risk work and to engaging patients in care. Depending on how and where provider selection becomes a reality, this transition could significantly affect the Value that patients derive from their health care. As discussed in our prior article on Patient

Experience, providers aren't uniformly ready to work with consumer needs and patient realities.

Let's examine how ideas about patient choice are changing, and what safeguards must be present in order to have a fair choice process that contributes to health care Value.

How Free Patient Choice Is Quietly Changing

In the private sector, patient selection of primary providers is already being constrained, with coverage restricted to narrow, selective networks that are developed by direct employer-to-provider contracts or by exclusive health plan networks. Some employers are creating on-site clinics to manage care costs.

In governmental programs, Medicare and Medicaid programs are implementing methods to create more affirmative connections between beneficiaries and primary care providers while maintaining that patient alignment is voluntary. CMS Rules now require ACOs to inform patients that they have been included in an ACO after seeing an ACO primary provider, and CMS also enables choice of primary physician on the MyMedicare.gov website. Primary care models such as Direct Contracting include voluntary alignment provisions that are augmented by incentives that may be paid to Medicare beneficiaries for visits within the Direct Contracting network.

Implications for Patients Under Alignment Efforts

Under competitive risk programs without valid outcome and patient experience standards, there is a danger that patients

lose their consumer rights as purchasers of health care. They become, instead, the owned assets of the risk-bearing entity that will determine what health care they need.

While Voluntary Alignment may be a far reach from patient lock-in to a provider risk organization, the presence of private sector plans with limited or no choice should alert consumers to restrictions on choice of provider.

Whether there is a real danger to patients depends, of course, on "valid outcome and patient experience standards." Although Value-Based Health Care Programs have quality and some outcome measures, these measures are not enough to protect consumers. Here's why:

> Most of the measures are related to the most basic requirements for medical processes—preventive checks for chronic disease patients, for example, or capture and advice on smoking—but aren't enough for consumers to make choices of providers.
> Measurement and publication of key outcomes for providers—including mortality standards—is largely voluntary, so consumers can't assess where they may get the best care before choosing a provider. In addition, results for how providers improve outcomes in the long-term, across the spectrum, is either not measured at all or measured inconsistently and without validation by outside auditors.
> The lack of transparency in costs, quality, and other patient experience factors put consumers at a disadvantage in choosing providers. They literally cannot determine who will be responsive to them prior to an actual experience—after which time they are already "aligned."

> There currently exists no process to adjudicate patient complaints or cases, outside the provider's own reach. Providers move frequently now between "in" and "out" of network status by virtue of negotiations and personal change of practice/insurance decisions. Patients have no way of knowing whether their provider will remain or not within their coverage choice.

Trust and Transparency Criteria for Mutually Beneficial Patient-Provider Alignment

All purchasing arrangements—the underlying premise for Value-Based Health Care—are based on a set of defined purchasing factors, plus additional factors that influence the purchasing decision itself. With patient alignment or selection, patients are asked to make a semi-exclusive and long-term purchasing arrangement that will involve repeat purchases of services.

If we want consumers to shoulder the burden of health care costs and better engage in their outcomes, these direct and indirect factors must be satisfied so that patients are not endangered by the incentives under provider financial risk—denial of access based on risk, or refusal of treatments based on cost.

So let's take a moment to review how consumers make purchasing decisions. The elements are pretty standard across all industries and include key product features as well as comparative information.

For any product or service, consumers need to know:

- Product detail;

- Quality information related to the product (in the case of routine services, consumers regularly consult Yelp and Amazon ratings);
- Cost of the product;
- Similar information about comparable products or services.

The purchasing decision itself, which in this case is a long-term alignment with a provider, assumes acceptance of the product information, but then adds:

- Confidence in the seller;
- Customer service;
- Other experiences of friends and family with the provider.

When it comes to selecting a PCP, patient alignment with providers must be a positive and shared arrangement based on trust. That trust is borne by meeting reasonable expectations of services and outcomes, inclusion of other trust agents in the care process, and transparency of value of services. A body of research from various Robert Wood Johnson grants in collaboration with AcademyHealth reveals important findings as to how to achieve positive patient improvements and experiences, while building trust.

In particular, as providers transform their patient operations to meet Value-Based Health Care Goals, they should concentrate on meeting the tests for Trust and Transparency. These include:

1. Increase Physician Time and Resources/Support for Patient Care during Scheduled Visits

Physician burnout is a known obstacle to Value, and nearly 80 percent of providers say they are overextended. Ensuring physician time for exams as well as questions is essential, and the inclusion of patient support networks in communication and appointments are key. Before patients can be expected to commit to providers, they must be able to perceive the respect of providers and receive input from their supportive family members or friends. Physicians must be supported by other staff who gather patient preferences and risk details so that clinical time is optimized. Patients will be quick to recognize the sufficiency of the process and should provide feedback that is subsequently used for improvement.

2. Ensure Medical Decision-making Process for Chronic Conditions and Major Surgical Procedures

Providers should actively take into account patient goals and preferences as well as barriers to treatment, and ensure transparency around cost, clinical effectiveness, and outcomes history. While many parts of a care team must be involved in such a process—not only the physician—this will save significant time in later coordination activities. Patients' ability to gain knowledge and actually make decisions with their providers will forge a bond that is personal and inspirational, and will help them achieve outcomes.

3. Ensure Clinical Responsiveness Outside of Visit Time

Centralized call centers (purportedly to help focus clinicians on their patients)—coupled with no means for patients to message their providers or any clinical staff—sends a clear signal to patients that they are unmoored from a physician-patient relationship. There must mechanisms set up for responding to patients, and made clear to patients and their support network, whether via telemedicine, secure messaging or emails, or covering provider options (that do not involve hospital emergency rooms).

4. Publication of Quality, Outcomes, and Patient Responsiveness Data

Patients should be able to assess the quality and performance of an institution, specialty group, or primary physician before a commitment. Rather than marketing clinical specialty or “patient-centric” prowess, providers should give consumers their performance information and details about how they are measuring their clinical performance.

5. Cost Transparency

The only understandable way for consumers to accept cost transparency is through episodic costs. Price lists assume that the consumer can identify and obtain costs for the additional components of care that go beyond physician services, which are impossible for them to obtain in an insurance environment. But it’s not impossible for providers to create such a resource; they know who and what will be included in an episode, and they also have benefit and allowed cost information (or can get it).

Without argument, this is an ambitious list of transformative items that can’t be completed in one year or even two. But if ACOs and providers believe this is too much to do, then it’s a sure sign that they are also not prepared to fully commit to ensure what patients need in a mutual long-term relationship with its guaranteed repurchase of services. Unless we are working to achieve the Trust and Transparency required to make Value-Based Health Care a reality, we will also miss the opportunity to make health care work for both providers and patients.

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Image: Sharon McCutcheon

Roji News Roundup: Fall 2019 Edition

written by Evelyn Herwitz | November 14, 2019

In a range of recent industry publications, Roji Health Intelligence CEO Terry Hush shares her insights on the latest moves by CMS and health care trends:

Are Value-Based Models Helping or Hindering Care Delivery for Primary Care Providers

AJMC Managed Markets Network, October 10, 2019

This article by Jaime Rosenberg summarizes Terry's presentation at the National Managed Care Physicians 2019 Fall Managed Care Forum in Las Vegas. Value-based models continue to enter the health care system, affecting a variety of fields, including primary care. And while success stories have been shared by payers and CMS touts these models as a way to "save" primary care, Terry explains why revising payment models without changes by practice won't be enough.

How primary care physicians can navigate business intelligence challenges under risk models

HFM, September 5, 2019

Terry explains how primary care physicians have been enlisted in the Value-Based Health Care effort, with revenues linked to meeting targeted cost measures to entice practice participation. But many of these physicians lack the business intelligence capabilities needed to be successful under these models.

As MIPS, practice hassles get harder, pay-for-performance gets more attractive

Decision Health/Part B News, September 5, 2019

Terry is among the experts quoted in this article by Roy Edroso that examines how MIPS requirements and fee-for-service may be

driving some providers out of business or into new payments systems preferred by CMS.

Nine Reasons Health Execs Are Excited for the Future

Managed Healthcare Executive, August 26, 2019

One of nine health care execs quoted in this roundup by Tracey Walker, Terry highlights the trend toward consumer empowerment in managing their medical decisions and costs as a game changer in health care cost control.

5 Actions ACOS Should Take Now: Takeaways from Proposed CMS

ACO Newstand Weekly, August 15, 2019

Terry explains why ACOs should take a holistic approach to reading CMS's proposed revisions to the PFS and QPP, as well as the proposed Outpatient Prospective Payment System (OPPS) rule.

Three key quotes on bundled payments in ASCs

Becker's ASC Review, July 11, 2019

Terry is one of three experts quoted on this top-of-mind issue for many ASC leaders.

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Image: Robert Bye

The Hedge Bet for Risk is Patient Experience

written by Theresa Hush | November 14, 2019

Creating a good Patient Experience in health care has gained little traction, despite being touted as one of the Triple

Aim's key goals in Value-Based Health Care. Health systems have been more focused on how to increase patients via health plan negotiations and consolidating regional providers, rather than focusing on the slower paced process of improving customer appeal.

But now Patient Experience appears to be gaining some attention, and some forward-thinking providers are innovating to be more attractive to patients. Why? Because in the fiscal landscape of Risk, growing patient volume is essential. Providers are beginning to realize that there actually is competition for those patients.

Patient Experience Should Address Issues Beyond Convenience, Including Quality and Cost

From choosing a physician to paying for completed services, consumers have registered many complaints about the Patient Experience. Let's examine just the highlights:

- Lack of easy-to-find information (beyond basic credentials) to help decide choice of provider;
- Difficulty accessing new provider within a reasonable timeframe;
- No availability of online scheduling;
- Restricted or no access to established provider (directly to office) for urgent needs;
- Long waiting times at appointments;
- Not enough time with physician during appointments;
- Lack of data or information supporting treatment proposal;
- Lack of cost information on treatment;
- Cumbersome, time-consuming authorization and referral policies;

- Billing issues.

However, the issues go deeper than convenience. We haven't really addressed what consumers have a right to expect from health care providers in Value-Based Health Care—including the safety and quality of the experience.

In fact, the measurement of Patient Experience is somewhat controversial, as defined by two different schools of thought. One school holds that Patient Experience should be informed by satisfaction with health care entities' convenience and responsiveness. The second school counters that measuring whether health care delivers a good Patient Experience raises a larger question that also incorporates the quality and safety of health care services. How to properly account for what consumers should expect, and how to measure it, is at the root of the World Health Organization's (originators of the Patient Experience discussion) efforts to examine how best to respond to consumers.

For providers, this broader definition means they should also assume responsibility for responding to a second set of issues as part of Patient Experience strategies:

- Health care outcomes and quality measure results;
- Mortality rates associated with key procedures and/or hospital diagnoses;
- Readmission and surgical redo rates;
- Costs associated with medical and procedural episodes;
- Medical decision-making processes and information that will be provided to patients;
- Inter-operability and policies on access to medical records;

- Patient safety results, including MRSA and infection control policies.

Obviously these are not issues that can be resolved in the near term, but every provider needs to understand that patients cannot segment their experiences into convenience and quality. That fact is becoming clearer as we look at how young adults are deciding how to get their health care services.

According to a 2018 Kaiser Family Foundation study, 45 percent of millennials between the ages of 18 and 29 have no primary care physician. The survey also found that young adults tend to rely on retail pharmacy clinics and online telemedicine sites. Conveniences in scheduling and hours, as well as cost, are responsible for the shift in thinking. However, that doesn't tell the whole story. Because if consumers could distinguish the value of health care and expect a Patient Experience of higher quality and known cost, the trends might well be different.

As Value-Based Health Care educates consumers, they will expect data and information on both convenience and quality to be standard fare. The Patient Experience, to convey more value, cannot be minimized as simply average wait times or hours of service. It has to ensure that the patient and consumer—as for any personal service or, in fact, even any retail experience—can make prudent decisions based on quality and price. To do that, providers must supply clear and accurate data to patients and consumers as they choose providers, seek services, and make medical decisions.

Provider Consolidation Too Often Works Against Good Experience

Consolidated health care has brought centralization and bureaucracy to health care, alienating physicians—but also their patients. Health care consumers are trading war stories about how to get through the health care system, especially the new centralized call centers and appointment scheduling, which now cover literally thousands of physicians.

The frustration of bureaucracy is just starting to emerge in data, which appears to indicate that while consumers are more satisfied with a high degree of insurance consolidation in their locale, they are much less satisfied with the effects of a big health care bureaucracy.

Efficiency and quality cannot be achieved by increasing the distance between clinicians and their patients, when they most need help, without affecting the Patient Experience. Ask patients what they want—and have always wanted: time with their doctors. Not surprisingly, physicians complain about the same thing.

Urgency of Strategies for Patient Experience Under Risk

The governmental health care market is moving Value-Based Health Care rapidly toward Risk. In addition to new Risk models for Primary Care and Accountable Care Organizations (ACOs), Medicare has aggressively promoted Medicare Advantage (MA), approving inclusion of attractive benefits beyond straight Medicare, and favorably characterizing the plans. MA plans have continued to maintain high enrollment growth over several

years, and now cover one-third of beneficiaries as the Medicare population surges. CMS predicts that MA plans will cover half of beneficiaries by 2025.

If Medicare patients continue to choose Medicare Advantage (MA) plans based on their costs and advantages, however, health systems will find themselves trapped in an insidious downward spiral of Risk. Intensifying the pressure, as MA plans grow, healthier, lower cost patients will go with them; as a result, providers will be less able to manage under the risk-based reimbursement being incorporated into Medicare ACOs, Primary Care Models, and Bundled Payments.

Medicaid is on a similar trajectory to Value-Based Health Care, although every state is slightly different. Medicaid Value-Based Health Plans and risk-based payments are a common theme, but with the lower rates that accompany that program.

Large, non-government health care is also transitioning—to employer-contracted narrow provider networks. With large health plans largely acting as financial intermediaries rather than actual insurers, employers are now directly working with local hospitals and physicians to supply services to employees. Walmart, the largest employer in the nation, is testing such a plan. Progressive providers, such as Cleveland Clinic, are implementing a strategy to expand through employer contracting of health care services.

As Value-Based Health Care matures, there won't be any "outs" for providers to find purchasers, either health plans or patients, who aren't motivated by Value. Consumers will have more access to comparative information on the Internet—truthful

or not. Many strategies require a long lead-time, but that's all the more reason for taking action now.

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: Asa Rodger

How Physicians Can Navigate to Get Better Value from Specialty Services

written by Thomas Dent, M.D. | November 14, 2019

In recent articles, we've discussed how Value-Based Health Care must help consumers make good decisions. Equally as important, CMS is now emphasizing how physicians should serve as navigators for their patients, providing information and guidance.

Let's take a closer look at how the triad of primary care physician, specialist consultant, and patient can effectively engage in a process that improves Value through better outcomes and lower cost. To focus on the shifting role of primary care physicians (PCPs), we use "physician navigation" to describe PCP actions to coordinate care for their patients. To emphasize continuity of care at stake for the patient, we describe specialty physician involvement as "consultation" rather than "referral."

Improvement of the Consultation Process Drives Value for Providers Under Risk

More than a third of patients are referred to a specialist each year in the U.S., and specialist visits constitute more than half of outpatient visits. Given breakdowns in all components of the specialty-consultation process, this is an area ripe for improvement.

Most Medicare Risk models, such as ACOs and Direct Contracting, hold primary care physicians responsible for cost. To avoid revenue loss, PCPs must scrutinize the sources of cost and ensure that they are participating in the consultation process. Organizations must recognize that the vast majority of costs do not stem from direct primary care services, but, rather, from those ordered or performed by consulting specialists. Pinpointing where the consultation process has successfully delivered cost savings and quality—and why—is essential to the process of developing future interventions to improve quality and efficiency.

Primary Care Physicians Lack Critical Information About Their Patients' Consultations

This takes more than just reviewing EHR data, which typically does not provide PCPs with enough clinical context to support their understanding of whether their patients have received services of value. Our experience at Roji Health Intelligence in data aggregation and analytics teaches that information that is explicitly evaluative (particularly in a negative sense) will most often not be found in the EHR. Poor results may only be inferred from some data, such as laboratory results (e. g., elevated Hemoglobin A1Cs), readmissions, or high volume of ER

visits.

In some cases, this is not anyone’s ”fault,” but, rather, a consequence of a patient’s advanced disease state or some factors beyond the physician’s or patient’s capacity to address. There’s also the human nature factor: When things go wrong, clinicians are reluctant to highlight a bad outcome. When things go right, the reasons are often not clear, and successful outcomes are often taken for granted.

Use of passive data collection, directly pulled from claims and/or the EHR, has been touted as a benefit to clinicians because it reduces paperwork. However, this removes the potential for PCPs’ scrutiny and oversight. When this data is used to evaluate clinicians and patients without any clinical context, it fosters blame games and resentment.

Capturing meaningful data requires direct input from the primary care physician, specialist consultant, and patient. This process should serve to engage and motivate physicians and patients. The crux of improving the consultation process is how to manage this process effectively for both primary care physicians and specialists.

Three Key Elements for a Better Consultation Process

As organizations move into Risk contracting, they need to maintain a healthy balance on how they scrutinize consultations. Over-referring creates cost issues for the organization, while under-referring risks patient harm, physician dissatisfaction, and increased liability.

The following three elements should be part of an effort to focus on the efficacy and effectiveness of patient outcomes involving consultations with specialists. As with every good improvement process, building a positive foundation for physician engagement requires education, innovation, and valid measurement of results.

1. The consultation process should be viewed as an educational opportunity for collaborating and improving patient results. Communication among the parties is essential.

Education should involve all participants in the consultation triad: the primary care physician, specialist, and patient.

The specialist should use the consultation as an opportunity to update and inform the referring clinician of the patient's condition or any planned procedure. Creating a personal link encourages future consultations and can improve the long-term care of the patient. The specialist should, of course, educate the patient and make sure he or she understands the diagnosis and recommended plan of care.

The PCP should give the specialist feedback from the patient's perspective of what went well in the consultation, as well as ongoing information on the patient's status. In turn, the primary care physician should also inform the patient about prior patients' favorable experiences with the consultant.

The patient should provide feedback on the experience of the consultation process, highlighting the learning opportunities for both the PCP and specialist.

2. Innovation, not cookie-cutter processes, will succeed in improving patient outcomes.

Positive and innovative approaches have more success with physicians. But there are no shortcuts to improvement, and feedback from diverse sources as well as physician involvement is necessary. Organizations must dig into the consultation process to see what techniques are worthwhile and successful, with both PCPs and specialists involved in a positive, results-focused effort.

Each organization and practice has its own idiosyncrasies that either enhance or cripple results. These are worth understanding and addressing through positive feedback.

3. Physician engagement in consultation improvement must be measured to get better buy-in and results.

ACOs can measure clinician and patient engagement in the consultation process as follows:

- For the primary care clinician, has appropriate coding been used to indicate that a request for consultation occurred?
- Have the PCP, specialist, and patient completed a post-consultation assessment? This information should be part of the PCP review of the consultation.

Rewarding creative interventions derived from positive outcomes assessments, particularly for challenging cases, can encourage clinician involvement in the process and provide new material for intra-network education and collaboration.

Just getting clinicians to look at the consultation results is a big step. Having clinicians respond on selected consultations that have had a favorable impact is essential. Determining causes of success affords a non-defensive approach more likely to be championed by the clinicians, and lowers the barrier to getting patient feedback.

Primary Care Physician Role as Patient Navigator

This focus on the consultation processes is a key step toward fostering patients as informed health care consumers and physicians as navigators. Even when the patient may decide as a consumer not to follow through on the consultation, the referring clinician should be aware of this decision in order to appropriately modify the treatment plan.

In short, the physician navigator needs to track the consultation in order to make sure nothing falls through the cracks, or to determine reasons for patient hesitancy.

It’s worth noting that any efforts that involve PCPs should be gradually integrated into practices. The pushback against added requirements can be extreme, with some calling the current system a “human rights violation.”

Rewarding clinicians for volume of patients versus improvement in care must change. Combined with other incentives, measuring and rewarding engagement is at the core of changing the system. Finding and exploring success creates an environment favoring improved results.

ACOs and Risk-Bearing Organizations Should Resist Network Steerage of Patients

Increasingly, the choice of specialist consultants is driven by factors beyond patient decisions and PCP preferences. Choice of consultants is often limited by the patient's enrollment in a health plan with a narrow network of specialists. Who is included in the network and how specialists are selected are both critical factors in the patient's choice of health plan; but the need for a specialist cannot always be anticipated at the time when a patient enrolls. If consultation beyond some organizations is discouraged, the patient's and PCP's options are significantly curtailed.

Some large employers are now steering the consultation process. Walmart Centers of Excellence, which uses nationally recognized centers for highly specialized care, is one example of this emerging trend. Volume as a surrogate for quality for uncommon procedures and conditions has been resurrected.

The great majority of consultations, however, are not for such rare situations. A program to improve the efficacy of office-based consultations should prove valuable for ACOs and payers. For this effort to succeed, the primary care physician, patient, and specialist consultant must each contribute, listen to one another, and collaborate. Maintaining a focus on continuity of care and long-term outcomes is essential.

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Image: John Thomas

How Consumers Can Choose Quality in Value-Based Health Care

written by Theresa Hush | November 14, 2019

In our last article on how Quality should be reflected in Value-Based Health Care, we looked at the problematic route of quality measurement and reporting. The intent to develop payment for quality has resulted in a complex measurement system that produced provider-specific performance scores across hundreds of measures, yet has failed to advance achievement of better health care outcomes. The system creates flexibility for providers by allowing choice of measures, which eliminates consumers' ability to see differences among providers.

The quality agenda needs to mature. In its developmental period, there was a need to achieve consensus on the standard of care and outcome criteria. Providers were not initially on board with public measurement, so there was a slow, voluntary, and specialty-specific implementation. The idea that fairness required universally applied quality measurement was a common theme, and many early clinical integration efforts focused on all-physician measurement.

Quality Must Be Linked to Consumer Knowledge and Information

If providers should be paid based on Value, however, Quality must be refocused on goals that are calibrated to the central question of Value. That is, can consumers choose health care services wisely if they have the right data on outcomes and cost?

There is a corollary to this question of consumer choice, for every choice of health care services also involves a choice of providers who will deliver such services: Can consumers choose health care providers based on data that shows their specific quality and cost?

Granted, these questions assume that the central focus of Value-Based Health Care should be on the consumer/patient—not just as a beneficiary, but also as a decision-maker. That shift in consumer roles is key to the emerging plan for Quality as part of VBHC, and whether it works to advance care for patients.

Restated CMS Value Goals Give Consumers a Central Role in Quality

A few days ago, CMS released comments that summarized its redefined concepts for Value as four goals, all of which touch on Quality:

> Transform patients into empowered consumers.
> Enable health care providers to be accountable patient navigators of the health system.
> Pay for outcomes and expand payment of episodic payments.
> Prevent disease before it occurs.

A recent development in VBHC is the use of "consumer" language. Consumerism is concerned with shopping and choosing, understanding Value components of Quality and Cost. Even in defining providers as "accountable patient navigators," CMS is specifying that the provider role is *to help patients choose* based on benefit (quality and outcome) and cost.

The agency further defined how these goals should be reflected in its fact sheets on payment models, with specific reference to the changing role of patients (to be consumers) and providers (to be navigators), emphasizing the need for transparency through interoperability, data, and a revised focus for quality measurement.

Indeed, along with redefining Value, CMS is proposing a major simplification of quality measurement beginning in 2021 with a redraft of MIPS quality measurement to focus on "what matters." There is no doubt that MIPS has not met its goals. Critics charge that too many quality performance measures make it impossible to compare physicians, all of whom have freedom to

choose different quality metrics—a conclusion reached by Medpac, the congressional Medicare Payment Advisory Commission, in 2017. The truth of this is irrefutable.

In addition to significantly reducing the number of quality measures for physicians, CMS has proposed using claims data to evaluate quality, focusing on core primary conditions and major specialty episodes, and reducing burdensome data gathering for clinicians.

Can Consumers Recognize Health Care Quality Now?

It is the rare consumer who is educated and informed enough to make wise health care purchasing decisions. Smart consumer decisions involve more than transparency and interoperability. Consumers must have the ability to determine quality in order to participate in Value—including quality of provider and appropriateness of treatment.

Consumers' ability to decide treatment options based on Value are limited by medical literacy, coverage, ability to pay, and information from the provider. Few would disagree that the current system is plagued by shortage of face time between physicians and patients, which impacts ability to decide well. Good data on outcomes and costs of treatments is not readily available to consumers if providers don't supply it. Also unavailable is data that validates provider expertise in achieving outcomes through enough volume and a standard of care.

Physicians cannot be navigators of medical decisions unless they have centralized data to provide to patients. Decision-

oriented patient education is rarely provided now, and is, at best, oral.

Thus, our first task in achieving Quality must be to address how to get valid data to consumers. To cite just one high profile example, the failure of the University of North Carolina Children's Hospital to reveal mortality data about its pediatric heart program, even as staff cardiologists expressed concerns about surgical outcomes, should make us pause to ensure that the basic requirements of adequate volume, public reporting of mortality and other quality outcomes, and patient-reported outcome data contribute to consumers' ability to decide.

If the MIPS program is reduced to a set of core measures, how are patients to determine a particular provider's quality if it falls outside that arena? We must ensure that consumers have the data to see quality and compare outcomes between providers.

Every payment system—including Risk—has incentives to provide or deny care, or to vary the regimen. Under provider risk, we need to ensure that consumers have an independent and neutral source of data to evaluate whether they are being "navigated" inappropriately—along with an appeals process for consumer complaints, which will undoubtedly occur.

Five Essentials of Consumer-Oriented Quality Measurement

For VBHC to empower consumers, Value must embody measurement of consumers' access to care when they need it and their ability to make quality-based choices about treatment and providers. Time, often categorized separately as part of "patient

experience," is a quality indicator to consumers. These five essentials should drive consumer-oriented quality measurement in VBHC:

1. Standardized data to determine quality and engagement potential with providers should be available to consumers and patients.

Patients should be able to know basic provider practices prior to committing to care and to see data that reveals accessibility and emergency room usage. Additionally, safeguards under risk payment should be established to ensure that higher risk or older patients are not shunted away from the practice in an attempt to avoid risk. Tops on the list of standardized data that should be available:

- Average time to appointment for established patient;
- Off-hours access for covering provider, yes or no;
- Electronic health record access for patient;
- Patient lab results posted in EHR annually, yes or no;
- Use of EHR for provider-patient communication;
- Patient use of Emergency Room care, Per Member Per Month (PMPM), for primary and medical specialties;
- Patient use of Emergency Room care within two weeks of procedure, Per Episode (procedural specialists);
- Number of patients dismissed or refused care in practice when the practice accepts new patients.

2. Quality of core outcomes should measure improvement over time, rather than absolute values of instance-based intermediate outcomes, for both primary care and medical specialties.

Improvement is an indicator of whether the provider and patient are working together to improve outcomes. This, in turn, is a function of physician-patient communication and decision-making, and commitment to improvement.

3. Specialty episodes should use a standard unit for evaluating specialty procedural and management quality and costs.

For procedures, patient-reported outcomes on functionality at various times from a procedure (e.g., eight weeks, six months, and one and three years from the procedure);
For medical patients, improvement of key outcomes should be measured over time.

4. Clinical data harvested from EMRs should populate outcome measures.

This should be integrated with billing or claims data to identify patient episodes or services. However, quality data should also not be dependent totally on EMR and claims data, but must incorporate measures of physician engagement, communication, and feedback loops from physicians and patients.

5. Core clinical outcomes reporting should form the backbone of quality measurement.

Organizations should be held responsible for internally measuring processes to meet standard of care in primary and specialty medicine:

- Core clinical outcomes should include mortality, procedural complications, and repeat procedures, as well as clinical outcomes and patient-reported functionality.
- Process measure results should be submitted to a qualified registry or data vendor for validation, in a process similar to audited financial statements.
- All core clinical and process measure results should be posted on provider websites and in patient promotional marketing.

The objectives of quality measurement in VBHC, while lessening the burden on physicians, must create Value for the consumer. Outcomes measurement can be streamlined, but still be even more clinically relevant, and can be standardized for comparison of providers. More is needed, however, for ensuring that patients' access to services and communication with physicians—important indicators of engagement and quality—are part of the quality measurement process.

While the importance of moving to Value-Based Health Care can't be overstated, modifications to the existing system must be applied gradually, and performance results measured. The reform of quality measurement creates potential risk to consumers and patients by moving away from measurable processes of care, even if unwieldy. This is especially relevant at a time when consumers face an increasingly consolidated health care

industry where they bear more cost but have weaker relationships with providers. Replacement measures should be tested and implemented, with consumers playing a key role in the process.

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Image: Debora Bacheschi

Emergency Rooms Cannot Be the Only Option for “Regular Sick” People in Value-Based Care

written by Theresa Hush | November 14, 2019

I don’t normally write articles on health care based on personal experience. Fortunately, my health is good and my non-routine health care mostly involves orthopedic injuries. Those injuries have taken me more than once to hospital emergency rooms, where I usually am able to leave afterwards and not, instead, have surgery. No chronic illnesses and no prescription meds. I realize that I am a rarity.

In the context of Value-Based Health Care (VBHC), most administrators assess emergency department use as optional. As if, except for traumatic injuries, orthopedic injuries, and heart attacks, doctor-office visits are an available alternative to going to the ER, at least for those who are just “regular sick” people. By extension, VBHC assumes it’s okay to penalize those doctors or health systems for *not* diverting patients from the ER via better care coordination, and to make patients pay a big penalty for going there. But do these

penalties just stress out patients and physicians who realistically have no other option?

My experience last Tuesday night made me realize how our basic system is completely inadequate to handle the needs of people experiencing a common sickness—regardless of whether they have physicians and insurance.

That event started a week ago on Tuesday evening during dinner, when I felt something wash through my right eye. Alarmed, I checked in the bathroom mirror. Half my eyeball was beet red, no veins visible. I panicked. Was it a stroke? Retinal detachment? Had something else burst in my head?

Are Doctors Quitting More Often, or is This Random?

I decided that my problem could not wait to be addressed. In fact, I realized—wait for what? For reaching my doctor? Because my doctor had actually quit, the second doctor to leave me in three years. I know I'm not the only one experiencing the reality of physicians leaving regular practices for concierge medicine, or executive medicine, or for health plan jobs. In fact, shortly after my doctor quit, my husband's doctor of ten years also quit. So we are both "between" doctors.

I found a primary physician in a different practice. My appointment, scheduled in July, is for late November. Reaching a doctor, therefore, was not a possibility.

Is Urgent Care a Safety Net?

I called a Lyft and headed for the emergency room. On the way I

googled urgent care centers, debating lighter options. Not that I felt comfortable without a skilled ophthalmology exam, but to my astonishment, every urgent care center on the list—in the busy heart of Chicago—was closed.

The fact is, having already investigated urgent care as well as drug store clinics during a minor ailment last month, I found no appointment times that were in any way "urgent." If I had the flu, I would not have met the short timeframe wherein Tamiflu would work.

If urgent care was a safety net in our health care system, interoperability of health records would be a reality. Clinics would be open in the evening, not closed after five on a weeknight, with only the emergency room as an alternative. Care would be seamless and designed for regular sick people.

To get my annual flu shot through the local retail pharmacy clinic, however, I had to register with another health system operating the clinic. None of my normal records are available there. Is it reasonable to trust a medical system that knows nothing about you to provide more than a flu shot? For a bleeding eye, for example?

145 Filled Emergency Beds, and 50 Waiting

So I continued on to the nearest emergency room, an academic center with a large operation, and which also happens to hold all my records. It was a week-night, and there was not one vacant seat. It was the last place I really wanted to be. It would be a miracle if I escaped there without a virus clinging to every hair.

Besides filling all the seats, people were parked under blankets in wheelchairs, in the aisles and along the walls, some slumped sideways in an attempt to recline. Clearly, people had been there for hours. Some were pale with sunken eyes, confused either from illness or dementia. Some resisted having their vitals rechecked—they complained it had been already done, but that was actually hours ago.

A sympathetic nurse came out and made an announcement. Everyone would be seen, she said, and she was sorry that it was taking so long. There were 125 emergency beds, but they were all filled, and there were 50 people waiting to get to those beds. The process for admitting people to the hospital was very slow, and they were trying to speed that up, but there was a shortage of available hospital beds. She promised that everyone would be seen, and that there were plenty of doctors and nurses.

She ended on a pessimistic note: the longest wait time was six hours. Most people around me had been there for more than three. She made the offer that some of us might want to go into the hospital lobby and wait where there was more room, and they would get us. Not many takers, although I weighed the option.

While I waited, I surveyed the crowd of fellow travelers. There were a few people who were ambulatory, like me, but most patients were quite ill, as if with flu. They spanned the spectrum of Chicago humanity. A mix of diverse races and ethnicities, some appeared affluent, others not. I heard many languages spoken. I guessed that some might be homeless, but most had family in attendance. The patient next in line after me announced emphatically that he had a mental illness. Anyone suffering from a heart attack or gun shot wound was already in

the beds or trauma unit. The rest of us were regular sick people all waiting to be seen because we had no one else available.

I lucked out. Ophthalmology has a room with a chair, so I didn't have to wait for a bed to empty. My in-and-out time was 2½ hours, and my diagnosis wasn't impending blindness or worse. Now I worry that someone—or myself—is going to pay a penalty for checking out my bleeding eye in the ER.

Too Many Disconnects Between VBHC Incentives and Patient Ability to Access Care

Processing my emergency care experience, I was struck by the huge disconnect between the incentives under VBHC and the organization of health care practice. The ER default I found myself in is symptomatic of a much larger disconnect, where consolidation in health care and modern medical practices can work against patients getting the service they need, when they need it.

The physician-patient relationship is not only truncated inside the exam room, where lack of time, EMR documentation needs, and "playing to the test" of the quality templates gets in the way of real dialogue. Outside the exam room, maintaining the connection between people and their physicians is even harder. An administrative bureaucratic layer lies between consolidated health systems—with employed physician practices—and the patients.

Patients in such a system are literally unable to actually reach the primary care physician's office. Instead, they reach a central call number for all 5,000 or so physicians, where the

patient's complaint will be handled by a clerical person with rules to enforce, and no medical knowledge. As consolidation in health care continues to expand, more physicians and their patients are falling into that chasm.

But if Value is to succeed, we have to create policies that will make a stratified delivery system possible. That means ensuring the existence of a quality urgent care system with information that feeds back into physician practices and health systems; the alternative, creating real 24/7 care within all physician practices and health systems, should be officially declared dead for lack of provider interest. Nonetheless, even with the existence of urgent care, health systems need to rethink their centralized communication mechanism with patients and ensure that patients can actually work with their physicians, and vice versa.

Points of access between patients and their health care providers are essential, if the job of a delivery system is to provide care when needed. We can't build incentives around an idealistic version of how medicine should work, and then hold providers and patients responsible for the failure of idealism. Value-Based Health Care needs a good dose of contingency planning and reality checks.

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Image: Aimee Vogelsang

Are Patients at Risk when Quality Measures Scale Back?

written by Theresa Hush | November 14, 2019

CMS is now poised to roll back quality reporting requirements in 2021, vastly altering the direction of quality measurement. Simultaneously, CMS will reduce the weight in Value formulas dedicated to quality, transferring the balance to Cost over the next five years. As providers face risk-based reimbursement, what protections are needed to ensure that patients get the right care? Does streamlining the program give providers a pass on quality? And, how do patients choose providers when there is no standardized measurement?

In this second in our series on whether Value-Based Health Care is on track to meet its mission, we take a closer look at Quality and its role in defining Value.

What's the Point of Quality in Value-Based Health Care?

Most industry people connect Value-Based Health Care with money, purchasing, affordability, services—the finances and transactions of health care. But Quality is really the heart of Value. Quality and its more measurable results, Outcomes, are what Value-Based Health Care was intended to incorporate—for real people. It is a benefit-to-cost ratio that involves consumers as well as third party purchasers.

Value-Based Health Care is not just about controlling costs; it's about what we get for our investment. If we spend more than any other country on Earth, yet our life expectancy is lower, we have a deficit of public health benefits in relation to what we are spending. More evidence: the highest maternal death rates among all industrialized countries, the highest opioid addictions, and inequities in outcomes for African Americans. Throughout our health care system, outcomes are

falling short in relation to what we pay.

That is where we now stand with Value-Based Health Care. Quality was supposed to be a key component, measured by whether individual patients' care and results reflect Quality. However, the imperfect design of Quality measurement, the use and abuse of its "scores" by provider organizations and CMS, and the flaws in the Reporting system for Quality have each worked to sabotage meaningful efforts to measure and implement good care.

How Did Quality Measurement Go So Wrong?

The early and voluntary Physician Quality Reporting Initiative (PQRI) was the first formal Quality reporting to Medicare, based on newly adopted measures accepted by the American Medical Association and provided to CMS. Managed care plans had used HEDIS measures approved by the National Committee for Quality Assurance (NCQA) for years, with data sometimes compiled by providers and reported to health plans. PQRI measures resulted from work groups, with ultimate oversight by the AMA, which brought together specialty physicians and experts to agree on standards. Existing measures from the National Quality Foundation (NQF) and Association for Health Research and Quality (AHRQ) as well as HEDIS measures formed the basis of PQRI measures, but other organizations also came into play.

One key precept was that quality measurement in medicine should be universally applied. That meant that measures were constructed for all specialties and all physicians, so that everyone could participate in quality measurement.

Let's think about the effect that has had on today, with 250

MIPS measures in 2019 (actually reduced significantly from previous years).

Quality measurement was designed, despite individual patient measurement, to be physician-and specialty-focused. The "fairness" rule was applied by the founders of the system: it was unfair for one group of physicians to be measured and another not. To accomplish that across about 38 medical specialties and subspecialties—including some for which quality mattered to patients more than others—required, at the outset, a system with many measures.

How Provider Organizations' Applied-Quality "Scores" Hurt Physicians

Administrators eager to push their organizations to achieve higher Value-based incentives used raw measure results as cudgels, embarrassing or punishing physicians with poorer measure results, without understanding the data's limitations.

There are many reasons why data is incorrect or not captured correctly. Data is not pure, complete, or even correct because it comes from a database. It's often just bad data or not well-collected, and good and bad results alike need to be reviewed and validated by some provider-driven process.

Having received data from thousands of systems, our company once provided pretty awful "Data Integrity" scores back to provider clients. Our intention may have been good, to help moderate the use of the measure data and to improve data capture and storage. But it was still a bad idea that we stopped quickly. Our clients were also victims of their vendor's systems and their implementation by long-gone staff,

not to mention that change is slow.

Making Reporting Easy Also Makes Quality Impossible to Compare

One of the obvious goals of PQRI, then PQRS and MIPS, was to use Quality results not only for Value-Based incentives, but to improve. Also, in the early days of Value-Based Health Care, optimists believed that comparing quality measure results by practices would help patients choose doctors. The CMS Physician Compare site was established to realize that vision.

But CMS allowed "give" in quality reporting from the beginning. A quick and easy sampling of patient quality results was given the green light in lieu of all-patient reporting. A transitional year was introduced under MIPS to permit providers to report just one measure. Group reporting versus individual provider reporting, reporting through various organizations or directly through EMRs, or, for ACOs, submitting fewer quality results on a sample of patients were all okayed. Finally, since providers could select measures to be reported, they could optimize their results under reporting.

In each case, lenient reporting has reflected the reality of a health care system that is too complex and too varied to be easily pigeonholed. Quality in Value-Based Health Care was idealistically designed, but has proved to be unwieldy.

Calculating the Appropriate Burden of Quality Measurement

There is no doubt that organizations have hired legions of administrators to oversee quality measurement and data capture,

affecting support staff and, sometimes, clinicians in practices. Clinicians have also had to ensure that they have captured the detail supporting measures in EMRs during or after patient visits. Practices without EMRs have had to find alternatives at great expense and manually input data into other systems. And sometimes those systems don't store the data in a way that is easily retrievable, so post-audits of clinical records are necessary.

The work of quality measurement can't be minimized, but we should separate the underlying systems issues, such as:

> How can certified systems be unable to produce stored data in standard formats? Shouldn't minimum data reporting functionality be required as part of certifications?
> If we have determined that electronic record systems serve the public good (which I think is the case), shouldn't providers ensure that practitioner use of the system results in retrievable quality and clinical data?

The fact is that if EMRs are well implemented and maintained, clinical and quality data is retrievable and of high value, with very little burden on physicians or staff. That is demonstrated by excellence in most of our clients' data, which can be processed quickly and seamlessly flows into quality measure results.

Limitation of data capture to claims will dumb-down the Value associated with Quality in a big way. Instead, our efforts should focus on making real Quality reachable and easier to attain.

Should We Abandon or Roll Back Quality Measurement?

The famous Peter Drucker quote, “We can’t improve what we can’t measure,” is truth. Without measuring specific results, we don’t know how close we come to the standard of care, nor can we address variations. Before the current Quality effort, there was virtually no standardized method that required physician performance measurement.

There should be concern, under financial Risk, that patients who are sick will be steered away from organizations that are paid per patient. It happened under previous Risk models. Our economic system has a perfected acumen for maximizing profits, and as health care systems have consolidated into mega health enterprises, the bottom line is watched closely.

These questions are essential:

- What unintended effects will occur if providers are no longer required to submit quality scores?
- If we require providers to internally capture and measure performance but do not require reporting, would effectiveness diminish or accuracy suffer?
- What other measures should we establish to protect patients from poor quality under Risk?
- Is universal physician quality measurement necessary—or even desirable?
- Can administrative data (claims), under CMS proposals for Quality in 2021, provide enough to support quality measurement without clinical outcomes data?
- How should quality measurement deal with new scientific studies on effectiveness and/or unintended effects?

> Where do patients weigh in on quality of care? How can we make patient-reported outcomes practical and add to the value of measuring Quality?

We need these questions answered in the process of revamping quality measurement and reporting. Quality measurement should be addressed not only by providers affected by the process, but also by consumers and advocates. As we think forward to how to best configure Quality as a part of Value, we should do less roll-back and more reshaping. We'll tackle that challenge in future articles.

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: Ella Olsson

Fixing Clinical Science Requires a Moonshot

written by Robert McNutt, M.D. | November 14, 2019

“We chose to go to the moon”

President John Kennedy’s statement instigated a monumental marshaling of resources to achieve a remarkable goal. Those famous words also established a powerful metaphor for aiming high. We need an equally monumental shift in purpose and

commitment of resources for how we conduct clinical science. Nothing less than our nation's health is at stake.

In my view, there are only three possible ways research efforts might proceed:

First, the conduct of research might not change, but continue to rely on observational studies and non-generalizable randomized trials (RTs). If so, populations of subjects included in studies, even large ones, will remain unclearly constructed and fail to include large enough groups of people with varying prognostic differences. As a result, our ability to maximally advance care will languish. To cite but one example, the massive National Lung Screening Trial (NLST) did not recruit systematically, or randomly, so generalizability is a concern.

Second, clinical research might be usurped by artificial intelligence (AI). Some believe studies will become comparative analyses gleaned from data sets. Comparisons of medical treatments and plans based on algorithms are common and growing in volume. Some comparisons, even, are manufactured under the rubric of "machine learning." However, these efforts are just a form of observational research, claiming superiority merely by the sheer size of the data sets.

I do not think AI, as conducted at present, is good research, as pointed out previously. Correct comparisons require three components:

- a random sample of a complete populations' data, or the complete population of patients;

outcome data gathered systematically to answer a targeted question; and
planned interventions uniformly applied to groups being compared.

In my view, if research only follows the AI idea, it may hurt more than help us, especially if we blindly follow the “black-box,” non-transparent production of information. AI programs must face the scrutiny of high quality research, not serve as a proxy for it.

Third—my hope—would be a shift toward systematic RTs using generalizable random samples of subjects and full population interventions. We have not examined fully enough, in my view, how to harness our advancing data gathering, sharing, and analytic expertise to enhance research.

How to Get There

How might we organize for better research? Here are some ideas:

1. Reorganize the National Institutes of Health to Consolidate Data

I will not recount the organizational chart of the NIH, as its description would fill this blog and dozens of others. The NIH, in all its glory, is a difficult-to-coordinate cacophony of efforts. Don’t get me wrong. Amazing work is done, both in basic and clinical research domains, but if better RTs are the goal and better full population research studies are needed, then consolidation of NIH efforts will be needed. Presently, in my view, the NIH is inefficiently designed and managed.

One consolidation approach would be to have all clinical research efforts organized by the existing Center for Information Technology (CIT). Each individual institute presently manages both basic and clinical research. If clinical research with RTs becomes systematic, like the Gallop model, there would be no need for each institute to house, maintain, and query any other group of research subjects, other than those in full population disease registries. These disease registries could be collated and maintained by CIT. Each individual institute might advise on what diseases should become registries, but they would not have to develop their own. For example, if the National Cancer Institute decided to conduct research on breast cancer patients, the CIT disease registry event database would be queried. In other words, if there were a national disease registry database, clinical research efforts for all centers could be consolidated.

2. Encourage Creation of Private Sector Disease Registries

While I still believe that government is the best leadership source for research efforts (the NIH paid for nearly a third of all research conducted, even outside the auspices of the NIH), that is not necessarily the only option. Another model would be private enterprise. If I ran an electronic medical record company (EHR), for example, I would maintain disease registries. This idea is not a foreign one; I have seen EHR/insurance partnerships intent on building disease registries for research with their patients. While private enterprise may hasten the development of disease registries, however, they will still need to be linked to other disparate electronic database companies for full population random

samples. This requirement for sharing between different private enterprises may require government leadership.

3. Foster Tools to Search Large Data Sets for Specific Disease Conditions

A model for full sample query of different datasets across multiple sites of medical care might be accomplished by a "disease research registry app" capable of trolling large data sets for disease domains. This, also, is not a new idea. Our government is now demanding that data be shared, and data sharing models are being developed in response. It's only a matter of time before some bright young data programmer figures out how to query any electronic data set to find specific disease conditions. I would even wager that machine learning is pointed to this idea in the future.

4. Promote Full Population Studies as the Foundation for Defining Quality of Care

The process of paying for quality of care must evolve beyond the present scientifically unsound efforts to, instead, full population studies. Paying for quality is laudable, but, presently, many are unsure that quality is being measured and whether paying for quality (as currently measured by processes and one-point-in time measures) actually makes care better for patients. My next post in this series will compare and contrast the present quality payment system versus full patient population studies, like the stock-market model, and demonstrate that we should only be paying for a "prove you improved" model.

Research can be better. Too many studies are wrong and cannot

be replicated. There is a reason; we are doing studies poorly. Getting better will require new ides about assuring random samples of full populations, or full sample research. In addition, we will need to think hard about how we should develop our leaders in both the private and government sectors to foster better research models. It is time to go to the moon for better research.

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Image: SpaceX