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

written by Theresa Hush | April 6, 2017

Health systems' Centers of Excellence that attract patients through clinical prowess may be heading for an upset. Under the MACRA MIPS program now entering its first year, physicians will

be scored for cost performance in some of the same clinical areas that they have promoted to distinguish their care—and compared against their peers. Since Centers of Excellence are likely to be higher cost in comparison with other providers, associated episodic cost measures may possibly be used to penalize their providers. The impact won't be felt immediately, however; in 2017 the MIPS Cost component is scored but not calculated in the final MIPS incentive or penalty tally.

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

MACRA MIPS Cost Scores and Episodes Explained

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

The attibution formula for physicans varies by MIPS cost component and is the subject of much debate. In general,

physicians are held responsible for primary care patients if they have provided the plurality of outpatient visits, and for procedural or admitted patients if they were primarily involved in the procedure or admission.

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

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

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

Hip Replacement or Repair
Knee Arthroplasty (Replacement)

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

Episodes are generally triggered by a DRG, CPT or HCPCS code but will often include services prior to the trigger. The trigger does not necessarily "start" the episode, however, since often pre-admission or pre-procedure costs are included in the episode. Once the list of episodes expands to chronic conditions, there are likely to be diagnosis triggers.
Episode groups include direct clinician costs, hospital inpatient or other facility costs, diagnostic tests and the services of other physicians. Pre- and post-acute costs are often included. The exact services to be included or excluded vary by episode and are not finalized yet. Inclusion of drug costs is still be considered.
Risk adjustment of the episodes is performed as part of the scoring process, through an algorithm. How this algorithm accounts for clinical complexity of a case is not known. Also unknown is how groups of patients will be assigned risk, based on other circumstances outside the procedural episode.
Quality and outcomes are measured outside the episode. Although CMS acknowledges the strong link between quality and cost measures, there is no assessment of outcomes in the episodes that will bridge the cost to quality or to outcomes.

Will a Provider Strategy Backfire for Centers of Excellence?

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

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

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

In the Centers of Excellence model, there is ideally a synchronization between population-based care delivery and the care to be delivered to specific patients at risk. The episodic cost measure can be useful in identifying areas where costs are higher, but they also pose risks, such as:

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

7 Strategies for Making Cost Episodes Effective in Centers of Excellence

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

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

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

Create health system episodic measures that incorporate cost and quality. This will be most effective if your

providers are collaborating on measures, but it makes sense to use the 10 procedural episode groups for MIPS 2017 as a start, since they match your Centers of Excellence services. You should also consider adopting multiple cost episode measures, because this will be more efficient once you design the interface and processing for reviewing episodic costs and quality in tandem.
Ask your Qualified Clinical Data Registry (QCDR) to create specifications for these measures and implement them for you as part of you MACRA performance improvement activities. This is one of the areas where a QCDR can benefit you and will give you credit for completing another MACRA activity.
a) Ensure that all the providers that contribute to the types of episodes you adopt are participating in your QCDR efforts and sharing data, including private providers.
b) Your data specifications for this activity will need to meet the scope of the episodes, capturing claims and payment data in addition to the typical data elements for performance measures.
Establish quality measures and outcomes for each episode. Since these will be internally monitored rather than reported out, you should attach as many quality indicators and outcomes as needed to finesse your model in the future. It is likely that the quality and outcome measures will add as much to your understanding of data sufficiency or problems as to the outcomes themselves, and that is the point of experimenting at this phase.
Develop a process for review and feedback on the care episodes with physicians, identifying and collecting additional data that will help you assign risk.

Ensure that patient-reported outcomes are incorporated in the design of your performance improvement projects.
Once initial review of data is performed, establish interventions that have the promise to show better outcomes and efficiency. Ensure that these interventions are separately measured with the project, so that you can see the results of both cost and quality stemming from each intervention itself.
Consider developing bundled payments for certain episodes to prepare for these in future risk programs, allowing you to market the services to payers and employers.

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

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Why Bundled Payments Are a Win-Win for Specialists and Health Care Consumers

written by Theresa Hush | April 6, 2017

Bundled payments, a health care payment innovation that has been widely praised for controlling costs, recently got a bad rap. Secretary of Health and Human Services Tom Price has delayed implementation of the final Medicare rule for several bundled payment programs that were set to start this year. He has criticized the bundled payments initiative for moving too fast and "experimenting with patients' health."

Other industry experts disagree. They strongly favor the concept for both improving care and cutting costs.

Bundled payments reimburse physicians and hospitals according to a set fee that includes all care associated with a procedure or medical episode. Far from new, they have been a part of provider and insurance company package pricing and negotiations for decades. However, within the mainstream reimbursement system, bundled payments are still limited to specific

procedures and types of care, commonly including organ transplants, cardiac surgery and joint replacements.

Bundled Payments Ensure Price Transparency for Consumers

The fact that health care is far from affordable for many Americans has been center stage during the debate over the ACA Repeal. Consumers want and need relief because they are paying a greater share of the burden for both coverage and direct payments to providers. Yet they have no ability to make any sense of what they are paying for, because prices are so misleading.

By contrast, a bundled payment gives clear information to consumers about the full cost of a procedure and associated hospital stays and follow-up care. Bundled payments are, by design, constructed for price transparency.

Some bundled payment mechanisms are also linked to performance and quality metrics. This is essential, but not always universal. However, most insurers retrospectively monitor quality to ensure that consumers are not hurt by providers skimping on services to make the bundled payment profitable at the patient's expense. Medicare Bundled Payments for Care Improvement (BCPI) includes quality measurement of the initiative's implementation.

The future of bundled payments will center on patient choice. This assumes that insurance companies and others post bundled payment prices and quality metrics so that patients can make informed choices by knowing both cost and quality. There will also need to be safeguards in the system to make sure that the

reimbursement does not create unintended consequences.

Bundled Payments Help Specialists Gain Control of Treatment Plans and Services

Specialists have a lot to gain under reimbursement through bundled payments. The first advantage is freedom to structure the treatment plan and services delivered to a patient. Under the fee-for-service system, insurers micromanage aspects of care—both prospectively through pre-authorization processes and retrospectively through claims denials—to control costs. Under a bundled fee, the care team can include all necessary components of care without hassle to their staffs or to the patient.

Second, specialists have much to lose under various other Risk models, especially ACOs. If they are fully participating providers, they essentially redline their territory and become exclusive to a broader business entity, as CMS ACO participation rules dictate. If they participate as an "other entity" under the rules, they maintain their referral base with other health care systems but can suffer under MACRA MIPS attribution methodologies for patient costs, which assess them for the full costs of patients who see the specialists regularly but haven't seen a primary care provider.

Participation in bundled payments creates the opportunity for specialty groups to market and sell their services to ACOs and other physician groups and physician (and hospital) contracting organizations. Those arrangements will support ongoing referrals and should be structured to protect the specialists from cost attribution by ensuring a connection with the patient's primary care provider.

Third, specialists stand to gain from bundled payments by setting pre-established terms with hospitals and other providers. This creates an avenue for marketing to consumers and employers as well as negotiating insurance contracts. Established, transparent prices are a big win, not a trade-off, for the group’s competitive positioning in a market with an overabundance of specialty groups.

Providers who act early to establish bundled payments reap additional rewards from taking the initiative while the market is open and voluntary. They can drive negotiations that will better position their group and evaluate their costs experience under a still-voluntary payment mechanism. They can also negotiate payments with patients for elective procedures if they already have a high reputation for good outcomes, and market broadly to groups in a wider market.

Finally, the physician-hospital relationship is enhanced by having package pricing, because hospitals also win in the bundled payment arena. They can have greater assurance of their volume for procedures, and physicians can take advantage of preferential scheduling as well as other benefits.

How Bundled Payments Are Structured

Bundled payments are often designed by the insurance payer, which defines the care to be included in the package price. Most often this includes, for procedural care, the services rendered by all physicians (surgeon, assistant surgeon, anesthesiologist, radiologists and consultants), the facility fees (inclusive of inpatient stays), and accompanying laboratory or other services. Sometimes post-acute therapy such as physical therapy is covered, but often, not. The episode of

care usually also includes other care after hospital discharge, such as surgical follow-up visit(s).

The CMS Bundled Payments for Care Improvement (BCPI) initiative for Medicare reaches farther than most programs by defining 48 distinct episodes of care eligible for bundled payment over time. But the inclusion of the packages allows for gradual expansion of provider fees to be included in the bundle; it also allows for both retrospective payments based on a package as well as prospective payment bundles.

Five Ways To Make Bundled Payments Work for Both Specialists and Patients

Make bundled payment packages as inclusive as possible of services, incorporating all expected physician, facility and ancillary services. If post-acute services are always performed and critical to the outcome, they should be included. Bundled payments should be an offensive strategic move, not defensive. Other providers (including hospitals) should be able to see the value of securing volume and services from a reputable specialty group and be willing to create an inclusive package. The consumer will only be attracted if the care package is as comprehensive as possible.

Ensure that Quality Measurement and Improvement is a key component. Bundled payments are meant to be a value-based initiative, which means that quality and outcomes should be measured. Patient-reported improvement in functionality should be on the list of quality measures, as well as pain and pain management. Once bundled payments are adopted as a mainstream specialty reimbursement, selection and

reimbursement indexed to quality will also follow. Early adopters should establish data and performance improvement into the culture shift that will accompany transition to bundled payments.

Create feedback loop with Primary Care Physicians (PCPs), not only to ensure better continuity of care, but also to gain insight into the ongoing functionality improvements for patients. PCPs should provide information back to specialty groups on patient outcomes at extended intervals so that specialists can understand the long-term implications of their procedures and treatments.

Seek early opportunities to form and demonstrate bundled payments, and identify areas of Risk. Medicare's BCPI program or single insurer arrangements are a good beginning, but specialists should develop their bundled payments initiatives for all types of patients and a variety of coverage. A bundled payment initiative should not be directed only to the lowest risk patients; rather, it should be based on all risk levels and socio-economic groups. Participation in multiple insurer and payer initiatives will help groups structure exclusions or extra payments for outlier cases and individuals of varying risk levels.

Safeguard patients with shared decision-making processes. The creation of care episodes should not be construed to exempt providers from clear discussions of benefit and harm related to the procedure or treatment. There is a potential danger that we shift the emphasis to the shopping part of the health care transaction, at the expense of informed decision-making. One way to alleviate this is to define the process of decision-making, and measure that activity separately, along with the patient decision.

Bundled payments have been part of the mix of cost control tools for a long time, but are only recently getting serious inspection. As costs continue to rise, along with medical debt, the options for simply pushing costs off on consumers will become less tenable. The possibility of bundled payments as a central feature of specialty reimbursement is very likely to be on the horizon, regardless of what happens with Medicare. The advantages of bundled payments, which can be adjusted to patient risk, evaluated for quality and outcomes, and which motivate coordination of care, are too good to be ignored.

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Health Care Price Transparency for Consumers Starts with Provider Action

written by Theresa Hush | April 6, 2017

“Consumer choice” is at the heart of the national health care debate. This presumes access to accurate information about costs. While consumers woke up to health care costs a few years ago as their share began to rise, they lack the necessary facts to make intelligent decisions about the quantity and quality of what they are purchasing. As costs continue skyward, this crucial information, especially price transparency, is what consumers are now demanding.

But health care pricing remains a mystery that can’t be solved by consumers, on their own. While “pricing” to consumers includes insurance premiums and payments to providers, only providers have the key to correct the problem that is largely driven by provider decisions and costs.

Without Clear Pricing on Health Services, Consumers Risk Significant Debt

The proposed American Health Care Act promotes "freedom of choice" for consumers, replacing current subsidies and plans with Health Spending Account tax incentives for consumers to purchase what they need. But how will consumers be able to make choices without clear pricing on health services? Absent that information, they risk piling up debt for unpaid medical bills.

The average contribution into Health Savings Accounts (HSAs) was $1,864 in 2015. It is clear that even consumers who are making coverage choices now are not properly estimating the costs of care, failing to set aside the basic average deductible amount for their insurance coverage, let alone the co-insurance for services. Furthermore, those consumers are the currently covered and employed. Higher risk or poorer individuals losing coverage under the ACA repeal will be less able to set aside necessary resources.

For Consumers, Health Care "Prices" Are Fake

I recently read an article that compared health care to getting a car fixed, because in the initial stages of diagnosis and treatment, the future costs are unknown. This is a big understatement of the problem for consumers.

The first issue facing consumers is not prediction, but basic pricing facts. The reality is that even though there is a "schedule of fees," those fees are not the truth. Real fees are the ones negotiated with each individual insurance company or health plan. Those prices don't create a schedule of prices for "gall bladder surgery," for instance; they only indicate what

the health plan will pay Provider A for the physician charges for that service. Provider B in another network has a different negotiated fee.

Charges are what the provider puts on the bill to the health plan; *the real price is what the health plan will allow for payment*. That is why a consumer can get an initial estimated bill from a hospital for a $33,000 CT scan (that says “DO NOT PAY” on it), yet an Explanation of Benefits (EOB) from the health plan that shows the allowed charge as $5,000, and “a write-off” for the difference. The $5,000 is the price that was negotiated with the health insurance plan. But the consumer doesn’t know those prices, which vary widely across carriers and markets.

In today’s market, almost all prices are negotiated between providers and health plans. The only exception is that some providers refuse to participate in certain health plans, and do not accept insurance company “assignment” (willingness to accept their payment in full for covered charges). The idea of real “fees” changed long ago during the transition to Managed Care HMOs and PPOs, when health plans realized they could take money out of payments to providers by negotiating prices.

Without confirmed prices, it is difficult or impossible for patients to know their costs in advance. As a practical matter, even if a physician, who wanted to be responsive to a consumer, could estimate his or her own fee, the figure would not reflect the consumer’s total costs; there would also be hospital inpatient or outpatient charges (diagnostics or procedures), plus other physicians and services (anesthesiology, pathology, and assistants or consultants). For the consumer, making a

health care purchasing decision is as risky as writing a blank check.

Consumers Face a Trap of “In and Out of Network” Costs

Even if consumers make the wisest decisions on their health coverage—meaning that they have verified that their own providers participate in the plan before purchasing—they still get caught in a pricing issue. How? Because under the same system negotiation that dictates fees that health plans will pay providers, there are usually separate negotiated agreements for physicians and hospitals. It is entirely possible—in fact frequently probable—for patients to be able to see their physicians under their plan, yet be out of network for diagnostic tests or procedures at that physician’s institution.

Health plans can change or modify benefit plans, and often do, effective the first of January. However, contracts between health plans and providers are not on such a rigid schedule. Consumers can sign up for a plan believing their services will be covered but find their providers go out of network, forcing the consumers to change providers because the rules prevent them from changing coverage during the enrollment year.

Pricing Incorporates Regional Market Inefficiencies

Market negotiation of provider prices may give payers greater leverage than the previous “Usual and Customary” charge calculations, but the outcome is still simply to push existing cost problems to employers and consumers.

Higher regional costs produce higher fee negotiations, without relief for consumers. Indeed, under the latest high-deductible/high-coinsurance benefit plans being purchased, consumers are paying a larger and larger share of actual payments, in addition to a larger share of premiums. But they have no power to directly challenge prices to either health plans or providers.

Five Principles of a Consumer-Directed Price Transparency Strategy

While some believe state directives and legislation are necessary for price transparency, elaborate schemes and claims databases are really not required. Why? First, because providers already hold a centralized source of information for their own tangled web of health plan agreements and, thereby, prices. They also are in command of efforts to reduce their costs.

Second, market competition, as well as economic sense, will ensure that providers paint neither too rosy nor too harsh a price picture. The exercise should instill, rather, a reexamination of their pricing to the benefit of consumers. As the consumer share of reimbursement grows, this will be more obvious to providers because consumers will demand the truth or choose provider systems that are responsive.

This is why providers are the logical first responders to consumers' need for coherent pricing. To remain in business as it becomes heavily consumer-financed, providers will need to pivot their economics to better help patients make wise choices. We all know that the co-insurance alone for the treatment of any major disease will not easily be borne by

consumers. It is in the provider's best interest to help consumers make affordable and cost-effective choices for their care.

There is another reason that action must come from providers. The health care payment system, including Medicare, Medicaid and private insurance, has insulated providers from the effects of their own internal actions that increase costs. There is an inherent immunity to the costs that patients will pay for the treatments they prescribe, compounded by the drive to purchase the latest technology and equipment, invest in new buildings, and promote growth strategies that providers assume will be covered by ever-willing insurance and consumer payments.

The fee-for-service payment system has numbed providers to the ramifications of decisions and pricing at all levels. The only way for providers to begin addressing the consumer issues is to comprehend their own pricing and costs, and to recognize the impact on their customers.

The implementation of a consumer-directed price transparency strategy will be most beneficial if it incorporates principles that address the problems for consumers:

> Develop a price transparency strategy with the input of consumers and consumer groups. This is important to both building a constituency of consumers, and receiving consumer perspectives that will vary across patient cohorts, coverage and utilization of services. Consumer affordability issues deserve a hearing by providers.
> Ensure that the whole cost is included in price transparency. Consumers should not have to ferret out what

the “price” includes. It should include everything that is known in the treatment plan. This must include physician, hospital inpatient, outpatient surgical and diagnostic, and post-care, if essential. Episodic pricing is the optimal way to cover large case costs, using the bundled payment list most recently used by Medicare.

Focus on the allowed price, either on average, by category of coverage, or by price individualized to health plan. Price transparency built on charges misinforms consumers. It will be difficult competitively to reveal contracted prices, but creative combinations of health plan types, or categories of care, can cover proprietary concerns and still meet consumer needs. The process of patient communication can be carefully implemented to avoid the public “price list” that most providers fear, although providers must realize that in the future, such information will be readily available for comparisons by consumers.

Identify areas where there are excluded or uncovered services. All providers know the gray areas of coverage. They should identify these to their patients, as well as the costs associated with them.

Tie cost-related performance improvement initiatives into price transparency. Consumers should know the areas where providers are making the effort to keep costs down, so that they can be a partner in those goals. Cost performance has been undernourished in health care systems unless in response to reimbursement policies, but deserves a place in price transparency and consumer awareness.

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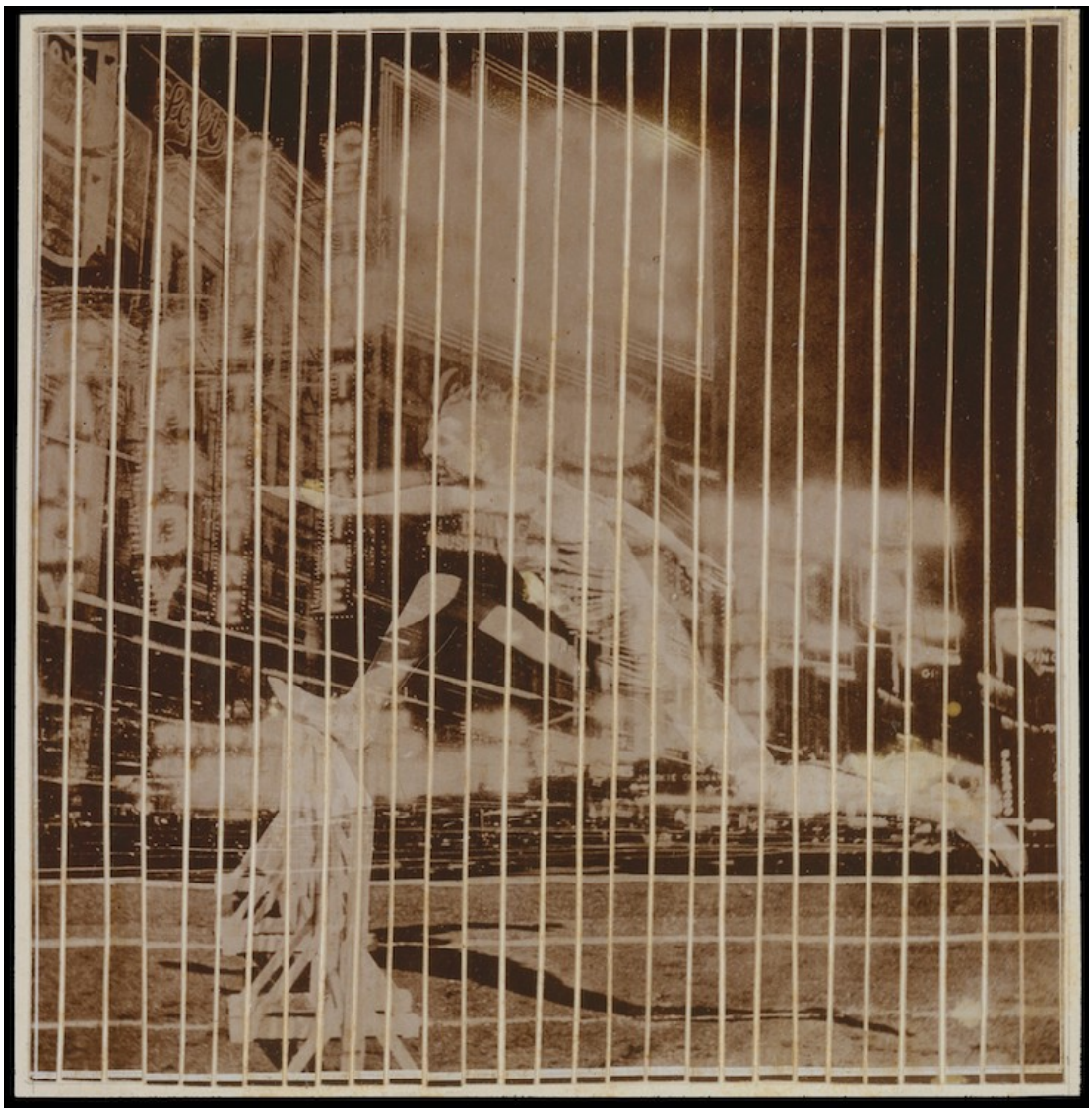
Image Credit: Vladimir Kudinov

Fast Forward: Why Patients Should Own Their Medical Records

written by Theresa Hush | April 6, 2017



Up to now, who owns patient medical records hasn’t been a big issue. In fact, the “who owns” question has been largely confined to provider purchasing discussions regarding health care data analytics or other sharing of patient records, when providers want to assert their ownership of the data. Patients have had no voice in this conversation.

Few people question the provider’s ownership of a patient’s record, which is supported by state statutes (only one state grants ownership to patients) as well as the rare case of litigation.

All that changes going forward. Why? Because big revisions in health insurance will make it necessary for patients to control their own data so that they can also control their costs. Patients will need data history to navigate the health care system, discuss options with providers, and make informed choices based on benefits and cost. The technology is already available to do so without disrupting providers' clinical systems.

This is the new reality: Health care consumers not only *will* own their medical records, but they *should*.

Assault on Consumer Health Care Costs Is Just Beginning

By any measure, the cost of health care coverage and expenses are rising for consumers, at a faster rate than their ability to pay. Employers, too, are scrambling to manage the increasing costs of health care, but their solutions are to adopt benefit plans that share these costs with their employees, through more employee premium sharing, deductibles and coinsurance. As a result, more consumers are finding it difficult to pay for their health care.

These are retrospective trends; bigger problems lie ahead, and not just for people who may lose coverage under the ACA Repeal. Tom Price, Secretary of Health and Human Services, is supporting legislation that would allow providers to bill patients for the balance of provider charges above the Medicare payment.

Providers' willingness to accept "assignment"—payment in full from Medicare for covered services—has been the backbone of

Medicare for its beneficiaries. Rollback of these protections would create a huge increase in costs to consumers, since provider charges are set voluntarily. They conform to no "rational" pricing model because almost all prices are negotiated with insurance carriers. Physicians set their charges arbitrarily high—3 to 4 times the Medicare fee—and then discount those fees for patients who cannot pay.

The result of a rollback: on top of other cost shifts to consumers and loss of coverage, patients may also end up paying for a big pay hike for providers. While we can expect health care consumerism to take hold gradually as part of broader social and economic trends, these federal cost-cutting proposals, if adopted, may well turbocharge a powerful grassroots political movement for fundamental change in health care.

Consumer-driven Medicine and Patient Loyalty

Health care providers frequently move in and out of insurance networks, causing problems for consumers. Those consumers may have chosen the coverage out of a list of their employer's offerings because of provider preference, only to discover later that their providers exited the network. This common fallout from price negotiations between insurance companies and providers leaves consumers angry and continually at risk of finding new providers.

Providers can't blame patients for lack of loyalty when they are willing to cancel their agreements with insurers, or when consolidation among providers cause changes in the patient's plan coverage.

Medical Records Are Hidden and Don’t Travel Well to Patients

Even when patients finally restart care with accepted network providers, they frequently face disruptions in continuity of care that are not their fault, because they are forced to deal with the cost, hassle and inevitable delays of transferring their medical records from previous providers.

Despite the fact that providers have adopted EMRs that could trade data broadly, this almost never happens, even between systems on the same EMR. Patients are left to manage the situation on their own. In fact, even in 2017, it can take months for patients to get real data from one provider to another in the same city, using the same electronic medical record. To make matters worse, patients receive no verification or information about what was sent from one provider to another.

Even for patients who are not changing providers, but just want to seek second opinions or research on their conditions and alternative treatments, the need to compile their information and original records makes it difficult to proceed. It’s no surprise that patients justifiably feel trapped when their records are held in systems they cannot control.

Access to Medical Records Via Provider Portals Doesn’t Cut It

Providers have made a huge investment in clinical systems and patient portals that give their patients access to test results, payment records and so on. So why is this not enough?

First, test and lab results, as well as all other records such as inpatient clinical data, are under the control of providers who release some (but not all) of the information. Patients almost always see lab results only after their physicians do. However, there is a growing minority of patients who want to get their data immediately and don't care to have it filtered by a physician. As rising costs engage consumers who are used to controlling their information in other spheres of their lives, that group is likely to become the majority.

Providers have long held the belief that they are responsible for using their expertise to appropriately convey complicated clinical results to patients. But some of these concerns may be unfounded, as case studies reveal. In fact, the sharing of data appears to contribute to better communication and partnership between patient and provider.

Second, records accessed through patient portals are incomplete. They do not contain images, or tumor samples, or other physical and digital specimens. So even if patients could download the reports, they could not independently direct them to another provider, because the reports don't always contain sufficient data for that provider to assess clinical status.

Third, in order for patients to transmit the relevant data to a provider, they must create a medical records request, specify the data requested, and direct that data to another provider. And then wait as many as four to six weeks for the records transfer to take place (if ever).

Why is Medical Record Ownership Important for Patients?

The words “empowerment” and “freedom to choose” are given new political meaning in the current health care debate. They also signal a transition away from “patient engagement” and “patient adherence,” common phrases among providers that mean patients should follow their providers’ plan of care.

The problem for patients is that they cannot necessarily afford the plan of care outlined by the provider, and that there are real informed choices to be made. Much of medicine is still not well researched, and irrefutable answers are not common. Unfortunately, the body of evidence is often lacking on “evidence-based” research, because outcomes are rarely studied adequately. In addition, it is far from universal practice among physicians to read medical research, as several medical journals have revealed. Physicians are too busy to read, have trouble with the language, or don’t have time or inclination to evaluate the strength of the research.

There is not only room for patients in the medical decision process; this is essential. Only by being able to review and manage their own data can consumers have the medical literacy they need to participate in those decisions.

Finally, we must address the whole American idea of “ownership.” When records were paper, it was perfectly logical that they be kept by the provider for reference and management. But now we are in a different world. It is common for people to own data, and the idea that something as essential to your life as clinical data is “owned” by providers and “granted” to consumers will not be well accepted in the future. As the

younger population and digital natives enter into the health care system for the first time, they will expect to have their own records to manage their own costs and direct their own care.

Companies and Technology are Creating Alternatives for Consumers

The big tech companies all recognize the prospective possibilities of creating centralized consumer health records, the failure of Google and Microsoft notwithstanding. They all know now, as we are beginning to see, the possibilities of housing the patient's record via a CDA standard transfer. Further, we are seeing startups that may work as storage houses for these records, as well as data platforms that can share communications and progress notes, as well as clinical data.

As consumers become more independent and organized, they will undoubtedly begin choosing providers based on their adoption of consumer-friendly practices and technology. One organization that is worth watching in this space, with experience in a retail consumer market and eager for health care prowess: Walmart.

Providers, Start Here

Most providers have a strong patient vision but are struggling to manage competing technology efforts. Adoption of EMRs, analytics, revenue cycle software and, perhaps, population health and marketing has left them breathless. They want a break. But that time is *not* now.

Providers without a patient portal should consider it as a top

priority. However, for the reasons mentioned above, understand that this alone is not enough. Reflect on and evaluate these options as you develop a stronger consumer-focused strategy:

Help Providers Move Toward Shared Decision-making

Build physician support and understanding for changes in the physician-patient relationship. If you can help physicians appreciate the culture change in their role as well as that of the patient, you can help them be more effective coaches and communicators.

Begin a formal shared decision-making process, including mentoring of physicians, as a performance improvement initiative. While doing so, you should measure the results of changes in attitude for both providers and patients, as well as changes in outcomes.

Examine and revise your policies and operations for the review and release of patient results. While this includes educating and working with physicians on changes to the timing or communication about results, it may also make sense to evaluate technology for full sharing of records and notes, getting physicians on board in the process.

Increase Your Patient Centeredness

Insist on consistency and longevity as part of your health plan strategy so that patients are not forced to leave by changes in coverage. This means evaluating your managed care contracting and decisions to prioritize patient tenure along with fees;

Discover your out-of-network flow of patients. If you don’t have the data from your insurance carriers and Medicare, you

can obtain this for analysis. This data will also be essential to track your relative per patient cost compared to other providers in the market, which is calculated by Medicare for you.

Find out why patients go elsewhere. There may be preferred providers elsewhere, but don't discount the possibility that patients are not getting the support or communication they need to achieve their goals. They will vote with their feet.

Create consumer advisory committees to inform your strategies. You have business experts on your boards to develop the business, and physician leadership to guide your clinical directions. You should also ask your customers.

Develop your price transparency plan. In addition to clinical data, patients will demand information on how your prices compare, and what their episodic costs will be if they get care from you. This will no doubt force you to evaluate your entire price strategy that was once geared exclusively to insurance coverage. It should now be redirected to patients.

Start Now to Get Data to Patients

Push your EMR to develop fast mechanisms for expanding your current portal. If you don't have one, fix that.

Evaluate your options for getting patients a feed of their data to go into a portable record. You may partner with an entity that already has a product, or take a developmental track.

Expand your data outreach to patients with features that will enhance your shared goals, such as sharing quality measures applicable to the patient, so that your patients are aware of how you—and they—are being measured.

- Share episodic pricing as appropriate for your organization: for procedures, management of common conditions, and inpatient/outpatient stays by condition.

As the environment pivots to adjust to the new driving force of health care consumers, health care providers will need to be ready. We have been in a regulatory and insurance driven market for a long time, and that has tended to slow the pace of change. Be prepared for time to speed up. Consumers act fast.

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

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The Problematic “A” in the ACA Repeal and Replace

written by Theresa Hush | April 6, 2017

Last week, my sister sent me a copy of an email that she had sent to her inner circle. It began, “I am writing you today as a metastatic breast cancer patient . . . and also as your

friend or relative who wants you to have the best resources and care if this disease ever affects your life or loved ones."

It was a plea for women to understand what would happen to breast cancer patients if the Affordable Care Act (ACA) was repealed, linked to an article. She was hoping to reach across a divide to raise consciousness about health care, especially among women. Instead, she was surprised to get pushback about the unaffordable premiums of the ACA, and why it couldn't work. She asked me if a single payer system is the solution. I struggled with a response that would clarify the economics.

My message to my sister is this: There are several paths to providing financial coverage. But only the health care industry can make it affordable. Here's why:

The Issue Is Affordability of Health Care, Not Just Insurance Economics

The ACA debate has been grounded in blurring the line between insurance/financing and health care. The effort to expand access to care—the real "A" in the Affordable Care Act—relied on traditional insurance to make that possible. Affordability was to be achieved by creating the largest possible pool of insureds, including young and healthy people. That is basic insurance economics. But that objective had no time and possibly no potential to be realized. The results were difficult for both insurers and consumers. Growing opposition to the ACA likely advanced the exit of insurers who saw no reason to stick it out.

We should acknowledge this: Affordable premiums come from affordable health care, which we do not have. When 17.8 percent

of our 2015 national outlay goes to health care and rises every year, we cannot still expect “affordable” health insurance premiums—especially if we design a system that only covers some people. If you shrink the pool of insureds, which happened in the exchanges, the premiums just get higher. Obamacare generally covered those who most needed it, so the cost was even higher on a smaller group of citizens.

Every payment system has its flaws, unintended effects and costs. This includes a single payer system. Both providers and patients learn to game the system or leave. We have only to look at the U.K. National Health Service to see that health care costs continue to go up and health care outcomes lag , with quality concerns as well. But for many other reasons—essential health care access, for example—nationalized health care in the U.K. is broadly supported. That may well be facilitated by a tax-based financing system that eliminates the need for consumers to regularly decide on the value of health care services.

No matter what the financial structure, the bottom line is that costs drive premiums (or any other system for paying health care providers, including drugs). The premiums of different groups are higher or lower according to the number and risks of people covered. Sicker people will always cost more, and older people tend to be sicker and cost more.

Can Consumers Really Be Held Responsible for Affordability?

Proposals for ACA alternatives—including the American Health Care Act introduced by House Republicans on March 6—center on tax credits and health spending accounts, which also seek to

make insurance a more affordable choice. But they do not address the costs of health care, which impact people unevenly because of their conditions. As health care costs continue to rise, the tax credits will be inadequate to offset premiums or uncovered expenses (even if coverage can be obtained initially) for traditional insurance plans. Like the ACA but not as obvious (under a "private" health insurance market there will be no publication of rates), the ACA replacements have insurance economics as well as health care affordability problems.

I want to know how my sister and other women like her will cover the average $85,800 in breast cancer treatment for the first year, alone. Are they better off simply not paying for insurance and negotiating the debt with providers, who are reportedly deeply discounting and extending payment plans? The yet-undiagnosed may choose this option.

Consumers have limited capability, at best, to make their own health care affordable. They have less capability when needed health care is time-critical and expensive, like breast cancer treatments, or when they cannot really participate in clinical decision-making. There will be casualties under the ACA replacement. There were probably also casualties before and during the ACA.

Long term, consumers can become educated; over time, their choices should be able to wield greater influence on providers and treatments. As discussed in a previous post, we might well see a revolution among patients that leads to lower costs. However, no freedom of choice in procuring insurance can outweigh the fact that consumers currently have a lesser voice

in the costs and choices of the system that is supposedly built for them. Any shift in that dynamic will undoubtedly take a long time. Too long for my sister or others to see how a rising tide of consumerism can make health care affordable and accountable to them.

Provider Cost Accountability Will Be Key to Survival—and Affordability

Health care providers under ACA Repeal have a problem. There is little doubt that patient debt will rise, as vulnerable consumers cannot pay for treatment they are receiving. Medical debt is already high in the U.S., with one in four adults under the age of 65 having past-due medical debt (the national average is 23.8 percent). While many believe that health care institutions and physicians will charge more or shift costs to other payers, as a practical matter, that is difficult to do. Most rates are already locked in with insurance companies and Medicare/Medicaid fee schedules. Unpaid services will just hit the bottom line.

The insurance system, Medicare, and Medicaid have rewarded providers by covering their escalating costs through a Fee for Service system. We will see that system shrivel away under the need to cap costs.

The repeal of both individual and employer mandates for coverage, as well as a diminishment of Medicaid coverage, will lead to an increase of uninsured and newly covered individuals. Insurance companies, freed of the ACA plan requirements, will create different benefit plans that cap costs and put providers at risk, so they don’t lose money, and these will attract consumers. Despite the current existence of Accountable Care

Organizations, the conservative drive to reduce regulations will almost certainly trend away from provider risk models in Medicare and Medicaid, eliminating those that are unsuccessful in saving money. We should expect to see these be replaced by Medicare Advantage and Medicaid Managed Care.

The year 2017 is the first year of MACRA implementation, although significant opportunities exist for providers to take a pass on the Quality, Cost, Performance Improvement, and other initiatives. Providers who delay these initiatives, however, are ignoring the ACA Repeal and Replacement patients who are hoping that they read the fine print.

My sister turns to me for help understanding the health care industry and what it might become. I am a part of that industry. For her, I want providers to hurry up. I want them to be the best they can be and to take on the mantle of health care change so fast that they will ensure quality health care will be both affordable and accessible for all the patients whose lives depend on them.

I want to say to my sister, we have your back.

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How to Turn 2016 PQRS Success into Better Care (and a MIPS Win)

written by Dave Halpert | April 6, 2017

March has arrived. The submission window for PQRS shuts on March 31. It's the moment of truth for providers, practices and Registries. Are you ready to report, ready to panic or somewhere in-between?

It's probably too late to implement an initiative designed to improve your PQRS measures, but with the right Registry partner, there is still a path to 2016 PQRS success, even if you aren't "PQRS Ready." More importantly, if you follow these three steps, you'll also create a pathway to success in the Quality Payment Program (either through MIPS or an APM)—both by avoiding penalties, as well as tailoring the new program around your ability to improve patient care.

Step 1: Review Charts and Documentation

If you are short of the reporting requirements, scour your patients' records and use your Registry or QCDR to add responses in cases where they were previously missed. For those in this group, work quickly, but be careful! The text in the measure title may be misleading, so you should read the measure specifications carefully before entering your response. These documents include definitions and guidelines, and some are very strict.

For example, "shared decision making" prior to a procedure isn't just a documented discussion with a patent—by attesting to having completed this measure, you are stating that there is documentation of "empirical, personalized risk assessment based on the patient's risk factors with a validated risk calculator using multi-institutional clinical data," and that you can produce the name of the risk calculator you used. Not only that, all of this was discussed with the patient and/or

patient's family.

When CMS audits records (and they do), if you are unable to produce the documentation that the action was performed, you may fail the audit, which would enable CMS to recoup incentive money or retrospectively penalize practices.

Yes, the measure is complicated, but it's a great example of one that can make a difference to a patient and to the patient-provider relationship. Clinicians, consider past instances when you have performed a procedure with an optimal outcome, only to find that the patient and/or family are still upset with the results. All too often, patients and family members feel unprepared for the effects of a procedure, either in the short-term (post-operative delirium) or the long-term (ongoing pain levels, range of motion, necessary lifestyle modifications, etc.). This disconnect between providers, patients and their families is a perfect example of how a quality measure can be used to fulfill a program's requirements as well as improve patient experience and care.

Step 2: Confirm Providers and Results

Double-check your participation list, and not just by looking at names and spelling. In both PQRS and MIPS, providers are defined by the combination of two numbers: individual provider NPI and practice Tax Identification Number (TIN). This is different from Meaningful Use, so make sure that providers are identified correctly, using each program's rules. Fortunately, that conflict will end for the 2017 MIPS performance year, as the Quality component (formerly PQRS) and the Advancing Care Information component (formerly Meaningful Use) are now under the same program.

Once you've confirmed who is under measurement, look closely at the results. Are measure denominators reflective of your practice? Do they appear to be tied to the correct providers? Look at the measure specifications before responding, as each requires a different set of denominator criteria, and these result in some quirks. For example, a provider may have a large population of patients with asthma, but a comparatively smaller group who are between the ages of five and fifty and on Medicare Part B. Checking to see if the services provided match the types of measures being reported can help to confirm that data is flowing correctly from the point of care to data submission . . . or not. For instance, if primary care providers are reporting on surgical measures, that should raise a red flag.

Isolate and resolve these issues now, as they will become exponentially more difficult to fix in coming years. This will be critical for your next step:

Step 3: Strategically Select Measures (and Understand the Implications)

There are almost 200 measures with Registry Reporting options and PQRS, and even more under MIPS; remember that what you report has implications beyond PQRS.

For the 2016 PQRS, CMS will use your performance compared to others on those measures in order to categorize you as high, average or low quality, which will account for half of the calculation behind your Value Modifier in 2018. This can have a positive, neutral or negative impact on your reimbursement rates. In 2017, the process is similar—the 2017 reporting period will affect 2019 reimbursement—but it will all be under

MIPS, rather than the multiple (but related) programs.

You should also consider your public profile. CMS is expanding what is available on the Physician Compare website, including the measures that were reported for PQRS. Reporting on measures that are not clinically relevant may be easier for you in the short-run, as there are likely to be fewer patients in the denominator. In the long run, however, you may find that you've damaged your public image and made yourself less appealing to patients compared to similar practices.

How? As Physician Compare becomes more robust, it will become a research tool for patients and families seeking clinicians who specialize in a particular type of care. Newly-empowered patients will be able to see what measures providers have reported, as well as quality results. When looking side-by-side at providers who perform those services, a patient will more likely find comfort in seeing that the provider has voluntarily reported on related metrics to the government, compared to one who did not.

Under MIPS, patients will have even greater access to quality and outcomes information. MIPS requires that at least one outcome measure or high-priority measure is reported, which will make it more challenging to stand on the results of process measures—which, in many cases, are measures of documentation, rather than of care. The goal of MIPS is to break free of this trap, giving patients the ability to dig deeper.

Rather than looking at anecdotal evidence online, they can, for example, browse potential surgeons to see who had a higher rate

of unplanned re-admissions within 30 days. Outcomes data is far more illuminating than seeing the rate at which antibiotics were discontinued in a given timeframe, which is often a standing order. This outcomes data will be even more comprehensive than PQRS, as MIPS requires reporting on all patients, which will help to standardize results. Reporting outcomes for a larger patient pool may eliminate many provider and patient complaints that a Medicare-only program is only important for Medicare patients, and that different standards of care are in no one's interest when trying to improve the health care delivery system as a whole.

Learning from 2016 PQRS

There is an important distinction here—succeeding in 2016 PQRS may be largely retrospective, but there are lessons to learn from PQRS that will help you succeed in MIPS. More importantly, MIPS can offer clinicians the opportunity to use quality measures as tools to improve patient care, rather than as administrative documentation templates. Done right, MIPS success will also mean healthier patients.

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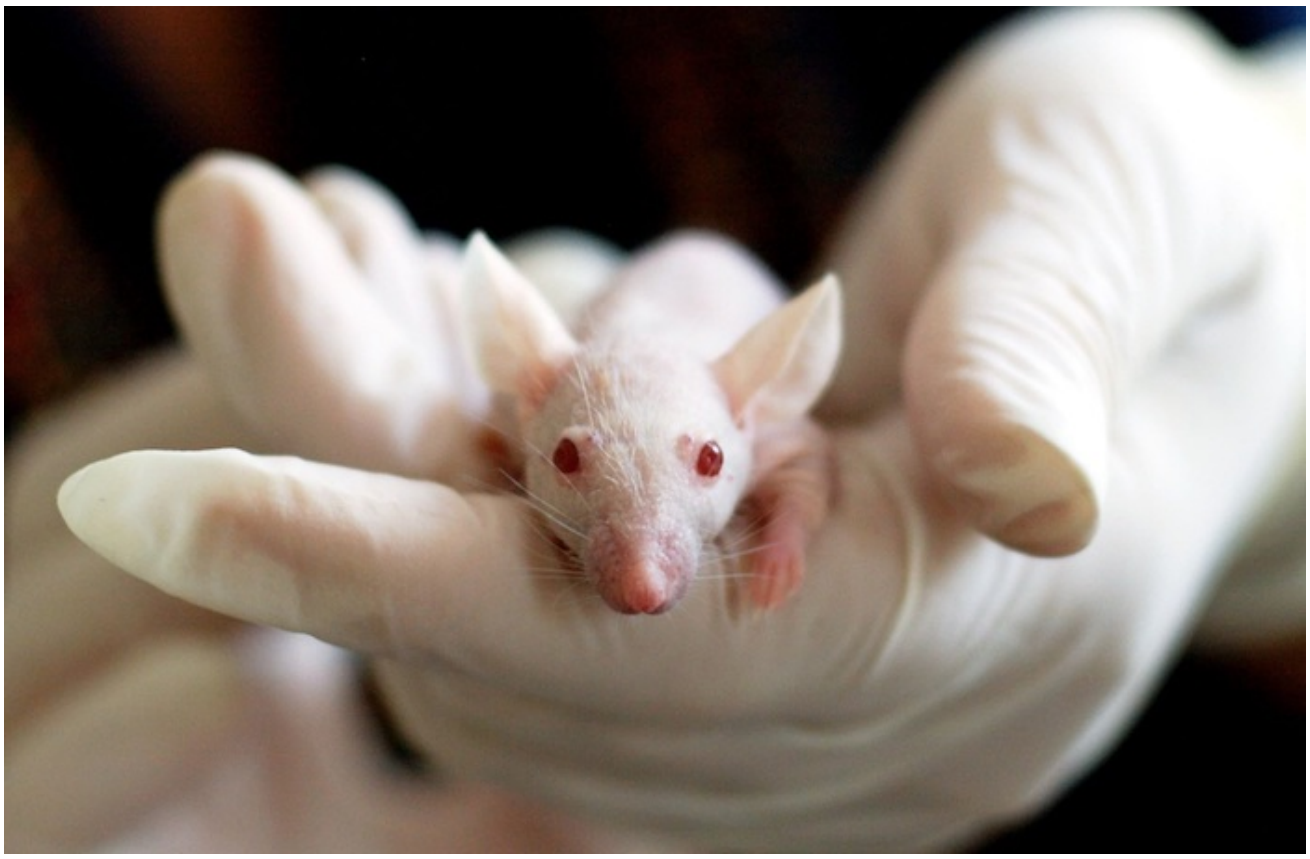
Image Credit: Thomas Richter

For Patients, “Trust Me” Is No Longer Good Enough for Medical Decision-Making

written by Robert McNutt, M.D. | April 6, 2017



It’s time to rethink ideologies of medical care that no longer make sense. The following may sound revolutionary, but are nonetheless true:

- Patients are the future leaders in medical care.
- Patients must and can make their own medical decisions after being informed.
- Patients can and must learn to discern useless from useful information.
- Science must improve to match the increasing abilities of patients.

At present, none of these concepts are fully embraced by the business of medicine and, in fact, may be a 180-degree reversal from the way things work now. So, why are these statements important? Because getting the best health outcomes, those that weigh benefit and cost, depends on a new role for the patient

as decision-maker.

Unfortunately, in the current environment, it is very difficult for patients to make those decisions. That must change. This is the first in a series of occasional posts about what consumers need for intelligent and cost-conscious health decisions.

Treatment Option Discussions Require Reliable Data, Not Emotionally-Laden Words

Patients need to understand their medical problems and related choices for managing their health. But discussion of "treatment options" is often superficially used with patients. They are often simply told why a proposed test or treatment is best. A patient recounted that her oncologist proposed radiation for breast cancer because it would "clear tumor," and it was "imperative" to clear tumor to "limit" the chance of recurrence. This conversation can be viewed as offering reasons; "clearing tumor," "imperative" and "limit" are words of size and intent.

These words conveyed nothing, however. She asked, "What do you mean by limit?" The physician said, "Reduce the chance of recurrence from 50 to 10 percent, a 40 percent difference." That sounds like better information; it is numeric, it is tangible and it has meaning. But it was incorrect (the actual difference for this patient's chance of recurrence was 5 percent, and the physician had either forgotten or exaggerated the results.).

Presenting information with numbers instead of non-specific words is essential, but not the standard for communicating with patients. The reason it is not a standard is that the numbers

may be useless. For example, what if benefit information is derived from weak studies? What if the information is based on average population estimates rather than an individual's peculiar circumstances? Population health, after all, should be the accumulation of best decisions made by individuals.

It will benefit patients to become aware of what medical information is most likely true, as much is not. This is a bold statement; many claim that patients can't and shouldn't need to understand medical information. They should trust the medical system to provide tests and treatments that are proven to produce more benefit than harm from the patient's perspective. Unfortunately, this is a specious argument. There are too many conflicts of interest for those interpreting medical information.

Even a High School Student Can Learn and Understand Medical Information

It is my belief that patients can attain the skills needed to scrutinize and assess the quality and relevance of medical information as a basis for informed decisions about their treatment options.

I requested a high school student to assess a paper suggesting that patients cared for by a woman physician while in the hospital have a lower chance of dying in 30 days after being admitted. I gave the student some ground rules for thinking about a research study:

1. A study must ask a reasonable question.

   The question, if answered, must have a "do something about

it" solution.

2. Consider problems with measurement; if compromised, science is precarious.

First, examine how the study population's data was collected.

What is the source of data?
How was the data sampled and collected?
Was the data for the study obtained with the question in mind or does the study expediently use data collected for other reasons?
How many people are in the study?
Do the characteristics of the patients in the study resemble you?

Second, are the items being studied and the outcomes measured accurately and reproducibly?
Third, what personal, patient factors, if not balanced in compared groups, may make one option look better than it really is?

3. Does the study type assure that the item being studied is solely responsible for the better outcome?

Is it a randomized study? If not, the study is likely not clinically credible.

4. What is the average and range of estimates for the absolute difference between the compared options?

Is the difference clinically significant?

5. Interpret the study results.

   Is the study result likely true or false?

After discussing these guidelines, I told the student about the study and showed her the tables and the abstract. Here were her answers to the above questions about the study:

1. Study question?

   This is not an actionable study question. What could we do if we found that a woman physician's care for a hospitalized patient might lead to better outcomes? Would we demand only women care for admitted patients?

2. Measurement issues?

   Women and men are likely correct measures.
   Women cared for only 30 percent of the patients. Physicians, then, could not have been randomized to days of care in the hospital.
   The student noted it is not certain if the named physician actually cared for the patient. She told me of her experience. Her mother's hospital bill was from a physician who saw her only one of the four days.
   The student also asked if residents took care of the patients. Recounting her mom's care again, she said that only residents spent time with her mother. (In fact, in the study, 29 percent of women worked in academic medical centers versus 21 percent of males, raising the possibility that women physicians more likely had residents sharing in care.)

3. Study design issues?

   The student asked about the data; I told her that it was not collected for the explicit reason of the study question.
   She noted that the patients were all over 65 years of age and wondered if it would be the same for other patients.
   The study was not a randomized trial (cross-sectional, observational trial).

4. Difference in outcome?

   The difference in the main outcome measurement, 30-day mortality, was minuscule and rounded to equivalent mortality rates for patients treated by women versus men (11.07% [women] versus 11.49% [men]).

5. Interpretation?

   The language used in the study suggested women were better physicians, despite the study design not being able to determine that.
   The student thought the study showed equivalent care but thought there were measurement problems, so she could not be sure. She did not believe care was better with women.
   She summarized: there is nothing we could improve if the study is true, the data were not collected for the question at hand, and the difference in mortality was “really small.”

In short, she nailed it. These astute and correct “critical appraisal comments” were made by my high school student after one half-hour chat about medical studies.

Patients Have a Right to Know the Truth and Applicability of Data for Decisions

I am using this example to reveal the goal of medical care communications. Each of us must learn to critically assess information provided by physicians or the media. The media took to this study like a duck to water and discussed it as factual, which it is not (we can't say for certain that care is better with women).

Patients, when being informed about their care options, should be taught how to discern useless from useful information. It is equally important that patients know if the information they use is true for them as well as how to use the information for their decisions.

Patients, in my view, have the right and the ability to be discerning. If patients were taught to be discerning, they might open a path to a more obliging system of care. Patients may demand better studies and become aware of biased interpretations. Indeed, patients, in my experience as a physician, are better at knowing the value of information than those in the "system" who are promoting it. Patients, after all, face the consequences of their choices; no one in medical care can share a patient's outcomes. As we shift who is in control of medical decision-making from physicians to patients, we will need to ensure that patients are educated in the skills of medical decision-making. Informed patients making educated decisions is a requisite step to better care.

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

Image Credit: tiburi

Turning Patients into Health Care Consumers—For Economic Survival

written by Theresa Hush | April 6, 2017

If we want to help people take better charge of their health—both physically and financially—we should start by treating them as real consumers, instead of patients. While that may seem like a simple change in terminology, it is anything but.

A Patient Is a Recipient of Services, Not the Actor

Health care organizations often work hard to welcome patients and provide as many services as needed. They design facilities to be comfortable, and there are often superb training programs for staff to be courteous, communicative, and to make patients

comfortable.

But let’s be honest. Health care is a business concern, and the primary actors in the business are physicians. They don’t just deliver care. They have rank in their organizations that is based on how much they contribute to the business in revenues, volume of patients and reputation. The services that are delivered also follow financial principles. To cite just one example, although many patients prefer to talk to their physicians and get treatment by a phone call, providers will not do so unless there is reimbursement for telephonic services.

Patient scheduling, treatment flow and most health care decisions are made by providers. Unless patients are prepared to be forceful about knowing and deciding on every aspect of their care, they are expected to fall in line with the provider’s plan, which usually starts with the words, “What we need to do is . . .” Ask any patient who circles up parking garage ramps, past reserved physician spaces to the public spaces on the roof: Who is at the center of this health care organization?

There cannot be a “patient” without a provider. The provider speaks of “my patients,” and feels both responsible for them and takes on the role of steward. It is a heirarchy embedded in a personal relationship, in which the physician is really parent, and the patient compliantly follows instructions.

The Future of a Health Care System Based on Patients Is Financially Bleak for All Involved

The future is clearly headed toward more patient responsibility and patient-borne expenses as a means of holding down costs for employers and governments. On the employer front, human resource professionals are being advised to create avenues to transfer costs to employees or to put a limit on contributions. For both Medicare and Medicaid, there is a strong push toward health spending accounts, vouchers and block grants to limit the automatic escalation of expenses.

For those people who will be seeing increased deductibles, copays or cuts in coverage, however, there are no guides to help them lower their health care costs. Currently, many individuals seeking medical treatment beyond their means resort to budget cutting tactics: avoid care, delay tests, wait out symptoms, or don't pay health care providers for services they received.

Let the seller beware: As financial pressures increase, those same people may become activists, forcing health care organizations to be more responsive. Take a look at what millennials are doing to change how businesses are structured and located, with a move to return corporate headquarters to urban centers where more young employees want to live. As those same millennials age and begin using health services at a higher rate, it is almost certain that they will demand online scheduling, telemedicine and customized treatment designs. They will demand research and information, as well as options for treatment.

The millennials—and others impelled by busy lives and financial

responsibility—will not be mere patients. They understand that businesses face competition, and they are used to demanding and getting what they want. They will act like health care consumers, because they will choose health care organizations that can meet their needs. Indeed, information and data-savvy millennials will most likely invent the technology and tools to identify those organizations.

Equally as significant, millennials will soon be taking a lead role in the care of their Baby Boomer parents. All of their ideas and demands for managing their own care will extend to that population, as well.

It's time to prepare for a sea change in the management of the "patient" enterprise.

Meeting Needs of Health Care Consumers Requires a Tectonic Plate Shift

Creating a system that will meet the needs of actively engaged health care consumers will involve a reengineering of health care systems:

- Accessibility. Health care consumers are as busy as providers and will require more immediate access to scheduling, as well as care, at lower cost. A few operational areas and systems that must change include:
  - Scheduling for physician and other provider appointments, diagnostic tests and procedures must be more consumer-friendly and online whenever feasible, and include the capability for bundling one or more of these services. Telemedicine in place of physical appointments will be

essential. IT workers are not going to take time off to take a parent to the physician and wait prior to seeing providers. They also will not be willing to meet a mandated visit schedule when they can provide their own clinical information online for review by a provider, or use other, cheaper options.

Alternative providers must be integrated into delivery systems to lower cost. Walgreens, Walmart and CVS, for example, have taken over many primary care functions at much lower cost to consumers. Not many people will get vaccines at a physician's office when they can do so at one-fourth the price at an alternate provider. Health organizations need to develop relationships with these entities for continuity, or develop more cost-effective options, like airlines' new cheap seats.

Records availability. In the view of many patients, health care systems hold their personal clinical data hostage. Patients need to pay money, in some cases, to get their information, and, at a minimum, must go through administrative hassles to obtain it. If they pay for a test almost anywhere, they don't get immediate access to it without waiting for the physician to review and clear the results. These are all signs of discrediting actively engaged health care consumers who believe they have a right to their own information, especially when they are paying for it. Providers should be planning for the distribution of data to patients and reassess the costs they charge consumers. Failing to do so will only speed up the scenario that is almost certain to develop: a patient-held, comprehensive clinical record, constructed from providers' contribution of data, but held and controlled by the patient in a cloud database.

Access to information, data and research. Providers may cringe when patients come in with Google-researched issues, diagnoses and treatment options. But they should understand that patients do not have access to the same information that physicians do and figure out how to make research results data available. Research studies are simply not accessible on a universal basis without a cost or subscription. Health care systems need to create better access to medical studies—as well as allocate a time and process for deliberation with patients. In addition, providers are well advised to invest in their patients' medical literacy and understanding of clinical protocols, and to teach them evidence-based medicine. That is the foundation for intelligent shared decision-making and the solution to better outcomes at lower costs.

Shared Decision-making. Health care consumers want to make prudent decisions, and they need full information to do so. It will no longer be enough for providers to lay out a pre-determined plan, no matter how confident the provider is in its outcome. At a minimum, the consumer needs to understand the benefit and harm of the proposed treatment, as well as alternatives, and the real, total cost of each option. The provider needs to encourage, not discourage, the patient from seeking outside information. Health care isn't a test of loyalty to a provider, and better outcomes will come from the patient's commitment to the course of action.

Pricing. The old cost-based pricing does not work for consumer decision-making. We all know that charges are pretend, and the real prices are negotiated with the insurer or other payer. That makes it almost impossible for consumers to predict cost prior to treatment. This is unacceptable when they must pay a large portion of the cost

> and should be making informed decisions among treatment options. Health care providers, who have better information about their contracted prices, as well as expected services in an episode, should develop systems that will provide calculated episodic costs to patients for comparison among treatment options.

As the health care industry prepares for the transition of purchasing power to consumers, we also have a responsibility to ensure that we enable consumers to make good decisions. Our assistance is required to foster a demand for evidence and communication, so they can make choices based on benefits, cost and personal values. A responsible partnership with patients does not mean an open ticket to any services promoted by vendors or to drugs inappropriate for the patient's condition (e.g., antibiotics or opioids). It does mean that we respect a person's prerogative to know and to steer his or her own life and health.

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Image Credit: skeeze

Roji Health Intelligence's Roji Registry Earns ONC-Health IT Certification from Drummond Group LLC

written by Theresa Hush | April 6, 2017

Roji Health Intelligence has reached another milestone, enhancing Solutions to help providers achieve better outcomes and lower costs.

Roji Registry has earned Office of the National Coordinator for Health Information Technology (ONC-Health IT) 2015 Edition Health IT Module Certification via Drummond Group LLC, an Authorized Certification Body (ACB). See details here.

Why ONC-Health IT Certification is Important to Current and Future Roji Health Intelligence Clients

ONC-Health IT Certification provides Roji Health Intelligence with additional capabilities for streamlining performance measurement and improvement. This is especially important for the Roji Health Intelligence Qualified Clinical Data Registry (QCDR), which has unique advantages for multi-specialty groups

trying to manage under MACRA and move toward a financial risk model.

Special benefits of ONC-Health IT Certification for Roji Health Intelligence QCDR Clients include:

- Expanded Measures for Roji Health Intelligence Reporting. Roji Health Intelligence will be able to report EHR measures in addition to Registry measures for MIPS. This will ease the reporting burden for clients while still retaining the maximum data needed for performance improvement. Integrating both medical record measures as well as other performance measures will help providers better centralize and manage their programs of measurement and improvement.
- Roji Health Intelligence QCDR Reporting of both sets of Advancing Care Information Measures: Advancing Care Information Objectives and Measures plus 2017 Advancing Care Information Transition Objectives and Measures. Creating full-spectrum measurement and reporting for quality enables Roji Health Intelligence to become the full command center for data used in meeting quality standards and improving outcomes across all patients.
- More robust QCDR performance improvement activities are facilitated by ONC-Health IT Certification because of availability of additional measures, such as closing the referral loop between specialists and referring clinicians. The QCDR will be able to help address network-wide referrals and offer other activities beyond the scope of EHR services, but using EHR data.
- Additional options for EHR data collection available to Roji Health Intelligence clients. In addition to other data format options, Roji Health Intelligence will also provide

the option to clients of submitting QRDA Is, which can be provided by any certified EHR.

Roji Registry ONC-Health IT Certification Details

Roji Registry has achieved Office of the National Coordinator for Health Information Technology (ONC-Health IT) 2015 Edition Health IT Module Certification via Drummond Group LLC, an Authorized Certification Body (ACB). Drummond Group has been empowered to test software for compliance with the requirements of the federal government's program. The stamp of approval designates that the software offers the functionality that enables eligible providers and hospitals to meet Meaningful Use requirements, qualifying these organizations to receive payments under the ongoing EHR adoption program.

To earn the certification, Roji Registry was tested to be in accordance with applicable standards and certification criteria put forth by the Department of Health and Human Services (HHS).

With more than 15 years of testing experience across various industries, Drummond Group LLC (DG) brings a high level of technical expertise to this process. Its healthcare experience also runs deep, having certified hundreds of EHRs since becoming an ACB in 2010.

Roji Registry Version 2016, which met the requirements for ONC Certified HIT, 2015 Edition, was tested for Modules relating to calculation and import-export of Clinical Quality Measures, Privacy and Security features, and the use of a Quality Management System. In addition, Roji Registry was tested for all Clinical Quality Standards for Eligible Professionals and

Eligible Hospitals.

The specifics of the Certification are:
Developer: George Hernandez, Roji Health Intelligence LLC
Product: Roji Registry Version 2016
Website: https://rojihealthintel.com
Address: 641 W Lake Street, Suite 103, Chicago, IL 60661
Contact Information: Partnering@rojihealthintel.com, (312) 258-8004
Contact Individual: Jackie Walton
Date of Certification: February 2, 2017
Certification Number: 15.04.04.2951.Roji.16.0.0.170202

Modules Tested: 170.315 (c)(2-4); (d)(1-3, 5); (g)(4,5)

Clinical Quality Measures Tested: 2v5; 22v4; 50v4; 52v4; 56v4; 61v5; 62v4; 64v5; 65v5; 66v4; 68v5; 69v4; 74v5; 75v4; 77v4; 82v3; 90v5; 117v4; 122v4; 123v4; 124v4; 125v4; 126v4; 127v4; 128v4; 129v5; 130v4; 131v4; 132v4; 133v4; 134v4; 135v4; 136v5; 137v4; 138v4; 139v4; 140v4; 141v5; 142v4; 143v4; 144v4; 145v4; 146v4; 147v5; 148v4; 149v4; 153v4; 154v4; 155v4; 156v4; 157v4; 158v4; 159v4; 160v4; 161v4; 163v4; 164v4; 165v4; 166v5; 167v4; 169v4; 177v4; 179v4; 182v5; 9v4; 26v3; 30v5; 31v4; 32v5; 53v4; 55v4; 60v4; 71v5; 72v4; 73v4; 91v5; 100v4; 102v4; 104v4; 105v4; 107v4; 108v4; 109v4; 110v4; 111v4; 113v4; 114v4; 171v5; 172v5; 178v5; 185v4; 188v5; 190v4

Additional Software Used: none

Additional Disclosures:

This Health IT Module is 2015 Edition compliant and has been

certified by an ONC-ACB in accordance with the applicable certification criteria adopted by the Secretary of Health and Human Services. This certification does not represent an endorsement by the U.S. Department of Health and Human Services.
Additional costs will be incurred by an EP, EH, or CAH to use the Roji Registry to meet MACRA or meaningful use objectives and measures. Additional capabilities of the Roji Registry, such as meeting MIPS requirements for Advancing Care Information, Performance Improvement Activities, and use of Additional EHR Measures, will be limited to QCDR clients. QCDR clients must purchase MIPS Solutions through a Roji Health Intelligence Services Agreement that includes these features in order to meet meaningful use and MACRA measures.

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: Julia Caesar

The Dirty Little Secret About Performance Measurement Data

written by Theresa Hush | April 6, 2017

“The data just hooks up.” That was an opening remark from a competitor applauding his company’s scoring system for physician quality. He went on to explain how this data produced

reliable scores on quality.

The idea that data hooks up and produces a true scoring system for quality is a fantasy. Not only is data itself flawed, but it doesn't always tell the exact truth. Treating data casually amounts to an off-hand dismissal of the complexity and inherent biases of performance measurement.

But here's the kicker: we need to measure performance, anyway. In fact, it's more critical than ever to measure clinical quality and costs.

Why? Because we need a starting point. Both providers and patients require data for decision-making, even if it is flawed. And, there isn't any other way to calculate where we are on using various evidence-based protocols, what our potential cost or quality issues are, or variance among providers. We just need to be honest about what the data really says.

Translation of performance measurement directly into scores is inappropriate. The stewards of large patient databases must safeguard the rules of performance measurement and not oversell the technology. Resulting outcomes begin the inquiry; they should not be used to turn results into immediate provider penalties.

The Truth About Data

How can data lie? To answer this question, we need to go back to how and where information is being directly captured and entered into databases.

Most identified patient data comes from one or more of three sources:

- Billing records from providers or billing companies;
- Clinical data in an EMR;
- Claims data from health plans or other payers, including all services for a population of patients for which employers, ACOs or providers of patients are responsible.

Billing data emanates from the provider and contains only those providers' services. Claims data from payers, on the other hand, will include all providers' charges for the covered patients, so that you can construct a comprehensive view of services received by a particular patient. Through the use of both provider-sourced data and claims data, more comprehensive profiles of both providers and patients can be developed.

Common among all these data sources is that each data element is entered by a human at or after a patient encounter. It then may be modified further with additional information, such as lab values obtained later, or by other individuals managing the patient or the record. The human input of the data creates a possibility of error, and the most common errors are:

- Inconsistent patient demographic data between records, including different spellings of names, wrong birth dates and gender;
- Incorrect coding of diagnoses and procedures;
- Inconsistency in the use of the EMR template itself, so that services or data are recorded differently than they actually occurred for the sole purpose of attaching a procedure code.
- Readings that vary by location of care, position of the

patient, or who is performing the service. Blood pressure is a notorious example; wide swings in blood pressure values result from where and how the blood pressure is taken. Data that is missing altogether for patients.

EMR technology may also introduce data problems. For example, codes may be out of date (yes, this frequently happens), or the EMR itself may be structured to use reporting codes (such as G-codes or Category II codes) as opposed to discrete values, so the actual "measure" values may be imprecise. Contrary to what proponents contend, getting data from an EMR does not make that data "better," for all the reasons above. EMRs simply make data more accessible.

Finally, the transmission of data could be flawed. For a variety of reasons, the data expected to be in a particular table of the database is elsewhere. The data harvested would be therefore incorrect or missing.

Diverse Patients Also Bias Population-based Results

Aside from true data errors, comparing performance measures across providers introduces other issues. Patients have different genetic makeups as well as different risk factors and variations of disease. They come from different environments and have a varying ability to pay or manage treatment regimens. And they may have different belief systems that affect measurement results.

Grouping patients for performance will always be inexact, and no amount of risk adjustment will fix that. Again, it's good to start an inquiry with population-based results, but applying

those results to scores is not a good fit.

The evaluation of outcomes, as opposed to process measures, is, ultimately, a patient-by-patient process. Measuring population-based results provides questions but not enough answers to serve as “scores” of quality. This means that there must be a capacity within performance measurement and improvement for input by the provider and/or patient so that the results can be explained.

Measures Have Problems, Too

If all these issues weren’t enough to dispel an idea of the perfect measurement system, take a look at the measures themselves. Most performance measures are still “process” and not outcome measures. What they are measuring is whether or not a medical service was provided. For example, there is a measure of how many patients meeting eligibility criteria have colon cancer screening. Patients may get this service anywhere, so the measurement is always insufficient to explain what the provider’s results are across a population. This and similar measures for preventive services are almost always incorrect if taken literally.

In addition, outcome measures themselves can be problematic. For example, recent research into one of the most common outcome measures for patients with diabetes, HgBA1c levels, finds that the actual levels may be less important than the medication used to control hemoglobin levels.

Also important is the absence of measures related to outcomes—complications, redos and infections are just a few surgical measures left out of all but customized programs.

Physicians largely do not consistently code such problems, and yet they are clearly indicators of trouble.

Some measures also create unexpected results, such as inappropriately higher-cost follow-up services. A few years ago, ductal carcinoma in situ was demoted as a form of breast cancer that always required treatment. Improved imaging technology, coupled with higher rates of measurement, had an unintended effect of increasing the number of cancer diagnoses and surgeries.

The Measurement Process Itself Compounds Errors

The truth of the matter is that the following are inherent weaknesses in the process:

> Providers want something quick and dirty, mainly because they don't see measures as meaningful. They often don't have the time or interest to even look at their data.
> Payers are looking for a label of quality to demonstrate concern, and the accuracy of the information is secondary.
> Hidden financial interests corrupt the measures themselves.
> When the research backing up guidelines/measures may not be fully reported, how can we blame providers for lack of commitment?
> Who pays for provider measurements? Providers. This is backward; the measurement should be more independent.
> Provider fear of measurement fosters extreme reactions that may undercut the measurement process, depending upon the penalties, rewards or public disclosure involved.

How to Make Performance Measurement More Accurate *and* More Relevant

Regardless of limitations, measuring performance is now a necessary process in the industry. It usually has widespread support from health systems (although not necessarily providers), and is required by Medicare and many private payers.

But how do we make these efforts more meaningful and relevant?

> Focus on measures of clinical significance to providers. Measures are often delegated to administrators and other office staff because physicians considered this a “Mickey Mouse” process task. To engage providers in real progress, focus on outcome measures that matter.
> Lay out the measures in a performance improvement inquiry, rather than using them as scores. The fact is that we don’t know what accounts for variation between providers or patients, and thus we should be questioning that legitimacy.
> Collaborate instead of legislate. If performance measurement is meant to lead to improvement, it should not be part of a scheme to legislate behavior. Care processes and outcome measures should be distinct, and outcome measures—which can include cost-related outcomes—deserve the investigation of alternatives for improvement.
> Seek more data. The questions raised about the performance must be answered, and it will almost certainly lead to more data, probably from patients or their caregivers. That’s normal and it is an opportunity to involve those patients in improving their results.
> Measure provider engagement, collaboration and

responsiveness. Make it a top priority to help providers focus on their data and participate in improvement projects. Share results among teams. Improving performance requires the sharing of success stories and tactics that work. Change is social, and the technology you are using should be able to accommodate a dynamic process.

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Image Credit: Ryan McGuire