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

written by Theresa Hush | April 20, 2017

Do consumers and other health care purchasers have the ability to choose providers based on quality and cost? That's the assumption beneath attempts by Medicare and health plans to

reimburse providers based on their ability to deliver better quality while constraining costs. Value-Based Health Care also includes programs by commercial insurance to offer "narrow" provider networks that select physicians and hospitals by performance.

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

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

Can Consumers Choose Doctors Based on Quality and Cost Scores?

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

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

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

Consumers may never have the tools for choosing providers that will ensure their health care is high quality and affordable. This adds to other missing pieces of information that consumers need if they are to make smart and cost-effective decisions, such as knowing prices and having access to clinical information (including their own).

Why Do Current Performance Rankings Prevent Reliable Provider Comparisons?

Medicare's MACRA-based MIPS program, the successor of previous Medicare programs for physicians to report quality and compare quality and cost, is the largest scale effort to evaluate and rank physician quality and cost. In its first year of implementation, MIPS uses hundreds of

quality measures, vetted by physician specialties, to assess quality performance. The measures include both process measures (services that patients should get based on risk factors, such as age, condition or procedure) and “intermediate” outcome measures that identify the health status of the patient (such as blood pressure control). In addition to quality, MIPS also uses sophisticated algorithms for determining the costs generated by physicians.

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

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

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

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

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

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

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

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

Stakeholders have put the wrong emphasis on performance measurement since quality-based

reimbursement began, interpreting results as “scores” and punishing providers. Rather, performance measurement should be understood as a powerful tool for identifying variances in care, lack of adherence to evidence-based practices, and areas for improvement. At the same time, those activities must always acknowledge and seek to improve the underlying flaws in documentation and data, and try to incorporate more investigation into the process.

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

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

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

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

How Can Consumers Identify High Value Providers?

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

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

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

quality and cost scores.

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

> How consumer-friendly is the office in scheduling, communicating with you, and connecting you to the physician or nurse when you call?
> How willing is the physician to help you meet your goals, even if the physician doesn’t share them (e.g. running a marathon)?
> Does the provider participate in measuring performance, and how? What is the physician’s attitude toward performance measurement?
> What data does the provider review with respect to your health status? He or she should be able to tell you where you stand in your clinical status compared to other patients, so that you know your actual outcomes are being tracked over time.
> How willing is the provider to vary treatment recommendations based on your preferences, including cost, conservative or aggressive approach, or other factors?
> How does the provider keep up with the latest research? Have him or her explain that process, because medical knowledge is changing quickly.
> Does the provider allow automatic release of test results, or does the provider insist on explaining those to you first?
> Does the physician electronically prescribe medicines? This is a quality measure and helpful to you.
> Will the provider ensure that all referred services, including diagnostics, are covered by your insurance?
> What criteria does the provider use to choose providers for referrals?
> If you have a condition requiring follow-up with a specialty physician or testing, does the office facilitate or coordinate that appointment to cut the time for you to be seen?
> Will the provider or office provide total cost of treatment to you? Are there episodic pricing packages?

Assessing provider value will not be a scientific exercise of comparing provider scores. But the pathway does not need to be subjective, either. These questions identify specific areas where the provider-patient partnership will produce predictable costs and better outcomes because both parties are engaged.

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

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

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

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