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DEVELOP A DATA STRATEGY TO EASE THE TRANSITION TO PAYING FOR VALUE IN HEALTHCARE

by Gienna Shaw

The healthcare industry reached a key milestone in its push to tie payment to quality of care when the Centers for Medicare & Medicaid Services (CMS) issued the final rule implementing the Medicare Access and CHIP Reauthorization Act (MACRA). With the release of the final rule, CMS has greatly accelerated the shift toward risk-based reimbursement.

The agency's position as the largest payer in the U.S. healthcare industry only increases the momentum of a movement that has been underway on both the public and private sides of the commercial space for some time, as stakeholders look toward financial incentives that prioritize high-quality care over the volume of services delivered.

The magnitude of this shift requires healthcare stakeholders to consider fundamental changes to all aspects of their operations. In particular, organizations must rethink the ways they manage and use data as they seek more efficient ways to deliver, pay for and measure the quality of care they deliver.

THE EVOLUTION OF MACRA

In essence, MACRA evolved to address a practical concern, according to David Nace, M.D., chief medical officer at MarkLogic, a global technology company headquartered in Silicon Valley. Medicare's sustainable growth rate (SGR) tied physician reimbursement amounts to a rate far less than the rate of healthcare inflation. Congress developed MACRA as a way to replace the SGR, and, in the process, took advantage of a broader industry trend advancing what the Institute for Healthcare Improvement dubbed the Triple Aim: improving the overall quality of healthcare in the U.S., reducing the cost of care and improving patient satisfaction. Because of this, MACRA functions not only as a replacement for the SGR, but also as a tool to accelerate the ongoing shift in reimbursement from the legacy fee-for-service model to a model that pays clinicians based on the efficient delivery of high-quality care.

Dr. Nace likens complying with MACRA to getting on a highway, with MACRA's practical implementation representing the paths providers can take to get up to speed. In this analogy, MACRA's first track, the Merit-Based Incentive Payment System (MIPS), represents an on-ramp allowing providers in different stages of readiness to get used to the reporting burden demanded by risk-based reimbursement without taking on the full risk required to participate in a full-blown pay-for-value model. MACRA's second track, participation in various Alternative Payment Models, allows clinicians who already have such capabilities in place to jump right onto the highway.

The magnitude of MACRA's impending changes has raised alarms given the relatively short timeline for the law's implementation. Providers and advocacy groups have successfully lobbied to expand the window of time during which providers will need to figure out their best options within the new system and how they will begin to submit the appropriate information to CMS. Clinicians have also been very vocal about their concerns regarding the reporting burden they see taking shape in the MACRA implementation. In response, CMS provided new pathways for organizations to comply with MIPS at a pace more suited to developing their reporting capabilities.

PAYING FOR VALUE REQUIRES DELIVERING THE RIGHT DATA AT THE RIGHT TIME

The concept of paying for value requires a shift in thinking. The industry needs to define "value" in a way that makes it possible for providers to meaningfully measure and report on it. Regardless of how it's measured or reported, paying for value requires both payers and providers to use, share and analyze data.

For all its faults, the legacy fee-for-service system made for easy reporting, since it tied a single activity to a single payment. Nearly any other model requires providers and payers to collect, track, manipulate and report a substantially larger and more varied set of data. "You can't do any of this without data," Dr. Nace points out. "You have to be

able to measure quality before you can tie it to the way you deliver and get paid for care. You need to be able to figure out how this is all going to work, to figure out where you can collect data, figure out which model to participate in and which quality measures you can track. All of this requires data."

At the same time, healthcare reform has moved care delivery from a provider-centric system to a patient-centered one. That change in focus also impacts the data providers collect. "As a physician or as a health system delivering care to a population, your data will need to be centered around the patient and population. Currently, data exists in silos tied to each individual healthcare provider. These changes require a totally revolutionary way of thinking about how you collect data, what data you have, and how you use it," says Dr. Nace.

In fact, he points out, medical practices have become increasingly data-driven over the past decades, whether doctors have noticed it or not. The legacy standard of medicine for hundreds of years involved a visual examination and a set of fairly rudimentary tools. Today, we deal regularly with common diseases and conditions that are impossible to identify or quantify without data, such as hyperlipidemia. "You can't see it. You can't ask somebody about it. It's a measured quantity done from a test—it's a data point," Dr. Nace says. What's more, in order to address the disease, a cardiologist might take advantage of a range of information drawn from other historically "non-traditional" sources, such as data from a wearable activity tracker, biometrics or a portable cardiac monitoring device.

If a physician's practice represents a car coming up to speed to get on the quality-of-care highway, data represent the fuel the practice uses to get there. In that context, implementing a data strategy means configuring the engine to generate the best possible fuel economy.

Providers have also begun to look beyond traditional clinical data sources to augment care delivery and improve care quality. At the level of population health, data on socioeconomic and behavioral factors correlate strongly with both the presence and outcome of certain chronic conditions. Real-time information available on the Internet can even yield information on drug interactions that used to only be available after long trials or evaluations. According to Dr. Nace, "there is a bit of a quiet revolution going on where physicians are moving from what has been a long-standing legacy practice of medicine to what is now becoming a data-driven practice of medicine."

To extend the highway metaphor, if a physician's practice represents a car coming up to speed to get on the quality-of-care highway, data represent the fuel the practice uses to get there. In that context, implementing a data strategy means configuring the engine to generate the best possible fuel economy.

KEY ELEMENTS OF A MODERN HEALTHCARE DATA STRATEGY

With all this in mind, a successful healthcare data strategy has to cope with a number of challenges:

- Both providers and payers must **efficiently handle a huge volume of data.** Rock Health expects the volume of healthcare data to reach 25,000 petabytes by 2020. As data volumes increase, the efficiency penalty for piping data from system to system grows, as does the potential for mistranslation when data get copied from application to application.
- Data strategies must **handle heterogeneous data** generated by the proliferation of non-traditional

patient-centric and population-centric sources, such as income, education, housing and social services data, all of which are increasingly being incorporated into alternative payment models.

- Information must be **stored and handled securely,** to maintain regulatory requirements and to ensure patients' peace of mind. The recent spate of ransomware attacks have drawn additional attention and innovation to this key area, according to John Sotos, M.D., worldwide medical director at Intel Corporation.

- The underlying technology must facilitate interaction with the data by supporting **ease of search and reporting.** As CMS Acting Director Andy Slavitt put it, "the burden needs to be on the technology, not the user," which means new technology has to fit comfortably with clinical workflows and support clinicians' goals.

- Technological advances in both hardware and cloud technology make a **data-centric architecture** an avenue worth exploring. Such systems eliminate the requirement to move and copy data between applications, which in turn eliminates inefficiencies that stem from shoehorning data into rigid rows and columns. This results in shorter development cycles, making it easier for healthcare stakeholders to adapt to a rapidly changing landscape and shifting business needs.

THE DATA-DRIVEN FUTURE

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A healthcare system that rewards high-quality care is a healthcare system that relies more heavily on data than ever before. No matter how MACRA unfolds, providers and payers that plan and execute a flexible, efficient data strategy will find themselves best prepared to meet the challenges of transitioning to risk-based reimbursement.