# Best Practice MIPS Quality Reporting: QCDR Group with Individual Accountability

written by Dave Halpert | June 15, 2017

The “transition” phase of the Merit-Based Payment System (MIPS) is half over, and so, too, is the time needed to prepare for the full rollout in 2018. Yet during the 2017 MIPS “transition” year, many providers are still trying to pigeonhole MACRA’s MIPS into the previous quality program, PQRS. That choice may have worked for simple quality reporting, but it doesn’t work for MACRA’s more comprehensive approach. Among other things, it overlooks a key decision—whether to base quality reporting on group practice or individual provider results.

The problem is this: MIPS is not PQRS. It is a full-fledged Value-Based Health Care program. The choice between Individual or Group Practice quality reporting has huge implications for future revenues, public quality reports, and possibly consumer and payer choice. The financial stakes are high—within three years, there will be a financial gap of 18 percent between providers at each end of the scoring spectrum. The financial

rewards (or penalties) are derived from the differences in patients' outcomes and experience.

## How Individual and Group Quality Reporting Methods Differ

Practices at the Tax Identification Number (TIN) level have the choice of reporting as individual clinicians or as a Group Practice. Group Practice reporting means that the *Group Practice is scored as a whole*. Some providers will have a larger impact on scoring than others, but, in the end, the practice is scored as a collective unit. Organizations do not need to register for Group Practice reporting in 2017, unless reporting directly through the CMS web interface.

Individual reporting requires that *each provider meet successful reporting criteria,* so more measures will be used under this method than under Group Practice Reporting. Individual reporting is exactly that—one provider's scores may differ substantially from another's, even if they're in the same practice.

Organizations that choose to report individual providers share a few common reasons:

- They want to hold providers accountable for meeting quality measures by maintaining measures for everyone, or
- Their structure of TINs, practice subunits and multiple locations are too complicated to reward providers for efforts based on unique group results, or
- Certain providers do not want to be linked to metrics that are not exclusively based on the care that they've provided.

## Individual Reporting Focuses on the Provider, Not the Patient

Under Individual reporting, the organization's focus is on provider-based results. How? Because they are focused on changing provider behavior, making providers more accountable, or meeting provider interests. The organization has pursued individual accountability for the purpose of fairness, making sure that all providers have quality measures and are doing their part to meet specialty standards of quality.

Let's be clear: it is not necessarily bad to pursue a path of fairness or comprehensive quality metrics. But even if it is not bad practice, it may be poor quality reporting. Why? Because the incentives of MIPS scoring are focused on the group and not individual providers. The complex scoring of MIPS does not create a good reward structure for individual practitioners because most of the other scoring components fall as a group. Further, the poor-quality reporting that results from ensuring enough specialty measures for every practitioner can bring down the organization's total score.

## Performance Measurement Should Focus on the Patient

The real downside to an overemphasis on providers and provider comparisons, however, is that it misses the point of performance measurement—the patient.

Performance measurement that is patient-centric is designed to determine whether patients received the care they should have, and whether their outcomes are improving. A patient-centric performance measurement focuses on patient results while still

linking all providers to that patient.

For example, a primary care physician and an orthopedic surgeon will trigger different sets of measures, but each provider's care for a common patient will affect the other's quality scores. The primary care provider won't be performing a total knee replacement, but a successful TKR may mean the difference between a sedentary patient and an active patient, and that active patient will have a much better chance of lowering A1c, blood pressure or BMI.

On the flip side, a patient who has stopped smoking and whose chronic conditions are well controlled will be less likely to experience complications following surgery. This means lower costs surrounding the procedure, which means better cost scoring for the surgeon in a bundled payment initiative and in MIPS. Cost will be increasingly important as a scoring factor in MIPS, and as mentioned above, it's calculated at the TIN level already. More important, a lower episodic cost means that the patient had a better outcome and experience.

## Differential Benefits of External Quality Reporting Versus Performance Measurement

Organizations can and should see performance measurement as an opportunity to discuss shared goals that focus on patient care. Performance measurement can encompass measurement of specialty-driven outcomes as well as improvement in patient outcomes over time. The regulatory disadvantages of quality measures, for example, can be relaxed under an organizational performance measurement program—and they should be.

For example, a MIPS hypertension measure evaluates the

percentage of adult patients with hypertension whose blood pressure was adequately controlled. Under this measure, blood pressure must be taken once in 12 months. However, organizations that are really focused on improving hypertension management will instead plan to measure how patients with poor control progress over time with frequent readings. The MIPS hypertension measure meets reporting requirements and allows for crude comparisons between providers. But by internally evaluating their measure results over time, the organization is in a better position to assess the status of patient care.

The same goes for the application of measures across providers. It is completely possible to include all providers under a performance measurement process, yet choose MIPS Quality Reporting on a smaller set of measures as a group practice.

Satisfying MIPS Quality Reporting is a complicated process of numbers—number of providers, number of measures, “topped out” performance, deciles and patient volume. MIPS Quality Reporting represents a scoring algorithm, not a quality program. Quality Reporting can also be “gamed” by careful selection of measures to best represent high performance areas. This is an advantage to organizations that also have a comprehensive and ambitious performance measurement and improvement program, because they will have many more measures that “fit the bill” for high MIPS Quality Scoring.

The smart way is to do both: concentrate on provider excellence and on patient results, and create a split path of performance measurement and quality reporting.

# Best Practice Dual Path Combines QCDR Group Quality Reporting and Performance Measurement

Group Reporting and Individual Accountability are not mutually exclusive. Practices should maintain individual provider views, as these are critical for benchmarking and identifying discrepancies in outcomes, so that they may be addressed. However, patient outcomes change and are influenced by providers across the spectrum of care. It takes coordinated efforts across the group to produce a measureable difference, and fragmentation pulls time and resources from your overall strategy. The goal should be to improve outcomes over time, maximize Value-Based Care incentives, and provide the best care to patients.

Here's the path:

> MIPS Quality Reporting as a Group Practice, while simultaneously tracking individual measures, and
> A comprehensive performance measurement based on both MIPS and customized measures across the organization.

A QCDR with capabilities across all MIPS components can enable both single- and multi-specialty practices to *report at the group level while maintaining individual accountability among all providers*. We call this a "dual path" because it satisfies both the need for comprehensive measurement across the organization and all providers for quality and cost performance, and a MIPS-focused strategy for Group Practice quality reporting.

Provider organizations that have not reported as groups are often leery of Group Practice reporting, fearing that providers

and administrators will lose the ability to look at individual performance. They needn't worry; a good QCDR can maximize ability to succeed in MIPS while maintaining providers' individual results in both analytics and registry views.

A word of caution: Provider organizations who choose Group Practice reporting should confirm with their QCDR or other Health Information Technology vendor that the data will be submitted at the group level. The provider organization should have the opportunity to review your results on an ongoing basis and prior to submission, at both the group level (to maintain reporting focus) and provider level.

## Why a QCDR is Critical to the Best Practice Approach

Why is this the territory of a QCDR? Because a QCDR that can measure both quality and cost performance as well as conduct performance improvement (unfortunately, not all QCDRs have these functionalities) will be able to measure outcomes over time, gather discrete data to clarify performance results, and create non-MIPS measures to customize performance improvement. These are necessary for a full scale, all-patient performance improvement approach.

A provider determined to focus on what he or she believes are the most important and clinically relevant metrics or strategies is an asset to any group. Single-specialty groups are largely aligned already when it comes to quality measurement, but they need to retain the ability to benchmark and compare for internal quality purposes. Even though multi-specialty groups see patients across the spectrum, they benefit from group reporting as well, while retaining the ability to

pursue broader initiatives to measure and improve quality and cost performance.

Under the dual path of performance measurement and quality reporting, a provider's data results may contribute to the QCDR's database for measuring performance and contributing to other cost and improvement projects, but that provider may also contribute to quality scoring if that benefits the group.

The dual path provider who refuses to play any part in quality reporting stands out as inactive and below par because of absent results. This warrants the organization's legitimate concern and creates the basis for follow-up. It's true that many quality reporting initiatives have previously been relegated to IT or administrative staff, but the Quality Payment Program (both MIPS and APM paths) have changed the landscape. Providers who reject the concept of performance measurement create impediments to improvement, which is harmful for MIPS, but, more importantly, to patients.

## Other Benefits of Group Versus Individual MIPS Quality Reporting

In our experience, *no organization that has previously reported as a group has gone back to individual reporting*. They've found that Individual reporting is too much of an administrative burden and has a tendency to leave certain providers in a precarious position with regard to reporting options; not everyone has the same measures available.

MIPS has shifted extra administrative burden onto those who choose to report as individuals. In fact, reporting as a group eliminates the tedious process of confirming each individual's

MIPS Eligibility status. Even if a provider is MIPS-eligible, that provider may qualify for automatic re-weighting within the Advancing Care section. This actually shifts extra weight to the provider's Quality score, which is one more thing to track. It was challenging enough in PQRS to ensure that each individual was meeting reporting requirements—adding two additional modules (Improvement Activities and Advancing Care Information) triples that burden.

While it's true that Group Reporting will include providers who may not be "MIPS-Eligible Clinicians" on their own, the administrative burden is still eased considerably. Painstakingly entering providers' NPIs into the CMS look-up tool (and then bringing the eligible clinicians up to speed) is a wasted effort—you're better served by coordinating care efforts and improving processes going forward.

Syncing quality reporting efforts means that practices can set outcome-based goals, rather than scramble to ensure that everyone is meeting numeric (but not necessarily meaningful) MIPS thresholds. By selecting and performing improvement activities to achieve your objectives, groups can work strategically to improve quality and cost scores, simultaneously earning credit for your activities. Once again, rather than struggling to confirm that everyone is checking the right boxes, an organization that aligns practice creates better processes to deliver better care. The result is a win-win: higher MIPS scores and healthier patients.

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*their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.*

Image Credit: Joel Herzog

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# Physician Comparisons Based on Performance Don’t Tell the Right Story

written by Robert McNutt, M.D. | June 15, 2017

Medical decision-making requires a comparison. There is, most often, more than a single option for your care. New tests and treatments are constantly being added to the medical portfolio by scientific inquiry. The only way to advance care, in fact, is by comparing options.

Comparing incites a difficult task, however: the compared option that is best for your disease-related outcome may be worse for your test- or treatment-related outcomes. For example, for men with early stage prostate cancer, surgery may reduce the chance of dying of prostate cancer from 8 to 6 percent over 10 years, but surgery increases, simultaneously, the chance of impotence by 20 to 80 percent. Such a trade-off requires individuals to balance the chance of added benefit and harm to know if the potential value to gain is worth the potential value to lose.

## Medical Care Should Inform Individuals About Trade-Offs

Given this vision of decision making, the goal of medical care is to inform individuals of trade-offs and allow them to choose the one test or treatment that is best for them. “Best for them” means that it is likely that two people will choose differently. The goal of the best medical care, then, is to maximize individuals’ variations, rather than the population of individuals’ similarities.

As a result, the best medical care leads to variable decisions made by patients. This means that I may have patients with some diseases who make different choices than yours. And my patients’ choices may lead to differences in their outcomes compared to yours. This is a good thing if patients are making their choices after being informed.

## Comparing Physicians Based on Outcomes, Alone, Fails to Account for Patients’ Decisions

But it may not good for comparing physicians’ care if these individual decisions are not taken into account. The present, similarity-based approach to physician comparisons focuses on outcomes, not decisions. For example, someone comes up with an idea about a valuable outcome measure of care (for example, A1C), measures that item in the population of patients you care for, and then compares your measure of that item to a benchmark derived from many other practices measuring the same thing. If your group of patients has a lower average A1C than another group of patients cared for by other physicians, you are rewarded in kind. But when the focus of care is on individuals, patients may choose to forgo side-effects of more aggressive

treatments aimed to lower the A1C, and, hence, have higher A1C levels. Individualized care and population-based care may well be at odds.

I can understand the desire to compare physicians and health systems. However, it is a complex task from a statistical standpoint. There are more than 240 quality-of-care benchmark measures, each with different numbers of patients involved in the measures, with different prevalence rates of base-line performance among compared physicians. In addition, these measures are being taken out of context. Patients' probability estimates for outcomes will vary based on clinical and personal characteristics (the context). But none of these personal variations will be measured, and presently there is no reasonable risk-adjustment for unmeasured and immeasurable patient variations. Now, throw into the mix the complexities of how people will value outcomes in terms of how those outcomes will affect their lives, and you have a pretty sticky statistical problem on your hands.

## Aggregate Data Comparing Physicians Can Be Misleading

It's not a new idea that comparing individual physicians will be a difficult task. In a study of 11 million patients, only about 2 to 8 percent of physicians were comparable on even the most reliable of quality-of-care measures. Grouping measures improved the number to about 15 percent. These percentages, while paltry, likely overestimate the subset of physicians who can be compared. Why?

Because important measures of patients and their decision-making practices are presently missing from data sets. For

instance, no patients in this study were asked about their choices and trade-offs, and there were no measures of their unique, clinical and personal nuances (I am ignoring the fact that those physicians being compared may not even be involved in similar types of measures or cases). This means that the estimates from this study are not “risk-adjusted” for those attributes of individuals’ informed choices.

With these personal, co-dependent, confounding measures of patients’ choices added to data sets in the future, the comparable number of physicians might be as low as 0 percent because of the large number of confounding patient factors that are unequally distributed among physician groups. Increasing variation in a data set makes comparison more difficult, as greater numbers of patients will be needed for reliable comparative estimates. If individual physicians are to be compared on these sorts of aggregate data sets, we need far more information about their patients and the process their patients use to make choices.

## Accurate Physician Comparisons Need Measures of the Doctor-Patient Decision-Making Process

But, maybe I am wrong; maybe 11 million people are not enough people to adequately test the veracity of comparing individual physicians. Maybe 11 million is too small of a “big” data set, and someday we will have 100s of millions (really big data). This may improve estimates of the numbers of physicians who can be compared, but these population measures, I claim, will still aim at the wrong target. Medical care is practiced behind closed doors between patient and physician. The duo should be spending time discussing the consequences of the patient’s

choice; they should be determining whether the patient wants a better A1C, or what he or she may be willing to give up to lower cholesterol.

Averaged out, large data is at odds with the small data relationship that mirrors a physician-patient bond. As we learn more about comparing groups of individual physicians, I hope we also cultivate, in parallel, the development of a useful measure of the cottage industry of physicians and their patients working to maximize what matters to the patient. For instance, we may need to measure a patient's numeric understanding of the consequences of the choices being made and, concomitantly, how well the physician informed the patient of those consequences.

Science should inform the progress of medical care, and measurement is a key component of science. Measuring physicians and their patients will require more than just data, however. It will involve knowing if patients understand what they are getting into when they encounter the medical care system, and how they, ultimately, direct the system to perform best for them, and not others.

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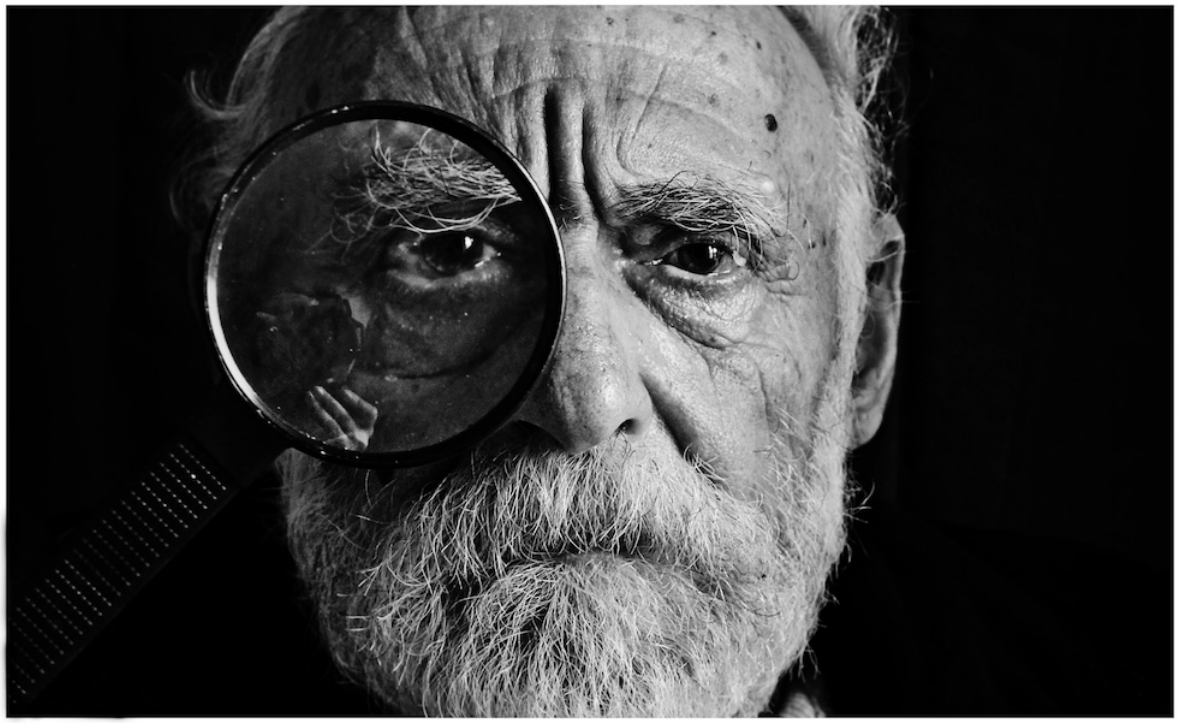
Image Credit: Dietmar Becker

# How to Improve Patient Outcomes with a Multi-Specialty QCDR

written by Dave Halpert | June 15, 2017



Care coordination and HIT interoperability are touted throughout the healthcare world as “must haves” for any provider, practice or health system. The reason is simple:

information from multiple sources helps providers and patients to make informed clinical decisions and provide better care.

A key pillar in any program that quantifies whether providers are “meaningfully using” their EHRs is the ability to send and receive information on a specific patient. If that’s true at the point of care, doesn’t it make sense that performance measurement and improvement would benefit from the same treatment?

Qualified Clinical Data Registries (QCDRs) were created specifically to go beyond the administrative task of quality reporting in order to help providers improve care. A QCDR that can take in data from multiple sources and multiple specialties, including data from hospitals, ambulatory practices (for both private and employed providers) and others (e.g. patient satisfaction survey vendors), can track patients and populations across the spectrum of care, creating a global view of outcomes and costs.

This view of the whole patient sheds light on the “why” behind health episodes. Those using Specialty-Centric QCDRs can track specific outcomes in detail and gain insight on where they stand compared to others who perform similar services. The drawback to this approach is that opportunities for improvement are only apparent when you attempt to see the bigger picture. Specialty-Centric QCDRs significantly benefit the evaluation of specialty-specific outcomes and results. But if you’re in an academic or multi-specialty setting, they may not satisfy all the needs of the entire organization to meet cost and value goals.

## Locus of Focus: The Difference Between Multi-Specialty and Specialty-Centric QCDRs

Specialty-Centric QCDRs pool data from specialists across the country, enabling them to aggregate and benchmark information related to specific conditions, procedures and settings. Ideally, specialists who utilize these systems can continually raise the bar in each setting. As each specialty improves its own care, better outcomes and lower costs will follow. Certainly, there are benefits to this approach, such as comparative studies of the efficacy of specific techniques, long-term disease- or procedure-focused studies, and resulting improvement of existing treatment outcomes.

The drawback to an exclusive specialty focus is the narrowly focused setting. In a Specialty-Centric Registry, poor outcomes are a reflection of the provider, and to improve outcomes, the burden sits exclusively on that provider's shoulders.

Multi-Specialty QCDRs, in turn, draw from a larger dataset of both primary care and specialty contributed data, and the patient issues can become clearer. By looking at all specialties in the network, a multi-specialty QCDR can follow the patient across the spectrum of care. In so doing, the QCDR can integrate data from outside of one specialty group, adding context to patient outcomes. In other words, a multi-specialty QCDR assumes that measurement and improvement cannot occur in a vacuum.

Both types of review have their purposes. Ideally, data should be shared between specialty and multi-specialty organizations to perform both specific and multi-factor review of patient outcomes.

## Episodic Costs: An Illustrative Benefit of Multi-Specialty QCDRs

Episodic care—treatment provided before, during and after a hospitalization—has gained significant attention over the last several years. Programs like Bundled Payments (whether voluntary or mandatory) and the distribution of Supplemental Quality and Resource Use Reports (SQRURs) highlight how tracking patients across specialties is critical to understanding patient experience and outcomes.

For example, if a surgeon hits all marks during a procedure, but the episode produced astronomic costs (e.g. the patient did not follow up with a primary care provider and developed a subsequent complication), who benefited? It certainly is not the patient, and unless the reasons behind those costs are examined, other patients are similarly at risk.

By looking at the underlying causes of high episodic costs, a multi-specialty QCDR can help you address them, benefiting both the provider and the patient. Understanding episodic cost is critical—not because of the pending scoring in MIPS, but because the episodic costs are indicative of whether complications have occurred, and with what frequency. If your costs per episode are out-of-sync with what's expected, you need to know why.

## Next Steps: Develop System-Wide Improvement Techniques with a Multi-Specialty QCDR

Using a Multi-Specialty QCDR, you have the ability to look across the network. The specialty-specific data is still there, with a rich context. Indeed, the right Multi-Specialty QCDR can

act as a hub between Specialty-Centric QCDRs. This benefits all providers—and their patients. Here are just a few examples of how a Multi-Specialty QCDR can facilitate improved outcomes and decreased costs:

## Track follow-up visits following a surgical procedure, a "scary" diagnostic, or post-discharge.

At these visits, providers can identify early signs of complications, investigate other providers' concerns, answer patient's questions, clarify discharge instructions, and customize treatment plans—all of which can facilitate a quicker recovery or slow the progression of disease. An advanced Multi-Specialty QCDR can track patients across the network, whether in the hospital or in the ambulatory setting—even if that means matching patients between separate EHRs (and even if patients do not share medical record numbers across data sources). This facilitates improved care coordination, as well as reduced costs.

## Provide mechanisms for improving rates of screening and/or early detection.

In systems where screening is lacking, potential concerns become real concerns. What could have been a simple screening and follow-up becomes a high-cost—and sicker—patient who needs specialty care. Specialty-Centric QCDRs recognize that complex or advanced cases are more likely to result in poor outcomes. Providers won't necessarily be penalized in these situations, as these patients will be risk-adjusted during scoring; but, once again, while this process attempts to compare providers fairly, patient information may not receive enough attention

because care extends beyond the specialists.

A Multi-Specialty QCDR can engage certain specialists and primary care providers in collaborative projects and screening activities designed to keep patients healthy. Determining, for example, which patients are overdue for screening and quantifying improved screening rates following outreach puts the emphasis back on improving patient care.

## Obtain clinician feedback to identify underlying causes.

In cases where an unexpected outcome has occurred, feedback from clinicians can provide insight into why. For example, a high re-admission rate alone is not actionable. The Multi-Specialty QCDR may also allow for providers to submit feedback on contributing factors, and these may be related to something outside of a provider's control. A Specialty-Centric QCDR may be able to identify that a set of providers have high re-admission rates, but a Multi-Specialty QCDR can show that this may be due to poor discharge instructions or excessive admissions through the emergency department.

Multi-Specialty QCDRs can strengthen your network for patients and providers alike. A patient who requires specialty care is not likely to select a practice that's a thousand miles from home, even if that practice's outcomes are better than a local group. The flip side is true, too—the specialty group has limited control over their patient pool, as referrals are going to come mostly from local networks. Therefore, it's in both patients' and providers' best interest to improve care at the system level. By partnering with a QCDR that can look across the spectrum of care, you can provide excellent care as a

unified network while still collaborating with Specialty-Centric QCDRs to improve their outcomes.

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Image Credit: Mari Lezhava

# Can Consumers Help Reduce Rising Costs of Medical Technology?

written by Theresa Hush | June 15, 2017

In years to come, the current health care financial scene may seem like the “good old days” of health care for middle class Americans. Despite escalating consumer costs, proposed cuts in coverage, and an ever-rising cost of care, most Americans can still access health care services. They believe health care will be there for them, even if not everyone can get it.

But the affordability of health care, regardless of coverage source, will soon be everyone’s problem. Medicare is projected to run out of money in only 10 years (some say less), and each year the cost of health care goes up 7 percent or more. Small companies say they will drop coverage, and large ones are looking for ways to cap benefits and costs.

The real kicker is that our health care costs exceed those in other countries, but fail to produce better benefits for our health, despite—and, in fact, because of—medical technology. Repeated examinations of annual increases in U.S. health care costs highlight that new or improved medical technology

accounts for at least half of the total, or more.

Current health care reform agendas are premised on empowering consumers to use health care more responsibly. With medical technology a major driver of total costs, the reform proposals implicitly blame consumers for overusing those resources. Is that possible?  And if so, what role can consumers realistically play in stemming these costs?

## The Supply of Medical Technology is Created by Providers, but Consumers Pay

Medical technology includes any new or improved surgical, medical or diagnostic technique; advances in diagnostic equipment; new drugs; and even technology purchased by providers to improve care. Your electronic medical record, for example? Medical technology.

The supply and availability of medical technology is clearly not within control of consumers, even though consumers will be paying a larger share of that expense along with other health care costs. Medical technology is solely the realm of companies and health care providers who invent, acquire or use these new procedures and agents. This year when I went for my mammogram, the technician told me that the images were being taken with a new 3D machine. I definitely did not order that machine, but I did wonder if its super sensitivity might lead to a second diagnostic test I didn't need.

## Consumers May Drive the Need for Technology, but Will Millennials Be Different?

Health care marketing—especially by drug companies—has

refocused marketing strategies away from providers and toward consumers. Messaging emphasizes having the best doctors, the best facilities, the latest new technologies, the most targeted and effective drugs. Providers are competing in busy markets, and they encourage patients to distinguish between health systems as much by access to the best and most innovative technology as by the presence of caring health providers. There is a logic to this strategy: Consumers do compare notes; anecdotal comparisons are still the primary method of gathering information about system value.

At least a subset of consumers is advanced enough to research and request diagnostic investigation of symptoms. It has become so commonplace to get CT scans and MRIs that most patients would question why they did not get one for a knee or shoulder injury, and wonder about the quality of the physician who failed to order the diagnostic. To some extent, their preference for high tech systems drives that expense further, but only indirectly.

More significantly, consumers have been taught—incorrectly—that medicine can always provide answers and relief. Some individuals may want to pursue open questions of their genetics, various symptoms, or physical attributes that are causing health issues. Or they may want to simply eliminate pain or dysfunction and are uninformed about the prospect of total relief, then submit to surgical interventions or drugs that have insufficient results. Thus they pursue an expensive path using emerging technology.

Because consumers are almost always entirely unaware of the efficacy of different diagnostic tests, only when cost

information is shared—or the clinician poses alternatives—does the question of value of various technologies associated with the patient's outcome typically emerge as a discussion item.

However, demographics may help to change this dynamic, along with cost sharing incentives. Millennials, for example, tend to believe more in technology, but are also more cost conscious and value communication. As Millennials and Gen-Xers become a larger part of the health care consumer base, these digital natives will be more focused on results and cost-based decisions, and less likely to follow the advice of authority figures (i.e. physicians). The national economics and cultural changes are perfectly aligned to support the balanced provider/consumer decision-making required to achieve better value.

## How Consumers Can Question Wise Use of Medical Technology

Health care today is relatively bountiful for most Americans. Consumers and providers alike have been insulated by the existence of rising health care costs by insurance and payment systems. Providers have had the luxury of pursuing an investigation of diagnostics and curating skills for treatment. Consumers have faced no impact by going down the same track. Providers, in turn, can satisfy the desire for diagnostic certainty and precision.

Health care reform proposals, along with consumer cost sharing and the loss of coverage altogether, will change that scenario dramatically. And it should. Imaging, pharmaceuticals, and medical and surgical techniques bring both progress and unexpected harm to patients. There are long term effects of

radiation, secondary cancers, side effects, and functionality outcomes associated with most diagnostic technology, drugs and treatments.

Consumers should ask these seven questions:

- What is the goal of the diagnostic test/medical or drug treatment/surgery?
- What difference will this diagnostic make to the treatment decision or results, as a percentage of success?
- Is there literature that you can share with me about the effectiveness and value of this course of action?
- What are the alternatives to the test or treatment, and how do they differ in effectiveness as well as harms?
- What is the cost?
- What happens if I don't go ahead with this?
- If I have to pay for this out of my own pocket, how would that change what you do?

## Providers Should Prepare Consumers for Technology Decision-Making

Clinicians must do a better job of helping consumers through a decision-making process involving diagnostic tests and various treatment modalities. Older consumers, used to placing unquestioning trust in their providers, may not have the understanding, or even the desire, to make clinical decisions. But as with any major financial decision they face, these consumers can learn how to make value-driven decisions and understand health care consequences. And behind them, the Gen-Xers and Millennials will push for cost-conscious decisions and providers that will work with them to achieve their broader vision of better health.

The era of limitless health care is coming to an end. Physicians and other clinicians will be measured on how well they deliver value in their health care services, and this will require explaining that value to patients to reach the optimal decision.

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Image Credit: Andreas Rønningen

# Increase MIPS Versatility and Results with an ONC-Health IT Certified QCDR

written by Dave Halpert | June 15, 2017

Providers focusing on MACRA in 2017 have a menu of choices for

implementation—perhaps even too many. But don't overlook this option for meeting requirements for MIPS (or preparing for an Alternative Payment Model or APM): a Qualified Clinical Data Registry (QCDR). And make sure that your review of the QCDR option focuses on the top tier. That means your QCDR should be both ONC-Health IT Certified and have capabilities that go beyond quality reporting.

There is a growing recognition of the unique role that clinical registries may play in improving outcomes over time, and related benefits. CMS has reinforced that role through a special reporting method that rewards use of Qualified Clinical Data Registries. Partnering with a QCDR can help you succeed in Medicare's MIPS and APMs, as well as realize long term improvement in cost and quality.

But, does the QCDR you're considering meet all your needs, or is something missing?

Each QCDR is unique, with different tools and technology for accomplishing its objectives. Just because a QCDR has been newly sanctioned by CMS for data submission in MIPS does not guarantee that it can report all measures or help you fulfill the Improvement Activity or Advancing Care Information components of MIPS. The distinguishing feature that allows for these functions is Health Information Technology Certification from the Office of the National Coordinator (ONC).

With an ONC-certified QCDR, you can take advantage of its features for a one-stop-shop for MIPS success. Let's take a closer look at some of those key features:

## Scoring Advantage for MIPS Quality Measures

There are 271 total MIPS Quality measures. Some may only be submitted through one mechanism (e.g. the all-cause readmission measure may only be calculated by CMS), and others have multiple options for submission. The QCDR will give you the greatest number of measures available for reporting.

> If you are planning on only picking measures that can be submitted via EHR, there are 53 measures available, but not all EHRs have modules for each measure.
> If you are reporting through a Registry or QCDR, there are 241 measures available (although not all Registries and QCDRs are qualified for each measure).

An ONC-certified Registry (qualified for both EHR and Registry measures) can submit for either set, and that set includes all but two MIPS measures. The freedom to choose from 269 potential measures is advantageous to you for several reasons:

> “Topped Out” measures cap your performance: 61 MIPS measures are “topped out” when submitted through the QCDR/Registry or EHR methods. This means that unless your performance is perfect, there’s an artificial ceiling on the number of points you may earn.
> Measures without benchmarks are risky: 72 MIPS measures have not been benchmarked using either the EHR or Registry/QCDR submission methods. Unless they are subsequently benchmarked, they are only worth 3 points out of 10, making them poor risks.
> There are limited specialty-specific measures: Even with 271 total MIPS measures (of which 269 may be reported by an ONC-Certified QCDR), certain specialties are under-represented

in terms of available clinically relevant measures. For example, the Orthopedic Surgery set does not include an outcome measure. Any limitation can make success more challenging.

For many specialists, having four times as many potential measures can be a critical advantage, because the MIPS Quality category is worth the majority of the MIPS Composite Score.

## More Options for Improvement Activities and Advancing Care Information

If your QCDR is ONC-Certified, you can link your Improvement Activities and Advancing Care Information measures in a way otherwise unavailable.

As for the Quality category, having a QCDR can open Improvement Activities to you that are unavailable through another reporting method. There are 13 Improvement Activities that require a QCDR to complete the activity. If your QCDR is ONC-Certified as well, you also gain an opportunity for bonus points in the Advancing Care Information category.

An ONC-Certified QCDR can submit the 18 Improvement Activities that enable providers to earn a bonus in the Advancing Care Information category. Even if you actually tracked and performed them in your EHR, your ONC-certified QCDR may submit the results on your behalf, so that you earn the bonus points.

## Seamless End-to-End Electronic Reporting

An ONC-Certified QCDR can also fulfill “End-to-End” Reporting, wherein a MIPS-Eligible group or clinician submits measure data

through multiple systems (e.g. EHR to QCDR to CMS) in a “hands-off” manner, meaning that numerators, denominators, exclusions and scores are calculated exclusively using the data transmitted from source to source. End-to-End Reporting requires that all information must flow electronically from one source to another, and if an individual manually adds or updates a record in the QCDR, that chain is broken. This includes data abstraction.

With End-to-End Reporting, any results or observations made in free text, or scanned/saved images or documents, will not be included in your data transmission, and may not be subsequently added to your results. For example, you may know that a patient received a mammography, but if you only have the report and not discrete data that shows that the patient’s breast cancer screening results are current, you will not receive credit for that measure.

End-to-End Reporting can be a disadvantage if you are not confident that your EHR is configured to ensure complete inclusion of data to support measure performance. However, if you are ready to take this step, you can do so with an ONC-certified QCDR, which will allow you to adhere to End-to-End Reporting guidelines, and also support the greater measure capabilty, improvement activities, and Advancing Care information.

## ONC-Certified QCDR Can Propel Value-Based Health Care Into Incentives

With all of these features, an ONC-Certified QCDR can not only help you meet MIPS requirements, but potentially lift your total MIPS score into the realm of incentives. Especially in a

year in which Cost is weighted at zero in the MIPS formula, it is a benefit to providers to start experimenting with QCDRs.

ONC-Certification of QCDRs, coupled with unique functions in MIPS, signals that a higher bar is being set for Medicare's Value-Based Health Care programs. That bar is Performance Improvement in both quality/outcomes and in cost. QCDRs are unique in the health care technology spectrum because they offer more extensive technology and services, and meet the requirement to track outcomes over time.

Under previous programs, providers needed only to report quality measures and activities under PQRS and Meaningful Use. Although the Value Modifier calculations performed by CMS compared and penalized providers below the norm in quality and cost, providers often were unaware that this occurred. But under MACRA—both through MIPS reporting and APM risk—the stakes are higher and providers are being pushed into improving performance in cost and quality.

*Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.*

Image Credit: Andrea Reiman

# Can Consumers Get Essential Information to Make Good Health Care Decisions?

written by Theresa Hush | June 15, 2017

In the rancorous public debate about how to provide health care

to Americans—and especially to vulnerable people with higher risks, lower income, or both—there is a common explanation for rising costs: it's the patients' fault. According to this argument, we need to stop the "overuse" of health care services by consumers that are causing our costs to skyrocket.

But what if consumers really wanted to be excellent, cost-effective purchasers of health care. Could they actually do it? Could they legitimately question their physicians about recommended treatments?

There is little argument that the system of financing health care has immunized both providers and patients from the full cost of health care. But benefit plans that insulate consumers from any costs have disappeared from the market, and most consumers now have heavy deductibles and co-insurance provisions that tax them for received health care services.

Consumers motivated to purchase cost effective care need two essential tools: real costs and actionable information. Health care cost—known as price transparency—is not yet a reality. But if costs can be estimated, can consumers get enough information to support good decisions?

Unfortunately not, and here's why:

## Access to Patient's Own Health Care Data Is Insufficient

Patients don't have enough information about their own health status for a variety of reasons. In part, this is due to where the information lies—either in paper records or in providers' Electronic Health Records (EHR) systems.

Even if the provider has an EHR, patients don't always have access to their personal data. At best, they may be able to see or download test results, but will not see physician notes, diagnoses, visit data or synopses of treatments prescribed. That means that patients are universally required to remember exactly what was said during a visit, including medical terminology used, as well as treatment explanations. Health care is always provided in an "immediate" timeframe, which can stymie patients' efforts to deepen their understanding.

Specifically, without access to data that the physician used to make determinations—which could include unmentioned physical exam details—patients universally have no recourse later to investigate. This is one reason why access or ownership over patient health records is an issue. Unless patients can retain all the details of their own health status, they do not have the power to independently investigate their options.

However, consumers have demonstrated that they want access to their health data and will use it. Indeed, there is a growing movement of consumers who are demanding better information and data in order to make better health care decisions.

## Access to Medical Research and Clinical Trials Is Even Worse

Even minimal information to investigate conditions and treatments—for example, a CT scan report—would potentially provide a diligent consumer researcher with enough fuel to investigate severity and risk, and certainly more information for discussion with the physician.

That investigative journey would still be arduous, but could

yield some real information. A nice itinerary of the process reveals some of the tools consumers could use. Nonetheless, there would be many dead ends, simply because consumers currently can not access research results.

Research falls into two categories: (1) medical studies on disease, progression of disease, causes, markers and effectiveness of various treatments; (2) pharmaceutical and device research ("clinical trials") and other privately funded research in various dedicated medical areas, such as genetics and laboratory tests. Medical studies are often funded by the National Institutes of Health (NIH), and account for less than half of all research. Clinical trials are funded by pharma firms and other private companies and account for more than half of total spending.

Access to the two types of research is dramatically different, with medical studies sometimes accessible—but not always. Consumers can find medical journal abstracts through the national database on PubMed, and, occasionally, general conclusions. However, finding the full article on the published journals and relevant data is harder. It's also expensive. Prices for journal access range from $84 for 24-hour access to hundreds of dollars for unlimited periods.

Because all NIH funded research must be available to consumers, some full articles are available for free through PubMed Central or, infrequently, publishing journals' websites. Hopefully, the number of free articles will grow due to federal funding requirements. Email requests of an article for personal use is another option. But the process, even for the most determined consumer, is daunting and likely impossible for

patients trying to access multiple articles.

The lack of medical research data is bad news for consumers. Given the history of researcher competition, there is growing agreement in health care and even political circles that change is long overdue. As for pharmaceutical research, the hunt is tricky even for knowledgeable consumers. Pharma trials that show poor results are abandoned early on, with no published results.

## The Quest for Truth in Clinical Research

Accessing medical research is challenging enough. Then there's the question of the study's veracity. The data is not always true, or the study design is bad. Clinical trials go through several phases, and early promising results may be completely overturned by later phases.

Unless consumers are very sophisticated, they may not be able differentiate good research from poor research. The good news, however, is that they can learn the basics of how to analyze studies.

## How Can Physicians Help Patients Be Informed?

Physicians can and should be the curators of medical information for their patients. However, it will take a push from their patients to make that happen.

Patients must gain the confidence to understand the basic concepts of health care, even as they have been trained to defer judgment to their physicians (by the medical community). These concepts are key:

- Medical science is always on a continuum, because it is a discovery process. Therefore, it is essential to question whether what “we knew” is still correct.
- Decisions weighing benefit and harm should be made by the patient.
- Asking simple questions will lead to knowledge of benefit vs. harm—or to the alternative of recognizing that not enough is known.

With these concepts in mind, there are realistic actions that patients can take to obtain information from their credible source, their physicians:

- Patients should ask their physicians to provide literature for major diagnostic and therapeutic interventions. Physicians will then be cued to their patients’ concerns and desire for further information.
- Patients should ask for a second opinion and also review literature with the consulting physician.
- When options include both pharmaceutical and procedural approaches, patients should seek consulting opinions from both medical and surgical specialists.
- Patients can use the specialty websites to further review research pertinent to their conditions or procedures for discussion with their physicians, and access patient advocate websites as well. However, note that advocacy websites are often directly funded by pharmaceutical and device companies, which should be taken into account.
- Finally, patients should question physicians and investigate whether specific research has been done related to their particular circumstances, such as age, gender, race, physical capabilities or chronic conditions.

Physicians aren’t all busy poring over medical journals, but they have the resources to help patients weigh their options and guide them through medical knowledge and patient decision-making. That will take work from both physicians and their patients, and time for consumers to get accustomed to evaluating health care just as they do other purchases.

In the meantime, the health care industry needs to understand that consumers aren’t “over-users” by choice. They have often been guided to that end by experts, and they haven’t had the tools to choose wisely.

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Image Credit: Eugenio Mazzone

# Health Care Providers Need Performance Data Audits to Market Trust

written by Theresa Hush | June 15, 2017

Health care systems once thought it was crude and undignified

to use marketing to attract patients. No more. Now they use qualitative anecdotes to promote status at a time when data is king and consumers view comparative quality data on the Internet. Why not use quantitative evidence? Because their data doesn't promote their cause—and even they don't believe it.

That avoidance behavior is a huge mistake. Health care organizations need to take steps now to turn performance data into valid indicators of both quality and cost. Otherwise they will risk losing control over their stories as providers of excellence. Consumers will make decisions based on whatever is out there, accurate or not.

## Health Care Marketing Practices Ignore Data and Evidence

Let's admit it: the public face of health care systems is unresponsive to consumers at a time when there is a growing distrust of institutions—including insurance companies, hospitals and doctors. While consumers grapple with rising health care costs and the media reports on medical errors as the third leading cause of death, health care organizations still try to attract patients with "trust me" messaging:

> We're in the top 10 hospitals/physician groups of (some popular survey, like *U.S. News & World Report*).
> The best sports teams are treated by our doctors.
> We are rated the best by our patients (responding to our surveys).
> We have the latest technology and facilities.
> We have the most advanced doctors (talking to each other on commercials about saving patient lives).

Unfortunately, this “trust me” attitude turns a blind eye to health care consumerism trends, Value-Based Health Care and responsible stewardship of quality and cost.

## Performance Data Is Often Sidelined in Health Care Organizations

There are many reasons why health care organizations distrust their health care performance data, and many of these reasons are valid. When the problematic data is then aggregated and used to compare physicians, additional issues compound the unreliability of comparative performance.

However, health care organizations also have played a role in promulgating invalid performance data. Their high investment in electronic medical records—and magical thinking—has often obscured investigation about how patient data is mapped to performance measures, as well as how that data is retrieved and sent to CMS and other external entities, not to mention that the mapping is often erroneous or missing data. They have frequently also been “soft” on the standard implementation of their EMRs, in the interests of providing clinicians with flexibility.

Providers have also often viewed performance measurement as a “compliance” activity for outside reporting, not as a baseline for identifying areas for improvement. Therefore, since the data has not (until recently) been publicized, health care organizations did not see it as relevant to a public perception of their performance.

But these reasons should now compel providers to take performance data seriously. When data becomes public—especially

data that will weigh into public perception of patient safety and quality—the ability for providers to control their own story is limited.

The bottom line is this: data spit out of systems is not ready for prime time. To ensure that data can serve as a useful starting point for both measuring and improving performance, it must be evaluated and curated for that purpose.

## Which Performance Data Really Matters?

Health care systems should arguably have a broad-based program for measuring both physician and hospital performance, regardless of what is reported to payers or other entities. Why? Because tracking all performance also helps to upgrade the data involved in performance measurement and to identify missing data. At a minimum, performance data needs to include the following:

- All standardized quality measures that are being tracked by CMS, Medicaid, health plan contracts, specialty organizations and various certification programs (e.g. NCQA and PCMH);
- Cost performance calculations included in CMS QRUR and SQRUR calculations, and health plans, as feasible, including costs associated with episodes of care;
- Outcome measures that include those in performance measures—which are "intermediate" measures of patient status—but also those not included, such as infection and complication rates, surgical re-dos, post-surgical DVTs;
- Patient safety measures;
- Patient functional status as reported by patients and/or to providers;

> Patient satisfaction, which should incorporate not only historical issues but also those of more current relevance to health care consumers.

This should be clear: in order for the data to be valuable, it must be grounded by a patient-centric performance database that will ensure that all data for given patient is correctly attributed. This will allow for correctly populating data in quality measures and validation of that data by providers.

A patient-centric, shared database also keeps the results honest. For example, by including data from multiple sources, under-coding by single providers will be less significant. The existence of a post-surgical DVT can be contributed within radiology data to a patient's records, and surgical infections can be identified in the hospital or primary care office. These can offset lack of data by a surgeon.

## External Auditing Is Key to Usable Performance Data

There is a reason that organizations use accounting firms to validate financial statements and guarantee them to stakeholders. Trust. For the same reasons, quality and outcome results should assure trust to stakeholders, including consumers, donors and clinicians who are participating in the enterprise. Raw data that is retrieved out of systems is not curated for achieving that level of trust.

Health systems may initially challenge the notion of audited performance data. Instead, they should welcome it. Only by ultimately improving their own performance data will they be able to gain the engagement of their physicians and other

providers in performance improvement. It is easy to challenge false data, but once the data becomes trustworthy, it becomes the basis for collaboration and improvement.

Consumers who are making selective choices of providers will be more convinced by the organization's self-publication of audited performance data than by infomercials. It speaks volumes to patient care commitment if providers are willing to engage in comprehensive performance measurement, contract with experts for outside opinions and submit their data for review.

## Who is the Best Data Auditor?

One question remains: who can perform such an external auditing function? The most obvious choice is a Clinical Data Registry (CDR) that is already aggregating and measuring provider data in a patient-centric database.

But not all registries undertake this task comprehensively, and many have performed the function of quality reporting as a data transmission exercise, without investigating or reporting underlying data problems, nor trying to remap EMR data to measures. While Medicare is pushing the concept of "Qualified" Clinical Data Registries to upgrade the standards of organizations curating performance data, we are in early days.

My role as a CEO of a CDR—with perhaps a unique perspective on the problems of data-generated performance scores—discourages me from saying a lot more, except that my goal is to push the envelope for better health care and not particular organizations. The organizations involved in data, performance measurement and improving outcomes are still evolving.

Consumers may not wait for that evolution, however, and neither will entrepreneurs. The story of providers may well be told by Apps that use existing data, good or not. Health care organizations should act quickly to examine their own data, choose methods of validating that data, and put a priority on curating and improving both data and clinical performance.

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Image Credit: Ryan McGuire

# Primary Care Physicians' Ethical Dilemma: Meet Goals for Patients or Practice Owners?

written by Thomas Dent, M.D. | June 15, 2017

Primary care physicians are on a collision course with health care consumers—their patients. While trying to deliver best clinical care, they must navigate a competitive business environment that encourages higher spending.

The business of health care has undergone rapid consolidation in physician practice ownership. Spurred by the need to compete for patients, use EMR technology and manage within the heavily regulated health care industry, physicians have moved from smaller to larger group practices. Primary care physicians have made this transition faster than specialists by selling their practices, and are now more likely to be employed by a hospital.

But this arrangement is not always in the consumer's best interests, because it leads to higher costs and greater use of specialists. Primary care physicians are required to fulfill

hospital directives, even if they don't always share the same goals.

## Physicians' New Business Environment Increases Pressure for Productivity and Referrals

Hospitals are working to maintain revenues in a market that is moving back to financial risk through ACOs and health plans. They have solidified their position by recruiting physicians (especially primary care) and building a physician network through a combination of ownership and joint ventures. Their ability to provide EMRs and other technology as well as administrative support to practices has been highly attractive to physicians looking for a way to escape administrative burdens.

In the past, hospital-physician relationships were tightly controlled by Stark anti-kickback laws that prohibited hospitals from providing financial benefit to their referring physicians. But that all changed when hospitals started paying those doctors' salaries.

In fact, the Stark Law says an employment agreement with a physician *can require* the physician to make referrals to the hospital employer unless: (1) the patient expresses a preference for a different provider; (2) the patient's insurer determines the provider; (3) the referral is not in the best interest of the patient's medical care in the physician's judgment; or (4) the required referral is beyond the scope of the employment (i.e. the physician is employed part-time by the hospital and is still required to refer all of the physician's private patients unrelated to the part-time employment by the hospital).

Primary care physicians thus may have referral obligations that their patients know nothing about. This is complicated by the fact that when physicians are employed by a larger organization, the business functions are out of sight. While this arrangement holds financial benefits for the organization, how does this affect patients' financial interests and outcomes? There is more at stake than strictly inside referrals; the primary care physician's judgment is constrained as to who will best achieve better results for the patient.

## Patients Want Lower Cost, More Control

Health care consumers are experiencing more financial risk with higher deductibles, copayments and premiums. As patients, they want knowledgeable assistance in making health care decisions that carry big cost consequences, and they want this help from their doctors.

However, that discussion may not be occurring. In a study where 63 percent of patients reported a desire to speak with their physician about out-of-pocket costs, and 79 percent of physicians believed that patients, in general, want to discuss these costs, only 35 percent of physicians and 15 percent of patients reported ever having discussed these costs.

Made aware of these issues, primary care physicians will and do respond to their patients' financial distress, but this response is reactive and not part of an organized effort.

The question—and challenge—is this: How can primary care physicians act in the best interests of their patients when they are separated from the decision-making apparatus of the large organizations to which they belong, as well as the

critical financial information they need to share?

## How to Create a Patient-Responsive, Financially Viable Organization

The financial pressures on patients will ultimately impel them to act like consumers, choosing providers based on cost and quality profiles. As we all know, however, those “scores” are, at best, weak indicators and, often, erroneous. Nonetheless, hospitals and physicians must respond to patients’ needs to address large, unaffordable costs and achieve better results for patients, and primary care physicians—like it or not—must be aware of the mounting cost burden on patients.

Assisting patients in treatment decision-making is a role well suited to primary care physicians. However, the entire health care organization that employs the physician must adopt principles and practices that will promote the delivery of efficient quality care. If the organization maintains goals and reward systems internally based on volume, it will put pressure on primary care physicians to reflexively order more referrals, diagnostic testing and other hospital-based services—without first reviewing the patient’s financial situation and value of the services.

How do organizations make the shift?

> Establish a process to measure quality, outcomes and costs for the most common conditions and procedures (episodes). Aggregate data to perform these measurement, which will best involve a Qualified Clinical Data Registry, since providers may be able to qualify the activity as a performance improvement activity under MACRA MIPS.

Measure specialists in the referral network to include input and feedback from the primary care physicians who have referred to these specialists: Do the primary care physicians receive reports or notification if they are on the same systems? Are they included in the process of defining outcomes for the patient and in the final, shared decision process?

Measure primary care referral practices. Primary care physicians should also be subject to assessment by their consultants. Was the need for the specialist referral (and the expectations) adequately communicated to the consultant? This is what it means to “close the loop” in the referral /consultation process.

Create episode-based cost transparency for patients. Primary care physicians should have access to the calculated costs of episodic care and be responsible for delivering that information to patients as part of shared decision-making.

Establish and train physicians in a shared decision-making process. Physicians are not trained to coach patients in dealing with harm and benefit of treatments, discussing cost issues and affordability. This needs to become a priority in physician education as well as part of an organization’s culture.

Provide resources to physicians to access latest research data on benefit and harm. Current research reveals a woeful lack of ability for physicians to read research, which could lead to flawed understanding of the numbers and an inability to help the patient. Having access to basic data, such as the kind of research, the numbers of patients, the absolute improvement in outcomes (if any), is essential to teaching the patient how to assess a treatment’s value. Organizations should consider how they can develop tools that will assist

physicians in this context.

Measure the outcomes in referred episodes of care. Outcomes measurement must be impartial. When proceduralists measure the outcomes of their own procedures, the results probably won't be trusted even by peers, particularly if money and rankings are involved. Referring clinicians should be able to assess and capture results related to their referrals. The organization should analyze variations, including unexpectedly good or poor outcomes.

Performance improvement and results sharing should be part of the process. Implementing interventions to improve the outcomes and tracking the results should follow. Sharing the results of interventions should be considered a quality measure. These interventions should include cost as well as quality/outcomes in the interventions.

Hospitals will need to assess honestly the value of specialist services independent of employment status. It will often be more effective for the primary care physician to refer the patient outside the system than to capture the patient inside the system. As financial risk for providers is implemented, clarifying financial and outcome performance, this goal will be more achievable.

The role of the primary care physician will evolve along with the financial incentives of both health care organizations and their patients. We should expect to see a return of the primary care physician to the center of the patient-care team relationship.

In that new environment, primary care physicians must become facile in discussing cost options during treatments and helping

patients navigate the system. Primary care physicians may need to work with entities retained by patients to address financially challenging situations. Awareness of these negotiations and their results by the primary care practice can also benefit other patients.

Patients in the future will be able scrutinize and compare costs and the results for referrals, diagnostic services, and medications, with close support from the primary care physician. These clinicians will quantify the results from their referrals and share them with patients and like-minded primary care physicians. Access to cost information such as Medicare's SQRUR can serve as a beginning, with all-payer data being the goal. Patient ownership of medical records will be essential for managing the information flow.

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Image Credit: Matthew Henry

# Can Value-Based Health Care Help Consumers Choose Doctors? 12 Questions to Ask

written by Theresa Hush | June 15, 2017


Do consumers and other health care purchasers have the ability to choose providers based on quality and cost? That’s the assumption beneath attempts by Medicare and health plans to reimburse providers based on their ability to deliver better quality while constraining costs. Value-Based Health Care also includes programs by commercial insurance to offer “narrow” provider networks that select physicians and hospitals by performance.

Choosing value presumes that consumers and employers have the right knowledge and information to select providers who deliver the best clinical results at lower cost. The need to provide that information has fueled efforts over the past decade to measure physician performance and publish comparative scores.

Proponents believe that employers and consumers will be able to choose better value by comparing physician scores. But if consumers continue to use providers in the “high” end of the cost spectrum or the lower tier of quality, Value-Based Health Care efforts cannot work.

## Can Consumers Choose Doctors Based on Quality and Cost Scores?

The concept works in theory. But here are the facts: consumers and other purchasers lack the knowledge and information to make value-based decisions. Existing information is both insufficient and misleading for consumers, and cannot be used to identify physicians and hospitals that can improve their health status or keep their costs down.

Many in the health care industry will agree that the current state of scoring performance is deficient, but justify this as growing pains. There have not been sufficient data, participation among providers, or time for comparisons of physicians. These facts are true.

But it’s also true that it may *never* be possible to accurately compare provider value.

Consumers may never have the tools for choosing providers that will ensure their health care is high quality and affordable.

This adds to other missing pieces of information that consumers need if they are to make smart and cost-effective decisions, such as knowing prices and having access to clinical information (including their own).

## Why Do Current Performance Rankings Prevent Reliable Provider Comparisons?

Medicare's MACRA-based MIPS program, the successor of previous Medicare programs for physicians to report quality and compare quality and cost, is the largest scale effort to evaluate and rank physician quality and cost. In its first year of implementation, MIPS uses hundreds of quality measures, vetted by physician specialties, to assess quality performance. The measures include both process measures (services that patients should get based on risk factors, such as age, condition or procedure) and "intermediate" outcome measures that identify the health status of the patient (such as blood pressure control). In addition to quality, MIPS also uses sophisticated algorithms for determining the costs generated by physicians.

Critics point to the sheer number of quality measures. Covering every specialty and major condition or procedure, the program ambitiously tries to ensure that clinical care is measured across all its dimensions. MIPS measures are also used to compare providers.

But there are many reasons why these comparisons don't work.

First, data can be inaccurate or missing, and the performance measurement process itself creates additional flaws. Any flaws in aggregated performance results are compounded when providers are then compared to each other. A documentation failure or

variances in EMR use appear as low quality, damaging providers.

Second, physicians choose different quality measurements to report; this hinders volume in the reported numbers per measure. With only a few measures required out of hundreds to meet the MIPS requirements, providers can be selective and report only performance that appears good. Thus there is an apples-to-oranges comparison between providers, negating any value for consumers.

Third, underlying all the data are patients with different risks, co-morbidities and progress of disease. The measurements, even if they are risk adjusted, cannot account for the variations in clinical care associated with these individuals. Physicians with sicker or more highly complex patients may appear deficient in any comparison.

Besides these shortcomings, providers can take a “pass” on MIPS requirements in 2017, thereby suspending measurement of physician performance altogether.

## Does Measuring Quality and Cost Performance Have Any Value for Consumers?

If performance measurement doesn’t deliver the knowledge necessary for physician choice, can it still be helpful for consumers and purchasers?

Stakeholders have put the wrong emphasis on performance measurement since quality-based reimbursement began, interpreting results as “scores” and punishing providers. Rather, performance measurement should be understood as a powerful tool for identifying variances in care, lack of

adherence to evidence-based practices, and areas for improvement. At the same time, those activities must always acknowledge and seek to improve the underlying flaws in documentation and data, and try to incorporate more investigation into the process.

In short, performance measurement should be an explorative process that leads to questions and education.

How does performance measurement benefit consumers? It clarifies whether their providers are willing to engage in a system to measure and improve quality. Even from outside the system, consumers understand that if a health care system is not measuring its quality through a detailed process, it also cannot focus on improvement. The reason consumers need to see performance results online is to validate that the provider is measuring its quality.

Consumers can also evaluate the absolute performance scores, and use these to question the provider's processes and quality. Even if data does not represent completely accurate or comparable performance results, questioning providers will lead to better data in the future.

Consumers would also benefit from knowing which performance measures are triggered for their care. Why shouldn't they benefit by explicitly participating in the measurement process? Direct involvement would inform them how their care is being measured and help them to assess their health status versus benchmarks.

## How Can Consumers Identify High Value Providers?

If scores aren't the answer, how should consumers make choices? They should start by asking questions.

Consumers must know whether a provider will work *with them* on their own health care. The questions identify the foundation of any good partnership: collaboration, shared information and communication. The physician must be curious and invested in a patient's specific health issues and care. That is a qualitative assessment, but any patient will immediately be able to sense whether a physician speaks to him or her as a partner or as an authority figure.

This requires an interview. Consumers should be prepared for surprise—maybe a bit of defensiveness—by providers. They are not used to responding to these concerns, and the concept of an interview itself may not be welcome. As more consumers request answers, we can expect to see services that "grade" providers along these relevant criteria, as opposed to quality and cost scores.

Here are twelve questions consumers should ask to determine if the provider is a good "fit":

- How consumer-friendly is the office in scheduling, communicating with you, and connecting you to the physician or nurse when you call?
- How willing is the physician to help you meet your goals, even if the physician doesn't share them (e.g. running a marathon)?
- Does the provider participate in measuring performance, and

how? What is the physician’s attitude toward performance measurement?
What data does the provider review with respect to your health status? He or she should be able to tell you where you stand in your clinical status compared to other patients, so that you know your actual outcomes are being tracked over time.
How willing is the provider to vary treatment recommendations based on your preferences, including cost, conservative or aggressive approach, or other factors?
How does the provider keep up with the latest research? Have him or her explain that process, because medical knowledge is changing quickly.
Does the provider allow automatic release of test results, or does the provider insist on explaining those to you first?
Does the physician electronically prescribe medicines? This is a quality measure and helpful to you.
Will the provider ensure that all referred services, including diagnostics, are covered by your insurance?
What criteria does the provider use to choose providers for referrals?
If you have a condition requiring follow-up with a specialty physician or testing, does the office facilitate or coordinate that appointment to cut the time for you to be seen?
Will the provider or office provide total cost of treatment to you? Are there episodic pricing packages?

Assessing provider value will not be a scientific exercise of comparing provider scores. But the pathway does not need to be subjective, either. These questions identify specific areas

where the provider-patient partnership will produce predictable costs and better outcomes because both parties are engaged.

Consumers can benefit from Value-Based Health Care initiatives, but mostly because health systems and their providers are subject to external scrutiny of quality measures and cost. This makes them pay attention. But consumers should not expect that MIPS or any health plan will do the work of identifying value.

Consumers can, however, navigate the way through provider choice decisions with better information than the health plan's provider list, opinions of family and peers, and marketing surveys. The exercise of asking questions will prepare them for the real decisions to be made after choosing a provider: steps to achieve better health.

*Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.*

Image Credit: *Doctor* by Paul Klee (1930), The Berggruen Klee Collection (1984), Metropolitan Museum of Art.

# Why MACRA MIPS Cost Episodes Make Good Products for Health Care Consumers

written by Theresa Hush | June 15, 2017

Here’s a radical idea: What if providers re-envisioned MIPS as a patient marketing initiative, not a regulatory response? Yes, I’m serious. From the beginning of PQRS and Meaningful Use to MACRA, health systems considered these efforts to be merely “compliance” with regulations and not market initiatives. But this view is shortsighted.

As outlined in MACRA rules, all of the MIPS initiatives parallel changes that consumers, employers and health plans have been demanding: lower costs, quality, improvement and value. Analyzing the MIPS component of Cost provides a good way to evaluate how providers could use Medicare data to help remap their care products and pricing.

## Cost Control Is a Market Imperative

Virtually everyone in the health care industry agrees (even most providers) that the Fee for Service method of paying

providers helps to drive costs. By ensuring payment for every component of care, Fee for Service can insulate providers and patients from considering the full cost of services.

Those economics spurred the federal effort to transition Medicare to financial risk for providers through Alternative Payment Models (APMs) such as ACOs, and through commercial Medicare Advantage plans. But Medicare is also trying to replicate risk incentives through MIPS Episode Cost Measures, which reward or penalize providers who are participating in Fee for Service.

The Cost component of MIPS involves three different scoring components that compare providers along a spectrum in terms of (1) per capita costs, (2) Medicare spending per beneficiary costs and (3) Episodic costs associated with a number of different chronic conditions, inpatient admissions or procedural episodes. Episodic payments are new to MACRA, but provide the strongest opportunity for providers to design the best consumer health product.

## How Features of MIPS Episodes Translate Into Consumer Health Care Products

Medicare has established a huge number of chronic conditions, procedures and admissions for comparing costs between providers. That's the hard part. If you're not paying attention to how your care is generating costs to patients and Medicare, you could end up on the high cost part of the spectrum and lose Medicare revenues.

But here's the good part: Using these episodes providers have a perfect opportunity to build a consumer product that they can

market to patients, health plans and employers. Providers can create opportunity to take patients from decision-making to purchasing services, using comprehensive, reliable information about services and costs. Because the patients are engaged in the process, they are also engaged in securing better outcomes for the health care services they receive.

The MIPS Episode Cost Measures create this market opportunity because, for both chronic conditions and procedures, *there are established and well-defined populations built on coded diagnoses and procedures.* These target populations empower providers to customize many of the features that can be used to promote and sell the product:

> Organized services that create predictability and trust for consumers about what will be included in the episode, so that they can make a good purchasing decision. One of the big problems with the current Fee for Services environment is that health care services are provided and paid on a piecemeal basis, creating unpredictability and cutting patients out of decision-making.
> Pre-determined provider network and referrals that eliminate the guessing game of who's on the care team. Consumers currently don't know when or if they will be see a bill from a provider who they didn't even realize was involved in their care. Sometimes that provider will even be outside their insurance network, triggering larger patient costs. Being able to anticipate both services and providers that are in an episode package gives patients the ability to make better purchasing decisions. For providers, pre-establishing the networks creates the capability to choose providers who will collaborate and willingly participate in cost control.

This also removes the mystery and guesswork for providers about who should get referrals for components of care.
Quality measures and outcomes to help providers and patients assess both the goals and results of the episodes, and to participate in data collection for meaningful performance measurement.
Price transparency of episodes for patients so they can anticipate and plan their share of expenses; this also enables providers to negotiate individual components within the episode price. In addition, price transparency is the key to marketing the episodes as bundled payments, as well as for establishing variations that will reflect patient options and preferences.
Options within the episode package that reflect patient choices, focused on services or extras that are important to patients. This helps the discussion of value and customization to individual patient needs.
Streamlined education and communications with patients on their conditions and procedures. Because episode products can be presented as a package of services focused on a given goal, rather than an *à la carte* shopping experience, the whole episode can be explained by a centralized source. Patients can receive a comprehensive education on the condition or procedure based on the collective consensus of all providers participating in the episode, rather than individual provider interest.

## Episode Purchasing Requires Shared Decision-Making and Personalization

Informed purchases of episodic care packages depend on an essential first step—defining the interests and preferences of

the patient through a shared decision-making process. This process needs to meet two separate goals:

- Ensure that the treatment has value for the patient that outweighs any potential harm. In establishing care packages, providers must not assume that the central premise of the treatment's value holds for any given patient. Each patient must be able to assess the benefit and harm with quantifiable information and be educated on existing research and data.
- Personalize the treatment to the patient. With any procedure or treatment, there are variations of care that must be synchronized to the patient's own circumstances and preferences. Devices that are geared to a 60-year-old patient may not have the appropriate strength and durability for a 30-year-old, and this must be managed through a series of options explained to the patient. Exercise tolerance, lifestyle and other conditions must be considered so that the patient's decision reflects the known facts about the interventions as well as personal appropriateness.

## Cost Episode Products Help Providers, Too

In 2017, the MIPS formula doesn't place any weight on the Cost component. Why should providers pay attention, anyway? Because the market is demanding cost control. Getting ahead of other providers on this goal will be key to success in winning patients.

Cost episodes help providers prepare for the inevitable financial risk in the next phase of the Medicare budget. In fact, Cost episodes may be essential for practicing how to survive under the Medicare Advantage plans or APMs.

Providers have demonstrated ingenuity in organizing care through Centers of Excellence to market to consumers. Cost episodes are the next logical step toward creating products that will help those Centers thrive under new economics.

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